Bundle Quality, Safety & Experience Committee 19 November 2019

9.30am Boardroom, Carlton Court, St Asaph, LL17 0JG

V2.0

1.0 OPENING BUSINESS AND EFFECTIVE GOVERNANCE

1.1 QS19/158 Chair's Opening Remarks

1.2 QS19/159 Declarations of Interest

1.3 QS19/160 Apologies for Absence

1.4 09:30 - QS19/161 Minutes of Previous Meeting Held in Public on the 24th September 2019 for Accuracy, Matters Arising and Review of Summary Action Log

QS19.161a Minutes QSE 24.9.19 Public V0.02.docx

QS19.161b Summary Action Log QSE Public Live.docx

1.5 09:45 - QS19/162 Patient Story : Mrs Deborah Carter

QS19.162 Patient story Primary Care November 2019.docx

1.6 09:55 - QS19/163 Quality and Safety Awards and Achievements : Executive Directors

Verbal updates

2.0 FOR DISCUSSION

2.1 Performance Reports - Mr Mark Wilkinson

2.1.1 10:00 - QS19/164 Annual Plan Monitoring Report

Recommendation:
The Quality, Safety & Experience Committee is asked to note the report and to assist in addressing the governance issues raised.

QS19.164a APPMR Coversheet September 2019 FINAL.docx

QS19.164b Annual Plan Progress Monitoring Report - September FINAL3.pdf

2.1.2 10:10 - QS19/165 Integrated Quality & Performance Report

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

QS19.165a IQPR coversheet.docx

QS19.165b IQPR.pdf

2.2 Item Deferred

2.3 10:30 - QS19/167 Advanced Paramedic Roles and the Development of Multidisciplinary Teamworking : Dr Chris Stockport

Verbal update

2.4 10:35 - QS19/168 Infection Prevention : Second Safe Clean Care review by Jan Stevens (May 2019) : Mrs Deborah Carter

Recommendation:
The Committee is asked to note the report and the resources required to address the recommendations and sustainability for Safe Clean Care campaign.

QS19.168 Infection Prevention.docx

2.5 10:50 - QS19/169 Corporate Risk Register and Assurance Framework Report : Mrs Deborah Carter

Recommendations:
The Committee is asked to:
1. Consider the relevance of the current controls:
2. Review the actions in place and consider whether the risk scores remain appropriate for the presented risks:
3. Approve the 2 risks for escalation onto the Corporate Risk Register.

QS19.169 CRR final 12.11.19 1426.docx

2.5.1 11:10 - comfort break

2.6 11:15 - QS19/170 Listening and Learning from Patient and Service User Experience Report : Mrs Deborah Carter

Recommendations:
The Committee is asked to note the report.

QS19.170a Listening and learning report coversheet.docx

QS19.170b Listening and learning report.docx

2.7 11:35 - QS19/171 Safeguarding and Protecting People at Risk of Harm : Mrs Deborah Carter

Recommendations:
The Committee is asked to:
1. Note the progress made this year by the Corporate Safeguarding Team, particularly in relation to the implementation of the HASCAS/DO recommendations.
2. Note the significant improvement of the Quarterly Assurance work within Corporate Safeguarding, supported by the Organisation and evidenced within the National Safeguarding Maturity Matrix (SMM).
3. Note the emphasis of the Corporate Safeguarding Team to implement and evaluate continual improvement through developing benchmarking, peer review and identifying data led areas for improvement in an open and transparent way.

QS19.171a Safeguarding_coversheet and exec summary.docx

QS19.171b Safeguarding report Q1 and Q2.docx

2.10 11:50 - QS19/174 Children's Services - Healthcare Inspectorate Wales' Thematic Review : Dr Chris Stockport

Recommendations:
The Committee is asked:
1. To note the progress that is being made to services for children, young people and their families.
2. To note the actions being undertaken to address the recommendations within the review.

QS19.174a HIW Thematic Review_coversheet.docx

QS19.174b HIW Thematic Review Sept 2019 v03 reformatted.docx

QS19.174c HIW Thematic Report C&YP.pdf

2.11 12:05 - QS19/175 Mental Health Services - Quality & Performance Assurance Report : Mr Andy Roach

Llinos Edwards (Service Improvement Facilitator) to attend

Recommendations:
The Committee is asked to note:
1. The progress that is being made to Mental Health and Learning Disability Services, specifically as requested in relation to:
• Benchmarking information against the Cefni report
• NHS Benchmarking local analysis
• The analysis of mortality in West area team [Gwynedd] and early findings and update on mortality as a result of incidents across the MHLD Division
• Position in relation to MHLD policies and procedures
• Trajectories for implementation of the Together for Mental Health strategy and operational plan
2. In addition the report also updates QSE Committee on
• Improvements and compliance with Mental Health Measure
• Lessons Learned from incidents
• Recent HIW inspections & outstanding actions
3. The risks that are identified are being managed through locality structures and overseen by Divisional Directors
4. Trajectories for implementation of Together for Mental Health Strategy

QS19.175 MHLDS Quality Performance Report.doc

2.12 12:25 - QS19/176 Mortality Surveillance Report April to September 2019 : Dr David Fearnley

Recommendation:
The Committee is asked to note this report and seek any further assurance.

QS19.176a Mortality.docx

QS19.176b Mortality CHKS Appendix.pdf

2.13 12:40 - QS19/177 Primary & Community Care Assurance Report : Dr Chris Stockport

Recommendations:
It is recommended that the QSE Committee:
Part 1:
1. Reviews the core indicators and notes the actions taken;
2. Notes the new Quality Assurance Improvement Framework (QAIF) requirements of the General Medical Services (GMS) contract and considers any related future reporting requirements;
3. Considers any further detail that they may require for future reports;
4. Considers any 'focus on' topics that the Committee would find useful.
Part 2:
1. Note the overarching approach to improving quality and assurance supported by the National Commissioning Collaborative Unit (NCCU).
2. Endorse the ongoing work to develop a single quality monitoring tool and a single care home action plan.
3. Approve the report for submission to Welsh Government as mandated.

QS19.177a Primary Community Assurance Report_coversheet.docx

QS19.177b Primary Community Assurance Report Part A.doc

QS19.177c Primary Community Assurance Report Part B CHC.pdf

2.13.1 13:00 - comfort break - attendees to bring their own lunch

2.14 13:20 - QS19/178 Occupational Health and Safety (OHS) Quarterly 2 Report 1st July to September 30th 2019 : Mrs Sue Green

Recommendations:
The Committee is asked to:
1. Note the position outlined in the Quarterly Report.
2. Support the proposed actions of the OHS, Security plans resulting from the gap analysis of legislative and security compliance.

QS19.178a H&S Report reformatted.docx

QS19.178b H&S Manual Handling Plan Appendix 1.pdf

QS19.178c H&S Security Action Plan Appendix 2.pdf

QS19.178d H&S Compliance Appendix 3.pdf

QS19.178e H&S SEQOHS Action Plan Appendix 4.pdf

3.0 FOR CONSENT

3.1 13:40 - QS19/179 Nurse Staffing Levels (Wales): Adult Acute Medical And Surgical Inpatient wards : Mrs Deborah Carter

Debra Hickman in attendance

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

QS19.179 Nurse staffing reformatted.docx

3.2 13:50 - QS19/180 Policies, Procedures or Other Written Control Documents for Approval

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

QS19.180a Policies coversheet.docx

3.2.1 Levels of Enhanced Care for Adult In Patients Policy : Mrs Deborah Carter

QS19.180b Enhanced Care Policy - FINAL as at 28.10.19.docx

QS19.180c Enhanced Observation Policy_EqIA.docx

3.3 13:55 - QS19/181 Quality Safety Group Assurance Reports : Mrs Deborah Carter

QS19.181 QSG report.doc

3.4 14:05 - QS19/182 Improvement Group (HASCAS & Ockenden) Chair's Assurance Report : Mrs Deborah Carter

Recommendation:
To note the progress against the recommendations to date

QS19.182a HASCAS Ockenden Review_coversheet.docx

QS19.182b HASCAS Ockenden Review_progress report final.docx

4.0 14:15 - FOR INFORMATION

4.1 QS19/183 Issues Discussed in Previous In Committee Session

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

QS19.183 In Committee items reported in public.docx

4.2 QS19/184 Issues of Significance to inform the Chair’s Assurance Report

4.3 QS19/185 Date of Next Meeting

Tuesday 28.1.20 @ 9.30am

4.4 QS19/186 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 24.9.19 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
Mrs Marian Wyn Jones	Independent Member (*part meeting*)

In Attendance:

Mrs Deborah Carter	Associate Director of Quality Assurance (*part meeting*)
Mrs Kate Dunn	Head of Corporate Affairs
Dr David Fearnley	Executive Medical Director
Mr Steve Forsyth	Director of Nursing, Mental Health and Learning Disabilities (*part meeting*)
Mrs Fiona Giraud	Director of Midwifery & Women's Services (*part meeting*)
Mrs Sue Green	Executive Director of Workforce and Organisational Development (OD)
Mr Dave Harries	Head of Internal Audit
Ms Louise Howard-Baker	Assistant Director for Medicines Management (East Area) (*part meeting*)
Mr Rhys Jones	Healthcare Inspectorate Wales (HIW) (*observing – part meeting*)
Ms Rebecca Masters	Consultant in Public Health (*deputy for Miss Teresa Owen)*
Dr Melanie Maxwell	Senior Associate Medical Director / 1000 Clinical Lead (*part meeting)*
Dr Jill Newman	Director of Performance
Dr Berwyn Owen	Chief Pharmacist (*part meeting*)
Mr Andy Roach	Director of Mental Health and Learning Disabilities (MHLDS)
Ms Emma Scott	Healthcare Inspectorate Wales (HIW) (*observing*)
Dr Chris Stockport	Executive Director of Primary and Community Services
Mr Adrian Thomas	Executive Director of Therapies and Health Sciences
Mr Mark Thornton	Chair of Community Health Council (CHC)

Agenda Item Discussed	Action By
QS19/126 Chair's Opening Remarks The Chair welcomed everyone to the meeting.	
QS19/127 Declarations of Interest None were declared.	

QS19/128 Apologies for Absence Apologies were recorded for Mr Gareth Evans, Mrs Gill Harris and Miss Teresa Owen	
QS19/129 Minutes of Previous Meeting Held in Public on the 16.7.19 for Accuracy, Matters Arising and Review of Summary Action Log **QS19/129.1** The minutes were agreed to be an accurate record and updates were provided for recording within the summary action log. **QS19/129.2** A matter arising was raised regarding children's services and the Executive Director of Primary & Community Services undertook to share a copy of the relevant Healthcare Inspectorate Wales report ahead of it being agendered (alongside the organisational response) in November. **QS19/129.3** A matter arising was raised regarding breast radiologists and the Executive Director of Therapies & Health Sciences confirmed that plans were progressing to enable the risk to be reduced in due course, with existing capacity being maximised to provide a service on all three acute sites.	CS
QS19/129 Briefing Notes Circulated to Members **QS19/129.1** Members asked that the briefing note circulated on the 3.9.19 regarding mapping of indicators from the operational plan be revisited for appropriateness, particularly around which indicators should be mapped to the other Committees, such as the Strategy, Partnerships & Population Health (SPPH) Committee.	JN
QS19/130 Patient Story **QS19/130.1** The Associate Director of Quality Assurance presented the patient story which related to a dementia patient and issues raised by her son around their experiences within the Emergency Department (ED) at Ysbyty Glan Clwyd (YGC). The story highlighted concerns around the use of the dementia butterfly sticker on the patient's bed, and the proximity of the bed to the nurses' station that had caused confusion to the patient when she overheard discussions. **QS19/130.2** A discussion ensued. Members felt it would be worthwhile investigating alternative mechanisms for identifying dementia patients (eg; coloured wristbands or dementia 'passports') but acknowledged that individuals and families may have different preferences. The Associate Director of Quality Assurance confirmed that patient safety would always be prioritised but agreed to feedback on the discussion to the Dementia Lead Nurse. It was also acknowledged there was variation across sites, particularly in community hospitals, and the availability of trained dementia co-ordinators. The Associate Director of Quality Assurance and the Executive Director of Primary & Community Services would work to develop an assurance report for the Committee.	DC DC CS
QS19/131 Mental Health & Learning Disabilities Division Exception Report *[Mr Steve Forsyth joined the meeting]*	

QS19/131.1 The Chair thanked the team for what she felt was a much more balanced, informative report. The Director of Nursing, Mental Health and Learning Disabilities (MHLDS) alerted the Committee to areas of positive progress in that the memory service in the West was the only one in Wales to achieve formal accreditation, and that the service had received positive feedback following a recent unannounced visit by HIW to Cefni Hospital. He invited comments and questions on the paper. **QS19/131.2** A question was asked regarding the timelines for actions within the improvement plan and it was confirmed that the November report would include clear trajectories for compliance. A comment was made that some of the actions appeared to be simple things which should be able to be implemented quickly without the need to pilot any arrangements, and also that many of the issues were estates related. It was reported that pilots were being carried out within a safe environment before rolling out, and that in terms of estates issues the Division was working very closely with the estates teams with appropriate escalation being made to the Director of Estates and Facilities. The Chair of the CHC noted that issues had been raised regarding documentation and record keeping which he felt were fundamental aspects of quality. It was noted that this was a consistent theme within the ward accreditation process as well and that the move from paper notes was a priority. A member enquired whether the use of agency staff or administrative vacancies was a contributory factor to poor record-keeping but it was reported that this wasn't a significant issue for the Division although there was an administrative and clerical review ongoing across the Health Board. The Director of MHLDS explained that the review of the service model going forwards includes looking at referrals from primary care and how to engage with clusters. The Health Board Vice Chair stated it was heartening to see the impact of changes being made but that more assurance was required around the delivery of the Strategy and investment within mental health for the future. The Director of MHLDS confirmed that the November paper would include further detail around the delivery plan and business case, benchmarking data and clear milestones against delivering the Strategy. He also wished to assure the Committee that there was a mitigating plan for pharmacy in the East. **QS19/131.3 It was resolved that** the Committee note: 1. The progress that is being made to Mental Health and Learning Disability Services, specifically as requested in relation to: • Compliance with Mental Health Measure • Lessons Learned from incidents • HIW outstanding actions • Milestone and measures in relation to implementation of the Together for Mental Health strategy and operational plan but requested further detail on this at the next meeting. 2. The risks that are identified are being managed through locality structures and overseen by Divisional Directors *[Mr S Forsyth and Mrs M W Jones left the meeting]*	AR AR
QS19/132 Annual Plan Monitoring Report **QS19/132.1** The Director of Performance presented the report which sets out progress against key actions within the annual plan. She suggested that the relevant reports be circulated via email on the intervening months between QSE Committee meetings. The Director of Performance also highlighted that the actions had been RAG rated and	JN

milestones included where they existed. She apologised that two of the red rated actions did not have an accompanying explanatory narrative. These related to endoscopy against which a paper was submitted to the in committee session of the Finance & Performance Committee in August setting out plans for additional capacity, and secondly relating to diagnostics which was being addressed through the work with the Interim Recovery Director and insourcing. A member asked about the update on the robotic service which was referenced in the paper and it was explained that this narrative had been included for the Finance and Performance Committee. The Chair suggested that the quality checks of this paper need to be improved. A member also asked if the format could be reviewed to ensure that the progress aligns with the actions more clearly. **QS19/132.2** The CHC Chair noted that for the previous year the Board had achieved 60% completion against the plan and felt that very often the focus dropped off part way through the year requiring the need for a sudden increase in effort at year end. The Director of Performance explained that there was an enhanced level of scrutiny on a monthly basis by the Executive Team on a confirm and challenge basis, although there was naturally more activity within quarters three and four. **QS19/132.3 It was resolved that** the report be noted but that the Committee have requested improved quality assurance on the information contained within the paper.	
QS19/133 Integrated Quality & Performance Report **QS19/133.1** The Director of Performance presented the report and highlighted that there were a number of 'greyed' indicators which was due in part to the mix of annual and monthly indicators, and also the effect of a major IT incident in Wales on data availability. She added that there was a continued reduction in serious untoward incidents and that a more detailed paper was on the agenda relating to falls and pressure ulcers. The Director of Performance referred to performance against postponed procedures at short notice, accepting these result in a very poor experience for patients and did not support the efficient use of resources. She went on to highlight that the vacancy levels remained of concern in terms of the Board's ability to consistently maintain high standards of care to patients across all sites. She concluded by reporting that there was evidence of short term investment into Child Adolescent Mental Health Services (CAMHS) and that overall performance against the Mental Health Measure was good for CAMHS. **QS19/133.2** A discussion ensued. Members expressed concern at the performance for postponed procedures and noted that there was a related audit report that had been received by the Audit Committee. Associated challenges around the availability of high dependency beds and anaesthetists were noted. The Associate Director of Quality Assurance reported that there was a defined work programme in place and the Executive Director of Workforce and OD indicated that variations in practice should be discussed at job planning meetings and appraisals but this remained challenging. The Chair suggested that whilst the narrative within the paper was helpful it needed to align more closely to the actual indicator so it is clear what action is being taken to address postponed procedures for non-clinical reasons not all reasons. She asked that an exception report be timetabled in six months to inform the Committee how the organisation was responding to the audit report. A member noted the deterioration in mortality rates. The Senior Associate Medical Director indicated that an update was awaited for the Wrexham site but accepted that the variance needed to be understood. The CHC Chair referred to the incidents graphs on	KD

page 13 which he felt implied that the plan was to achieve half of the target by year-end. The Director of Performance clarified that the plan was for the monthly trajectories and performance was being tracked against these with the target taking precedence not the plan. The CHC Chair also noted a deterioration in infection rates which was disappointing given the level of effort that had been invested. The Associate Director of Quality Assurance stated that the target related to healthcare acquired infections whereas the majority of infections within BCU were community acquired. She felt that the Board should be most concerned about those avoidable infections acquired whilst patients were in its care. With regards to mental health targets for adult assessments and therapeutic interventions it was noted that the graphs appeared to indicate performance was drifting downwards. The Director of MHLDS indicated that some areas were consistently compliant but others had real capacity issues and short terms posts were being considered to change the model of delivery. He assured the Committee that BCUHB was not a significant outlier across Wales. A member raised the issue of ward staffing levels and skill mix and the Executive Director of Workforce and OD reported that this element of the report did not provide bank agency usage and vacancy and the ratio was skewed as it included additional duties which were predominantly undertaken by health care support workers. **QS19/133.3 It was resolved that** the Committee note the current performance and commitment to improve the relevance of the narrative against actions. The Committee also resolved to receive an exception report on postponed procedures at a future meeting.	
QS19/137 Medicines Management Key Risks *[Agenda item taken out of order at Chair's discretion. Dr Berwyn Owen and Ms Louise Howard-Baker joined the meeting]* **QS19/137.1** The Chief Pharmacist presented the paper which provided the Committee with a copy of HMP Berwyn's first Her Majesty's Inspectorate of Prisons' inspection report which included a joint inspection with Health Inspectorate Wales of the Health and Wellbeing Services at HMP Berwyn, together with the associated action plan. He invited a discussion or questions from members. **QS19/137.2** The Chair referred to previous discussions around pharmacy support within mental health. The Chief Pharmacist confirmed that funding was historically based on clinical risk. In terms of MHLDS the legacy goes back to the closure of the Denbigh Hospital and a belief that pharmacy services within mental health was funded corporately. The Associate Director of MHLDS confirmed there was now a clear agreement in place and the strategy was being worked through with the Medicines Management team. A member raised the issue of the EU exit and potential medicines shortages. The Chief Pharmacist indicated that the EU exit was only one of several factors regarding shortages but work was ongoing with a small team with expertise in procurement. The issue of communicating key messages around any shortages was raised and the worry that members of the public may unnecessarily choose to stockpile medicines. The Chief Pharmacist was confident there would be an appropriate communications strategy in place by the time of the EU exit. A question was raised regarding the risk set out regarding prescribing competencies of new intake FY1, FY2 and locum doctors. The Assistant Director for Medicines Management explained that this related to occasions where it was not possible to identify the prescriber. Reference was also made to concerns around staffing shortages and offsite dispensing for a particular pharmacy corporate that had been reported in the media. The Chief Pharmacist explained that the company were moving away from branch dispensing and confirmed the	

Medicines Management teams were working closely with the company concerned. The Assistant Director for Medicines Management indicated that as part of the quality improvement element within the new GP contract there was work ongoing to target potential harms, and she tabled a screenshot from All Wales Toxicology and Therapeutics Centre data. She said that clinical coding would be key to collecting supplementary information and discussions were taking place as part of a national programme. A proposal would be prepared. **QS19/137.3 It was resolved that the** Committee note the report. *Dr Berwyn Owen and Ms Louise Howard-Baker left the meeting*	
QS19/138 Royal College of Obstetricians / Royal College of Medicine (RCOG/RCM) Review of Maternity Services at Cwm Taf Health Board (15-17 January 2019) : Report Published by Welsh Government on 30th April 2019 : Q 2 Update *[Agenda item taken out of order at Chair's discretion. Mrs Fiona Giraud joined the meeting]* **QS19/138.1** The Director of Midwifery and Women's Services took the opportunity to inform the Committee of an unannounced visit to Ysbyty Glan Clwyd (YGC) by Healthcare Inspectorate Wales (HIW) the previous week. There were some actions for immediate attention which were being picked up and the learning from the visit had been shared with staff the next day. Ms Emma Scott confirmed that HIW had been welcomed at the inspection and she was assured that the immediate actions had been dealt with, and there was demonstrable evidence of good leadership. **QS19/138.2** In terms of the RCOG/RCM review members felt that the paper provided a good level of assurance in terms of maternity services as a whole in light of the Cwm Taf review and that progress was commendable. Members noted however, that the volume of paperwork provided was felt to be overwhelming. The Associate Director of Quality Assurance suggested that the coversheet did take members through the key areas of concern. A question was raised around resuscitation trolley checks and it was confirmed this rested with ward nursing staff. A member asked whether the reference to a perinatal mortality review should be a matter of concern and the Director of Midwifery and Women's Services confirmed this was not the case and it has been developed to provide assurance ahead of publication of the full EMbRACE report. **QS19/138.3 It was resolved that** the Committee to note the assurances provided by the Directorate which were commendable and support the identified areas for improvements. *[Mrs F Giraud, Mr R Jones and Dr M Maxwell left the meeting]*	
QS19/134 Concerns, Litigation, Incidents, Coroner and Healthcare Inspectorate Wales (CLICH) Report **QS19/134.1** The Associate Director of Quality Assurance presented the report to members, noting that many areas of work had been discussed under earlier agenda items but invited any comments or questions. **QS19/134.2** The Chair wished to record her thanks for the improved level of analysis within the report although she felt the outstanding HIW actions could be more clearly identified. A	

member noted that the Central area appeared negatively in a range of areas and sought assurance that this was recognised by the area. The Associate Director of Quality Assurance confirmed that the area team had responded positively to the challenges. The CHC Chair referred to expectations around addressing complaints within 30 days, and it was reported that there were trajectories in place but meeting the target consistently remained challenging due to competing priorities within the teams, and the impact of holiday and sickness absence. The Chair noted reference to "operator error" having been identified in a claim and enquired whether the human factor elements such as supervision had been explored. The Associate Director of Quality Assurance reported that there was a known complication with the particular procedure in question, and that the experienced clinician concerned had undertaken retraining and there had been no reoccurrence. The Executive Medical Director welcomed the learning from claims however felt that learning should commence at the point that the organisation was aware something had gone wrong, not at the end of the claim process. The Chair enquired whether any of the unexpected deaths reported were of specific cause for concern and the Associate Director of Quality Assurance reported that none of the cases related to BCUHB care provision being directly attributable to the death. The Chair also referred to a Never Event relating to the incorrect use of oral and intravenous syringes and the Associate Director of Quality Assurance gave further background to the case and confirmed that different colour syringes were now in use. The CHC Chair noted the HIW action regarding separation of commissioner/provider role for managed practices and the Executive Director of Primary and Community Services confirmed that this had been a live conversation since the first managed practice was established but he confirmed that operationally there had not been any issues of concern. **QS19/134.3 It was resolved that t**he Committee to note the content of the report	
QS19/135 Occupational Health and Safety Gap Analysis Report **QS19/135.1** The Executive Director of Workforce and OD presented the report which provided an evidence-based assessment of where the organisation was in terms of health and safety. She highlighted that the report set out the need to develop a three year risk-based improvement plan which would provide the ability to plan in a systematic way and to identify correlation between the gap analysis, legislation and incidents. Members were assured that the intensive gap analysis process had been led by the Health and Safety team with the support of stakeholders and Trade Union partners and had involved visits to 117 premises, a generic health and safety audit and more detailed assessments of violence and aggression, security and occupational health. The Executive Director of Workforce and OD assured the Committee that any significant concerns identified were addressed at the time of the audit, and that areas of good practice were also identified. Throughout the process there had been good engagement and a willingness to move forward in a sustainable manner, with an acknowledgement that there had been a lack of ownership to health and safety in some areas. The Executive Director of Workforce and OD indicated that there would be a clear need to undertake a re-audit at some point and that in terms of the methodology used it was noted that an internal audit review indicated a level of reasonable assurance. The Health and Safety Executive (HSE) had commenced a programme of inspections of Welsh Health Boards and BCUHB were likely to be involved. Reference was made to the overarching risk on the corporate risk register which had been reviewed following the gap analysis and it was noted a refreshed risk would be developed. Finally the Executive Director of Workforce and OD reported that the issue of security across the organisation had been separated out from the health and safety gap analysis	

and following a change in tender arrangements would be subject to a full review with a separate report being provided to the QSE Committee in due course. **QS19/135.2** The Consultant in Public Health welcomed the comprehensive risk assessments but suggested that it would be helpful to establish links between Estates and Facilities and legionnaires. The CHC Chair felt the gap analysis and testing of the service would stand the Health Board in good stead for any HSE review. The Committee Chair found the report to be transparent and thorough and would provide a robust basis on which to move forwards with actions being prioritised by risk. She noted that the outcome of the previous self assessments undertaken against this gap analysis would suggest this process needs improving. **QS19/135.3 It was resolved** that the Committee: 1. Note the position outlined in Gap Analysis Report. 2. Support the proposed improvement plan and findings of the gap analysis of legislative compliance and subsequent proposed project plan and time line.	SG
QS19/136 HMP Berwyn : Health and Wellbeing Service Her Majesty's Inspectorate of Prisons' Inspection Report and Action Plan **QS19/136.1** The Executive Director of Primary and Community Services presented the paper, highlighting that the inspectorate report related to the whole prison service and not just the provision of health care. He confirmed it was the first inspection of this nature at the prison and that the healthcare element had been undertaken jointly by Her Majesty's Inspectorate of Prisons and Healthcare Inspectorate Wales (HIW). Overall the report was broadly positive with a small number of observations requiring attention. **QS19/136.2** A discussion ensued. A member expressed concern at the level of dental provision and the Executive Director of Primary and Community Services suggested that the issue related to the estate not being fit for purpose and secondly around capacity to deliver. Since the inspection a second dentist had now been appointed and some of the estate's issues had been addressed. A member queried the decision to remove men from the dental waiting list if they had less than six months of their term to serve, and the Executive Director of Primary and Community Services confirmed he has also raised this very point as a concern. Members were pleased to see the positive impact of deploying a paramedic to the prison site in terms of preventing emergency admissions and that the pilot had been escalated to Wales Ambulance Services Trust to seek approval to provide on a more sustainable basis. In response to a question regarding medication lockers for those men with chronic diseases it was confirmed that the majority of such medication was self-managed. A member asked how the prison service was evaluating progress against the philosophy set out when the facility first opened, and the Director of Mental Health & Learning Disabilities (MHLDS) reported that he had met with the new governor who was keen to drive the rehabilitation agenda far more robustly. He also indicated that the MHLDS Division had a strong interaction with the prison including the provision of psychiatric sessions. Finally, the Executive Director of Primary and Community Services referred to a recent adverse news article and assured the Committee that BCUHB officers had picked up some of the specific healthcare points. **QS19/136.3 It was resolved that** the Committee receive and note the report.	

QS19/139 Quality & Safety Group Assurance Reports July and August 2019 **QS19/139.1** The Committee Chair reported that she had raised a number of points with the Associate Director of Quality Assurance outside of the meeting in relation to the report. It was noted that the risk around breast radiology had been mitigated via an appointment of a breast radiologist and cover being provided from other areas. In terms of the Countess of Chester issue it was confirmed this related to North Wales maternity patients and there was a meeting scheduled next week to review, although the Committee were assured there weren't any concerns around individual patients. Reference was also made to an incident within radiology with an MRI scanner being out of service for a period of time and which had been mitigated by using scanners on other sites. The Associate Director of Quality Assurance also explained that the reference to a number of clinically complex cases within Women's Services would be detailed within the next scheduled report to the Committee from the Division. The Committee Chair enquired about the paediatric ophthalmology issue and it was confirmed this related to the loss of a clinician however resources were being utilised from other sites to mitigate the risk. The Executive Director of Primary and Community Services drew attention to the closure of a Wrexham care home and that the intervention had been undertaken on a joint basis with the Local Authority. The CHC Chair made reference to a new nutrition and hydration screening tool and the Associate Director of Quality Assurance confirmed that the nursing teams were well sighted but the nutrition team had felt they were not fully consulted. **QS19/139.2 It was resolved that** the Committee receive and note the report.	DC/TO
QS19/140 Progress report of recommendations arising from HASCAS independent investigation and Ockenden governance review **QS19/140.1** The Committee Chair reported that she had raised a number of points with the Associate Director of Quality Assurance relating to the report outside of the meeting. The Associate Director of Quality Assurance set out the intention to move as many of the actions as possible onto a routine business footing, and confirmed that progress would also be subject to internal audit scrutiny. Whilst there had been significant progress against the breadth of the recommendations the challenge was to be able to provide assurance that an action had been completed as far as it could possibly be. The Chair queried the proposal to record a closed action as 'fully implemented' and suggested that there needed to be a clear audit trail in this regard. A comment was made that there was now a more helpful integration of actions and themes from a range of reviews. It was highlighted that the stakeholders themselves were clear that they would not be part of a decision to close off an action. **QS19/140.2 It was resolved that** the Committee note progress against the recommendations to date.	
QS19/141 Ward Accreditation, Health Acquired Pressure Ulcer (HAPU) Collaborative & Falls Collaborative update **QS19/141.1** The Associate Director of Quality Assurance presented the paper, highlighting that 70 wards had now been assessed, with a gold standard yet to be confirmed. "Going for Gold" workshops were planned to share the learning from Year 1 and to try and help silver wards move into the gold category. It was noted that one 'red' ward was classified as	

having significant safety concerns and was subject to weekly monitoring and a revisit planned during October. It was hoped that ward accreditation would also be undertaken within Emergency Departments. **QS19/141.2** A discussion ensued. A member noted that further financial support may be required and the Associate Director of Quality Assurance confirmed that the previous allocation of £1m per year would continue. With regards to the process for identifying the cohorts for the collaboratives it was confirmed that a suite of actions for the areas with the most significant issues would be rolled out. The CHC Chair acknowledged that there was a real energy across sites for the programme and a clear aspiration to improve. **QS19/141.3 It was resolved that** the Committee continue to support the Ward Accreditation process and implementation of the Improvement Collaboratives.	
QS19/142 BCUHB Response to Healthcare Inspectorate Wales (HIW) Annual Report 2018-19 **QS19/142.1** The Associate Director of Quality Assurance presented the report, reminding members that there had been full discussion by the whole Board at a workshop. She added that the report demonstrated the breadth of the inspection programme undertaken by HIW. **QS19/142.2 It was resolved that** the Committee note the contents of the HIW Annual Report and the Health Board's response to the report.	
QS19/143 Public Sector Ombudsman Wales Annual Letter 2018-19 **QS19/143.1** The Committee Chair welcomed the broadly positive report which she felt reflected the good work undertaken by the Concerns team. In response to a question from a member it was confirmed that the Ombudsman had not to date used their additional powers. **QS19/143.2 It was resolved that t**he Committee note the Annual letter and the actions taken by the Health Board for information.	
QS19/144 2019 Annual Nurse Staffing Levels (Wales) Act 2016 Reporting framework **QS19/144.1** The Associate Director of Quality Assurance presented the paper which detailed a slightly amended framework for reporting. It was noted that the suggested timetabling would need to be adjusted further to marry up with the meeting pattern of the Committee. **QS19/144.2 It was resolved that** the Committee amend its cycle of business in respect of the compliance report for Nurse Staffing Act 2016.	KD
QS19/145 Accessible Healthcare Annual Report incorporating Wales Interpretation Translation Service Report **QS19/145.1** The Associate Director of Quality Assurance presented the report to the Committee. Members welcomed the information provided but a comment was made that a	

self assessment would have been helpful to provide an indication to the reader as to whether the organisation was on track or not, and for the report to more clearly highlight good news and positive stories. This would be fed back to the team as it was noted the report was written using a provided template. A suggestion was made that the Board could look at leading by example in terms of accessibility – for example, using some British Sign Language within introductions at meetings. The recommendation within the paper was considered and members felt it should be softened to read: **QS19/145.2 It was resolved that** the Committee endorse the controls/corrective actions highlighted in this report aimed at ensuring staff, managers and other stakeholders recognise and act on their responsibility to ensure that service users with sensory loss are able to access our services on the same basis as all other service users.	
QS19/146 Policies, Procedures or Other Written Control Documents for Approval The Committee Chair stated that the Committee would be unable to approve any of the submitted documents as she felt the accompanying Equality Impact Assessments were not fully compliant. In addition, she was disappointed that many of the documents contained typographical and formatting errors. The other members supported this view and the Executive Director of Workforce and OD agreed that further work was required on the EQIAs. **QS19/146.1 Organ Donation Policy** In addition to the generic comments above, the Committee noted a specific typographical error that the word “implanted” should read “implemented”. Members were fully supportive of the policy principles. The Executive Director of Therapies and Health Sciences would take these comments back for further consideration. **QS19/146.2 Handcuffs Policy** In addition to the generic comments above, the Committee queried whether the terminology could be amended, however, the Executive Medical Director outlined the specific nuances around the use of handcuffs which required the policy. The Independent Member (Trade Union) suggested that the policy should describe more clearly the scenarios and options when a member of staff needs to agree to be handcuffed to an individual. The Director of Mental Health would take these comments back for further consideration. **QS19/146.3 Threats to the Person in Forensic Establishments Policy** In addition to the generic comments above, the Committee queried the consistent reference to the Firearms Act within the EQIA and why this was deemed to be relevant against each protected characteristic. The Committee also suggested the policy should be reviewed by the Occupational Health and Safety Group. The Director of Mental Health would take these comments back for further consideration. **QS19/146.4 Major Incident Protocol – Ty Llywelyn Medium Secure Unit** In addition to the generic comments above, the Committee queried why there was reference to referrals from GPs when the policy relates to a forensic medium secure unit	AT AR AR

and how this protocol differed from the Threats to the Person in Forensic Establishments Policy. A member queried the necessity of involving the Modern Matron in advance of calling 999. The Executive Director of Workforce and OD noted the lack of reference to security providers within the scope. The Committee also suggested the protocol should be reviewed by the Occupational Health and Safety Group. The Director of Mental Health would take these comments back for further consideration. **QS19/146.5 It was resolved that** the Committee require each of the written control documents to be amended in light of the specific comments, reviewed for grammatical and typographical errors, their EQIA refreshed, and resubmitted to the next meeting or for Chair's action.	AR
QS19/147 Issues Discussed in Previous In Committee Session **It was resolved that** the Committee note the information in public.	
QS19/148 Documents Circulated to Members **It was resolved that the** Committee note the circulation of the following briefings and information: 12.6.19 Concerns Trajectories 4.7.19 Policy approval process 9.7.19 Gosport briefing 9.7.19 Homeless & Vulnerable Groups qualitative report 9.7.19 Complaints handling / PSOW letter 16.7.19 QSG notes May and June 2019 24.7.19 Copy of endoscopy paper with formatting corrected 17.9.19 QSG notes July and August 2019	
QS19/149 Issues of Significance to inform the Chair's Assurance Report To be agreed outside of the meeting	
QS19/150 Date of Next Meeting Tuesday 19.11.19 @ 9.30am	
QS19/151 Exclusion of Press and Public Resolution to Exclude the Press and Public - "That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960."	

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**
19th March 2019				
B Owen	**QS19/37.5** Give further consideration to how a safety programme in Wrexham regarding suspected medication-related admissions might be rolled out across all three sites in North Wales and linking in with the Quality Improvement Hub.	July	21.5.19 Noted is also a board action and in hand via Louise Howard-Baker. 16.7.19 Would be picked up as part of the medicines management report due in September. 17.9.19 Medicines Management paper on agenda does not cover this action specifically. The Assistant Director for Medicines Management (East) reports that - pharmacists on all three acute sites are now consistently using the same process for reporting medication-related admissions so that they can be coded correctly. The 1000 Lives National Primary Care Programme Manager is visiting BCUHB in September to discuss how this project can be rolled out across Wales to fit the new WG strategy to reduce medication-related admissions. A national safety dashboard has been developed. The outcome of this meeting will inform the safety programme for BCUHB to reduce medication-related admissions. 24.9.19 DF to seek a briefing note from the Head of Pharmacy.	September November
21st May 2019				
D Carter	**QS19/70.2** Consider whether non-patient elements need separating from the CLIICH report in terms of	Sept	24.9.19 discussions between teams ongoing as part of gap analysis.	January

	category 'abuse of staff by patients', for next submission		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.	
~~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
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	~~Closed~~

			Experience' group (LLG) (LLE was stepped down for 6 months to review the function/purpose of the meetings and capture the correct attendees in alignment with QSE and QSG). The LLG will focus on outlining targets and reporting frameworks to link the connections between Patient & Service User feedback and service improvements. The LLG will be the quality assurance measure to monitor reports and translate them into improvement work and celebrating best practice. This includes Patient Stories. Patient Stories will be integrated into the Clinical Harm Dashboard along with all other feedback methods. Quality improvement actions will be captured, monitored and measured in triangulation with incidents and complaints. The one system approach strengthens the service improvement management. 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
J Newman	**QS19/100.3** Ensure a strengthened narrative on planned care in next IQPR	Sept	22.8.19 A planned care plan was presented to the August F&P committee. 24.9.19 JN clarified related to postponed procedures.	Closed
J Newman	**QS19/101.3** Work with Exec Team to consider how best to reflect performance and to provide robust monitoring within the AMR	Sept	24.9.19 JN reported that Exec Team undertook a monthly peer review of RAG ratings.	

C Stockport	**QS19/102.2** Work to provide a heat map summary in future primary care reports	By next report (March)		
C Stockport	**QS19/102.4** Ensure that future reports include narrative on lessons learned from incidents	By next report (March)		
D Carter A Roach	**QS19/104.3** Work with Peter Bohan to understand the data regarding deaths as a result of incidents within mental health	Sept	13.9.19 Interim Assistant Director of Service User Experience (Kath Clarke) is meeting with Peter Bohan 24.9.19 DC confirmed that the data wasn't of concern but that the search terms led to inconsistencies. AR suggested that this information be consolidated within next MHLDS report to the Committee.	November
D Carter P Bohan	**QS19/104.4** Jointly take forward the issue of there being no consistent system for tracking RIDDOR root cause analysis	Sept	24.9.19 Noted that an update had been provided after the deadline date. A review of RIDDOR had been undertaken and a 12 month action plan developed. All RIDDOR reports and RCAs are reviewed by the Strategic Occupational Health & Safety Group. The Health and Safety team review all incidents/accidents to ensure RIDDORS are identified and reported in timely manner.	Closed
D Carter C Owen	**QS19/105.3** Work to improve the analysis of data to show improvements within future Listening and Learning reports	November	13.9.19 The Head of Patient and Service User Experience is reviewing the report content detail and has requested a meeting with QSE Chair to discuss. 24.9.19 Committee agreed to reopen until next listening and learning report received.	Closed November

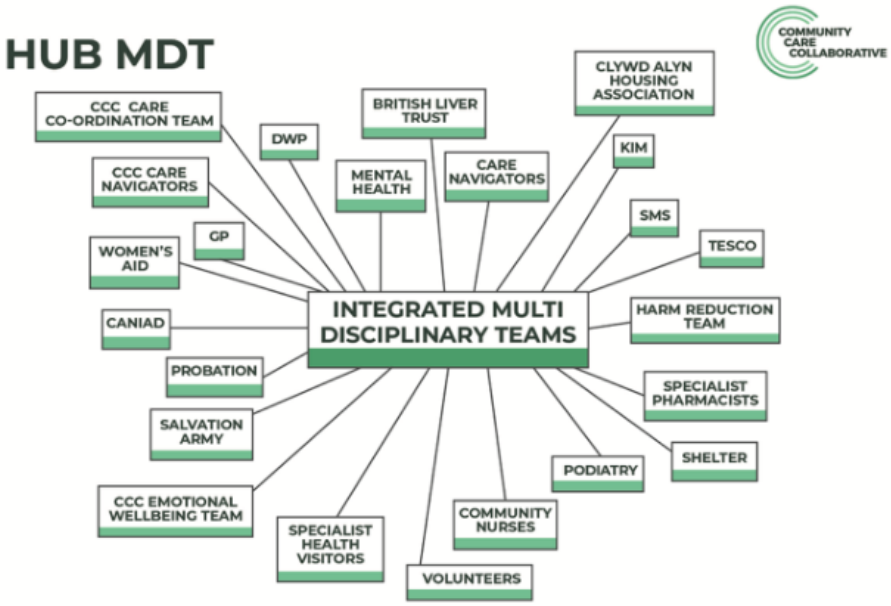
			12.11.19 Listening and Learning report agendered for discussion at November Committee meeting. Members' feedback invited on whether format addresses previous concerns.	
A Roach	**QS19/107.2** Take into account the discussion (detailed in minutes) around content and format of future MHLDS assurance reports	November	3.9.19 The Director of Mental Health and Learning disability has met with the Chair of QSE and agreed the future reporting requirements into the committee, it has been agreed that an exception report will be provided to the September committee to provide additional information and assurance to the Chairs comments under section 19/107.2 with agreed reporting and content being included in the November MHLD assurance report 24.9.19 Committee happy to close action.	Closed
C Stockport	**QS19/109.2** Arrange for the organisational response to the HIW thematic review of children's services be agendered for the next meeting.	Sept	Added to cycle of business. 13.9.19 Agreement reached with QSE Chair to defer to November meeting. 12.11.19 on November agenda.	November
A Thomas	**QS19/112.3** Follow up query from the May QSG report as to whether the related patient safety alert had been closed at the time, even though a Medical Devices Safety Officer was not in post.	Sept	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.	November
24th September 2019				
C Stockport	**QS19/129.2** Share a copy of the HIW report into children's services (ahead of it being formally agendered with the BCU response in November)	Oct	23.10.19 Circulated via email	Closed

J Newman	**QS19/129.1** Revisit the briefing note on mapping of indicators to reflect members' comments re appropriateness and mapping to SPPH	Oct		
D Carter	**QS19/130.2** Feedback on the discussion of the patient story to the Dementia Lead Nurse. Work with Chris Stockport regarding development of an assurance report on dementia care (including community hospitals) for future meeting.	Oct January	31.10.19 Feedback provided to the dementia lead nurse.	
A Roach	**QS19/131.2** Ensure that the November paper from the MHLDS Division includes further detail around the delivery plan and business case, benchmarking data and clear milestones against delivering the Strategy.	November		
J Newman	**QS19/132.1** Ensure that Annual Plan Monitoring Reports are circulated via email on the months between Committee meetings.	October onwards	Arrangements made to circulate via Kate Dunn (Committee secretariat)	Closed
S Green	**QS19/135.1** Provide report to QSE in due course on security arrangements.	January	17.10.19 Security review completed with recommendations for moving this H&S governance structure forward. A report will submitted to the January meeting.	
D Carter T Owen	**QS19/139.1** Ensure that next report from Women's Division includes detail of the reported clinical complex cases.			
K Dunn	**QS19/144.1** Adjust timetabling of Nurse Staffing Levels reports to marry up with QSE meeting pattern.	November	12.11.19 Confirmation received that annual report will be provided in May, with a mid year update in November.	Closed

A Thomas	**QS19/146.1** Feedback the Committee's specific comments on the organ donation policy and review for grammar/typo's, and refresh of EQIA	November	12.11.19 Policy has been resubmitted with Chair's Action being sought.	
A Roach	**QS19/146.2** Feedback the Committee's specific comments on the handcuffs policy and review for grammar/typo's, and refresh of EQIA	November		
A Roach	**QS19/146.3** Feedback the Committee's specific comments on the threats to person in forensic establishments policy and review for grammar/typo's, and refresh of EQIA	November		
A Roach	**QS19/146.4** Feedback the Committee's specific comments on the major incident protocol and review for grammar/typo's, and refresh of EQIA	November		

Patient Stories Transcript Form

Betsi Cadwaladr University Health Board
Patient's Stories Transcript Form

Who took the patient's story:	East Patient and Service User Experience team
Contact details:	East Patient and Service User Experience team Ysbyty Wrecsam Maelor
Reason for taking the story and areas covered: Background to Community Hub	Raise awareness of new ways of working in East Primary Care. "The Hub was developed by the Community Care Collaborative (CCC) and delivered in partnership with the Salvation Army and BCUHB and other local agencies". The first chapter in the story is the CCC Hub with the developments of 3 Primary Care holistic multi-disciplinary model practises in the East area. Entering the Hub it feels like a regular social gathering; relaxed chattering, laughing, huddled conversations. It doesn't feel like a clinical setting. The purpose; "helping people achieve stability in their lives". So many of the people attending face social exclusion; here at the Hub it's about supporting people to support themselves and reduce harm. The CCC 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 Community Care Hub, led by Dr Karen Sankey and Dewi Richards was established in the Salvation Army, Wrexham 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".

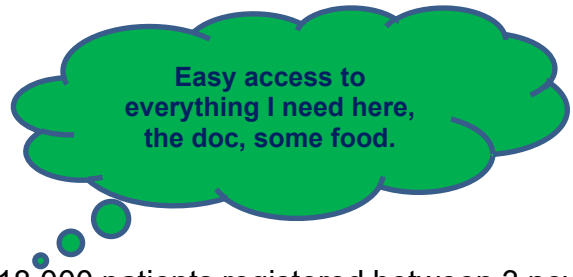
"We have no rules, it's open door, open access, no appointments, anybody can come in and access help."

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

Our '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.

Speaking to staff you get a real sense of engagement and feel-good factor. "Making substances as safe as possible, needle syringe provision, joint working, wound care, blood borne virus testing, reducing drug related deaths, Hepatitis C treatment, reducing barriers to hospital led services. Reducing the stigma of Hepatitis C; "there is more stigma from the drug using community than from elsewhere, so being Hepatitis C free is enabling…it's about wraparound care and interactive support".

	"I know people want the treatment but the hospitals have too many barriers, when you see people who have been Hepatitis C positive and failed the hospital route and here they have been treated effectively. Feels like I'm making a real difference. They need weekly treatment dispensing because they have nowhere to store a month's worth –they often have no fixed address so it makes sense to bring the care to them". "The van is outside serving the community as the Hub session is happening". Speaking to one particular client now aged 32 years and has been in the system since he was 16 years old. He feels the benefit of attending the weekly Hub. "It supports me to keep off the stuff…keeps me occupied. Keeps me off the streets, I'm homeless but you know what we look after each other, like a family. I sleep on the street in a doorway. The woman who opens the shop makes me a coffee. Coming here helps me not to feel ashamed of the way I'm living now. I'm supported to be open with my 'using'…I'm a binger not an addict , so when I stop binging I can work, and I'm a really good worker you know. Coming here keeps the spark going". He looks smart and takes a pride in his appearance; "I woke in a doorway last week and my shoes were wrecked, heels had come off. Two workmen came and asked me my shoe size and then bought me a pair of trainers and also gave me money to get some food. I felt like crying….they were so kind". The theme coming through from the staff attending the Hub session; "Friday morning is the best day of the week". Outside there's a van serving the community changing wound dressings and attending to clinical needs. One member of staff shared their personal experience; "I've been here….slept rough when I was 13 years old and there was no help like this for me". Another person explained, "we come here to support the community as a whole". A client explained how he had experienced homelessness for 2 months;" worst time ever…not nice. This place is a saviour…it gives me a purpose…aim". He asks for toast and coffee from the Salvation Army volunteers and they chat about things in general. The psychologist shares; "We can't solve people's problems…only they can do that…we offer a moment of stability. They have to be their own agent. People only change when they want to change…change will happen when they are ready. The purpose here is to offer an environment a moment of

	stability…gives a moment of being just a person not a service provider.  There are 18,000 patients registered between 3 newly developed Primary Care practices in the East. The clients attending the Hub are registered here. *'We can do this on a bigger scale for the whole community'* are Dewi Richards's words, building on the success of the Community Care Collaborative (CCC) Hub in Wrexham. The aim is to replicate the CCC Friday model across the East practices. The ethos of the CCC is a holistic care model with a multi-disciplinary team (MDT) 'wrap-around' approach. This model includes 3 GP's. National recommendation supports between 9-10 GP's (1 per 2,000 patients). GP recruitment is a National issue. Not everyone needs to see a GP. Innovation leads the way; with 60 staff in 3 practices, including social workers, mental health trained practitioners, district nurses, pharmacists. This is a nurse led MDT model. The mental health staff support has cost less than one GP. Patients who have complex needs, are homeless, frail are provided with individualised care planning and the MDT actively engage and manage patients out in the community. The question is 'where would the patient be otherwise'? The answer is the Maelor hospital Emergency Departments (EDs), GPs. Out of Hours services, or simply not accessing services. The next steps is to gather information around ED, Welsh Ambulance services, measuring and monitoring the impact on patients' lives and wellbeing. The services are working closely with the Patient and Service User Experience team to gather patient and service user feedback. The 'You Said We Did' model will be applied to areas of improvements and the positive feedback data will be sourced and shared. Many of the issues faced by the patient group relate to social care, this is the first service to have direct social worker associated support.
Brief summary of patients story:	One client shares his story, he's been homeless for many years. He states :

I've been like this, homeless, all over the place really, not worked for years. I'm 40 odd years old, so possibly like this 20 years I guess. Services, they come and go, it's not always there. My health is rubbish really. I came to Wrexham, I think about 4 years ago. I was a heavy heroin user then. I drink too, I need it most of the time, the street is tough. I did get some help then, I saw a GP for a while, and drug agencies. I am on a methadone paper now. I can't go to my old GP though, I did kick off one day, and I never went back. I was just angry, they didn't seem to give a toss.

Anyway, this place opened, I don't know now when, but I have

been here since then, Its ideal for people like me. I know most of them here. We see new ones, they have no idea what's coming especially in the winter.

Anyway, what do I like?? Well I get me script, see the doc, and health people. Sometimes the feet people are here. I got some shoes and a coat one week too. I can get a cup of tea, toast. Today they are giving out fruit, yoghurts and some sweets.

I can get my benefits sorted too, they can be a problem so its handy they are here.

I come here because it's everything in one place, I'm not judged can get help if I need it. No one forces anything on me, it's up to me. I trust them.

You can see all services at once. No waiting!

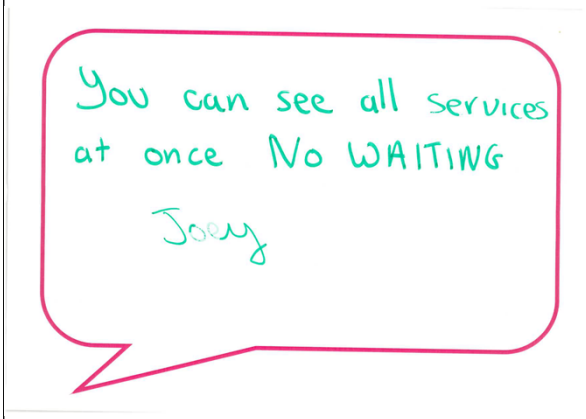
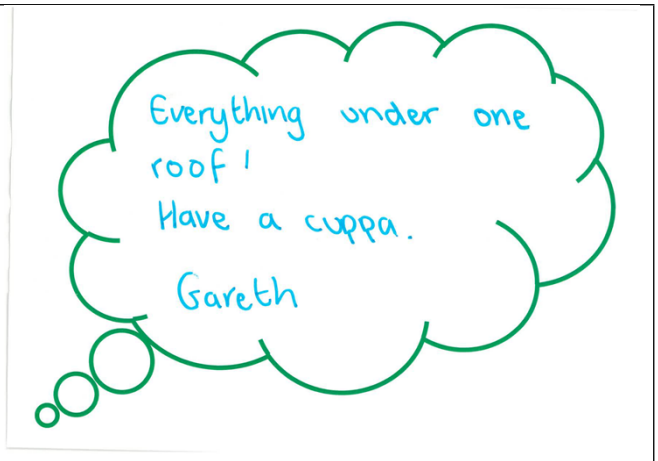
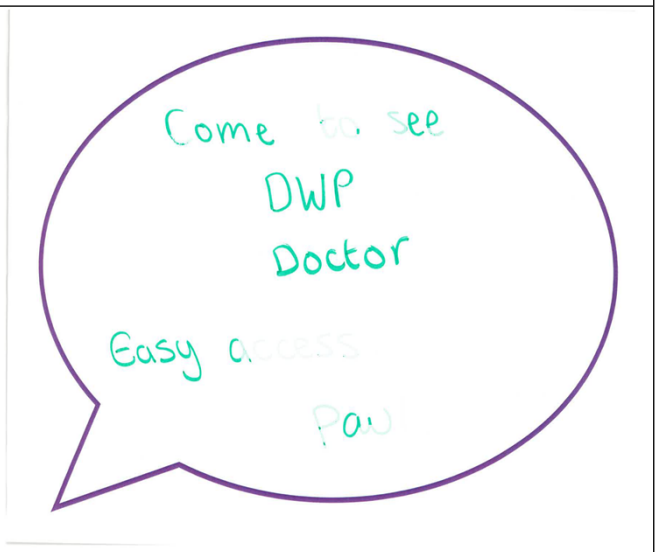
I'm NOT judged here

Another client in her mid-40 describes her lifestyle as chaotic, on methadone script, and states “other dependencies”. She share’s that she has been in prison.

She states:-

“I’m upset today, I get blamed for things. The ladies here, they make me a cup of tea, they hold my hand. I’m upset yeah. But they hold my hand, they listen, that helps a lot, I don’t really like anywhere else really. I have been to the hospital I don’t like it, they treat me like I’m dirt. I have health things going on. I can see the doc here though”.

One of the volunteers at the Hub shares that this is a way of “giving something back” for the help he has received.

	
Joey explained how he finds it difficult to sit in waiting rooms, he gets anxious and can't sit still, he said that makes people look at him. Coming to the hub is good you can see all the services you need with no awkward waiting spaces.	Gareth spoke about the ladies making a nice cup of tea just like his Nanna used to make. He doesn't attend his GP services but finds it more accessible to attend the hub.
	
'I'm 6 months clean, I am' said proudly When asked why do you come to the hub? I was told 'I come to see my friends. You can get help when you need it here.	Paul was having a cup of tea when he shared this information. He attends the hub to see the doctor and DWP, he told me it has easy access.

Key themes emerging:	Service users do have a mistrust of "authority". The hospital set up as a whole presents multiple barriers, i.e. 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.
Lessons learnt:	**"I'm 6 months clean, but I come here to see my friends and the GP as I am not registered any were else".** The overarching aims of this model are to: Reduce barriers to public services for those who are in crisis Ensure people are listened to and respected, whilst having their individual needs understood Bring together local socially-driven organisations, so they can work more efficiently Lower demand on mainstream public services
Proposed action:	
Sensitive issues to be aware of:	CCC Hub customers have chaotic and transient lifestyles. They have a mistrust of strangers and Authority.

Quality, Safety & Experience Committee **19.11.19**	GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board ***To improve health and provide excellent care***

Report Title:	Annual Plan Progress Monitoring Report (APPMR)
Report Author:	Mr Mark Wilkinson, Executive Director of Planning & Performance
Responsible Director:	Mark Wilkinson, Executive Director of Planning & Performance
Public or In Committee	Public
Purpose of Report:	This report provides the Committee with a summary of progress against the key Actions within the Annual Plan
Approval / Scrutiny Route Prior to Presentation:	This paper has been scrutinised by the Executive Team and approved by the Executive Director of Planning and Performance.
Governance issues / risks:	N/A
Financial Implications:	N/A
Recommendation:	The Quality, Safety & Experience Committee is asked to note the report and to assist in addressing the governance issues raised.

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

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

Special Measures Improvement Framework Theme/Expectation addressed by this paper

This paper supports the revised governance arrangements at the Health Board and supports the Board Assurance Framework by monitoring the progress in implementation of the Board's operational plan with increased scrutiny on progress from the executive team.

Equality Impact Assessment

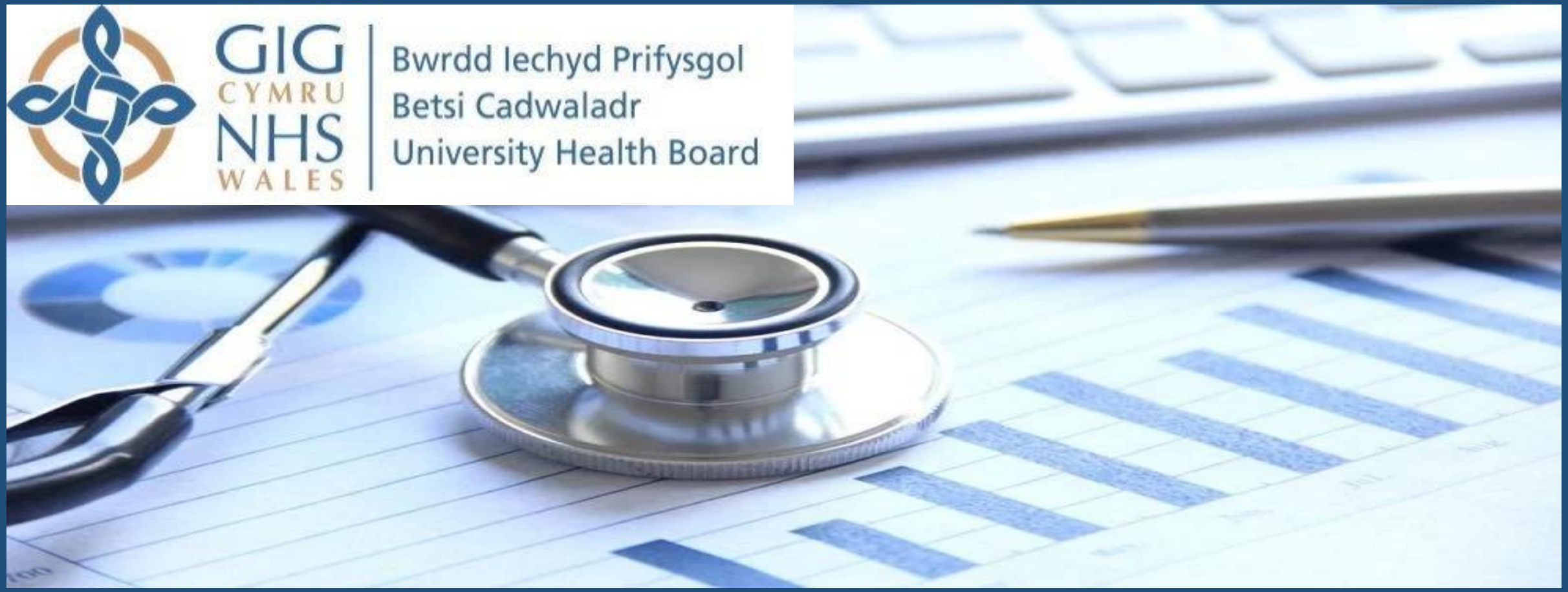
The Health Board's Operational Plan has an equality impact assessment completed. This report provides evidence of progress against this plan.

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

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

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board



September 2019

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

September 2019

About this Report

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

The ratings have been self assessed by the relevant lead executive director. All the ratings have been reviewed and approved by the executive team. Additional assurance will be provided on a quarterly basis with narrative in support of the rating given to a random selection of plan actions . Where a red rating is applied in any month, a short narrative is provided to explain the reasons for this and actions being taken to address.

As it is the end of the second Quarter 2019/20, this report includes a sample of evidence for two of the Actions within each programme. Lead Executives have compared their rating in light of the Q2 milestones. The sampling aims to provide a consistency check on the application of the RAGP rating and additional evidence to provide assurance that the rating is appropriate.
To interpret this report, it is necessary to note the basis of the rating which provides a succinct forecast of delivery, combined with an assessment of relative risk.

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

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

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Programme Health Improvement & Health Inequalities Matrix

Plan Ref	Actions	Executive strategic Lead	Submitted to Committees			Self Assessment and Milestone due indicator (M) from revised outlook report July 2019									
			Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
AP001	Smoking cessation opportunities increased through Help Me Quit programmes	Executive Director of Public Health	G	G	G	G	G	G						M
AP002	Healthy weight services increased	Executive Director of Public Health	G	G	G	G	G	G						
AP003	Explore community pharmacy to deliver new lifestyle change opportunities	Executive Director of Public Health	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	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	A	A	G	G	G	M						M
AP006	Improve outcomes in first 1000 days programmes	Executive Director of Primary and Community Care	G	G	G	G	G	G			M			M
AP007	Further develop strong internal and external partnerships with focus on tackling inequalities	Executive Director of Public Health.	G	G	G	G	G	G			M			M
AP008	Partnership plan for children progressed with a strong focus on Adverse Childhood Experiences	Executive Director Primary and Community Care		R	A	A	A	A						M

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Quarter 2 Sample Report: AP001 - Smoking cessation opportunities increased through Help Me Quit

Milestones due to be met in Quarter 2:
There are no milestones to meet in Quarter 2 for this Action.

Summary of Position

- Uplift (65%) in smoking cessation staff for Help Me Quit in Hospital
- Following transfer of Stop Smoking Wales service to Health Board, developing closer integration of cessation services and healthcare services to utilise all elements of the system to their best effect – pooling expertise and experience.
- Review of Level 3 Pharmacy service practices in order to enhance smoking cessation offer and recording of validated quit rates.
- Implementation of a rolling programme of Help Me Quit in Primary care.
- Supporting GP Clusters to prioritise tobacco control in Cluster IMTPs.
- Smoke Free Premised Task and Finish Group coordinating actions in support of planned introduction of Regulations in 2020.

Quarter 2 Sample Report: AP008 - Partnership plan for children progressed with a strong focus on adverse childhood experiences (ACE)

Milestones due to be met in Quarter 2:
There are no milestones due for Quarter 2 for this Action, However, achievement of the Milestone for Quarter One, "AP008A - Review of the Neurodevelopment Pathway" is yet to be confirmed.

Summary of Position
Following the two successful bids in August to Welsh Government for Neurodevelopment Services; Recurrent funding to close capacity and demand gap; Non recurrent funding to address current waiting list position a Regional Neurodevelopment Steering Group has been set up to roll out the bids and address 6 key work-streams:

1. Plan of Action
2. Data recording and reporting
3. Development of a North Wales Service Specification
4. Workforce opportunities
5. Waiting List Recovery
6. Communication.

Work streams 1 & 2 have been completed, Work-stream 3 has identified in practice all three health economies are now using the All wales Standard for referrals, though the workforce applying them differ slightly. Work stream 5 has developed a tender to go out in the next month. Work-stream 5&6 in development. Initial findings suggest the timeframe for workforce recruitment to close capacity – demand gap is likely to be 9-12 months, during which the demand will exceed capacity and therefore add an additional 150-200 onto the Waiting list recovery work-stream. Once the tender is public we will be in a better position to estimate how many suppliers and by inference the length of time to clear the 1200(+150-200) currently waiting beyond the target

Improved partnership working is taking place across children's services. All services are gradually focusing their work with an 'ACE aware and trauma informed' approach. This particularly takes place within our services for Children who are Looked After (LAC) where there is significant multiagency team work to enable earlier intervention. This is as a result of the Children's Transformation Bid investment. Partnership working is also evident for the implementation of the Additional Learning Needs (ALN) Act, with work taking place to develop the role of the DECLO. More recently a multi- disciplinary arrangement has been agreed between the health board and third sector partners in the development of an On-call rota for the provision of care to children at the End of their Life, as expected within the palliative care standards.

Programme Care Closer to Home Matrix

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

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Quarter 2 Sampled Report: AP010 - Put in Place Community Resource Team Maturity Matrix and support to progress each CRT

Milestones due to be met in Quarter 2

There are no milestones to achieve in quarter 2 for this Action.

Summary of Position

- Integrated/ partnership elements of the Care Closer to Home project have been incorporated within the Community Services Transformation Programme. A key element of this work is the establishment of 14 integrated health and social care Localities, based on the geography of GP clusters. The development and expansion of Community Resource Teams (CRTs) is central to this work.
- To support this work, a **Localities Road Map** is now in place to guide Area Integrated Service Board's (AISBs) in the development of integrated health and social care Localities. This Road Map is supported by an agreed **Project Workbook** which provides a number of practical tools to support development, including:
    - Glossary of terms
    - **Maturity matrix**
    - Mobilisation plan
    - Stakeholder analysis
    - Communications plan
    - Risk register
- Area ISBs are applying the **Maturity Matrix** in order to establish a baseline, and then again at 6 and 12 months, as a way of evidencing distance travelled.
- Conversations are being had across Areas to agree **Locality Leadership/** management structures for the new integrated health and social care Localities, with the Central Area holding a facilitated session in early September 2019. Similar conversations in the other Areas are expected to take place over the coming months.
- Working collaboratively with Public Health Wales, work has started to develop a regional template for **Locality Population Needs Assessments**. The data developed as a result of these assessments will inform and support the development of CRTs, by providing the evidence base from which to make decisions about resource allocations and service development priorities.

Quarter 2 Sampled Report: AP017 - Develop and Implement a Social prescribing model for North Wales

Milestones due to be met in Quarter 2
There are no milestones to achieve in quarter 2 for this Action.

Summary of Position

- There are a plethora of predominantly county-based social prescribing programmes across North Wales, commissioned through short-term funding streams. All are focused on the 3rd sector, and respond to locally-identified needs.
- BCUHB is now working to commission the Elemental software package that will allow for greater co-ordination, tracking and measuring of outcomes between the various programmes.
- At a North Wales level, a Community of Practice (COP) has been established as a partnership between BCUHB and Wrexham Glyndwr University, to enable practitioners to network, share good practice, identify learning and training needs, and identify opportunities for research and evaluation. The COP meets on a quarterly basis, and is attended by over 80 participants on each occasion.
- BCUHB has also worked with Bangor University to identify research funding, which aims to enhance the local evidence base. On an All Wales basis, BCUHB is a partner in the Wales institute for Social Prescribing Research, working with a number of academic institutions, and looking to access significant research monies to build the academic infrastructure around social prescribing in Wales.
- Proposals are currently being formulated to ensure the continued funding for 2019-20 programmes so that the current good practice can be continued.

Programme Planned Care Matrix

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

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AP021. Implement preferred model for acute urology services.

The preferred service model is being reviewed against the overarching Health Board Strategy to ensure it remains aligned. This is as a result of the uncoupling of the Robotic Assisted program and the potential of introducing a new model of care which could enhance day case surgery. This model may form part of the planned care strategy rather than being specific to Urology, this will be explored in a further and final workshop, scheduled for 25th October 2019.

AP025 - Implement year one plans for Endoscopy

Milestone 1/June 2019 - Put in place in year service delivery plan
There is an in year service delivery intention which is awaiting confirmation of funding from WG. Delivery of this plan has been hindered by the delay in the Vanguard unit being commissioned and the rooms in Wrexham coming fully on stream. YG and YGC have insourced additional capacity regularly at the weekend as agreed.

Milestone 2/September 2019 – Endoscopy deliver sustainable delivery plan including staffing and estate.
The North Wales Endoscopy Group has been established with workstreams including Workforce, Estates, Capacity & Demand and Pathways. These mirror the National Endoscopy Programme Board; with which the H Board is fully engaged, workstreams;. The H Board has undertaken Capacity and Demand modelling with the DU and this is to be further refined during November and will inform our plan going forwards. The H Board have continued to insource activity as above and await a decision on funding.

Milestone 3/March 2020 - Endoscopy develop JAG accreditation timetable/plan
The National Endoscopy Programme Board has commissioned a JAG preparation visit for all Health Boards which is currently being arranged. This will inform the planning process to achieve full accreditation.

AP025 - Systematic review and plans developed to address diagnostic service sustainability
Milestone 1/June 2019 – Ensure capacity plan for in year demand is in place.
Insourcing for CT, MR and Non Obstetric Ultrasound has been agreed for the Radiology Service until the end of December 2019 with RMS. Insourcing will be required until March 2020 and additional funding for Radiology has been requested from Welsh Government.

Milestone 2/March 2020 – Develop capacity plan for future demand (equipment and staff)
Kendall Bluck are currently conducting a review of Radiology Services and this will be used to inform the basis of the proposal for sustainable radiology services in time for the Milestone date.

Quarter 2 Sample Report: AP022 - Business case, implementation plan and commencement of enabling works for orthopaedics

Milestones due to be met in Quarter 2:
AP022A - Finalise Orthopaedic Plan
AP022B - Commence implementation plan and enabling works for Orthopaedic Services

Summary of Position
The 3 funded elements of the Orthopaedic Plan are progressing well;

1. Consultant recruitment the HB has received an excellent response to the adverts for ortho cons with over 50 applications.Interviews scheduled for October 2019. However RAG remains amber as there will be a time lag before the posts are filled and they will impact upon additional activity for this year.
2. Outsourcing 750 cases to NHS England providers. Transfer of patients has begun to take place to Agnes Hunt and Countess of Chester in accordance with the plan. Treatment has commenced and we do not anticipate any issues in delivering the planned 750 cases.
   Further outsource capacity is being sought from other providers to support delivery of the backlog reduction. Contracts not yet finalised hence rating remains amber
3. Estate – capital planning work is progressing with costed returns expected by the end of December 2019.

Quarter 2 Sample Report: AP026 - Fully realise the benefits of the newly established SURNICC service

Milestones due to be met in Quarter 2:

There are no milestones to achieve in quarter 2 for this Action.

Posts	Central - WTE	Current Position
Consultant Neonatologists	7	Fully recruited
Band 5	37.12	38.12 (0.92 WTE Over Recruited)
Band 6	16.5	13.08 WTE (Under Recruited)
Band 3	5.5	5.1 WTE (0.4 WTE Under Recruited)
Total WTE	66.12	56.3

Summary of Position

- The North Wales Neonatal Service underwent it's final Transition in November 2018.
- Babies under 26 weeks gestation and those requiring Surgical or Cardiac care are transferred to England.
- Transfer pathways are in place and are working well.

CARE DAYS	YGC Q1 Total	YGC Q2 Total	YGC Total	WMH Q1 Total	WMH Q2 Total	WMH Total	YG Q1 Total	YG Q2 Total	YG Total
Total Intensive Care Days	106	98	204	10	14	24	5	6	11
Total High Dependency Care Days	313	175	488	41	77	118	58	46	104
Total Special Care Days	484	406	890	444	668	1112	305	287	592
Total Normal Care Days	1	0	1	0	1	1	23	37	60
Cannot calculate care level total	0	1	1	4	7	11	0	0	0
Total Patient Care Days	904	680	1584	499	767	1266	391	376	767

Medical Staffing

Representation from the Wales Deanery visited YGC in February 2019, it was agreed that Neonatal Trainees would be returning to YGC from March 2020, we are expecting 4 Trainees. All the Neonatal Consultants have agreed to become Educational Supervisors. We are now fully recruited to our Neonatal Consultant posts, there is cross cover at Tier 2 Registrar Level with the Paediatric Team and there are 2 SHO's due to commence soon.

Nurse Staffing

Recruitment is ongoing, 1 WTE B6 and 2 WTE Band 5 are due to commence in post in October 2019. Over recruitment of Band 5 Nursing Staff to address difficulties in recruiting band 6, to undertake QIS – Quality in Speciality Course in Conjunction with Bangor University.

01.12.18 - 30.09.19 North Wales Activity

24 babies were cared for at YGC between the gestational age of 26 Weeks and 31+6 Weeks who were booked in WMH

4 babies were cared for at YGC between the gestational age of 26 Weeks and 31+6 Weeks who were booked in YG

5 Babies were cared for in WMH between the gestational age of 30 Weeks and 31+6 Weeks

2 Babies were cared for in YG between the gestational age of 31 Weeks and 31+6 Weeks

01.04.17-30.09.19 26W - 26W+6D

11 Babies 26w - 26w+6d gestation were cared for in YGC from 01.04.17 to 30.09.19

IC Days	HD Days	SC days
85	473	323

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Programme Unscheduled Care Matrix

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

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AP031. Workforce shift to improve care closer to home

This action required the recruitment of advanced nurse practitioners, which has not been successful to date. We have been out to agency with limited success and are continuing to try and recruit to the posts. We have significant gaps at Wrexham in both nursing and medics, hence the highlighted Red position.

AP039. Stroke Services

The business case could not be approved at the present time as the proposed clinical model did not have a financial pipeline to support the revenue costs. Therefore further work is being undertaken to revise the case and develop the clinical pathway.

Quarter 2 Sample Report: AP032 - Demand - Improved Mental Health Crisis response

Milestones due to be met in Quarter 2:
AP032A – Implement alternative crisis pathway

Summary of Positon

- Integrated ICAN Pathway has been developed and agreed will support people of all ages and will focus on ensuring that people receive the right support, in the right place, at the right time.
- ICAN Centres have been tested both in the community and within unscheduled care.
- The ICAN Mental Health Urgent Care Centres, support people in crisis who present at our Emergency Departments between the hours of 7pm and 2am but do not require medical treatment or admission to a mental health facility.
- Since launching in January, the service has supported over 1,400 people in crisis.
- An evaluation report will be provided within the next reporting period.
- A recent social return on investment analysis found that for every £1 invested, more than £5 of social value was created.
- We have identified our First ICAN Community Hubs. Community Hubs will offer a local one stop shop of resources to better support people in their communities, ensuring people get the right help and support at the right to prevent problems from escalating.
- We have identified our first ICAN Primary Care test sites.
- We have tested ICAN Volunteers operating from Ambulance control with a view of a implementing a pilot study
- ICAN Training has been accredited and launched. We **will be starting to deliver the training across organisations and communities in North Wales**

Quarter 2 Sample Report: AP036 - Flow – Ablett/PICU for Mental Health

Milestones due to be met in Quarter 2:
There are no milestones to achieve in quarter 2 for this Action.

Summary of Positon

Actions	Outcomes	Timeline
Meetings progressing well with plan	Scoping work and data analysis to be undertaken	With sustained focus, the T&F & Board are on track to deliver the programme. There is however; a significant amount of work to be undertaken. To progress this work, Ward Manager needs to be released and backfilled for the agreed period of 3 months.
Clinical and Operational Pathways drafted	Further evidence base sourced	
Transport options scoped, to remain the same by offering a blend of using our own transport & for those patients presenting a higher risk, 365 will be commissioned	Teams informed and engaged, communication plan drafted	
Detailed data analysis undertaken including demand and capacity exercise	Detailed programme plan agreed	
Engagement with CHC and partners underway with clear plan to progress	PID agreed & CAMMS updates up to date	
EQIA, DIPA & HIA complete	Pathway drafted	
Seclusion options have been worked through and the group agreed the need for Tryweryn to have extra care area. A bid will need to be completed for the enabling works	Transport arrangements agreed	
Seclusion Policy to include the use of extra care facility	Consensus agreed on Seclusion	
Further evidence base sourced, literature search complete and informed any decisions made thus far		
ECT arrangements are under review		
Decommissioning of Taliesin and future plans requires further discussion		

Programme Workforce Matrix

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

Three Year Outlook and 2019./20 Annual Plan

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

September 2019

Quarter 2 Sample Report : AP045 - Develop an integrated multi professional education and learning improvement programme in liaison with HEIW

Milestones due to be met in Quarter 2:
AP045A - Enhance working relationships with local education providers to develop stronger academic links
AP045E - Improve attraction

Summary of Position
AP045A - Enhance working relationships with local education providers to develop stronger academic links:
An Education Improvement plan is in place to develop relationships and promote joint working between BCUHB, Higher Education partners, Further Education partners and Local Authority Education leads.
A new Multi-Professional Educational Governance Group has been established, the objectives of which are to strengthen relationships and partnerships with education providers including Health Education Improvement Wales (HEIW), to support and develop education pathways to build a competent, sustainable and flexible workforce. Draft Terms of Reference for the group have been updated to reflect new contacts with education partners and Health Education Improvement Wales (HEIW). The draft Terms of Reference build on those established for the existing 'Training and Education' sub group, which were developed to support the delivery of the Recruitment Strategy.
Mapping of local and national education provision has been completed in readiness for the first meeting. The first meeting will be held on the 21st October 2019

AP045E - Improve attraction:
A scoping exercise has been conducted to map all events, the target groups, age range of targeted groups, and event type in order to ensure appropriate engagement between the Health Board and external partners in order to attract the local population to consider careers within the NHS. 38 events were supported in the 2018/19 school year, 15 events have been planned or already supported in this academic year to date (September-November). A Careers advisor event is being organised by HEIW, BCUHB are represented, the event provides local career advisors with information about health careers. A meeting has taken place with a small local company who delivers careers advice to primary schools WOW (World of Work) sessions are delivered in a fun and interactive way to encourage children to start to think about the types of work available.

Quarter 2 Sample Report: AP046 - Develop a strategic equality plan for 2020-2024

Milestones due to be met in Quarter 2:

AP046E - Aligned the objectives to:-

- Living Healthier Staying Well (LHSW) priorities, the Clinical Services Strategy and Workforce Strategy
- The seven partnership well-being objectives, developed in accordance with our duties under the Well-being of Future Generations Act 2015
- The objectives aligned to the Regional Population Needs Assessment and BCUs North Wales Area Plan priorities in response to the Social Services and Well-being (Wales) Act 2014

AP046F - Developed draft SEP 2020- 2024 in line with the duties and undertaken external consultation prior to presentation to Board

Summary of Position

The Strategic Equality Plan has been developed to meet our statutory requirements following extensive research and engagement with a broad range of Stakeholders between January and July 2019. This has included our Equality Stakeholder Group comprising individuals representing people with protected characteristics; the Gwynedd Older People's Forum; the Centre for Sign Sight Sound; Local Partnership Forum, Local Negotiating Committee and Healthcare Professionals Forum; Betsi Cadwaladr University Health Board Stakeholder Reference Group; staff groups and a range of individuals both within and outside the organisation.

The Corporate Engagement Team have also been involved in distributing questionnaires at events they have attended over the last few months. This work has informed the development of a number (8) of strategic equality objectives that will be aligned to the development of the Integrated Medium Term Plan so that they become embedded within operational plans for the organisation. The Plan was approved by the Equality and Human Rights Strategic Forum in August 2019 and was submitted to Strategy Partnerships and Population Health (SPPH) Committee on 1st October 2019 where approval was given for a period of public consultation. The Plan will now be widely circulated and published on our website for public consultation. The final draft will return to SPPH in December 2019 before going to Board for final approval.

Programme Estates Strategy Matrix

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

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AP069 Ablett Mental Health Unit.

Following appointment of the Supply Chain Partner, the Project Board has reviewed the programme

- The outline business case is the key document in that it defines the case for change and sets the project programme and budget envelope
- The Project Board have noted that the timescale for completion of the OBC is dependent upon 2 critical factors:
  1. The consultation/engagement in support of the relocation of services from Bryn Hesketh
  2. Together with the SCP the Project Board have undertaken further work to assess the risks and deliverability of the current preferred option (partial demolition, rebuild and refurbishment of the existing unit) This review has indicated that consideration should be given to the benefits/consequence of an alternative option to develop a new build solution on the YGC site (to mitigate the risks of the interface with operational services and expected planning objections)
- Together these factors have indicated the need to extend the period of development of the OBC from Jan 20 to May 20.
- By ensuring the OBC is robust and comprehensive the Project Board believe that the planned completion of the FBC and commissioning of the new facility will not change from the original programme.

Estates Strategy
Statutory Compliance

Quarter 2 Sample Report: AP062 - Statutory Compliance/Estate Maintenance

High Risks (£m)	Significant Risks (£m)	Moderate Risks (£m)	Low Risks (£m)	Risk Adjusted Cost (£m)
28.6	20.1	54.5	38.6	53.4

Milestones due to be met in Quarter 2:
There are no milestones to achieve in quarter 2 for this Action.

Summary of Position

Estate condition and performance summary report 2017/18 (2018/19 Report available in November 2019)

- Agreed programme of discretionary capital investment across BCU 19/20
- Estates & Facilities budget £3m
- Project delivery reported through to the Capital Programme Management Team
- Projects delivered on priority and based on Estates & Facilities Risk Register
- Pan BCU Projects - Fire Management and Asbestos Removal
- All projects currently on target for delivery by 31st March 2020 and draft bids for 20/21 currently being developed from Estates & Facilities Risk Register

WG Indicator	Definition	BCU Performance	NHS Wales Average
Physical condition	A minimum of 90% of the estate should be sound, operationally safe and exhibit only minor deterioration	74%	81%
Statutory compliance	A minimum of 90% of the estate should comply with relevant statutory requirements.	78%	87%
Fire Safety compliance	A minimum of 90% of the estate should comply with relevant statutory requirements.	79%	90%
Functional suitability	A minimum of 90% of the estate should meet clinical and business operational requirements with only minor changes required.	85%	82%
Space utilisation	A minimum of 90% of the estate should be fully used	88%	91%
Energy Performance	The estate should consume no more than 410kWh/m2	<421 kWh/m2	<409kWh/m2

Quarter 2 Sample Report: AP074 - Integrated Care Fund (ICF) schemes

Milestones due to be met in Quarter 2:
There are no milestones to achieve in quarter 2 for this Action.

Summary of Position
Proposals have been reviewed across the Health Board and Councils to provide integrated joint office accommodation (CRT's) and schemes that support dementia services. The following details progress to date.

- OPMH Dementia Unit, Bryn Beryl. Is a new build extension to provide day care accommodation for Older / Adult Mental Health. The scheme has been procured with planning approval received, and is now at business case stage. **AMBER**
- Tywyn Community Resource Team. Work has been completed to provide integrated joint office accommodation, with the Hospital in Tywyn **GREEN**
- LlanfairPG Community Resource Team. Feasibility to provide accommodation for an integrated joint office is complete up to planned permission stage. However as number of ecological and planning issues have been raised, which need resolution before the scheme can progress any further. **RED**
- Cefni Garden will provide a dementia friendly garden within a courtyard on the Cefni Hospital Site, design is complete with procurement ongoing. It is anticipated the scheme will be completed before March 2020. **GREEN**
- Amlwch Community Resource Team. Procurement is complete to provide integrated joint office accommodation within the Health Centre at Amlwch. Subject to approval, the scheme will be completed by December 2019. **GREEN**
- Denbighshire Community Resource Team. Design and procurement have been completed for integrated joint office accommodation on the Denbigh Hospital Site. Subject to approvals, the scheme will be complete by January 2020. **GREEN**
- Conwy CRT's at Prestatyn and Abergele Clinics. Scoping and feasibility is ongoing to provide integrated joint office accommodation on the Prestatyn and Abergele clinic sites. Once design is signed off procurement can progress, subject to approvals the schemes will be finished April 2020. **AMBER**

Programme Digital Health Matrix

Plan Ref	Actions	Executive strategic Lead	submitted to Committees				Self Assessment and milestone due indicator (M) from revised outlook report July 2019						
			Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
AP051	Phase three of Welsh Patient Administration Project (PAS) starts. It will replace the Commercial PAS system in the West and standardise processes relating to this system in other sites	Executive Medical Director	G	G	G	G	G	M						M
AP052	Completion of pilot studies to learn lessons to inform wider installation and utilisation of the Welsh Community Care Information System	Executive Medical Director	A	A	R	R	R	M			M			M
AP053	Reconstitute the Welsh Emergency Department System upgrading the Emergency Department System in the East (phase 1) and extending instances to Central and West (phase 2 and 3)	Executive Medical Director	G	G	G	G	G	M						M
AP054	Phase 2 of a local Digital Health Record which will strengthen our investment and approach to the delivery of an electronic patient record	Executive Medical Director	G	G	G	G	G	M						
AP055	Support the identification of storage solution for Central Library	Executive Medical Director	A	A	A	A	A	M						
AP056	Transition program to review the management arrangements for ensuring good record keeping across all patient record types	Executive Medical Director	G	G	A	A	A	A						M
AP057	Delivery of information content to support flow/efficiency	Executive Medical Director	A	A	G	G	G	M						M
AP058	Rolling programmes of work to maintain / improve the digital infrastructure e.g. migration of telephone infrastructure from an end of life solution to one which is fully supported and capable of underpinning service change e.g. single call centre	Executive Medical Director	G	G	A	A	A	A						M
AP059	Provision of infrastructure and access to support care closer to home	Executive Medical Director	A	A	A	A	A	A						M
AP060	Support Eye Care Transformation	Executive Medical Director	G	G	G	G	G	G						M
AP061	Implement Tracker 7 cancer module in Central and East.	Executive Medical Director	A	A	G	G	A	M						

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Quarter 2 Sample Report: AP055 - Support the identification of storage solution for central library

Milestones due to be met in Quarter 2:
AP056A - Specify the storage and logistics requirements for long term storage of acute patient records in Central Support the Hospital Management Team, Planning and Estates department to identify and appropriate solution.

Summary of Position
Agreed Business Case to be aligned with Mental Health Case timescales i.e. vacating the current casenotes housed in the 2nd store by March 2021.
Draft Ministerial Brief prepared for sign off at next meeting on the 23/09. This meeting will focus on the available options/models for housing the YGC file library, including in scope those housed in the primary library. Following this meeting work will commence on the YGC Single Stage Business Case.

Quarter 2 Sample Report: AP056 - Transition programme to review the management arrangements for ensuring good record keeping across all patient record types

Milestones due to be met in Quarter 2:
There are no milestones to achieve in quarter 2 for this Action.

Summary of Position
New Deputy Head of Health Records has started in post as of 1st October 2019. The B7 Project Manager has been confirmed in principle and funding is being secured through the HASCAS and Ockenden Programme Board. Once in place the baselining work can commence, Mental Health Services will be the priority area. Original aim to complete this work by March 2020 is at risk due to the delays on the Project Manager post.

Appendix A: Further Information

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

The link to these papers is shown below:

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

Quality, Safety & Experience (QSE) Committee **19.11.19**	GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board ***To improve health and provide excellent care***

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

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

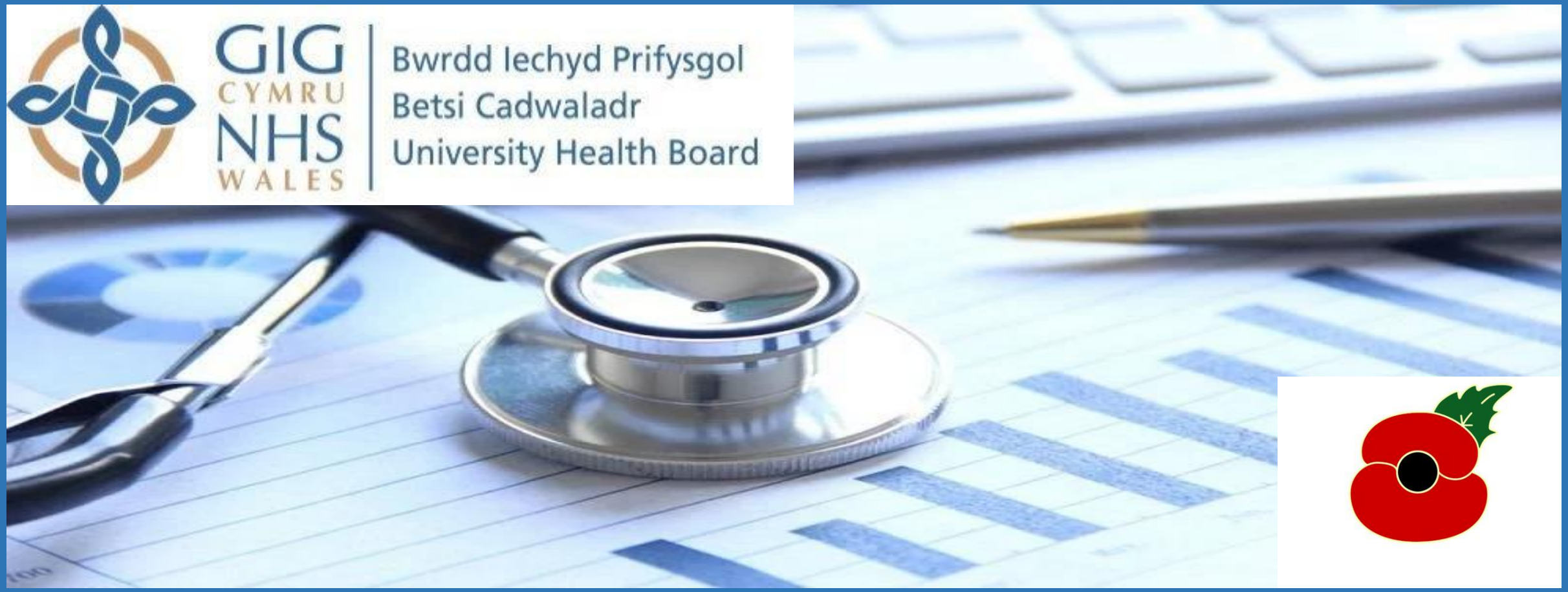
2.To target our resources to those with the greatest needs and reduce inequalities	√	2.Working together with other partners to deliver objectives	√
3.To support children to have the best start in life	√	3. Involving those with an interest and seeking their views	√
4.To work in partnership to support people – individuals, families, carers, communities - to achieve their own well-being	√	4.Putting resources into preventing problems occurring or getting worse	√
5.To improve the safety and quality of all services	√	5.Considering impact on all well-being goals together and on other bodies	√
6.To respect people and their dignity	√		
7.To listen to people and learn from their experiences	√		
Special Measures Improvement Framework Theme/Expectation addressed by this paper Performance is part of the Special Measures Improvement Framework			
Equality Impact Assessment The report considers the performance against the Operational Plan of the Board which has had an EqIA carried out			

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

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

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board



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Integrated Quality and Performance Report
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About this Report

Section 1: Report Structure

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

The measure code relates to the code applied within the NHS Wales Annual Delivery Framework, which Welsh Government hold the Board accountable for delivering. A key difference in the structure of the IQPR for 2019/20, in comparison to 2018/19 is that it is that the report reflects the organisational priorities as set out in the Operational Plan approved by the Board . The report maps each the measures included against the corresponding work programme within the Annual Plan for 2019/20. This is done via a reference number in the 4th box of the Measure Component Bar. The next page contains a list of all the Programmes in the Annual Plan in the order of the reference numbers.

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

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

About this Report

Section 3: Report Content for 2019/20

Profiles

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

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. 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 October 2019 where the measure and profile is reportable monthly.
This report also includes the local indicator ; Healthcare Acquired Pressure Ulcers and provides disaggregation of the Health Care Acquired Infection data to demonstrate the split between hospital and community recorded infections and disaggregation of S.aureus indicator to show numbers of MRSA and MSSA infections and number of C.difficile infections which contribute to the overall rate for both national measures.
An additional slide is provided this month on the actions being taken to address the backlog incidents requiring closure.
In addition to this report all committees are provided with a RAGP self-assessment of progress against the actions within the Annual Plan.

Improved

Code	Measure	Status	Annual Plan Profile	National Target
DFM002	Immunisation: 3 doses of 6 in 1	95.90% ↑	>= 95%	>= 95%
DFM004	Healthy Child Wales Programme	94.40% ↑	Improve	Improve
DFM060b	MHM1a - Assessments within 28 Days (CAMHS)	85.56% ↑	>= 73%	>= 80%

Of Most Concern

Code	Measure	Status	Annual Plan Profile	National Target
DFM024	Total Number of New Never Events	2 ↓	0	0
DFM023	Serious Incidents Assured within timescales	39.00% ↓	>= 45%	>= 90%
DFM021c	Cumulative Rate: C.Difficile	29.31 ↓	<= 22	<= 22.13

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Executive Summary

This report demonstrates continuing improvement in the delivery of the mental health measure within the Child and Adolescent Mental Health Service (CAMHS) following investment in the service. Unfortunately the overall delivery of the mental health measure is adversely affected by performance within adult mental health services. Following a deep dive, the service has a good understanding of the teams most challenged with this and are actively working to address this with focus on both backlog of patients and addressing the pre-referral provision for the high proportion of patients discharged at first assessment.

The Committee are asked to note the low level of performance in relation to the two relatively new measures : psychological therapies and neurodevelopment. Work is continuing nationally to improve consistency of information in relation to measurement of psychological therapies. Resource has been received to improve access for neurodevelopment and this is expected to result in improvement during this financial year. The growth in demand of neurodevelopmental services is such that further work will be required to determine the sustainable service model for these children.

This report presents the infection information in a greater level of detail than previously, enabling the committee to understand the origin of the infections reported. It is positive that no further cases of MRSA are reported this month, and that for this infection performance is better than plan and an improvement on the same time last year. However, in common with other Health Boards in Wales the overall picture of infections rates is worse than the national targets.

The committee are asked to note the overall improvement in the number of open serious incidents, however performance on timeliness in closure of incidents remains below expected standards at this time. Delay in closure of incidents in a timely manner is recognised as important to ensure learning from the incident can be utilised to reduce the risk of repeat incidents. Work under the new assistant director of patient experience has commenced to reduce this delay through simplification of the process.

The committee are asked to note that 3 never events have occurred since the last report and that the investigations into these are not yet complete.

Chapter 1 – Quality Graphic Summary

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Chapter 1 – Quality Summary Page 1

Code	Measure	Status	Annual Plan Profile	National Target
DFM008	Alcohol Attributed Admissions	444.4	N/A A	Reduce
DFM009	Learning Disabilities Annual Health Check	36.50%	AP	>= 75%
DFM010	Disclosure and Barring Checks: Children			
DFM011	Disclosure and Barring Checks: Adults			
DFM012	Hospital Admissions mention Self Harm in Children & Young	4.53	0	0
DFM013	Amenable Mortality Rate	127.2	AP	Reduce
DFM014	Sepsis Six Bundle: Inpatients	100%	100%	Improve
DFM015	Sepsis Six Bundle: Emegrgency Department	52.36%	>= 77%	Improve
DFM016	Preventable Hosptial Acquired Thrombsis	0	NIP	Reduce
DFM017	Opiod Average daily quantities per 1,000 patients			
DFM018	Antipsychotic Prescriptions for Over 65s			

Code	Measure	Status	Annual Plan Profile	National Target
DFM019	Antibacterial Items per 1,000 STARPUS	292.0	<= 327.1	Reduce
DFM020	Combined 4 Antibacterial items prescribed	7.80%	<= 8.20%	Reduce
DFM022	Patient Safety Solutions Wales Alerts and Notices	2	<= 6	0
DFM023	Serious Incidents Assured within timescales	39.00%	>= 45%	>= 90%
LM023a	Serious Incidents: Patient Falls	6	<= 11	<= 11
LM023b	Serious Incidents: Pressure Ulcers	10	0	0
LM023c	Total Number of Healthcare Acquired Pressure Ulcers	539	AP	AP
DFM024	Total Number of New Never Events	2	0	0
DFM027	Universal Mortality Reviews within 28 Days	89.60%	>= 95%	>= 95%
DFM028	Crude Mortality Rate (Under 75 years of age)	0.75%	<= 0.70%	Reduce
DFM032	New Medicines made available	99.40%	1	100%

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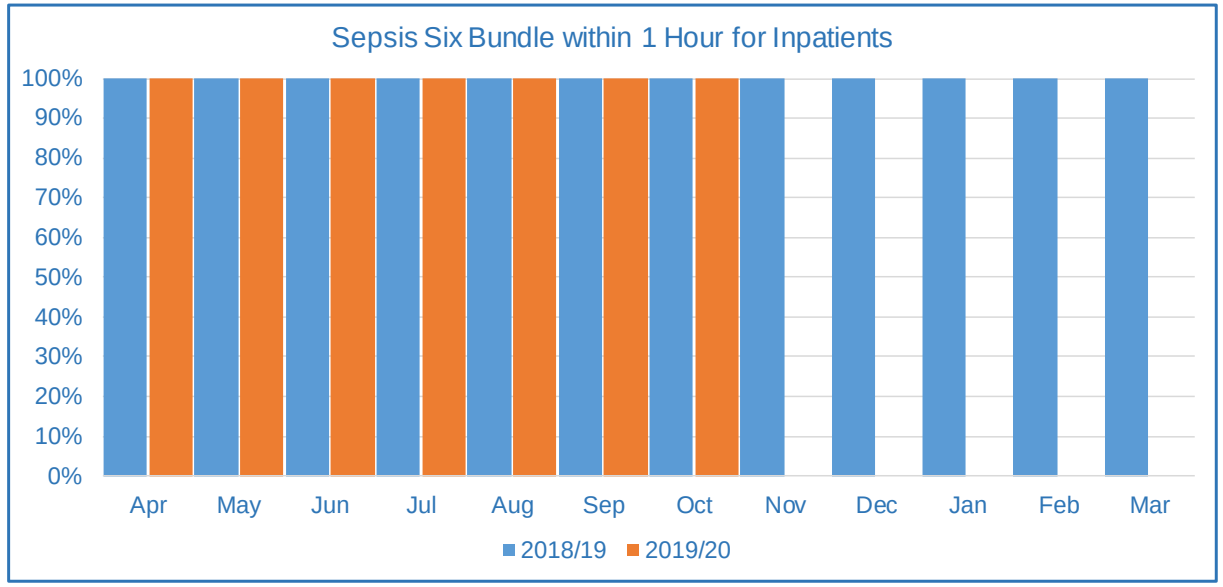
Chapter 1 – Quality Summary Page 2

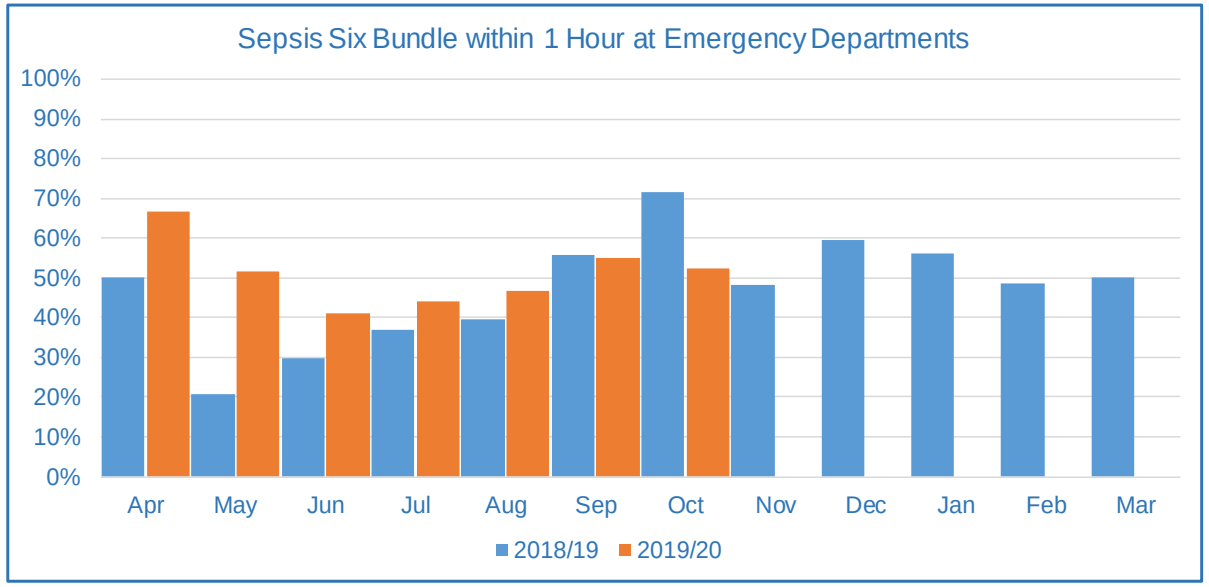
Code	Measure	Status		Annual Plan Profile	National Target
DFM033	Number of Clinical Research Studies				
DFM034	Number of Commercial Research Studies				
DFM035	Number recruited to clinical studies				
DFM036	Number recruited to commercial studies				
DFM037	Survey Results: Satisfaction with Health Services	6.17	↓	Improve	Improve
DFM038	Number of Postponed Procedures (Non-clinical)	2,227	↑	Reduce	Reduce
DFM039	Evidence of Responding to service user experience				
DFM040	Concerns Replies within 30 Days	61.90%	↑	>= 40%	>= 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	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)	87.00%	↑	>= 95%	>= 95%
WGM002	Ward Staff Skill Mix (Nursing)	56.00%	↑	>= 60%	>= 60%

Sepsis Six Graphs

Code	Measure Description	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	Improve	AP039	100%	Oct-19	100%	➡	#VALUE!	100.00%	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	Improve	AP039	>= 77%	Oct-19	52.36%	⬇	#VALUE!	47.06%	66.21%	51.55%	44.78%	-	44.27%	53.13%	58.50%	-	52.36%			-				





Why we are where we are: We are driving work in Emergency Departments (ED) but performance remains variable depending on current ED pressures. Collaboratives are work in progress and a further event is scheduled in the new year.

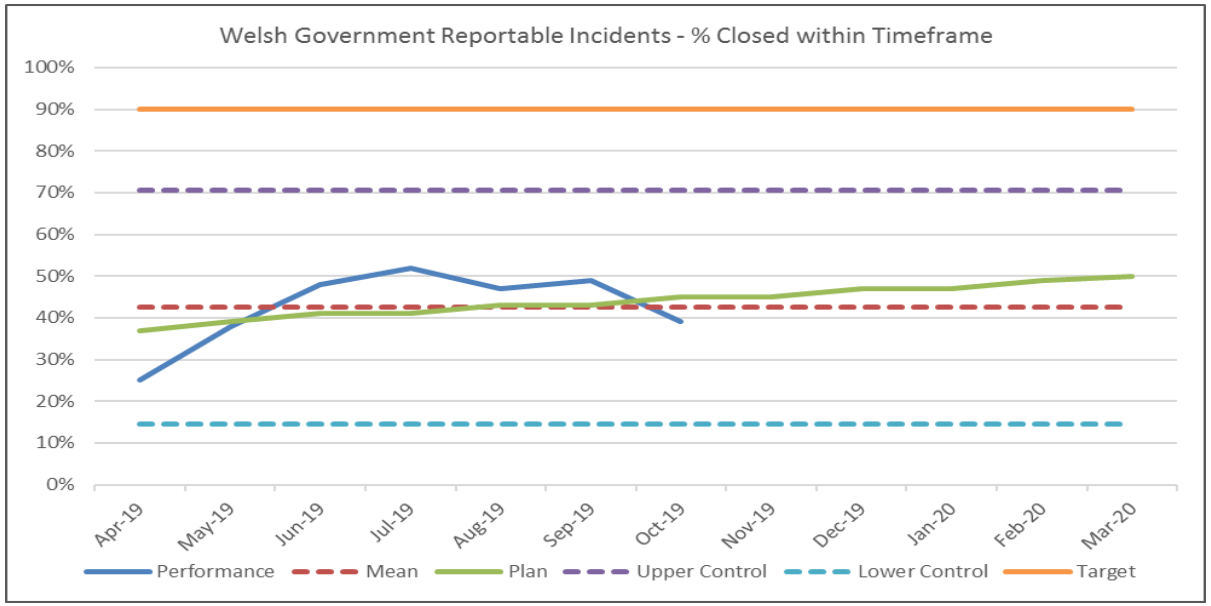
Sepsis Six Bundles

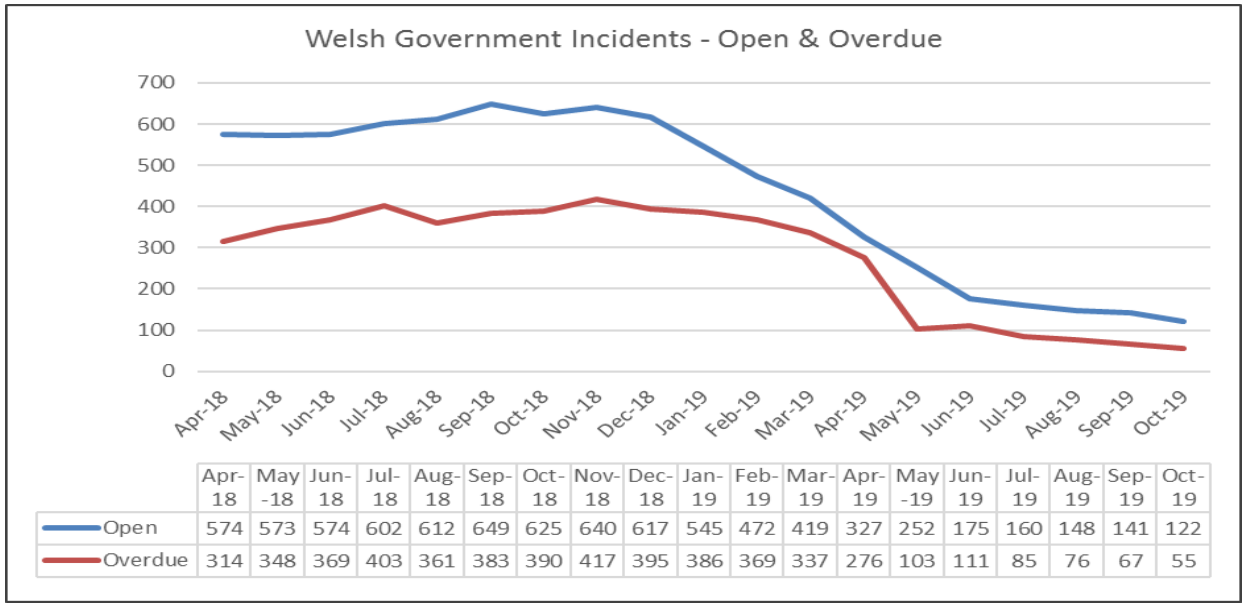
Actions	Outcomes	Timeline
1. Sepsis collaborative in Emergency Departments (ED) • Day 4 of the sepsis collaborative took place on 5th Sep 2019, currently planning for Day 5 collaborative in early 2020 • Reduction in mortality is being seen now on some sites as a result of on going improvement work	•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

***D**ata, **R**eview the cases, **I**mprovements, **P**lot the dots, **S**hare and celebrate

Incidents Graphs

Code	Measure Description	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
DFM023	Of the serious incidents due for assurance, the percentage which were assured within the agreed timescales	>= 90%	AP039	>= 45%	Oct-19	39.00%	↓	4th	25.81%	25.00%	38.24%	48.28%	-	51.52%	46.51%	51.60%	-	39.00%			-				-





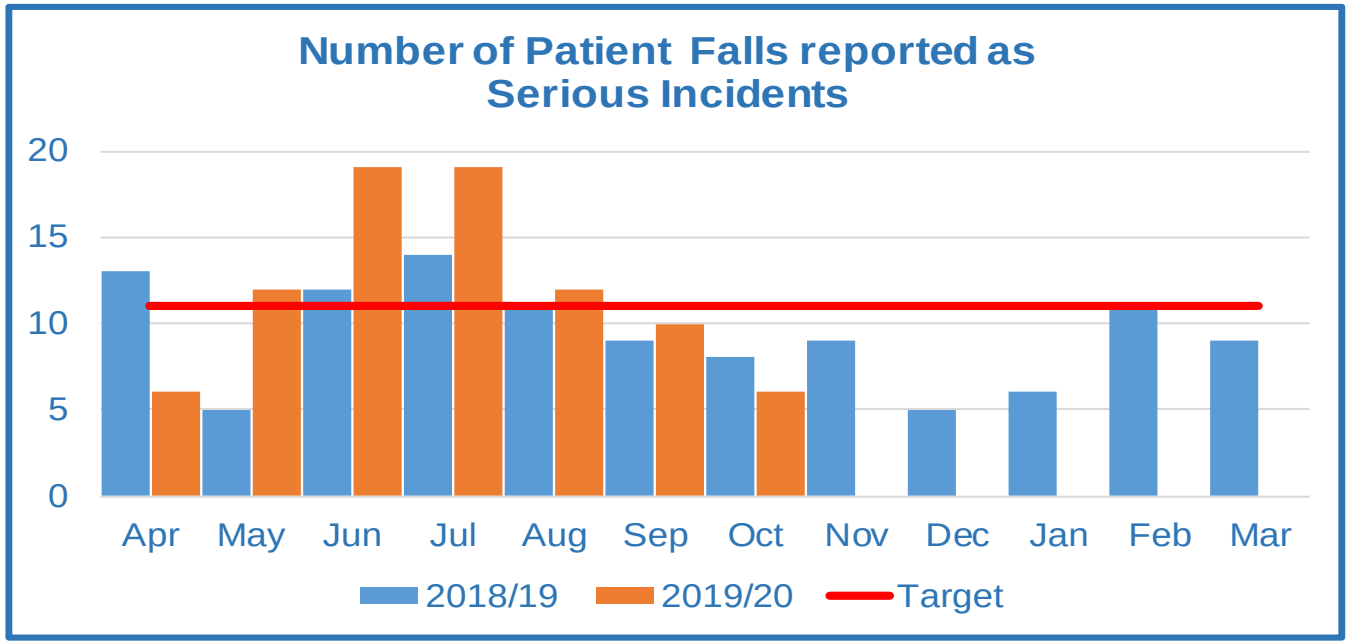
	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Open	574	573	574	602	612	649	625	640	617	545	472	419	327	252	175	160	148	141	122
Overdue	314	348	369	403	361	383	390	417	395	386	369	337	276	103	111	85	76	67	55

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 month on month, with the number open as of the 31st October 2019 being 122, of which 55 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.

Actions	Outcomes	Timeline
1. The new Assistant Director of Service User Experience is commencing a review of the procedures and processes for incidents with a view to streamlining and simplifying. This will be done in co-production with divisions	Simpler process for staff to follow reducing delays	31 March 2020
2. Development of a new modular training programme for incident reviewers and Continuous Professional development (CPD) programme for the corporate team	Improved quality of investigations and closure forms reducing the need for amendments and revisions	31 March 2020
3. Implementation of the new All-Wales Concern System (replacement Datix system)	Simpler, improved and more accessible recording of investigations and learning and easier reporting to Welsh Government (WG)	National rollout during 2020-2021 (WG led programme)
4. Review of incident performance scrutiny processes, improved performance reporting and strengthened local ownership – this will include consideration of the review of the Serious Incidents (SI) Framework underway by Welsh Government	Earlier and local resolution of delays and targeted support from the corporate team to area experiencing greater challenge	31 December 2019

Serious Incidents: Patient Falls Graphs

Code	Measure Description	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
LM023a	Number of Patient Falls reported as Serious Incidents	<= 11	NIP	<= 11	Oct-19	6	↑	N/A	8	6	12	19	0	19	12	10	-	6			-				-



Harms resulting from patient falls in October 2019:
Total of **6** Falls (inpatient) reported to Welsh Government:

2 falls Community Hospital (West Area)

- Glasmor Ward, Penrhos Stanley Hospital-fracture hip
- Cader Ward, Dolgellau Community Hospital-fracture hip

4 falls Secondary Care (Wrexham Maelor Hosptial)

- Medical Assessment Unit- fracture hip
- Fleming Ward - fracture pubic rami
- ENT Ward –fracture hip
- Emergency Department -fracture pubic rami

Serious Incidents: Patient Falls

Actions	Outcomes	Timeline
1. Falls Collaborative wards shared learning to date and successes to date 23rd September 2019	To reduce inpatient falls by 15% for collaborative wards	30th November 2019
2. Collaborative wards (as a group) early indications suggest achieving the target as early indication suggest reduction of 17%	To reduce inpatient falls by 15% for collaborative wards	30th November 2019
3. Implementation of the all Wales Falls and Bone health risk assessment supports collaborative interventions and will replace the BCUHB Falls pathway	Health Board wide adoption and implementation	30th April 2020

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

Code	Measure Description	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
LM023b	Number of Healthcare Acquired Pressure Ulcers reported as Serious Incidents	0	NIP	0	Oct-19	10	↓	N/A	40	3	4	2	-	2	6	2	-	10			-				-
LM023c	Total Number Healthcare Acquired Pressure Ulcers(All Grades)	AP	NIP	AP	Oct-19	539	↓	N/A	ND	508	452	543	-	550	502	482	-	539			-				-

Why we are where we are: Total of 10 HAPU's reported for October 2019: Community (clinic) 4 reported and 5 secondary care 1 MHLD

Actions	Outcomes	Timeline
1.HAPU Masterclasses held across the Health Board in October 2019 included the revised SKKIN Bundle and all Wales Risk Assessment (Purpose T).	Masterclasses attended by 155 to date	4th November 2019
2.Risk Assessments to be implemented as part of the introduction of revised booklet April 2020	Combined Risk Assessment and SKKIN bundle will support identification and preventative interventions to reduce incidence of HAPU	30th April 2020

Never Events

In this reporting period 3 Never Events have been reported:-

One in September 2019:-

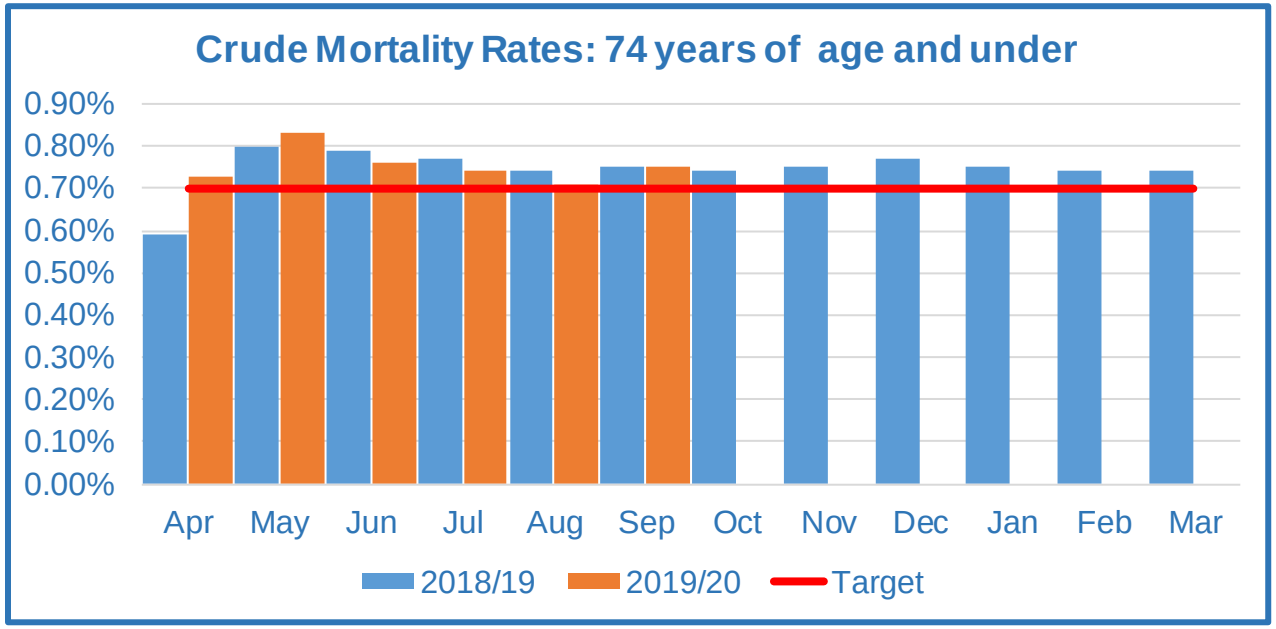
- Wrong route administration of medication. Patient booked on emergency list for below knee amputation. Agreed that patient was to have a spinal anaesthetic followed by a femoral block. Discussed with patient and verbal consent given. Consultant supervised trainee to perform both spinal and block. Successful spinal anaesthetic performed in sitting position then laid supine to perform block. Sedation given to patient, scan performed on right leg and then block performed. On application of the second part of the World Health Organisation (WHO) Checklist it was identified that the block had been performed on the wrong side. Full investigation remains underway at time of writing.

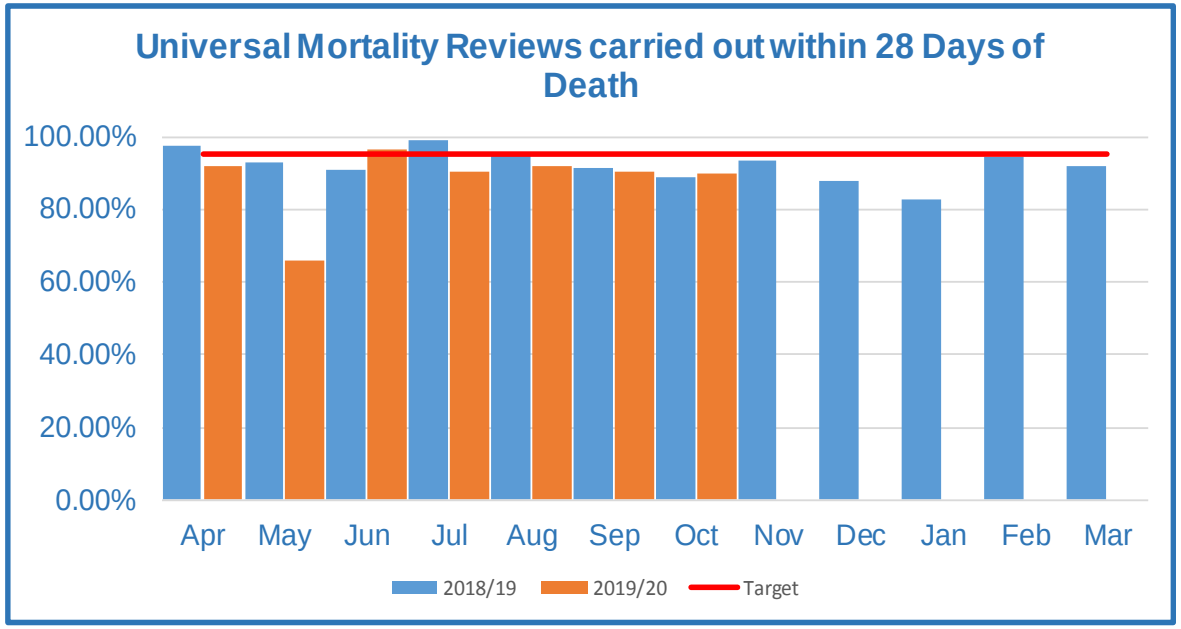
and two in October 2019:-

- The first event was a wrong site surgery, where the patient was referred for OGD and Colonoscopy in error. The wrong patient label was put onto the referral form resulting in the patient having both upper GI Endoscopy and Colonoscopy performed. The full investigation remains underway at the time of writing.
- The second was a retained foreign object post-operation where a central catheter was placed into patient's right arm and was correctly positioned, however, the locking and suturing clamp were not attached to the line. The line was sutured into position but was reported to not be flushing or working correctly. On attempting to remove the line only a small connector was able to be removed with no line left in view. The patient was taken to x-ray were a radiologist successfully removed the line with no apparent ill effect to the patient. On removing the line it was identified that the guidewire was still attached. The full investigation remains underway at the time of writing.

Mortality Graphs

Code	Measure Description	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
DFM027	Percentage of universal mortality reviews (UMRs) undertaken within 28 days of a death	>= 95%	AP039	>= 95%	Oct-19	89.60%	↓	2nd	85.80%	92.10%	95.80%	96.70%	-	90.50%	91.70%	90.50%	-	89.60%			-				-
DFM028	Crude hospital mortality rate (74 years of age or less)	Reduce	AP039	<= 0.70%	Sep-19	0.75%	↓	4th	0.75%	0.73%	0.83%	0.76%	-	0.74%	0.71%	0.75%	-				-				-





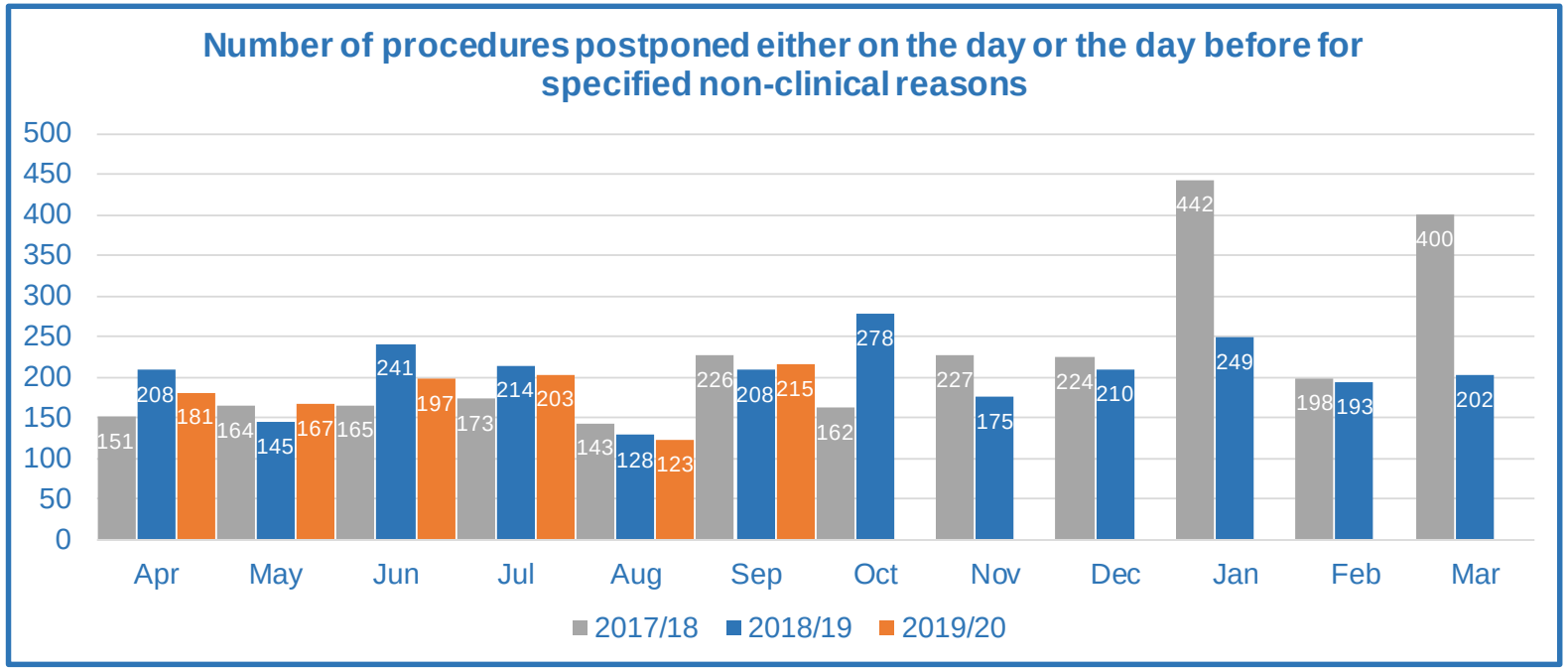
Why we are where we are: Latest data continues to show Stage 1 mortality review performance below 95% completion target at Wrexham. Anticipated this will improve significantly with move to DATIX.

Crude Mortality in under 74 years of age is performing at expected levels and completed review of crude mortality shows no statistically significant variation in our figures which would raise any concern.

Actions	Outcomes	Timeline
1. DATIX Mortality module implementation • Implementation of Stage 1 continues in YGC. • Progress delayed by security log-on issues and integration with PAS. • These being worked through with the National Team. • Workshops held on three DGH sites and feedback used to revise Stage 2 Mortality screens. • Work progressing to develop Mental Health and Learning disability reviews using DATIX system • Stage 2 spread will take place during 2020	• Enables delivery on the requirements set-out in the BCU Learning from Deaths Policy • Performance facilitation and tracking • Potential for analysis and reporting, to be made available as up to date dashboards • Improves rigour over current processes. • Compliant with ME services as these develop	2019 and 2020 calendar year
2. Introduction of Medical Examiner (ME) role • Plan for complete cover by Medical Examiner (ME) services by April 2021 • Several doctors are now actively completing online modules in order to apply for interview stage and attending further training in London. • National Team have now advertised seeking expressions of interest for ME and Medical Examiner Officers (MEO) • Advised will advertise post in “weeks” • Service to be delivered for all deaths through offices in the 3 DGH • ME services working in close relation to bereavement services, though completely separate	• Provision of independent scrutiny in the certification of all deaths • This will replace Stage 1 mortality review • Potential referrals for Stage 2 review may increase as ME request Health Boards review certain cases. • More appropriate referral to Coroners. • Pilots suggest coroners will receive fewer referrals, but those received more likely to require inquest, leading to a NET increase in workload. • Improved relations with the bereaved • Potential positive impact on complaints and litigation	April 2021 (predicted)
3. Improvement collaboratives	• Work continues on sepsis • Acute Kidney Injury (AKI) recognised as a significant contributor to mortality. • To be targeted as major component of medicines related harm • Work in progress to assist primary care tackle this as a QI initiative delivering on the 2019/20 and 20/21 GMS contracts	September 2020 expected to deliver evident improvements (Metric development required)

Postponed Procedures Graphs

Code	Measure Description	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
DFM038	Number of procedures postponed either on the day or the day before for specified non-clinical reasons (Rolling 12 Months)	Reduce	AP025	Reduce	Aug-19	2,227	↑	5th	2,796	2,242	ND	ND	-	2,236	2,227		-				-				-



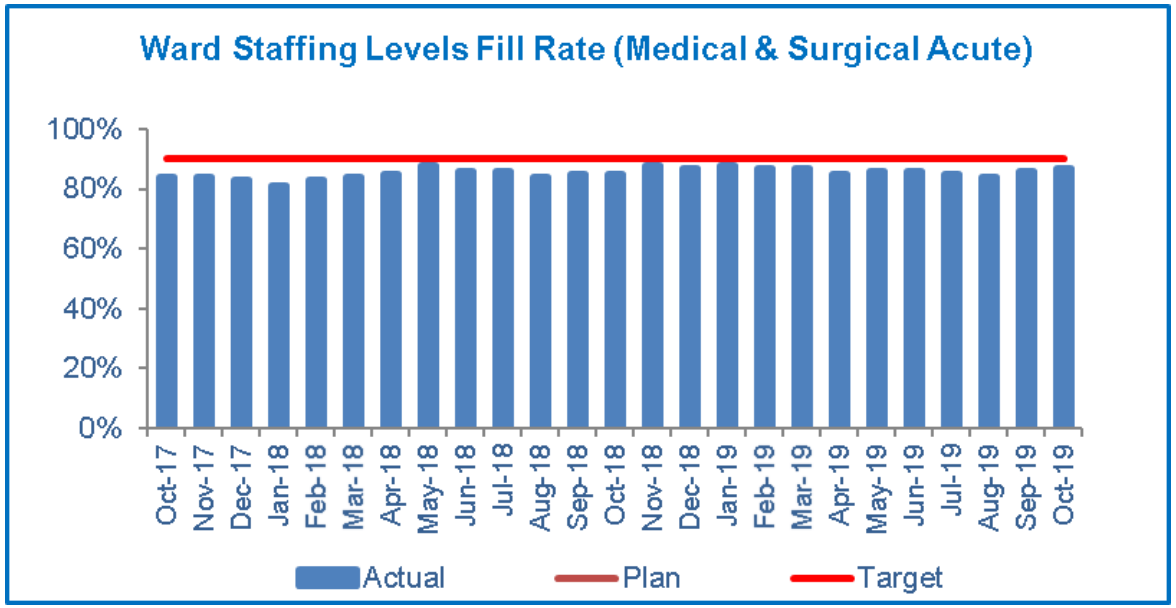
Why we are where we are: There are a variety of reasons why procedures are unfortunately postponed at short notice including unscheduled care pressures, failure to identify issues at pre-op assessments and unexpected theatre overruns. A full breakdown of reasons and what is bieng done to remedy them will be included in the next IQPR for QSE Committee in January 2020.

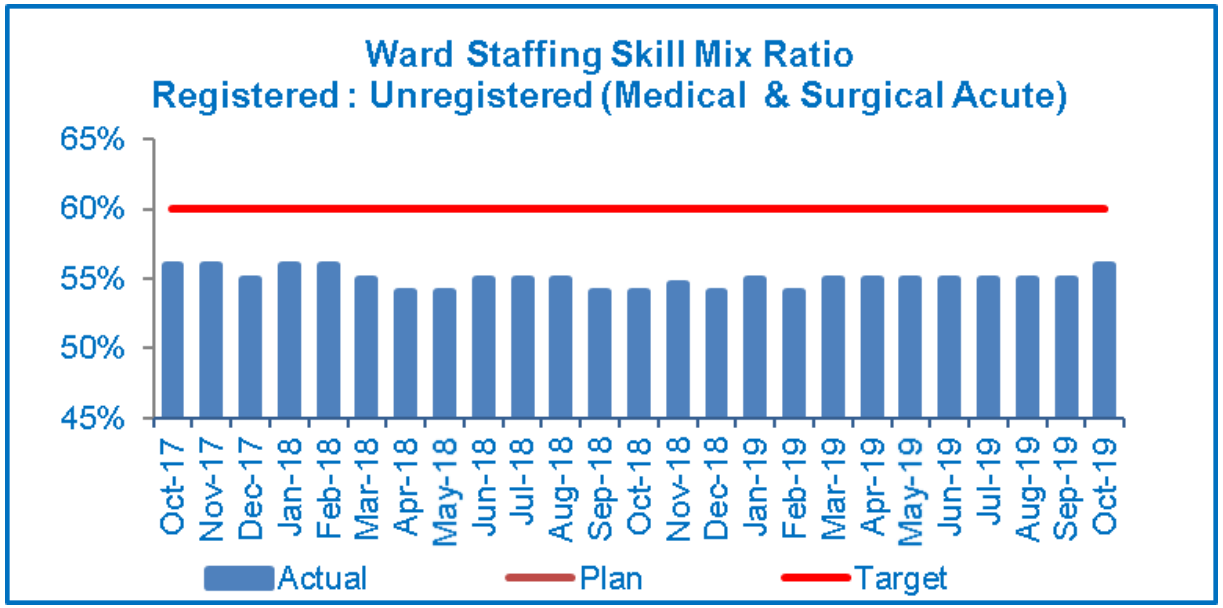
Postponed Procedures - Report

Actions	Outcomes	Timeline
1. On the day escalation policy in place to avoid any cancellations	Contribute to reduction in on the day cancellation to Financial Year benefit of 1,600	30/11/2019 Standard Operating Procedure (SoP) has been approved by Planned Care Improvement Group (PCIG) in October 2019.
2. Review of avoidable on the day cancellation as a part of weekly access meeting at site level. This is now part of weekly access agenda.	Better understanding of cancellations reasons by speciality to help manage cancellations.	30/01/2020 Avoidable cancellations are reviewed weekly as part of site level access meetings with agreed corrective actions.
3. Deep dive into Pre-operative Assessment pathway in challenged specialties	Improve quality of pre-op to help reduce cancellations for clinical reasons	28/02/2020
4. Improved Theatre scheduling process	Contribute to reduction in on the day cancellations to financial year benefit of 1,600	28/02/2020

Ward Staffing Levels Graphs

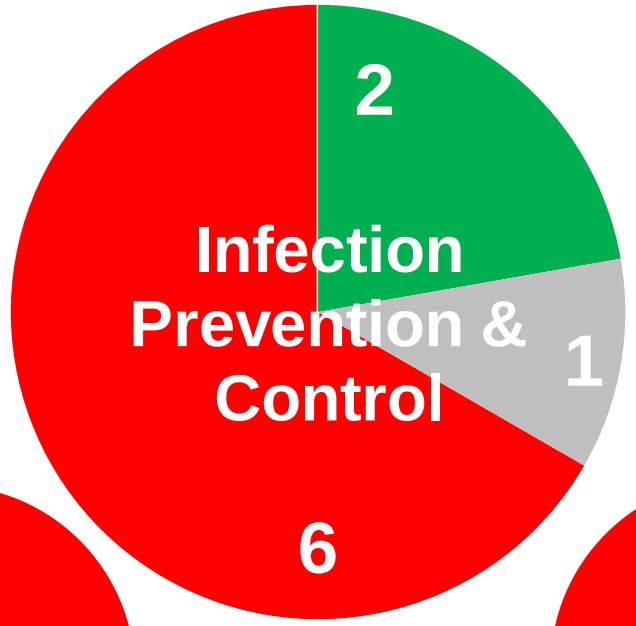
Code	Measure Description	National Target	Plan Ref	Plan Target	Current Period	Actual	Status	Wales Benchmark	Same Period Last Year	Apr-19	May-19	Jun-19	Qtr 1 19/20	Jul-19	Aug-19	Sep-19	Qtr 2 19/20	Oct-19	Nov-19	Dec-19	Qtr 3 19/20	Jan-20	Feb-20	Mar-20	Qtr 4 19/20
WGM001	Ward Staff Fill Rate Percentage	>= 95%	NIP	AP	Oct-19	87.00%	↑	N/A	85.00%	85.00%	86.00%	86.00%	-	85.00%	84.00%	86.00%	-	87.00%			-				-
WGM002	Ward Staff Skill Mix Ratio of Registered v Non-Registered Percentage	>= 60%	NIP	AP	Oct-19	56.00%	↑	N/A	54.00%	55.00%	55.00%	55.00%	-	55.00%	55.00%	55.00%	-	56.00%			-				-

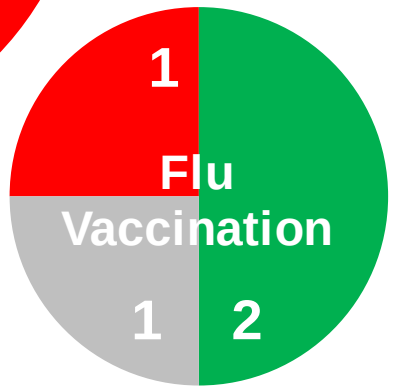




Chapter 2 – Summary

Infection Control





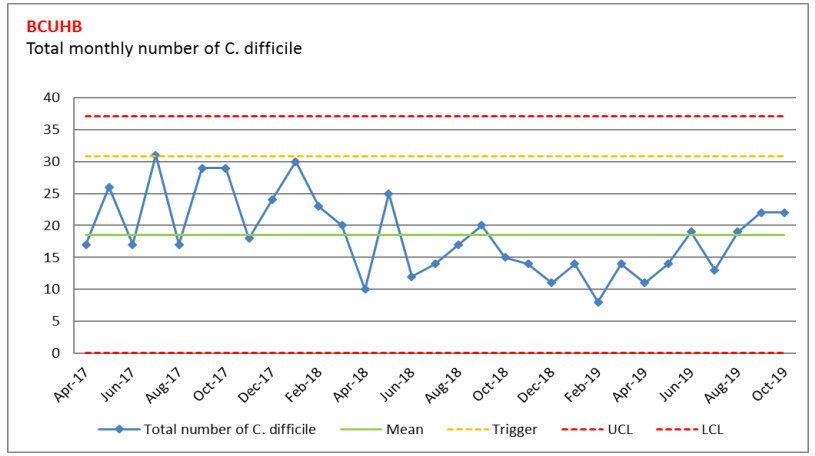
Code	Measure	Status		Annual Plan Profile	National Target
DFM021a	Cumulative Rate: E.Coli	83.04	↑	<= 67	<= 67
DFM021b	Cumulative Rate: S.Aureus	29.31	↑	<= 20	<= 20
DFM021c	Cumulative Rate: C.Difficile	29.31	↓	<= 22	<= 22.13
DFM021d	Cummulative Number: Klebsiella sp	89	↓	<= 58	<= 106
DFM021e	Cumulative Number: P.aeruginosa	13	↓	<= 10	<= 27
DFM005a	Flu Vaccination: 65's and Over	19.80%	↓	>= 30%	>= 75%
DFM005b	Flu Vaccination: Uner 65's at Risk	53.90%	↓	>= 10%	>= 55%
DFM005c	Flu Vaccination: Pregnant Women				
DFM005d	Flu Vaccination: Health Care Workers	41.06%	↑	>= 10%	>= 60%

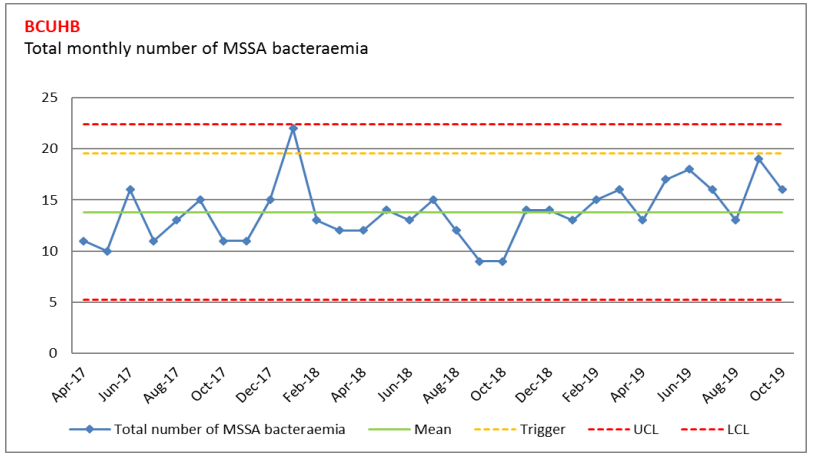
Chapter 2 – Infection Control Measures

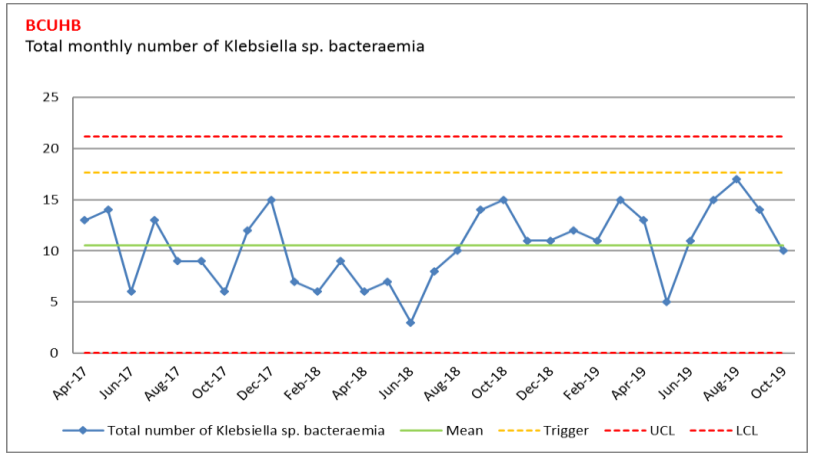
Code	Measure Description	National Target	Plan Ref	Plan Target	Current Period	Actual	Status	Wales Benchmark	Same Period Last Year	Apr-19	May-19	Jun-19	Qtr 1 19/20	Jul-19	Aug-19	Sep-19	Qtr 2 19/20	Oct-19	Nov-19	Dec-19	Qtr 3 19/20	Jan-20	Feb-20	Mar-20	Qtr 4 19/20
DFM021a	Cumulative rate of laboratory confirmed E.coli bacteraemia cases per 100,000 population	<= 67	AP039	<= 67	Oct-19	83.04	↑	3rd	82.85	97.85	83.59	88.38	-	83.77	85.63	83.39	-	83.04			-				-
DFM021b	Cumulative rate of laboratory confirmed S.aureus bacteraemias (MRSA and MSSA) cases per 100,000 population	<= 20	AP039	<= 20	Oct-19	29.31	↓	3rd	22.55	26.21	27.57	29.29	-	28.35	27.75	29.13	-	29.31			-				-
LM021b1	Cumulative Number of laboratory confirmed MRSA cases	0	AP039	0	Oct-19	6	→	N/A	9	1	2	4	-	6	6	6	-	6			-				-
LM021b2	Cumulative Number of laboratory confirmed MSSA cases	<= 139	AP039	<= 77	Oct-19	114	↓	N/A	80	14	31	49	-	63	75	96	-	114			-				-
DFM021c	Cumulative rate of laboratory confirmed C.difficile cases per 100,000 population	<= 22.13	AP039	<= 22	Oct-19	29.31	↓	3rd	27.21	19.22	21.54	25.42	-	24.06	25.69	27.99	-	29.31			-				-
LM021c	Cumulative Number of laboratory confirmed C.difficile cases	<= 153	AP039	<= 88	Oct-19	120	↓	N/A	100	11	25	44	-	56	74	98	-	120			-				-
DFM021d	Cumulative Number of laboratory confirmed Klebsiela cases per 100,000 population	<= 106	AP039	<= 58	Oct-19	89	↓	6th	0	13	18	29	-	43	59	74	-	89			-				-
DFM021e	Cumulative Number of laboratory confirmed Aeruginosa cases per 100,000 population	<= 27	AP039	<= 10	Aug-19	13	↓	4th	0	1	3	6	-	11	13	19	-	24			-				-

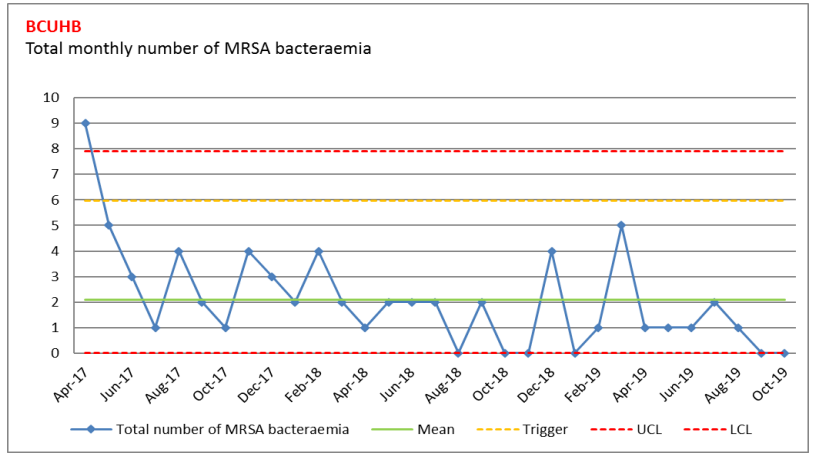
Why we are where we are: Natural variation is expected. An increase in Gram Negative/Multi Resistant Organisms and MSSA is been seen throughout the UK, and none of the Welsh Health Boards are on track to achieve the 2019/20 trajectories for gram negative infections or MSSA. The majority of Blood Stream Infections (BSIs) in BCUHB are not Health Care Acquired.
There is some consideration that Clostridium Difficle infections maybe from previous hospital exposure and/or antimicrobial treatment and there are actions in place to address this consideration. MRSA figures are continuing to decrease.

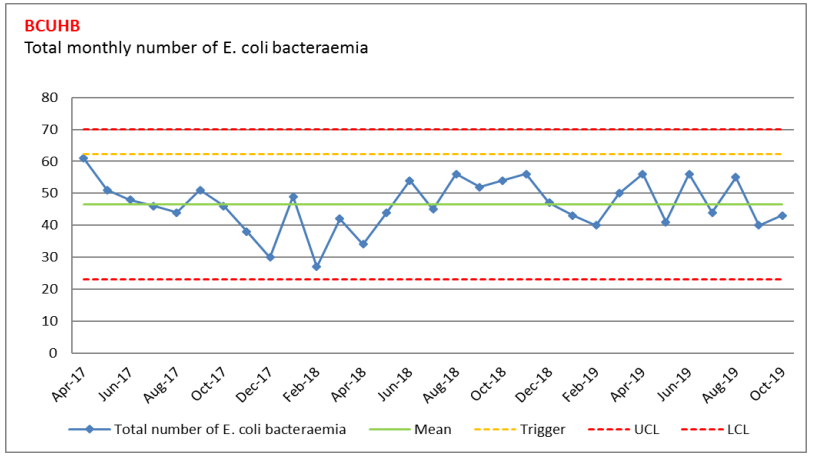
Graphs – Number of Infections identified

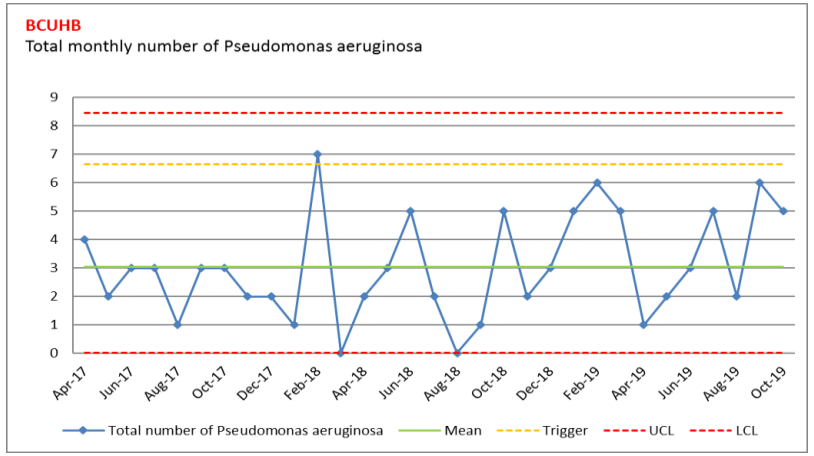




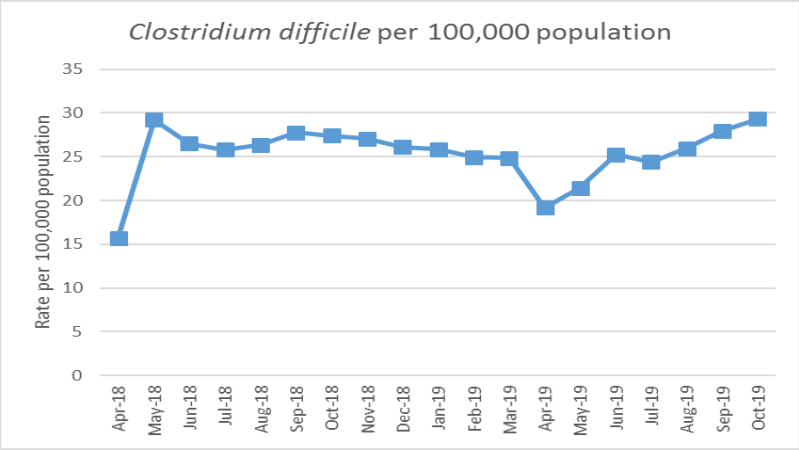


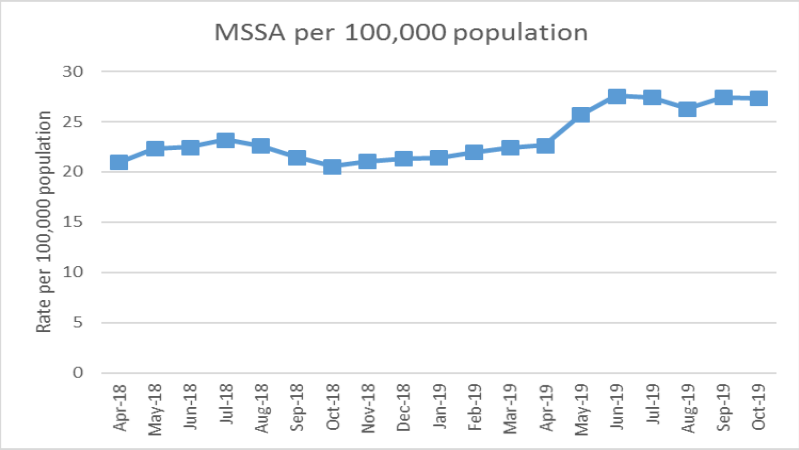


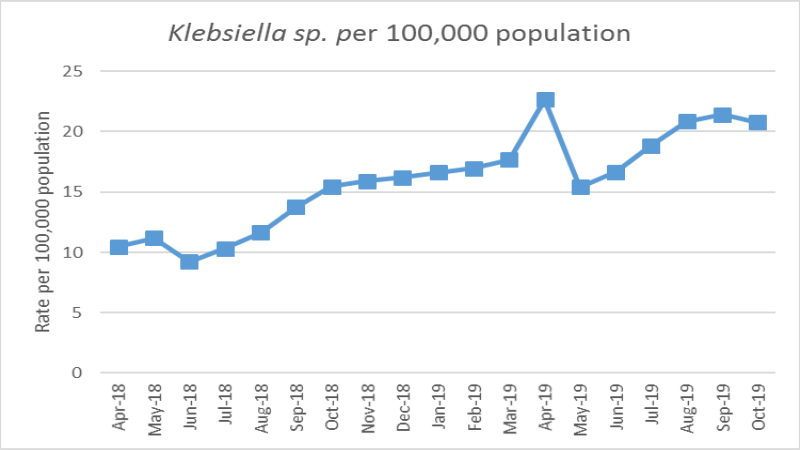


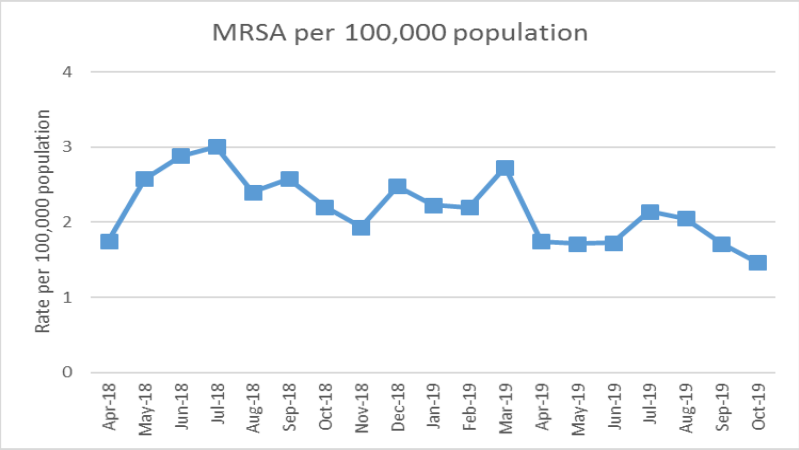


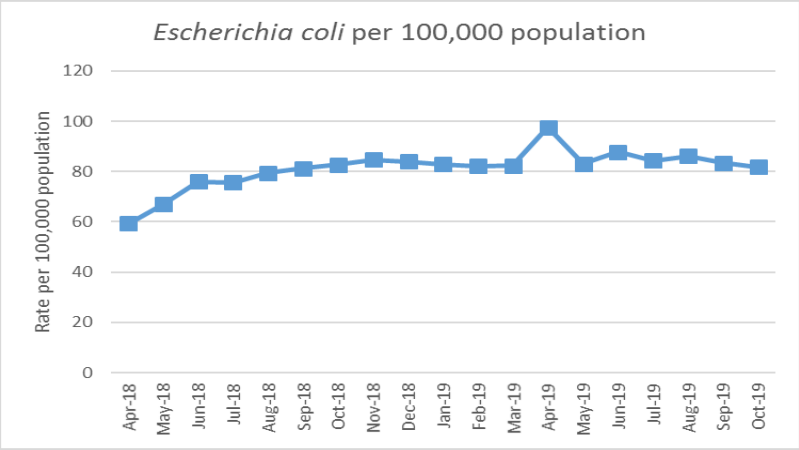
Graphs –Rate of infections

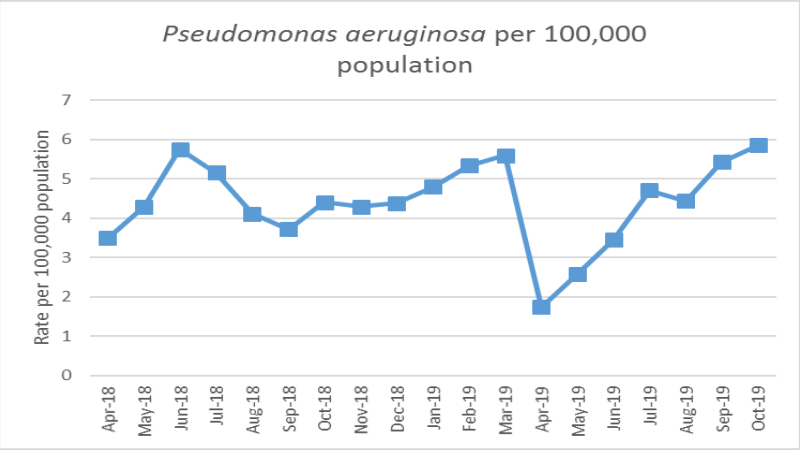








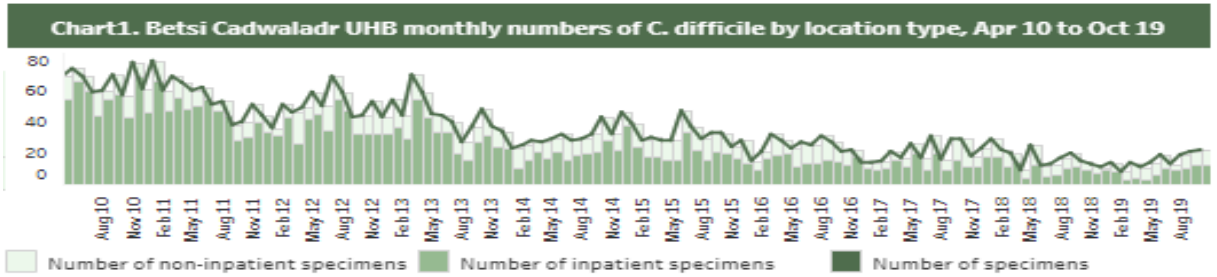


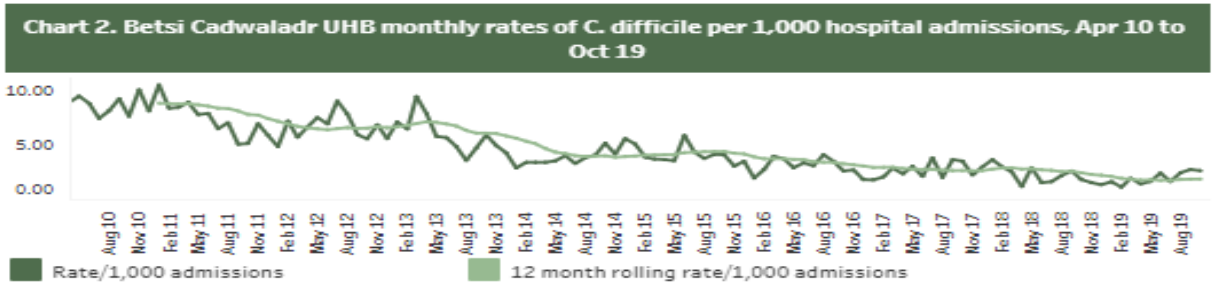


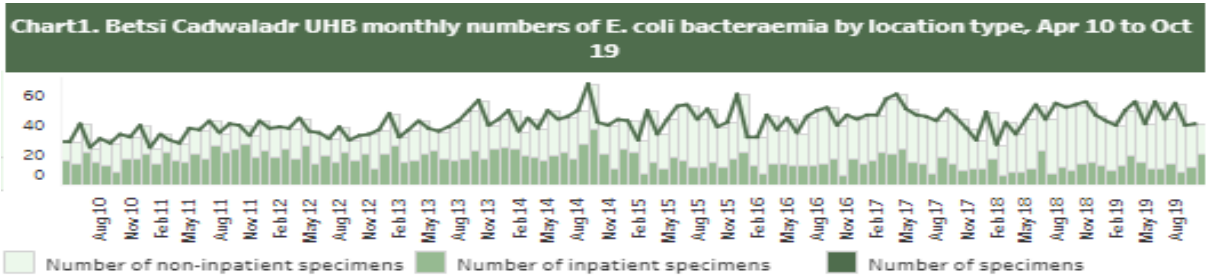
Chapter 2 – Infection Control Report - Page 1

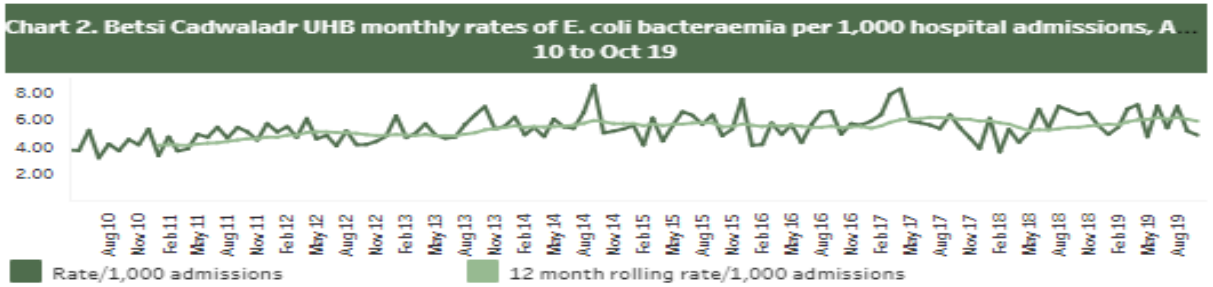
Actions	Outcomes	Timeline
1. Continue with the weekly analysis and trends which includes every infection within the 6 trajectory organisms.	Clostridium difficle numbers are increasing as well as Klebsiella and small peaks in Pseudomonas cases (not water related). These may be related to environmental exposure, therefore a one off sporicidal clean has been implemented and a "back to basics" approach for cleaning. This will be supported by a focus on decluttering and devices in Quarter 3.	Continuous
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.	Continuous
3. Need to deliver robust environmental cleaning delivered by facilities department and deep clean team, and an uninterrupted HPV programme by having allocated staff and a decant area. To do this we need to reduce the C4C audits.	This will reduce the bio burden of microorganisms in the healthcare environment and the risk of environmental cross infection. Staff will know what they are responsible for cleaning and with what product. This will also realise time to care by clinician's. Environmental associated cross infections will be significantly reduced.	December 2019
4. A benchmark audit took place in September 2019 to understand the prevalence of urinary catheters and associated infections.	There is unwarranted variation in catheter care and the rationale for catheterisation. Working with the continence service to implement a trail without catheter initiative and inpatient daily review of all devices to remove where possible, including urinary catheters in Quarter 3. Re audit Spring 2020.	Spring 2020
5. Increase the visibility of the Infection Prevention team and senior clinicians in terms of quality support visits, audit and introduction of the Link Practitioner programme in September 2019.	Educational event to take place on 6th December 2019. Timely support and actions to respond to any Infection Prevention & Contro gaps in practice, cleaning and the environment.	December 2019

Chapter 2 – Infection Control Report – Page 2









Clostridium difficile (CDI)

There is an increase of 1% in infection rates compared to 2018/19. Molecular testing was introduced last year and guidance suggested we may see a 1-2% increase in figures due to the sensitivities.

Some of these cases are relapses in infections and the IP teams continue to follow up all patients for at least 4 weeks to monitor for relapse and instigate treatment where required.

East have seen an increase in CDIs more recently. There is also some indication that this MAY be due to exposure in in patient areas in East. A one off sporicidal clean is taking place across the Health Board with 12 key actions sent out to senior teams for enablement. This is being monitored on a weekly basis.

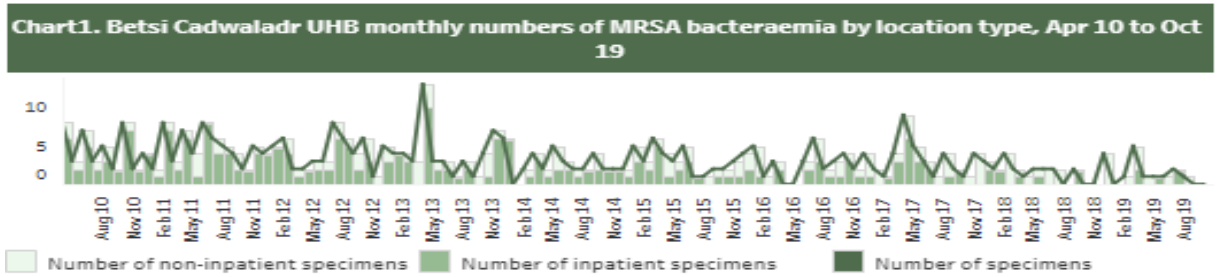
Escherichia coli

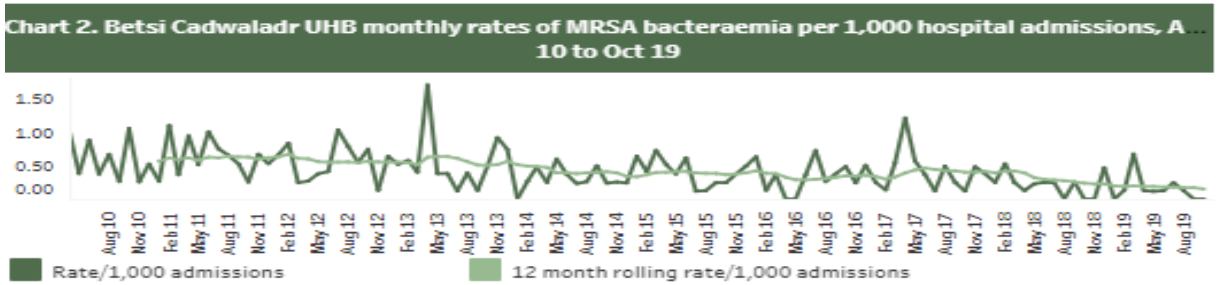
A significant amount of these gram negative infections are Community Onset, 46 to 9 respectively with the most being from Central Health Economy.

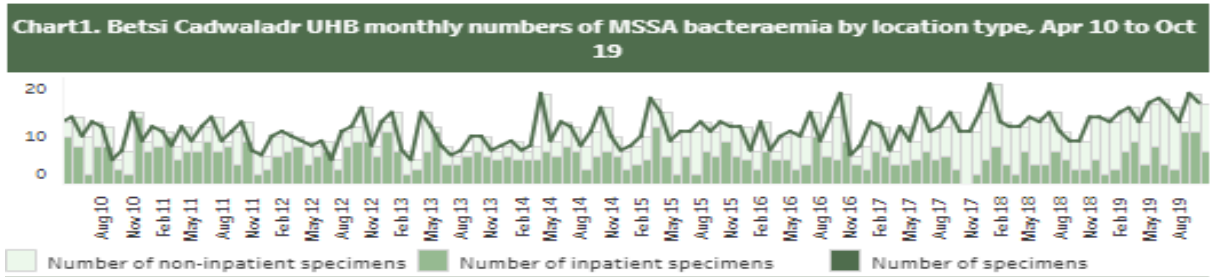
Numbers peaked in August but have fallen again in September. These are usually associated with Urinary Tract Infections and we expect to see increases during periods of warm weather considering there is a definite link to dehydration.

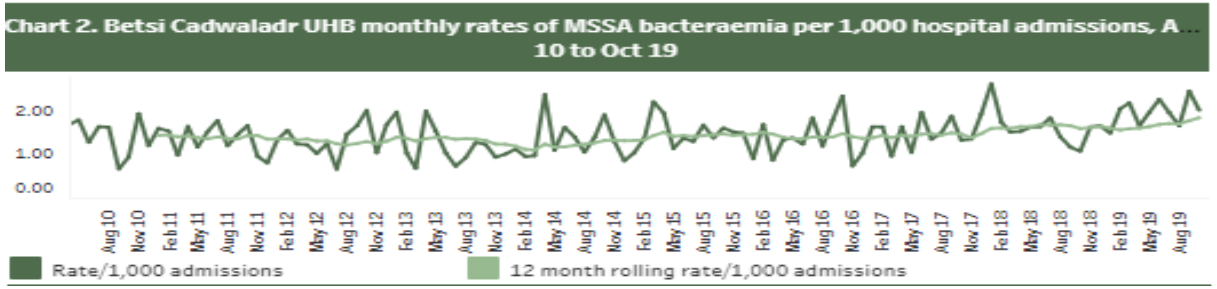
“I hydrate” colleagues will be promoting hydration for care home staff in an event early 2020, and currently the IP teams and practice development staff are also supporting this health promotional work.

Only a small amount of these patients have any health care interventions.









MRSA bacteraemia

6 cases have been identified to date which is 33% lower compared to the same period last year.

All have been in male patients' over the age of 65. 50% of these were avoidable and presented to Exec led reviews.

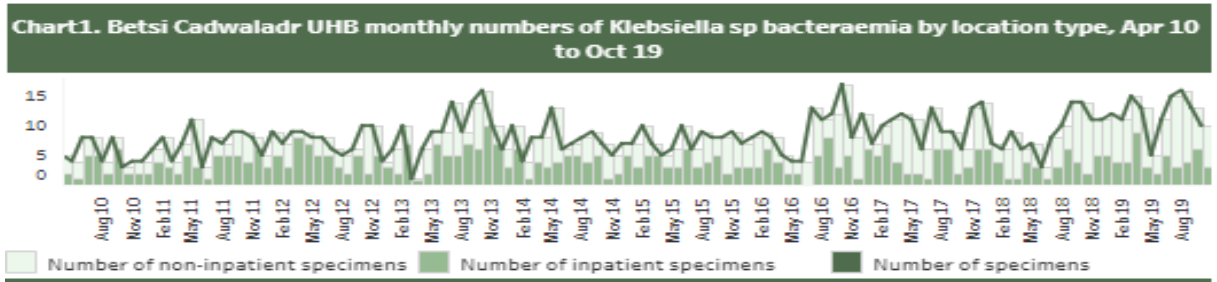
More in Central area.

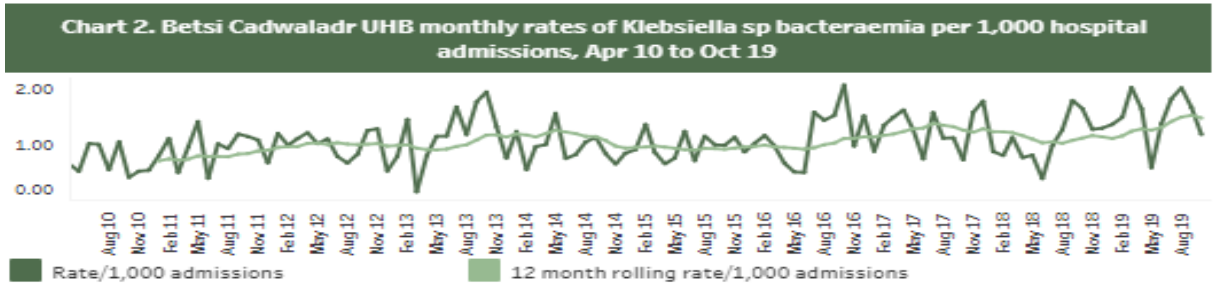
MSSA bacteraemia

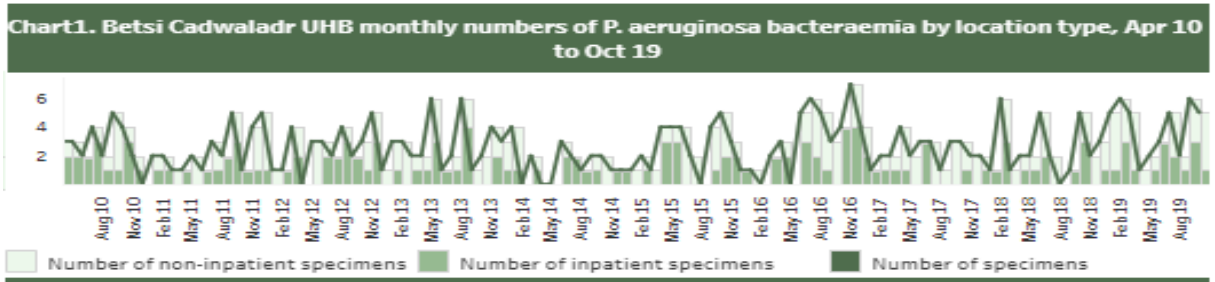
There has been a significant increase in infection numbers.

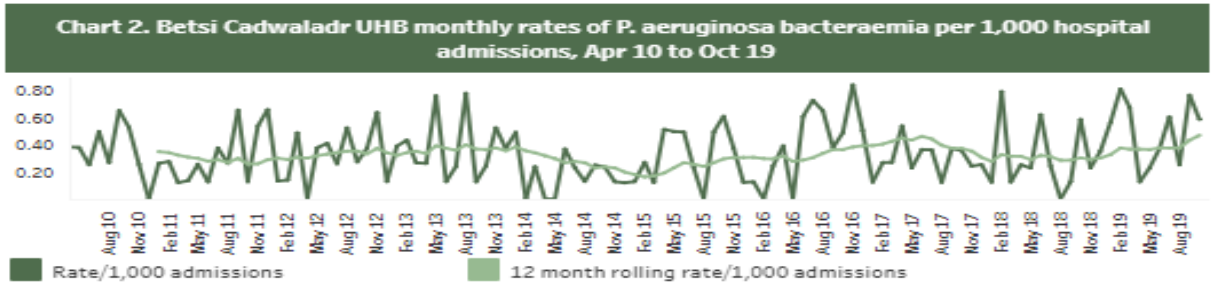
From analysis these appear to be related to skin related and the team are focused on collecting Culture and Sensitivity from all open wounds, pus related in addition to the usual MRSA screening.

May and June saw a peak and then again in September. The deep dive does not suggest these are cross infections; however the numbers of Hospital Onsets have increased in August and September.









Klebsiella sp. bacteraemia

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 health care 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.

There is high resistance to Co amoxiclav, Gentamicin and others in the West.

Pseudomonas aeruginosa bacteraemia

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.

Flu Vaccine Measures

Code	Measure Description	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
DFM005 a	Uptake of the influenza vaccination among: a. 65 year olds and over	>= 75%	AP007	>= 30%	Oct-19	19.80%	↓	3rd	43.80%	-	-	-	-	-	-	N/D	-	19.80%							-
DFM005 b	Uptake of the influenza vaccination among: b. Under 65s in risk groups	>= 55%	AP007	>= 10%	Oct-19	53.90%	↓	1st	68.00%	-	-	-	-	-	-	N/D	-	53.90%							-
DFM005 c	Uptake of the influenza vaccination among: c. Pregnant women	>= 75%	AP007	N/A	Mar-20				88.20%	-	-	-	-	-	-	-	-	-	-	-	-	-	-		-
DFM005 d	Uptake of the influenza vaccination among: d. Health care workers	>= 60%	AP007	>= 10%	Oct-19	41.06%	↑		41.05%	-	-	-	-	-	-	N/D	-	41.06%							-

Influenza Vaccination Uptake for Over 65's and Under 65's at Risk - 3rd November 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	68,507	127,564	**53.70%**	2nd	14,873	84,054	**17.70%**	6th
Betsi Cadwaladr	89,990	167,103	**53.90%**	**1st**	17,763	89,691	**19.80%**	3rd
Cardiff & Vale	42,640	86,983	**50.80%**	4th	11,523	62,703	**18.40%**	5th
Cwm Taf Morgannwg	45,618	93,815	**48.60%**	5th	10,359	65,771	**15.80%**	7th
Hywel Dda	42,738	98,196	**43.50%**	7th	9,149	49,307	**18.60%**	4th
Powys	18,272	38,219	**47.80%**	6th	3,953	16,225	**24.40%**	1st
Swansea Bay	44,296	82,723	**53.50%**	3rd	10,562	52,824	**20%**	2nd
Wales	**352,061**	**691,603**	**50.90%**	-	**78,182**	**420,575**	**18.60%**	-

Why we are where we are: The rates aren't available for Flu vaccinations of Pregnant women until April 2020. So far this flu season, Betsi Cadwaladr has vaccinated 1,156 pregnant women (28% of all pregnant women vaccinated for flu in Wales). Reporting of uptake for Under 65's at Risk groups has been affected due to vaccine supply issues that has delayed the start of the vaccination campaign.

Flu Vaccine Report

This is the first report for the 2019/20 flu vaccination season.

The Flu Vaccination Uptake report is being published weekly but it is important to note when interpreting the data that this year's uptake figures cannot be compared to last year's figures as it is not a like for like comparison.

Flu Vaccinations for patients of 65 years of age and over

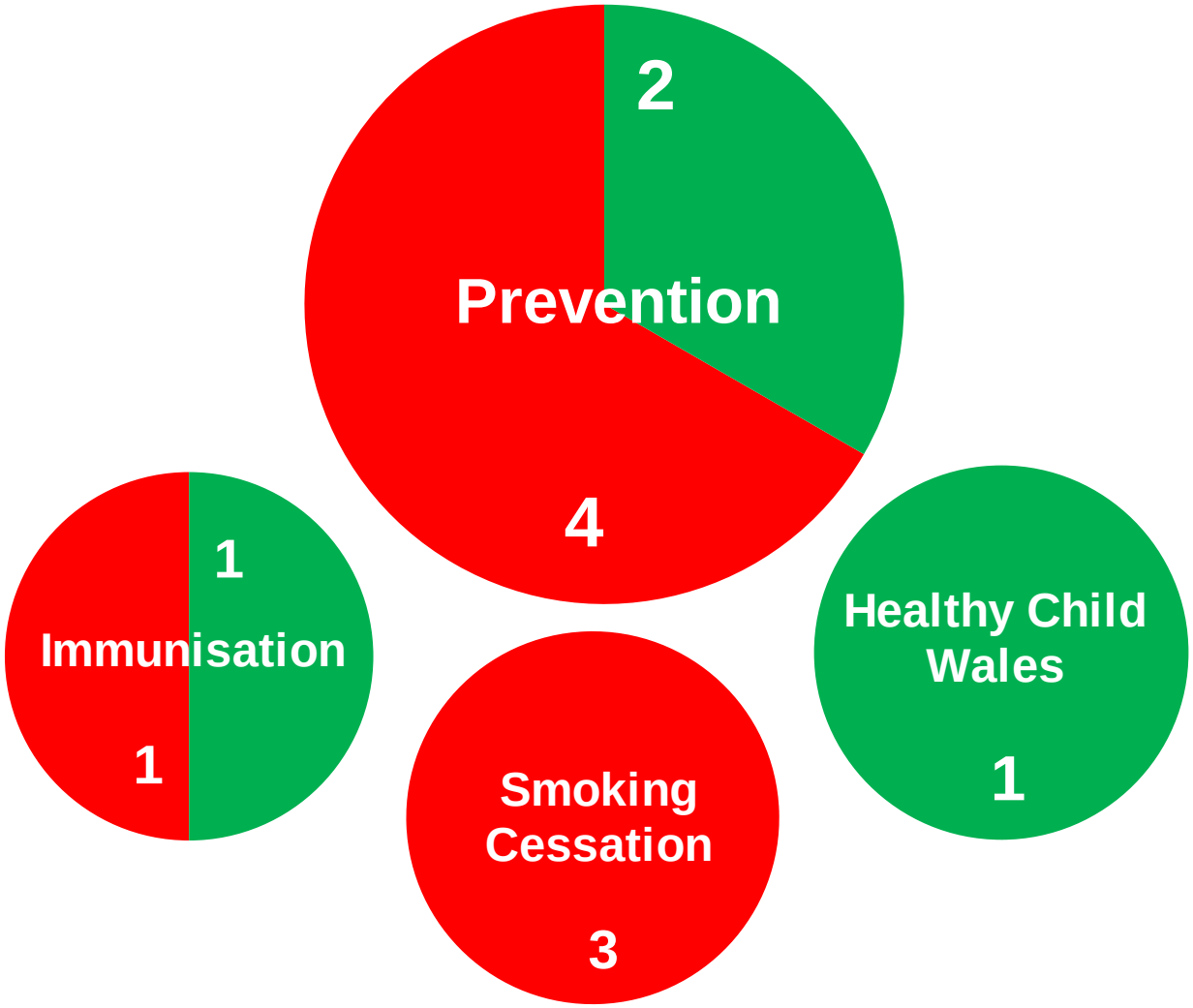
There was a supply issue last year which affected the uptake as deliveries were delayed and staggered. However, there are no such issues with supply of vaccines for this group in 2019/20.

Flu Vaccinations for patients aged 6 months to 64 years in at risk groups

There was no supply issue last year but this year is adversely affected. There are 6 suppliers of the vaccine for this age group. Only one company is reporting a supply issue but unfortunately, it is the bulk provider for north Wales. This provider has unexpectedly delayed and also staggered their deliveries meaning the first delivery arrived on 23rd October 2019 over a month later than in previous years. Furthermore, deliveries are expected to continue until late November 2019, which again is much later than usual. Some practices have negotiated their contract and sourced a new supplier to enable them to commence their campaigns earlier. This issue does not affect any of the BCU Managed Practices as they were supplied with the same vaccine used for BCU staff.

Flu Vaccination of Staff

The staff flu vaccination campaign should be unaffected as the Health Board ordered Flucelvax (Cell based Quadrivelant Vaccine(QIVc)) as opposed to the egg based vaccine (QIVe) which is affected by supply issues.



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	95.90%	↑	>= 95%	>= 95%
DFM003	Immunisation: 2 doses of MMR	94.20%	↑	>= 95%	>= 95%
DFM004	Healthy Child Wales Programme	94.40%	↑	Improve	Improve
DFM006	Smoking Cessation: % Service Use	1.26%	↑	>= 3.9%	>= 5%
DFM007	Smoking Cessation: Validated as Quit	35.00%	↓	>= 38.0%	>= 40%

Code	Measure Description	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
DFM006	The percentage of adult smokers who make a quit attempt via smoking cessation services	>= 5%	AP001	>= 3.9%	Qtr 1 19/20	1.26%	↑	1st	0.97%	-	-	-	1.26%	-	-	-		-	-	-		-	-	-	
DFM007	The percentage of those smokers who are CO-validated as quit at 4 weeks	>= 40%	AP001	>= 38.0%	Qtr 1 19/20	35.00%	↓	7th	41.00%	-	-	-	35.00%	-	-	-		-	-	-		-	-	-	

Why we are where we are:

Help me Quit Community: There was a drop over the summer months due to leave & sickness. The transfer of staff from Public Health Wales (PHW) employment to BCUHB has been slightly destabilising but this will get back on track. New clinics are being added to fill some gaps and a couple of clinics that were very quiet with low numbers have been changed. Advisors are working with Primary Care colleagues to do some work in managed practices so this should also see an increase in numbers over the coming months.

From a community pharmacy perspective, quit rates continue to be below target, but we are working with community pharmacy wales to try to engage pharmacists around improving this. Steps taken are:

- Pharmacy level quit rates shared with contractors via Community Pharmacy Wales (CPW)
- Contractors reminded of the need for carbon Monoxide (CO) monitoring via CPW newsletter and ongoing support with obtaining mouthpieces and new COP monitors
- Making clear to contractors that continuously low quit rates are not acceptable and that we will be reviewing commissioning for contractors where this is the case, with no justifiable reason

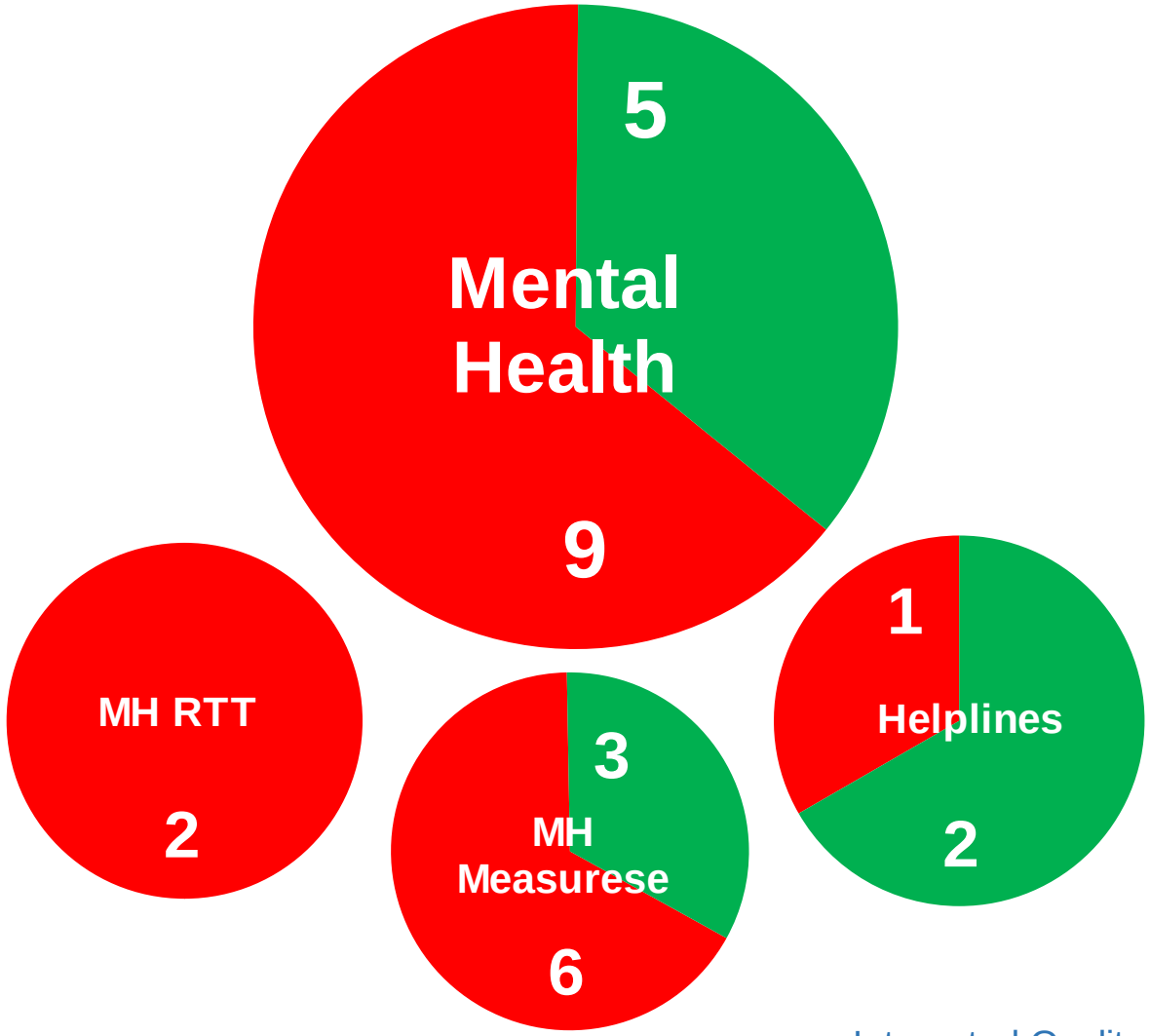
In addition, we are looking to try to maximise number of treated smokers and are currently redrafting the service specification to allow trained counter staff to provide the behavioural support – this should open up the service in areas where pharmacist and pharmacy technician provision is lacking to help address unmet need.

Help Me Quit Baby: During July and August we had significant sickness with the Stop Smoking Wales (SSW) service that has now resolved but we do now have 1.0 Whole Time Equivalent (WTE) vacancy which is being interviewed for mid November 2019. Once the service is fully staffed again we hope to see the quit rate rise. No update from Help Me Quit (HMQ) Hospital this time

Chapter 3 – Prevention Smoking Cessation

Actions	Outcomes	Timeline
1. Development of Model for Integrated Service for all Help Me Quit (HMQ) services	Improved quit rates from more streamlined management and equitable delivery	March 2020
2. Increase of uptake of smoking cessation services and quit rates due in part to services being fully staffed and extra emphasis placed on all teams to improve figures	Improved quit rates from more streamlined management and equitable delivery	March 2020
3 Further roll out of primary care project working with targeted clusters	Improved quit rates from more streamlined management and equitable delivery	March 2020

Chapter 4 - Summary



Mental Health

Code	Measure	Status	Annual Plan Profile	National Target
DFM0058	26 Week Wait: Adult Specialist Mental Health Psychological Therapy	20.21% ↑	AP	>= 80%
DFM0059	26 week Wait: Children and Young People Neurodevelopment Assessment	35.55% ↓	AP	>= 80%
DFM0060	MHM1a - Assessments within 28 Days (Combined)	59.8% ↓	N/A	>= 80%
DFM0061	MHM1b - Therapy within 28 Days (Combined)	65.6% ↓	N/A	>= 80%
DFM060a	MHM1a - Assessments within 28 Days (Adult)	57.61% ↓	>= 72%	>= 80%
DFM061b	MHM1b - Therapy within 28 Days (Adult)	64.51% ↑	>= 68%	>= 80%
DFM060b	MHM1a - Assessments within 28 Days (CAMHS)	85.56% ↑	>= 73%	>= 80%
DFM061b	MHM1b - Therapy within 28 Days (CAMHS)	72.92% ↓	>= 73%	>= 80%
DFM062	MH Independent Mental Health Advocacy (IMHA)	100% →	0%	100%
DFM082	MHM2 - Care Treatment Plans (CTP)	92.00% ↑	>= 89%	>= 90%
DFM083	MHM3 - Copy of Agreed plan within 10 Days	100% →	100%	100%
DFM079	Helplines: CALL	250.3 ↑	>= 212	Improve
DFM080	Helplines: Dementia	11.1 ↓	>= 9	Improve
DFM081	Helplines: DAN	46.0 ↓	>= 50	Improve

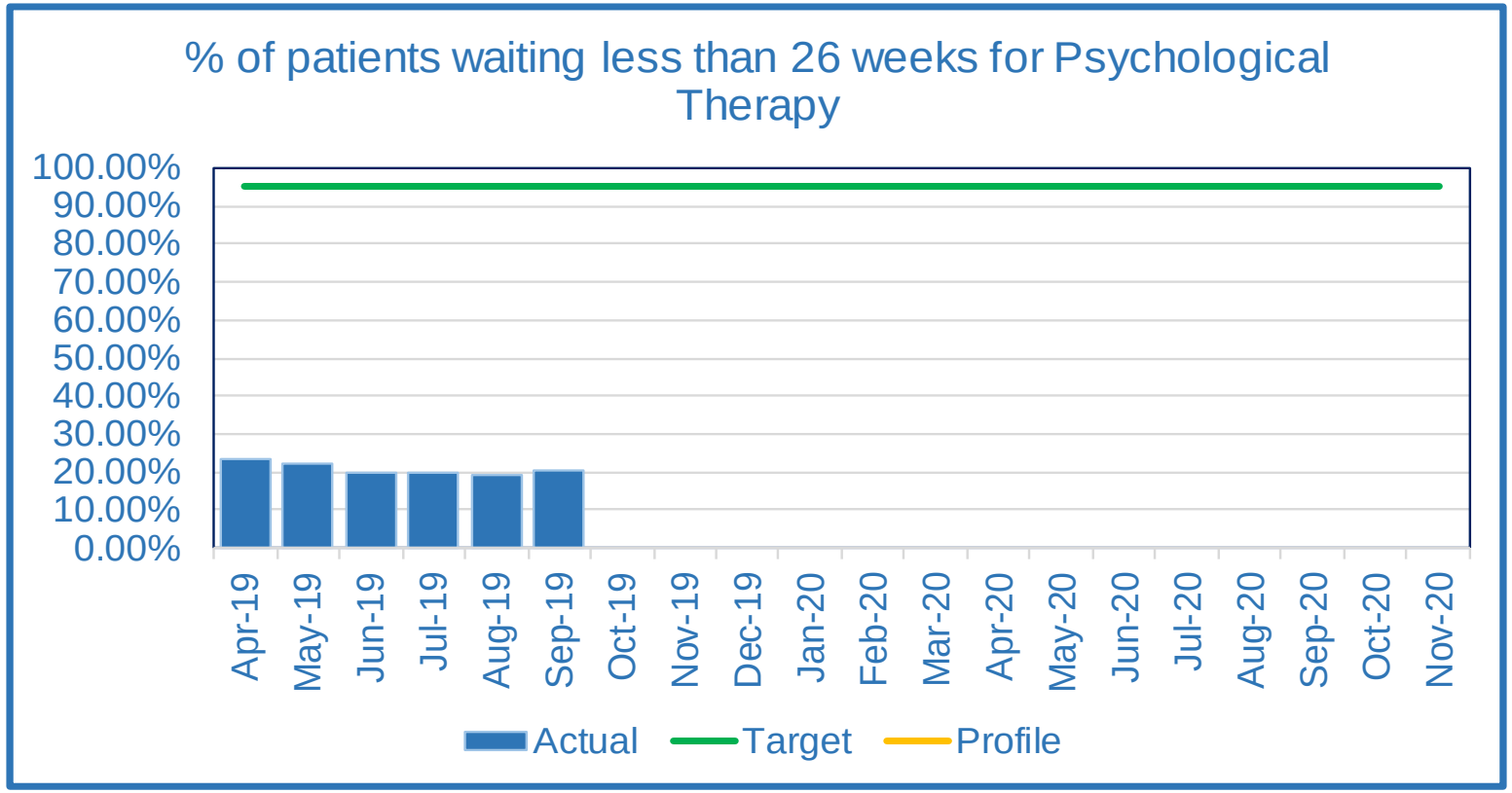
Integrated Quality and Performance Report
Quality, Safety & Experience Committee Version

October 2019

Chapter 4 – Mental Health

Psychological Therapy 26 Week Waits

Code	Measure Description	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
DFM058	Percentage of patients waiting less than 26 weeks to start a psychological therapy in Specialist Adult Mental Health	>= 80%	NIP	AP	Sep-19	20.21%	↑	7th	New 19/20	23.56%	22.37%	19.96%	-	19.85%	19.00%	20.21%	-				-				-



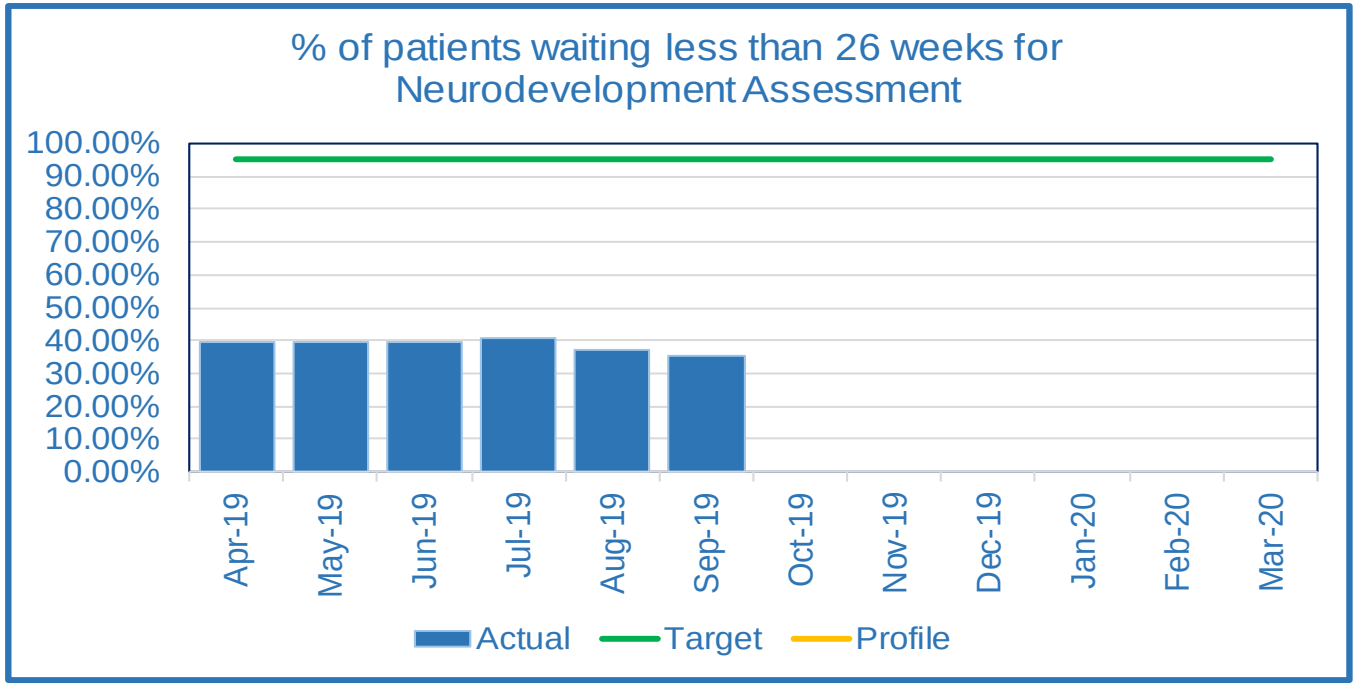
Psychological Therapy 26 Week Waits

Actions	Outcomes	Timeline
1.Ongoing scrutiny of waiting lists – East is a major outlier and skewing the regional figures where compliance is better. 2. Ongoing capacity and demand analysis. 3. Ongoing training and supervision in MDTs 4. Recruitment (3 psychologists out of total of 11 pan region vacant posts,; vacancy impact significant in small workforce)	1. High risk cases are prioritised, and development of appropriate pathways. 2. Specialist capacity optimised. 3. Lower intensity therapies available via MDT colleagues, increase in groups. 4. Recruitment successful for 2 out of 3 posts in the last 2 months, but recruitment time adds delay.	Immediate and ongoing
5. East Waiting List Remedial Action Plan 6. Specification completed with commissioning officer plan re: short term waiting list project – short term outside tender.	5. Work is ongoing. 6. Awaiting funds to support this going ahead.	3 months – 9 months
7. External psychological therapies review completed; next actions are take recommendations forward. 8. Main recommendations is whole system and culture change across generic services, to support the stepped care model with appropriate resource, organisation support and infrastructure.	7. Plans ongoing in Mental Health & Learning Disabilities	This is long term, system wide, multiple service transformation, starting with ongoing initiatives. Requires resource and infrastructure to fully operationalise.

Chapter 4 – Mental Health

Neurodevelopment 26 Week Waits

Code	Measure Description	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
DFM059	Percentage of children and young people waiting less than 26 weeks to start a neurodevelopment assessment	>= 80%	AP005	AP	Sep-19	35.55%	↓	6th	New 19/20	39.34%	39.53%	39.76%	-	40.62%	37.21%	35.55%	-				-				-

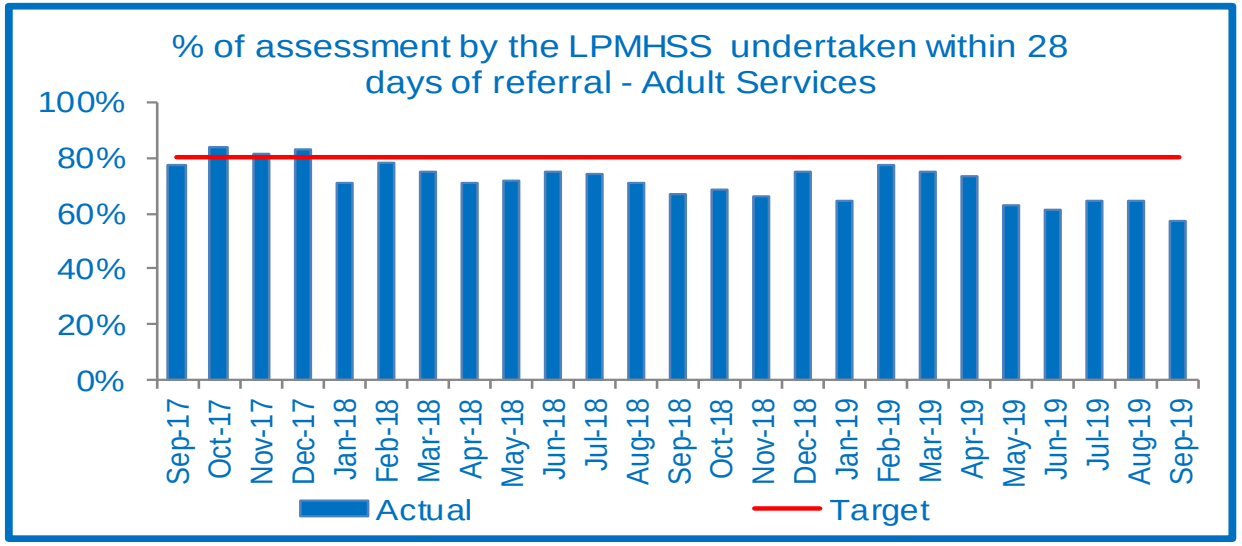


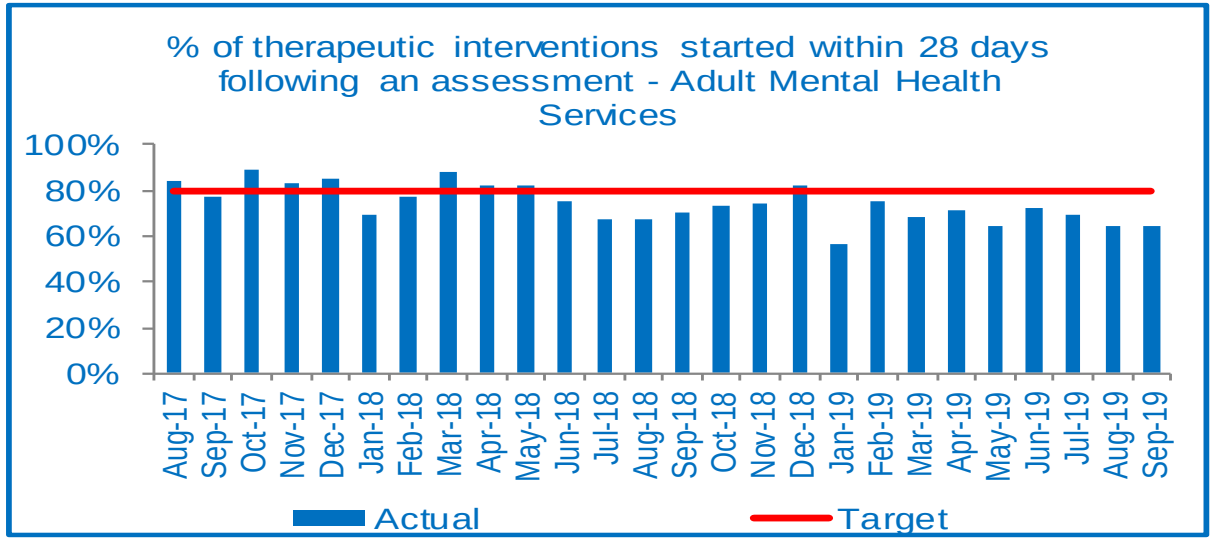
Why we are where we are: Since the establishment of the ND service (being removed from CAMHS) in 2017 there has been a significant Capacity Demand gap with a growth in the waiting list every year, 12.5% 2017-18, 47.2% in 2018-19 and 5.6% YTD, a third of the growth in 2018-19 is accounted for by a change in the start date following national guidance this occurred in Jan 2019 figures

Chapter 4 – Mental Health Neurodevelopment 26 Week Waits

Actions	Outcomes	Timeline
In June this year we submitted a third bid for additional funding which was approved by WG in Aug with recurrent funding commencing Jan 2020 and non recurrent funding to address the Waiting list	The Area Executive requested that a regional approach was established which is lead by East Area (largest WL) Regional Neurodevelopment Steering Group Establishment(Chaired by Director of Nursing Area East : a 6 work-stream approach has been taken across the service, 1) Recovery plan 2) Data validity 3) Workforce 4) Model of Service 5) Waiting List Recovery programme 6) Communication	1. The Recovery plan was given to the Area Executive in August 2019 2. Data validity was confirmed in compliance with WG standards in August 2019 3. Workforce all post funded by the WG monies have completed the ECR process and are currently in the Advert to Start phase. Funding commences Jan 2020 4. The model of delivery of Service is similar across the region with narrative and impact of variation now being collected (Due Dec 19) 5. A regional agreed tender process is currently at advert stage with closing date of early Dec 19 6. Internal communication between teams and users established and themes identified development of wider communication plan due in Dec 19
Workforce & Waiting List: It take between 6-9 months to recruit and start the full establishment of team following the uplift. Additional staffing to support delivery of activity is being used as well as some external suppliers (under historical tender).	Currently additional staffing (extra hours, bank, agency staffing) is being used and to date £60K has been spent on this. Existing suppliers tenders have been extended whilst new tender is completed with to date approx. £80K spent These factors have reduced the growth in the Waiting list to 5.6% for YTD (2019-20) compared to 21.8% for the same YTD period last year (2018-19) No additional capacity is available until completion of the new tender process	Workforce will always be a challenge and have time lag, BCUHB current average is 84 days from post completion of the ECR process to starting. As part of work stream 3 career development, recruitment and retention will be explores with regional approaches being developed. Quarter 4 2019/20 Due to the tender process it is likely no significant reduction in the waiting list will be seen until the end of Q4 (2019/20) or Q1 (2020/2021)
C&YP Actions: Engagement with both our users (Parents on the waiting list) and key referrers (GP and Education) has identified 3 key themes, communication, assistance with education and support.	It has been identified that families would like to be updated with waiting times and reminders of support workshops on a more frequent basis. Referrers, GP have voiced a desire for a regional referral form this is being explored under work-stream 4. Families have expressed a clear desire to complete this assessment is the belief that additional help is only available post a positive diagnosis, this is not the case as advised by LA and BCUHB	New A&C posts currently within the ECR Process likely start date now Q1 2020 Work on universal referral form to be commenced Jan 2020 Work on joint LA, Education and Health leaflet for Families about accessing help to be completed Feb 2020

Code	Measure Description	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
LM060a	The percentage of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral (Adult)	>= 80%	AP027	>= 72%	Sep-19	57.61%	↓	N/A	67.29%	73.26%	62.55%	61.61%	-	64.40%	64.80%	57.61%	-				-				-
LM061a	The percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS (Adult)	>= 80%	AP027	>= 68%	Sep-19	64.51%	↑	N/A	70.15%	71.22%	64.18%	72.21%	-	69.41%	64.00%	64.51%	-				-				-





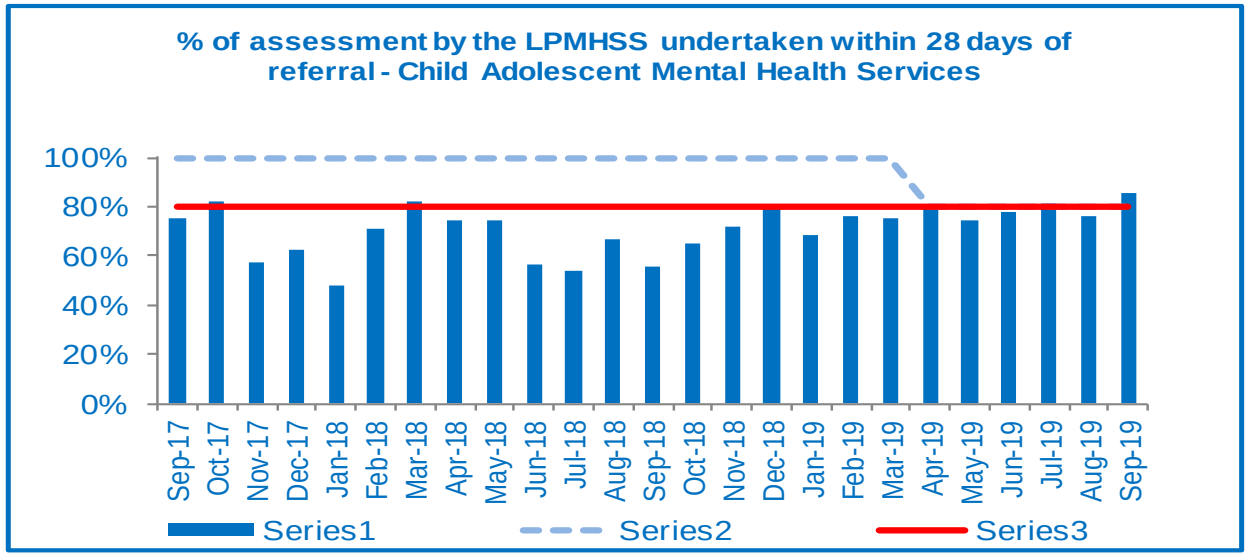
Why we are where we are: The MHLD Division continues to work on achieving the target across all teams, however, high referral rates, sickness and recruitment to vacancies continues to impact on delivery. The recent deep dive analysis has highlighted that a large percentage of patients are assessed and discharged with advice, information or signposting elsewhere, in some teams this is over 60%. The solution to target achievement is a complete service transformation for this identified group which is currently been worked through via the strategy implementation. The Division is benchmarking nationally against CNA's & DNA's to ensure we are offering a fair and consistent service within Primary Care in line with guidance and national standards.

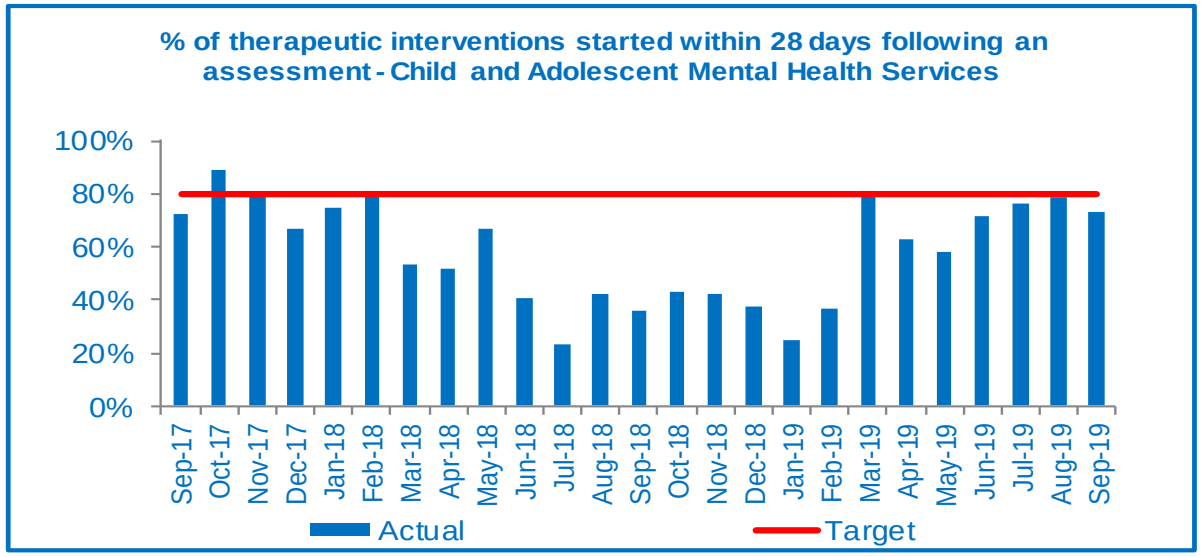
Actions	Outcomes	Timeline
1. Patients 'treated in turn' has been widely adopted which has had a negative impact on performance but, is clinically the right action for patients.	Proactive management of caseload to ensure patients are seen as quickly as possible. Improved quality and safety.	Backlog and waiting list trajectory to clear March 2020
2. Timely weekly reporting direct to area teams and a weekly 'deep dive' analysis to focus on potential breaches. We have also standardised intervention outcomes & reporting. Thus, ensuring CNA & DNA are accurately and timely recorded.	Correct & validated information ensuring Teams are timely informed and engaged and also can implement any remedial actions quickly.	Current and ongoing action
3. MHM Lead(s) are supporting areas to increase focus and traction on specific issues and action plans. We have closer monitoring & scrutiny of referral activity which also informs the weekly targeted intervention meetings.	Correct & validated information. Teams timely informed and engaged.	The solution to target achievement is a complete service transformation which is currently been worked through via the strategy implementation.
4. We have undertaken piloting TAG, hold weekend & additional clinics and have strongly focused on recruitment and workforce issues such as: • STR workers are now working through the interventions backlog • Secured additional funding for extra posts / recruitment ongoing • Clinical & Social care staff deployed to focus on areas performing below target	Skilled workforce deployed to improve activity and compliance and provide a community asset based approach which supports earlier intervention and GP based consultations.	Compliance with part 1a and 1b profiled for April 2020
5. Increased Senior Manager focus to lead a Focus Group to address performance and continually develop and implement the agreed Divisional and local action plans and to provide leadership to improve targets.	Developed and implemented action plans to improve performance against 80% target.	The solution to target achievement is a complete service transformation for this identified group which is currently been worked through via the strategy implementation.

Chapter 4 – Mental Health

CAMHS Graphs

Code	Measure Description	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
LM060b	The percentage of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral (CAMHS)	>= 80%	AP027	>= 73%	Sep-19	85.56%	↑	N/A	63.35%	80.15%	74.74%	78.00%	-	81.20%	75.80%	85.56%	-				-				-
LM061b	The percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS (CAMHS)	>= 80%	AP027	>= 73%	Sep-19	72.92%	↓	N/A	36.00%	63.24%	58.14%	71.64%	-	76.00%	79.00%	72.92%	-				-				-





Why we are where we are: Ongoing capacity issues particularly in the Central Area due to vacancies and significant levels of sick leave resulting in insufficient capacity to meet the demand.

Actions	Outcomes	Timeline
1.Recruitment of staff across teams following successful bid for Mental Health Service Improvement funding. All teams are currently going through the recruitment process	Development of Early Intervention teams and enhancement of core service to deliver Part 1 targets	Staff in post February 2020
2.Recruitment of CAMHs Practitioners in GP Clusters following successful bid for Mental Health Service Improvement funding. Evaluation of pilot post in Denbighshire GP to be shared.	CAMHs Practitioner based in each GP Cluster to provide support and advice to manage demand appropriately	Staff in post in 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 and report from HIW.	Clarity of Primary/Secondary Care thresholds/improved record keeping/improved communication with GPs/service specification clarity and consistency	Full action plan to be completed by March 2020
5.Weekly meetings held across the teams to assess demand and review capacity available in form of core staff availability, additional hours, bank and agency staff. Clinical prioritisation is robust, and alternative provisions to meet the need being established eg group interventions.	Understanding of current demands levels and capacity available to meet, identifying any gaps/anticipated breaches	Ongoing

Appendix: Further Information

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

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

Further information on our performance can be found online at:

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

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

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

Quality, Safety & Experience Committee 19.11.19	GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board ***To improve health and provide excellent care***

Report Title:	Infection Prevention Control (IPC) : Second Safe Clean Care review by Jan Stevens (May 2019)
Report Author:	Jan Stevens - external reviewer – original report Amanda Miskell, Assistant Director Nursing, Infection Prevention - summary report
Responsible Director:	Mrs Deborah Carter – Interim Director of Operations / Associate Director of Quality & Assurance
Public or In Committee	Public
Purpose of Report:	To provide the Committee with the report of the revisit by Jan Stevens to BCUHB (see Appendix 1).
Approval / Scrutiny Route Prior to Presentation:	Received by Independent members, Infection Prevention Sub Group, Senior Management teams, Local Infection Prevention Groups and Summarised at Quality & Safety Group in the quarterly Infection Prevention reports
Governance issues / risks:	Overall the review shows an increase in assurance and a reduction in Clostridium difficile and Meticillin Resistant Staphyloccocus Aureus blood stream infections. There are some recommendations including the continuation of the Safe Clean Care campaign and how this is resourced and financed.
Financial Implications:	Approved for 2019/20. Consideration for 2020/21 finance resource to continue the campaign and maintain sustainability.
Recommendation:	The Committee is asked to note the report and the resources required to address the recommendations and sustainability for Safe Clean Care campaign.

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

2.To target our resources to those with the greatest needs and reduce inequalities	√	2.Working together with other partners to deliver objectives	√
3.To support children to have the best start in life		3. Involving those with an interest and seeking their views	√
4.To work in partnership to support people – individuals, families, carers, communities - to achieve their own well-being		4.Putting resources into preventing problems occurring or getting worse	√
5.To improve the safety and quality of all services	√	5.Considering impact on all well-being goals together and on other bodies	√
6.To respect people and their dignity	√		
7.To listen to people and learn from their experiences	√		
Special Measures Improvement Framework Theme/Expectation addressed by this paper Leadership and governance			
Equality Impact Assessment *N/A*			

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

1. Executive Summary

The first Stevens review took place in August 2017. It was clear from the review that whilst considerable effort was being made, it was not focussed on the activities that would address the organisational, cultural and operational challenges, nor achieve the transformation essential to make sustainable improvement. Building on the recommendations made by Professor Duerden in 2013, the key recommendation from the Stevens review in 2017 was to develop adopt a campaign approach to the implementation of the required activities and action required. This resulted in the Development of the **Safe Clean Care Campaign** that would mobilise the whole organisation and be underpinned by greater Executive focus and rigorous Programme Management.

In May 2019, Jan Stevens revisited BCUHB to review and comment on the actions and progress made. Key points are acknowledged below:

Achievements:

- Individuals and teams that have clearly worked incredibly hard to take forward the recommendations from the initial report.
- The campaign has been undertaken robustly with effective programme management and as a result very positive changes and progress have been made.
- The focus on Healthcare Acquired Infections (HCAI) has been transformed and it is clear that the recommendations made in August 2017 have been taken seriously and given real focus and attention.
- MRSA and Clostridium difficile levels of infection are now reducing, with wards now showing significant numbers of days without either infections occurring.
- There is a much greater sense of ownership and a clear recognition that reducing infection is “everyone’s responsibility.”
- Ward managers expressed real pride and enthusiasm for the work that has been done to improve rates of infection. All wards were displaying information and staff were rightly proud of their results.
- The Board has invested £1million pound to improve the environment, increasing the number of single rooms, refurbishing wards to make them easier to clean and decontaminate.
- There is strong nursing leadership from the senior team, which should be commended.
- The Infection Prevention Team has broadened their work to adopt a whole system approach by working with your Community Hospitals, Mental Health Unit and GP’s. This is an impressive development and will help in the longer term sustainability of your programme. The profile of the IPC team is much higher and staff reported how much improved their visibility and support now is.
- Antimicrobial stewardship and decrease in use of Proton Pump inhibitors in the East & West area is impressive in the organisation and should be published. The activities to promote prudent prescribing are robust and impressive. The enthusiastic team have continued to build on their good work and have introduced effective strategies. The focus in East/West should be mirrored in Central.

- The Decontamination Audit in 2018 stated “overall there has been a significant improvement”.
- “All the areas I visited were clean, environments were tidy and uncluttered”. The cleaning standards framework was being used and staff reported how helpful this has been. The Cleaning staff have all gone through further training and assessment of competence and this has had a good impact on cleaning standards.
- Given the improvements made it would be possible to quantify the gains in terms of quality, safety, cost and productivity and it would be worth sharing this with the Board.

Recommendations:

- There is still an amount of work to be done to ensure the level of improvement continues and can be sustained. Therefore a further year of robust programme management and Executive oversight is essential.
- It is important that all staff see this as a Board priority, rather than hand over to the IPC team as the work still required is whole system and not solely the domain of the IPC team.
- Review of hand hygiene audits and discussion with staff highlighted medical staff regularly needed reminding off the importance of Bare Below the Elbows and hand hygiene.
- Further work is required regarding aseptic technique when inserting lines.
- In addition to audit the care bundles you should use observation of practice, achieved by practice development nurses, the IPC team and also through “rounding” by the senior nurses when they are assuring overall quality and safety.
- To work with the Ambulance service to reduce the “just in case” cannulations.
- It is recommended that there is stronger accountability across all sites which requires the input of all medical leads and the new Medical Director to tackle inappropriate non-compliance to your guidelines.
- It is recommended that Facilities stop doing so many audits so they could effectively supervise. There needs to be a balance between assuring through audit and having time to ensure results are acted on. There equally needs to be sufficient time to train and proactively work to ensure the environment is kept clean.

2. Recommendation to QSE

The Committee is asked to note the report and the resources required to address the recommendations and sustainability for Safe Clean Care campaign.

Appendix 1

Revisit May 2019 to review progress following recommendations made after review August 2107 Prevention and Control of Healthcare Associated Infections in the Betsi Cadwaladr University Health Board (BCUHB)

Report written by Janice Stevens CBE DSc (hons) MA RGN

BACKGROUND

Professor Duerden has undertaken three HCAI reviews of the organisation. At each he made a set of recommendations. In the second follow up review in 2016 he stated "there are still very significant challenges in BCUHB in ensuring the delivery of an effective IP programme and bringing the rates of Healthcare Associated Infections (HCAI) (Meticillin Resistant Staphylococcus Aureus bacteraemia and Clostridium difficile Infection specifically) into the target range set by Welsh Government. The Board received a paper on 21 July 2016 where it was highlighted that whilst progress had been made, HCAI remained on the Corporate Risk Register with a score of 20. With this level of risk, you recognised that further input was required to provide, and to understand why progress was not being made and what needed to be put in place to improve.

The first Stevens review took place in August 2017. It was clear from the review that whilst considerable effort was being made, it was not focussed on the activities that would address the organisational, cultural and operational challenges, nor achieve the transformation essential to make sustainable improvement. Building on the recommendations made by Professor Duerden, a Campaign approach was suggested that would mobilise the whole organisation and be underpinned by greater Executive focus and rigorous Programme Management.

In May 2019, BCUHB invited me to review and comment on the actions and progress made and offer my opinion on how the improvement effort should continue. It was my pleasure to meets individuals and teams that have clearly worked incredibly hard to take forward the recommendations from the initial report.

HEADLINE FINDINGS

The key recommendation in 2017 was to develop adopt a campaign approach to the implementation of the required activities and action required. This resulted in the Development of the **Safe Clean Care Campaign**. This has been undertaken robustly with effective programme management and as a result very positive changes and progress have been made.

The focus on HCAI has been transformed and it is clear that the recommendations made in August 2017 have been taken seriously and given real focus and attention. MRSA and Clostridium difficile levels of infection are now reducing, with wards now showing significant numbers of days without either infections occurring. There is a much greater sense of ownership and a clear recognition that reducing infection is "everyone's responsibility." It was a pleasure to meet your teams, visit the wards, and see the real changes that have been made and meet the staff, especially the

ward managers who expressed real pride and enthusiasm for the work that has been done to improve rates of infection. All wards were displaying information related to Safe Clean Care such as audit results and how many days between infections and staff were rightly proud of their results.

The Board has invested £1million pound to improve the environment, increasing the number of single rooms, refurbishing wards to make them easier to clean and decontaminate and redesigning layout to reduce clutter and create a clinical environment that staff are delighted to be working in. It was reassuring to hear that you have decided to commit the same funding in the next year as there are still areas that would benefit from this investment.

There is strong nursing leadership from the senior team, which should be commended. The introduction of your new IPC Lead Amanda Miskell has been received very positively and the profile of the IPC team is much higher and staff reported how much improved their visibility and support now is.

The Infection Prevention Team has broadened their work to adopt a whole system approach by working with your Community Hospitals, Mental Health Unit and GP's. This is an impressive development and will help in the longer term sustainability of your programme

The recommendations I am making aims to build on the significant work you have done, provide a focus to refresh the campaign and target over the next 12 months and those activities that will offer the opportunity to reduce infections further and to continue the cultural change that you ultimately need to achieve sustainable low rates of HCAI.

RECOMMENDATIONS

1. Whilst an enormous amount of work has been done and real progress made there is still an amount of work to be done to ensure the level of improvement continues and can be sustained. Therefore a further year of robust programme management and Executive oversight is essential. Anwen has provided excellent programme management and I would strongly recommend that she needs to continue to do this (even if this is not full time). It is important that all staff see this as a Board priority, rather than hand over to the IPC team as the work still required is whole system and not solely the domain of the IPC team

2. Whilst there are pockets of excellent engagement from medical staff including Dr Mottart at the Bangor site, there is still opportunity for improvement. It was good to see doctors are now bare below the elbows, and ward staff reported that there had been a shift in attitude whereby they no longer receive "abuse" when challenging medical colleagues. However, review of hand hygiene audits and discussion with staff highlighted medical staff regularly needed reminding off the importance of BBE and hand hygiene and juniors have to be challenged regularly regarding aseptic technique when inserting lines.

You have also introduced not wearing lanyards which is good practice and whilst most staff are complying, several staff were challenged on our walkabouts. This suggests the cultural change necessary is evolving but the required behaviour is not yet embedded and further action is required. There are still gaps in key controls; Further evidenced through findings from PIRs indicate that MRSA bacteraemia numbers could be further reduced with a renewed focus on peripheral line care including appropriate insertion from Ambulance and ED to ongoing care and preventing contaminants when undertaking blood cultures. Therefore it is recommended that:

a. You continue to use the branding of Safe Clean Care and take the campaign approach to increasing the focus on line care. Seek out tools and approaches used by others including utilising the NHS Wales 1000 Lives STOP campaign

b. Whilst good documentation is important – you should place more focus on assuring that actual practice is correct through more observation and clinical rounding to be assured staff are inserting and caring for lines correctly. I would recommend that in addition to audit of the care bundles you use observation of practice, achieved by practice development nurses, the IPC team and also through “Rounding” by the senior nurses when they are assuring overall quality and safety. I understand you want to refresh how you do the Matrons Ward round which is timely and can include this recommendation. I also heard about the work being undertaken with Beckton Dickinson who have helped you map the key elements of line insertion to enable you to focus where to focus training and improvement. This is to be commended and should be continued as part of this programme of work.

c. Work with the Ambulance service to reduce the “just in case” cannulations. West Midlands Ambulance services in England have undertaken a programme of work to do this and would be worth connecting with.

d. The newly appointed Medical Director supported by the site medical leads lead should champion and lead a programme of work to ensure the competence of doctors in hand hygiene, line insertion and taking blood cultures. This will require the same rigour of training and assessment that nurses have undertaken for all doctors – regardless of level. Leeds and Wolverhampton hospitals put in rigorous processes to deliver this with subsequent real reductions in MRSA bacteraemia and would be useful points of contact.

e. Continue to reinforce not wearing lanyards

3. ISOLATION AND PPE.

You have reduced the risk of not being able to isolate patients by investment in the estate and increasing the availability of single rooms, which is commendable. Staff reported that generally there were far less times when there is a delay due to lack of a single room. You do now have a much clearer escalation process, however you still cannot articulate how many times this occurs. I would recommend you keep track of this and be clear about the level of risk rather than accept the anecdotal information provided.

The signage and instructions for isolation are now much clearer and easier to read. The use of signage to show “door open” “door closed” is a positive step, however I saw 4 rooms on different wards that should have been kept closed but were open and staff could not really offer a clear explanation as to why. In the 2017 review most doors were open and there was little understanding as to why this was a problem (including from members of the IC team) whilst this position has improved significantly – it is not fully embedded or sustained and therefore needs continued focus.

PPE equipment was available outside or near isolation rooms but placed in or on numerous different typed of trolleys, wall mounted storage or drawers. I recommend you achieve consistency in this and use the same appropriate storage everywhere. There are Danicentres in a number of your wards which are commonly used so I would suggest these could be used everywhere.

3 PRUDENT PRESCRIBING

The activities to promote prudent prescribing are robust and impressive. The enthusiastic team have continued to build on their good work and have introduced effective strategies including

- Limiting use of higher risk antibiotics
- Introducing a new prescription chart that forces 72 hour review
- Participating in the ARK research programme
- Continuing to utilise junior doctors to undertake audits
- Impressive work with GPs to reduce use of antibiotics with measurable reductions in East/West
- All cases of Clostridium difficile are followed up in the community now, and the case is discussed with the GP
- You have achieved a 16% overall reduction in antibiotic use in the community
- You have seen a reduction in use of PPIs (with GPs receiving monthly data) in East
- Overall you describe a sense of greater collaboration and cooperation between teams across organisation and community

Moving forward, I recommend you continue this work. I would also look for ways to share and promote the practices you have put in place as they are impressive. The work done with GPs is excellent and you should consider entering this for awards such as HSJ or Nursing times under either patient safety or community collaboration. The focus in East/West should be mirrored in Central following discussion with Tania.

In addition, although you have put in place ways to control use of high risk antibiotics, some PIRs still show antibiotics could have played a part in CDI and therefore I would recommend that there is stronger accountability across all sites which requires the input of all medical leads and the new Medical Director to tackle inappropriate non-compliance to your guidelines.

4. ENVIRONMENT & CLEANLINESS

All the areas I visited were clean, environments were tidy and uncluttered. The cleaning standards framework developed was being used and staff reported how helpful this has been.

The Cleaning staff have all gone through further training and assessment of competence and this has had a good impact on cleaning standards as seen by the improvement in the audit results. When I visited in 2017 I observed that Supervisors were spending most of their time undertaking audits and therefore not actually supervising, training or being able to support their teams. I therefore recommended that teams stopped doing so many audits so they could effectively supervise. I do still recommend this. There needs to be a balance between assuring through audit and having time to ensure results are acted on. There equally needs to be sufficient time to train and proactively work to ensure the environment is kept clean. You have a local cleaning audit which all staff find beneficial and the audit required by NHS Wales. I understand you have been asked to go back to auditing this monthly which is a time consuming exercise. My suggestion is that you work with NHS Wales to determine the most effective way to provide assurance that enables you to continue your improvement work.

I reviewed all the Sluices /Dirty Utility rooms on all wards I visited. Whilst overall they were clean they do require further attention. Many were overstocked with disposable bedpans, bags, urinals and were therefore exposed to potential contamination from infective waste. Therefore I recommend

- The IC lead agrees a specification /standard operating procedure for dirty utility rooms. Include in this a way to cover, enclose stock that you require in the area
- Quickly reduce stock in those areas, keeping to a minimum.in the short term to reduce the risk whilst you make necessary changes.

I talked to a number of housekeeping staff who reported that newly refurbished wet room floors were difficult to effectively clean (especially in the corners) using the equipment they had. One of the team showed me what the concern was and I could

see that there was value in raising this. I did not have sufficient time to review this in detail to determine the risk but would suggest that you investigate this further.

5 POST INFECTION REVIEW (PIR)

The overall approach to undertaking PIR has improved. You have two different tools in use, both contain helpful elements. Improved approaches to completing them are evident but variation exists. There are good examples of scrutiny following completion including Dr Mottart leading a monthly scrutiny group. I reviewed a number of completed PIRs and believe they could be strengthened. I therefore recommend the following

- Review your PIR tools and adopt the best of each to create a single review toll that can be used across all sites to improve consistency
- Review the different approaches you have to complete the PIR to ensure information can be collected and documented as soon as possible. Good practice would be to undertake a 72 hour review with staff involved to go through the patient records and discuss the case. This would enable any action required to improve to be taken quickly. The final version should then be completed and scrutinised within 20 working days.
- It is important that the actions agreed are specific and measurable and have clear timescales.

6 SUSTAINABILTY ASSESSMENT

To determine where you are in terms of achieving sustainable change – I would recommend you use the NHS Improvement Sustainability tool to identify where further focus may be required. This is best done with the involvement of a number of staff who each assess the factors required to increase the likelihood of sustaining your improvement

7 COMMUNICATION

To raise the focus of this work, the Safe Clean Care Campaign has been a great success.
Given the reputational damage you have had in the past regarding infection rates, it is important to start to share your successes, improved practices, the investment you have made and the plans you have for the future. The Decontamination Audit for example in 2018 stated “overall there has been a significant improvement” The reduction in use of antibiotic and work with GPs could be promoted as part of the fight against antibiotic resistance. Your ward accreditation has helped improved standards and created real pride on the wards is good practice – not used everywhere. Although the message needs to be tempered with the fact you are not there yet, there is much to share with patients and the public about your approach and progress.

8 QUANTIFY BENEFIT

Given the improvements made it would be possible to quantify the gains in terms of quality, safety, cost and productivity and it would be worth sharing this with the Board.

Janice Stevens
June 2019

THIS SECTION COMPARES FINDINGS IN 2017 TO 2019

AUGUST 2017 ORGANISATIONAL CULTURE	MAY 2019
• There was little compelling evidence that the organisation had truly acknowledged that the current levels of infection were still intolerable and that many patients were suffering avoidable harm. • Reasons such as emergency pressures, environment and staffing levels were often cited as reasons why reductions could not be achieved • An overreliance on IC team to sort • Action reactive rather than pro-active Effort from nurses but not MDT focus • Doctors not BBE	• It was evident from discussion with senior leaders, ward staff & clinical teams that there is now insight into the extent of the problem and much greater recognition that real improvement is achievable despite other pressures. • There is greater ownership and acknowledgment that this is "everyone's" responsibility although there is further work to do with medical staff. Doctors were BBE although staff said they still had to be reminded at times • Action due to the campaign is proactive

IMPROVEMENT ACTIVITY.

AUGUST 2017	MAY 2019
HAND HYGIENE • staff described "getting abuse" from colleagues when they attempted to challenge non-compliance to hand hygiene and bare below the elbows • Audits were not always completed and scores were mixed	• Hand hygiene audit scores have shown improvement but staff reported still having to remind medical colleagues to BBE • All staff were BBE during visit
LINE CARE	• Progress has been made however data shows that there are still

• Staff were receiving training to undertake aseptic technique using ANTT to build capability. • We were also impressed that the Director of Nursing was seeking assurance on the numbers of nursing staff trained. • On-going care of peripheral lines is equally important and ensuring lines do not stay in longer than required is essential. Examples of lines being in place longer than recommended were observed during the walk about. • It was unclear what guidance was used for insertion of lines by paramedics and we would suggest this is checked. In the past lines were regularly inserted "just in case"	peripheral line related bacteraemias and contaminants still occurring and this requires focus. • There is a focus on ensuring the bundle documentation is completed which whilst important is not addressing the root cause. • Nurses are undergoing training and assessment of competence in ANTT however this level of rigor is not being applied to the medical staff. • There was a belief (which I couldn't test in the time I had) that paramedics were still putting peripheral lines in "just in case" and no assurance as to whether this was done aseptically
PROMPT ISOLATION & USE PPE • We did hear from staff who said there was variation in practice regarding when to isolate patients and confusion from some about obtaining results and when to take action. • There was also genuine confusion and a lack of knowledge of the importance of keeping isolation room doors closed • IC nurses were not providing consistent messages • There were regular delays in some sites finding a single room and no assurance of how long it actually took to isolate a patient • Signage with instructions on standard precautions was not easy to follow as too much detail was included	• Investment in the estate has enabled the creation of more single rooms meaning the risk of not being able to isolate has significantly reduced. There is a clear protocol for those occasions when there is a delay which staff were aware of but reported rarely needed to use. • Signage for isolation is much clearer and easy to understand and follow. • The introduction of a simple door open /door closed sign is helping to address the gap in understanding seen in 2017 that doors need to be kept closed. • During the walk about though I saw 3 doors open that should have been closed, indicating there is further work to be done. • PPE was available near all rooms where patients were been isolated. It was however available on a range of trolleys, boxes.
PRUDENT PRESCRIBING • You appointed an Antimicrobial Consultant Pharmacist who is enthusiastic and committed	• The activities to promote prudent prescribing are robust and impressive. The enthusiastic team

• They have analysed antimicrobial prescribing practices to determine where to focus improvement action and whilst there is still high usage, you have seen some improvement in Primary Care. • Have a range of audits in place with plans to develop secondary care indicator. • You have identified that there is a need to create local clinical ownership as prescribing outside the guidelines is still a regular occurrence. • Reviews of cases of Clostridium difficile also showed that prescribing practices were likely to have been contributory factors.	have continued to build on their good work and have introduced effective strategies including • Limiting use of higher risk antibiotics • Introducing a new prescription chart that forces 72 hour review • Participating in the ARK research programme • Continuing to utilise junior doctors to undertake audits • Impressive work with GPs to reduce use of antibiotics with measurable reductions • All cases of Clostridium difficile are followed up for at least 4 weeks, in the community and the case is discussed with the GP • 16% overall reduction in antibiotic use in the community • Reduction in use of PPIs (with GPs receiving monthly data) • Overall sense of greater collaboration and cooperation between teams across organisation and community. • Central Antimicrobial Pharmacist.
CLEAN ENVIRONMENT & EQUIPMENT • An enthusiastic team who spoke positively about the new investment received. It was encouraging to hear that a gap analysis against Cleaning standards had been undertaken which has resulted in the organisation providing additional resources to increase the number of cleaning staff and that recruitment to these posts is underway. • Poor state of cleanliness, and general maintenance, chipped cupboard doors, rips in patient chairs • Issues with estates cleaning in this area only 28% compliant, • Cluttered and storage of equipment on floors • Cleaning compliance C4C 70-80%	• Overall – there had been a significant improvement in cleanliness, standards and assurance • Following the 2017 review we recommended the huge number of audits were stopped to enable supervisors to ensure their teams were properly skilled. This revealed significant gaps in their knowledge & skills and therefore a programme of training and supervision was introduced to address the gaps. This led to significant improvement in standards The numbers/frequency of C4C audits are excessive and do not add the value required. Moving to quarterly monitoring would be a more effective

• Supervisors spending time mainly doing audits and not "supervising" • Not assured about competency of cleaning staff	use of resources and enable sufficient time to act on the results New cleaning standards between Domestics/Clinicians are to be piloted to determine if it provides more effective assurance for the future. Facilities Teams reported that there was much greater collaboration and sharing of the standards with Infection Prevention and Clinicians. Wards were clean and the ward managers demonstrated real pride in their results and standards. The Cleaning Standards framework – that clearly identifies who is responsible for cleaning which area/piece of equipment is good practice and provides greater clarity for accountability Impressive to see introduction of decant areas to ensure areas can be deep cleaned

AUGUST 2017	MAY 2019
GOVERNANCE AND ASSURANCE • Levels of assurance in numerous important areas are recorded as either inadequate or moderate. • Actions recorded are not robust enough to raise the levels of assurance e.g. " x offered support", "arrange meeting" " to discuss annual validation" • Attendance is mixed and has limited medical input. • The level of debate noted is still primarily operational • Many actions recorded on the tracker are overdue Line of sight from floor to Board was confusing. It was unclear how the roles of the Quality Assurance Executive, Executive IPC, SIPC all function and	It is important to be assured that the controls you put in place to measure compliance are robust. You have simplified your governance and accountability and line of sight is now clearer Terms of Reference for IPC Committees have been strengthened and reports are clearer and more delivery focused. The Safe Clean Care action plan that has replaced your tracker is significantly better as is uses a project management approach. Oversight is robust and will need to continue

contribute to a streamlined assurance process. unclear how performance and accountability for HCAI plans and infection numbers are effectively monitored and individuals/management teams held to account Data presented does not provide the appropriate level of assurance.	Data presented in reports is more robust and use of SPC charts has enabled you to accurately report on progress and determine trends and variation

POST INFECTION REVIEW (RCA) 2017	**MAY 2019**
• Matrons carry out a 72 hour review however variation in how this was undertaken and recorded. • Impression more of a tick-box exercise • Lack of clear findings, lessons to be learnt, and actions to be implemented. • Using old tool developed by the NPSA in 2005 and an adapted PIR. Recommend you update and simplify the tool you use.	• The process has been strengthened and there is improved oversight (especially at Bangor – led by Dr Mottart). • You are using two different RCA tools across the organisation. Each contain good elements of review, consider merging these 2 documents. • Having reviewed a number of completed PIR's, whilst the quality has improved there is still scope to make further improvements to the quality of these in terms of investigation, review, actions and assurance

TRAINING	**MAY 2019**
There was variation in knowledge and practice and a reliance on the IC team to provide training, Knowledge and skills gaps equally go beyond specialist IC practice and relate to fundamentals of care. Staff were unclear about what action to take and there was different advice being offered from different IPC nurses	You have simplified and made much clearer what action staff need to prioritise through your Safe Clean Care Campaign. This has been welcomed by staff You have improved and varied the methods of training which has had an impact on staff knowledge one ward manager said " I am now clear about exactly what I need to do now"

CONSULTANT MICROBIOLOGY ESTABLISHMENT 2017	**MAY 2019**

The situation seen by Prof Duerden has not been resolved and the team were seriously depleted	I was unable to determine exactly whether there was still a gap in provision but overall there is now an increased microbiology presence and resource available to the organisation

INFECTION PREVENTION CONTROL TEAM 2017	**MAY 2019**
• A knowledgeable lead for IPC with good funded establishment but team not fully trained and all lacked leadership & change management skills • Turnover, sickness and low morale • Lack of visibility in clinical areas – with staff reporting their role as "policing" • Lack of consistency of advice & practice	• The introduction of a new leader has had a real impact on the reputation and presence of the IPC team • Amanda Miskell has refocused the team, restructured the resource, undertaken team building and brought them together to enable them to create a more consistent message. • Overall morale and sickness have improved • Staff on wards reported that there had been a positive change and that the team were visible, helpful and supportive.

Quality, Safety & Experience (QSE) Committee **19.11.19**	 ***To improve health and provide excellent care***

Report Title:	Corporate Risk Register and Assurance Framework Report
Report Author:	Mrs Justine Parry, Assistant Director of Information Governance and Assurance Mr David Tita, Head of Risk Management
Responsible Director:	CRR02 Executive Director of Nursing and Midwifery CRR05 Executive Director of Nursing and Midwifery CRR16 Executive Director of Nursing and Midwifery CRR03 Director of Primary and Community Care CRR13 Director of Mental Health and Learning Disabilities **Risks for Escalation** CRR20 Executive Director of Workforce and Organisational Development CRR21 Executive Director of Workforce and Organisational Development
Public or In Committee	Public
Purpose of Report:	• To present an extract of relevant risks on the Corporate Risk Register and Assurance Framework Report to the QSE Committee for review, scrutiny and consideration for approval. • To provide assurance that relevant risks to the Health Board`s objectives and priority areas as defined in its 3 Year Plan are being robustly and effectively mitigated and managed.
Executive Summary	Over the last few months, the Risk Management team has been supporting Directorates, Divisions and Area teams in timely updating and refreshing risks on their risk registers as engagement and staff capacity building in risk management are critical in embedding risk management. The Health Board recognises that it is on a risk management improvement journey which in the next few years will culminate in the implementation of an Enterprise Risk Management (ERM) Model. The support generated by Senior Leaders across the Health Board in driving forward improvements in our risk management culture is important in ensuring success and embedding a positive risk management and governance architecture. This renewed energy has created a positive culture of risk awareness and momentum across the Health Board that is providing focus to our ongoing debates and conversations around how best to capture, strengthen and monitor the

	effective management of our principal risks. This will over the next few months enable us:- • To appropriately identify, assess and capture the Health Board`s principal risks which are aligned to the achievement of its objectives as defined in its 3 Year Plan and emergent clinical strategy. • To align this to an assurance mapping exercise as a key part of developing our Board Assurance Framework (BAF) and widening our understanding of our key principal strategic risks as well as providing assurance that there are systems, processes and governance arrangements in place to robustly identify, assess, monitor and manage them. • To robustly establish a symbiotic relation between the BAF and CRR as complementary mechanisms for providing assurance to the Board and fostering a better understanding of the Health Board`s strategic and extreme operational risks. Defining the principal risks and BAF will enable the Health Board to appropriately frame and inform agendas. It will enable a timely response to any gaps in controls and assurance in a more dynamic way. The attached report has been produced from the web-based Datix system and details the risk entries allocated to the Quality, Safety & Experience Committee (QSE). These risks were also presented to the Board on the 7th November 2019, however due to a timing issue any updates from the Board meeting have not been captured in this version being presented to the QSE Committee. **CRR02 Infection Prevention and Control.** Key progress: Infection Prevention quality visits have commenced to replace the previous “audit programme”. These visits encompass observation of clinical practices, support and advice, micro teaching, safe clean care updates, hand hygiene observations, screening and any other relevant support needed by the ward staff. Scrutiny of every avoidable infection and lessons learnt are regularly shared. There has been no change to the current risk scoring. **CRR03 Continuing Health Care.** Key progress: This risk has been reviewed and re-assessed with emphasis placed on the CHC elements while the component around Care Homes and their development will be risk assessed as a new distinct risk. There has been no change to the current risk scoring. The Committee are asked to agree to the removal of the Care Homes risk to form a separate risk to be managed as part of the Executive Nurse portfolio.

	CRR05 Learning from Patient Experience. Key progress: Mitigating controls have been updated to note Performance and accountability reviews include concerns monitoring as Patient Advice and Support Service has been initially established in YGC. There has been no change to the current risk scoring. **CRR13 Mental Health Services.** Key progress: Whilst the target risk date has been updated, further evidence to support the reduction in the risk score has been requested by Committee members. Therefore the current risk score has reverted to the August 2018 score until further evidence is presented. However remarkable progress with this risk is corroborated by the HIW report demonstrating improvements in services. **CRR16 Safeguarding.** Key progress: Risk controls have been strengthened to include business planning, a refreshed reporting framework and the introduction of a senior management Tier in the safeguarding structure. Further actions have also been updated to support achieving the target risk score and linked to operational risks, however the target risk date must be reconsidered. There has been no change to the current risk scoring. **Risk Escalation** Two risks are presented for approval onto the Corporate Risk Register. These are: • **CRR20 Security Risk** - A comprehensive review of security management identified shortfalls in the systems including CCTV, lone working, lock down procedure, security contract, violence and aggression, key holding and alarm systems. This is a new identified risk. • **CRR21 Health & Safety Risk** - Through a gap analysis of 31 pieces of legislation, Occupational Health and Safety identified areas of concern in the safety management system and compliance with the law. This is a revised risk for escalation consideration and approval. The Audit Committee agreed on the 16th October, that commencing in 2020/21 all corporate risks will be presented at each Committee meeting. Therefore these risks will next be presented to the Committee in April 2020.
Approval / Scrutiny Route Prior to Presentation:	The full Corporate Risk Register and Assurance Framework (CRAF) is scrutinised by the Health Board twice per year and is published on the Board's external facing website. Individual risks are allocated to one of the Board's Committees for regular consideration and review.

Governance issues / risks:	The report provides for the identification of the risk, the arrangements in place presently to control the risk and further mitigation action/s required.
Financial Implications:	These are identified through the development of business cases and plans required as part of the further actions to achieve the target risk score, as detailed in each risk register entry.
Recommendation:	The Committee is asked to: • consider the relevance of the current controls: • review the actions in place and consider whether the risk scores remain appropriate for the presented risks: • approve the 2 risks for escalation onto the Corporate Risk Register.

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

Due to the nature of this report an Equality Impact Assessment is not required.

Key to abbreviations within the attached register.

Strategic Goals

1) Improve health and wellbeing for all and reduce health inequalities.
2) Work in partnership to design and deliver more care closer to home.
3) Improve the safety and outcomes of care to match the NHS' best.
4) Respect individuals and maintain dignity in care.
5) Listen to and learn from experiences of individuals.
6) Support, train and develop our staff to excel.
7) Use resources wisely, transforming services through innovation and research.

Principal Risks

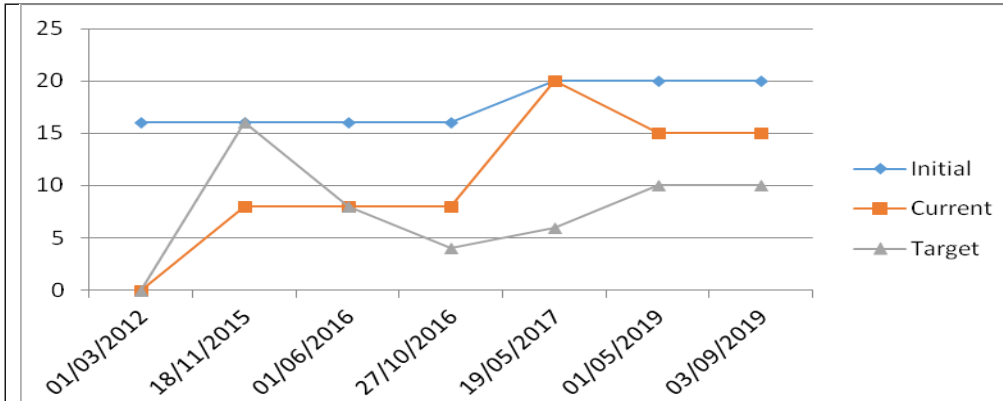
The Health Board has determined its principal risks to achieving its strategic goals as follows:-

Principal Risk 1: Failure to maintain the quality of patient services.
Principal Risk 2: Failure to maintain financial sustainability.
Principal Risk 3: Failure to manage operational performance.
Principal Risk 4: Failure to sustain an engaged and effective workforce.
Principal Risk 5: Failure to develop coherent strategic plans.
Principal Risk 6: Failure to deliver the benefits of strategic partnerships.
Principal Risk 7: Failure to engage with patients and reconnect with the wider public.
Principal Risk 8: Failure to reduce inequalities in health outcomes.
Principal Risk 9: Failure to embed effective leadership and governance arrangements.

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

CRR02	**Director Lead:** Executive Director of Nursing and Midwifery	**Date Opened:** 1 March 2012
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 3 September 2019
	Risk: Infection Prevention & Control	**Target Risk Date:** 31 March 2020

There is a risk that patients will suffer harm due to healthcare associated infection. This may be caused by a failure to put in place systems, processes and practices that would prevent avoidable infection. The impact of this may increase morbidity and mortality, increase admissions and longer length of stay, increase treatment costs, reputational damage and loss of public confidence.



	Impact	Likelihood	Score
Initial Risk Rating	5	4	20
Current Risk Rating	5	3	15
Target Risk Score	5	2	10
Movement in Current Risk Rating since last presented to Board in January 2019	**No Change** ⇔		

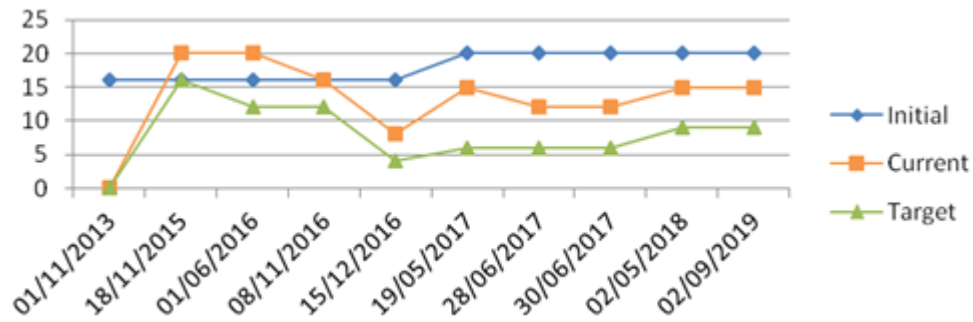
Controls in place	Further action to achieve target risk score
1. Infection Prevention Sub-Group scrutinise trajectories and performance through the regular cycle of business, quarterly and annual reports to Quality and Safety Group. 2. Surveillance systems and policies/SOPs in place for key infections, with data presented through the governance route to Board. 3. Areas and Secondary Care sites governance arrangements. 4. Monthly Executive-led scrutiny meetings to review infections and learning from each site in place. 5. Continued progress on ANTT staff training, with key trainers in place, increased focus on medical staff supported by MDs, competencies held by individuals managers.	1. Continue the implementation of SCC and IP via annual work programmes. Await report from re visit from Janice Stevens in May 2019 for any further recommendations. 2. Implement the other actions identified in the 2019-20 annual infection prevention programme. 3. Implement actions in response to Welsh Government Antimicrobial Delivery Plan, relevant Welsh Health Circulars and in response to multi-drug resistant organisms. Part of the ARK study. 4. Continue to progress key actions from Duerden report 2016 in relation to Consultant Microbiologist staffing and capacity, Antimicrobial Stewardship, Estates and Facilities, policies and procedures.

6. External review performed August 2017; report on further actions presented to Board. Second review report recieved in August 2019 shows improvement, as does the internal audit on SCC assurance in June 2019. 7. Safe Clean Care Programme (SCC) launched 29-01-18, consideration to align SCC with IP annual work programme. 8. CAUTI snapshot planned for September 2019. 9. Deep dive considers every 6 organisms under WG scrutiny.	5. Scrutinise every avoidable infection and lessons learnt from these are shared formally. 6. Progress work on influenza preparedness in preparation for winter 19-20.

Assurances	**Links to**		
	Strategic Goals	**Principal Risks**	**Special Measures Theme**
1. Professor Duerden report 2016. 2. WG review of decontamination. 3. Demonstrable improvement in line with National Benchmarks. 4. CHC Bug watch visits. 5. HSE reviews. 6. Internal Audits of Governance Arrangements.	1 2 3 4 5 6 7	PR1	Leadership

CRR03	**Director Lead:** Director of Primary and Community Care	**Date Opened:** 1 November 2013
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 2 September 2019
	Risk: Continuing Health Care	**Target Risk Date:** 31 December 2019

There is a risk that the CHC Framework and process will not be fully adhered to. This is due to inconsistent application and service pressures including availability of suitable provision. This could lead to poor patient experience and outcomes and associated complaints and retrospective claims.



	Impact	Likelihood	Score
Initial Risk Rating	4	5	20
Current Risk Rating	3	5	15
Target Risk Score	3	3	9
Movement in Current Risk Rating since last presented to Board in January 2019	**No Change** ⟺		

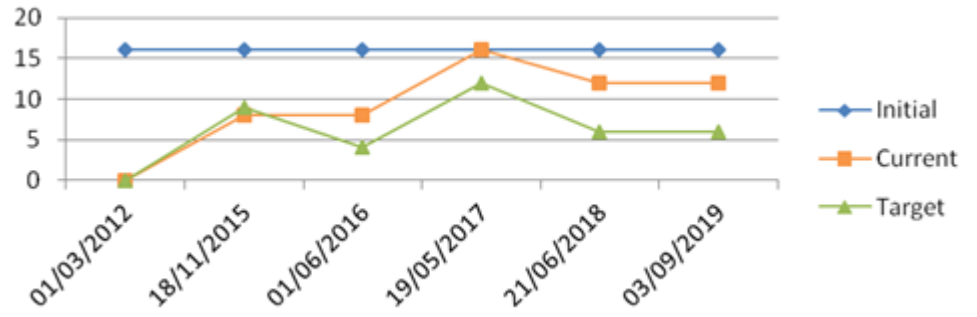
Controls in place	Further action to achieve target risk score
1. 2014 national CHC Framework. 2. Revised CHC structure in place including Practice Development Team. 3. All Wales Retrospective Claims process (Powys). 4. Joint LA & BCU CHC Regional Implementation Group. 5. Revised BCUHB CHC Governance Framework agreed. 6. PMO Scheme for CHC with associated project management and reporting in place. 7. Annual WG self assessment. 8. North Wales care home market place community project. 9. Contracts and contract monitoring team in place. 10. Implemented Scheme of Delegation Process within Areas. 11. Implemented Skills and Knowledge Framework. 12. Recruited to Retrospective Team.	1. Implement revised CHC Governance and Strategic Commissioning Team. 2. Finalise and implement regional SOP. 3. Development of dashboard KPI's for CHC with Broadcare. 4. Monthly exception reporting. 5. Develop CHC commissioning strategy. 6. Implement the Older persons Commissioner and Operation Jasmine action plans. 7. Roll out Bevan Exemplar care home support team. 8. Finalise and implement joint quality monitoring tool across north Wales. 9. Implement patient and family feedback process. 10. Increase partnership working with the sector to include shared services.

13. Implemented revised national retrospective claims procedure. 14. CHC Contracts in place for all placements. 15. Care Home QAF in place. 16. Care Home Market position statement developed.	11. Develop training and workforce strategy for Care Homes. 12. Development of training and workforce strategy for CHC process.

Assurances	**Links to**		
1. Regular meetings with Regulators (CSSIW). 2.Inter-agency processes in place to review escalated concerns. 3. FNC Judicial Reviews of NHS Wales fee setting methodology implemented. 4. National reporting on CHC placements.	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	2 3 4 5 6 7	PR1	Strategic and Service Planning

CRR05	**Director Lead:** Executive Director of Nursing and Midwifery	**Date Opened:** 1 March 2012
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 3 September 2019
	Risk: Learning From Patient Experiences	**Target Risk Date:** 31 January 2020

There is a risk that the Health Board does not listen and learn from patient experience due to the untimely management and investigation of concerns. This could lead to repeated failures in quality and safety of care.



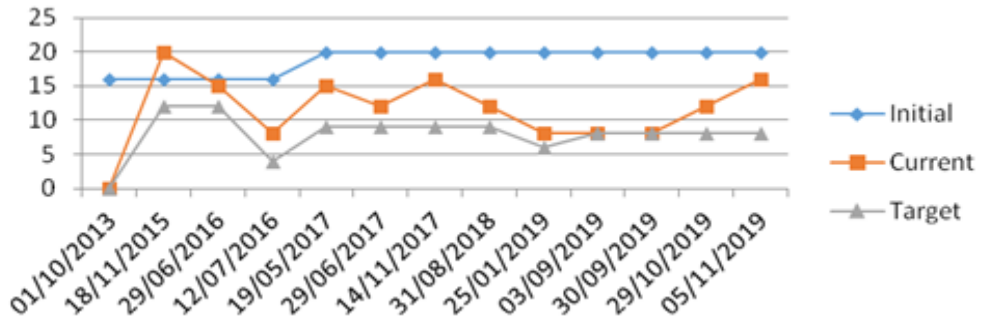
	Impact	Likelihood	Score
Initial Risk Rating	4	4	16
Current Risk Rating	3	4	12
Target Risk Score	2	3	6
Movement in Current Risk Rating since last presented to Board in January 2019	**No Change** ⇔		

Controls in place	Further action to achieve target risk score
1. Corporate concerns team embedded in operational management structures. 2. Performance and accountability reviews include concerns monitoring. 3. Weekly divisional PTR meetings being held. 4. Monthly reporting and monitoring of performance and learning to QSG. 5. Enhanced monitoring of claims with Welsh Risk Pool. 6. Ongoing programme of work in place as part of the IMTP to deliver improvement. 7. Patient Advice and Support Service established in YGC initially. 8. Minimum data sets provided monthly to all divisions regarding Concerns. 9. Initial review (72hr) of serious incidents implemented. 10. Revised trajectories agreed as part of IMTP.	1. Concerns management and investigation processes being reviewed with support of new ADQA with a particular emphasis on incident management. 2. Review and revision of corporate concerns management to enhance learning in the divisions and create capacity to support training and development for the divisions. 3. Manage performance in line with revised trajectories. 4. PALs service introduced into East and West. 5. Learning from complaints now added into QSE reports. 6. Peer review of complaints redress reimbursement commenced on an All Wales basis to share learning across Wales. 7. Development of newsletter to include learning. 8. Focus on training and development of human factors training programme.

11. Significant reduction in total numbers of complaints open - focus on resolving complaints as OTS where possible. 12. Harm dashboard launched and being informed by Datix. 13. Weekly teleconference with corporate and divisions to monitor complaints. 14. Associate Director Quality Assurance in post. 15. Process commenced to manage historic incidents to closure and learning. 16. Additional support identified to manage overdue complaints and allow divisions to focus on new complaints raised. 17. Weekly Incident review meeting established to review all serious incidents and complaints over 3 month overdue.	9. Implementation of new "Once for Wales" RLDatix concerns management system to aid learning across Wales.

Assurances	**Links to**		
1. Welsh Risk Pool Reports. 2. Monthly review by Delivery Unit. 3. Public Service Ombudsman Annual Report, Section 16 and feedback from cases. 4. Regulation 28 Reports from the Coroner.	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	3 4 5 6	PR7	Leadership

CRR13	**Director Lead:** Director of Mental Health and Learning Disabilities	**Date Opened:** 1 October 2013
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 5 November 2019
	Risk: Mental Health Services	**Target Risk Date:** 31 March 2020
There is a risk that patients receive inappropriate care within Mental Health Services due to failings in leadership and governance at all levels within the Division which could result in poor quality outcomes for patients.		



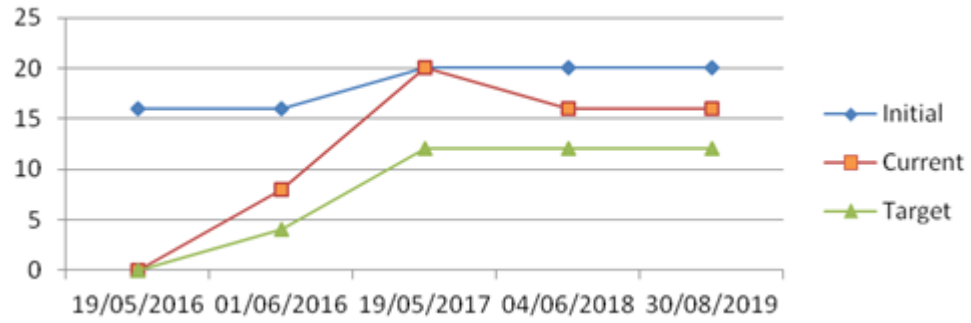
	Impact	Likelihood	Score
Initial Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	2	8
Movement in Current Risk Rating since last presented to Board in January 2019	August 2018 Score Reinstated		

Controls in place	Further action to achieve target risk score
1. Improvement plan in place and subject to ongoing review. 2. Enhanced monitoring in progress at Board level. 3. Renewed focus and escalation arrangements for dealing with operational issues. 4. Governance Framework developed and implemented within mental health. 5. Mental Health Strategy approved by the Board. 6. Senior Management and Clinical Leadership holding structure in place. 7. Older Person's Mental Health action plans in place. 8. Weekly PTR meeting in place. 9. Revised interim leadership, management and governance arrangements in place November 2017.	1. Ongoing implementation of performance and accountability reviews across the division. 2. Continue to improve internal divisional communication systems. 3. Contribute to HASCAS investigation and wider governance review. 4. Undertake review of demand, capacity and skill mix. 5. Ongoing review of staffing levels. 6. Consultation on permanent structure to be completed. 7. Embed revised arrangements for safeguarding, and dynamic risk assessment. 8. Standardise operational procedures for acute inpatient care.

Assurances	Links to		
	Strategic Goals	**Principal Risks**	**Special Measures Theme**
1. Board and WG oversight as part of Special Measures. 2. External reviews and investigations commissioned (Ockenden and HASCAS). 3. HIW Reviews. 4. External Accreditation (AIMS). 5. Delivery Unit oversight of CTP.	1 2 3 4 5 6 7	PR1	Mental Health

CRR16	**Director Lead:** Executive Director of Nursing and Midwifery	**Date Opened:** 19 May 2016
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 30 August 2019
	Risk: A major safeguarding failure occurs	**Target Risk Date:** 31 October 2019

There is a risk that the Health Board does not discharge its statutory and moral duties in respect of Safeguarding. This may be caused by a failure to develop and implement suitable and sufficient safeguarding arrangements, develop an engaged and educated workforce and provide sufficient resources to manage the undertaking. This could impact on those persons at risk of harm to whom the BCUHB has a duty of care.



	Impact	Likelihood	Score
Initial Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	3	12
Movement in Current Risk Rating since last presented to Board in January 2019	**No Change** ⇔		

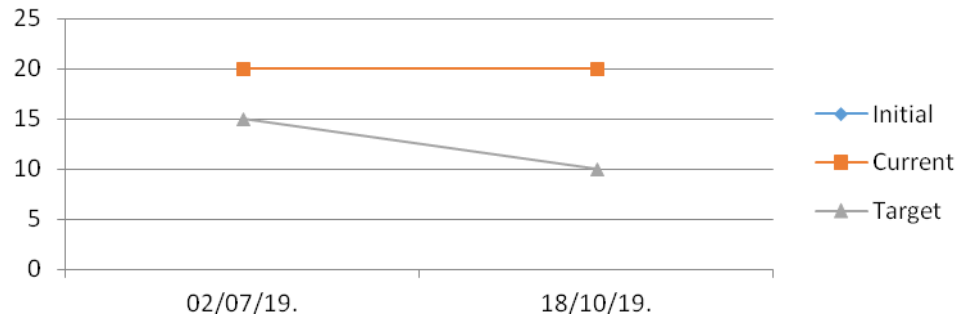
Controls in place	Further action to achieve target risk score
1. A cycle of Business Planning meetings have been implemented within the Nursing and Midwifery Directorate which scrutinises and reviews Level 1 and 2 Risks and is attended by the Associate Director of Safeguarding. 2. A refreshed Safeguarding Reporting Framework has been implemented within safeguarding which sets out clear lines of accountability and is underpinned by a Business Cycle. 3. A standardised data report on key areas including Adult at Risk, Child at Risk and DoLS is submitted to Area Forums in order that data is scrutinised and risks identified.	1. A further service reconfiguration is ongoing. The second phase of safeguarding JDs are in the process of being reviewed. 2. Further structural activity is planned to ensure business continuity and stability within the Corporate Safeguarding Team. This includes the provision of a 7 day on call, flexible working service. This will be implemented once financial approval is gained and consultation complete. 3. A Safeguarding Communications Strategy is a priority activity for 2019-20.

3. Risk Management has been embedded into the processes of the Reporting Framework by being included as a standing item on the Safeguarding Governance and Performance and Area Forum Agendas. Issues of Significance reports require risks to be identified and reported on in terms of mitigating action. 5. A new Senior Manager tier has been appointed to within the Safeguarding Structure. This will strengthen strategic oversight in key areas.	4. The programme of works relating to the governance and accountability of Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act is under review and implementation of key tasks including signatory training has been implemented. See Risk 2548. 5. A review of the DoLS structure and service provision is a priority activity for 2019-20 and a key requirement from HASCAS. An options paper which sets out options for the DoLS Team will be presented to QSG in Nov 2019. See Risk 2548. 6. The appointment of a Named Doctor, Safeguarding Adults is still outstanding however positive discussions have taken place with the Office of the Executive Medical Director to move this forward. The post holder when appointed will hold a position on the NWSAB. 7. A Training Needs Analysis is underway and a 2019-2020 Training Strategy has been developed to ensure that staff are competent to support and embed the Safeguarding agenda across BCUHB.

Assurances	**Links to**		
	Strategic Goals	**Principal Risks**	**Special Measures Theme**
1. Strengthened Governance and Reporting arrangements. 2. Enhanced engagement with partner agencies. 3. Safe and effective data collection and triangulation of organisational data to identify risk. 4. Improved compliance against recognised omissions relating to the review and development of Safeguarding policies and Training materials. 5. Regional Safeguarding Boards.	3 7	PR9	Governance

Risks for Escalation onto the CRR:

CRR20	**Director Lead:** Executive Director of Workforce and Organisational Development	**Date Opened:** 2 July 2019
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 18 October 2019
	Risk: Security Risk	**Target Risk Date:** 1 December 2019
There is a risk the Health Board fails to ensure that a suitable systems are in place to protect staff, patients and stakeholders from security, violence and aggression incidents arising out of our work activity. This is due to lack of formal arrangements in place to protect premises and people in relation to CCTV, Security Contract issues (personnel), lone working, lock down systems, access control and training that provides assurance that Security is effectively managed.		



	Impact	Likelihood	Score
Initial Risk Rating	4	5	20
Current Risk Rating	4	5	20
Target Risk Score	2	5	10
Movement in Current Risk Rating since last presented to Board in January 2019	**New Risk**		

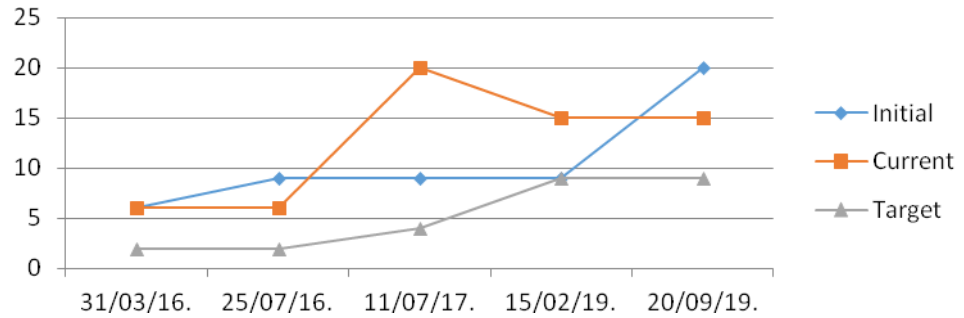
Controls in place	Further action to achieve target risk score
1) There is a system in place for a contractor (Samsun) to manage the physical/people aspects of Security for the organisation. 2) A V&A Case manager is in place to support individuals who have been exposed to violence and aggression incidents. 3) CCTV Policy is being developed. 4) An external contractor is supporting the Head of H&S to review all aspects of Security across the Board. 5) An external Police Support Officer is in place part time to support the organisation and staff.	A systematic approach is required to both physical and people aspects of the risks identified. This includes: 1. A complete review of CCTV and recording systems. 2. Clear lines of communication with the contractor, review of the contract in relation to key holding responsibilities and reporting on activities. 3. Responsibilities of Security roles within BCUHB clearly defined. 4. Lone worker procedures and risk assessments further established. 5. Reducing numbers of violence incidents to staff through clear markers and systems for monitoring violent patients.

	6. Comprehensive review of Security on gaps in system which was provided to the Strategic OHS group. It was agreed that risk remains at 20 with a target outcome of of 10. A comprehensive action plan is being developed by 1st October to look at mitigating the risk. It is likely that significant investment is required in personnel and structure to support the recommendations identified in the review.

Assurances	**Links to**		
None recorded	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	8		Not Applicable

CRR21	**Director Lead:** Executive Director of Workforce and Organisational Development	**Date Opened:** 31 March 2016
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 20 September 2019
	Risk: Health & Safety Leadership and Management	**Target Risk Date:** 1 November 2019

There is a risk that the Health Board fails to achieve compliance with Health and Safety Legislation due to insufficient leadership and general management. This could have a negative impact on patient and staff safety, including organisational reputation and prosecution.



	Impact	Likelihood	Score
Initial Risk Rating	4	5	20
Current Risk Rating	5	3	15
Target Risk Score	3	3	9
Movement in Current Risk Rating since last presented to Board in January 2019	**Existing Risk for Escalation**		

Controls in place	Further action to achieve target risk score
1. Health and Safety Policy requires updating. 2. Health and Safety Management arrangements further developed. 3. Strategic Health and Safety Group in place meeting regularly (3 times in 3 months). 4. Risk Assessments and safe systems of work. 5. Mandatory Training. 6. Clinical and Corporate Health and Safety Teams. 7. Corporate Health and Safety Team. 8. Programme of Annual Self-Assessment Audits. 9. Gap analysis in place. 10. Health and Safety Walkabouts. 11. Health and Safety Report to QSE and Board. 12. Health and Safety Improvement Project Plan.	1. Undertaken gap analysis of 31 pieces of legislation. Completed within specified time frame (117 inspections in 7 weeks). 2. Action plan developed based on non compliance with legislation. 3. Develop a programme of intervention and training through TNA Review. 4. Identified RIDDOR reports and scrutiny of process, looking at improved RCA system. 5. 12 Month action plan developed and 3 year strategy, that is owned by Divisions and Senior Leaders. 6. Further develop individual risk register for items of none compliance identified through gap analysis 8-10 specific items. 7. Review Divisional governance arrangements so that they marry with H&S governance system and reporting to Strategic OHS Group. 8. Implement findings of internal audit review of process of inspection and governance.

	It was agreed that the evidence from the gap analysis required the scoring to remain at 20 as there is significant risk of prosecution and the desired outcome should be 10.

Assurances	**Links to**		
None recorded	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	8		Not Applicable

Quality, Safety & Experience Committee **19.11.19**	 **To improve health and provide excellent care**

Report Title:	Listening and Learning from Patient and Service User Experience Report
Report Author:	Carolyn Owen Head of Patient and Service User Experience
Responsible Director:	Mrs Deborah Carter, Associate Director of Quality Assurance and Interim Director of Operations
Public or In Committee	Public
Purpose of Report:	To provide a summary of the rich sources of patient and service user feedback received and highlights actions taken to respond to this feedback.
Approval / Scrutiny Route Prior to Presentation:	The report has been reviewed by the Associate Director of Quality Assurance and Director of Operations
Governance issues / risks:	Examining patient and service user feedback provides direct insight into what is working well and not so well in the way BCUHB is delivering care. The majority of feedback received is good. The report includes examples of good practice where lessons have been learnt, and, areas where improvements have been made.
Financial Implications:	No financial implications have been identified
Recommendation:	The Committee is asked to note the report

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

4.To work in partnership to support people – individuals, families, carers, communities - to achieve their own well-being	√	4.Putting resources into preventing problems occurring or getting worse	√
5.To improve the safety and quality of all services	√	5.Considering impact on all well-being goals together and on other bodies	√
6.To respect people and their dignity	√		
7.To listen to people and learn from their experiences	√		
Special Measures Improvement Framework Theme/Expectation addressed by this paper Engagement			
Equality Impact Assessment			

Listening and Learning from Patient and Service User Experience Report

Contents:

Section 1

What patient and service user feedback is and how we gather the information in BCUHB.

Section 2.

Understanding the findings from feedback

Section3.

Sharing feedback

Section 4.

Action planning –'You Said We Did'

Section 5.

Highlights

Introduction

Measuring patients' experiences of care and treatment highlights areas that need to improve to provide a patient led healthcare service. This report outlines how BCUHB meet the challenges of improving services across the health board by finding out what patients and service users think and share about their experiences.

The BCUHB Patient and Service User Experience Improvement Strategy 2019-2022 listening and Learning from Patient Feedback framework objectives describe that the Health Board will report on progress being made.

Summary

The summary section provides an overview of key areas of performance ('challenges' and 'highlights') and identifies any actions being taken as a result

Challenges	Highlights
Feedback responses are below the 20% targets across the health board.	PALS service successfully implemented across all regions. Positive influence on early resolution for patient, service user, relatives and staff enquiries. Supporting areas of lower feedback compliance.
West feedback responses consistently lower that other sites.	PALS roll out of Care to Share feedback supporting the balance of lower real-time feedback responses. 97% consistent positive feedback achieved.

Central feedback responses have been inconsistent.	50% increase in total feedback responses in Central secondary care.
Community areas feedback consistently low.	Monthly Care to Share programme delivery in West and Central. East area will be introduced in next quarter.
Primary Care feedback responses not captured.	Primary care developed in order to gather patient feedback in next quarter.
Action planning for improvement in response to patient and service user feedback is limited without a consistent tracking method. An action plan will be developed supported by the the Listening and Learning strategic forum. Clear goals and objectives with each task divided into manageable steps.	Engaging and sharing with local communities, reaching key groups by adapting the patient and Service User team approach and methods of communication. Including for example harder to reach communities including refugees, asylum seekers, and homeless, blind and deaf service users.
With a view to improving feedback response rates and scores consistently across all areas of the health board different modalities need to be used to support.	Social media engagement is developing well with a total of 97,923 views counted from May to July 2019 with the staff comment of the week; Friday Feel-good'.
	For quarter 3 of 2018/19 the health board received higher levels of patient and service user satisfaction in their feedback than 2017/18.
	Survey results and comments will be considered alongside all other patient and service user experience data, in order to agree action planning to ensure quality improvements are made.

Section1.

What patient and service user feedback is and how we gather the information in BCUHB.

The aim is to demonstrate reliable and rigorous feedback obtained systematically through various methods as shown here.

This is how we do it in BCUHB.

Patient feedback is having a positive impact on staff; “staff feel very proud and motivated when they see the feedback from patients”, Community Response Team East Area.

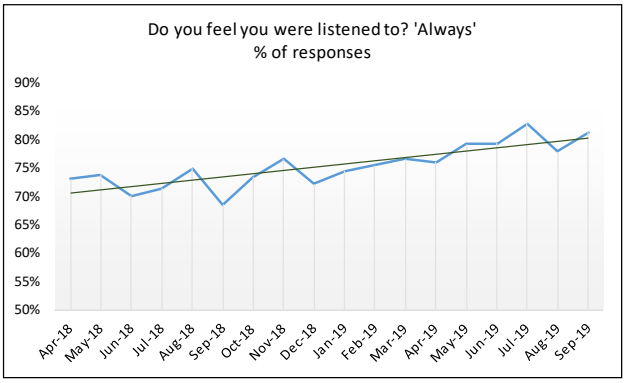
Section 2. Understanding the findings from feedback

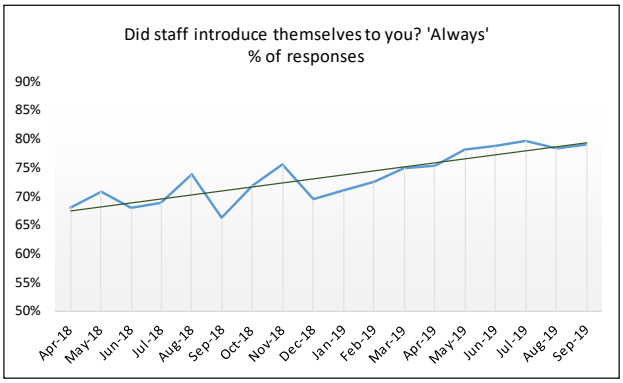
Feedback information can be studied and illustrated in a number of ways depending on the type that is gathered e.g. patient stories, care to shares or surveys.

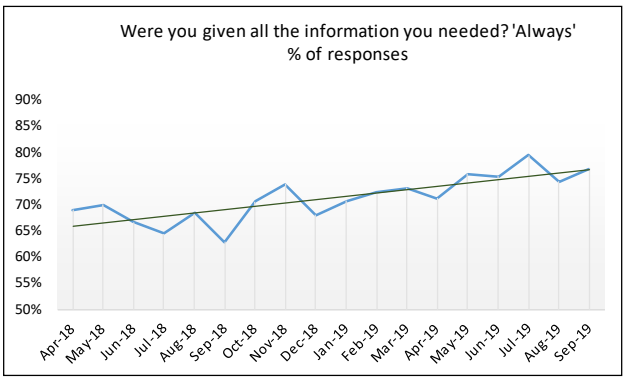
The real time feedback survey asks patients and service users specific questions and uses the responses range from ‘always’ to ‘never’. The graphs below demonstrate aggregated response data for all three acute hospitals and a small number of community hospitals.

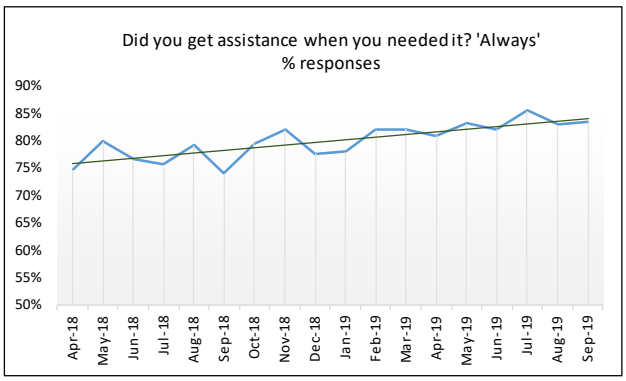
The graphs demonstrate performance over time; month on month reporting and monitoring allows any dips in performance to be further interrogated to understand whether the problem is Health Board wide or specific to a service area.

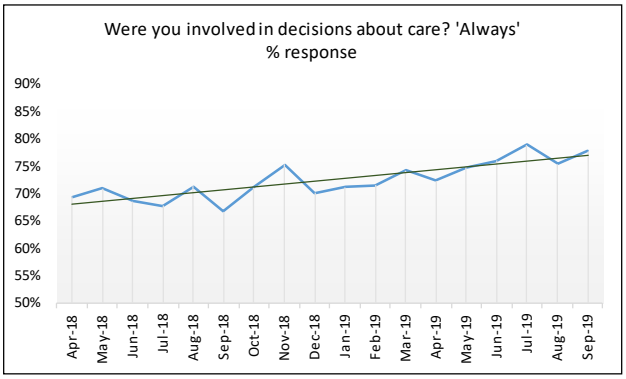
As shown, there is an overall improvement across the board for all questions.

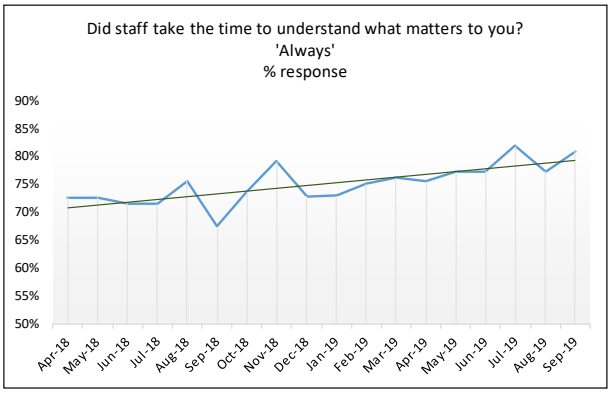






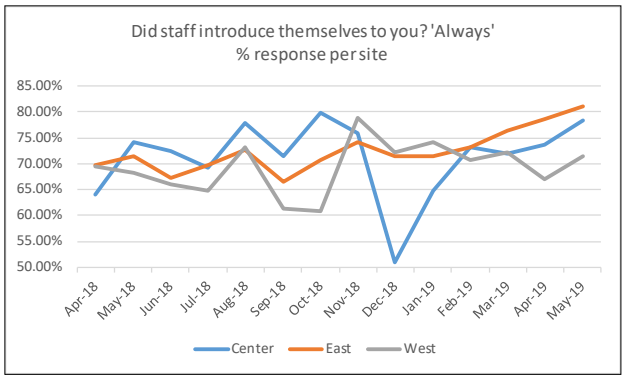




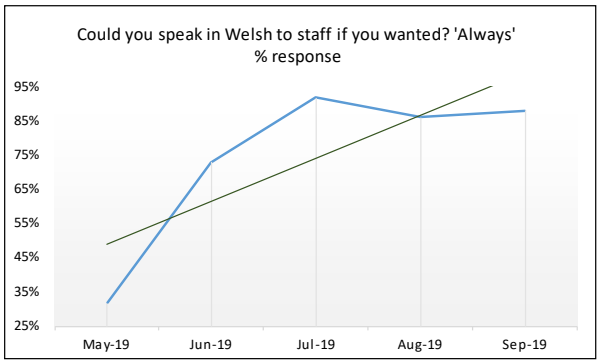


Through a combination of collaboration with service user experience and feedback to individual reporting areas each question above is now demonstrating continuous improvement; the aim of all services is to continuously improve the performance in line with the strategy.

The data for each question can be further broken down per site. For example:



Welsh Language



*this questions was introduced in May 2019 in response to the new Welsh Language Standards.

Responses across all areas demonstrate that overall patients and service users feel that they are consulted as to whether they wish to speak in Welsh to a staff member.

Below are a sample of both positive and negative comments shared by Ysbyty Gwynedd patient and service user feedback from 1st April -1st November 2019. The Patient and Service User Experience team are working in collaboration with the Welsh language service team to support specific areas that require improvements with the Welsh language to meet the requirements.

Positive Comments to Welsh language - YG	**Negative Comments to Welsh language - YG**
It was also good to be able to communicate in my first language Welsh with the majority of the staff. Night staff were approachable and very understanding of my needs.	TALK WELSH FIRST TO A PATIENT
Nice to have so many Welsh speakers.	I don't speak or understand Welsh so felt uncomfortable if I needed to interrupt a conversation.
Excellent to be able to speak Welsh to majority of staff. A very good experience!	More Welsh speakers.

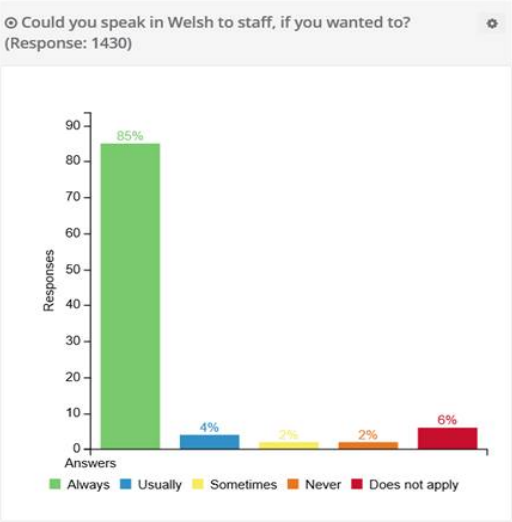
Can speak welsh to most staff, even welsh learners do their best to speak welsh to me.	More welsh.
Many speaking Welsh or learning.	Not one member of staff asked her if she was Welsh-speaking but she initiated conversations in Welsh.
Hearing the Welsh spoken language	Whilst staff spoke Welsh they usually addressed him in English even though he is a Welsh speaker.
She thought there were enough Welsh speaking staff on the ward.	
Pleased with the level of Welsh speaking staff on the ward.	
The patient noted that most of the staff spoke Welsh, particularly on the night shift, but that the doctors did not.	
Most of the staff she had come into contact with someone on the ward who spoke Welsh.	
He felt the ratio of Welsh-speaking staff on the ward was 50:50 which he was happy with.	
The patient's wife stated that more than 50% of the staff appeared to speak Welsh.	
Plenty of staff who spoke Welsh on the ward	
Most of the staff were Welsh-speaking and were very good at speaking with her in Welsh.	
There were a number of English staff on the ward but appreciated that they tried to speak Welsh.	
The patient noted a larger number of Welsh speaking staff on the assessment unit as opposed to the current bay.	
Happy with the level of Welsh speaking staff and noted that 'everyone is bilingual'.	

The following tables and graphs illustrate in more detail, by site, including the response rates to this question. Whilst it is recognised that there are more Welsh speakers in the West as seen by the number of 'does not apply' responses, the percentage of patients and service users who feel that they could 'always' speak in welsh to staff is similar (East 83%, West 90%, Central 84%). However, there still needs to be a focus on improving the figures particularly where patients and service users responded 'never'.

East

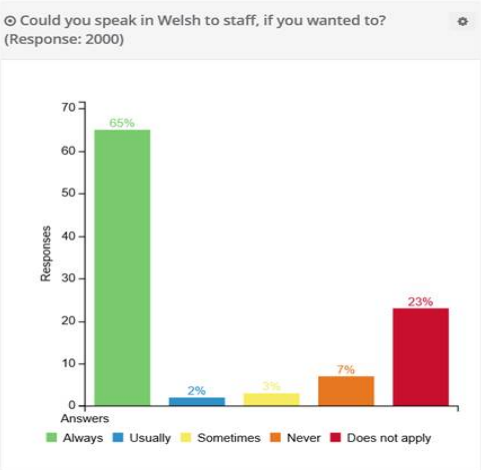
Responses	
Always	2073
Usually	36
Sometimes	107
Never	286
Does not apply	1072

West



Responses	
Always	1216
Usually	57
Sometimes	29
Never	29
Does not apply	86

Central



Responses	
Always	1300
Usually	40
Sometimes	60
Never	140
Does not apply	460

Due to the differences in response rates this may not fully illustrate the true picture therefore there is ongoing work to increase the response rate per site as this will provide increased confidence in the reliability and validity of the data.

As mentioned, depending on the type of feedback method, the way in which the experience is illustrated and shared is different. The emotional impact of stories and the richness of narrative is difficult to demonstrate graphically. The BCUHB patient feedback internet pages has a patient story library which can be supportive to both service users and staff.

Recently we have introduced Care to Share interviewing with patients in clinical areas. We have found that the majority (if not all) provide positive feedback.

A particular positive theme demonstrates how important cleanliness is to patient experience which indicates the value of a focussed question in the survey. By using a mixed methodology of capturing patient experience we can increase both the reliability and granularity of real patient and service user experience.

"You could eat off the floor". Cleaning staff always wiping the trays and cleaning on the ward.
Dulas Ward Ysbyty Gwynedd

Happy with the environment and cleanliness of the cubicle. All areas were clean and tidy and he complimented staff who came in regularly to clean and clear areas. Staff were observed washing their hands. Peblic Ward Ysbytv Ervri

The ward was clean, pleasant and quiet, giving every attention quickly, appropriately and discreetly. I tend to be highly critical of hospitals, its environment, its staff and the care it gives.
I could not find a single fault, and my care was 100% positive" –
Ablett Unit Glan Clwyd hospital

Cemlyn Ward at Ysbyty Cefni is a community hospital dedicated for older people with memory problems. PALS recently gathered feedback comments using the Care to Share approach from patients and family members. Below are a sample of

comments and observations. There is value in attending and gathering this kind of feedback; families felt assured that feedback is being sought and considered. Despite the challenges experienced by the patients, many were able to share their opinions. In addition they welcomed the opportunity to engage and recollect memories with the PALS team (all three are Welsh speakers), many of whom spoke in Welsh. Staff welcomed the engagement opportunity.

"Staff yn lyfli, mae nhw fatha teulu imi yma"

"They are like a family to me"

Patient Comment

"*The Activity Co-ordinator is excellent"*

Patients Commented

"I feel okay about leaving him as he is safe and is being cared for. I'm grateful for the care he gets".

Patient's wife

"*The ward felt Warm and homely. Patients looked clean, tidy and wore their own clothes. All the staff were caring and inclusive, ensuring everybody was enjoying themselves at the Halloween Party".*

PALS officer's observations

BCUHB wide response themes

Thematic analysis is used to understand where the majority of patient and service users feel their experience is positive and also an opportunity for improvement.

Positive themes:

Staff – described as “kind, polite, caring, courteous, helpful and hardworking”.
Patients received “excellent care”.
Patients felt “listened to” and appreciated the explanations given.
Patients felt that the ward environments were “clean, relaxing, cheerful and friendly”.
Professionalism.
Enjoyable food.

Women’s services set up an ‘Afterthoughts’ service and listening groups.

Examples of opportunities for improvement are:

Women and their partners want unrestricted access to maternity wards
Action: Allowing partners 24 hour visiting. Set up Birth Choice service.

Waiting times (Emergency Dept.).
Action: The Director of Operations and the Secondary Care Medical Director and Nursing Director have been leading work to improve performance in Emergency Departments with a particular focusing on supporting Wrexham Maelor Hospital which has been demonstrating improvements.

Appointment waiting times/communications.
Action: A newly improved text reminder system has been introduced to help patients remember their appointment details and reduce the number of missed appointments. The improved text reminders will include the first name of the patient, the date, time, speciality (e.g Urology) and location of their appointment. Text reminders will also encourage patients to get in contact if they can no longer attend, or rearrange their appointment by sending a response.

Communication/lack of personal interactions (need more one on one time).
Actions: Patient focussed rounding has been introduced across BCUHB local analysis of data will support understanding how effective this is being.
A number of training events have been delivered across the BCUHB delivered by Professor Brian Dolan focusing on the value of patient time and the importance of patient interactions: Professor Dolan was the creator of the Last1000Days campaign and #endPJparalysis campaign and the sessions have been received extremely well by staff.

Food (choices and dietary requirements).
Action: BCUHB catering services have increased menu variation adhering to All Wales recipe library which are nutritionally analysed, calorific value, portion size and protein. All menus are assessed by dieticians and different portion sizes can be requested. Allergen information has been included. Diet type is available.

Parking.

Action:

As part of the travel plan review process options being considered include greater use of public transport, expanding the community transport schemes, cycle to work and car share options. All three travel plans will seek to address distinctions between patient/visitor and staff parking together with suitable enforcement to ensure safe parking on site. The updated travel plans will inform the Health Boards investment plans and management arrangements to deliver a longer-term sustainable solution for parking. The Health Board fully recognises the benefits of stress free parking for patients/visitors and staff alike and therefore in delivering Welsh Governments policy of free parking on hospital sites and therefore has to consider other opportunities to achieve improvements. Ysbyty Glan Clwyd 'park and ride' facility has been extended to March 2020.

Section 3. Sharing feedback

Increase and sustain feedback

To ensure all areas are compliant with capturing 20% experience feedback, the Patient & Service User Experience teams will continue to support all services ensuring every opportunity is taken to capture a minimum (1in 5) patients and service users either discharged or patient appointment feedback across the board in the next quarter. The aim is to improve quarter on quarter / year on year feedback.

The feedback is shared both internally and externally to raise awareness of the need for feedback which demonstrates an open an honest reporting culture and increases engagement with the public. The BCUHB newly developed website allows the public to view the patient story library, to ensure that they are used effectively and not forgotten.

Gwrando Listen

Sylwad Adborth yr Wythnos

Feedback Comment of the Week

Gwobrir y dystysgrif hon i / This certificate is awarded to

Ward Acton Ward

Ysbyty Maelor Wrecsam / Wrexham Maelor Hospital

"Caring, friendly staff.
My Mum has been cared for and cherished.
Thank you"

Gyda diolch oddi wrth Tim Dehongliadau Gwasanaeth (Dwyrain)
Thank you from the Service User Experience Team (East)

Llofnod/Signature: Carolyn Owen

Pennaeth Profiad Cadfan a Dehongliadau / Dwyrain
Head of Patient & Service User Experience Team

Dyddiad/Date: 6 Septembre 2019

'Friday Feel-good' Comment of the Week, provides feedback to the ward/department who are deemed to have had the most motivational feedback comment of the week. They are selected by the Patient and Service User Experience teams in each of the regions every Friday and publicised locally and on BCUHB social media. The ability to utilise service user feedback to increase staff motivation, well-being and job satisfaction is extremely important for BCUHB.

Recent insights data for the best performing posts for the 'Friday Feel-good' feedback results on social media from May, June and July 2019 has shown a dramatic response. This information has been shared with each department involved to let them know how well their social media posts have been received with the number of people who have read them. Over the three months a total of 97,923 audience 'hits' were counted (East 38,695, Central 27,644, and West 31,584). Further detailed data can also be provided.

Section 4. Action planning - You Said We Did

Gathering patient and service user feedback is a limited exercise unless something constructive is done with the findings to bring about improvements. Based on patient and service user experience reported using all methods, service areas were asked to identify the emerging key themes that encompassed positive feedback and also those areas that patients and service users felt needed improvement. The service areas were then asked to provide detail of the changes proposed to enable that improvement to happen.

You said…	We did …
Sensory Loss Deafness Twitter feed @bsmhdeaf together for mental health conference in Cardiff. Great opportunity to remind people that Deaf BSL users	BCUHB hosting 'It Makes Sense' event 28/11/19 and sign up to the Charter for British Sign Language (BSL) and make five pledges to improve access and rights for Deaf BSL users. https://bda.org.uk/project/bsl-charter/. The Charter is designed as a vehicle to remove direct and indirect discrimination, empower local deaf communities and resolve conflicts between service providers and Deaf people. Its aim is to increase awareness of Deaf issues and BSL issues and provide better educational opportunities for Deaf children.
East Area Health Visiting **Information on infant feeding:** more information required about breastfeeding	Infant feeding group now established and recruitment to an infant feeding champion to advise on complex issues and coordinate staff training – in line with the new BCUHB Infant feeding strategy.
Community Response Team East Area Approximate appointment times given but delays happen	Accurate timings can be challenging to achieve. Improved communication instigated, measured and monitored by Team Leader: Patient kept informed by phone. New approach being tested.
HMP Berwyn **Access to services:** dental in particular is a concern raised regularly	Discussions are progressing with the prison to extend the dental service outside the current hours when men are available for appointments.

HMP Berwyn

Opportunities for the men to communicate issues of concern relating to their health care needs

Established Health & Wellbeing Peer Mentor service including Helpline which men can call, manned by prison residents providing support, advice and signposting. Bi-monthly Health & Wellbeing focus group to raise issues and hear about any service improvement developments.

Pharmacy (hospital)

Waiting at main reception (nursing/AHP staff)

Inpatients would rather we dispense only new medicines or those where there has been a dose change as long as they have a supply at home

Introduction of a separate desk for issuing prescription which can staff can use

Only dispense new of dose change medicine when patient has been in 3 days or less

Improved work in pre-operative clinics to encourage patients to bring their own medicines

Stop supplying paracetamol and ibuprofen

East Area Speech & Language

Time taken to answer the phone and cancelled appointments

Working with the admin staff to fix the issue of time taken to answer the phones

Clinical team are developing their use of the electronic diary to ensure improved booking of appointments

Section 5.

Highlights

Patient Advice and Liaison Service (PALS)

The PALS service has now been fully implemented with teams based in each of the three regions.

In addition to offering a bi-lingual Welsh and English service, the PALS officers have also all completed BSL accredited course which was fully supported by the Awyr Las charity.

East PALS

East PALS service was officially launched on 8th October 2019 (pictured below), at their new hub in the Wrexham Maelor Hospital Main Entrance foyer. PALS report,

“location is perfect because it is customer facing and easy to find and supports relationship building with patients and staff”. Awyr Las charity funding supported comfortable chairs which are greatly appreciated and is making a significant difference to patient and service users comfort.

“The PALS service is an absolute gem”

“Very friendly, open, transparent. Excellent service. Caring, compassionate.”

East PALS service is already thriving with various face-to-face enquiries and requests for information received prompting early resolutions. Feedback is very encouraging; “someone who listened and helped by understanding my concerns, everything was sorted”. PALS service are already having a positive impact both with patients, their relatives and staff.

PALS are busy networking both internally and externally with plans to attend the Professional Nurse Forum in November, collaborating with the Caia Park Health Centre and with the Community Care Hub. The next stage is to roll out to Community Hospitals with Care2Share programme. In the next 3 months planned activity and engagement with Primary Care will be commenced. PALS will be work closely with HMP Berwyn in their resettlement scheme.

In addition PALS are actively progressing in collaboration with key staff a number of additional surveys, including:

Diabetes Survey. Community hospitals want to learn more about patient’s healthcare experiences when they are diagnosed with diabetes.

Elective Colorectal Cancer service want to capture the experience from diagnosis through to surgery with the ‘prehabilitation’ surgical programmes.

Emergency Department are asking patients about their recent experiences in the department at Wrecsam Maelor Hospital.

Cognitive Stimulation Therapy Groups at Wepre House and Heddfan Unit are requesting specific feedback based on specialist group of people affected with memory issues.

The results will be shared in the next report.

Community Care Collaborative Hub (CCC)
PALS are working in collaboration with CCC to capture the voices of the people using the service. CCC is a social enterprise bringing multi agencies to people who need social, emotional and medical care at the point of need. This support highlights the impact on clinical interventions. PALS initially attended CCC weekly drop in sessions building relationships and trust with service users and now attend monthly to support, liaise and bridge services between primary and secondary care. A programme of 'stories' and Care to Shares are being developed.

West PALS

West PALS service official launch date 5th November. The feedback from patients, service users and staff is very positive. The focus has been on collaborative working with Matrons and Ward Managers to effect behavioural change following Care to Share across secondary care and the communities. The feedback shared by the PALS has been welcomed by ward managers and matrons; in many cases providing a supportive evidence based approach for ward managers to improve practices, such as providing patients with an opportunity to ask questions.

Central PALS

Central PALS service are now in their third year of operation and continue to work collaboratively with the Acute and the Community settings to maintain improvement of feedback returns to enable the learning and improvements. This includes further Care to Shares, ward visits and other tools of enabling greater participation of patients and their carers/families in sharing their experiences as appropriate. For instance a Focus Group discussing the Cochlea Implant patients has taken place aiming at improving the rehabilitation services provided by the Audiology Unit in Ysbyty Glan Clwyd.

A Community Hospital patient story had resulted of an employment of dedicated Dementia Support Practitioner. The next step is to influence and monitor that all community hospitals have dedicated dementia support in place.

In addition to sitting with different Cancer Centre Patients groups, the PALS team introduced the service to other patients groups and engagement forums such as the Conwy Arthritis patient group, and the Engagement Practitioners network in Denbighshire and Conwy seizing the opportunity to work with local Third Sector and Community Groups such as Conwy and Denbighshire Self Advocacy Group for people with learning disabilities ,the Refugees and Asylum Seekers health Visitor in North Wales and North Wales British Red Cross.

Syrian Refugees

PALS are working in collaboration supporting the BCUHB specialist Syrian refugee Health Visitor by supporting the 'drop in' meetings to build confidence and develop relationships. The plan is to hear their stories and capture Care to Shares. The PALS will be work collaboratively with Public Health Wales to influence quality improvements. Wrexham is one of the dispersal areas in Wales for Syrian refugees. To date there are 180 refugee and asylum seekers in Wrexham in 39 properties. Depending on their status they have different access to services. Examples of

service provided are the twice weekly ‘drop-in’ community resource-language skills. One issue of concern is the inequity of medical services not using interpreters which leads to an increase in repeat access to resolve medical needs.

So far the key areas for improvements are:

- Interpretation access to all services; highlighting Women’s services as a key area of concern
- Access to General Practitioners appointments due to limited GP resource
- Transport to medical services as frequently GP services not allocated close to home

All Wales Surveys

Dermatology BCUHB responses

BCUHB fully supported a recent All Wales dermatology outpatient service questionnaire survey to establish patient and service user feedback. 83 questionnaires returned across North Wales with the majority in the 75-84 age range. Overall results very positive, ranging from the practicality and convenience of appointments. 45 reported that their experience was excellent and 81 stated they were would recommend the service to friends and family.

Paediatric Survey

Public Health Wales are planning an All Wales paediatric questionnaire which has been developed alongside youth advisory boards and linked to the National participation standards. On completion, BCUHB results will be shared with QSE.

Public Event

At the ‘It Makes Sense’ event BCUHB plan to sign their British Deaf Association (BDA) British Sign Language (BSL) charter to the 5 pledges.
The British Deaf Association is asking local authorities and public services across the UK to sign up to the Charter for British Sign Language (BSL) and make five pledges to improve access and rights for Deaf BSL users.
https://bda.org.uk/project/bsl-charter/
The Charter is designed as a vehicle to remove direct and indirect discrimination, empower local deaf communities and resolve conflicts between service providers and Deaf people. Its aim is to increase awareness of Deaf issues and BSL issues and provide better educational opportunities for Deaf children.

Accessible Information and Communication Standard for People with Sensory Loss

‘It Makes Sense Event’ Public Health Wales, Welsh Government Initiative 28th November 2019.

BCUHB are hosting this year's 'It Makes Sense Event' to raise awareness and education for sensory loss; visual and hearing loss, blind and deaf. The British Deaf Association (BDA) charter pledges will be added to BCUHB sensory loss current actions in relation to work completed to improving compliance with the Accessible Information and Communication Standard for People with Sensory Loss (WG, 2013).

BCUHB current elements include:

- Accessible Health Care Programme
- Toolkit
- WITS Contract
- Engagement with Deaf Clubs
- Patient & Service User Experience Feedback Systems
- Equality Impact Assessment

The BDA Charter 5 Pledges

Pledge 1 – Consult formally and informally with the local Deaf community on a regular basis

Pledge 2 – Ensure access for Deaf people to information services

Pledge 3 – Support Deaf children and families

Pledge 4 – Ensure staff working with Deaf people can communicate effectively using BSL

Pledge 5 – Promote learning and high quality teaching of BSL

BCUHB pledge to:

1. Ensure that all service users whose first language is BSL are provided with interpretation services to ensure informed consent as the basis for access to and participation in health services on same basis as other users. (Pledge 2, Pledge 4)

2. Actively seek feedback from Deaf and Hearing Impaired Service users through the key engagement frameworks cited within the Patient & Service User Experience Strategy (BCUHB, June 2019) including Patient Stories, Care2Share, Real-time and Retrospective Patient Feedback Instruments, to ensure that the voice of deaf service users are heard and acted on in line with our statutory and mandatory obligations. Including undertaking and Equality Impact Assessment on all proposed service changes/developments. (Pledge 1)

3. Ensure that the voices of deaf service users are heard by the Board, are a standard agenda item at executive sub-groups such as the Listening & Learning from Experience Group, Quality Safety & Effectiveness Group, the Quality & Safety Group etc., and that management are accountable for acting on such feedback wherever this is feasibly possible. (Pledge 1)

4. Ensure that essential information in relation to how to provide feedback to BCUHB and where appropriate bring complaints to the health board attention using the Putting Things Right All Wales Complaints procedure will be made available on out internet via BSL video. (Pledge 2)

5. ALL Patient Advice and Liaison officers will be required to complete an accredited level 1 sign language course. (Pledge 4)

6. BCUHB will undertake an annual audit of ALL service points against the criteria inherent in the All Wales Standards for Accessible Communication and Information for People with Sensory Loss (WG, 2013) as the basis of (i) organisational assurance, (ii) developing localised action plans with the aim of improving services for deaf service users and (iii) ensuring operational accountability for this process. (Pledge 2, Pledge 3)

7. Utilise the ward accreditation process and associated audit instrument to ensure that staff and managers are aware of their responsibilities in relation to ensuring access to and participation in health care services for deaf and hearing impaired patients and carers on the same basis as other service users. (Pledge 2, Pledge 3)

8. We will ensure that in line with NWIS project specification our patient information systems are enabled to capture the communication needs of service users, including those whose first language is BSL, and develop the standard operating procedures to ensure that service users are encouraged to share this with us and it is recorded in an accurate, complete and timely manner. (Pledge 2)

9. Following on from above, where appropriate the standard ‘Alert Sheet’ to be used in conjunction with the standard adult nursing documentation, to identify communication needs, all wards and other service points to ensure that

specific communication needs are with the permission of the patient/carer documented and shared with the care team. (Pledge 2, Pledge 3)

10. Continue to develop the skills, knowledge and awareness of health board staff in relation to the needs of service users with a sensory loss including those who are deaf or hearing impaired via 'Treat me Fairly', the continued review and updating of the Sensory Loss Toolkit in particular (Fact Sheets 1-4), Provision of Intranet Based Materials, via local/departmental induction/orientation programmes, and via sensory loss awareness month etc. Additionally staff will be encouraged and supported to develop basic BSL skills where this is has been highlighted within the Performance Appraisal & Development Review (PADR) process. (Pledge 2, Pledge 3, Pledge 4)

11. BCUHB recognise the challenges that Deaf Service users experience when they need to arrange, confirm and amend appointments and the Patient and Service User Experience team will ensure that BCUHB Patient Appointment Centre managers and staff are cognisant of these challenges and continue to utilise appropriate enabling technology to ensure that Deaf and Hearing Impaired service users are able to access and participate in health services on the same basis as other service users. (Pledge 2, Pledge 3)

12. Continue to fund the Accessible Health Care Scheme, which in collaboration with third sector organisation, provides a health advocacy programme which supports individuals with sensory loss to access and participate in health services on the same basis as other service users. (Pledge 1, Pledge 2, Pledge 3, Pledge 4, Pledge 5)

Quality Safety & Experience Committee **19.11.19**	 ***To improve health and provide excellent care***

Report Title:	Safeguarding and Protecting People at Risk of Harm
Report Author:	Michelle Denwood – Associate Director Safeguarding
Responsible Director:	Mrs Gill Harris, Executive Director of Nursing and Midwifery Mrs Deborah Carter, Director of Quality Assurance
Public or In Committee	Public
Purpose of Report:	The purpose of this report is to present an overview of the Corporate Safeguarding activity in the first 6 months of 2019-20 (April – September 2019). This in relation to safeguarding adults, children and young people at risk of harm, Violence against Women, Domestic Abuse, and Sexual Violence (VAWDASV), Deprivation of Liberty Safeguards (DoLS), Dementia and the overarching safeguarding activities under the remit of the Harm agenda. The format of the report responds to 5 key domains within the Safeguarding maturity matrix which supports the Safeguarding Quality Assurance Framework.
Approval / Scrutiny Route Prior to Presentation:	The 6 monthly Safeguarding Report has had full engagement with the Corporate Safeguarding Team. The Quarter 1 and Quarter 2 reports have been presented at each of the Area Safeguarding Forums represented by all Departments and Divisions of BCUHB, with the Chair of each forum reporting as part of the Safeguarding Reporting Framework through to the Safeguarding Governance and Performance Group. Similarly the Quarterly Reports are presented at both the Adult & Children Delivery Group with full engagement of multi agencies to include the North Wales Safeguarding Board for both Adults and Children. There is emphasis on the requirement of the specialist knowledge of the Corporate Safeguarding Team given the changes of procedures within DoLS, Adult and Child at Risk in line with legislation nationally. The work plan and priorities within the Corporate Safeguarding Team reflects this and is carried forward to the remainder of 2019-20.
Governance issues / risks:	The Corporate Safeguarding Team work plan for 2019 – 2020 robustly supported the priorities laid out per Quarter in the 2018 – 2019 Annual

	Report. This has contributed in mitigating and reducing safeguarding risks to the population of North Wales and BCUHB. There are currently six (6) divisional risks identified on the Corporate Risk Register, and each has a clear mitigation plan. There is one Corporate Level risk identified within this report. This currently has a Risk Score of 16 however; the trajectory of risk is with a target Risk Score of 12 as a result of the successful implementation of the identified key priorities for 2019 -2020.
Financial Implications:	There are no financial implications arising from this report.
Recommendation:	The Committee is asked to*:* 1. Note the progress made this year by the Corporate Safeguarding Team, particularly in relation to the implementation of the HASCAS/DO recommendations. 2. Note the significant improvement of the Quarterly Assurance work within Corporate Safeguarding, supported by the Organisation and evidenced within the National Safeguarding Maturity Matrix (SMM). 3. Note the emphasis of the Corporate Safeguarding Team to implement and evaluate continual improvement through developing benchmarking, peer review and identifying data led areas for improvement in an open and transparent way.

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

5.To improve the safety and quality of all services	√	5.Considering impact on all well-being goals together and on other bodies	√
6.To respect people and their dignity	√		
7.To listen to people and learn from their experiences	√		
Special Measures Improvement Framework Theme/Expectation addressed by this paper Leadership and Governance			
Equality Impact Assessment			

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

BCUHB Corporate Safeguarding Team
Safeguarding and Protecting People at Risk of Harm
Quarter 1 & 2: 6 Monthly Report 2019-2020
Executive Summary

1. Introduction

1.1. The purpose of this report is to present an overview of activity driven by the Corporate Safeguarding Team during the first 6 months of 2019-20 (April – September).

1.2. The format of the report is presented within the key domains of the National Safeguarding Maturity Matrix (SMM).This is a quality Assurance Framework based upon Safeguarding legislation, which provides a clear framework to evidence progress and performance.

2. Risk management and Governance

2.1.1 Safeguarding Maturity Matrix

The Safeguarding Maturity Matrix is a self-assessment tool addressing interdependent strands regarding safeguarding, service quality improvement, compliance against agreed standards and learning from incidents and reviews. All Health Boards and Trusts within Wales used the self-assessment tool and submitted an improvement plan in September 2019.

2.1.2 Each domain is scored using a maximum 5 points. The table below demonstrates the considerable progress and assurance made against the identified domains during the last year.

Maturity Matrix	2018-19	2018-2019	Trajectory
Governance and Rights Based Approach	3	5	⇧
Safe Care	3	4	⇧
ACE Informed	3	5	⇧
Learning Culture	2	4	⇧
Multiagency Partnership Working	3	5	⇧
Total	14	23	

Table 1

2.2 The HASCAS Investigation and Donna Ockenden Review

2.2.1 The HASCAS Improvement Group monitors the implementation and progress of these recommendations across BCUHB. The Associate Director of Safeguarding is a member and reports on progression and compliance.

2.2.2 In April 2019, the Associate Director of Safeguarding in consultation with the Chair reviewed the trajectory and recommended four (4) of the six (6).

2.2.3 HASCAS Recommendations 8 and 12 remain ongoing with the trajectory of implementation noted to be on track. Due to a recent Supreme High Court Judgement, relating to 16-17yr olds organisational engagement is required to progress full implementation of the DoLS service provision. In addition, the challenges relating to the implementation of clinical/medical leadership for Adult at Risk also requires organisational engagement to ensure progress.

2.2.4 Stakeholder engagement has been fully integrated to ensure transparency and true partnership working.

HASCAS and Donna Ockenden Recommendations

Reference	Recommendation	Recommendation Position
HASCAS 4	Safeguarding Training	Implemented
HASCAS 5	I Informatics, and Documentation	Implemented
HASCAS 6	Policies and Procedures	Implemented
HASCAS 7	Tracking Adult at Risk across North Wales	Implemented
HASCAS 8 /Ockenden 6	Review and implementation of the Corporate Safeguarding Team Structure	Ongoing
HASCAS 12 /Ockenden 9	Review of the Deprivation of Liberty Safeguards (DoLS) work plan identified in 2017-18 for implementation in 2018-19 into 2019-2020	Ongoing

Table 3

2.3 Internal Audit 2018 – Progress and Actions

2.3. An Internal Audit took place relating to the period January 2017 – January 2018 with the findings presented on 31 July 2018 with an outcome position of limited assurance.

Nine (9) recommendations were identified for action **– All have been implemented.**

Prio Priority (H/M/L)	H	M	L	Outstanding	Trajectory
Number of Recommendations	4	3	2	0	

Number of Recommendations fully implemented	4	3	2	9	

Table 4

2.4 key Priorities

2.4.1 It is important to note that the priorities remain key areas of work and will remain an ongoing activity beyond the implementation of the HASCAS / DO recommendations.

2.4. 2 Two (2) recommendations remain ongoing from HASCAS/DO in relation to the review and implementation of the Safeguarding Team Structure, and the review of the Deprivation of Liberty Safeguards (DoLS) work plan.

These continue to be high priority, and high-risk areas, but work is underway to mitigate risk.

2.4.3 A fully resourced team is essential for this progress to take place, and the implementation of the full Corporate Safeguarding Structure in Q3 and Q4 is 7critical.

2.4.4 During Q3 & Q4 two further Internal Audits will be undertaken, one is to review governance and reporting in light of the previous position of Limited Assurance and the second audit is for Deprivation of Liberty Safeguards (DoLS). DoLS has never been audited during the formation of BCUHB.

3.0 Corporate Risk Register

R Ref	2019-20 Corporate Risk	Previous Risk Rating	Current Risk rating	Target Risk rating	Trajectory
1078	That the Health Board fails to discharge its statutory and moral duties in respect of safeguarding	20	16	12	⬇

4.0 Conclusion

4.1 This is only part of the picture the ongoing development and implementation of the safeguarding agenda which is complex, challenging and developing with pace. Fully resourced and supported teams are required to fulfil this challenging arena for both Children and Young People and Adults and their families.

4.2 The agenda and legislative footprint is vast and requires true multi-agency partnership working. Our report evidences we have again shown vast improvement with this engagement, it is sustained, relevant and due to the number of accolades from our partners' we have clearly made a welcomed difference. Our trajectory of compliance and identification of performance data have shown vast improvement in areas. It is envisaged, due to our expectation of further enhanced reporting and

triangulation of data we will continue to evidence greater compliance but more importantly this will demonstrate the impact our activities have made on those and their families who are deemed most vulnerable.

4.3 We identified priority activities for 2019-2020, evidencing vast improvement with Governance and Performance as evidenced by the National Safeguarding Maturity Matrix (SMM). We have an overall position of 23 out of 25 which prior to formal validation, is currently the highest in Wales.

4.4 The three key domains, which evidenced the greatest level of improvement, were the Governance and Rights Base Approach, Learning Culture and Multiagency Partnership Working. This improvement was due to key targeting and implementation of Governance and Performance Frameworks and by developing evidenced based learning and communication pathways. The Welsh Governments independent review of the Safeguarding Adult Board evidences the engagement and partnership with our partners.

4.4 Safeguarding activities must be integral to every service provision, commissioned service and every aspect of care and treatment.

5.0 Recommendations

5.1 Note the progress made this year by the Corporate Safeguarding Team, particularly in relation to the implementation of the HASCAS/DO recommendations.

5.2 Note the significant improvement of the Quarterly Assurance work within Corporate Safeguarding, supported by the Organisation and evidenced within the National Safeguarding Maturity Matrix (SMM).

5.3 Note the emphasis of the Corporate Safeguarding Team to implement and evaluate continual improvement through developing benchmarking, peer review and identifying data led areas for improvement in an open and transparent way.

BCUHB Corporate Safeguarding Team
Safeguarding and Protecting People at Risk of Harm
Quarter 1 & 2: 6 Monthly Report 2019-2020

1. Introduction

1.1 The purpose of this report is to present an overview of activity driven by the Corporate Safeguarding Team during the first 6 months of 2019-20 (April – September).

1.2 The format of the report is presented within the key domains of the National Safeguarding Maturity Matrix (SMM).This is a quality Assurance Framework based upon Safeguarding legislation, which provides a clear framework to evidence progress and performance.

1.3 An update is provided of the activity and achievement of the Corporate Safeguarding Team to provide Organisational assurance. The priority actions identified from the Corporate Safeguarding Work Plan for Q1 & Q2 are evidenced for the period 2019 – 2020.

1 Governance and Rights Based Approach

2.1 Rationale
There should be a clear line of accountability, without doubt or ambiguity about who is responsible at every level for the well-being and protection of children and vulnerable adults.

The United Nations Convention on the Rights of the Child [UNCRC] states that children should be free from abuse, victimisation and exploitation. The environments where children and vulnerable adults are treated should be safe, secure and child friendly.

2.2 Safeguarding Maturity Matrix

2.21 The Safeguarding Maturity Matrix is a self-assessment tool addressing interdependent strands regarding safeguarding, service quality improvement, compliance against agreed standards and learning from incidents and reviews. All Health Boards and Trusts within Wales use the self-assessment tool and submitted an improvement plan in September 2019.

2.2.2 Each domain is scored using a maximum 5 points. The table below demonstrates the considerable progress and assurance made against the identified domains during the last year.

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2.3.2 In April 2019, the Associate Director of Safeguarding in consultation with the Chair reviewed the trajectory and recommended four (4) of the six (6) HASCAS/DO recommendations were fully implemented.

2.3.3 HASCAS Recommendations 8 and 12 remain ongoing with the trajectory of implementation noted to be on track. Due to a recent Supreme High Court Judgement [26th September 2019], relating to 16-17yr olds organisational engagement is required to progress full implementation of the DoLS service provision. In addition, the challenges relating to the implementation of clinical/medical leadership for Adult at Risk requires organisational engagement to ensure progress. This is being progressed with the Executive Medical Director.

2.3.4 Stakeholder engagement has been fully integrated to ensure transparency and true partnership working.

HASCAS and Donna Ockenden Recommendations

Reference	Recommendation	Recommendation Position
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HASCAS 8 /Ockenden 6	Review and implementation of the Corporate Safeguarding Team Structure	January 2020
HASCAS 12 /Ockenden 9	Review of the Deprivation of Liberty Safeguards (DoLS) work plan identified in 2017-18 for implementation in 2018-19 into 2019-2020	March 2020

Table 2

2.4 Internal Audit 2018 – Progress and Actions

2.4.1 An Internal Audit took place relating to the period January 2017 – January 2018 with the findings presented on 31 July 2018 with an outcome position of limited assurance.

Nine (9) recommendations were identified for action **– All have been implemented.**

Priority (H/M/L)	H	M	L	Outstanding	ajectory
Number of Recommendations	4	3	2	0	
Number of Recommendations fully implemented	4	3	2	9	

Table 3

2.4.2 During Q3 & Q4 further Internal Audit will be undertaken, one for Safeguarding and one for Deprivation of Liberty Safeguards (DoLS). DoLS has not been audited since the formation of BCUHB.

2.5 Safeguarding Governance and Partnership Engagement

2.5.1 To ensure full Organisational reporting, escalation and engagement the Corporate

Safeguarding Team continue to update the agreed Safeguarding Reporting Framework. An additional Task Group was formed in this period, 'Performance and Scrutiny Task Group' that enables the interrogation of data, performance measures and evidence.

2.5.2 This framework fully supports multi-agency and partnership working and recognises the statutory and legislative requirement for engagement at both a senior and specialist level. In this period Corporate Safeguarding have reported 100% compliance for engagement at both the Adults and Children's Boards and supporting sub groups.

2.6 A review of North Wales Safeguarding Adults Board

2.6.1 An independent review commissioned by WG titled *'We are not where we were then,'* was commissioned by Welsh Government. This was due to the additional challenges to the Board as a result of the increased level of scrutiny experienced by Betsi Cadwaladr University Health Board due to the public, professional and political concern arising from the published reports commissioned in connection with patient experience at Tawel Fan. It was noted in the scope of the review; the recent publication of the HASCAS report in particular, had brought challenges to the Board, which have had a negative impact upon partner relationships.

2.6.2 The outcome of the review was extremely positive with particular reference to the Associate Director of Safeguarding BCUHB, stating as Vice Chair, she plays a significant and crucial role within the Board and appears to have the impact within the Health Board that is necessary.

2.6.3 It was further acknowledged that she is an appropriate representative for the Health Board.

2.6.4 BCUHB have strengthened their representation at the Safeguarding Board with the support of the Chair to include a Senior representative from the Mental Health Learning Disability [MHLD] Division.

2.7 Practice Development & Training Task Group

2.7.1 This group has been proactive in reviewing and updating all BCUHB safeguarding training packages to reflect and support the health board's policies and procedures in relation to safeguarding adults and children at risk of harm. Safeguarding training compliance is monitored by this group and escalated through the Safeguarding Reporting Framework. It facilitates learning from all Practice Reviews, new legislation and evidence-based practice.

2.7.2 This group has collaborated with Mental Health and Learning Disability to implement the learning from the HASCAS and Ockenden reviews by reviewing the Level 3 Adult at Risk programme of learning. HASCAS Stakeholder engagement has been a key contributor to this work.

2.8 NWSB - North Wales Safeguarding Board Workforce and Training Sub-group

2.8.1 The focus of this group has been training in relation to the National Safeguarding Procedures and the implications for training across the region. This group also upholds the NWSB's strategic outcomes, which enables its members and partner agencies to fulfil their statutory responsibilities through a culture of learning and development.

2.9 NWSAB: Task and Finish Group: Adult at Risk on Adult at Risk Abuse

2.9.1 In response to the HASCAS report into Tawel Fan and the subsequent action plan the

NWSAB set an assignment for a Task and Finish Group to develop a protocol to support agencies to respond to allegations and concerns relating to Adults at Risk on Adults at Risk of Abuse.

2.10 Legislative Assurance Framework

2.10.1 The Corporate Safeguarding Team have been currently working with BCUHB Statutory Compliance, Governance and Policy Manager to identify and populate evidence/assurance against existing Safeguarding Legislation and new Safeguarding Legislation. This will be a six monthly activity.

2.11 Lead Practitioner (LP)

2.11.1 The role has been embedded into statutory legislation for Adult at Risk and requires all organisations to ensure that they have identified and actioned the provision of this service. BCUHB led by Corporate Safeguarding and in partnership with the MHLD Division and the North Wales Safeguarding Board (NWSB) are the first North Wales service to agree to implement the LP role within its organisation and as part of day-to-day practices. This is a key role and will enhance the safeguarding reporting process to reduce risk and harm and learn lessons.

2.12 Corporate Safeguarding Team Structure: HASCAS Recommendation.

2.12.1 This remains ongoing and is reported through the HASCAS Implementation Group. Key challenges remain with financial constraints affecting implementation of some posts with vacancies due to staff turnover featuring in this period. The Head of Safeguarding Adults and the Head of Safeguarding MHLD were appointed and commenced in their posts on the 1st October 2019.

2.13 Safeguarding Policies/Procedures/Standard Operating Procedures

Safeguarding Policy/Procedure/SOP	2017- 2018	18-19	19-20	Trajectory
Number In Date	3			⇧
Number Under Review	0			
Number out of Date	10			
Total Number	13			

Table 4

2.13.1 The Corporate Safeguarding Team are fully engaged in the development of the new Wales Safeguarding Procedures and learning materials, which are based upon the Social Services and Well-being (Wales) Act 2014. The Procedures will be launched in North Wales on the 14th November 2019 with a “go live date” of the 6th April 2020.

2.13.2 The Corporate Safeguarding Team produce a monthly Safeguarding Bulletin that is distributed to all BCUHB Users. This gives staff relevant up to date safeguarding information and provides a resource for learning.

2.14 Adults at Risk – Performance and Activity

In 2019-20, there were 584 safeguarding adult at risk reports; Q1 307 and Q2 277.

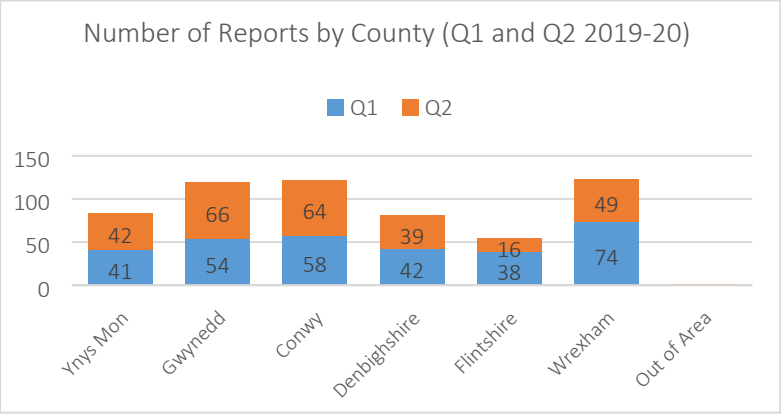


Figure 1

2.14.1 Comparative data from Q1 and Q2 2018-19 demonstrates an increase of 6%. There has been an increase in the receipt of adult at risk reports from both Central and West with a noted 43% decrease in the East. This activity is to be interrogated as an element of Quality Audit.

County	Q1	Q2	County Trend	Overall Reports Trend
Ynys Mon	41	42		
Gwynedd	54	66		
Conwy	58	64		
Denbighshire	42	39		
Flintshire	38	16		
Wrexham	74	49		
Out of Area	0	1		
Total	307	277		

Table 5

2.15 Reports by Age

Age Group	Q1	Q2	Trend
<24	21	22	
25-39	44	32	
40-59	36	41	
60-79	95	85	
80+	102	88	
Not Recorded by Referrer	9	9	
Total	307	277	

Table 6

2.15.1 48% of the overall Adult at Risk Safeguarding Reports relating to 80+ year old are generated in the West. 59% of the reports for under 24 year olds are from the East. Of all the reports two thirds (62%) relate to patients who are 60+ years old. This is comparable to last year's data.

2.16 Categories of Abuse

2.16.1 The below breaks down the reports by the category of alleged abuse:

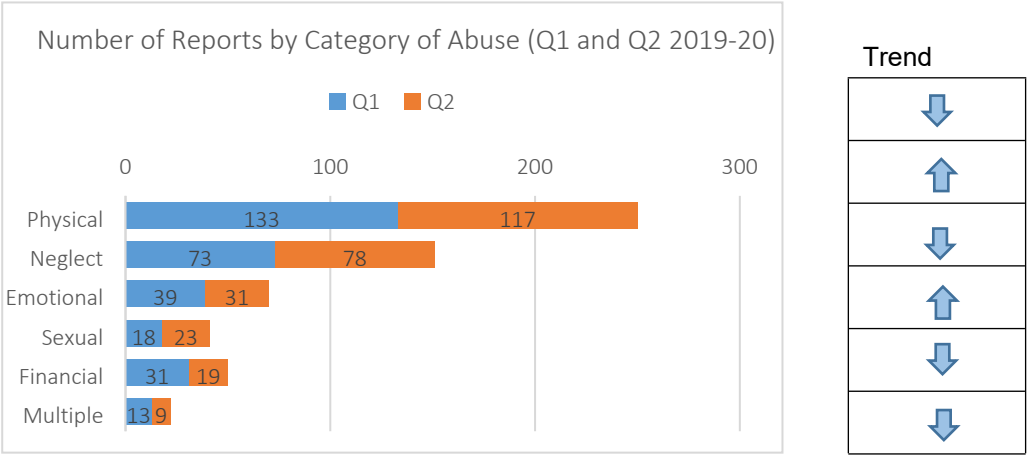


Figure 2

2.16.2 In both Q1 and Q2 (52% and 49%) respectively are related to allegations of physical abuse generated by the MH Units. There is a big upward trend in Q1 and Q2 2019-20 compared to 2018-19 with allegations of physical abuse reports, which, report an increase of 30%, and similarly allegations of sexual abuse has an increase 28%. Reports concerning allegations of Neglect report a decreased by 28%.

2.17 Location of Alleged Abuse

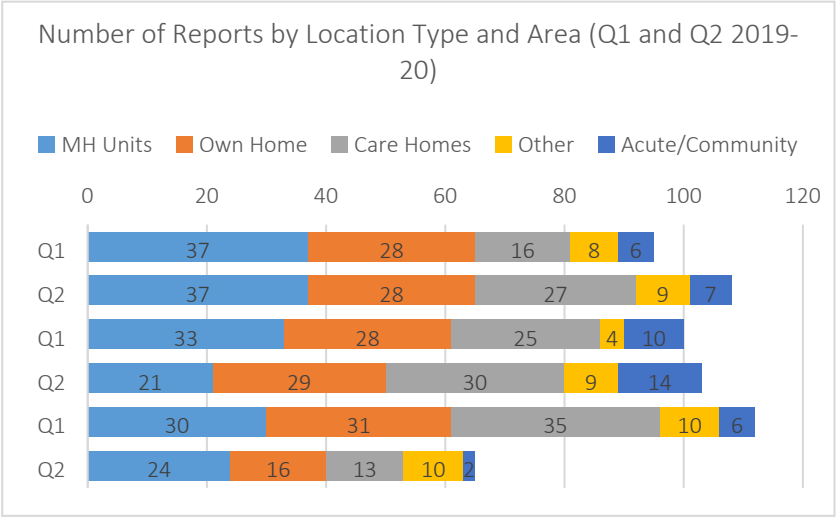


Figure 3

2.17.1 West make up a higher proportion of the MH Unit reports for both quarters. Central had a higher amount of reports from Secondary Care/ Community Wards in comparison to West and East.
*(** The 'Other' category includes reports from; friend's house, in the community, prison etc.)*

2.17.2 Comparable data from Q1 and Q2 2018-19 reveals a 47% increase in MH Unit reports.

2.18 Alleged Perpetrator

Perpetrator	Q1	Q2	Trend
Other Patient	108	84	↓
Unknown	66	59	↓
Family/Spouse	57	48	↓
Other **	26	36	↑
Care Home Staff	20	20	→
BCUHB Employee	15	16	↑
	292	263	

Table 7

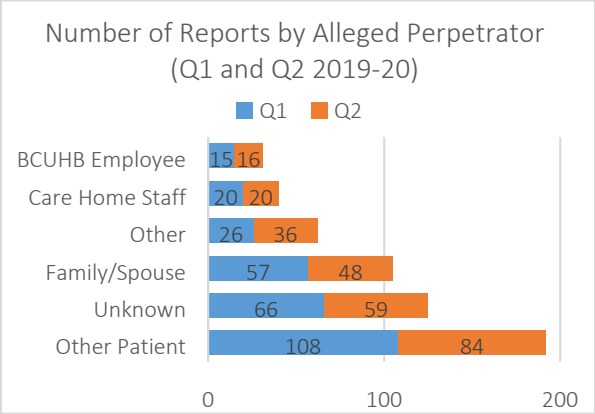


Figure 4

2.18.1 The biggest change from last year to this year is that reports raised as a result of another patient allegedly causing the harm has increased by 75%.
The increased reporting is the result of multi-agency learning and an amendment to practice.

*(**The 'Other' alleged perpetrator includes reports against; friend, neighbour, carer, individual contractor etc.)*

2.19 Self-Neglect

	Q1	Q2	Trend
Self-Neglect	15	14	↓

Table 8

2.19.1 The number of reports linked to self-neglect have decreased from Q1 to Q2. These numbers are comparable to 2018-19.

2.20 Children at Risk - Performance and Activity

2.20.1 The Corporate Safeguarding Team have been receiving reports into a new Children's Inbox from the beginning of May 2019. There has been 1224 reports during this period, which equates to an average of 245 a month. East have received 50% of the total since the 1st of May 2019.

Reports	West	Central	East	Out of Area	Total	Trend
May	24	105	116	1	246	-
Jun	28	89	122	1	240	↓
Jul	44	63	116	0	223	↓
Aug	38	75	132	3	248	↑
Sept	53	85	128	1	267	↑
Total	187	417	614	6	1224	

Table 9

Location type	Reports	% of Reports
Acute	570	47%
Community	632	52%
N/A	22	1%
Total	1224	100%

Table 10

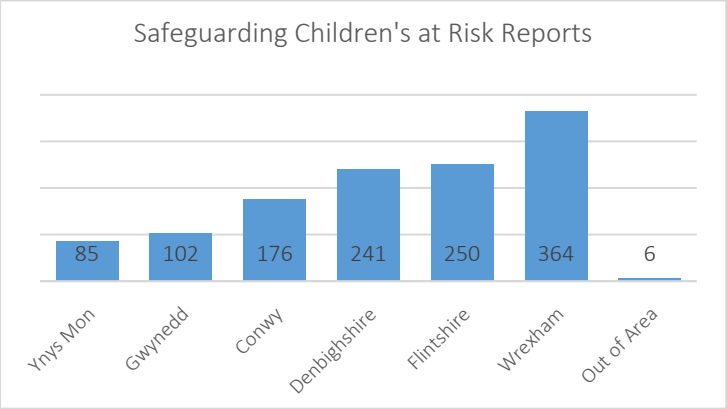


Figure 5

2.21 Reports by Location Type

2.21.1 Most reports have been received from the community, where the highest referrers are Health Visitors, followed by Midwives and CAMHS. Three quarters of the Secondary Care reports have come from the Emergency Department [ED].

2.22 Reports by Age

2.22.1 Table 11 provides the age groups of the children and where the reports have been raised. The under 5 year's old age group have had the highest number of reports to safeguarding (31%). Midwives have reported 83% of all the unborn cases. 81% of Health Visitor reports come from the <5 age bracket. This is in line with the National trend.

2.22.2 The most prominent age group for reports from CAMHS are the 11-15 year olds. The highest proportion of reports from ED also come from this age group (n=148 35%).

2.22.3 50% of all children's reports noted that a family member had been exposed to an adverse childhood experience (ACE's).

Age Groups	Acute	Community	N/A	% of Reports
Unborn	38	154	1	16%
<5	140	236	4	31%
5-10	111	76	2	15%
11-15	169	116	9	24%
16-18	104	48	6	13%
N/A	8	2		1%
Total	570	632	22	100%

Table 11

2.23 Under 18's Section 136 Assessment

Section 136 Assessment	Q1	Q2	Total
West	1	4	5
Central	1	3	4
East	5	3	8
Total BCUHB	7	10	17

Table 12

2.23.1 Of the 17 assessments, there were 3 inpatient admissions from the East in Q2.

2.24 Depravation of Liberty Safeguards [DoLS] Number of applications

Application	Q1	Q2	Trend
West	46	49	↑
Central	57	83	↑
East	115	121	↑
England	16	21	↑
Total	234	274	

Table 13

Application Breakdown	Q1	Q2	Trend
Urgent/Standard	197	234	↑
Standard	11	13	↑
Further	26	27	↑
Total	234	274	

Table 14

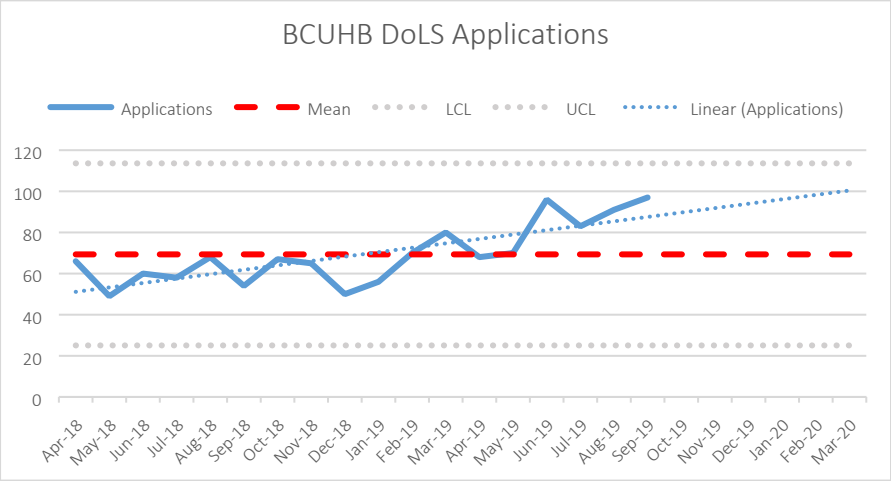


Figure 6

2.24.1 There has been a significantly high level of applications from all areas across the Health Board. In Q1, the Western region reported a 77% increase; the Eastern region 53% increase and Central region remains the same trend. There has been an 87% increase of applications allocated to a Best Interest Assessor (BIA) compared to 2018/19. The number of applications completed during Q1 show an increase and this is replicated in Q2 that it is a continuing trend.

2.24.2 The level of activity undertaken by BIAs' shows an increasing number of people assessed but it still remains that there are waiting lists for a DoLS to be assessed and authorised at any one time.

Non-Compliance with Applications	Q1	Q2	Trend
Issues with Forms	102	109	↑

Table 15

2.24.3 44% of applications in Q1 and 40% in Q2 have required further information or needing adjustments resulting in a delay within the DoLS process.

2.25 Court of Protection (COP)

2.25.1 The following cases have been referred to the DoLS team for involvement in s21 Appeals (Article 5(4) ECHR for a person subject to a DoLS in a hospital setting to the Court of Protection or for best interest decision, under Sections 4A (3) and 16(2)(a) of the Mental Capacity Act (2005) for an individual in a hospital or BCUHB involvement as 2nd respondents in the judicial proceedings.

Area	Q1	Q2
East	0	3
Central	1	0
West	4	3
Total	5	6

Table 16

2.25.2 During Q1- Q4 (2018-2019) there have been no cases referred through the Court of Protection with involvement of the DoLS Team. During Q1-Q2 (2019-2020) there have been 11 cases referred to the Court of Protection all these cases are coordinated by the DoLS Manager through to "*NHS Wales Shared Services Partnership Legal and Risk"*. Although cases are referred during this period there are still eight (8) cases continuing into Q3 through the Court of Protection.

2.26 Supervisory Body:

2.26.1 In order for the Health Board to carry out its legal duties under Deprivation Liberty Safeguards, a governance framework was developed to identify and support newly appointed signatories to carry out the function and role of a Supervisory Body. This work has been ongoing since March 2019. At the end of Q2, there has been 10 training sessions resulting in 44 trained staff. We have a nominated list of 76 named individuals Band 8a and above. Thirteen (13) of those staff have been nominated from within Mental Health/Learning Disability Division.

2.27 Mental Capacity Assessments

2.27.1 The DoLS Manager has been working with members of the Consent, Capacity Strategy Group to develop a bespoke mental capacity assessment that is 'fit for purpose' in the assessment of specific mental capacity issues for use by all relevant decision makers in hospital settings. The outcome from this work will be reported in Q4 with a view to definitive proposals for its use. This will aim to ensure that decision makers are able to evidence decisions in light of court and legal challenge, relating to an individual who lacks capacity.

Maturity Matrix Score 2018/2019	Maturity Matrix Score 2019/2020		Trajectory	
3	5		⇧	

2 Safe Care

3.1 Rationale

All organisations must have a safe recruitment process that takes into account the risks to children and vulnerable adults. There should be a system by which safeguarding concerns about employees should be raised and addressed. Departments and professionals delivering services must take full consideration of their safeguarding responsibilities. Assurance of safeguarding services and processes is evident across all levels within organisations.

3.2 Mental Health and Learning Disability (MHLD) Governance Activities

3.2.1 Over the last six months, Corporate Safeguarding have continued to engage with the MHLD Division. The monthly MHLD Safeguarding Forum, MHLD Divisional QSEEL, and weekly MHLD TWC (Today We Can) meetings.

3.2.2 Safeguarding training is a key target area and Corporate Safeguarding have worked in

collaboration with MHLD colleagues to achieve an average compliance score of above 80% across the division. This is using different methods of delivery and a pilot project.

3.3 Older People Mental Health (OPMH) Desktop Review

3.3.1 Following an increase in Adult at Risk reports, Corporate Safeguarding completed a case led desktop review, which focused upon safeguarding practices.

3.3.2 The results highlighted positive work being undertaken within the Division noting areas of improvement, which has resulted in the reduction of Adult at Risk Reports.

Adults at Risk on Adults at Risk reported via the Adult at Risk Data – MHLD Unit (West)		
Q1 [May – July]	Q2 [August – Oct]	Trajectory
27	18	⇩

Table 17

3.4 Safeguarding People living with Dementia

3.4.1 Within its key priorites Corporate Safeguarding engage with others and provide assurance that individuals living with Dementia are supported and protected from harm, abuse or neglect. This work is referenced within BCUHB's Dementia Action Plan and Progress Report.

3.5 Female Genital Mutilation (FGM)

3.5.1 There have been two (2) FGM cases reported to the BCUHB FGM Lead to date in 2019-20, one case from West Area in Q1 and one case from East Area in Q2.This is comparable to the previous year's data. There was no particular learning for the Organisation; however, as part of the improvement plan, the FGM Pathway will be embedded in more high-risk areas.

3.6 Training Compliance and Activities

3.6.1 Key Training Priorities for Q3

- Implementation of Safeguarding Ambassadors across BCUHB.
- Corporate Safeguarding to continue collaboration with ESR to implement reporting Level 3 Safeguarding data along with VAWDASV data to be reported in line with other subject areas and legislation.
- Lead Practitioner training to be delivered to BCUHB staff.
- Trauma Risk Management (TRiM) training has been commissioned by Corporate Safeguarding Team in November 2019 following a recent recommendation from a Child Practice Review.
- Corporate Safeguarding commissioned a leading legal training provider for non-lawyers to deliver, Safeguarding Investigation Training and Court of Protection Training to the Safeguarding Team.

3.6.2 Organisational Training Compliance

Compliance at the end of Q2	West	Central	East
MCA	82.1% (+0.3%)	80.8% (-)	81.4% (-0.1%)
Adults – Level 1	80.8% (+0.6%)	79.9% (+0.6%)	80.6% (+0.1%)
Adults – Level 2	77.6% (+1.2%)	76.8% (-1.2%)	80.8% (+0.1%)
Children – Level 1	82.0% (+0.6%)	79.5% (-0.5%)	80.4% (+0.3%)
Children – Level 2	80.0% (+0.5%)	78.2% (-2.8%)	80.2% (-)
Average Area Compliance	80.5% (+0.6%)	79.0% (-0.8%)	80.7% (+0.1%)
Compliance Trend	⇧	⇩	⇧

Table 18

3.6.3 The compliance includes, Permanent, Fixed Term, Temporary, Bank and Locum. A key objective is to determine assurance relating to the training compliance of Agency Staff. This has been highlighted to the BCUHB Mandatory Training Group led by Workforce and Organisational Development.

3.7 Emergency Department

3.7.1 The compliance trend for Emergency Department Medical Staff has decreased across the three (3) main Secondary Care sites during this period.

September Data	MCA	Adults – Level 1	Adults – Level 2	Children's – Level 1	Children's – Level 2	Compliance Trend
YG Medical Staff – ED	27.5%	30.0%	32.5%	30.0%	30.0%	↓
YG Nursing Staff – ED	88.2%	73.1%	67.7%	71.0%	65.6%	↓
YGC Medical Staff – ED	43.8%	43.8%	35.4%	47.9%	43.8%	↓
YGC Nursing Staff – ED	88.8%	80.0%	77.5%	82.5%	78.8%	↑
WH Medical Staff – ED	33.3%	26.2%	26.2%	28.6%	26.2%	↓
WH Nursing Staff – ED	83.2%	79.2%	63.8%	78.2%	69.6%	↑

Table 19

3.8 Violence against Women, Domestic Abuse and Sexual Violence (VAWDASV)

VAWDASV Compliance	Apr	May	Jun	Jul	Aug	Trajectory
BCUHB	71.1%	72.0%	72.6%	73.3%	75.5%	↑

Table 20

The table above demonstrates VAWDASV data has seen a month on month increase

3.9 DoLS Training Activity (Specialist)

DoLS	Q1	Attendees	Q2	Attendees
West	1	30	2	31
Central	1	10	2	39
East	3	44	1	38
Total	5	94	5	108

Table 21

3.10 Midwifery Training Activity (Specialist)

3.10.1 There was an additional 'Preparation for Practice', which is for 3rd year students.

Midwifery	Q1	Attendees	Q2	Attendees
West	3	27	2	18
Central	3	32	2	20
East	3	35	2	19
Total	9	94	6	57

Table 22

Maturity Matrix Score 2018/2019	Maturity Matrix Score 2019/2020	Trajectory
3	4	↑

3 ACE Informed

4.1 Rationale

Adverse Childhood Experiences (ACEs) such as exposure to domestic abuse, substance misuse and mental illness are known to have a direct and immediate effect on a child's health. The safety of the child and the safety of the vulnerable adult are intrinsically linked; preventing early exposure can reduce the impact on children and future generations.

4.2 Violence against Women Domestic Abuse and Sexual Violence (VAWDASV)

4.2.1 Head of Safeguarding Children has attended the quarterly Regional VAWDASV Board and the National VAWDASV Steering Group with 100% attendance. The activities within both these groups has been the consultation on the National Indicators and the BCUHB response regarding progress on the objectives within the Regional VAWDASV Strategy.

4.3 Domestic Abuse Routine Enquiry Audit

4.3.1 Compliance remains a key issue and is a target for implementation for both the Women's and Children's Division.

	Number of notes included in the audit	Number asked about domestic abuse and recorded in notes	Number not asked - accompanied	Number not asked about domestic abuse - no documented reasons why not
BCU	225	**105 (47%)** **95** *women asked twice or more in pregnancy*	42	78
East	75	**46 (61%)** **32** *women asked twice or more in pregnancy*	18	11
Central	75	**38 (51%)** **35** *women asked twice or more in pregnancy*	15	22
West (May-Aug)	75	**21 (28%)** **28** *women asked twice or more in pregnancy*	9	45

Table 23

4.3.2 There is a decrease of 22% in comparative data 2018 – 2019 to 2019 – 2020. The Improvement Plan is to be reviewed in the next Quarter. A member of the National Safeguarding Team PHW and the Head of Safeguarding Children are currently undertaking a National Audit of Routine Enquiry Domestic Abuse.

4.4 MARAC

MARAC Referrals	Q1	Q2	Trend
West	12	17	↑
Central	13	19	↑
East	12	10	↓
Total	37	46	

Table 24

4.4.1 From April to date, 98% of the MARAC referrals have been females, 12 of which were pregnant at the time of referral. 63% of victims already have children. Age range of victims is 17-71, where more than half were < 30 years old (59%).

4.5 Agencies Domestic Abuse Perpetrator Tasking [ADAPT]

4.5.1 ADAPT is a multi-agency approach of working with repeat perpetrators of domestic abuse. There have been 10,896 repeat perpetrators reported over the past 12 months. It will initially be piloted in the Central Area where there are 43 identified repeat perpetrators impacting on 76 victims, involving 91 children, 50% of which were known to child protection services. One repeat perpetrator was connected to seven (7) victims, which involved 16 children; this was the highest profile case in North Wales.

4.5.2 Corporate Safeguarding have engaged throughout the process and have committed to engage with the 12-month pilot.

4.6 Health Pre Birth Assessments

4.6.1 The BCUHB Health Pre-Birth Assessment (HPBA) Guidance and Tool was reviewed, and ratified in July 2019 and is being implemented into practice. As a recommendation of a Child Practice Reviews, Women's Services agreed to undertake a HPBA Audit.

4.7 Modern Day Slavery (MDS) MARAC's

4.7.1 During the period of Q2 North Wales Police has adopted the same process as colleagues in South Wales in relation to MDS case. Three meetings have taken place within Quarter 2 Chaired by North Wales Police Exploitation Unit with a total of 6 cases discussed; there was no cases from the West to date.

4.8 Multi Agency Public Protection Arrangements (MAPPA)

4.8.1 MAPPA are the statutory arrangements for managing sexual and violent offenders. Corporate Safeguarding representatives and Mental Health contribute to the identification and assessment of risk and agreed multi-agency risk management plan.

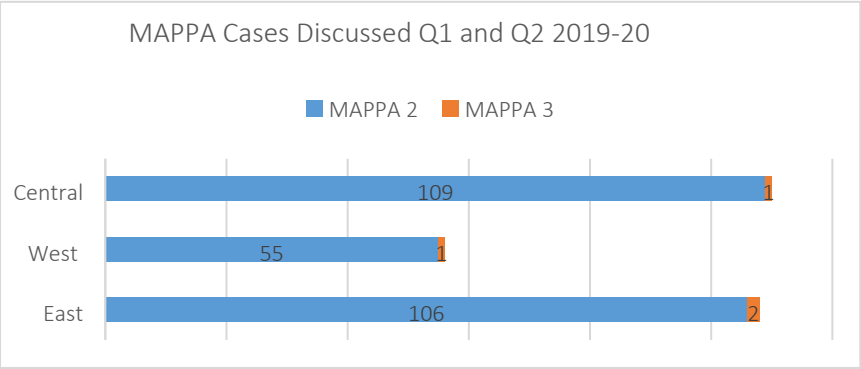


Figure7

4.8.2 There has been a 100% attendance in both MAPPA 2 & 3 in this reporting period. The number of MAPPA 2 cases in the West is almost 50% less than in East and Central.

4.9 Child Sexual Exploitation (CSE)

4.9.1 There is still currently an ongoing CSE operation, Operation Lenten, of which BCUHB remain fully engaged. The CSE Level 3 Training package is under review in line with the new Statutory Guidance.

4.10 Non Accidental Injury (NAI) Examinations

Resident of Child	Q1	Q2	Total
West	18	15	33
Central	25	10	35
East	29	38	67
Out of County		3	3
Total	72	66	138

Table 25

4.11 Key Priorities

4.11.1 The priority areas for the ACE informed Domain is noted below. Out of the 3 priority areas, 100% has been achieved.

Ref	Action	Position
PR25a	Development and implementation of a VAWDASV Service User Procedure	
PR25b	Implementation of a Domestic Abuse Workplace Safety Group	
PR25c	Implementation of A VAWDASV Workplace Procedure.	

Table 26

Maturity Matrix Score 2018/2019	Maturity Matrix Score 2019/2020	Trajectory
3	5	⇧

4 Learning Culture

5.1 Rationale

By promoting, a positive culture of multi-agency learning to generate new learning organisations can support continuous improvements in service delivery and practice. Feedback from patients and clients in the NHS must be used to monitor and improve the quality of services.

5.2 Datix

5.2.1 Datix report of all Adult at Risk reports is reviewed and reported weekly. A review of the safeguarding element on the Datix incident module has been undertaken.

5.3 Review of Childhood Suicides

5.3.1 The Head of Safeguarding Children and the Named Doctor Safeguarding Children have undertaken a review of all case notes of the young person involved. Nine children/young people died as a result of suicide during the time period with a high percentage dying by hanging (7 out of 9).There was a range of Adverse Childhood Experiences within the cases, and further review is to take place to aid learning.

5.4 Review of External Child Practice Reviews (CPR)/Health Inspectorate Wales Reviews (HIW).

5.4.1 Cardiff and Vale Safeguarding Board published a CPR following the death of a child in 2016. BCUHB reviewed the health recommendations of this CPR against our own practice by developing a Task and Finish Group. An Action Plan was developed and is monitored by

the Safeguarding Governance and Performance Group.

5.4.2 A three (3) month pilot was developed in ED YGC which included weekly safeguarding meetings to review attendance of children under the age of 1 years old, presenting with a head injury and/or burn and attendances of children under the age of 2 years old presenting with a fracture. An evaluation report will be presented in the Maelor Hospital and Ysbyty Gwynedd in November as part of National Safeguarding Week, with the objective of rolling out this activity.

5.4.3 Health Inspectorate Wales ABMU Review: the Corporate Safeguarding Team reviewed- ABMU Health's Board handling of the employment and allegations made against Mr W. An Action Plan was developed in relation to the safeguarding recommendations. All actions are complete by BCUHB Corporate Safeguarding Team. DBS Compliance remains an organisational activity.

5.4.5 In response to the Royal College of Obstetricians and Gynaecologists Report of Cwm Taf Health Board Maternity Services. The Corporate Safeguarding Team have identified areas within the report, which Safeguarding practices can be benchmarked against, and this is currently in progress.

5.5 Child Practice Reviews – Date Commissioned

CPR	2016-17	2017-18	2018-19	2019-20	Trajectory
	3	1	3	3	⇔

Table 27

5.6 Adult Practice Reviews (APR)

APR	2016-17	2017-18	2018-19	2019-20	Trajectory
	2	2	1	2	⇧

Table 28

5.7 Domestic Homicide Reviews (DHR)

DHR	2018-19	2019-20	Trajectory
	6	3	⇩

Table 29

Maturity Matrix Score 2018/2019	Maturity Matrix Score 2019/2020	Trajectory
2	4	⇧

5 Multiagency Partnership Working

6.1 Rationale

The protection and safeguarding of adults and children relies on multi-agency working and effective information sharing; working together to improve services and outcomes for all.

6.2 Procedural Response to Unexpected Deaths in Childhood * (PRUDiC)

6.2.1 The Corporate Safeguarding Team fully engages with all PRUDiCs. The Head of Safeguarding Children is the Single Point of Contact for the police. This process is in line with the PRUDiC Guidance 2018.

Area	Q1	Q2	Total
West	1	0	1
Central	3	1	4

East	1	0	1
Total	5	1	6

Table 30

6.3 Child Death Overview Panels

6.3.1 Child Death Overview Panels (CDOPs) are held across North Wales. Each area CDOP feeds into the relevant NWSCB Local Delivery Group and to the National Child Death Review Programme.

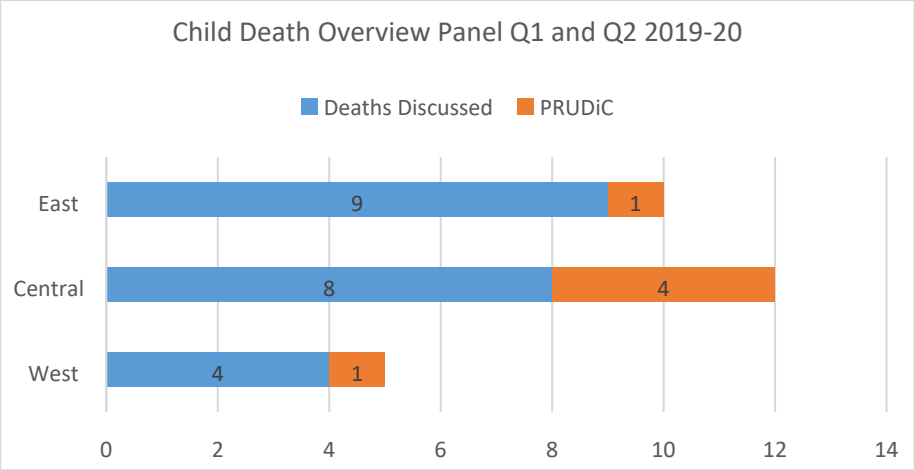


Figure 8

6.3.2 There are 27 Child Deaths in BCUHB in Quarter 1 and 2 with 6 of the 27 being PRUDiC. 40% of Child Deaths and PRUDiC's were in the Central Region.

6.4 County Lines and the Harm Agenda

6.4.1 Over the last six months Corporate Safeguarding, on behalf of BCUHB, have been engaged with North Wales Police (NWP) to support their work in relation to a North Wales County Lines Needs Assessment. This is an increasing agenda for all agencies.

6.5 PREVENT

6.5.1 The Associate Director of Safeguarding continues to attend the CONTEST Board on behalf of BCUHB. Corporate Safeguarding attends the All Wales PREVENT meetings for regular updates from the Welsh Extremism and Counter Terrorism Unit (WECTU). There is work being developed with Autism and with the Vulnerability Support Hubs in UK, which the Head of Safeguarding Adult MHLD will be attending as a representative of the All Wales Group.

6.6 Modern Day Slavery

6.6.1 The Regional Modern Day Slavery Group launched its Regional Action Plan 2019-2020. There are seven (7) key objectives. Reporting is currently to the North Wales Safer Communities Board, Regional and Local Safeguarding Broads & NW VAWDASV Group.

6.6.2 The All Wales Anti-Slavery Coordinator has stated that *"The hard work of the North Wales Group is now paying off by identifying more victims, to rescue and support them and where possible bring their perpetrators to justice "*

Maturity Matrix Score 2018/2019	Maturity Matrix Score 2019/2020	Trajectory
3	5	⇧

7. Risk Management and the Corporate Risk Register

7.1 The Corporate Safeguarding team have identified one (1) high profile risk, which is published on the Corporate Risk Register. All activity conducted within the Corporate Safeguarding Team is delivered to ensure that this safeguarding failure does not occur.

7.2 It is clearly reported throughout that the level of activity during this period has been substantial to ensure an improved position for safeguarding those most vulnerable and at risk of harm whilst accessing our services**.**

7.3 A key achievement is the implementation of the HASCAS and Ockenden recommendations from their published reports. The BCUHB Safeguarding Annual Report of 2018-2019 and action plan 2019-2020 clearly referenced significant progress.

7.4 Although significant activities have been ongoing to address two of the remaining outstanding recommendations, which are the implementation of the Safeguarding Structure and the activities relating to Deprivation of Liberty Safeguards, further progress is required. To enable ongoing improvements to reduce risks the implementation of these two significant recommendations are a priority.

Ref	2019-20 Corporate Risk	Previous Risk Rating	Current Risk rating	Target Risk rating	Trajectory
1078	That the Health Board fails to discharge its statutory and moral duties in respect of safeguarding	20	16	12	⇩

Table 31

8. Conclusion

8.1 This is an overview of the ongoing development and implementation of the safeguarding agenda, which is complex, challenging and developing with pace. Fully resourced and supported teams are required to fulfil this challenging arena for both Children and Young People and Adults and their families

8.2 The agenda and legislative footprint is vast and requires true multi-agency partnership working. Our report evidences we have again shown vast improvement with this engagement, it is sustained, relevant and due to the number of accolades from our partners we have clearly made a welcomed difference. Our trajectory of compliance and identification of performance data have shown vast improvement in areas. It is envisaged, due to our expectation of further enhanced reporting and triangulation of data we will continue to evidence greater compliance but more importantly this will demonstrate the impact our activities have made on those and their families who are deemed most vulnerable.

8.3 We identified priority activities for 2019-2020, evidencing vast improvement with Governance and Performance as evidenced by the National Safeguarding Maturity Matrix (SMM). We have an overall position score of 23 out of 25 which prior to formal validation, is currently the highest in Wales.

8.3.1 The three key domains, which evidenced the greatest level of improvement, were the Governance and Rights Base Approach, Learning Culture and Multiagency Partnership Working. This improvement was due to key targeting and implementation of Governance and Performance Frameworks and by developing evidenced based learning and communication pathways. The Welsh Governments independent review of the Safeguarding Adult Board evidences the engagement and partnership with our partners.

8.4 Safeguarding activities must be integral to every service provision, commissioned service and every aspect of care and treatment.

9. Recommendations

It is recommended that the Committee:

9.1 Note the progress made this year by the Corporate Safeguarding Team, particularly in relation to the implementation of the HASCAS/DO recommendations.

9.2 Note the significant improvement of the Quarterly Assurance work within Corporate Safeguarding, supported by the Organisation and evidenced within the National Safeguarding Maturity Matrix (SMM).

9.3 Note the emphasis of the Corporate Safeguarding Team to implement and evaluate continual improvement through developing benchmarking, peer review and identifying data led areas for improvement in an open and transparent way.

Quality Safety Experience Committee 19.11.19	 ***To improve health and provide excellent care***

Report Title:	Children's Services – Healthcare Inspectorate Wales (HIW) Thematic Review
Report Author:	Alison Cowell, Assistant Area Director (Centre) Children's Services
Responsible Director:	Dr Chris Stockport, Executive Director of Primary & Community Services
Public or In Committee	Public
Purpose of Report:	To provide the Committee with an organisational response to the HIW thematic review: "How are healthcare services meeting the needs of young people?"
Approval / Scrutiny Route Prior to Presentation:	Updates on Children's Services are provided to the Children's Transformation Group, Area Teams and the Regional Partnership Board
Governance issues / risks:	• Increasing capacity in Child Adolescent Mental Health Services (CAMHS) and improvement in waiting times and the pathway for those young people in a crisis • Implementation of the Transformation Programme with our partners in the Local Authorities • Timely care for children and young people in the Emergency departments • Ensuring young people know how to raise concerns • Timely and effective transition to adult services particularly for those with complex health needs.
Financial Implications:	The service is striving to deliver on its objectives within the core budget, supported by new additional Welsh Government (WG) funding
Recommendation:	The Committee is asked: 1. To note the progress that is being made to services for children, young people and their families. 2. To note the actions being undertaken to address the recommendations within the review.

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

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

Children's Services – Healthcare Inspectorate Wales (HIW) Thematic Review

1. Purpose of Report

In March 2019, HIW published its Thematic Report on, "How are Healthcare services meeting the needs of young people." This report drew together findings from inspections it had undertaken over the previous two years relating to children and young people and contains 37 recommendations, covering the whole of Wales.

The thematic review focuses on four areas:

- Child and Adolescent Mental Health Services
- General Healthcare Services for Young People
- Supporting Young people with Life Limiting Conditions Receiving Palliative Care
- Transition from Child to Adult Healthcare Services

This paper sets out the BCU's position against these recommendations.

Specifically for BCU the unannounced inspection of the Tier 4 CAMHS inpatient unit, (NWAS), June 2018, has contributed towards the Thematic Report.

2. Summary and Next Steps

BCUHB is performing well against many of the recommendations and has implemented actions against those that needed timely prioritisation, see the Action Log at Appendix 1.

The recommendations that need to continue to be progressed as a Health Board include: increasing capacity in CAMHS and improvement in waiting times particularly for those young people in a crisis; implementation of the Transformation Programme with our partners in the Local Authorities; timely care for children and young people in the Emergency departments; ensuring young people know how to raise concerns; and timely and effective transition to adult services particularly for those with complex health needs.

Within Children's Services there are three Clinical Advisory Groups, Acute Paediatrics/Neonates; Community; and CAMHS. These groups are responsible for ensuring clinical standards are being met across North Wales and quality improvement. They have been tasked with taking forward the actions within this report in partnership with adult services and the Local Authorities.

3. Child and Adolescent Mental Health Services

The recommendations in this section have come from inspections undertaken at the two NHS Tier 4 CAMHS units, Ty Llidiard, Cwm Taf (2017 & 2018), NWAS Abergele

(2018) and the WHSSC commissioned provision from Regis Healthcare Ltd (2018) and the findings from the *Mind Over Matter* 2018 report.

Recommendation 1.
Health boards and service providers must ensure environments protect the safety and wellbeing of young people. There must be robust systems in place to monitor risks within the environment and ensure maintenance work is conducted in a timely way.

During the visit from HIW to NWAS in June 2018, the outside environment was criticised although the work ongoing regarding ligature work was recognised as a positive step to reduce patient self-harm. Garden areas were observed to be overgrown and poorly kept, with regard to general maintenance it was found that this was not always carried out in a timely way.

Actions undertaken:

i. This has been addressed with Estates, grounds have been attended to and a programme of maintenance agreed.

Recommendations 2-3.

Health boards and service providers must ensure there is clear communication with young people to help them understand their treatment.

Welsh Government, health boards and service providers need to improve the communication with, and information available for, young people and their families at the point of referral.

Community CAMHS - within BCUHB the Choice and Partnership model is embedded in the service model, which should ensure that families work in partnership with the service to meet their specific needs. A letter is sent to all families explaining the service.

Inpatient CAMHS - during the HIW visit, it was noted that young people and their families felt that they wanted to know more about the unit and didn't always understand the clinical language used in terms of investigations and results.

Actions undertaken:

i. The NWAS Patient information leaflet has been updated and is now given out to parents and the young person on admission. This is recorded in the patient's notes. The case manager is responsible for auditing compliance and record keeping.
ii. Medical investigations and results are explained to the young person by the Speciality grade Doctor and named nurse, supported by the part time consultant Paediatrician within the team.

Recommendations 4-5

Welsh Government needs to consider the capacity within CAMHS services across Wales to ensure this meets the needs of young people, including those who are high risk.

Welsh Government and health boards need to review the waiting times for CAMHS services, ensure there are timely referrals to other organisations to support young people and how young people can access support at times of crisis.

Our delivery against the Mental Health Measure Targets has been improving, West and East Areas have consistently achieved the target. Central Area has a reduced capacity due to serious illness and vacancies which has had a significant impact on achievement against the target, however it is anticipated that BCUHB will continue to achieve the target or close to it. At the end of July 2019 we achieved 81% against the 80% target for assessment and 76% against the 80% target for intervention this was our strongest position to date. August saw a dip in performance which reflected the reduction in capacity during the holiday period, with 76% achievement for assessments and 80% for intervention. We have seen significant improvement in performance against the intervention target in recent months.

For those young people in distress, who are self-harming or have complex behaviour and attend our Emergency Departments resulting in an admission to the Paediatric wards, we have a 7 day CAMHS provision on the Paediatric wards. The number of self-harm risk assessments are increasing year on year, year to date it is 8% higher than the previous year. These young people are not waiting for a psychiatric bed, but they frequently need a multi-agency care package.

It is noted that are concerns that the inpatient care and crisis provision is not meeting the needs of the population of Wales resulting in out of area placements across Wales.

Welsh Health Specialised Services Committee (WHSSC) commission 12 beds at North Wales Adolescent Service (NWAS), these beds have been fully staffed for the past six months with 11 young people currently admitted and no young people waiting for admission. WHSSC have published a draft inpatient care specification for consultation which identifies the need for High Dependency beds. This will require a change to what is currently commissioned and require additional nursing and medical workforce.

Actions undertaken:

i. Recruitment of CAMHS practitioners with the new WG investment to meet the demand and improve the performance.

ii. We are working with the six Local Authorities with support from the Parliamentary Review Transformation fund to provide a multi-agency service

to address the needs of children and young people in crisis or who are on the Edge of Care or Looked After by the Local Authority.

iii. Supported by WG, we are assessing the feasibility of submitting a business case to address the requirements that would allow crisis admissions out-of-hours to NWAS and for those requiring Psychiatric Intensive Care. At present there are two young people out of area needing PICU/low secure care and on average there are four a year, this provision is on a UK framework commissioned by WHSSC.

Recommendations 6-7
Health boards and service providers must ensure there is clear information for young people on advocacy services and flexibility to enable young people to meet with advocacy services at a time of their choice.

Health boards and services providers must ensure young people know how to raise a concern.

This recommendation relates to Tier 4 inpatient care and requirements under the Mental Health Measure for advocacy. Young people who are inpatients at NWAS have access to both the Mental Health Advocacy Service and advocacy from Tros Gynnal Plant commissioned by BCUHB.

We strive to ensure that children and young people where ever they are in Children's Services are aware of the process for raising concerns within Putting Things Right, there are posters up and leaflets in clinics explaining the importance of raising concerns.

Recommendation 8 This recommendation relates to Tier 4 inpatient care

Health boards and service providers must ensure that:

- Patient records, care planning and statutory mental health documentation are comprehensive, accurate and completed in a timely manner.
- Emergency clinical items, including ligature cutters can be located without delay.
- Staff have sufficient knowledge on how to support and monitor patients before, during and after mealtimes.
- Any restraint must be carefully considered, risk assessed and monitored, with the involvement of the young person to ensure their safety, rights and dignity are protected as much as possible.

In NWAS Care plans are reviewed and checked on a regular basis ensuring that they are contemporary and meeting the needs of the young person. The statutory mental health documentation is reviewed in line with the Mental Health Measure.

Senior staff take responsibility for accepting any detained young person on to the ward, reviewing the paperwork immediately at the point of entry to the service. This was confirmed during the HIW visit.

All emergency items are accessible to all staff, this was confirmed by HIW during the visit in June. All staff have a set of keys to access these, visiting / bank / agency staff are allocated keys that they take responsibility for by signing for the duration of their working day.

Staff are provided with training by competent, experienced staff that include paediatricians and members of the dietetics team to ensure that they are aware of how to adequately offer post meal support.

The use of restrictive practice is not common place within the service, use of restrictive patient intervention (RPI) takes place when emergencies arise and it is necessary to ensure the safety of the young person, staff and visitors. The dignity and rights of the young person are considered throughout and appropriate actions are taken to meet the needs.

All young people have access to an Independent Mental Health Advocate (IMHA). Post restrictive patient intervention, reviews are completed ensuring that a de-brief of the incident can take place.

Recommendation 9
Health boards and service providers must ensure CAMHS staff have up-to-date safeguarding training.

BCUHB Tier 3 Community CAMHS is achieving 90% compliance with Safeguarding mandatory training. Tier 4 is achieving 96%.

Recommendation 10
Welsh Government, health boards and service providers must consider how issues around workforce within CAMHS units can be addressed to ensure young people receive care from the right staff with the rights skills to meet their needs.

A workforce plan focussed on skills and knowledge has been developed creating opportunities for a wider group of staff to be recruited whilst also being compliant with the Mental Health Measure regulations. With introduction of development posts and the use of social media to communicate interest, a recent recruitment day has created optimism that it is possible to recruit the workforce needed for North Wales. This recruitment plan needs to continue to develop and mature.

4. General Healthcare Services for Young People

The review primarily considered the evidence from the inspections of Noah's Ark Children's Hospital and Moriston Hospital Emergency Department; however the findings and recommendations are important and relevant to BCUHB.

Recommendation 11
Health boards must ensure that children and young people can consistently be treated within designated areas.
(This recommendation related to treatment within emergency departments)

Wrexham Maelor Emergency Department (ED) has a designated area for children which includes waiting area and treatment rooms.

Ysbyty Glan Clwyd has 2 cubicles that are solely for children, they are decorated and equipped appropriately and serve the designated children's waiting room. However, at the times children may still wait in the general waiting room.

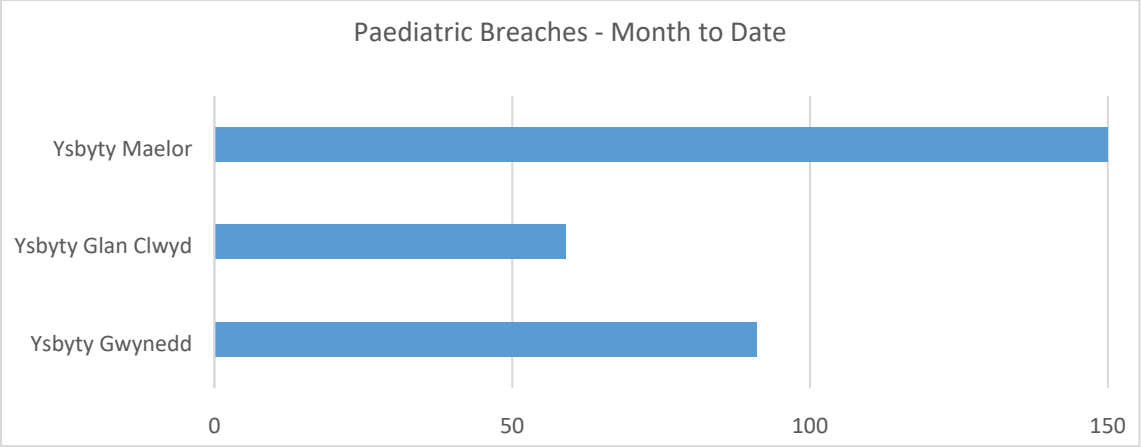
Ysbyty Gwynedd Emergency Department is currently going through the second phase of the new build with the final phase for completion being in Sept 2019. The new designated area will be swipe access secured with 2 side rooms and a separate waiting area.

Recommendation 12
Health boards must ensure young people consistently receive timely care and treatment within emergency departments and for emergency invasive procedures.

The findings relating to children and young people in Moriston Emergency Department confirms our own observations and concerns regarding the emergency departments in the three District General Hospitals (DGHs) in North Wales.

While improvements have been made, we are not fully achieving the 4-hour target for children in our Emergency Departments.

See below graph for month to date as of end of September 2019:



Each Health Economy, through the unscheduled care work programme, is addressing the waits in ED for children and young people and also the environment in which they are waiting.

A specific concern raised by HIW related to a single incident at Noah's Ark Hospital, when a child waited for seven days to go to theatre for an invasive procedure.

In North Wales in the majority of cases, where new central vascular access is needed, this will be done in Alder Hey.

In a situation of a critically unwell child who requires stabilisation prior to transfer out then the anaesthetic team may well secure central vascular access either in ED resus or the ward High Dependency Unit (HDU).

Recommendation 13
Health boards must ensure that young people know how they can raise concerns about their care within hospitals.

All staff are aware of their duties under Putting Things Right and the importance of ensuring that children and young people are aware of advocacy services from MEIC should they need to make a complaint.

Patient and Advice Liaison Service (PALS) walk the wards asking children and families about their experiences. Care2Shares, is being promoted, these are short discussions with service users (the patients, relatives, carers or other) and focus on the three key themes; first and lasting impressions, safe and healing environment & understanding and involvement in care. The outcomes of the discussion are shared with the staff to compliment the treatment given and/or suggestions for service improvement.

Patient Stories are also gathered these are semi-structured interviews which allow the service users to replay their care with use of open questions to prompt.

Children's Services are striving to ensure that the Children's Rights Approach is embedded in the organisation, within the planning process and in the delivery of our care. Our current priority is to develop a Children's Charter.

Recommendation 14
Health boards must ensure that paediatric risk and pain assessment documentation is comprehensive and completed in a timely manner.

Documentation for staff caring for children in ED has improved significantly with the introduction of PEWS and the children's pain assessment tools, further work is needed to ensure these are truly embedded in practice with audit programme to evidence improvement.

Recommendation 15
Health boards must ensure that staff working, who may work with children and young people have up-to-date safeguarding training.

BCUHB overall compliance is 80%

Emergency Departments: Ysbyty Gwynedd (YG) 64% Ysbyty Glan Clwyd (YGC) 73%, Wrexham Maelor 60%

Children's Services: West Area 93%. Central Area 93%. East Area 93%

Recommendation 16
Health boards must ensure there are sufficient numbers of staff with the right skills to meet the needs of children and young people.

The review refers to the Royal College of Paediatrics and Child Health Standards for Paediatric Emergency Units, all of our DGHs provide children's emergency care but none of our Emergency Departments have the activity to require a Children's ED. All three Emergency Departments have some Paediatric nurses, this needs increasing. Support, training, consultation is provided to the staff working in the EDs to develop the skills in managing acutely unwell child; and Paediatricians are having an increasing presence to assist with timely assessments, interventions and management of care. A training programme is being developed to support access to EPALS/APLS with future course access and nurse led courses.

5. Supporting Young people with Life Limiting Conditions Receiving Palliative Care

This section within the HIW Thematic review was primarily based upon evidence from inspections of two children's hospices, including Ty Gobaith in North Wales, to which BCUHB provides funding, through 'voluntary organisations grants'.

In general, all of the areas reviewed with regard to the hospice provision for our children and young people in Ty Gobaith was very positive with children and their families rating the care and treatment as excellent.

Recommendation 17
Service providers must ensure they have comprehensive and up-to-date environmental risk assessments and address any actions highlighted.

Recommendation 18
Service providers must ensure there are arrangements to support communication needs of children, young people and their families, including facilities to support people who use hearing aids.

Recommendation 19
Welsh Government needs to assess any unmet demand for palliative care services to ensure children and young people across Wales get the care they need.

Recommendation 20
Service providers need to be mindful of how they ensure young people and their families are made aware of how to raise a concern about their care.

Clinical services for children with Life Limiting Conditions and End of Life Care (Paediatric Palliative Care) have developed positively within the Health Board.

This is the provision of a high quality, responsive, and coordinated service which enhances quality of life (QOL) for children and young people diagnosed with life limiting conditions, their families and their community. There are two hospices in North Wales providing inpatient respite care and also outreach care at home integrated with services provided by the health board.

Currently we have 4 BCUHB doctors who have post graduate training and significant clinical experience in Paediatric Palliative Care and are trained to provide comprehensive symptom control including end of life care. Care takes a number of forms including hospital based, home care, end of life care and advanced symptom management. The 2016 NICE guidelines outline the need for advance care planning and choice of place of care at the end of life. The Health board has been successful in moving towards this model

6. Transition from Child to Adult Healthcare Services

The thematic review for this section was based on self-assessments completed by Health Boards in Wales. Within BCUHB, there is good awareness of the national guidelines.

Recommendation 21
Welsh Government and health boards must ensure there are clear transition pathways and policies in place for each service area. Where possible, there should be consistency in approaches to transition in line with national guidelines.

Recommendation 22 Health boards must ensure there are robust systems to monitor transition policies and pathways across healthcare services to ensure approaches are effective.

BCUHB is attending to this recommendation ensuring that there are written pathways for each specialty highlighting compliance with the WG Transition policy. A work stream has been established focussing on children with disabilities and the Policy for transition between CAMHS and Adult Mental Health is due to be ratified.

Recommendations 23-24 Welsh Government and health boards must ensure there are sufficient resources and capacity to support effective and timely transition.

Health boards must ensure a named key worker to coordinate transition is identified promptly and consider how to best support transition, including considering designated roles.

The Health Board has speciality nurses for Asthma, Epilepsy, Diabetes, Cystic Fibrosis, Palliative Care who are critical to supporting young people as they transition to adult services and act as key workers. Their capacity is stretched however within the current Health Board resources.

Recommendations 25-26
Health boards must ensure they have formal systems for involving young people in the design and delivery of transition processes and learn from their experiences.

Health boards must ensure young people are involved in the planning and transition process and are provided with adequate support to enable them to adjust.

Recommendations 27-28
Health boards must ensure there is sufficient time to allow for effective transition and planning starts as early as possible.

Health boards need to review the practices where transition starts later, particularly for services where this starts after the age of 16 and align with national guidelines.

Transition for those with disease specific conditions such as epilepsy, diabetes, neurology a Multi Disciplinary Team (MDT) approach is taken with well-established transition clinics between paediatrics and adult services.

Transition commences at 16 years for most children with disease specific conditions and 14 years for those with disabilities. After one or two transition clinic attendances the young person is then seen in the adult clinic and discharged by the paediatrician.

With some long term conditions there are insufficient numbers of patients for the complete MDT transition approach to happen, this has meant Transition to adult services has fallen short e.g we have a small number of renal patients of which maybe 2-3 a year graduate to adulthood. It has not been thought feasible to set up a formal transition process for them and we have instead a system in place where the service refer to adult colleagues but leave the patients on acute paediatric caseload until the patient has been seen by the adult services. Other specialties such as cardiology, endocrine, rheumatology etc numbers are equally small. This is an area where more work will need to be done for each service to demonstrate planned transition ensuring consistent approaches across the Health Board.

For those young adolescents with enduring mental illness the need for ongoing support and care from childhood into adulthood is vital. Given that many major

disorders emerge in the mid to late teens, a good transition is critical for mental health disorders. The newly developed BCUHB policy describes the process to be followed when a young person within CAMHS requires continuing care from Adult Mental Health Services.

Where transition starts late particularly for services where this starts after the age of 16 occurrences are reported by using the DATIX system.

Recommendation 29
Welsh Government and health boards need to ensure there are appropriate transition pathways and support for young people with complex health needs and life-limiting conditions.

The transition of young people with complex disabilities and multisystem disorders was highlighted in the review to be fragmented. In BCUHB the community Paediatrician and specialist nurses have key roles in co-ordinating services and in delivering services to the young person and their family.

As with the work on transition pathways for children with disabilities and mental health needs, pathways for those with complex needs and life limiting conditions are being addressed.

Recommendations 30-31
Health boards must ensure there are consistent and robust systems identify young people who will need to transition and support for attending appointments in adult services.

Health boards must ensure that adult services make every effort to engage with young people and communicate with other involved agencies, to ensure they can successfully transition.

It should be the exception that young people requiring transition to adult services are not under a Paediatrician or Psychiatrist and having care provided by our teams. The CAMHS transition work stream is addressing the requirement that Adult Mental Health need to work in partnership with CAMHS prior to turning 18 years old to ensure a smooth multidisciplinary handover of care.

Recommendations 32-33
Welsh Government and health boards need to review the differences between service models and thresholds between child and adult healthcare services and consider how young people can continue to receive holistic care and support into adulthood.

Health boards must ensure that parents and carers are sufficiently involved in transition planning.

There are differences in threshold for services between children's services and adult services. A full review would need to be undertaken to understand the detail of this for all specialities. We have acknowledged in children's services that we need to ensure that we are enabling young people to be independent young adults, building resilience rather than over- dependency on services, while enabling the bridge into adult services to be smooth.

Recommendations 34-37

- Health boards must ensure there is clarity across services about how all young people aged 16 and 17 should be appropriately treated, including how they will ensure staff have the right skills to care for them.
- Welsh Government needs to ensure there is clear guidance about how young people under 18 years of age, should be treated when needing care for physical health needs.
- Welsh Government and health boards must review the practice and frequency of placing young people on non-designated adult mental health wards.
- Welsh Government needs to consider the reporting and monitoring of underage admissions on adult (non-mental health) hospital wards to ensure there is oversight on this issue across Wales.

The Health Board has implemented the Public Health Wales risk assessment, undertaken when young people aged 16 and 17 years are admitted to adult wards, to ensure that the environment and their needs are understood and risks mitigated. The UN Rights of the Child and the Children's Rights Approach are informing our care as we strive to ensure that young people have choice and are respected whilst providing care in appropriate environments with the right workforce and skill.

Admissions to adult mental health wards is continually monitored and reported to the Mental Health Act Committee. There was 1 admission in 2018-19 and none thus far in 2019-20. CAMHS have been working closely with Adult Mental Health to ensure that a designated age appropriate bed required by Welsh Government is available and staffed appropriately.

APPENDIX 1: Action Log

Recommendations	Actions	Time scale	Progress
Recommendation 1 Health boards and service providers must ensure environments protect the safety and wellbeing of young people. There must be robust systems in place to monitor risks within the environment and ensure maintenance work is conducted in a timely way.	Being addressed with Estates, grounds have been attended to and a programme of maintenance agreed.	June 2019	Completed
Recommendation 2 Health boards and service providers must ensure there is clear communication with young people to help them understand their treatment Welsh Government, health boards and service providers need to improve the communication with, and information available for, young people and their families at the point of referral	The NWAS Patient information leaflet has been updated and is now given out to parents and the young person on admission. This is recorded in the patient's notes. The case manager is responsible for auditing compliance and record keeping. Medical investigations and results are explained to the young person by the Speciality grade Doctor and named nurse, supported by the part time consultant Paediatrician within the team.	Sept 2018 Sept 2018	Completed Completed
Recommendation 4-5	Recruitment of CAMHS	March 2020	Progressing with

Welsh Government needs to consider the capacity within CAMHS services across Wales to ensure this meets the needs of young people, including those who are high risk. Welsh Government and health boards need to review the waiting times for CAMHS services, ensure there are timely referrals to other organisations to support young people and how young people can access support at times of crisis	practitioners with the new investment to meet the demand and improve the performance. A crisis pathway bid has been developed should there be additional funding available. Implementation of the Parliamentary Review Transformation project Supported by WG, we are assessing the feasibility of submitting a business case to address the requirements that would allow crisis admissions out-of-hours to NWAS and for those requiring Psychiatric Intensive Care.	June 2019 March 2021 Oct 2019	vacancies going through the Establishment control process Bid to be approved for submission Progressing recruitment to MDTs. Progressing. WHSSC specification published for consultation.
Recommendation 10. Welsh Government, health boards and service providers must consider how issues around workforce within CAMHS units can be addressed to ensure young people receive care from the right staff with the rights skills to meet their needs.	A workforce plan focussed on skills and knowledge has been developed. This recruitment plan needs to continue to develop and mature.	Oct 2020	
Recommendation 12 Health boards must ensure young people consistently receive timely care and treatment within emergency	Each Health Economy area, through the unscheduled care work programme, to	March 2020	

departments and for emergency invasive procedures	address the waits in ED for children and young people and also the environment in which they are waiting.		
Recommendation 13 Health boards must ensure that young people know how they can raise concerns about their care within hospitals.	Children's Services are striving to ensure that the Children's Rights Approach is embedded in the organisation, within the planning process and in the delivery of our care. Our current priority is to develop a Children's Charter.	July 2020	Board development session being arranged
Recommendation 14 Health boards must ensure that paediatric risk and pain assessment documentation is comprehensive and completed in a timely manner.	Documentation for staff caring for children in ED has improved significantly with the introduction of PEWS and the children's pain assessment tools, further work is needed to ensure these are truly embedded in practice. To audit implementation	March 2020	
Recommendations 21 -22 Health boards must ensure there are robust systems to monitor transition policies and pathways across healthcare services to ensure approaches are effective.	A work stream has been established focussing on children with disabilities. The Policy for transition between CAMHS and Adult Mental Health is due to be ratified	Oct 2019 January 2020	Completed

Recommendations 27-28 Health boards must ensure there is sufficient time to allow for effective transition and planning starts as early as possible.	Where transition starts late particularly for services where this starts after the age of 16 occurrences are reported by using the DATIX system.	Oct 2019	Completed
Recommendation 29 Welsh Government and health boards need to ensure there are appropriate transition pathways and support for young people with complex health needs and life-limiting conditions.	Work Stream to be established.	Dec 2019	

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Thematic Report

How are healthcare services meeting the needs of young people?

Review date: 2019

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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 care.

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We place patients at the heart of what we do. We are:

- Independent
- Objective
- Collaborative
- Authoritative
- Caring

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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. Foreword

Healthcare Inspectorate Wales (HIW) committed to undertaking a review of how healthcare services are meeting the needs of young people, including those who need to transition from child to adult services. This work is part of wider thematic work undertaken jointly by Inspection Wales[1]. Our review will contribute to a wider evaluation of services which support young people's healthy development, wellbeing, and access to education and employment.

In conducting this review, HIW has looked back across its inspections over the last two years relating to children and young people, including in-patient Child and Adolescent Mental Health Services (CAMHS), treatment for physical health conditions in hospitals and care within children's hospices. In arriving at our conclusions, we have also considered a range of legislation, strategy, standards, guidance, and reviews.

The intention of this report is to identify key themes, issues and good practice in relation to youth healthcare services. We hope the findings from this review are used to improve services and to inform further work and investigation around the areas we have highlighted.

[1] Inspection Wales consists of the four inspectorates/audit bodies in Wales, Healthcare Inspectorate Wales, Care Inspectorate Wales, Estyn and Wales Audit Office

2. Summary

Within the three in-patient CAMHS units we inspected, it was positive to find that staff worked hard to provide compassionate, dignified and person-centred care. We also saw evidence of positive multi-disciplinary team working within the units.

However, across our inspections, we could not always be assured patients were receiving safe and effective care within CAMHS units. This is because we identified weaknesses around systems for ensuring safe care, including a system for locating emergency equipment. We also found improvements were needed to patient records, care planning and statutory mental health documentation. In the Regis Healthcare CAMHS unit, it was of particular concern to find excessive use of full physical restraint which compromised patients' safety, rights and dignity. We found there were ongoing challenges across CAMHS units to ensure there are sufficient numbers of staff with the right skills to meet the needs of young people.

Overall, HIW has significant concerns about the ability within CAMHS units to accommodate young people who are high risk due to challenges with staffing, environment and effective management and leadership.

General healthcare services for young people

We looked at the care provided to young people with acute, long-term and chronic physical health conditions in our inspections of Noah's Ark Children's Hospital and Morriston Hospital Emergency Department. We found staff were caring and talked to young people and their families about their medical conditions. Environments were generally suitable for young people and there were facilities to support families and carers.

In general, we found children and young people received safe and effective care. However, services needed to make improvements to ensure young people received timely care in emergency departments and for invasive procedures. We also found aspects of care documentation were not always completed and a number of staff had not completed training in how to safeguard children at risk. Despite attempts to recruit new staff, there were ongoing challenges in both hospitals to ensure they had sufficient numbers of staff with the right skills.

As a result, we found that in the emergency department, there was not always sufficient staff for children and young people to be treated in the designated children's area.

Supporting young people with life-limiting conditions and palliative care

We looked at the care and treatment provided to children and young people in the two children's hospices in Wales. Although we identified some areas for improvement, overall, we found that young people received safe and effective care. We found staff were kind and caring and there was good support available to families. Young people received care that was tailored to their specific needs and were supported with an extensive range of facilities and

programmes to enhance their well-being. Children, young people and their families were involved in decisions about their care, and hospice staff were particularly respectful of their wishes for end-of-life care and after death.

We also found evidence of good management and leadership at the hospices.

Transition from child to adult healthcare services

We found a varied and inconsistent picture across Wales in respect to transition. It was positive to find health boards generally worked to national guidance on transition, including having a named key worker, joint meetings with other services and typically starting transition at an appropriate age.

We found variation across services and health boards regarding the age at which transition usually starts. Although there should be no arbitrary age for transition, in practice, age appears to be the main determinant. We found examples where transition could be rushed and did not always start early enough. We were told that transition works very well for a small number of patient groups. However, in practice, particularly for young people with complex needs, this can be more fragmented and can feel like 'falling off a cliff edge'.

We found that differences between child and adult services meant that individuals did not always receive the same level of care and there may not be an equivalent adult service for a young person to transition to.

There also appears to be a lack of a formal and consistent mechanism to involve young people in monitoring or reviewing the effectiveness of transition processes. Some health boards said they had plans to engage young people in future within some services once transition pathways had been developed.

We found variation in how young people aged 16 or 17 years old are treated across healthcare services in Wales. Of particular concern were the occasions when young people would be treated on non-designated adult wards which may not provide suitable environments and staff to meet their needs.

Conclusion

Overall, it was positive to find young people had predominately good experiences of care within services. However, we are concerned about the current ability of CAMHS units across Wales to accommodate young people who are high risk, meaning some young people need to be placed out-of-area. This is not acceptable and we believe Welsh Government needs to take firm steps to address this problem. Many of the issues we have identified around transition are well known and greater consistency is needed across Wales. Health boards must take responsibility for ensuring there are clear transition pathways across all services they provide and have a robust system for monitoring their effectiveness. Further work is also needed to understand the experiences of young people with complex needs and life-limiting conditions.

A list of our recommendations can be found in Appendix A of this report.

3. Background

Focus of the review

This review considered what we know about how healthcare services meet the needs of young people in the following areas:

- Child and Adolescent Mental Health Services (CAMHS)
- general healthcare for young people (considering young people with acute, chronic, and long-term physical healthcare needs)
- supporting young people with life-limiting conditions receiving palliative care
- transition between child and adult services.

In this review we have identified key themes and issues from available evidence, drawn conclusions and made recommendations for improvement. Throughout this report we have highlighted areas of good practice, and in order to share learning across Wales, we have also included specific good practice examples around transition in Appendix B.

Context

There are a number of strategy, legislation, standards and guidance documents which relate to healthcare services for young people, in addition to a number of published reviews.

Some of the key legislation and standards include the following:

- Mental Health Act 1983[2]
- Mental Health (Wales) Measure 2010[3]
- Mental Capacity Act 2005[4]
- Social Services and Well-being (Wales) Act 2014[5]
- Well-being of Future Generations (Wales) Act 2015[6]
- United Nations Convention on the Rights of the Child[7]
- Independent Health Care (Wales) Regulations (2011)[8] and National Minimum Standards for Independent Health Care Services in Wales[9]

[2] https://www.legislation.gov.uk/ukpga/1983/20/contents

[3] https://www.legislation.gov.uk/mwa/2010/7/contents

[4] https://www.legislation.gov.uk/ukpga/2005/9/contents

[5] https://www.legislation.gov.uk/anaw/2014/4/contents

[6] https://www.legislation.gov.uk/anaw/2015/2/contents

[7] https://www.unicef.org.uk/what-we-do/un-convention-child-rights/

[8] https://www.legislation.gov.uk/wsi/2011/734/contents/made

[9] https://gov.wales/legislation/subordinate/nonsi/nhswales/2011/4927892/?lang=en

- Health and Care Standards 2015[10]
- All Wales Child Protection Procedures[11].

Overarching guidance around transition of young people from child to adult services includes the following:

- NICE guidelines: Transition from children's to adults' services[12]. (This applies across mental health, general healthcare, chronic and life-limiting conditions)
- Royal College of Nursing – Lost in Transition: Moving young people between child and adult health services[13].

We are also pleased to note that Welsh Government is in the process of developing guidance on provision of healthcare services for 16 and 17 year olds and handover of healthcare from children's to adult services. This guidance aims to address the issues and concerns raised in relation to the healthcare offered to 16 and 17 year olds, and their progress into adulthood 'transition'. The intention is to provide direction for Welsh health boards and trusts.

Key strategy, standards and guidance regarding Child and Adolescent Mental Health Services include the following:

- Welsh Government: 'Together for Mental Health' strategy[14]
- Together For Children and Young People Programme (T4CYP)[15]
- Good Transition Guidance for professionals from the T4CYP (2017)[16]
- National Assembly for Wales: Children, Young People and Education Committee – *Mind Over Matter* report 2018[17]
- Welsh Government: Admissions guidance[18]
- Royal College of Psychiatrists (2013) CAMHS guidance[19].

[10] https://gov.wales/topics/health/publications/health/guidance/care-standards/?lang=en

[11] https://gov.wales/topics/health/socialcare/safeguarding/?lang=en

[12] NICE Guidelines published 2016 (and transition pathway published in 2018) https://www.nice.org.uk/guidance/qs140

[13] https://www.rcn.org.uk/professional-development/publications/pub-003227

[14] https://gov.wales/topics/health/nhswales/mental-health-services/policy/strategy/?lang=en

[15] https://www.goodpractice.wales/t4cyp

[16] http://www.goodpractice.wales/SharedFiles/Download.aspx?pageid=185&mid=326&fileid=751

[17] http://www.assembly.wales/laid%20documents/cr-ld11522/cr-ld11522-e.pdf

[18] http://www.wales.nhs.uk/sitesplus/documents/862/Item14i.WG.AdmissionsGuidance.pdf

[19] https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr182.pdf?sfvrsn=8662b58f_2

Key strategy, standards and guidance regarding general healthcare for children and young people include the following:

- Welsh Government delivery plans for specific conditions including, diabetes, cancer, heart, neurological conditions, respiratory health, stroke, critical illness[20]
- Royal College of Nursing: Facing the Future: Standards for children in emergency care settings[21].

Key strategy and guidance regarding life-limiting conditions and palliative care include the following:

- Palliative and End of Life Care Delivery Plan 2016[22]
- Together for Short Lives Guidance[23]
- Children and Young People's Continuing Care Guidance[24].

HIW inspection framework

Within this report we have referred to HIW's inspections of NHS and independent healthcare services in the last two years.

In our inspections of NHS services, HIW considered how services met the Health and Care Standards (2015).

In our inspections of independent healthcare providers, HIW considered how the service met the requirements of the Independent Health Care (Wales) Regulations 2011 and the National Minimum Standards for Independent Health Care Services in Wales.

Where appropriate, HIW also considered how services complied with the Mental Health Act (1983), Mental Health (Wales) Measure (2010), Mental Capacity Act (2005) and Deprivation of Liberty Safeguards.

Further detail about how HIW inspects the NHS and independent services can be found on our website[25].

[20] https://gov.wales/topics/health/nhswales/plans/?lang=en

[21] https://www.rcpch.ac.uk/sites/default/files/2018-06/ftf_emergency_standards_digital_-_website_version.pdf

[22] https://gov.wales/topics/health/nhswales/plans/end-of-life-care/?lang=en

[23] https://www.togetherforshortlives.org.uk/resource/guide-end-life-care/

[24] https://gov.wales/topics/health/publications/socialcare/guidance1/care/?lang=en

[25] http://hiw.org.uk/about/whatwedo/inspect/?lang=en

Specific healthcare services for young people in Wales

There are three CAMHS in-patient units in Wales:

- **Tŷ Llidiard** – operated by Cwm Taf University Health Board for 12-18 year old patients from across South Wales. The service is commissioned by the Welsh Health Specialised Service Committee (WHSSC) to provide 15 beds for NHS patients.
- **Abergele** – provided within Betsi Cadwaladr University Health Board for 12 to 18 year olds from across North Wales. The service is commissioned by WHSSC to provide 12 beds for NHS patients.
- **Regis Healthcare Ltd** – registered with HIW to provide independent CAMHS services based in Gwent South Wales for 13-18 year old patients. It has capacity to provide 24 beds. However, due to HIW's concerns[26] about the service, the number of beds available has been reduced from 24 to 12. The service had previously treated Welsh NHS patients. However, due concerns of Welsh NHS commissioners, at the time of writing, Regis Healthcare are not currently commissioned to treat Welsh NHS patients.

There is one dedicated paediatric hospital in Wales:

- Noah's Ark Children's Hospital, based on the site of the University Hospital of Wales in Cardiff provides health care for children and tertiary services for children across Wales. The service is based within Cardiff and Vale University Health Board.

There are two independent paediatric hospices in Wales that provide care and treatment to children and young people:

- **Tŷ Hafan** – located in Sully, Cardiff. Registered with HIW to provide independent and collaborative specialist palliative care for up to 10 children and young people aged 0-18 years.
- **Tŷ Gobaith** – located in Groesynydd, Conwy. Registered with HIW to provide independent and collaborative specialist palliative care for up to five children and young people aged 0-25 years.

Evidence considered

During this review we considered evidence from the following sources:

- Legislation, national strategies, policies, guidance and standards on healthcare for young people and transition between child and adult services.
- Self-assessments completed by each health board in Wales on healthcare services for young people and arrangements on transition.
- A range of published reviews and research of healthcare services for young people.

[26] Due to concerns around the governance, management and leadership of the service, Regis Healthcare Ltd is under the closest scrutiny from HIW, within which we have imposed conditions on their registration and ability to take on new patients. Further details are included under 'Timely Care' within the 'Child and Adolescent Mental Health Services' section of this report.

HIW inspections of NHS and independent healthcare services including the following:

- Tŷ Llidiard 2017 and 2018[27]
- Abergele 2018[28]
- Regis healthcare 2018[29]
- Noah's Ark Hospital 2015 and 2017[30]
- Tŷ Hafan 2018[31]
- Tŷ Gobaith 2018 [32]
- Morriston Hospital Emergency Department 2018[33].

When considering what inspections to include as part of this review, we looked back at our hospital inspections over the last two years where there were findings around the care of children and young people. We have included our inspection of Morriston Hospital Emergency Department in particular, because it highlighted challenges around the care of young people which may also be present in other emergency departments across Wales.

Terminology in this report

Throughout this report we have referred to both children and young people. By the term 'children' we mean those aged 0-12 years old and by the term 'young people' we mean those aged 13-24 years old.

When we discuss 'transition', we mean young people moving from child to adult healthcare services, including mental health.

[27] http://hiw.org.uk/find-service/service-index/tyllidiard?lang=en

[28] http://hiw.org.uk/find-service/service-index/abergelehospital1?lang=en

[29] http://hiw.org.uk/find-service/service-index/regishealthcare89?lang=en

[30] http://hiw.org.uk/find-service/service-index/children'shospitalforwales20?lang=en

[31] http://hiw.org.uk/find-service/service-index/tyhafan122?lang=en

[32] http://hiw.org.uk/find-service/service-index/tygobaith119?lang=en

[33] http://hiw.org.uk/find-service/service-index/morristonhospital53?lang=en

4. Key themes

Child and adolescent mental health services

We found CAMHS did well in the following areas:

- Staff treated young people with respect and kindness.
- There was positive multi-disciplinary team working.
- Facilities for families and carers.
- Systems to listen to young people and learn from feedback.
- Young people were involved in their care.

We identified CAMHS needed to improve in the following areas:

- Timely completion of work to improve the physical environmental.
- Communication with young people and families at referral and on admission.
- Information on raising concerns and access to advocacy services.
- Ability to accommodate patients who are high risk.
- Waiting times and access to services for young people in crisis.
- Systems to ensure the safety and effectiveness of care, including location of emergency equipment and use of physical restraint.
- Sufficient numbers of staff with the right skills, and induction of new and temporary staff.

Why this issue is important

Approximately 50% of people with enduring mental health problems will have symptoms by the time they are 14[34]. The Mental Health Act required that age-appropriate services be put in place and that patients aged under 18 with a mental health problem requiring admission to hospital are accommodated in an environment that is suitable for their age. For those young people with enduring mental illness the need for ongoing support and care from childhood into adulthood is vital. All children and young people should receive safe and effective care from mental health services which meet their needs.

What the evidence shows

In this section, when evaluating how young people with mental health needs are cared for, we have primarily considered the evidence from our inspections of the three CAMHS in-patient units in Wales. This includes our inspections of Abergele unit within Betsi Cadwaladr University Health Board, Tŷ Llidiard unit provided by Cwm Taf University Health Board and Regis Healthcare's independent low-secure CAMHS unit where people with acute, long-term and complex needs are cared for. We have also considered the evidence from guidance, research and reviews around CAMHS services more widely.

Quality of patient experience

Across the three CAMHS units we inspected, we found young people had access to a range of activities within the units and in the community, including cinema/games rooms, cooking sessions, sports, gym and leisure facilities and arts and crafts. However, we found that at times, activities provided could be ad hoc or with limited availability due to insufficient staff being available to facilitate/supervise. On other occasions, we found that access to facilities and activities was affected by environmental issues such as damage to equipment and maintenance needed to indoor and outdoor spaces. We also identified that activities were not always clearly linked to the individual patient's care plan.

Environment

We found efforts had been made by services in the design and furnishing of the units to provide a suitable environment for young people to receive care. Young people had their own bedrooms which they could personalise with their belongings.

However, across our inspections, we found issues with aspects of the physical environment. We identified areas of damage and maintenance needed to internal and external areas. We found garden areas, which were intended to benefit young people by giving them time away from the unit, overgrown and poorly kept.

We found that both Abergele and Tŷ Llidiard units were undergoing anti-ligature work to the hospital environment. This was a positive step to reduce the potential opportunities for patient self-harm via ligaturing, thus improving patient safety.

However, whilst each unit had systems in place to deal with environmental issues and ongoing programmes of maintenance, work was not always carried out in a timely way. In our 2018

[34] http://www.assembly.wales/laid%20documents/cr-ld11522/cr-ld11522-e.pdf

inspection of Tŷ Llidiard, we found environmental changes were needed to ensure the safety and wellbeing of patients with more complex care needs. However, we were told it had taken a long time for the work to be completed.

In addition to updating furniture, fixtures and fittings to be anti-ligature, services also need to ensure that there are individualised plans to identify and mitigate the risk that young people may harm themselves or others. Services should also be aware of items left unattended which could be used by young people to self-harm.

Recommendation 1

Health boards and service providers must ensure environments protect the safety and wellbeing of young people. There must be robust systems in place to monitor risks within the environment and ensure maintenance work is conducted in a timely way.

Support for families and carers

CAMHS units typically had rooms for families and carers of young people to stay overnight. This was of great benefit to families and carers, particularly those who are located some distance away from the hospital.

Where appropriate, young people could also spend time with their families in private and could use their mobile phones or hospital phone to maintain contact with family and friends.

Dignified care

Overall, we found staff treated young people with respect and kindness. Staff made every effort to maintain patient dignity. Patients told us staff knocked on their bedroom doors before entering to respect their privacy.

For their safety, each bedroom had a see-through vision panel that could be used by staff to observe patients, without disturbing them. However, there were occasions when we found issues with repair needed to these observation panels and window coverings to promote patient's privacy.

During our March 2018 inspection of Regis, we were concerned about the impact of excessive use of restraint on young people's rights and dignity. We have addressed this further below under 'safe and effective care'.

Patient information and communication

On the whole, we found young people were provided with a range of information about their stay in the units.

Through our observations of staff-patient interactions it was evident that staff ensured they communicated effectively with young people. We also saw positive relationships between staff and young people.

Staff took time to undertake discussions using words and language suitable to the individual person. Where information remained unclear or misunderstood, staff would patiently clarify what was said. However, there were occasions when young people told us they didn't understand aspects of their treatment, including the next steps following their admission.

Within CAMHS services, health boards told us that young people are asked to provide written consent to treatment. However, there is also evidence to suggest that young people and their families don't receive adequate general information about CAMHS services at the point of referral to services. An Aneurin Bevan Community Health Council[35] report found that approximately half of the parents who had a child referred to CAMHS did not have the process explained to them and were not aware of what to expect. People also reported that when a referral was not accepted they were not told the reason for the rejection or offered the option of being referred to a more appropriate service elsewhere. The report also identified a misunderstanding of what CAMHS does and who is eligible for the service, which may then result in inappropriate referrals.

Recommendations 2-3

Health boards and service providers must ensure there is clear communication with young people to help them understand their treatment.

Welsh Government, health boards and service providers need to improve the communication with, and information available for, young people and their families at the point of referral.

Timely care

Capacity in services

In line with the findings of the *Mind Over Matter* report, produced by the Children and Young People and Education Committee, we also found a mixed picture of CAMHS in-patient capacity in Wales, to enable young people to receive timely care close to where they live. We are particularly concerned about the overall ability of units in Wales to accommodate young people who are high risk.

In our 2017 inspection of Tŷ Llidiard, we found the service was under significant pressure to provide care for more patients than the number it was commissioned for by the Welsh Health Specialised Service Committee (WHSSC). The hospital is commissioned for 15 patients but during our inspection there were 18 patients being cared for. In 2018, we noted the ongoing work to make environmental changes in order to reflect the increased complexity of patients care needs compared to those patients that were referred when the unit first opened. Due to these necessary changes, Tŷ Llidiard is operating a restricted criteria for referrals until the work is completed in 2019.

[35] http://www.wales.nhs.uk/sitesplus/documents/901/Child%20and%20Adolescent%20Mental%20Health%20Services%20in%20Gwent%20September%202018.pdf

In North Wales, the *Mind Over Matter* report also identified similar concerns regarding the restricted capacity within Abergele unit, which is commissioned to provide 12 beds. This was due to ongoing issues with recruiting and retaining the appropriate number and skill mix of staff.

Due to serious concerns regarding the quality and safety of the service provided by Regis Healthcare CAMHS unit (which treats young people from England and Wales), Welsh patients were removed by NHS commissioners in July 2018. The service operated under restricted regulatory conditions between July and December 2018 which prevented any new admissions. Whilst new admissions have been permitted since December 2018, the number of beds available have been reduced from 24 to 12. At the time of writing this report, 11 of those 12 beds were occupied by English patients and the service had not yet been placed back on the list of providers approved by commissioners to provide treatment to Welsh NHS patients.

As of February 2019, Regis Healthcare remains a service of concern, and is under the highest level of scrutiny from HIW. Until the service can demonstrate that the improvements made in recent months can be sustained it is unlikely that any increase in capacity will occur.

Due to the issues above, we are concerned that all three units in Wales are currently operating under restricted capacity and/or admissions criteria. This means CAMHS units in Wales may not effectively meet the needs of high risk patients. As a result, some high risk patients are treated out-of-area. It is also disappointing that the limited capacity within CAMHS units and need for out-of-area placements was also identified in a report in 2013 by HIW and the Wales Audit Office[36]. On an all-Wales basis, Welsh Government needs to review the demand for these services against the ability and capacity within CAMHS units to ensure young people can receive the treatment they need in Wales.

Waiting times and access to services

The current target for specialist CAMHS is that 80% of patients should wait no longer than 28 days (four weeks) from the date the referral is received by the clinic to a first outpatient appointment. However, this target has been consistently missed since April 2017, with an average of 57% of patients who waited no longer than four weeks, whilst the majority of patients waited between 4-26 weeks for their first appointment.[37]

The Aneurin Bevan Community Health Council report stated '… that many referrals are rejected, with the young people feeling that they 'weren't bad enough' to be seen by CAMHS and that 'serious' suicide attempts were the only way that young people could get any support through the health system'.

Furthermore, the *Mind Over Matter* report highlighted 'A&E becoming a "default" option, especially for cases of overdose and/or self-harm, because of historical/continued difficulties accessing support from specialist CAMHS and/or primary care'.

[36] http://hiw.org.uk/reports/natthem/2013/camhs2013/?lang=en

[37] Source – StatsWales, Waiting times by specialty and patient type – outpatient waiting times. https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Hospital-Waiting-Times/Inpatient-and-Outpatient-Waiting-Times-for-Non-RTT-Specialties/waitingtimes-by-specialty-patienttype

The *Mind Over Matter* report also highlights the 'missing middle' where urgent work was needed to address the lack of services for young people who need support but do not meet the threshold for specialist CAMHS. It was also identified that 'many young people may not require CAMHS provision; however, with no obvious alternative for young people experiencing mental ill health, referrals may be being made inappropriately'.

Recommendations 4-5

Welsh Government needs to consider the capacity within CAMHS services across Wales to ensure this meets the needs of young people, including those who are high risk.

Welsh Government and health boards need to review the waiting times for CAMHS services, ensure there are timely referrals to other organisations to support young people and how young people can access support at times of crisis.

Listening and learning from feedback

Each unit had arrangements in place for dealing with concerns or complaints raised by young people but, in our inspections, we found information about these processes was not always clear and prominent.

We found young people could often provide feedback on the care they received through surveys undertaken by the units. Several units had used online surveys to try and engage young people. Responses were then considered by the service with a view to making improvements. Staff also told us that young people had the opportunity to provide feedback in meetings about their care.

All units confirmed that there is independent mental health advocacy available for young people detained under the Mental Health Act. We found information provided for patients within the units typically included information about advocacy services, and representatives from advocacy services would visit the units on a regular basis. However, we found information on the Mental Health Act, independent advocacy provision, how to raise a complaint and information on HIW could have been clearer and displayed more prominently.

On one occasion, young people told us that timescales for independent advocacy visits did not always allow an advocate to attend all individual meetings. Young people felt it would be beneficial if advocacy visits were based on individual needs rather than set visiting times.

Recommendations 6-7

Health boards and service providers must ensure there is clear information for young people on advocacy services and flexibility to enable young people to meet with advocacy services at a time of their choice.

Health boards and services providers must ensure young people know how to raise a concern.

Delivery of safe and effective care

Across our inspections, whilst we found staff worked hard to provide compassionate and dignified care, we could not always be assured that young people were receiving safe and effective care within CAMHS units.

We generally found that care and treatment plans, developed as part of the Mental Health (Wales) Measure 2010, were completed to an appropriate standard and focused on individual needs. We also found that staff made efforts to involve young people and their families (where appropriate) in the development of their care plan.

However, we identified a number of areas of improvement needed to patient records, care planning and statutory mental health documentation, including the need to ensure:

- Correct and timely completion of statutory Mental Health Act detention documents by relevant staff to effectively maintain legal compliance.
- There are systems in place for managing, organising and auditing statutory documentation and patient records.
- Unmet needs are identified and recorded within care and treatment plans.
- Care and treatment plans are reviewed in accordance with their review dates.
- Individualised plans are developed on how the young person would like to be treated in the event of any challenging behaviour.
- Restraint risk management and implementation plans are in place to assist staff members to consider the young person's physical conditions and behaviours whilst implementing restraint.
- Appropriate plans are developed in response to findings from risk assessments and risk assessments are kept up-to-date to help identify patients' needs in relation to promoting their safety and wellbeing.
- Information on physical health needs are appropriately recorded, including chronic illnesses and allergies, and care plans for physical injuries.
- Observation records are complete and accurate.

During our inspections we identified weaknesses and concerns around systems for ensuring safe and effective care. We found issues with the location of emergency clinical items, including a delay in locating ligature cutters. Any delay in locating equipment in an emergency could impact the safety of a young person. During one inspection of Regis Healthcare, we also found some members of staff lacked knowledge on how to support and monitor patients before, during and after mealtimes. This is important particularly for young people with eating disorders.

Of particular concern was the excessive use of full physical restraint, identified in our Regis Healthcare inspection in March 2018. Consequently we were not fully assured that the young people were being cared for safely and outcomes monitored effectively. This resulted in HIW issuing a non-compliance notice[38] to the service. Where a form of control or restraint is used there must be suitable arrangements in place to protect the young people against the risk of such control or restraint being otherwise excessive. Whilst any form of restraint should be seen as a course of action used in exceptional circumstances only, it can be a potential breach of young people's rights[39]. Any restraint must be a considered, last resort decision, which is fully risk assessed.

Since the March 2018 inspection, Regis Healthcare has provided staff with further training on restraint and has developed additional documentation for recording when attempts are made to de-escalate challenging behaviour prior to restraint. However, during a follow-up inspection of Regis Healthcare, we found inconsistencies in the quality of incident reports being completed and identified improvements that could be made in the analysis of incidents and records.

Whilst we did not identify similar concerns regarding the excessive use of physical restraint at other units, it is important that all services maintain awareness of the appropriate consideration and use of this approach.

Recommendation 8

Health boards and service providers must ensure that:

- patient records, care planning and statutory mental health documentation are comprehensive, accurate and completed in a timely manner
- emergency clinical items, including ligature cutters can be located without delay
- staff have sufficient knowledge on how to support and monitor patients before, during and after mealtimes
- any restraint must be carefully considered, risk assessed and monitored, with the involvement of the young person to ensure their safety, rights and dignity are protected as much as possible.

[38] If, following an inspection, HIW find that a service provider is compromising patient safety and failing to comply with the terms of their regulatory requirements and registration, HIW will take immediate action by issuing a non-compliance notice http://hiw.org.uk/providing/enforce/?lang=en

[39] Human Rights https://www.legislation.gov.uk/ukpga/1998/42/contents, Children Act 2004 https://www.legislation.gov.uk/ukpga/2004/31/contents, Rights of Children and Young Persons (Wales) Measure 2011 https://www.legislation.gov.uk/mwa/2011/2/contents, Mental Capacity Act, United Nations Convention on the Rights of the Child

Safeguarding children at risk

There were established processes in place to ensure units safeguarded children and young people appropriately, with referrals to external agencies being made as and when required.

On our inspections, we found most staff had completed mandatory training on safeguarding. However, there were occasions when we found not all staff had completed this. This is important to promote and protect the welfare and safety of young people.

Due to the excessive use of restraint found at Regis Healthcare, HIW referred this to the safeguarding team at the local authority for it to be dealt with formally under multi-agency safeguarding procedures.

Recommendation 9

Health boards and service providers must ensure CAMHS staff have up-to-date safeguarding training.

Quality of management and leadership

Across units, the staff we spoke to commented positively on multi-disciplinary team working. Staff said the multi-disciplinary teams worked in a professional and collaborative way and individual views were sought and valued.

At both Regis Healthcare and Tŷ Llidiard we found there were a number of staff vacancies, including registered mental health nurses. Although considerable effort had been made to recruit to these posts, there appeared to be difficulties with recruitment. We are also aware of ongoing issues with the recruitment of nursing staff and consultant psychiatrists at Abergele. At Regis Healthcare, we identified insufficient staffing numbers on wards with a high reliance on agency staff. In our subsequent follow-up inspections, we found that staffing levels had improved but we remained concerned about a number of other areas of governance, management and leadership at the hospital.

Across inspections, we also identified improvements were needed to ensure there is appropriate induction of all bank and agency staff working within units to ensure they are familiar with the environment and day-to-day running of the wards so they can best care for young people.

Recommendation 10

Welsh Government, health boards and service providers must consider how issues around workforce within CAMHS units can be addressed to ensure young people receive care from the right staff with the rights skills to meet their needs.

General healthcare services for young people

We found hospitals did well in the following areas:

- Feedback from patients, families/carers about their care was positive.
- Physical environments were generally well maintained and suitable for children and young people.
- There were facilities to support families and carers, including overnight accommodation at Noah's Ark Hospital.
- Staff explained to young people who they were and talked to them about their medical conditions.
- Services had ways to seek feedback from young people, including the use of age-specific questionnaires.
- We saw evidence of strong management and leadership within services.

We identified hospitals needed to improve in the following areas:

- Ensuring children and young people can be consistently treated in designated areas in emergency departments.
- Consistent timely care in emergency departments and for emergency invasive procedures.
- Completion of risk and pain assessment documentation.
- Staff in emergency departments have up-to-date safeguarding training.
- There are sufficient numbers of staff with the right skills to meet the needs of children and young people.

Why this issue is important

The number of children and young people with long-term conditions and/or complex needs is rising. Children and young people are also more frequent users of emergency departments than adults[40]. It is important that young people needing to attend hospital receive age appropriate, safe and effective care in a suitable environment, whether they need treatment for acute care or for chronic and long-term conditions.

What the evidence shows

In this section, in considering how young people with acute, long-term and complex needs are cared for, we have primarily considered the evidence from our inspections of Noah's Ark Children's Hospital within Cardiff and Vale University Health Board. As stated earlier in this report, we have also considered evidence from our inspection of Morriston Hospital Emergency Department (ED) in particular, because it highlights challenges around young people's care which may also be present in other emergency departments across Wales.

Quality of patient experience

During our inspection of Noah's Ark Children's Hospital, we received positive feedback from patients, families/carers on the care and treatment they received.

In our inspection of Morriston Hospital ED, we highlighted the experience of children and young people attending for urgent treatment. Whilst this inspection did not focus solely on the care for young people, overall, patients and their relatives commented that they were content with the care and treatment provided at the department.

Environment

We found the environment within the wards we visited at Noah's Ark hospital to be generally clean and well-maintained, although some maintenance issues remained in regards to emergency call buttons by bedsides, which had been identified on our previous inspection.

During our inspection of Morriston ED, we found children and young people were seen and cared for within a protected, appropriate environment, away from other areas of the department. It was also positive to find a play area had been created within a section of the main outpatient area as a result of the views of, and collaboration with, one family who had experience of visiting the hospital.

Standards developed by the Royal College of Paediatric and Child Health for children in emergency care state that settings should be designed and provided to accommodate the needs of children and young people and their parents/carers and they should be provided with separate waiting and treatment areas. However, during our inspection, we saw occasions when children were not able to receive care in the designated paediatric area. This was because of the lack of paediatric trained nurses available at that time. Whilst we were able to confirm that ED staff ensured children and young people were seen and assessed away from the main waiting area to ensure their safety and wellbeing, this was a disappointing

[40] Royal College of Paediatric and Child Health – Facing the Future: Standards for children in emergency care settings – 2018 https://www.rcpch.ac.uk/resources/facing-future-standards-children-young-people-emergency-care-settings

finding considering this situation was also highlighted by the local Community Health Council during their visit to the department in 2016[41].

Recommendation 11

Health boards must ensure that children and young people can consistently be treated within designated areas.

Support for families and carers

We learned that a new facility had been created at Noah's Ark Hospital to enable the parents/carers of 30 patients to remain close to their children. It was hoped the facility would provide parents/carers with the extra support and comfort they may need. It was also positive to find a dining room table and chairs, and a television had been added to the family room in direct response to comments made within a monthly patient experience survey.

We also found that relatives and families were encouraged to remain with patients and we saw a relatives' room was available for private discussions within Morriston ED.

Dignified care

At Noah's Ark Hospital, we held discussions with parents in each of the four clinical areas visited and were provided with many positive comments about the kindness and respect of staff. Parents and carers also told us staff were very attentive, explained aspects of care provision very well, and that they took time to listen to what they had to say.

Within Morriston ED, we heard from a range of patients about their experiences. Whilst feedback was not specific to children and young people, most patients and their relatives/carers felt staff were always polite and listened to them, and to their friends and family.

Patient information and communication

We found Noah's Ark Hospital had addressed our previous recommendation to ensure that staff always introduced themselves to patients and their families ahead of any discussions or clinical interventions. Staff were regularly reminded of the need to introduce themselves to children, young people and their families.

Patients, families and carers at both Noah's Ark and Morriston ED told us that staff had talked to them about their medical conditions or helped to understand them.

We also found that patients were offered the option to communicate with staff in the language of their choice and felt their language needs had been met.

Through the completion of our self-assessments, health boards confirmed that their policies to guide staff on the consent to examination and treatment included arrangements for children and young people. Health boards confirmed that clinical staff were aware of the

[41] http://www.wales.nhs.uk/sitesplus/902/page/45235

legal issues in gaining consent, including parental responsibility for under 16s, assessments of Frazer and Gillick[42] competency and the mental capacity of the young person.

Timely care

Overall, we found that every effort was made to ensure that children received timely care and treatment.

Staff worked to ensure that children were seen promptly by a paediatric nurse for triage purposes within Morriston ED. There was, however, a period during day three of our inspection, when a paediatric nurse was not available. This resulted in children being assessed outside of the paediatric area (but still apart from adult waiting zones). This resulted in some delay in the children concerned receiving further advice, care and treatment.

We also learned of an isolated instance at Noah's Ark Hospital whereby a child had needed to wait for seven days to go to theatre for an invasive procedure (re-insertion of a long-term vascular access device for feeding purposes). We found that there were no formal, current National Confidential Enquiry into Peri-Operative Deaths (NCEPOD)[43] emergency theatre arrangements in place for children's services. In addition, we could not find evidence of dedicated vascular access services[44] available at the University Hospital for Wales (for adults or children).

Recommendation 12

Health boards must ensure young people consistently receive timely care and treatment within emergency departments and for emergency invasive procedures.

Listening and learning from feedback

In our inspections of Noah's Ark and Morriston ED, we were informed that patients and their families/carers were encouraged to raise any concerns they had with members of staff. Both hospitals had ways to seek and regularly review feedback, either through comments cards in reception, or through patient and family surveys. We also found evidence of additional facilities being provided for families and children following feedback.

We noted good practice in Noah's Ark around the use of three types of questionnaires for different age groups of children and young people (up to three years of age, age four to nine and 10 to 18 years). This was in acknowledgement of the different care and support needs of children.

[42] https://learning.nspcc.org.uk/research-resources/briefings/gillick-competency-and-fraser-guidelines/

[43] National Confidential Enquiry into Peri-Operative Deaths (NCEPOD) relates to the provision of 24 hour operating theatre time (and supporting standards) for emergency surgery..

[44] The Association of Anaesthetists of Great Britain & Ireland – Safe vascular access 2016 http://www.aagbi.org/sites/default/files/Safe vascular access 2016.pdf. p11. "Hospital's must organise and provide the following: Timely (within 1-3 days) insertion (and removal) of long-term CVCs in specialist locations (wards, theatres, radiology) via a dedicated service."

The Royal College of Paediatrics and Child Health standards state that children, young people and their parents/carers should be invited to feedback on the service received in urgent and emergency care setting to inform service improvement. Through self-assessments, health boards across Wales generally confirmed that young people are supported to raise concerns through putting things right arrangements, with help through carers/families and professionals working with them. Health boards also confirmed they would direct young people to advocacy services, including some services specifically for children and young people such as MEIC[45]. However, we found that information on how people can raise concerns was not always prominently displayed. This meant that there may be occasions when patients and/or their families may not know how to report their concerns, or what to expect of the health board.

Recommendation 13

Health boards must ensure that young people know how they can raise concerns about their care within hospitals.

Delivery of safe and effective care

Overall, we found evidence that safe and effective care was being provided in both Noah's Ark Hospital and Morriston ED. However, we found some evidence that the health boards were not fully compliant with the Health and Care Standards in all areas.

In Noah's Ark Hospital, we found the necessary steps had been taken to ensure patients' needs were being met. Some aspects of patients' notes were very detailed and helpful to staff in providing care. However, we saw that documentation was not always completed, including paediatric risk assessment and pain assessments. This meant that we were unable to determine whether the effectiveness of prescribed medication was being monitored or evaluated.

We also found many instances at Noah's Ark Hospital where young people over the age of 16 received fragmented in-patient care due to issues around transition arrangements. We have discussed this further in the 'Transition from child to adult services' section of this report.

Recommendation 14

Health boards must ensure that paediatric risk and pain assessment documentation is comprehensive and completed in a timely manner.

Safeguarding children at risk

In our initial inspection of Noah's Ark hospital, we found there were appropriate arrangements for safeguarding children, and as such, did not identify improvements needed for follow up in 2017.

[45] Whilst not a dedicated advocacy, MEIC is the national and advice helpline for children and young people in Wales and offers a confidential and free helpline 24 hours a day, 7 days a week. www.meiccymru.org

Within Morriston ED, we were able to confirm that members of the ED team we spoke with were confident in the use of the All-Wales safeguarding arrangements associated with adults and children. We found that ED staff had ready access to details about children who may be vulnerable, or at risk. This meant that there was a particular emphasis on the provision of safe care and management of such situations.

The Royal College of Paediatrics and Child Health standards for emergency care also emphasise that all staff who regularly look after children must have up-to-date safeguarding children training. However, we found that just fewer than 50% of the ED staff had completed up-to-date training sessions on safeguarding. All staff who may care for children and young people must have up-to-date safeguarding training of both adults and children at risk and have the appropriate level of training for their role.

As young people can also be treated by adult services, it is also important that staff working in adult services also have the knowledge and skills to safeguard them effectively.

Recommendation 15

Health boards must ensure that staff working who may work with children and young people have up-to-date safeguarding training.

Quality of management and leadership

We found evidence of strong management and leadership at both Noah's Ark and Morriston ED.

Within Noah's Ark, we learned of the health board's ongoing pro-active recruitment campaign which had resulted in securing 45 new members of staff. However, we found that challenges remained in relation to ensuring sufficient staff numbers within the paediatric critical care unit. We were told that patients were not admitted to the unit unless there was a sufficient number of registered nurses present and staff (with relevant skills) were deployed to the unit from other ward areas to support the substantive team.

New staff received a comprehensive induction to Noah's Ark Hospital. However, we identified issues with the use of bank healthcare support workers on one ward, who were not familiar with children's services. This meant that permanent staff needed to pick up additional duties to support patients.

We found the staff team at Morriston ED were very aware of the challenges they faced in providing care and treatment to children and young people. We found that new staff received an appropriate induction to ensure they could care for patients effectively. Staff were working within an extremely busy environment and indicated that they weren't always able to meet all the conflicting demands on their time at work. The senior management team demonstrated a clear understanding of the issues and challenges facing the Morriston ED as a result of increased demands for unscheduled care services.

The Royal College of Paediatrics and Child Health standards for emergency care state that every emergency department treating children must be staffed with two registered children's nurses, and a minimum of two children's nurses per shift in dedicated children's emergency departments. However, one of the challenges faced at Morriston ED related to the insufficient numbers of paediatric nurses available to work within the designated children's area.
The health board indicated that it has actively tried to recruit into paediatric posts, but has been unsuccessful due to limited available workforce.

Recommendation 16

Health boards must ensure there are sufficient numbers of staff with the right skills to meet the needs of children and young people.

Supporting young people with life-limiting conditions receiving palliative care

We found hospices did well in the following areas:

- Feedback from patients, families and carers was positive.
- Hospices had an extensive range of facilities and programmes to enhance the well-being of children and families, including provision for older children and young people.
- Good support was available to families from hospice services, including emotional support and counselling services.
- Patients and their families told us that staff were kind, caring and treated them with dignity and respect.
- Young people and their families were involved in decisions about their care.
- Care was person centred and tailored to individual needs.
- There was evidence of good management and leadership at the hospices.

We identified hospices needed to improve in the following areas:

- Up-to-date environmental risk assessments and actions are addressed.
- Facilities to support people who use hearing aids.
- Young people and their families know how to raise a concern about their care.

Care for children and young people with life-limiting conditions and needing palliative care is unique and complex. These young people often become gravely ill and then make an unexpected recovery on several occasions before their death. Such episodes can be months apart, making the workload pattern different from adult care.[46]

What the evidence shows

In this section, in considering how young people with life-limiting conditions and needing palliative care are supported in Wales, we have primarily considered the evidence from our inspections of the two independent children's hospices, Tŷ Hafan and Tŷ Gobaith.

Quality of patient experience

Overall, patients and their families were very positive about their experiences of care within the Tŷ Hafan and Tŷ Gobaith children's hospices and rated the care and treatment as excellent.

Environment

We found hospice environments were thoughtfully designed, cheerfully decorated and well maintained.

Both hospices had an extensive range of facilities and programmes to enhance the well-being of children and families, including complementary therapy rooms, multi-sensory rooms, arts and crafts areas, play rooms and lounges. Both communal and private areas were provided where children and young people could spend time with staff and their families.

It was positive to find there were lounge areas specifically designed to meet the needs of older children and young people with age appropriate facilities and games, including computers.

Each patient had their own bedroom which was spacious and well maintained. Patients were able to personalise their rooms with their belongings, and beds were individualised to their specific needs for sleeping.

Tŷ Hafan had extensive refurbishment plans in place for the building, including bedrooms and communal areas. We identified some areas of improvement were needed around the development of overarching environmental risk assessments for the building and following through on actions in relations to fire safety order.

Recommendation 17

Service providers must ensure they have comprehensive and up-to-date environmental risk assessments and address any actions highlighted.

[46] https://www.togetherforshortlives.org.uk/changing-lives/speaking-up-for-children/policy-advocacy/transition-adult-services/

Support for families and carers

We found there was good support available to families from hospice services.

The hospices provide families, including siblings, with a range of emotional support and counselling services, including bereavement and family support.

As described above, where appropriate, families are involved in the care planning for the child/young person. Families also have access to a family support worker to discuss any concerns or wishes at any time.

During end-of-life care, the wishes of children/young people and their families are considered, and facilities are available to enable the child/young person to lay, after death, in peaceful surroundings and to afford his/her family and friends the opportunity to say their goodbyes in their own time and in their own way.

Dignified care

Patients and their families told us that staff were kind and caring. We observed very positive interactions between staff and patients, with staff supporting patients in a dignified and respectful manner.

We saw staff making efforts to protect patients' privacy and dignity when providing assistance with personal care needs.

Both hospices were respectful of the wishes of patients and their families for end-of-life care and were able to provide individualised arrangements in order to best meet these.

Patient information and communication

We found that a range of appropriate information was available for patients and their families within the hospice.

Both hospices had comprehensive statements of purpose and patient's guides as required under the Independent Health Care (Wales) Regulations 2011. This provided information for children, young people and their families on the services available.

We found good practice at Tŷ Hafan which had developed a 'family contract' which clearly laid out responsibilities and expectations of families and staff during their stay. Staff explained they would discuss this information with families to ensure all parties were clear about the arrangements in place to care and support them and their child during their stay.

Staff communicated with patients in a calm, friendly and cheerful manner. We found staff members to be friendly, approachable and committed to delivering a high standard of care to patients and their families/carers.

We were assured that where possible, the wishes, preferences and consent of children/young people would be sought and they would be involved in decisions about their care. Parents and carers would also be involved in care planning discussions as appropriate.

Both hospices considered the communication needs of patients on an individual basis, including availability of Welsh speaking staff so that patients and families could communicate in their language of choice. However, we found that hearing loops were not available to aid communication for those using hearing aids and we recommended services address this.

It was positive to see information boards displaying the staff on shift and who would be working in the evening as a good way to let children and families know who was caring for them.

Recommendation 18

Service providers must ensure there are arrangements to support communication needs of children, young people and their families, including facilities to support people who use hearing aids.

Timely care

We did not identify concerns regarding timely care during our inspections. We were assured the hospices had sufficient numbers of staff to be able to meet the needs of children and young people promptly.

What was less clear from our research was how children and young people with life-limiting conditions across Wales, including those in more rural location can access the right care and support when they needed it. The number of children who need support with life-limiting and palliative care is rising[47], however, there are only two dedicated children's hospices serving the whole of Wales. This means that young people may need to travel considerable distances for in-patient hospice and respite care. Whilst we understand that hospices also work closely with GPs and paediatric and palliative care teams to support children and young people whilst they are at home, this area would be worthy of further examination.

Recommendation 19

Welsh Government needs to assess any unmet demand for palliative care services to ensure children and young people across Wales get the care they need.

Listening and learning from feedback

It was clear that hospices were open and responsive to the views and feedback from children and families. We understood that the number of complaints received were low and the hospices aimed to address any issues raised promptly.

[47] https://www.togetherforshortlives.org.uk/changing-lives/speaking-up-for-children/policy-advocacy/transition-adult-services/

Complaints procedures were in place and patients and families were informed of these arrangements through the statement of purpose and patient's guide, in line with regulatory requirements. However, we did recommend that this information could be displayed more prominently and that details of HIW were included as the regulatory body, in relation to raising concerns about the service.

We were told about the arrangements in place to provide children and their families with access to advocacy services, if required.

Recommendation 20

Service providers need to be mindful of how they ensure young people and their families are made aware of how to raise a concern about their care.

Delivery of safe and effective care

Overall, within both hospices, we were assured that children and young people received safe and effective care. We found good practice around providing person centred care within both services.

We found evidence that comprehensive assessments of care needs were being undertaken and these were reviewed and updated on a regular basis. Care plans were also detailed with regular reviews and updates undertaken. We found that care plans were bespoke and reflected children's individual needs. Patients were involved in the planning and provision of their own care, as far as was possible. Where this was not possible, parents/carers were being consulted and encouraged to make decisions around care provision. Children and young people were encouraged to do as much for themselves as possible in accordance with their preferences and abilities.

Safeguarding children at risk

We found there were appropriate procedures and arrangements in place to safeguard children and young people. We were assured that staff had received the appropriate level of safeguarding training for their role and responsibilities.

We noted good practice around use of a safeguarding symbol on patient information boards to alert staff if there was a safeguarding plan in place for a particular child or young person.

In Tŷ Gobaith, which also provides services to young people over the age of 18 years, we found that Mental Capacity and Deprivation of Liberty Safeguards assessments were conducted as and when needed in relation to any patients over the age of 18 years.

Quality of management and leadership

Overall, we found good management and leadership at the hospices.

We found there was a multi-disciplinary approach to the provision of care with good communication processes in place between involved professionals. There was evidence of very good multi-disciplinary working between the nursing, medical staff and therapy staff. The hospices also worked with their health board palliative care teams to ensure appropriate support and care was provided to patients.

We found staffing levels were sufficient in order to meet the care needs of the patients accommodated. Additional staff would be allocated should patients be admitted with high levels of care needs. We found there were suitable arrangements in place to ensure that any bank or agency staff used were familiar with the working environment in order to be able to care for patients. Both hospices had a pool of additional staff to draw upon, who were already familiar with the service.

Transition from child to adult healthcare services

We found services did well in the following areas:

- Health boards were aware of national guidance and used this in their approach to the transition of young people from child to adult services.
- Young people would be supported by a named key worker.
- The age of transition typically followed NICE guidelines.
- Transition works well for young people with some specific conditions such as diabetes.
- Young people can attend joint appointments with child and adult services so they are introduced to adult service practitioners.

We identified services needed to improve in the following areas:

- Consistency in approaches around transition and mechanisms to ensure these are effective.
- Effective transition pathways and support for young people with complex health needs and life-limiting conditions.
- Sufficient time, resources and capacity to support effective transition including consistent and robust systems to identify and support young people who will need to transition.
- Review the differences between child and adult healthcare services and consider how young people can continue to receive care.
- Young people are involved in the planning, design and delivery of transition process and supported to adjust to adult services.
- Clarify policies on whether young people aged 16 and 17 should be treated within child or adult services, taking into account their wishes and needs.
- Review the practice and frequency of placing young people on non-designated adult mental health wards.

Why it's important

Transition from child to adult services can be particularly stressful for young people, particularly for those with complex, long-term/chronic conditions and mental health needs. Young people between the ages of 14 and 24 years are also likely to face multiple, concurrent transitions in other areas such as education and social support services. Last-minute arrangements around transition and feelings of uncertainty and helplessness all increase stress and can reverse the progress that has been made in their care[48].

What the evidence shows

In this section, we have considered evidence from self-assessments completed by all health boards in Wales around the range of healthcare services provided for young people and the systems to support young people who need to transition from child to adult services. We have also considered key guidance, research and reviews around transition.

Examples of good practice around transition have been included in Appendix B.

Key themes

From our research, we identified the following key themes and barriers to ensuring young people have a positive experience of transition:

Variation in approaches

We found transition arrangements varied across healthcare services and health boards in Wales. Although we were told that common guidance and principles applied, different specialities had different procedures around transition.

The Royal College of Nursing publication *'Lost in transition'*[49] recommends that each service area has an agreed transition policy in place which clearly outlines transitional care arrangements, and that all staff working with young people have specific training to facilitate transition between services. However, this does not appear to be always happening in practice.

Most health boards confirmed they had policies and guidance in place for transition, alongside local arrangements or stated that they followed national guidance, such as NICE guidelines and the T4CYP Good Transition Guidance for CAMHS. However, some services told us they did not have a protocol or set of guidelines to support transition arrangements. Several health boards cited work to develop pathways for transition. Whilst others told us they had agreed transition pathways, but these were not always formalised and may vary between specialities.

Health boards told us there is flexibility within their policies for transition, but acknowledge that age restrictions apply in some specialties. We have discussed this further below under 'age of transition'.

[48] https://www.togetherforshortlives.org.uk/changing-lives/speaking-up-for-children/policy-advocacy/transition-adult-services/

[49] Royal College of Nursing – Lost in transition: moving young people between child and adult health services 2013 https://www.rcn.org.uk/professional-development/publications/pub-003227

Recommendation 21

Welsh Government and health boards must ensure there are clear transition pathways and policies in place for each service area. Where possible, there should be consistency in approaches to transition in line with national guidelines.

Systems to monitor the effectiveness of transition

We received mixed feedback from health boards on how transition policies or pathways are monitored or reviewed to ensure they are effective. Generally, health boards confirmed they had a system in place to review policies regarding transition. However, these seem to sit within the different specialties, rather than having a higher level oversight across specialties or clinical areas. Some health boards stated they had working groups looking at transition pathways.

Overall, it appears more work is needed by health boards to ensure there is effective governance around transition pathways across all services where this takes place.

Recommendation 22

Health boards must ensure there are robust systems to monitor transition policies and pathways across healthcare services to ensure approaches are effective.

Coordination of transition

We were told that effective transition is time consuming for involved professionals. Due to timescales and limited capacity within services, we learned there can be difficulties in coordinating relevant agencies and professionals to engage in the transition process. As a result, several health boards mentioned difficulties with attendance at multi-disciplinary meetings and in joint working with housing and local authorities.

Capacity for adult services to engage in transition planning at an early stage can also be challenging. We learned that the timescale for some adult services to commence their involvement with young people can be close to their 18th birthday, which gives very little time for in-depth assessments to be completed and for therapeutic relationships to be built.

All health boards told us they have joint working practices, including transition meetings, to allow for the sharing of expertise between child and adult health services, but acknowledged that practice varies between services.

In terms of support for young people during their transition, health boards confirmed that young people with specific health needs would be supported by a named key worker to coordinate their care in line with NICE guidance. However, there appears to be variation in how this is communicated with young people and their families and a lack of a formalised system to do this. We were also told there can be delays in allocating a key worker in some areas due to issues with resources, capacity and identifying a professional best placed to do this. Some services felt that a designated role of a transition coordinator for each health board would help to overcome some of these issues.

Recommendations 23-24

Welsh Government and health boards must ensure there are sufficient resources and capacity to support effective and timely transition.

Health boards must ensure a named key worker to coordinate transition is identified promptly and consider how to best support transition, including considering designated roles.

Involvement of young people

Across Wales, there appears to be no formal and consistent mechanism to involve young people in monitoring or reviewing the effectiveness of transition pathways and policies. Some health boards said they had plans to engage young people in the future within some services once transition pathways had been developed. However, the majority of health boards said a formal approach to involving young people in reviewing transition had not yet been developed.

The Children's Commissioner for Wales[50] emphasises the need for services to take a 'children's rights approach', empowering children and young people to make choices and to affect outcomes for themselves and to involve them in the design, monitoring and evaluation of services. The Royal College of Nursing also highlights that services need to be flexible and may need to be redesigned to truly meet the needs of young people, including involving young people in co-designing services. Furthermore, a Care Quality Commission report[51] on children's transition in England, highlights the importance of services listening and learning from young people and their families as they know what works and what goes wrong and services need to learn from their experiences.

Most health boards said young people are involved in their own transition process, typically through attending multi-disciplinary meetings about their care. For young people within CAMHS, we were told they would be involved in transition arrangements through discussion regarding their care and treatment plan. The majority of other health boards said they have regular meetings, involving young people and other agencies. However, they acknowledged there is some variation across individual services.

The Royal College of Nursing also highlights young people should receive support and education to prepare them to cope with transition. Particularly as research with young people across Europe has found that many find it difficult to adjust to the increased responsibility for care they are given in adult services.[52]

[50] Children's Commissioner for Wales: The right way – a children's rights approach in Wales https://www.childcomwales.org.uk/publications/right-way-childrens-rights-approach-wales/

[51] Care Quality Commission From the pond into the sea: children's transition to adult health services 2014 https://www.cqc.org.uk/publications/themes-care/transition-arrangements-young-people-complex-health-needs-children%E2%80%99s-adult

[52] European Observatory on Health Systems and Policies 2014 – European Child Health Services and Systems. Lessons without borders http://apps.who.int/iris/handle/10665/128707

Recommendations 25-26

Health boards must ensure they have a formal systems for involving young people in the design and delivery of transition processes and learn from their experiences.

Health boards must ensure young people are involved in the planning and transition process and are provided with adequate support to enable them to adjust.

Age of transition

There is variation across services and health boards regarding the age at which transition usually starts. Although NICE guidance states there should be no arbitrary age for transition, in practice, age appears to be the main determinant of transition.

NICE guidelines also state that transition should be planned as early as possible and recommend this takes place by school year 9 (13 or 14 years old) as this can lead to a better experience for young people. The majority of health boards said transition typically begins at age 14, however, this may also begin at age 16, 17 or 18 years old in some services. It was acknowledged that the transition for young people with the most complex care needs will be over a longer period of time and may begin at an earlier age. Although we were told the age of transition is dependent upon individual needs and the type of service, many services aim for full transition by the age 18. The Royal College of Nursing guidance recommends that the timing and duration of transition is negotiated with the young person and agreed by all relevant parties. However, as described further above, we are aware of some cases when the period of transition can be very short, taking place shortly before young people reach the age of 18.

The age at which child and adult services stop and start can also be a barrier for smooth transition. A Care Quality Commission report[53] into transition arrangements for young people with complex health needs in England found that some children's services cease providing care before the equivalent adult services have started. In Wales, an example of this can be seen in mental health, where adult mental health services generally do not accept young people below the age of 18 years. However, a number of young people may need to transition before the age of 18, whilst others aged 18 and over would benefit from remaining within CAMHS for longer.

Furthermore, a recent Aneurin Bevan CHC report has stated that '…young people had a feeling that the system would delay helping them until they turned 18 as then they would go to adult services and would no longer be the responsibility of CAMHS.'[54]

[53] Care Quality Commission 2014 – Transition arrangements for young people with complex health needs from children's to adult services https://www.cqc.org.uk/publications/themes-care/transition-arrangements-young-people-complex-health-needs-children's-adult

[54] http://www.wales.nhs.uk/sitesplus/documents/901/Child%20and%20Adolescent%20Mental%20Health%20Services%20in%20Gwent%20September%202018.pdf

Recommendations 27-28

Health boards must ensure there is sufficient time to allow for effective transition and planning starts as early as possible.

Health boards need review the practices where transition starts later, particularly for services where this starts after the age of 16 and align with national guidelines.

Transition of young people with complex health needs

We found a somewhat mixed picture in relation to transition for young people with complex health needs. We were told that transition works very well for a small number of patient groups, for example children with diabetes and HIV. The transition of young people with particular conditions is also supported by a range of guidance and condition specific delivery plans[55]. However, in practice, particularly for young people with complex needs, this can be more fragmented.

During our inspections of Noah's Ark Hospital in 2015 and 2017, we found many instances where patients with complex needs (who were over the age of 16) continued to experience fragmentation in their care and support at times when they required hospital in-patient care and treatment. Although in 2017, we found parts of the children's services had well established and effective transition arrangements in place for children with some long-term conditions, in general, transition arrangements needed to be more efficient and supported by good communication between relevant professionals and agencies.

In our inspection of Tŷ Hafan, staff explained that a barrier to young people getting appropriate palliative care when transitioning to adult services is that the number of young people needing paediatric palliative care is small compared to a much larger population of older adults, particularly with an aging population. Therefore, there is not the same demand for services to provide this type of specialist support. Furthermore, many adult services lack the resources, knowledge, understanding to meet the palliative care needs of these young people.

The *Together for Short Lives* charity has produced a number of resources and guides around transition of young people with life-limiting conditions[56]. The charity describes that 'For young people with life-limiting conditions, making the transition from children's to adult services is like falling off a cliff edge'. It also highlights the growing numbers of young people with life-limiting conditions as a result of medical advances. *Together for Short Lives* also emphasise that young people with life-limiting conditions have specific needs which differ from both younger children and older adults. However, they also report there is a lack of age and developmentally-appropriate palliative care services which can meet this growing demand. The transition these young people have to undergo from the comprehensive care offered by children's palliative care to unfamiliar adults' services can be daunting and is often not joined up.

[55] https://gov.wales/topics/health/nhswales/plans/?lang=en

[56] Together for short lives – Preventing the transition cliff-edge and securing the right care for young people https://www.togetherforshortlives.org.uk/changing-lives/speaking-up-for-children/policy-advocacy/transition-adult-services/

Recommendation 29

Welsh Government and health boards need to ensure there are appropriate transition pathways and support for young people with complex health needs and life-limiting conditions.

Getting lost in transition

We found the systems to identify young people who will need to transition varied across specialties and health boards. We also found that the arrangements to follow-up if young people missed appointments with adult services was also inconsistent.

In line with NICE guidance, most health boards confirmed that joint visits/appointments take place so that young people can meet practitioners from adult services during the transition period, but this varied between specialties.

In terms of ensuring that a young person needing transition is identified, attends their first appointment with adult services, and does not get 'lost in transition', we found there was no consistent formal 'flagging' system to monitor this. Health boards rely on practitioners and service meetings within individual specialities involved to do this. Some services felt that an IT system is needed across services to help identify these young people.

We learned of occasions where young people were discharged from adult services due to not attending appointments and this not being communicated to the paediatric service. Furthermore, in feedback from occupational therapy services, we learned that young people who are 'lost' in the transition to adult health services are more likely to present later with avoidable and treatable complications of their conditions.

The Royal College of Nursing guidance highlights the need for service providers to examine the way transition services are delivered. The guidance highlights that in order to reduce missed appointments and engage young people in their own treatment, services should be accessible and acceptable to these patients. For example, drop-in clinics and online information can make a service more accessible and approachable.

Concerns around discharge practices of services and responses to missed appointments were also identified in the HIW and Wales Audit Office joint follow-up review of child and adolescent mental health services in 2013[57]. This report identified that young people continue to be routinely discharged if there is no response from families / young people following a missed appointment with adult services. There was also found to be little evidence that the risks of discharging the young person were assessed or that clear communication routinely takes place with other agencies involved in their care.

Whilst it appears health boards are aware of the importance of ensuring that young people don't get lost in the system, and are not simply discharged for not attending appointments, it appears this can still be an issue.

[57] Healthcare Inspectorate Wales and Wales Audit Office – Child and Adolescent Mental Health Services: Follow-up Review of Safety Issues – 2013 http://hiw.org.uk/reports/natthem/2013/?lang=en

Recommendations 30-31

Health boards must ensure there are consistent and robust systems identify young people who will need to transition and support for attending appointments in adult services.

Health boards must ensure that adult services make every effort to engage with young people and communicate with other involved agencies, to ensure they can successfully transition.

Differences between child and adult services

We found that differences between the service models and provision within paediatric services and adult services can be another barrier for transition.

For example, there can be differences in service thresholds for support, meaning a young person who was supported by children's services, may no longer receive the same support in adult services. In our inspection of Tŷ Hafan, staff described that young people may not be eligible for support form adult palliative care, such as respite care, as the model of care is different. Furthermore, the environment within an adult hospice may not be appropriate to adequately meet the needs of a young person during end-of-life care.

There may also be a lack of an equivalent adult service for a young person to transition to, particularly for those with complex needs. We were also told that once a young person transitions to adult services it is on the basis of clinical speciality as opposed to a holistic approach to care.

Another key difference between paediatric and adult services is the involvement of parents and carers, which is not typically encouraged in the same way in adult services. We found the roles of parent's and carer's can change dramatically once a young person is in adult services which can be challenging to adjust to. NICE guidance also states that parents and carers should be involved in planning for transition to ensure they feel involved and know about future changes to services and care that the young person will receive.

Recommendations 32-33

Welsh Government and health boards need to review the differences between service models and thresholds between child and adult healthcare services and consider how young people can continue to receive holistic care and support into adulthood.

Health boards must ensure that parents and carers are sufficiently involved in transition planning.

Treatment of young people aged 16 and 17 years

There appears to be variation in how young people aged 16 or 17 years old are treated across healthcare services in Wales. This appears to depend upon the location and type of service they need. Some health boards told us there was no definitive policy on whether young people of this age should be treated within child or adult services as this may be dependent on their needs, consideration of the young person's choice and services available. Others

stated young people of this age would be referred to adult services, unless they are known to paediatric services. Clarity and consistency is needed across health boards and services on the approach to treating young people of this age group.

General healthcare services

Although young people may be given the choice about whether to be nursed on an adult or paediatric ward, this may not always be possible. We were told this may be affected by limited capacity and different admissions criteria for services.

In some areas, we learned that regional specialist paediatric teams will cease provision once a young person turns 16 years of age; some 16 and 17 year olds may therefore be cared for on adult wards. Health boards said they would consider the suitability of the accommodation within adult wards, such as providing a single bedroom, and carry out a risk assessment to ensure their safety and wellbeing.

We also found occasions when emergency departments find it difficult to locate suitable beds for young people aged over 16 years with acute health problems. We were told this can be because of strict adherence to admission policies for paediatric services and the inappropriate accommodation available within adult wards. In our inspection of Morriston ED, we highlighted the need for improved and timely transition of care arrangements for children who need to access adult services.

Generally, health boards do not have specific in-patient beds for young people, with the exception of some specific services such as CAMHS and the Teenage Cancer Trust. Typically, health boards said they did tend to group young people together within paediatric wards. However, from health board responses, it was unclear how they would monitor the need and provision of these beds.

To ensure that young people are cared for by appropriately trained staff when treated on adult wards, health boards confirmed that advice and support would be available from paediatric services. However, it was less clear how health boards ensure these arrangements worked effectively in practice. Health boards need to ensure staff, including those working in adult services, have the right skills to be able to care for young people.

A study[58] looking at the experience of young people aged 14 to 18 in England highlighted that young people feel that nurses in adult environments are unable to cope with their specific needs.

Mental health services

For mental health services, the Welsh Government's admissions guidance[59] and the T*ogether for Mental Health strategy* state that young people should not be admitted to adult mental health wards except in the most exceptional circumstances. This decision should be based on clinical needs, risk and wishes of the young person and should only be considered as a last resort.

[58] Dean and Black: Exploring the experiences of young people nursed on adult wards. Br J Nurs. 2015 Feb 26-Mar 11;24(4):229-36 https://www.ncbi.nlm.nih.gov/pubmed/25723268

[59] https://gov.wales/topics/health/nhswales/mental-health-services/policy/child-mental/?lang=en

Some health boards confirmed that young people of this age should not be accepted onto adult wards and arrangements are in place for them to be treated within a specific age appropriate area or 'designated bed' if required. However, in some circumstances due to urgency, acuity and capacity within CAMHS units, we are aware that young people can be placed on adult mental health wards. Health boards confirmed that maintaining the young person's safety and that of others, is the primary concern.

The HIW and WAO report on CAMHS highlighted that whilst it was common practice for health boards to have 'designated beds' within adult wards, some young people are still being placed on non-designated adult wards, if the designated beds are unavailable. It appears that this remains an issue and we have seen instances of young people being placed on non-designated adult wards in the last year through the serious incidents reported on Welsh Government. To date, since April 2018, there have been a total of 37 admissions of young people to adult mental health wards. This means that young people may be placed in unsuitable environments which may not meet their needs.

However, whilst there is reporting of underage admissions to adult mental health wards, there appears to be no such incident reporting category for young people treated on adult wards for physical health needs. Therefore, there is a lack of information on the scale and frequency of this issue across Wales.

Recommendations 34-37

Health boards must ensure there is clarity across services about how all young people aged 16 and 17 should be appropriately treated, including how they will ensure staff have the right skills to care for them.

Welsh Government needs to ensure there is clear guidance about how young people under 18 years of age, should be treated when needing care for physical health needs.

Welsh Government and health boards must review the practice and frequency of placing young people on non-designated adult mental health wards.

Welsh Government needs to consider the reporting and monitoring of underage admissions on adult (non-mental health) hospital wards to ensure there is oversight on this issue across Wales.

5. Conclusions

Although this review has identified a range of issues young people experience in healthcare across Wales, it was positive to find young people had predominately good experiences of care within in-patient services. It was also evident that services are provided by hard-working and dedicated staff who are passionate about providing care centred on young people's needs.

However, we are concerned about the current ability of CAMHS units across Wales to accommodate young people who are high risk, meaning some need to be placed out-of-area. This is not acceptable and we believe Welsh Government needs to take firm steps to address this problem on an all-Wales basis. Furthermore, the ongoing practice of admitting young people onto adult mental health wards (designated or non-designated) for assessment and/or treatment suggests further examination is required around the suitability of services to meet the needs of young people. With the recent Welsh Government announcement of an additional £7 million in funding[60] to improve the mental health of children and young people in Wales, there may be scope to use some of this additional funding to address the issues that we have highlighted.

It was disappointing to find that many of the issues around transition and the treatment of young people under 18 years of age which are well known, still appear to be present. Health boards must take responsibility for ensuring there are clear transition pathways across all services they provide and have robust systems for monitoring their effectiveness, with the involvement of young people.

Although there are a number of good examples where care and transition have worked well, we are concerned about the inconsistencies across health boards and service areas. This means that young people can experience fragmented care and may get 'lost in transition'. Effective coordination between services is vital to ensure young people have smooth transition. It should not be left up to young people to navigate their way between different services. Furthermore, it is important Welsh Government and health boards consider how services can be designed and delivered to remove the barriers to transition which the system creates, such as age restrictions and differing service models.

Our review has also highlighted that more work is needed to consider how young people with complex needs and life-limiting conditions can be better supported when transitioning between child and adult services. Whilst not included in this review, it also appears there is little known about transition for young people with learning disabilities.

We also found that whilst there has been considerable attention on admission of young people on adult mental health wards, there is not the same attention on young people who are placed in general adult hospital wards. For example, finding in-patients beds for young people who attend emergency departments for acute physical conditions. We believe this is an area which should be formally monitored across Wales.

[60] https://gov.wales/newsroom/health-and-social-services/2019/mental-health/?lang=en

This review further highlights the need for all-Wales guidance on transition and the care of young people, particularly those aged 16 and 17 years. We welcome the draft guidance around this which is currently being developed by Welsh Government which we hope will provide some much needed clarity to services across Wales.

6. What next?

We expect the Welsh Government, health boards and independent service providers to carefully consider the findings from this review and our recommendations set out in Appendix A.

Welsh Government is also asked to consider the issues we have highlighted around transition in the development of their guidance on provision of health care services for 16 and 17 year olds and handover of health care from children's to adult services.

Given the concerns we have raised around CAMHS in-patient unit provision, Welsh Government is asked to review the current arrangements to meet the needs of young people in Wales.

The following areas were not included in our review, but would benefit from further examination by other bodies:

- Continuing health care funding when a young person transitions between child and adult services.
- Sexual health and maternity care for young people.
- Transition arrangements for young people with learning disabilities.
- Capacity within services to support children in Wales with complex and life-limiting conditions, including those living in more rural locations in Wales.
- Review of underage placements of young people with physical health need on adult hospital wards.
- Detailed review of out-of-area placements of young people with mental health need and young people with complex physical health needs.

HIW will also consider the areas touched upon during this review around the support for young people in mental health crisis, as part of a wider thematic in 2019-2020 around mental health crisis services.

As part of the work being undertaken by Inspection Wales, HIW will help bring together key findings around services for young people to evaluate how they support young people's healthy development, wellbeing, and access to education and employment.

Appendix A

Recommendations

As a result of the findings from this review, we have made the following overarching recommendations which we expect, Welsh Government, all health boards and independent service providers to address.

No	Recommendations	Health and Care Standards (2015)
1	Health boards and service providers must ensure environments protect the safety and wellbeing of young people. There must be robust systems in place to monitor risks within the environment and ensure maintenance work is conducted in a timely way.	2.1 Managing risk and promoting health and safety
2	Health boards and service providers must ensure there is clear communication with young people to help them understand their treatment.	3.2 Communicating effectively 4.2 Patient information
3	Welsh Government, health boards and service providers need to improve the communication with, and information available for, young people and their families at the point of referral.	3.2 Communicating effectively 4.2 Patient information
4	Welsh Government needs to consider the capacity within CAMHS services across Wales to ensure this meets the needs of young people, including those who are high risk.	3.1 Safe and clinically effective care
5	Welsh Government and health boards need to review the waiting times for CAMHS services, ensure there are timely referrals to other organisations to support young people and how young people can access support at times of crisis.	5.1 Timely access
6	Health boards and service providers must ensure there is clear information for young people on advocacy services and flexibility to enable young people to meet with advocacy services at a time of their choice.	4.2 Patient information 6.2 People's rights
7	Health boards and services providers must ensure young people know how to raise a concern.	6.3 Listening and learning from feedback

No	Recommendations	Health and Care Standards (2015)
8	Health boards and service providers must ensure that: • Patient records, care planning and statutory mental health documentation are comprehensive, accurate and completed in a timely manner. • Emergency clinical items, including ligature cutters can be located without delay. • Staff have sufficient knowledge on how to support and monitor patients before, during and after mealtimes. • Any restraint must be carefully considered, risk assessed and monitored, with the involvement of the young person to ensure their safety, rights and dignity are protected as much as possible.	3.5 Record keeping 2.1 Managing risk and promoting health and safety 3.1 Safe and clinically effective care 4.1 Dignified care 6.2 People's rights
9	Health boards and service providers must ensure CAMHS staff have up-to-date safeguarding training.	2.7 Safeguarding children and safeguarding adults at risk
10	Welsh Government, health boards and service providers must consider how issues around workforce within CAMHS units can be addressed to ensure young people receive care from the right staff with the rights skills to meet their needs.	7.1 Workforce
11	Health boards must ensure that children and young people can consistently be treated within designated areas.	2.7 Safeguarding children and safeguarding adults at risk 3.1 Safe and clinically effective care
12	Health boards must ensure young people consistently receive timely care and treatment within emergency departments and for emergency invasive procedures.	5.1 Timely access
13	Health boards must ensure that young people know how they can raise concerns about their care within hospitals.	6.3 Listening and learning from feedback

No	Recommendations	Health and Care Standards (2015)
14	Health boards must ensure that paediatric risk and pain assessment documentation is comprehensive and completed in a timely manner.	3.5 Record keeping
15	Health boards must ensure that staff working who may work with children and young people have up-to-date safeguarding training.	2.7 Safeguarding children and safeguarding adults at risk
16	Health boards must ensure there are sufficient numbers of staff with the right skills to meet the needs of children and young people.	7.1 Workforce
17	Service providers must ensure they have comprehensive and up-to-date environmental risk assessments and address any actions highlighted.	2.1 Managing risk and promoting health and safety
18	Service providers must ensure there are arrangements to support communication needs of children, young people and their families, including facilities to support people who use hearing aids.	3.2 Communicating effectively
19	Welsh Government needs to assess any unmet demand for palliative care services to ensure children and young people across Wales get the care they need.	Governance, leadership and accountability
20	Service providers need to be mindful of how they ensure young people and their families are made aware of how to raise a concern about their care.	6.3 Listening and learning from feedback
21	Welsh Government and health boards must ensure there are clear transition pathways and policies in place for each service area. Where possible, there should be consistency in approaches to transition in line with national guidelines.	6.1 Planning care to promote independence Governance, leadership and accountability
22	Health boards must ensure there are robust systems to monitor transition policies and pathways across healthcare services to ensure approaches are effective.	3.1 Safe and clinically effective care 3.3 Quality improvement, research and innovation

No	Recommendations	Health and Care Standards (2015)
23	Welsh Government and health boards must ensure there are sufficient resources and capacity to support effective and timely transition.	6.1 Planning care to promote independence
24	Health boards must ensure a named key worker to coordinate transition is identified promptly and consider how to best support transition, including considering designated roles.	3.1 Safe and clinically effective care 5.1 Timely access
25	Health boards must ensure they have a formal systems for involving young people in the design and delivery of transition processes and learn from their experiences.	6.1 Planning care to promote independence 6.3 Listening and learning from feedback
26	Health boards must ensure young people are involved in the planning and transition process and are provided with adequate support to enable them to adjust.	6.1 Planning care to promote independence
27	Health boards must ensure there is sufficient time to allow for effective transition and planning starts as early as possible.	6.1 Planning care to promote independence 5.1 Timely access
28	Health boards need review the practices where transition starts later, particularly for services where this starts after the age of 16 and align with national guidelines.	3.1 Safe and clinically effective care
29	Welsh Government and health boards need to ensure there are appropriate transition pathways and support for young people with complex health needs and life-limiting conditions.	3.1 Safe and clinically effective care 6.1 Planning care to promote independence
30	Health boards must ensure there are consistent and robust systems identify young people who will need to transition and support for attending appointments in adult services.	3.4 Information governance and communications technology 6.1 Planning care to promote independence
31	Health boards must ensure that adult services make every effort to engage with young people and communicate with other involved agencies, to ensure they can successfully transition.	3.2 Communicating effectively 6.1 Planning care to promote independence

No	Recommendations	Health and Care Standards (2015)
32	Welsh Government and health boards need to review the differences between service models and thresholds between child and adult healthcare services and consider how young people can continue to receive holistic care and support into adulthood.	3.1 Safe and clinically effective care 6.1 Planning care to promote independence
33	Health boards must ensure that parents and carers are sufficiently involved in transition planning.	6.1 Planning care to promote independence
34	Health boards must ensure there is clarity across services about how all young people aged 16 and 17 should be appropriately treated, including how they will ensure staff have the right skills to care for them.	Governance, leadership and accountability 3.1 Safe and clinically effective care 7.1 Workforce
35	Welsh Government needs to ensure there is clear guidance about how young people under 18 years of age, should be treated when needing care for physical health needs.	Governance, leadership and accountability 3.1 Safe and clinically effective care
36	Welsh Government and health boards must review the practice and frequency of placing young people on non-designated adult mental health wards.	Governance, leadership and accountability 3.1 Safe and clinically effective care
37	Welsh Government needs to consider the reporting and monitoring of underage admissions on adult (non-mental health) hospital wards to ensure there is oversight on this issue across Wales.	Governance, leadership and accountability 3.1 Safe and clinically effective care

Appendix B

Examples of good practice around transition

Although we have identified some key issues around transition, during our review, we were told of examples of good practice where transitions has worked well. Several health boards also cited transition projects in place for improving experiences for young people.

In accordance with the all-Wales transition guidance[61], several health boards talked about the development of a transition passport for young people transitioning from CAMHS to adult services.

We were told that Tŷ Hafan has a transition worker in place to support young people and families to transition from paediatric to adult health and social care services. Tŷ Hafan continue to support young people up to the age of 25 years, excluding residential stays, and facilitates peer support groups for 16 to 25 year olds. Tŷ Hafan would also support families in discussions regarding the arrangements for continuing health care needs for young people as well as linking with agencies for independent living and legal advice for power of attorney.

Powys Teaching Health Board told us it has received funding to further develop the key worker model to support and coordinate services for children and young people with complex needs to enhance the coordination between child and adult services.

Hywel Dda University Health Board explained it operates a single point of access for all mental health referrals where young people would be signposted to a service that best suits their needs, such as primary care, counselling, or CAMHS. We understand that other health boards have similar models in place or in development.

Hywel Dda University Health Board also gave an example of the role of the WellChild Transitional Care Nurse who facilitates transition to adult community practitioners.

Betsi Cadwaladr University Health Board told us there have been some very proactive positive transition cases for learning disabilities, young people with physical complex health needs and a young CAMHS case. Multi-disciplinary teams worked together to meet the needs of individuals by coordinating all agencies. In particular, we heard that the community rehabilitation team in Wrexham are good at engaging with young people to support them in transition.

Cwm Taf University Health Board gave an example of the effective transition of a young person with a learning disability and palliative care needs which was led by a Palliative Care Nurse Specialist. The Nurse Specialist arranged regular meetings that involved adult services from both health and the local authority. Meetings were also arranged with senior nurses in acute areas and the family were invited to visit and attend transition meetings. With this level of support, education and training, a successful transition to a local authority day centre was facilitated.

[61] http://www.goodpractice.wales/SharedFiles/Download.aspx?pageid=185&mid=326&fileid=752

Cwm Taf University Health Board also talked about agreed epilepsy pathways. We learnt that transition conversations are initiated with the young person and their families around 14 to 15 years of age with a plan to facilitate attendance to the transition clinic around their 16th birthday. The transition clinics are run jointly by paediatrician, paediatric epilepsy nurse specialist and adult neurologist, adult epilepsy nurse specialist and wider professional teams as may be appropriate for an individual patient.

Cardiff University Health Board told us that a multi-agency group has been set up to agree processes and improve transition for children with complex needs and disability. The health board also have an All Wales lead for transition in palliative care who works with specialist paediatric and adult palliative care teams as well as children and adult hospices, to improve transition of young people with life-limiting conditions. The health board cited examples of transition working well in specific long-term conditions, including the following:

- For young people with diabetes, a teenage diabetes clinic is being run in conjunction with adult diabetes services. It is attended by a Diabetologist from adult services and Diabetic Specialist Nurse from adult services as well as the paediatric team. Diabetes services have appointed a youth worker who will follow patients through transition aged 16 into adult service.
- For young people with heart disease, congenital heart disease services have a dedicated transition service. Young people attend joint clinics run by both paediatric transition and adult health professionals.
- For young people with cancer, at age 14, they transition from paediatric oncology to the Teenage Cancer Trust where they are cared for from the age of 14 to 24 years. There is joint working between both services during this time.

Abertawe Bro Morgannwg University Health Board told us that within paediatric services, there are databases to identify children and young people with chronic and complex needs who will need to transition to adult services. These cases are then discussed and a plan agreed between teams involved.

Aneurin Bevan University Health Board described the 'Ready, Steady, Go' model which is in development and will support the assessment of the young person's maturity and 'readiness' for transitioning to adult services. This model will assist clinicians in assessing whether the young person is ready for transition and how best they can be supported.

Aneurin Bevan University Health Board also described clinics for young people with specific conditions such as diabetes which involve both adult and children's specialists. These clinics provide opportunity for sharing expertise and practice whilst working in collaboration to meet the needs of the young person. We also heard that transition nurses within specialist services provide good support to young people.

Quality Safety Experience (QSE) Committee **19.11.19**	 ***To improve health and provide excellent care***

Report Title:	Mental Health Services – Quality & Performance Assurance Report
Report Author and contributions:	Steve Forsyth, Director of Nursing, Operations and Service Delivery MHLD Dr Adrian Jones Assistant Director of Nursing Lesley Singleton Director of Partnerships Hilary Owen Head of Governance Llinos Edwards, Service Improvement Facilitator.
Responsible Director:	Mr Andy Roach, Director of Mental Health and Learning Disabilities
Public or In Committee	Public
Purpose of Report:	To provide an update on Mental Health and Learning Disability Services, importantly sharing the Division's progression and celebrations and highlighting where there are opportunities to continue to improve.
Approval / Scrutiny Route Prior to Presentation:	Updates on Mental Health and Learning Disability Services are approved by Divisional Directors
Governance issues / risks:	Risks highlighted in this report include: • Benchmarking Information from findings of Cemlyn Ward, Cefni Hospital • Heddfan bedroom doors • Ward Accreditation - Gwanwyn ward
Financial Implications:	The service is striving to deliver its objectives within the core budget, supported by new additional Welsh Government (WG) funding
Recommendations:	The Committee is asked to note: 1. The progress that is being made to Mental Health and Learning Disability Services, specifically as requested in relation to: • Benchmarking information against the Cefni report • NHS Benchmarking local analysis • The analysis of mortality in West area team [Gwynedd] and early findings and update on mortality as a result of incidents across the MHLD Division • Position in relation to MHLD policies and procedures • Trajectories for implementation of the Together for Mental Health strategy and operational plan 2. In addition the report also updates QSE Committee on

	• Improvements and compliance with Mental Health Measure • Lessons Learned from incidents • Recent HIW inspections & outstanding actions 3. The risks that are identified are being managed through locality structures and overseen by Divisional Directors 4. Trajectories for implementation of Together for Mental Health Strategy

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

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

Mental Health and Learning Disability Services

1.0 Purpose of exception report

To provide the Committee members with a full report on the quality and performance assurance metrics in place within Mental Health and Learning Disability Services (MHLDS).

2.0 Summary of Significant Quality and Safety Issues

Cemlyn Ward, Cefni Hospital

QSE Committee were updated through a recent exception report on the issues identified within Cemlyn Ward, Cefni Hospital as reported in September 2019. In summary, there were a number of safeguarding/adult at risk incidents reported. In response, led by the locality Triumvirate, supported by Divisional Directors, a Cefni Improvement action plan developed incorporating recommendations from the Cefni safeguarding Desk Top Review completed April 2019.

Products from this work include; improvements in compliance with training; improvements in family/ carers relationships with the ward, including opportunities to feedback concerns and compliments; changes to the environment in order to ensure compliance with Ward Accreditation and improvements around communication on the ward and with the wider Division. Cemlyn is reaffirming a Multi-Disciplinary Team (MDT) approach to admission, treatment, care planning, risk formulation and mitigation, and discharge. The action plan is reviewed monthly, via multi-disciplinary Cefni development group.

Cemlyn ward, Cefni Hospital was subject to an unannounced Healthcare Inspectorate Wales inspection on 16/17/18 September 2019. Inspectors reported that the inspection was part of the scheduled programme but was also taking place due to the recent WG reported issues. The review would focus on three main areas:

- Quality of experience
- Delivery of safe and effective care
- Quality of management and leadership

During informal feedback, Healthcare Inspectorate Wales (HIW) reported a positive inspection with no serious issues and no actions for immediate assurance. Their report for factual accuracy is expected within the next three months. The Division has already commenced action planning following their feedback.

Heddfan Bedroom Doors, Heddfan Unit

This report will not repeat the issues in relation to the Heddfan doors presented to QSE Committee in September 2019 but will provide an update. Since September 2019 Heddfan was impacted by six bedroom door failure mechanism issues identified with damage associated with the door component, door frame or door. We

have with Estates colleagues determined a solution for the continued disruption caused to the environment due to the doors not withstanding force.

Five of the doors have been repaired/replaced and the sixth door will be reconfigured to enable this to be opened outwards, with a view to rolling this out should this design prove successful.

There was a further incident on Tryweryn ward (PICU) October 2019, which resulted in the further decommissioning of two bedrooms. At the current time there are four bedrooms decommissioned from use.

Until the Heddfan unit reaches a stage of no further door failure mechanism, weekly checks of the doors remain an ongoing governance requirement for the east Senior Leadership Team. The risk remains at 15 due to the awareness that the risk of entrapment does not always correlate to fully functioning bedroom doors.

Gwanwyn Ward, Heddfan Unit

Gwanwyn ward, Heddfan Older Person's Mental Health (OPMH) received a BCUHB ward accreditation visit during October 2019 and was awarded a white rating. The locality senior leadership team have developed a Gwanwyn Improvement Group with a full set of actions to ensure standards are improved and progress made. Objectively, Gwanwyn ward has been subject to an unannounced Dementia Care Mapping exercise and the summary statement shows the ward is making progress *"following the critical report from the mapping exercise in September [2019] there has been a dramatic improvement. This unannounced mapping exercise today [22nd October 2019] found the highest recorded levels of engagement and well-being since the ward commenced mapping in 2013. The change in the physical environment and focus on interaction and meaningful activity is astonishing".*

Wrexham Community Mental Health Team

An internal MHLD Division/Wrexham Local Authority review has reported for Wrexham Community Mental Health Team (CMHT) in October 2019. The CMHT is supported by temporary agency staffing due sickness absence [both health and the Local Authority]. An action plan is being developed to address issues from the internal review and QSE will be updated.

2.1 Areas of Improvement

The Division continues to show that we are a good place to work and engage with innovation and new ways of working.

Key highlights include:

- Winner of the Nursing Times team of the year award 2019
- 2 finalists for Nursing Times Awards 2019
- I CAN Mental Health Urgent Care Centres to support people in crisis who do not require medical treatment or admission – since January 2019, service has supported >1700 people

- Currently piloting ICAN Work programme in partnership with Bangor University, CAIS and RCS
- Introduced I CAN Mental Health Awareness Training with 1500 people signed up to receive the training
- The innovative work of the Positive Intervention Clinical Services has led to assaults on staff reduced by almost 50% in the last five years
- Royal College of Psychiatrists Memory Services National Accreditation Certificate awarded to west area memory services
- Worked with Macmillan Specialist Palliative Care Services in conjunction with Tawel Fan family stakeholder group to improve the environment for people in last hours and days of life

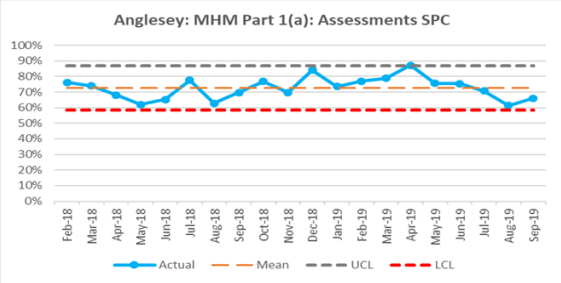
2.2	**Performance: Mental Health (Wales) Measure, Delayed Transfer of Care & Out of Area Placements**

Mental Health Measure

Summary of Significant Issues:

The MHLD Division continues to work on achieving the target across all teams, however, high referral rates, sickness and recruitment to vacancies continues to impact on delivery. Overall, Part 1a and b remains non-compliant but Part 2 and 3 remain compliant. It should be noted that the validated position always provide data one month in arrears.

Part 1a,b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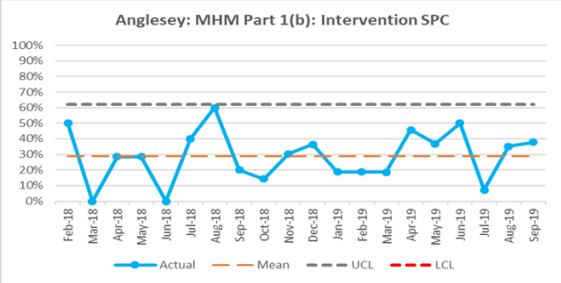
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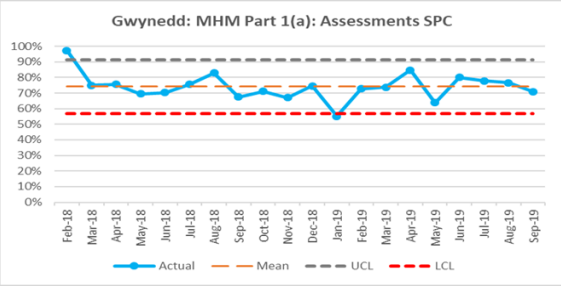
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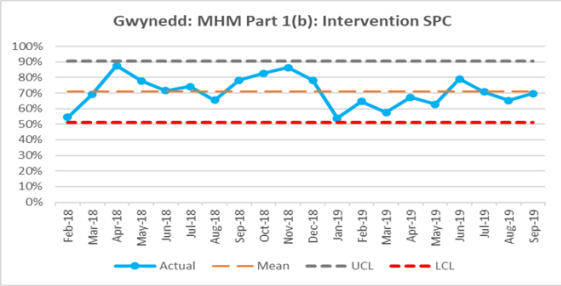
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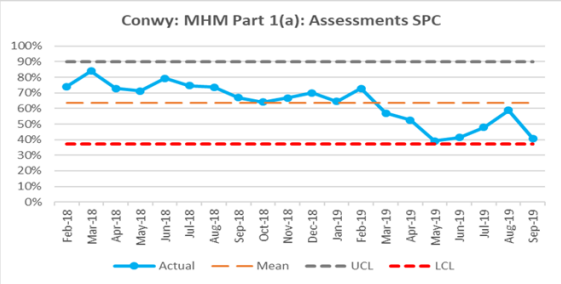
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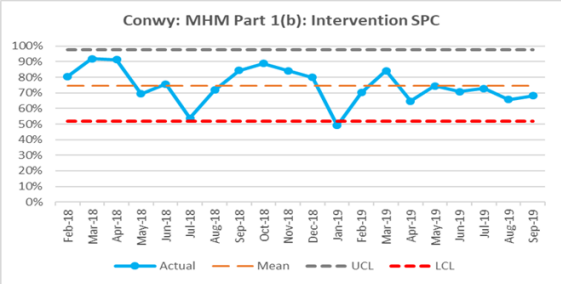
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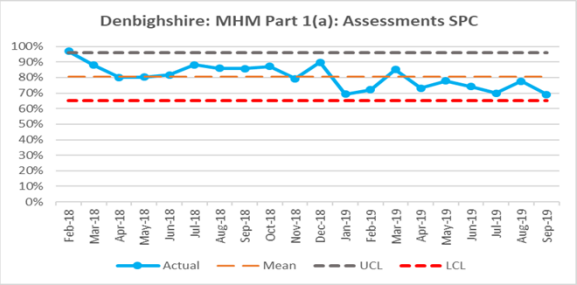
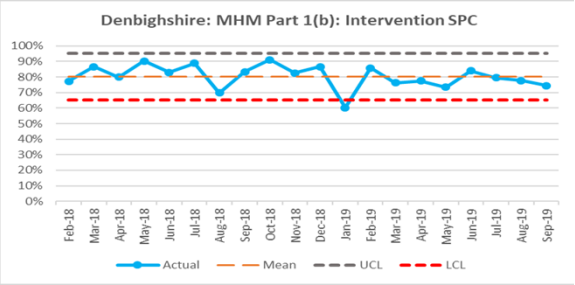
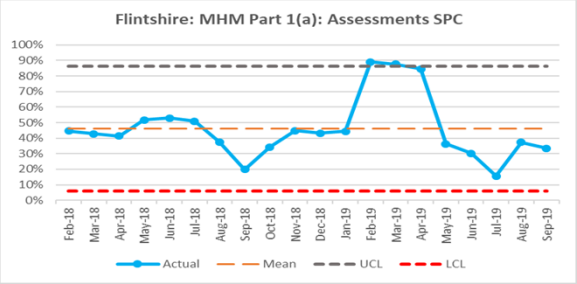
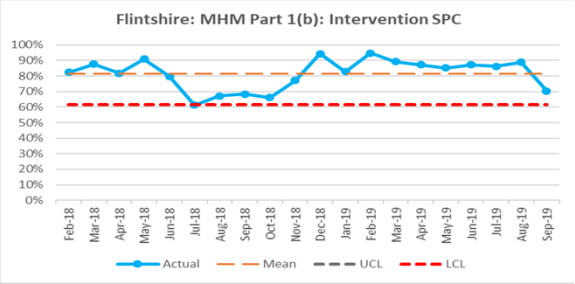
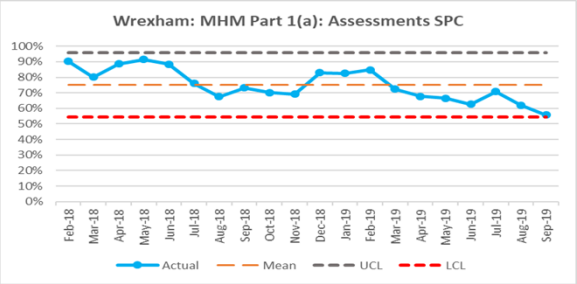
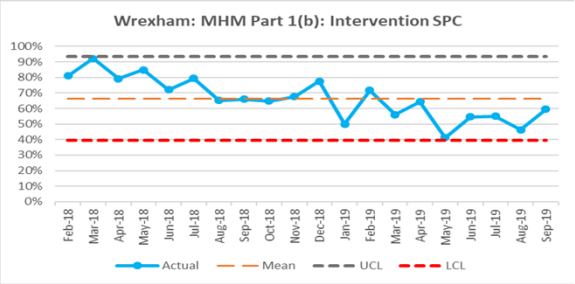












Part 2

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

Measure Part 2 - Valid CTP		Anglesey	Gwynedd	Conwy	Denbighshire	Flintshire	Wrexham	BCU Total
July	Compliant	577	932	734	787	948	1231	5209
	Non-compliant	100	77	87	50	87	128	529
	% with a valid CTP	85.23%	92.37%	89.40%	94.03%	91.59%	90.58%	90.78%
August	Compliant	564	929	714	781	956	1176	5120
	Non-compliant	120	78	68	39	70	162	537
	% with a valid CTP	82.46%	92.25%	91.30%	95.24%	93.18%	87.89%	90.51%
September	Compliant	559	910	707	760	931	1225	5092
	Non-compliant	105	85	60	45	76	101	472
	% with a valid CTP	84.19%	91.46%	92.18%	94.41%	92.45%	92.38%	91.52%
Combined	Compliant	1700	2771	2155	2328	2835	3632	15421
	Non-compliant	325	240	215	134	233	391	1538
	% with a valid CTP	83.95%	92.03%	90.93%	94.56%	92.41%	90.28%	90.93%

Part 3

Part 3 remains compliant across the region. Processes embedded to identify any breaches before they occur and rectified immediately.

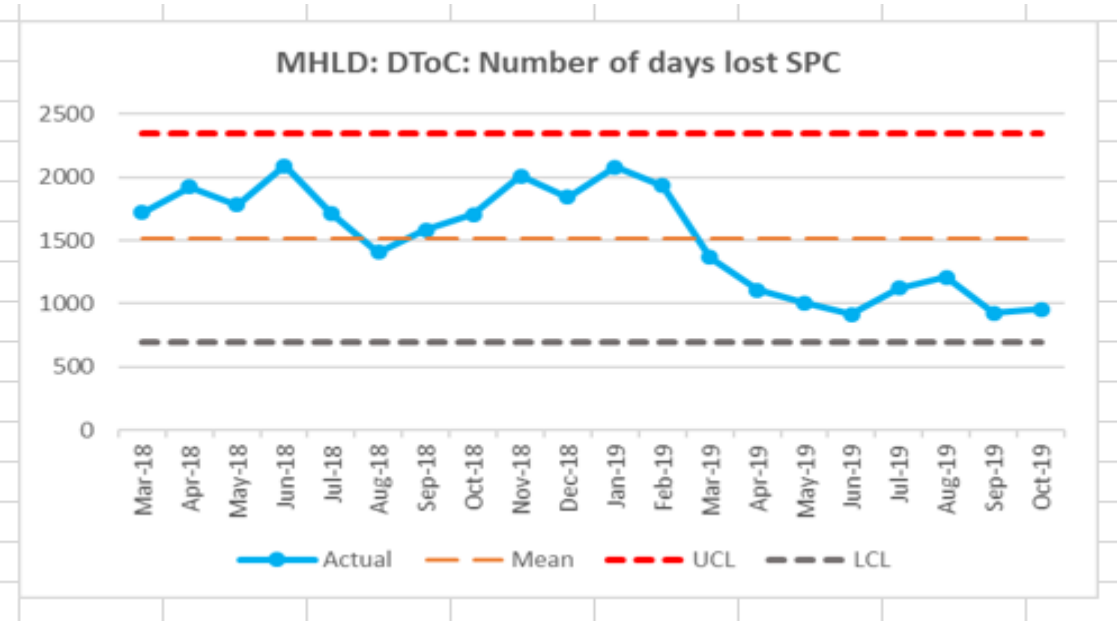
Improvement Plans:

Direct action to improve compliance against the Mental Health Measure (MHM) indicators is underway for Quarter 3 2019/20 and beyond. Focus is on the reduction of the backlog of people currently waiting for Part 1a of the Mental Health Measure. There is a need to ensure appropriate clinical response to demand and whilst prioritisation on clinical need continues, we deem those people who have waited in excess of 28 days for an assessment to be a priority. Our immediate actions include:

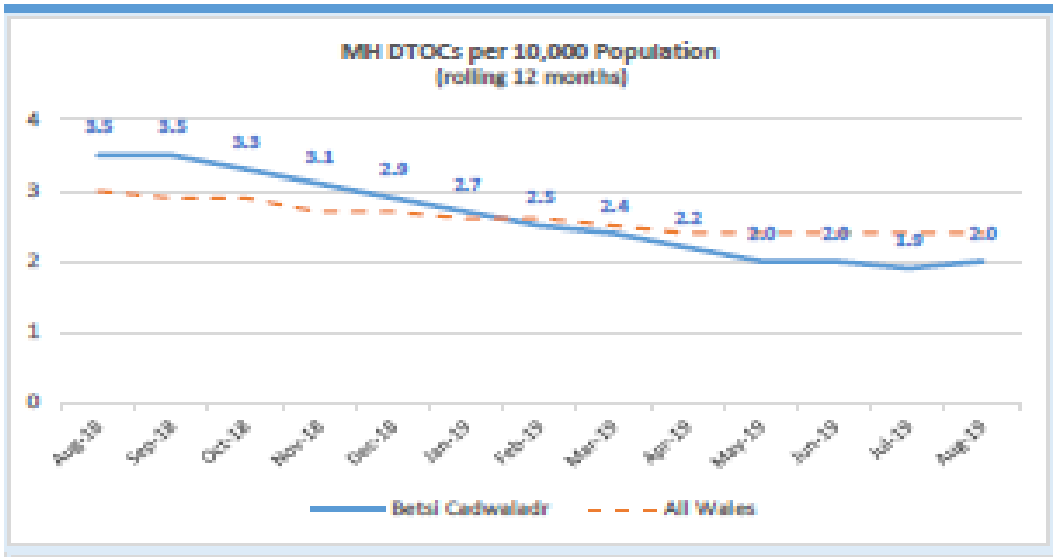
- Additional clinics at weekends to support reduction of the Mental Health Measure Part 1a waiting lists
- Recruitment of staff to vacancies within current establishment with a plan to have in post by November / December
- Controlled and temporary use of agency staffing in the short term using additional investment monies from Welsh Government, whilst recruitment continues for substantive posts
- Weekly reporting on MHM Part 1a backlog reduction, scrutinised through operational and management meetings
- Direct and immediate contact being made with people either by telephone or letter to ensure they are aware of their appointment details or where an appointment is not yet scheduled, assurance is given that they will be seen as soon as possible and the appropriate contact details to be used in the interim
- Review of Did Not Attend and Could Not Attend rates across the Community Mental Health Teams to improve use of capacity
- Review of referral patterns across teams, focusing on GP referral patterns, age groups, peaks and troughs of demand to support teams in management of staff and resource to accommodate the demands
- Partnership working with GP clusters to support more effective and integrated primary care / GP working
- QSE Committee updated in September 2019 on the detailed actions to improve compliance and sustained focus in being applied in order to reach consistent compliance across all areas of the measure by March 2020

Delayed Transfer of Care (DTOC)

The Division continues to drive forward in days lost to people's lives as they remain in hospital longer than necessary. Progress is being made across the Division as the days lost is showing a consistent downward trend.

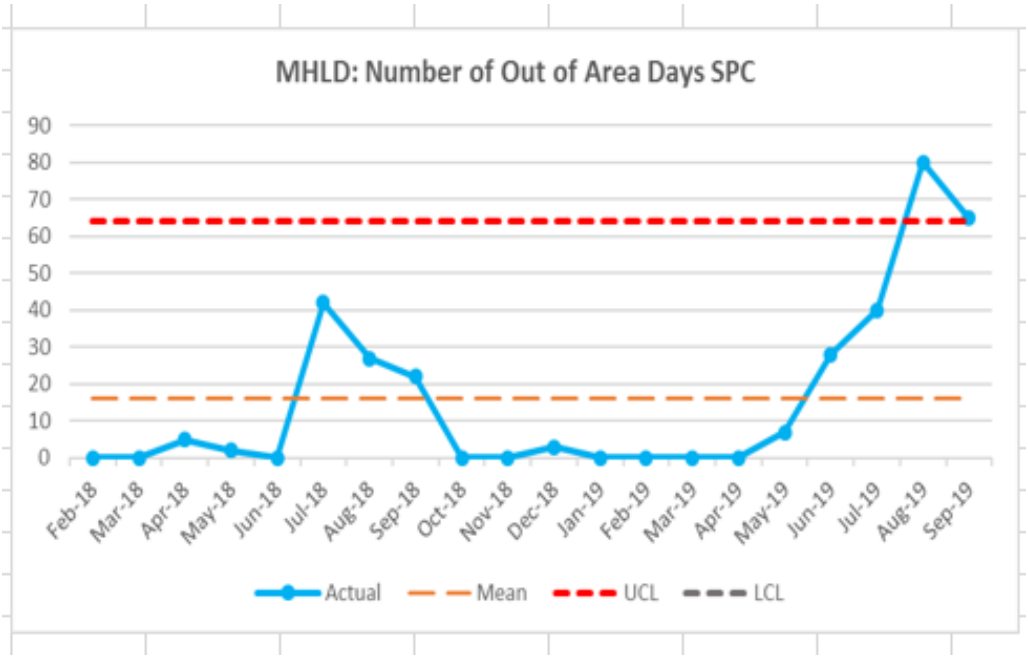


The MHLD Division also compares better compared to the All Wales average.



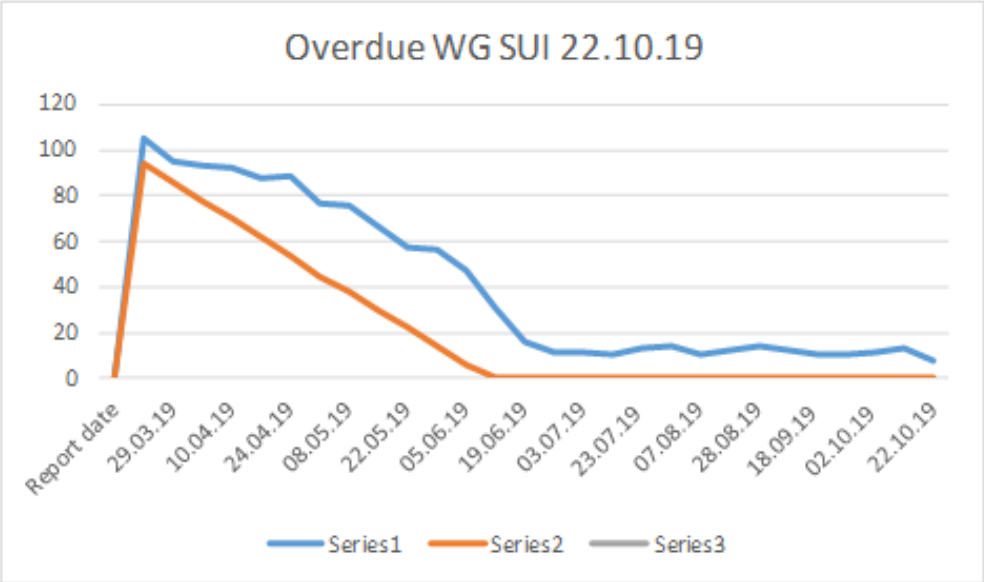
Out of Area Placements

The Division has experienced bed flow challenges over recent months with the problem of the decommissioned bedrooms in Heddfan Unit due to the door failure mechanism being a contributory factor. Each of the area Senior Leadership Teams have worked consistently to return people as soon as possible to the home area hospital and this number has returned to zero people out of area at the time of reporting to QSE Committee.



2.3 Lessons Learned from Incidents & Incident Management

The health board have a standard reporting framework for incidents and key issues following the Putting Things Right (PTR) Regulations. The Division's overall performance has been consistent in the response to meeting the performance target for breach Welsh Government reported incidents.



Learning through Concerns

Further examination of Datix, including themes and trends are reported through agreed governance structures via Divisional QSEEL. The Division will capture opportunities for learning through a structured conference format with the latest (fully

subscribed) event being held on 22 November 2019, in addition to more regular bulletins developed through the Risk & Governance sub group.

MENTAL HEALTH AND LEARNING DISABILITY DIVISION

QUALITY AND SAFETY LEARNING EVENT - "Change is the end result of all true learning"

TO BE HELD AT THE OPTIC CENTRE, ST ASAPH
ON FRIDAY, 22 NOVEMBER 2019

9.30 am	Welcome and housekeeping Mr Steve Forsyth, Director of Nursing MHLD
9.35 am	Introduction to the day and opening remarks Deborah Carter, Interim Executive Director of Nursing BCUHB
9.45 am	Patient Story Presented by the family of the late Linda Constantine
10.15 am	Serious Untoward Incident Learning – themes and trends Falls - Sean Page, Consultant Nurse Acute care pathway – Jean Lee, Senior Mental Health Nurse Co-occurring framework – Paul Hanna, Head of Nursing Family communication - Caniad Safe discharge – Clinical Director SPOA decisions – Tom Regan, Head of Nursing Care coordination and allocation – Mental Health Measure Team
11.00 am	Coffee
11.15 am	Launch of Learning Project – dissemination of learning and measuring its impact – Fran Moore, Risk and Governance Lead
11.45 am	Themes and trends – co-occurring framework - Mr John Gittins, H M Coroner central and east
12.30 pm	LUNCH and networking
1.30 pm	Postvention Suicide Support – Dr Sharon McDonnell, Managing Director of Suicide Bereavement UK and Honorary Research Fellow at the University of Manchester
2.30 pm	Concerns – On The Spot and formal – Quality and Safety Leads
3.00 pm	Tea
3.15 pm	WARRN – Tom Regan, Head of Nursing
3.45 pm	Launch of the Lead Practitioner Role – Safeguarding Lead
4.00 pm	The co-production Journey - CANIAD
4.30 pm	Next Steps and closing remarks - Mr Steve Forsyth, Director of Nursing MHLD

The table below provides data on Welsh Government reported incidents for the years 2019/2020 to date. The highest number of incidents (by category) is the unexpected death whilst under the care of MHLD services. This category includes those people who die from natural causes; however, currently there is still a requirement to report under this category.

Incidents by Welsh Government Incident Type and Reported (Month and year)								
	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Total
Abscondment of detained patient assessed as high risk	0	0	2	2	1	1	0	6
Any serious act of Violence or Aggression	0	1	0	0	1	0	0	2
Major Harm Caused	0	0	0	1	0	0	0	1
Mental Health - Attempted suicides as inpatients	2	1	0	0	0	1	1	5
Other type of incident	0	0	0	0	0	1	1	2
Patient fall resulting in harm/death to patient	1	6	1	0	2	3	0	13
Sensitive Issue	0	0	3	0	0	0	2	5
Suicide(or attempted) or homicide committed by an NHS MH patient	1	5	0	1	1	0	0	8
Unexpected Death whilst under the direct care of a health prof.	10	10	6	7	12	14	11	70
Total	14	23	12	11	17	20	15	112

QSE Committee were updated in September 2019 of the significant learning from 137 closure forms submitted to Welsh Government. Examination of the closure forms and actions the following 6 themes were identified and QSE is updated on this work programme:

1 Discharge Planning

A Central Locality review of the Acute Care Pathway is underway with a focus on the operational issues as the Division moves towards 72-hour follow up (rather than the current 7-day) highlighted by the 2018 National Confidential Inquiry into Suicides and Safety in Mental Health.[1] Once implemented fully within the Central Locality the revised Acute Care Pathway extended across the Division.

2 Risk Formulation and Risk Management

The 2-day Welsh Applied Risk Research Network (WARRN) training has been delivered across the Division for over 8 years. The training was implemented to improve standards of risk assessment and risk management across the Division. In addition to this, the Central Locality has launched in house refresher risk formulation and management training with 10 refresher sessions already delivered. To provide further capacity to deliver WARRN, risk assessment refresher training and to develop the Division's offer of suicide awareness training a Band 7 Risk Lead is currently on Trac for recruitment.

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

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

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

4 Timely allocation of care coordinator

Through the investigation of Serious Untoward Incidents, the Division has identified issues with timely allocation for Care coordination under Part 2 Mental Health Measure due to demand and capacity within the teams. The MHLD Division is currently recruiting additional resource at Band 7 and Band 6 to address the backlog of Mental Health Measure in Part 1,a,b. This will support flow to the whole system of care.

5 Quality of documentation/record keeping

The quality of documentation and record keeping is a re-occurring theme within Serious Untoward Incidents across the Division. This concern has been raised in various forums i.e. incidental to the incident and as a care and service delivery problem that has had an impact on care.

Work to date includes relaunching the Good Record Keeping Guidance (BCUHB 2017), annual Mental Health Measure audits, case file audits during planned supervision, monthly quality and safety audits (HCMS), monthly Matron Walkabout audits. Leads feedback on the outcome of audit to identify any notable improvements. Record keeping clinics piloted in the Central Locality in the forthcoming quarter.

6 Multiple case notes

The Integrated Case Note Standard Operating Procedure (SOP) has been reviewed and is progressing through the Policy approval process. Comments received during the consultation period for SOP have now been reviewed by the Business Support Managers and the Equality Impact Assessment is underway. When re-launched a Divisional wide memo will be disseminated to all staff alongside discussion at Operational Meetings and any other relevant forums. Audits of compliance are advised during staff supervision.

Learning Lessons through the Coronial Process

HM Senior Coroner North Wales (East & Central) wrote to the Division on 26 July 2019 to share his concerns regarding the localities message taking and response systems. In response, the Division has undertaken a considerable amount of work to ensure there is a robust and auditable system in place. A new Quality Improvement Lead role introduced to the Divisions Governance Team in November 2019 will implement the audit process to provide the required assurance to the Coroner.

A case was presented to HM Senior Coroner North Wales (East & Central) inquest relating to a detained person on a Section 37/41 Mental Health Act and the person's subsequent death. Issues of compliance with informing Ministry of Justice in relation to Section 17 leave, for ward hospital transfer, for allocation of Responsible Clinician, application of NEWS training identified for improvement.

Following a comprehensive Serious Untoward Incident review and formal feedback from HM Senior Coroner, issues were identified with those people who experience co-occurring substance misuse and mental health problems. The Division set up a task and finish group with an agreement that people will be jointly cared for and supported and that services within the Division will work jointly to the co-occurring framework ensuring coproduction of care plans etc. This has now progressed with a model of practice were Substance Misuse Services and the secondary care Community Mental Health Team in South Gwynedd operate joint clinics to support people with a complex presentation. HM Senior Coroner will discuss this further in his presentation at the Divisional Learning Event on 22 November 2019.

There have been no relevant Prevention of Future Death Reports (Regulation 28) issued via the Coronial process to other Health Boards in Wales. However, a Prevention of Future Deaths report issued to Cardiff and Vale in relation to post falls management has seen the identification of six recommendations within the MHLD Division [as reported in the September 2019 exception report]. All falls are reviewed by the MHLD Nurse Consultant with each of the area teams to examine compliance with process. This review indicates no trend or shift [as defined by SPC criteria] in the number of falls across the Division for the past 21 months. Audits of neurological observations post fall have been undertaken identifying an improvement in compliance with undertaking neuro observations post fall from 85% in 2017/18 to 93% in 2018/19. From 2019 / 20 a second consultant nurse for dementia with a physical healthcare portfolio is maintaining the NEWS and neuro-observation training plan.

OPMH wards have completed a two-year program, which has significantly improved post falls management. Attention is now being placed on prevention of falls for this high-risk population. The Division has developed a falls prevention bundle and online toolkit and will be piloting daily falls safety huddles and weekly MDT falls meetings in the Heddfan Unit in Wrexham.

Learning from Mortality, Suicide and Self-Harm Data

The MHLD Division continues to progress the staged approach to mortality based on the Royal College of Psychiatrists' recommendations; the transition has not been without difficulty for stage 2 referrals. It has been determined that at the point of notification of death, people in receipt of services in the community, the Division is not always able to determine if the death was of natural or unnatural causation or whether the death was expected or unexpected. These deaths are of course, reported to Welsh Government and investigated in accordance with PTR. If the rapid review determines the death was of natural causes and/or an expected death a closure form is sent to Welsh Government and no further action is taken. This may account for the reduced number of stage 2 mortality reviews currently being undertaken and further consideration must be given as to whether these should be sent for Mortality Review Group (MRG) despite being subject to a rapid review.

Substance Misuse Services (SMS) and Learning Disability specialists have agreed to form a joint SMS/LD MRG to ensure that all expected deaths are reviewed appropriately. Stage 1-referral forms are shared with the MRG coordinator and the

outcomes of MRG's review is reported through local QSEEL ensuring that information is available to move the Division towards a quarterly Mortality Report.

Furthermore, the role of the medical examiner is to be introduced in the near future. This independent person will review all hospital death and the MHLD Division awaits further clarification from the national mortality steering group.

The Ministry of Justice has recently published Guidance for registered medical practitioners on the Notification of Deaths Regulations 2019. This Guidance requires registered medical practitioners on the GMCs list to notify the Coroner of deaths occurring in certain circumstances. The death may already have been reported to the Coroner, however, the registered medical practitioner is still required to report. The Division has worked with H M Senior Coroner to agree a process for reporting.

The BCUHB Public Health Wales team review of suicides in Gwynedd resulted in a higher than expected number of suicide registrations in 2017 following a general request for data from the Health Board. The report further adds the statistically significantly higher rate of suicide registrations in Gwynedd residents in 2017 is most likely to be due to the large number of suicide occurrences in 2016 feeding through to the 2017 registration data due to the requirement to conduct a coroner's inquest. However, the number of suicides occurrences in 2016 does seem high. A detailed examination of individual suicide records for 2016 and 2017 did not reveal any specific connection in terms of time or place of death within North Wales that would suggest a cluster, or novel risk factor (Table 3). The key recommendation from the report is to monitor the number of suicide occurrences and registrations in Gwynedd for the next 3 years. This will be done in conjunction with Public Health Wales as part of their annual suicide report.

Table 3:

Suicides, counts and European age-standardised rate per 100,000, all persons aged 10 and over, Wales, Betsi Cadwaladr UHB and Gwynedd, 2017

	Count	Rate per 100,000 (95% CI)		Compared to Wales[1,2]	Compared to BC UHB[1,3]
Wales	360	13.2	(11.9 to 14.7)	-	-
Betsi Cadwaladr UHB	77	12.9	(10.2 to 16.2)	-	-
Gwynedd	24	24.6	(15.7 to 36.8)	Sig. high	Sig. high

Produced by Public Health Wales Observatory, using PHM & MYE (ONS)

CI = confidence interval

1 Sig. high = Significantly higher than comparison area, Sig. low = significantly lower than comparison area

2 For Wales comparison, Gwynedd's CIs have been compared to the Wales value

3 For HB comparison, a statistical test has been completed that takes into account both areas' CIs

In May 2019, the Court of Appeal in England and Wales handed down a ruling on the determination of suicide at inquest that is likely to affect the national suicide rate and

influence policy priorities. The ruling upholds a critical decision taken in 2018 by the High Court that the standard of proof required for a suicide conclusion (previously verdict) should be the civil standard i.e. balance of probabilities, rather than the previous criminal standard, beyond reasonable doubt. The lowering of the threshold is expected to lead to an increase in deaths recorded as suicide.

The MHLD Division has recently undertaken four locality thematic reviews in terms of confirmed suicides; currently being further developed into one Divisional report for key recommendations.

The Division awaits the next publication of the next National Confidential Inquiry report at the 6th NCISH Conference on 23 January 2020. Additionally, the launch of the National Suicide Bereavement Survey is eagerly anticipated.

The MHLD Division reviews self-harm data through local TWC meetings and the rate of self-harm during 24 hours shown for the last 6 months. Aneurin ward, Hergest Unit have reported the highest number of incidents in total for this reporting period.

By Location	**Apr 2019**	**May 2019**	**Jun 2019**	**Jul 2019**	**Aug 2019**	**Sep 2019**	**Total**
Aneurin, Hergest	8	8	6	2	3	3	**30**
Coed Celyn	0	21	4	1	0	0	**26**
Dinas Female Ward	2	10	3	2	5	4	**26**
Dyfrdwy Ward	3	3	5	2	6	1	**20**
Clywedog Ward	3	2	1	9	4	0	**19**

The MHLD Division also reports on suspected suicides to Welsh Government for those people known to mental health services. There have been no suspected inpatient suicides for inpatient services reported to Welsh Government over the reporting period.

2.4 Healthcare Inspectorate Wales – Outstanding Actions

External Regulation: Healthcare Inspectorate Wales Reports and Actions.

The most recent HIW inspection was for Ty Derbyn Community Mental Health Team on 15th – 16th October 2019. The Health Board awaits the full report for checking of accuracy and suggested actions. Work has already commenced on both inspections following the initial feedback and it is important to note no immediate action received.

Cemlyn ward, Cefni Hospital was subject to an unannounced Healthcare Inspectorate Wales inspection between 16th-18th September .Initial feedback was very positive, with no immediate actions. HIW have not yet issued the report to the Health Board for quality assurance and completion of the action plan.

From previous HIW inspections, 14 outstanding actions of the total 168 (including All Wales HIW actions) that require work and these are being progressed by each of the area triumvirates. This is a reduction of 3 since the previous September 2019 report. It is important to reflect the recent inspectorate visits that have determined a clear improvement year on year of the services delivered, whilst there is always room for improvement. Since we reported in the exception report September 2019, the oldest

relate to the visit to Heddfan in June 2017 (both awaiting capital progression) and the most recent covers the All Wales joint thematic review reported in February 2019.

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

Site	Date of visit	Number of outstanding actions	Issue	Update November 2019
Heddfan	June 2017	2	Lighting in garden area Enclosing nurses station on Tryweryn	Estates have assessed the area and business case developed by the Business Support Manager. There is currently no date for the works and it does not form part of the capital programme for 2019/2020, neither is it on the capital priorities for 2020/2021
Hergest	September 2018	1	S136 toilet door awaiting magnetic fixings	This has been escalated as no progress
Central – Nant y Glyn	November 2018	2	Awaiting hand wash basin in clinic room	This has been escalated and discussed at the central locality estates meeting along with the narrative that we are now a year on since request. Assurance received from estates that a date for completion is imminent.
Division wide – All Wales thematic review	February 2019	6	Review CMHT access criteria Equitable provision of advocacy inpatients and CMHTs WCCIS x 2 Delivery of Strategy	CMHT protocol is currently under review Being progressed via Caniad Corporate led action Working ongoing

2.5 MHLD Policy & Procedures

The MHLD Divisional starting position in September 2018 was 43 policies were published on the intranet with 20 (47%) being out of date. New policies developed and a number of policies reviewed and ratified following the new process and procedures and placed within the correct area on the intranet.

The updated position in relation to policies within the MHLD Division is: 62 policies published on the intranet with 13 showing as out of date. 4 have progressed through the MHLD Division process and are progressing through the Health Board ratification process. There are currently 9 (14%) which are out of date and have not been ratified, these are in various stages of review, consultation or ready for presentation at the next policy group meeting.

Developments since the last QSE report include:

Reviewed and ratified documents/policies completed HB process:
MHLD 0002 – Seclusion Policy
MHLD 0043 – Restricted Items Policy
MHLD 0051 – CTO policy
MHLD 0053/MM53 - SOP Meeting the Physical Health Care Needs of People admitted to an Older Persons Mental Health Ward
MHLD 0004 – Rapid Tranquilisation Protocol
MHLD 0052 – Standard Operating procedures for use of gyms and sports facilities
MHLD 0048 – Community Forensic Operational Policy
MM25 – SOP for the supply of take home Naloxone preparations

Approved by MHLD and progressing through HB process
MHLD 0008 – Threats to the person in forensic Establishments
MHLD 0009 – Major Incident Protocol Ty Llywelyn MSU
MHLD 0050 – Hafan Wen (BCUHB Substance Misuse Service) Inpatient detoxification prescribing guidelines
MHLD DIV003 – Protocol for the management of long acting antipsychotic injections (LAAI)
MHLD AC006 – ECT specification
MHLD 0041 – Policy for the use of Handcuffs (Specific to Ty Llywelyn MSU)
MHLD 0020 – S-CAMHS to Adult Transition Policy
MHLD 0029 – Perinatal policy
S136 Clinical Pathway

There are also three policies specific to Medium Secure Services that require further work, particularly in relation to EQIA and proof reading. There were also questions raised by QSE Committee:

Handcuffs Policy - The (QSE) Committee queried whether the terminology, i.e. the use of handcuffs, could be subject to amendment. However, the Executive Medical Director outlined the specific nuances around the use of handcuffs which required the policy. Handcuffs are referred to by the Ministry of Justice, including their directions for use. The policy has been considered by a specialist mental health lawyer who has agreed that to change this wording would not be feasible.

Threats to the Person in Forensic Establishments Policy. The (QSE) Committee queried the consistent reference to the Firearms Act within the EQIA and why this was deemed to be relevant against each protected characteristic. The Committee also suggested the policy should be reviewed by the Occupational Health & Safety Group. These recommendations are being considered.

Major Incident Protocol – Ty Llewelyn Medium Secure Unit - The (QSE) Committee queried the lack of reference to medium secure units, and how this protocol differed from the Threats to the Person in Forensic Establishments Policy. A member queried the necessity of involving the Modern Matron in advance of calling 999. The Executive Director of Workforce & OD noted the lack of reference to security providers within the scope. The Committee also suggested the protocol should be reviewed by the Occupational Health & Safety Group. These recommendations are being considered.

2.6	Quality & Safety Key Performance Indicators (KPI), Section 136, Under 18 admissions

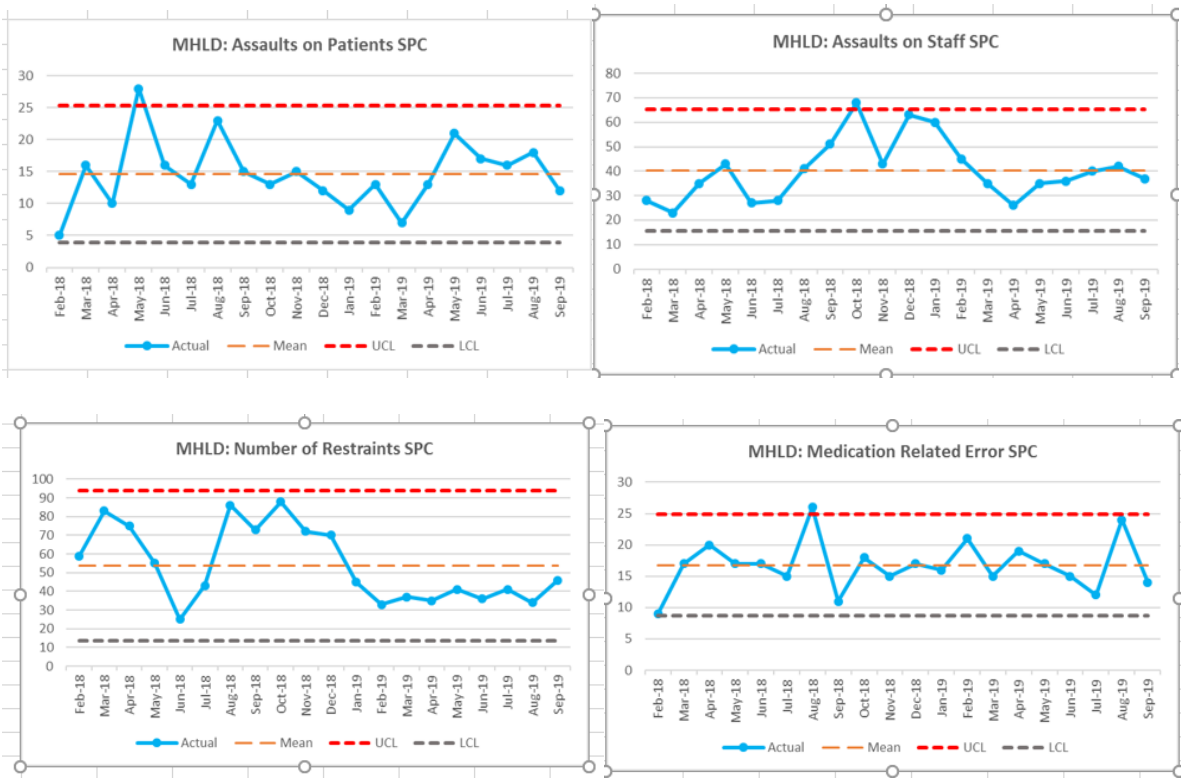
HARMS Dashboard

The Division continues to review data generated from the HARMS dashboard and discussed on a weekly basis at locality TWC meetings. This includes Hospital Acquired Pressure Ulcers (HAPU), falls, infection control and medication errors.

High level KPI summary:

The Division shows within range variation reporting for:

- Assaults on people
- Assaults on staff
- Numbers of restraint
- Medication related errors

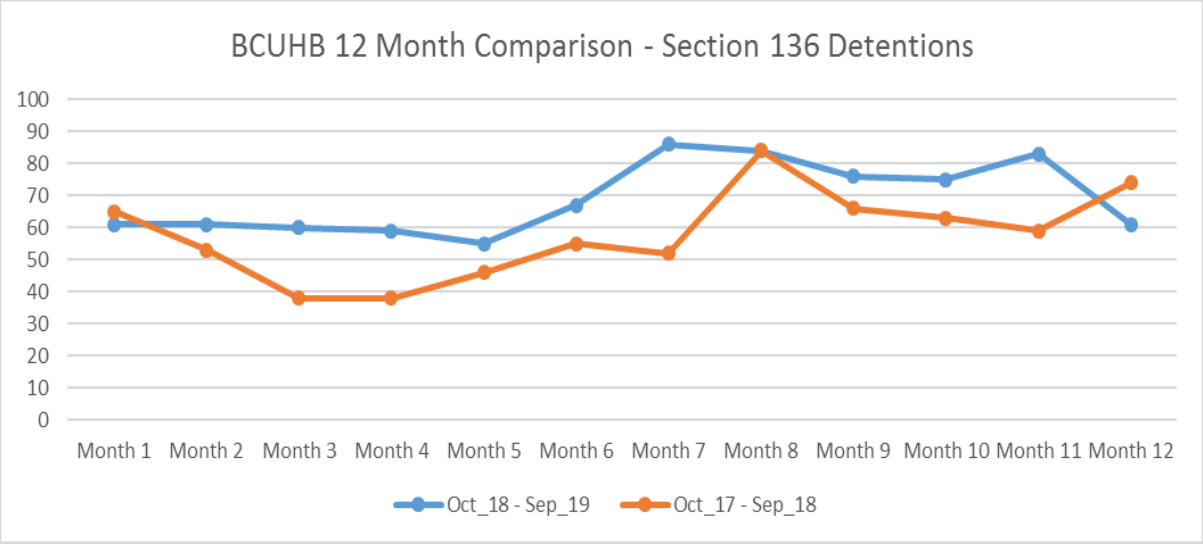


Section 136 Mental Health Act Powers of Detention

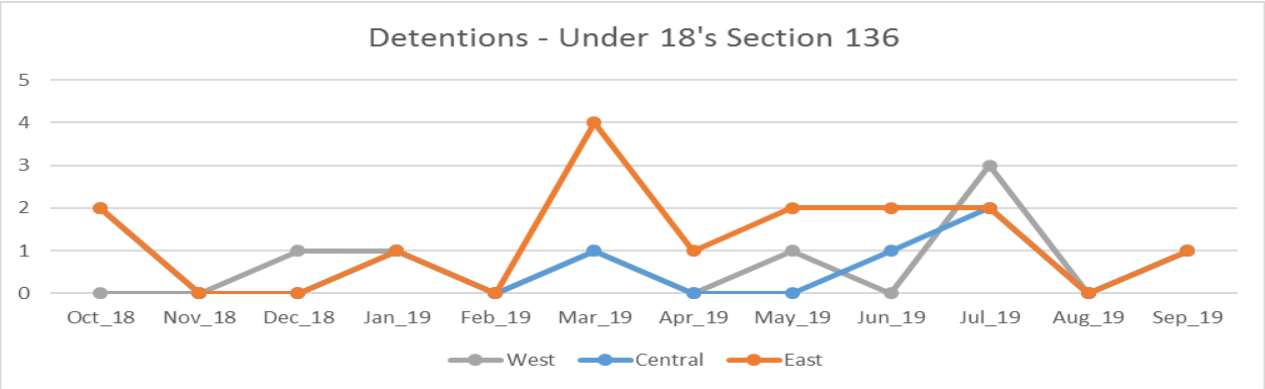
For 2018-19 S136 assessments have seen a rise of 15% (n=761) compared to the year 2017-18 (n=664). The first six months of this financial year 2019-20 there have been 465 S136 assessments; a rise of 17% compared to the previous year's data (see chart below).

From the 319 persons assessed:

- 166 were subject to initial consultation with Health Professionals (35%)
- 141 were admitted to Hospital (30%)
- 235 were discharged but referred to services or followed up by existing services (Community Mental Health Teams, GP, SMS) (50.5%)
- 84 were discharged following assessment with no mental disorder (18%)
- 5 sections came to an end prior to assessment under the Mental Health Act due to the need for medical treatment and them being unfit for assessment
- 7 were detained at Custody as the first place of safety
- 17 under 18's were subject to Section 136 MHA
- A Section 136 Protocol (draft) led by North Wales Police is currently out for formal consultation until 29 November 2019, and will progress through the respective organisations policy groups



Section 136 Assessments for under 18's and admission to adult beds



Absent without leave (AWOL)

In terms of missing people from MHLD unit, there were 10 incidences of AWOL reported to Welsh Government between 1 November 2018 and 31 October 2019. All people were returned to the units without harm to themselves or others.

Child Adolescent Mental Health Services (CAMHS) to Adult Transition

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

A task and finish group has been established to formally launch this policy and move this agenda forward.

2.7	Safeguarding

The Division continues to progress with continued scrutiny relating to safeguarding activity in line with the overarching Safeguarding agenda. Governance, reporting and data review concerning adult at risk activity [as one part of safeguarding] is overseen at local TWC, Divisional TWC, MHLD Safeguarding Forum, and Divisional QSEEL.

Key highlights

- Desk top review of adult at risk records for Bryn Hesketh ward in progress
- Weekly review of adult at risk records and active cases
- Strengthened arrangements in place to ensure MHLD attendance at Multi Agency Public Protection Arrangement meetings
- Continued progress to ensure staff are in receipt of a correct DBS for the role carried out.
- Young people admitted to mental health wards procedure currently in process of consultation
- Benchmarking activity concerning the findings and recommendations from the review of care home for learning disability service users

The Lead Practitioner (LP) role to be introduced with a presentation at the Divisional Learning Event on 22 November 2019 and this will follow the training on the All Wales procedures to be adopted April 2020. This will include:

- A description of the statutory requirement to have a Lead Practitioner role
- Confirmation that the Local Authority decide who will take on the LP role
- Information that Matrons, Ward Managers and their Deputies will all be eligible

- Confirmation that the LP role is key to the Initial Evaluation of each case
- Confirmation that the LP has the responsibility to make enquiries
- Confirmation that this includes having to speak to the Adult at Risk, their advocate or family, staff and other professionals.

2.8 Risk register and management

The Division currently has 31 risks on the risk register; 13 risks categorised as extreme [extract 4 November 2019]. Risk register reviewed at MHLD QSEEL and escalated to BCUHB QSG, and reported through to Divisional Directors.

CRR13 is the only risk at Tier 1 that relates to MHLD services – "There is a risk that people receive inappropriate care within Mental Health Services due to failings in leadership and governance at all levels within the Division which could result in poor quality outcomes for people". Divisional Directors are shortly to review the revised governance framework, evidence in relation to implementation of the MH Strategy, performance against each of the Adult MH measures, and the positive message about WG incidents management, PTR governance, external regulatory inspections, new ways of working through I CAN, and national awards.

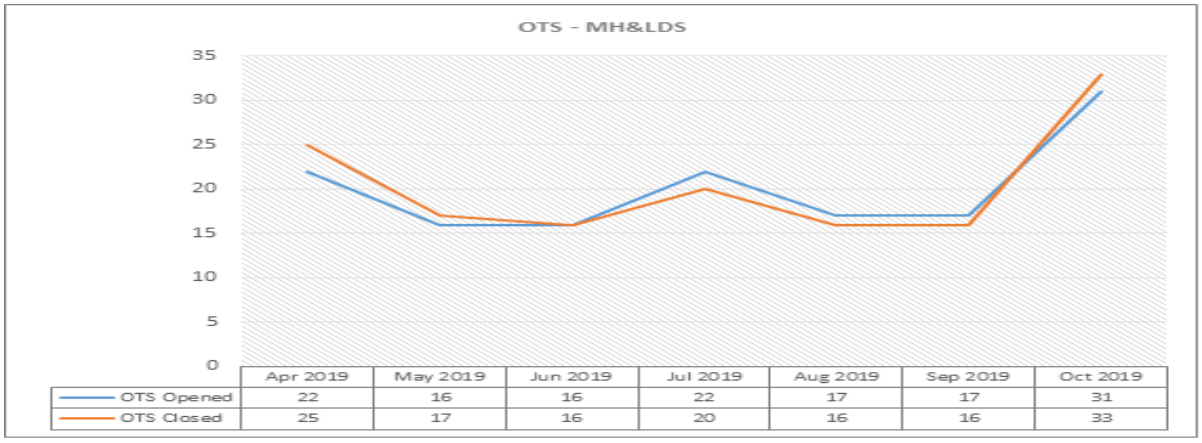
2.9 Compliments, concerns and complaints

The MHLD Division attempts to ensure compliance with PTR response times, and largely fulfils this compliance measure. Between April 2019 and September 2019 consent, confidentiality or communication remains the the most received to date for the year.

By Subject	**Apr 19**	**May 19**	**Jun 19**	**Jul 19**	**Aug 19**	**Sep 19**	**Total**
Consent, Confidentiality or Communication	4	5	5	5	3	2	**24**
Treatment, procedure	3	3	5	2	4	2	**19**
Access, Appointment, Admission, Transfer, Discharge	3	3	4	2	2	3	**17**
Abusive, violent, disruptive or self-harming behaviour	2	2	0	5	2	1	**12**
Clinical assessment (investigations, images and lab tests)	0	0	0	1	2	1	**4**

As of 4 November 2019, there are 13 formal complaints currently open regarding the Division of Mental Health with no breaches >30 days.

The Division's ability to respond to 'On the Spot' (OTS) concerns remains consistent over the last reporting quarter with the vast majority able to be successfully resolved. Whilst the number of OTS concerns has increased significantly (50%) during October 2019, the response and closure date remains within timescales. The hypothesis in relation to the increased numbers could relate to better reporting, however, will be monitored robustly moving forward. Key theme from the OTS relate to a combination of staff using the new telephone answering system.



	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019
OTS Opened	22	16	16	22	17	17	31
OTS Closed	25	17	16	20	16	16	33

2.10 NHS Benchmarking & MHLD Division

The MHLD Division has been part of the NHS Benchmarking exercise for a number of years and serves as a useful reference point for aspects of quality, safety and performance. The data has been compiled from providers from across the UK and is the largest mental health benchmarking study in terms of numbers and population coverage. The report includes detailed commentary on the shape of NHS mental health services in 2019 and looks closely at variation that can be seen in mental health services across the UK.

This year's submission from BCU is more robust than previous years with more data being available. Also using ward stay data has enabled more meaningful analysis of inpatient activity. The Division continues to work through the findings but key amongst these are:

Beds and length of stay: BCUHB sits within the interquartile range of bed provision for both adult and OPMH beds. Length of stay in adult mental health (AMH) is in the lower quartile range and OPMH is within the interquartile range

Admission and readmission rates: Readmission rate in AMH is in line with the UK median and OPMH is in the upper quartile

Use of restrictive interventions: BCUHB has a very low use of restraint. The peer organisation is reporting significantly higher use of restrictive interventions

Admissions under the Mental Health Act (MHA): Welsh Health Boards report some of the lowest rates of admissions under the MHA across the UK (all are below the median). BCUHB is the sixth lowest of all organisations

Registered Nurses and Psychiatrists per 10 beds: BCUHB has the second highest RN's per 10 beds in Wales on AMH and OPMH wards. AMH psychiatrists is on the UK median and for OPMH is the highest in Wales

AMH Inpatient Staff profile: BCU has total nursing of 39% in line with the rest of the UK but has low input of Occupational Therapists at 2% against optimal level of 5%

OPMH Inpatient Staff profile: BCUHB has a skill mix ratio of 65% for HCSW compared to the national average of 49%. Low input of Occupational Therapists at 2% against optimal level of 5%

2.11 MHLD Workforce Metrics

The MHLD Division continues to experience a challenge with recruitment to registered nursing (RN) vacancy. Of the total RN vacancy (128 WTE), half are progressing through TRAC and active recruitment planned for the March 2020 outturn of RN graduates. There are 235 WTE vacancy across the Division.

MHLD VACANCY & RECRUITMENT ACTIVITY REPORT - STAFF GROUP DATA
DATA SOURCE: QLIKVIEW (P06-20)
EXTRACT DATE: 9th OCTOBER 2019

Staff Group	Sum of WTE Budget	Sum of WTE Contracted	Sum of Variance (WTE Contracted - WTE Budget)
RP400: ADMINISTRATIVE & CLERICAL	263.22	238.50	-24.72
RP410: NURSING AND MIDWIFERY REGISTERED	894.47	766.01	-128.46
RP405: MEDICAL AND DENTAL	114.90	86.84	-28.07
RP415: ADD PROF SCIENTIFIC AND TECHNICAL	123.26	114.13	-9.13
RP420: ADDITIONAL CLINICAL SERVICES	601.99	566.85	-35.14
RP425: ALLIED HEALTH PROFESSIONALS	14.01	10.01	-4.00
RP435: ESTATES AND ANCILLIARY	10.57	4.28	-6.29
Grand Total	**2022.42**	**1786.62**	**-235.80**

The MHLD Division progressed the MHLD Inpatient Establishment Review covering rota optimisation, skill mix and nursing demand templates in September 2019 for a 4 week period. Feedback from the consultation events held across each of the 4 accountable areas of the Division have been analysed for themes and suggested ways forward. The Division will ensure the next steps for the establishment review are followed in light of Health Board process and also be considered against the All Wales Nurse Staffing principles for mental health recently released in a draft form. The Division will be completing the next stage of the All Wales Inpatient Nursing Assessment in November 2019 in line with the rest of Welsh Health Boards. These results considered further for the inpatient establishment review.

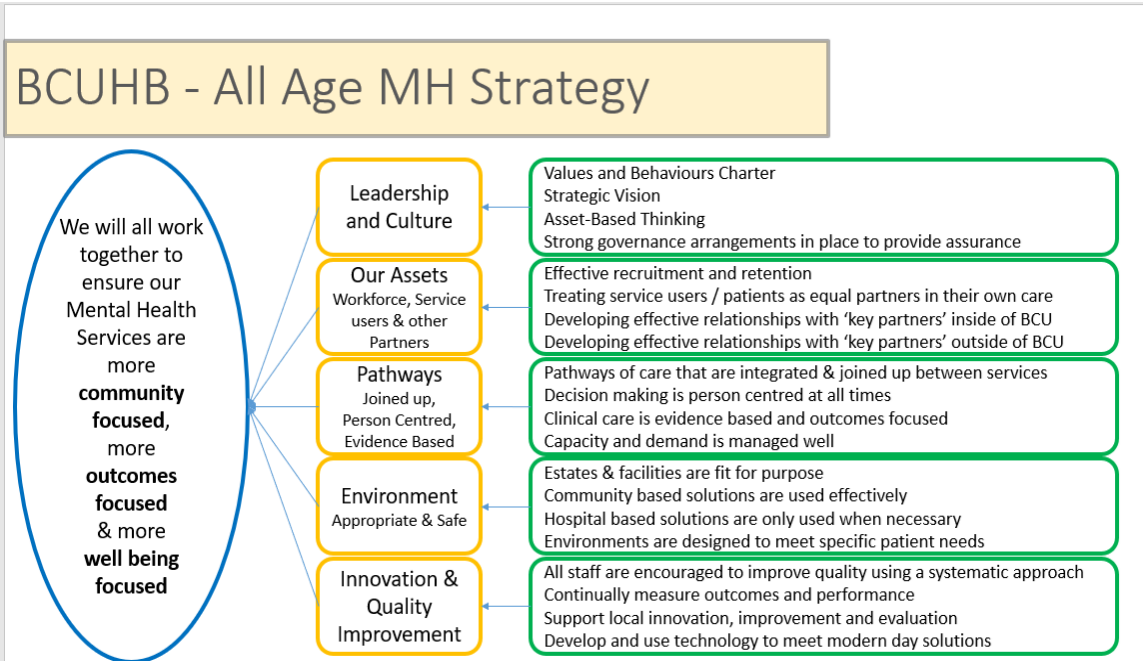
3.0 Milestone and measures in relation to implementation of the Together for Mental Health strategy and operational plan

The division has made positive progress in the implementation of the T4MH strategy as shown by the Delivery Plan; this delivery plan sets out how the mental health strategy across North Wales will be implemented for 2019-2024. The delivery plan will support mental health within the wider health and social care system to guide our approach to supporting good emotional wellbeing throughout our local communities.

Significant progress has been achieved in terms of aligning the T4MH Strategy and our Quality Improvement approach so that we undertake a whole system approach to service and quality improvement. A Quality Improvement workshop was undertaken in October with attendees from across the division. This interactive workshop gave the division an opportunity to build on the Quality Improvement methodology and the work of the TODAY I CAN movement going forward. In

addition it gave us an opportunity to build on how we implement and build on whole system quality improvement as part of the T4MH Strategy implementation.

The below 'Driver Diagram' represents the T4MH Strategy on a page and for the purpose of this report our focus is on *'Pathways – Joined up, person Centred, Evidence Based'*. This area of improvement has been our priority area over the past 12 months.



ICAN Pathway

Our delivery plan looks to implement the ICAN pathway approach by adopting an 'all age' process. Identifying times when emotional wellbeing and mental health may be at risk and helping to support local people with mental health needs to receive timely support for mental health problems.

To date we have established the ICAN Brand and concept, which is a campaign, aimed to improve the support available to people with mental health problems in North Wales. ICAN is being steered by people with lived experience of mental health problems, people working and volunteering in mental health services and those involved in local mental health charities.

We have tested the ICAN Mental Health Urgent Care Centres at North Wales' three Emergency Departments. I CAN Mental Health Urgent Care Centres support people in crisis who do not require medical treatment or admission to a mental health unit. Since January 2019 the service has supported more than 2,000 people and a recent social return on investment analysis found that for every £1 invested, more than £5 of social value was created.

Building on the learning from ICAN Unscheduled Care we will enhance the ICAN Unscheduled Care offer by introducing ICAN Volunteers into Wales Ambulance Services Trust (WAST) Control rooms. Working alongside duty GP's and SITAC. Patients who call due to stress, anxiety, loneliness or in crisis will be triaged by the GP and referred where appropriate to the ICAN Team. The ICAN team would offer the same support as that offered in unscheduled care. Follow up support will also be provided via telephone contact. This model has been tested in North Wales over a 7 day period, resulting in 5 ambulances being stood down. We will test this model further over the winter across North Wales.

Rich data and patient stories have been captured from the testing of ICAN Unscheduled Care. We are using this learning to inform the development of our ICAN Community Hubs and ICAN Primary Care Centres as part of the integrated pathway. The 3 Local Implementation Teams (LIT's) are tasked with driving forward the transformation at a Community Level. The LIT's have secured wide membership from across statutory, third sector organisations and people with lived experience of mental health services. Locality plans are in place, produced with a real understanding of need, demand for intervention and an understanding of community assets in each locality area.

The 'Healthier Wales' Mental Health Transformational Bid, which was successful and awarded £2,320,000 in December 2018 to cover project costs during the period 19 November 2018- 31 March 2022 is being used to drive at pace the work of the LIT's and the implementation of the ICAN Pathway with a clear focus on prevention and early intervention. This programme of work is key foundation work of the whole system transformation.

We have identified and are working to establish ICAN Hubs and I CAN Primary Care Centres test sites in all Local Authority Areas. The first of the Community Hubs and Primary Care Centres will become live in Quarter 3 (2019/20) with the second round being passed in quarter 4. This will enable us to test new models of care at a community and primary care level.

LA Area	ICAN Hub	ICAN Primary Care	Phasing
Anglesey	Llangefni Holyhead	Llangefni Holyhead	Qtr3 2019/20
Gwynedd	Pwllheli	Pwllheli	Qtr3 2019/20
Conwy	Colwyn Bay Llandudno	Colwyn Bay	Qtr4 2019/20 Qtr3 2019/20
Denbighshire	Prestatyn	Prestatyn	Qtr3 2019/20

Flintshire	Flint Connah's Quay	Flint Connah's Quay	Qtr 3 2019/20 Qtr 4 2019/20
Wrexham	Wrexham	Wrexham	Qtr 3 2019/20

To support the changes at a community level we have developed ICAN Training and this will be rolled out across all our ICAN Centres in North Wales. The training has also been offered out to organisations across North Wales, part of our offer to increase resilience within our communities, self-care and prevention and early help. The response to the offer of ICAN Training has been overwhelming and we plan to start the rolling out of this Training to organisations in North Wales from Quarter 3 (2019/20) onwards.

As part of ambition to develop sustainable new models of care that are aligned to the principles of the T4MH Strategy, we have developed a new commissioning framework agreed by the T4MH Partnership Board. We have also recruited a Mental Health Commissioning Lead to move this agenda forward. By establishing a significantly strengthened commissioning approach within the mental health and learning disabilities division, we will establish a function to manage the full commissioning cycle for the effective use of resources, value for money, and delivery of outcomes.

We are currently piloting an ICAN Work programme in partnership with Bangor University, Welsh Government, Cais and RCS. Based on the IPS (Individual Placement Support). The project aims to support patients with mild to moderate mental health needs to find paid work and stay in work by using the IPS model. IPS is evidence based, NICE endorsed intervention. The model relies on close collaboration between the clinician and the employment specialist to work together to support the service user to attain their employment goal.

Our focus over the coming months will be the roll out of and testing of the ICAN Pathway. Further work on the modelling of the ICAN Plus housing offer will be undertaken over the coming months with a view of Testing this model in 2020/21.

Primary Care

As already discussed the Division has focused on developing an innovative early intervention and prevention pathway that provides seamless links to community provision reinforcing strong links with GP Surgeries and primary care. This pathway offers the opportunity to develop an enhanced primary care offer which is, aligned to the ICAN Integrated Pathway and strengthens provision for early intervention and prevention, whilst reducing pressures on primary and acute care systems.

We have piloted initiatives within GP Clusters to embed Mental Health Practitioners within primary care systems (CAMHS North Denbighshire pilot), generating a strong evidence base which is supported by wider research across the Wales and the rest of the UK. We have developed a new proposed primary care pathway which is a clear departure from existing practice/provision and a move towards early intervention and prevention support. A study in Cardiff which utilised a similar model to this, clearly demonstrated the efficiency that such a proposal could generate within a short period of time and at minimal cost.

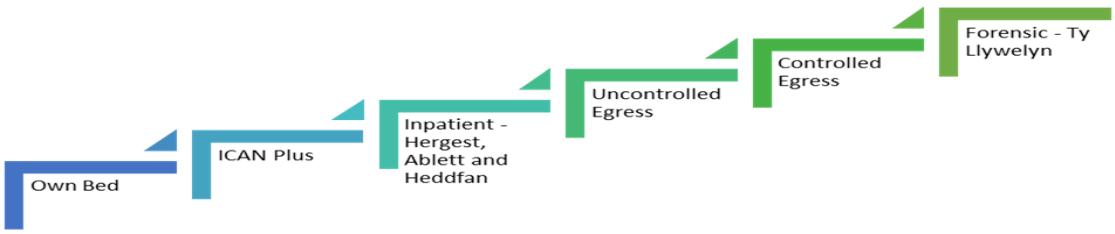
We have developed Business Cases and presented to the Finance and Performance Committee and to Welsh Government for 'pump priming' funding. Welsh Government have requested that we formally put forward the business cases for funding. Therefore, we have scoped and built on the original business case for additional primary care support. The Pump Priming funding will allow us to scope and test further the connectivity and pathways between the between the ICAN pathway, primary care and specialist services.

Bed Based Care (Rehabilitation Remodelling)
We have agreed the remodelling of Rehabilitation Services. We will no longer view 'Rehabilitation' as an intervention that happens in a Hospital Bed alone. Rehabilitation is an intervention that happens across the whole system by a wide range of professionals from different disciplines. We have also agreed a change of language - moving away from locked rehabilitation to controlled egress, and moving away from open rehabilitation to uncontrolled egress.

We have agreed new models of bed based provision of care, with the focus on delivery in the community. The concept that an individual's 'own bed' will be an essential part of the continuum of bed based care and is a significant cultural shift that will require a more agile and flexible workforce. This change along with the introduction of ICAN Plus step up/step down beds will ensure that we expand and enhance the bed based care offer for the citizens of North Wales.

There is significant clinical buy in and support for the model, which has been designed through co-production by clinicians, people with lived experience across North Wales and partnership stakeholders.

We consider that changing the current model to provide and enhanced bed-based offer with support pulled in through Community Resource Teams will ultimately improve outcomes for our patients. This new model of Bed Based care is part of a wider programme of bed based care transformation that will, once fully implemented provide for better flow of patients through the whole system.



As a Division we are currently caring for **67** patients within a range of locked and unlocked rehabilitation provision, within and outside of BCUHB. We have reviewed the patients placed out of area and are of the view that we can repatriate a number of patient in order for them to receive care, closer to home. In addition, a number of individuals currently within our Rehabilitation Units could be supported to live at home through a different way of working.

Our proposals is based on increasing BCUHB current Bed capacity from 32 to 44 Beds, a mix of 20 locked egress and 24 unlocked egress. With the increase in the bed capacity we would look to repatriate as many patients as possible who are

currently out of area along with 'Stepping Down' patients currently in BCU Rehab accommodation to more community based care.

A request to Welsh Government has been made for additional funding in order to 'pump prime' the phasing in of the new model. There is some risk that we may not receive the additional funding that will support the pump priming. This initial investment would allow us to reconfigure the current bed based model. The potential gross saving from the bed modelling work has been calculated; further pathway costing outside of inpatient costs will need to be undertaken to understand the overall net cost benefit from the service change.

In order to expedite repatriation of clients placed out-of-area whilst allowing the current community rehabilitation services to concentrate on establishing the ICAN+ service there will be a phasing in of the remodelling and transformation. In terms of next steps, we will develop the implementation plan for future Bed Based care, which will include the clinical review of all patients that can be cared for closer to home.

PICU Redevelopment
As part of the whole system transformation, the work to redesign the service model for Psychiatric Intensive Care has been progressing well.

The current PICU arrangement in North Wales does not provide an equitable service for those individuals who are acutely unwell and who require highly specialised intensive intervention by a multi-disciplinary team. Detailed data analysis has been undertaken including a demand and capacity exercise.

The new service model for PICU provision for North Wales has been designed through co-production by clinicians, people with lived experience across north wales and partnership stakeholders. 141 PICU Service users and their carers have been consulted on the service model options.

Our preferred Service Model is to establish one highly specialised PICU Unit for the residents on North Wales with more intensive community based support also provided within the Areas. Engagement events with CHC has been undertaken with further engagement work planned in the West at the request of CHC.

Summary of Milestones against First Year Priorities

Priority Areas	Progress so far	Next action	Qtr
Working to Prevent Mental Health crisis by focussing on early intervention and promoting emotional resilience Working with	**ICAN Unscheduled Care** Tested in 3 DGH's Captured Data, lessons learnt and patient Stories.	Test ICAN Unscheduled Care in WAST Control room. Recruitment of further ICAN Volunteers	Qtr 3-4 (2019/20)
	ICAN Community Hubs Specification developed in partnership through Local	Roll out of Hubs in all LA Area. Recruitment of	Qtr 3-4 (2019/20)

voluntary and third sector agencies to review their role with people at risk of severe mental health crises	Implementation Teams Test Sites Identified	Further ICAN volunteers Test new Service Models in each LA Area	
	ICAN Primary Care Test Sites identified Specification developed in partnership through Local Implementation Teams	Roll out of ICAN Training to each test site Recruitment of further ICAN volunteers. Test new service models and connectivity between Community Hubs	Qtr 3-4 (2019/20)
	ICAN Training Training has been developed and accredited. Launched training and established Data Base of interested organisations.	Roll out of ICAN Training across North Wales. Evaluate and Agree Training framework going forward.	Qtr 3-4 (2019-20) Qtr 4 (2019-20) Qtr 1 (2020-21)
	ICAN Workforce Established an ICAN Volunteer workforce	Further recruitment is required to support the ICAN Pathway. Develop ICAN a 'Workforce' framework that offers volunteer progression, training and opportunities to enter work.	Qtr 3-4 (2019-20) Qtr 3-4 (2019-20)
	ICAN Work (IPS Pilot) Established Pilot Project Recruited Employment Specialists and Team Leads Identified ICAN Work test sites Started the recruitment of Participants Commenced Evaluation	Complete recruitment of Participants Complete evaluation	Qtr 3 (201920) Qtr 1 (2020-21)
Developing local	**ICAN Plus – Step Up/Step**	Undertake	Qtr 3-4

alternatives to admission: crisis cafes, sanctuaries, strengthened Home treatment Services, step down services	**Down** Working Group has been established Agreed Bed Based Care remodelling	assessment of need. Further modelling of the ICAN Plus step-up model.	(2019-20)
Reviewing and improving the routine process of bed management and patient flow	Business Cases Developed - Crisis - Primary care - Bed Based Care – Phase 1	Formal Submission to Finance and Performance Committee and Welsh Government	Qtr3 (2019-20)
	Developed PICU Service Model Consultation and engagement with Service user, carers and partners and CHC undertaken	Further engagement events (WEST) Finalise Communication plan which will include workforce engagement	Q3 (2019-20) Q3 (2019-20)
Working with Criminal Justice services to divert demand arising from police, via section 136 arrangements, street triage or control room-based mental health staff.	**ICAN Unscheduled Care** Established ICAN Unscheduled Care in each DGH (7pm – 2am) Police Training programme underway Appointment of MH Staff for Police Control Room completed.	Further longer-term pilot of testing ICAN in WAST control Room, working alongside OOH GP. Implemented standard operating procedure for police control room and ICAN.	Qtr 3-4 (2019/20)
	VARM Business Case developed in partnership	Recruit to VARM Posts Test VARM approach across North Wales	Qtr 1 (2020-21)
	Crisis Care Concordat Local Action Plan developed linked to LIT's. Criminal Justice operational group established	Roll out of Projects	Ongoing

	Included in Cycle of Business fro T4MHPB		
The development of a clear plan for the future of our mental health services represents a significant step forward	Deliver Plan shared with F&P Committee July 2019. Introduced QI Methodology through TODAY ICAN	Continue to Develop Delivery Plan Develop and build on TODAY I CAN Embed QI Methodology	Ongoing Q3 (2019-20) Q1 (2020-21)

Audit Recommendations

Recommendation	Original Response to Audit	Actions Undertaken	RAG status
– Delivering the mental health strategy Management ensure the flow of information between all established groups, per the governance structure, is effective and consistent with cycles of business, thus ensuring agenda items are present.	We acknowledge that there was limited evidence of the Together for Mental Health Partnership Board (MHPB) formally disseminating information down to the Local Implementation Teams (LiT`s) and Quality and Workforce Groups (Q&WFG).	• The LIT Chairs together with the newly established Service Improvement Lead are invited to be 'in attendance' at all T4MHPBFromal feedback form T4MHPB is a standing agenda item on LIT and Q&W Group.	
		• The Chair of the Strategy and Service Redesign Group, sits on the T4MHPB. Formal feedback from the Board to the monthly Strategy and Service Redesign group is a standing agenda item.	
		• Chairs assurance reports have been developed for feedback to the T4MHPB from all reporting groups, including LIT's, SSRD, Commissioning, Criminal Justice and Suicide and Self Harm.	
	In response to improving the communication between the 3 LITs and the Q&W groups we offer the	• A new approach for joint working between the LITs and all Q&W groups was tested where each Q&W	

	following actions	group came together at a joint accelerated learning event for whole day. The first event proved to be extremely successful as it improved the potential for collaborative working, expedited decision making processes, ensured that groups take accountability for their work stream and improved communication flows.	
		• Dates for the year are established and we run these events every 8 weeks. This approach replaces the existing individual meeting of Q&W groups	
		• The reforming of the Mental Health Commissioning Group has been completed with a focus on developing a clear project support pathway for both the LiT`s and Q&W groups.	
		• Work to develop a commissioning framework has been completed by the group. The framework supports both the LiT's and	

		Quality and workforce groups in moving project proposals into business cases and through a collaborative commission framework.	
		• There is now an agreed Cycle of Business for the T4MH Board	
Delivering the mental health strategy – project plan and indicators The Strategy document is underpinned by a detailed project plan that captures milestones and all activities needed to deliver the required outcomes, so enabling scrutinisation of delivery. Update reports provided to the Strategy, Partnership and Population Health Committee include performance against the stated indicators.	The LITs are still relatively new in their development and the work that has been undertaken to build trust and confidence across the partnerships in North Wales cannot be underestimated. However, it is acknowledged that the 3 LITs did not have detailed action plans that included activities and milestones. To address this the following actions will be completed	• Development of a new project support pathway for the LiT`s and Q&W groups to ensure milestones, deliverables, outcomes and impact are captured and monitoring against them can be undertaken effectively	
		• Q&W Groups report bi-monthly to Strategy Service and Redesign Group on milestones & activities against the Delivery Plan	
		• Development of local delivery plans for each LIT will include key milestones and activities to demonstrate delivery against outcomes, these will be reported on in the ISB's and T4MH Partnership	

		Board	

4.0 Conclusions / Next Steps

The Division has outlined in this report progress made against key quality and safety metrics, highlighted the ongoing issues with the Heddfan doors, Cefni hospital and the latest ward accreditation visit for Gwanwyn ward.

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

The Division is also in the recruitment phase of additional staff funded through Welsh Government to address the backlog of cases in Part 1b. The solution to target achievement is a complete service transformation which is currently been worked through via the strategy implementation. The Division is benchmarking nationally against CNA's and DNA's to ensure the offer of a fair and consistent service within Primary Care in line with guidance and national standards. Sustained focus is being applied in order to reach consistent compliance across all areas of the measure by May 2020.

Overdue Serious Untoward Incident closures remains a priority for the localities and the Division and the position is reviewed and escalated weekly at Divisional TWC to monitor and maintain progress and achieve 'real time' position with all incidents.

The Division has progressed work on the TFMH strategy with clear plans in place that lays the foundations to deliver sustainable services for the future. This has included significantly improving operational planning including co-production, partnership working, and a transformational review of the service model.

5.0. Recommendations

The Committee is asked to note the contents of the MHLD Quality & Performance Assurance Report.

Quality, Safety & Experience Committee **19.11.19**	 ***To improve health and provide excellent care***

Report Title:	Mortality Surveillance Report – April to September 2019
Report Author:	Dr Brian Tehan, Medical Director for Quality & Transformation
Responsible Director:	Dr David Fearnley, Executive Medical Director
Public or In Committee	Public
Purpose of Report:	To provide a report on mortality across the Health Board for April-September 2019
Approval / Scrutiny Route Prior to Presentation:	The mortality report is normally reviewed by the Reducing Avoidable Mortality Steering Group (RAMSG), before Quality and Safety Group (QSG) and finally the Quality, Safety and Experience Committee. Due to meeting scheduling changes this report has only been shared with QSG members and will be reviewed by RAMSG at the next meeting.
Governance issues / risks:	• On CHKS (Comparative Health Knowledge System (UK NHS)) Crude Mortality to July 2019 was 1.74%, representing an improvement on July 2018 where it was 1.8%. RAMI (Risk Adjusted Mortality Index) has also improved and remains better than peer which is 99.3 • Septicaemia (except in labor) was 81.7 remaining better than average and peer • There are no alerting conditions • 30-day mortality from myocardial infarction has shown an improvement in RAMI since last report. • Hip fracture of concern in the previous report has also improved. • While the position on Stroke is average, this has deteriorated and remains worse than peer. • All are subject to national audit and crude death rate is as expected for all groups. This is currently reflecting common cause variation. • Previously flagged as a concern, Rate of Mortality in hospital within 30 days of elective surgery compared between those two time periods, has improved from 0.17 to 0.14%. This compares with a peer value of 0.12%
Financial Implications:	Financial implications have not been quantified

Recommendation:	The Committee is asked to note this report and seek any further assurance.

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

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

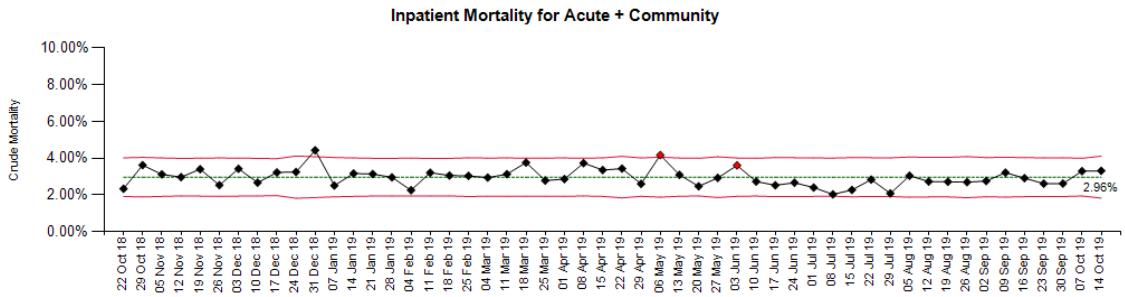
Mortality Surveillance Report-
April-September 2019

Introduction

This paper is presented to update QSE on mortality. The intention is this to first go through QSG and the Reducing Avoidable Mortality Strategic Group (RAMSG), allowing operational divisions to outline responses to findings within the report. An evolving process, RAMSG unfortunately has not met due to the number of apologies, to allow that elaboration.

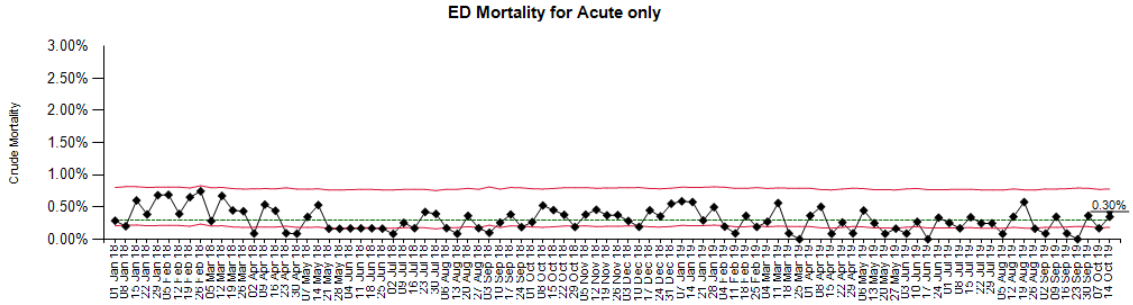
Crude Mortality Position

The average weekly inpatient and emergency deaths within BCU over the year to 20/10/ 2019 was 68. This consists of an average of 55 from the acute sites; 12 from Community beds and 7 from Emergency departments (ED). There is a decrease by 1 death a week for acute site inpatients since the last report, with community increasing by 1. There has been no significant change in Crude death rate, with an average of 2.96%. No special cause variation has been seen nor any new trends. This is outlined in the following graph for BCU:



Average weekly death rate % (year to 20/10/2019)	**East**	**Centre**	**West**
Acute	2.6	2.78	2.64
Community	10.08	7.18	12.32
ED	0.21	0.28	0.20
Crude rate	1.97	3.17	3.25
Comment	Rates are starting to rise	Rates are starting to rise	Slight rise

Ysbyty Glan Clwyd (YGC) ED crude mortality:
An area of particular concern, weekly mortality in YGC ED is a stable process with no evidence of special cause



Learning from Deaths

There is still variation in the application of all stages of the mortality review process across BCUHB. Stage 1 reporting with 72 hours of death expected to exceed 95%, only Wrexham Maelor Hospital (WMH) is failing to meet that target. (YG = Ysbyty Gwynedd)

Death Review Process Calendar Year– (Stage 1 to end September; Stage 2 to 18th October 2019)

	2018				
Site	**Deaths**	**% stage 1 completed**	**Stage 2 required**	**Stage 2 outstanding**	**% stage 2 completed**
YGC	1039	98%	168	38	77%
YG	**870**	94%	171	156	9%
WMH	1009	94%	251	176	30%

	2019				
Site	**Deaths**	**% stage 1 completed**	**Stage 2 required**	**Stage 2 outstanding**	**% stage 2 completed**
YGC	811	98%	161	106	34%
YG	629	95%	115	113	1.7%
WMH	734	92%	184	150	18%

Numbers referred for stage 2 remain high, yet completion is poor. Across BCU only 39% for 2018 have been reviewed, falling to 18% to date for 2019. Totalled by site this means numbers awaiting review 2018-2019 are YG (269); YGC (144) and WMH (326).

Progressing the move from a paper based to DATIX mortality module, working with Welsh Risk Pool, Stage 1 is currently being introduced at YGC, with a view to spread to others before end November. Notably this move has been associated with an increase in referrals for stage 2 review

On the same platform, Stage 2 has been re-designed based on "Structured Judgement Review". This change is to better align review processes with the expectations set out in the BCU Learning from Deaths policy. A number of workshops are being held throughout October, on each District General Hospital (DGH) site to familiarise staff and secure engagement in its development.

Secondary Care are aware of these problems, and there are plans for this to be discussed at Secondary Care Quality Group.

CHKS report July 18-July 19: (Includes In-Patient beds only) – appended to this document

CCS Group	Crude Death Rate (v peer)	RAMI 2018 (v peer)
Hip Fracture (Age 65 and over)	3.6 v 5.56	69 v 84
Sepsis	14% v 15.7%	81.7v 87.8
Pneumonia	15.25% v 15.76%	81.7 v 87.7
Myocardial Infarction	5.9% v 6.8%	104. v 96.5
Cerebrovascular disease including stroke	12.7% v 11.57%	100.1 v 89

Key points:

- On CHKS data, mean Crude Mortality over the year to July 2019 was 1.74%, representing an improvement on July 2018 where it was 1.8%. RAMI 99.3 has also improved and remains better than peer.
- Septicaemia (except in labor) was 81.7 remaining better than average and peer
- Taking a threshold RAMI of 150, and numerator greater than 50, there are no alerting conditions
- 30-day mortality from myocardial infarction has shown an improvement in RAMI since last report.
- Hip fracture of concern in the previous report has also improved.
- While the position on Stroke is average, this has deteriorated and remains worse than peer.
- All are subject to national audit and crude death rate is as expected for all groups. This is currently reflecting common cause variation.
- Previously flagged as a concern, Rate of Mortality in hospital within 30 days of elective surgery compared between those two time periods, has improved from 0.17 to 0.14%. This compares with a peer value of 0.12%

Top-10 codes associated with death accounted for 65.5% of deaths falling into the diagnoses below. More deaths on this occasion fall to this top-10, comparing with 51% previously. 68 deaths were un-coded at the time of reporting, accounting for 3.5% of all deaths for this period.

CCS Group	Deaths
122 - Pneumonia (except that caused by tuberculosis or sexually transmitted disease)	553
2 - Septicaemia (except in labor)	336
109 - Acute cerebrovascular disease	263
108 - Congestive heart failure; nonhypertensive	155
127 - Chronic obstructive pulmonary disease and bronchiectasis	141
157 - Acute and unspecified renal failure	117
19 - Cancer of bronchus; lung	115
129 - Aspiration pneumonitis; food/vomitus	88
159 - Urinary tract infections	87
42 - Secondary malignancies	85

Recommendations:

There are no significant issues highlighted in this report with most mortality being described as appropriate for the population served. Specifically, mortality rate in YGC ED has reduced over time.

1. Current information relates to in-patient deaths and excludes information from primary care and the majority of MH/LD patients. Further work is required to capture this activity. Meetings are in progress to investigate what information is available (Lead: Senior Associate Medical Director)
2. All sites need to review their mortality review processes to ensure that patients identified for stage 2 are reviewed, lessons learnt, and appropriate action taken. While the move to the DATIX mortality module should facilitate processes and reporting, all sites face a significant back-log.
3. Where the crude death rate has increased sites need to assure themselves that effective care is being delivered and findings from ongoing national audits inform improvement.
4. Expected reductions in crude death rate will require actions which reduce common cause variation; there are a number of actions in progress that support this including improved inpatient care (Lead: Interim Director of Nursing) and the sepsis collaborative (Lead: Senior Associate Medical Director). However, through the RAMSG a corporate work plan needs to be developed, targeting high impact areas such as pneumonia and Acute Kidney Injury (AKI). (Lead: Senior Associate Medical Director)

YGC ED deaths:

1. There is ongoing work to review “Dead on Arrival” patients to check the accuracy of the data and also, working with Wales Ambulance Services NHS Trust (WAST) to see if there were prehospital factors of note. There is work in progress with the Area team to review patients thought to be end of life on admission; investigating if there is value in a primary care review process to identify potential actions. Report awaited.
2. As a consequence of improvements in medical staffing, it has been agreed all deaths will be reviewed using Structured Judgement Review (SJR).
3. Three months of deaths have been reviewed using SJR by the ED team, and will be analysed by the Senior Associated Medical Director by the end of October for quality assurance as well as to extract lessons.
4. They are active members of the Sepsis collaborative and care bundle delivery has improved. This work needs to be embedded.

Description	Local Numerator	Tariff (£) without MFF	Jul 18 - Jul 19	Cost (£)	Jul 17 - Jul 18	Change	Peer Value	Performance	Alert	Notes
RAMI (Risk adjusted mortality index) 2018	3810		93.54	0	97.37		99.29		-	0 Note
HSMR (Hospital Standardised Mortality Ratio) +	0		-	0	-		-	No data to display	-	0 Note
SHMI (Summary Hospital-Level Mortality Index) +	0		-	0	-		-	No data to display	-	0 Note
Mortality Rate	3810		1.7440%	0	1.8145%		1.6869%		Amber	0 Note
Rate of Mortality in hospital within 30 days of elective surgery	11		0.13612%	0	0.16837%		0.12386%		Amber	0 Note
Rate of Mortality in hospital within 30 days of Non elective surgery	187		1.4070%	0	1.6313%		1.5191%		-	0 Note
% Mortality in hospital within 30 days of emergency admission with a heart attack (MI) aged 35 to 74	24		3.954%	0	3.323%		3.442%		Amber	0 Note
Rates of mortality in hospital within 30 days of emergency admission with a stroke	175		13.069%	0	14.018%		11.782%		Amber	0 Note
% Mortality in hospital within 30 days of emergency admission with a hip fracture (age 65 and over)	42		4.321%	0	4.440%		5.456%		-	0 Note

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FCE (Finished Consultant Episode) deaths with palliative care code Z515	739	19.733%	2,427,837	20.783%		20.998%		-	0 Note
Sign and Symptoms as Primary Diagnosis (Episode 2)	1888	8.455%	2,452,058	8.946%		12%		-	0 Note
% Uncoded FCEs (Finished Consultant Episodes) - Blank Primary Diagnosis	4518	1.8236%	0	2.6987%		6.939%		-	0 Note

Time periods:

Current	From July 2018 to July 2019
Comparison	From July 2017 to July 2018
Peer	From July 2018 to July 2019
Peer group:	User defined peer group (Includes 9 sites)

Attribution
PbR HRG

Show By
None applied

Filters
None applied

Notes
0 Note

+ - These indicators have time period issues.

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Quality, Safety & Experience Committee **19.11.19**	GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board ***To improve health and provide excellent care***

Report Title:	Primary & Community Care Assurance Report
Report Author:	Clare Darlington, Assistant Director Primary Care (Central Area) Grace Lewis Parry, Assistant Director Primary Care & Community Services
Responsible Director:	Dr Chris Stockport Executive Director Primary Care & Community Services
Public or In Committee	Public
Purpose of Report:	The report it presented in two parts. Part 1: To provide an overview report in relation to primary care and community services assurance. Part 2: To provide the quarterly report to the Board (via the QSE Committee) regarding Continuing Health Care (CHC) which is a requirement of Welsh Government (WG).
Approval / Scrutiny Route Prior to Presentation:	The development of the report has been progressed as a result of discussions at the North Wales Primary Care Quality & Safety (Q&S) Group, as well as Q&S meetings at an Area level. All such reports will be considered at the North Wales Primary Care Q&S and Area Q&S groups that immediately follow the quarter for which information has been collated. A CHC Improvement Group has been established as part of the Health Board's wider governance arrangements to develop clear and robust delivery and implementation plans. The Improvement Group oversees this work.
Governance issues / risks:	The Health Board is responsible for the commissioning and provision of primary care and community services in North Wales. The level and range of services required by the population as a whole is significant, with demand increasing, and the Health Board must ensure the provision best meets the needs of all residents, is safe and of an agreed quality.
Financial Implications:	There are no financial implications associated with this report.

Recommendation:	It is recommended that the QSE Committee: Part 1: • Reviews the core indicators and notes the actions taken; • Notes the new Quality Assurance Improvement Framework (QAIF) requirements of the General Medical Services (GMS) contract and considers any related future reporting requirements; • Considers any further detail that they may require for future reports; • Considers any 'focus on' topics that the Committee would find useful. Part 2: • Note the overarching approach to improving quality and assurance supported by the National Commissioning Collaborative Unit (NCCU). • Endorse the ongoing work to develop a single quality monitoring tool and a single care home action plan. • Approve the report for submission to Welsh Government as mandated.

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

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

Primary & Community Care Assurance Report – Part A

1. Purpose of report

The QSE Committee receive specific detail in relation to primary care services and to date have considered papers in March and July.

The Committee has requested that future reports are developed to include an overview of community services, over and above the assurance reports already presented from the Quality Safety Group (QSG), including detail in relation to Continuing NHS Health Care (CHC).

It is noted that quarterly reporting to the Board (via the QSE Committee) regarding CHC is a requirement of Welsh Government (WG) to ensure there is scrutiny and accountability at a local level.

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

2. Introduction

In line with the request of the QSE Committee, the following paper is divided into two parts as follows:

Part 1:

- Primary Care Q&S Core Indicators and related data in relation to primary care services for 2018/19 and the first 2 quarters 2019/20;
- Primary Care Assurance;
- A 'Focus On' highlighted topic area;
- Overview of reports in relation to Community Services and managed practices.

Part 2:

- An overview of Continuing Health Care (CHC), Funded Nursing Care (FNC), and Joint Funded Care.

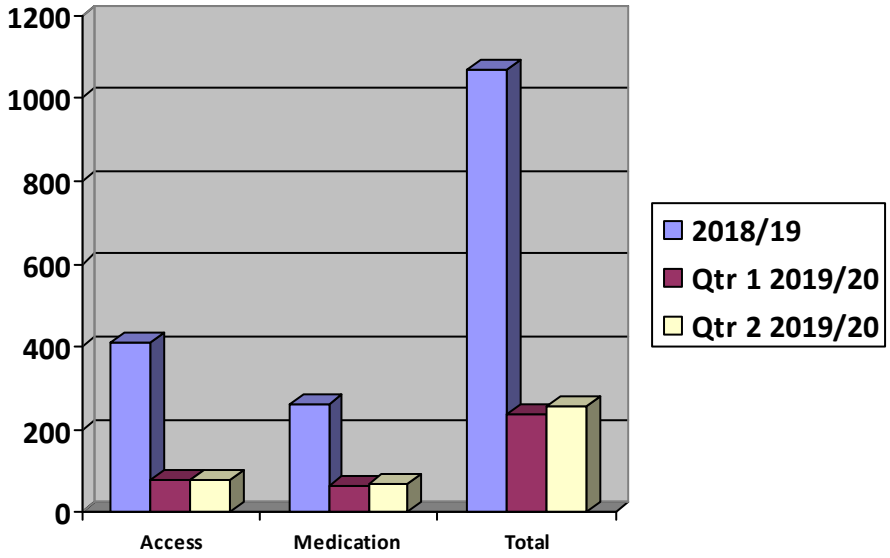
3. Primary Care Q&S Core Indicators

3.1 Incidents Reported

The number of incidents in 2018/19, and the first two quarters of 2019/20 are detailed below.

The main classifications for incidents reported in primary care are:

- Access, Appointment, Admission, Transfer, Discharge
- Medication

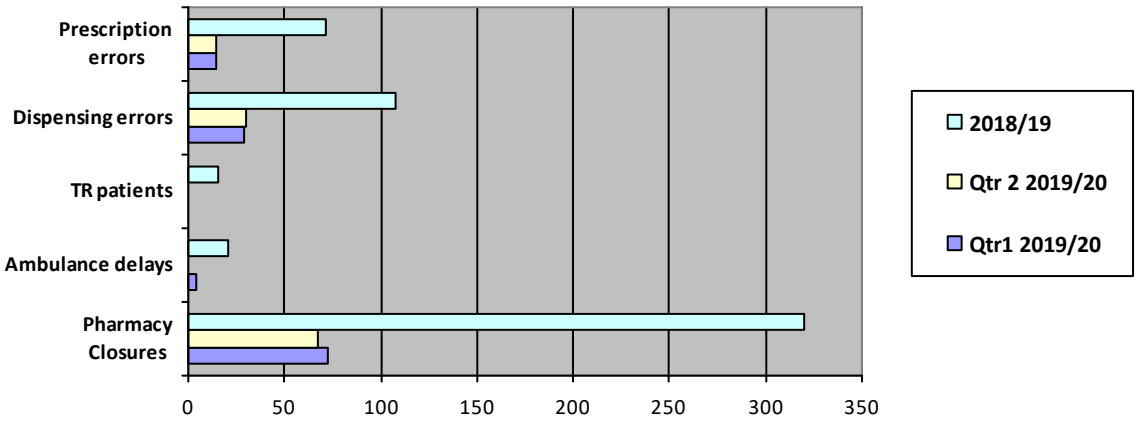


	Access	Medication	Total
2018/19	412	259	1069
Qtr 1 2019/20	80	64	236
Qtr 2 2019/20	79	70	256

The most notable sub-categories to these include:

- Temporary Pharmacy closures;
- Ambulance delays;
- Related to temporary resident patients;
- Preparation of medicines / dispensing in pharmacy;
- Medication error during the prescription process.

The breakdown of incidents into these categories in 2018/19, and the first two quarters of 2019/20 is detailed below:



	Pharmacy Closures	Ambulance delays	TR patients	Dispensing errors	Prescription errors
2018/19	320	21	16	108	71
Qtr 2 2019/20	67	1	0	30	15
Qtr1 2019/20	73	4	0	29	15

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

- Regular contact is made with the multiple community pharmacies in relation to temporary closures, to understand why there have been gaps in service and actions taken place to ensure future provision.
- All medication errors are investigated and any lessons learnt shared via the Primary Care 'Stories for Sharing' newsletter to reduce the likelihood of future errors.

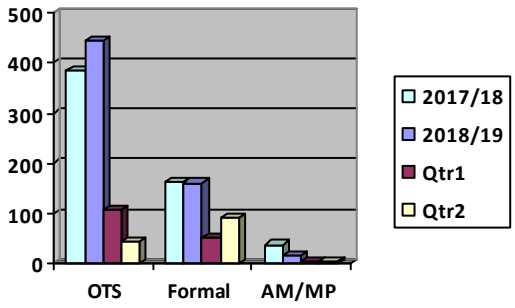
3.2 Concerns Reported

The number of concerns in 2018/19, and the first two quarters of 2019/20 are detailed below.

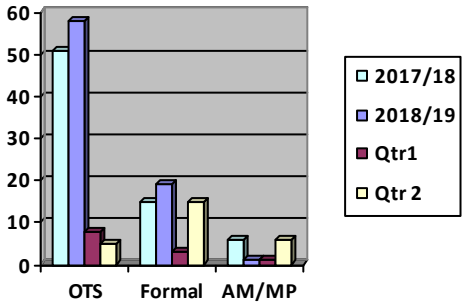
Contractor	Number of OTS* Q1 (2019/20)	Number of OTS Q2 (2019/20)	Number of Formal Q1 (2019/20)	Number of Formal Q2 (2019/20)	AM/MP Enquiry Q1 (2019/20)	AM/MP Enquiry Q2 (2019/20)
GP Practices	107	43	50	92	2	4
General Dental Practices	8	5	3	15	1	6
Community Pharmacies	1	7	1	3	0	0
Optician	0	0	0	0	0	0

* OTS = 'on the spot'

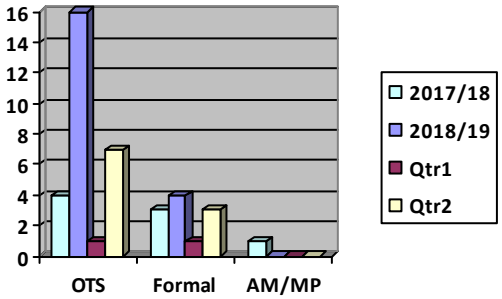
GP Practices:



Dental Practices:



Community Pharmacies:



The main categories of concern in GP practices in Quarter 2 related to consent, confidentiality and communication (47), often in relation to obtaining results or

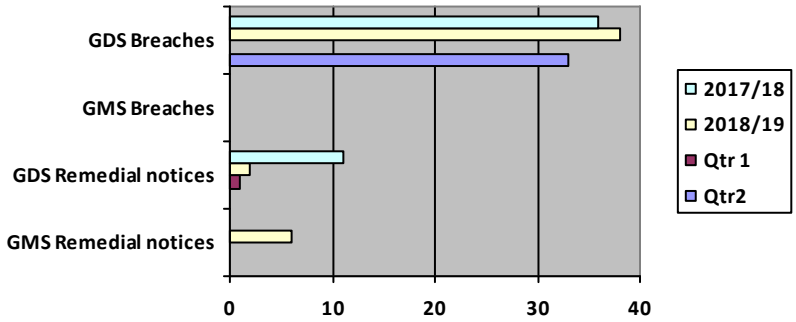
miscommunication with practice, and access, appointments, admission, transfer and discharges (36), with most of the OTS complaints related to access to an appointment.

The AM/MP concerns regarding General Dental Practices received during Q2 all related to access to primary care dental services in the Anglesey and Bangor area. Work is ongoing with regard to the development of a dental strategy for North Wales with a focus on equitable provision. Service option proposals are being progressed to try to address concerns in Gwynedd.

3.3 Contract Breaches

The number of remedial notices and breaches in 2018/19, and the first two quarters of 2019/20 are detailed below:

Contractor	Number of Remedial Notices Q1(2019/20)	Number of Remedial Notices Q2(2019/20)	Number of Breaches Q1(2019/20)	Number of Breaches Q2(2019/20)
GP Practices	0	0	0	0
General Dental Practices	1	0	0	33



During Q2, 33 General Dental Services (GDS) contractors were issued contract breach notices relating to under delivery of contract activity by more than 5% during 2018/19.

3.4 Performance Issues

As at October 2019 the number of suspensions and General Medical Council (GMC) / General Dental Council (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	0	0	1
West	0	1	2	1	4
Central	0	0	2	0	2
Total	**2**	**1**	**4**	**1**	**7**

3.5 Prescribing Indicators

Primary care prescribing is improving 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. This supports collaborative working between Primary Care and the Pharmacy and the BCUHB Medicines Management team.

Antimicrobial stewardship
Since 2014/15 there has been a steady decline in prescribing of antibiotic items per 1000 STAR-PU across primary care in North Wales. There have been reductions of prescribing in all 14 clusters, the reduction in the first quarter of this financial year is 11%. There remains a focus on the 10% of practices with the highest antibiotic prescribing rates to improve further.

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

Efficiency indicator – Proton pump indicator
Since 2014/15 there has been a significant reduction of prescribing of Proton Pump Inhibitors (PPI). Divided Daily Doses (DDD) per 1000 PU was achieved, with continued steady progress across North Wales. This has been supported by a combined strategy involving primary and secondary care pharmacy teams. Where PPIs have been initiated during an inpatient stay, the pharmacists ensure there is a clear management plan, or the medication is stopped prior to discharge. BCUHB has moved from being the worst, to being ranked 3rd best in Wales, which is detailed in the diagrammatic representation at Appendix 1. Unfortunately a recent alert has led the widespread recall of an alternative dyspepsia treatment “Zantac® / ranitidine”. In order to provide effective care for patients with gastrointestinal disease patients have been offered a review and an alternative treatment option of an antacid or a PPI. It is likely that there will be a significant growth in PPI prescribing across England and Wales from September 2019 onwards.

Falls prevention
Pharmacy and Medicines Management is a member of the strategic falls group. The diagram in Appendix 1 demonstrates the continued steady progress across North Wales to reduce the use of hypnotics and anxiolytics, which are known to significantly increase the risk of falls. There have been reductions of prescribing in all 14 cluster areas, giving an overall reduction in total usage of 1.47%. There continues to be a focus on the 10% of practices with the highest prescribing rates to improve further, particularly in Gwynedd, and Wrexham. Denbighshire has made significant improvement over the last quarter.

3.6 General Dental Services Indicators

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

Quality indicators for the last quarter of 2018/19 and first 2 quarters for 2019/20 are set out below:

	Q4 2018/19		Q1 2019/20		Q2 2019/20	
Quality Indicators	**LHB**	**Wales**	**LHB**	**Wales**	**LHB**	**Wales**
Radiographs Rate per 100 FP17s *	22.6	20.8	22.8	21.0	22.5	20.6
Fluoride Varnish Rate per 100 FP17s (3-16 yr old patients)	43.6	42.9	44.6	45.2	45.8	49.2
Extractions Rate per 100 FP17s	5.9	6.0	5.6	6.0	5.9	5.9
Re-attending within 3 months – Child	5.6	6.0	5.5	6.0	5.6	6.0
Re-attending within 3 months – Adults	12.5	12.9	12.0	12.4	12.3	12.4
% satisfied with dentistry received	92.7	92.4	92.9	92.9	92.9	93.1
% satisfied with wait for an appointment	87.0	87.2	86.7	87.4	85.1	87.4

-* 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. Patient satisfaction with wait for an appointment is lower and reflects the patient access issues currently being experienced, particularly in the West Area.

4. Primary Care Q&S Assurance

4.1 Quality Assurance Visiting Programme

A Quality Assurance Visiting Programme (QAVP) is in place across GP Practices, Dental Practices and Community Pharmacies which serves to seek assurances that providers have adequate clinical governance frameworks in place.

The programme has been paused for GP practices whilst processes have been reviewed. A revised approach has been developed which utilises information from the Clinical Governance Self Assessment Tool (CGSAT) as a focus and also includes learning from Healthcare Inspectorate Wales (HIW) inspections and performance issues. Every GP practice will be included in the re-launched programme and if it is concluded that a practice would benefit from greater assistance, a further visit from a wider multi disciplinary team will be arranged. The QAVP for GP Practices will be commencing in Q4 2019/20.

4.2 Health Inspectorate Wales & 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:

Contractor	**Number of Visits 2018/19**	**Number of Visits Q1 2019/20**	**Number of Visits Q2 2019/20**
GP Practices	5	1	3
General Dental Practices	9	1	3

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	No report published as yet.
Meddygfa Gyffin, Conwy	12/09/19	No report published as yet.

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	No report published as yet.

5. Focus On: GMS Contract 2019/20

The 2019/20 GMS contract agreement included the Quality Assurance and Improvement Framework (QAIF) which replaces the previous Quality and Outcomes Framework (QOF). This puts the focus on quality assurance of provision of care and quality improvement and is intended to support a cultural shift from what has been previously perceived by some as a "tick box" exercise. It also seeks to build on Welsh Government's approach to incentivise and prioritise cluster working.

Achievement for Quality Assurance (QA) and Quality Improvement (QI) will be measured at 30th September each year, with the first assessment date being 30th September 2020

The QA domain has been designed to take account of complimentary engagement in national audits. The QA domain has two component parts, clinical indicators and cluster network indicators.

QAIF Clinical Indicators

The clinical indicators for 2019/20 consist of active and inactive indicators, as was the case with the QOF in 2018/19. This will allow Welsh Government and the Health Board to look further at the data behind the inactive indicators during the year and to evaluate activity.

Clinical active indicators include disease registers, two flu indicators and a dementia indicator.

Clinical inactive indicators will be reported on for 2019/20 cycle and paid at full point value. All other clinical indicators from the former QOF have been retired.

QAIF Cluster Network Domain

Mandatory membership of a GP Cluster network is now included in the requirements of the core GMS contract.

This domain enables the maintenance of a clear link between activity and financial reward through reformed cluster output/activity indicators related to engagement (at least 5 meetings, contributing information to cluster Integrated Medium Term Plans (IMTPs), which are due for completion by September each year, and the delivery of outcomes for relevant services.

Significant work has been undertaken within the Health Board to ensure that Cluster IMTPs were completed by the end of September 2019. Whilst the feedback from the BCUHB submissions was excellent, it is also acknowledged that this is their first year of production and there have been some issues with the availability of data produced nationally. The expectation is that these first iterations will be further developed and improved for 2020.

QAIF Quality Improvement Domain

The Quality Improvement (QI) domain is based on QI projects that practices will complete. The work will be overseen at cluster level with agreed and measured improvements to be delivered.

In 2019/20, practices will undertake:

- Patient Safety Project aimed at reducing medicines related harm (mandatory)
- QI training to help develop their approach to quality improvement
- One QI project (from a selection available)

In 2020/21, practices will undertake:

- Patient Safety Project (mandatory)
- Two QI projects (from a selection available)

QAIF Access Standards

The Minister for Heath and Social Services announced new access standards for GMS in March 2019, and the expectation is that these will be achieved by March 2021. £13 million has been invested across Wales to improve access which includes an investment of £3.7 million into Global Sum this year. This is to support practices in securing and implementing the necessary infrastructure in order to achieve the standards. Health Boards will also be expected to support with this.

There are 2 groups of standards to be achieved:

- Group 1 – infrastructure & systems (5 standards)
    - Telephony systems
    - Digital access
    - Consistent messaging & signposting
- Group 2 – understanding patient needs (3 standards)
    - A more informed public
    - Understanding & responding to patient needs at a practice & cluster level

Achievement for the standards will be assessed on financial year basis (unlike the other QAIF domains), with practices required to submit evidence by 31st March.

Within Group 1, practices can choose to achieve 3, 4 or 5 of the standards and payment will be made accordingly. Where practices choose to achieve all standards in Group 1 and Group 2, then they will be eligible for an additional Achievement Quality payment bonus of 25 points.

QAIF Reporting & Monitoring

There are a number of additional requirements placed on Health Boards in relation to the verification, reporting and monitoring of these standards. With one small exception, the expectation is that 100% practices will achieve all standards by March 2021.

The Health Board is required to establish an "Access Forum" to review and monitor performance against the standards, share best practice and assist with development of initiatives through clusters. BCUHB will re-constitute a former group, with some amendments to meet this requirement.

The Access Forum is expected to report to the appropriate leadership group within the Health Board, and ensure that quarterly updates on access are provided to Executives and Board level. Performance against the standards will also routinely feature at quarterly Quality & Delivery meetings between the Executive Team and Welsh Government.

5. Further Reports

In addition to the detail provided in the sections above, indicators and reports are also generated for community services and draft key performance indicators (KPIs) are being piloted for managed practices.

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.

For managed practice a dashboard of various performance indicators has been developed over and above the core GMS indicators highlighted in the earlier

sections of this report. These are divided into workforce, finance and Q&S indicators, which include concerns, incidents, access and capacity measures. Collation of this information has commenced, with further work to be undertaken once the coordination of managed practices is brought together into a single managed practice unit.

As this work develops detail can be presented to the QSE Committee as required.

6. Conclusion

The paper provides assurance to the Committee regarding the management of quality & safety in primary care. Reference is made to the current assurance processes for community services and the developments in place in relation to managed practices.

Part 2 provides the quarterly report required for Continuing NHS Healthcare.

7. Recommendations

It is recommended that the QSE Committee:

- Reviews the core indicators and notes the actions taken;
- Notes the new QAIF requirements of the GMS contract and considers any related future reporting requirements;
- Considers any further detail that they may require for future reports;
- Considers any ‘focus on’ topics that the Committee would find useful.

(Recommendations in relation to CHC are detailed in the Part 2 report)

APPENDIX 1
Prescribing Indicators (BCUHB trend in bold)

Main Dashboard - Indicator Filter

SPIRA

AWTTC

2019/20 NPIs - Antibacterial Items Per 1000 STAR-PU(13)

Click on the name of a single healthboard below to highlight data for that healthboard.

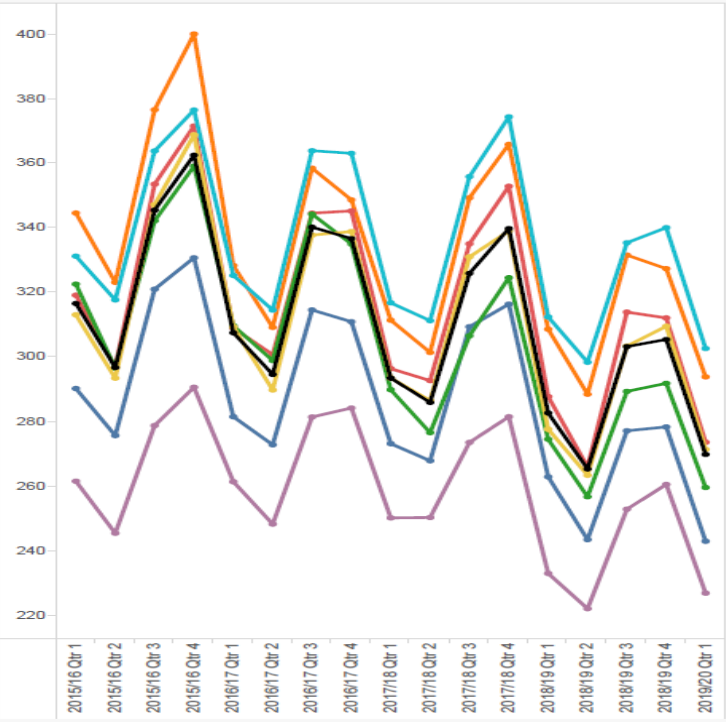
NPIs for 2019/20

Indicator Description
Antibacterial Items Per 1000 STAR-PU(13)

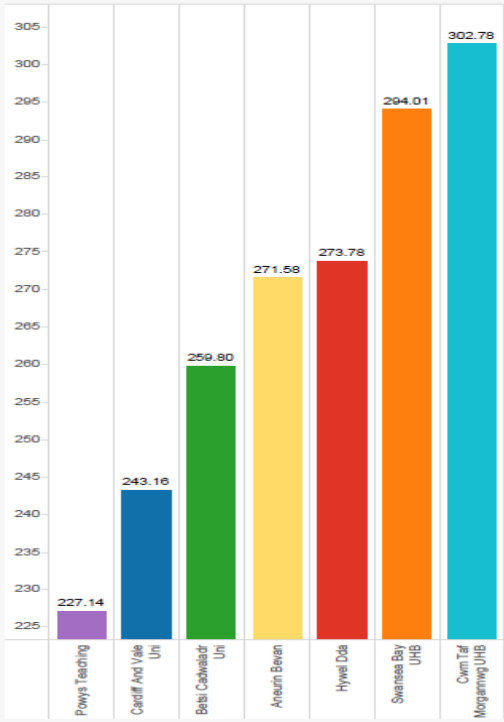
Click Revert (at the bottom left of the screen) or click in an empty space to remove highlights and reset the dashboard

	Values				Absolute Change - Qtr on Qtr				% Change - Qtr on Qtr			
	2018/19 Qtr 2	2018/19 Qtr 3	2018/19 Qtr 4	2019/20 Qtr 1	2018/19 Qtr 2	2018/19 Qtr 3	2018/19 Qtr 4	2019/20 Qtr 1	2018/19 Qtr 2	2018/19 Qtr 3	2018/19 Qtr 4	2019/20 Qtr 1
Aneurin Bevan	263.60	303.52	309.65	271.58		39.93	6.13	-38.07		15.15%	2.02%	-12.30%
Betsi Cadwaladr Uni	256.93	289.52	292.02	259.80		32.59	2.50	-32.22		12.68%	0.86%	-11.03%
Cardiff And Vale Uni	243.67	277.34	278.52	243.16		33.67	1.18	-35.36		13.82%	0.43%	-12.70%
Cwm Taf Morgannwg UHB	298.54	335.48	340.16	302.78		36.94	4.68	-37.38		12.37%	1.39%	-10.99%
Hywel Dda	266.14	314.03	312.23	273.78		47.89	-1.80	-38.45		17.99%	-0.57%	-12.31%
Powys Teaching	222.34	253.09	260.75	227.14		30.75	7.66	-33.60		13.83%	3.03%	-12.89%
Swansea Bay UHB	288.64	331.69	327.47	294.01		43.04	-4.22	-33.46		14.91%	-1.27%	-10.22%
NHS Wales	265.54	303.37	305.58	270.02		37.83	2.20	-35.55		14.25%	0.73%	-11.64%

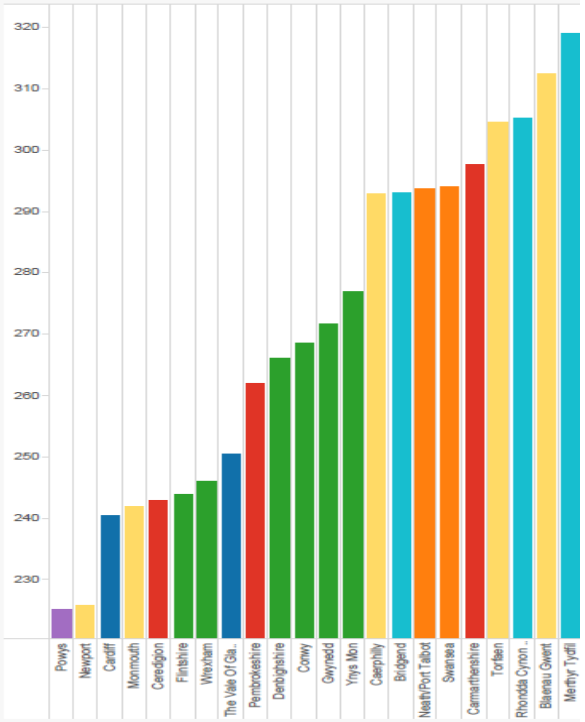
Quarterly trend line
Health Board only target - 5% reduction 0.00



Health Board data for the latest quarter - 2019/20 Qtr 1



Locality data for the latest quarter - 2019/20 Qtr 1



Main Dashboard - Indicator Filter

SPIRA

AWTTC

2019/20 NPIs - Proton Pump Inhibitors DDDs per 1000 Pus

Click on the name of a single healthboard below to highlight data for that healthboard.

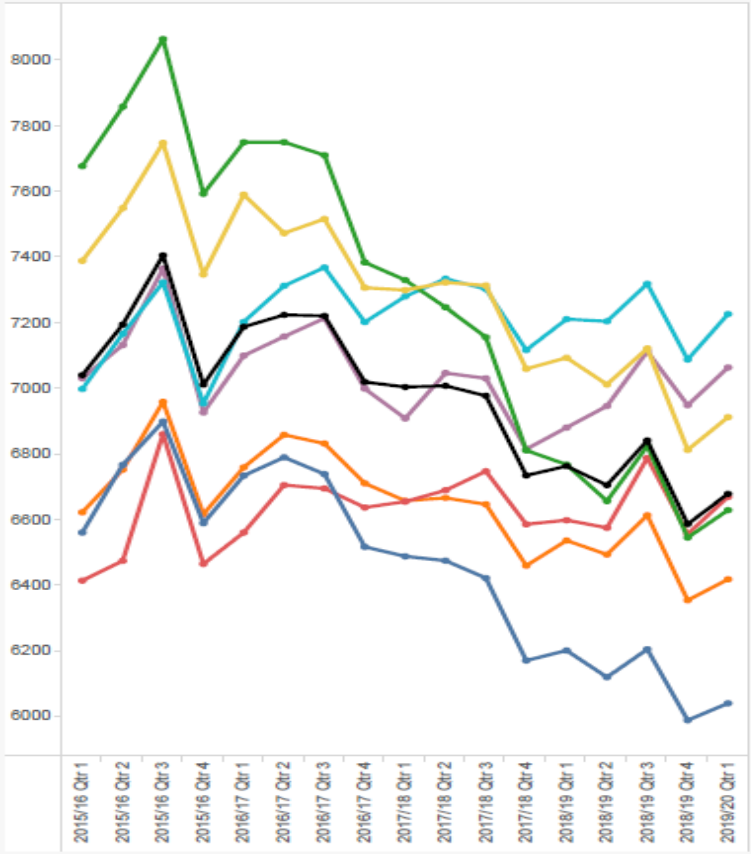
NPIs for 2019/20

Indicator Description
Proton Pump Inhibitors DDDs per 1000 PUs

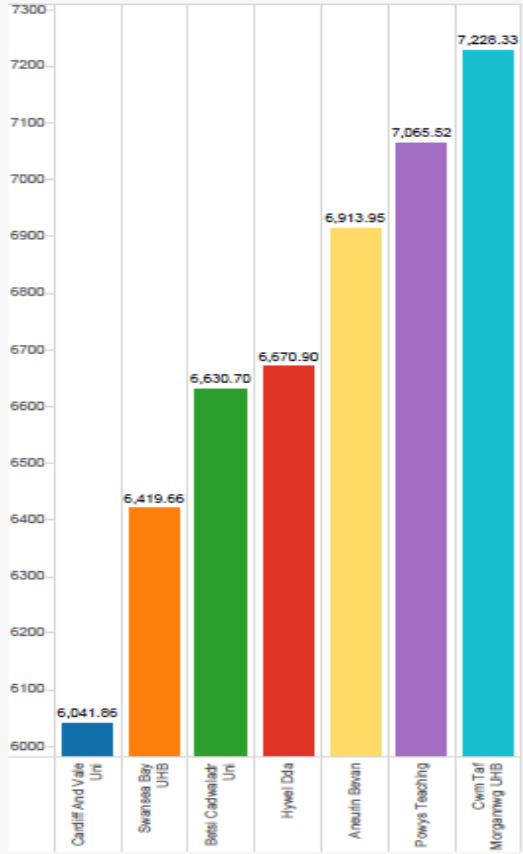
Click Revert (at the bottom left of the screen) or click in an empty space to remove highlights and reset the dashboard

	Values				Absolute Change - Qtr on Qtr				% Change - Qtr on Qtr			
	2018/19 Qtr 2	2018/19 Qtr 3	2018/19 Qtr 4	2019/20 Qtr 1	2018/19 Qtr 2	2018/19 Qtr 3	2018/19 Qtr 4	2019/20 Qtr 1	2018/19 Qtr 2	2018/19 Qtr 3	2018/19 Qtr 4	2019/20 Qtr 1
Aneurin Bevan	7,013.83	7,123.60	6,814.32	6,913.95		109.76	-309.27	99.63		1.56%	-4.34%	1.46%
Betsi Cadwaladr Uni	6,658.43	6,826.01	6,546.97	6,630.70		167.57	-279.04	83.73		2.52%	-4.09%	1.28%
Cardiff And Vale Uni	6,121.41	6,206.44	5,990.09	6,041.86		85.03	-216.35	51.77		1.39%	-3.49%	0.86%
Cwm Taf Morgannwg UHB	7,206.15	7,320.53	7,089.58	7,228.33		114.38	-230.96	138.75		1.59%	-3.15%	1.96%
Hywel Dda	6,576.82	6,789.84	6,558.00	6,670.90		213.02	-231.84	112.90		3.24%	-3.41%	1.72%
Powys Teaching	6,947.84	7,114.63	6,950.52	7,065.52		166.78	-164.11	114.99		2.40%	-2.31%	1.65%
Swansea Bay UHB	6,495.30	6,614.96	6,355.80	6,419.66		119.66	-259.16	63.86		1.84%	-3.92%	1.00%
NHS Wales	6,706.64	6,843.01	6,588.05	6,680.55		136.37	-254.95	92.50		2.03%	-3.73%	1.40%

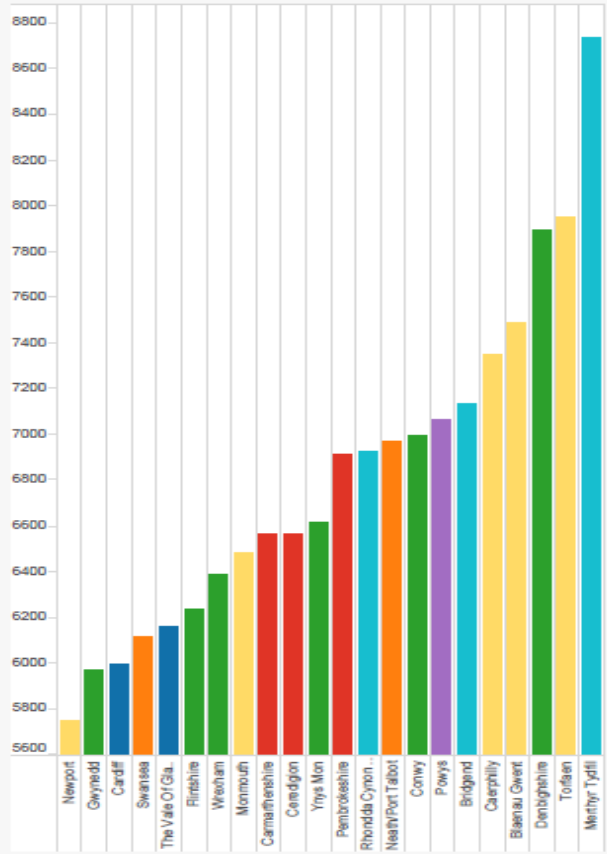
Quarterly trend line
Lower values are closer to the threshold 5,954.37



Health Board data for the latest quarter - 2019/20 Qtr 1



Locality data for the latest quarter - 2019/20 Qtr 1



Main Dashboard - Indicator Filter

SPIRA

AWTTC

2019/20 NPIs - Hypnotics and Anxiolytics (UDG) ADQ Quantity per 1000 STAR-PU(13)

Click on the name of a single healthboard below to highlight data for that healthboard.

NPIs for 2019/20

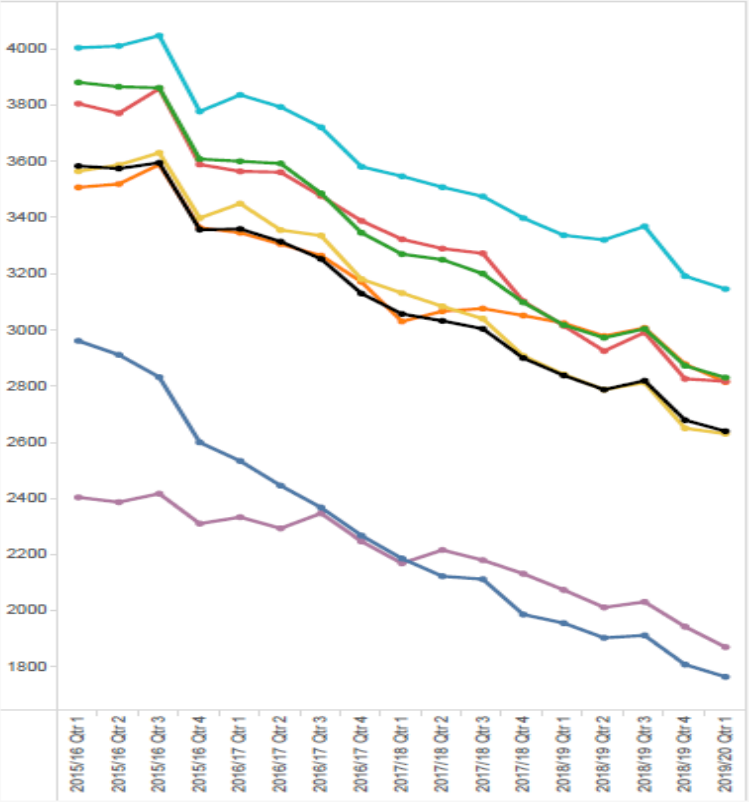
Indicator Description Hypnotics and Anxiolytics (UDG) ADQ Quantity per 1000 ...

Click **Revert** (at the bottom left of the screen) or click in an empty space to remove highlights and reset the dashboard

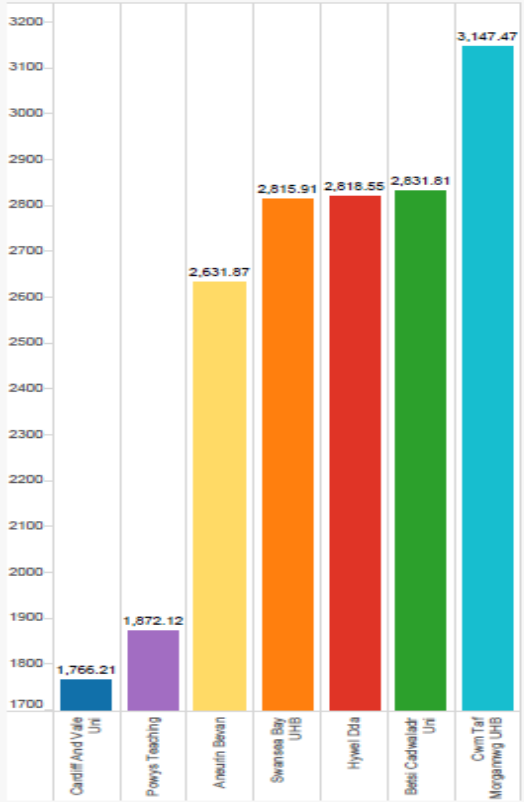
	Values				Absolute Change - Qtr on Qtr				% Change - Qtr on Qtr			
	2018/19 Qtr 2	2018/19 Qtr 3	2018/19 Qtr 4	2019/20 Qtr 1	2018/19 Qtr 2	2018/19 Qtr 3	2018/19 Qtr 4	2019/20 Qtr 1	2018/19 Qtr 2	2018/19 Qtr 3	2018/19 Qtr 4	2019/20 Qtr 1
Aneurin Bevan	2,789.01	2,813.84	2,651.52	2,631.87		24.83	-162.31	-19.65		0.89%	-5.77%	-0.74%
Betsi Cadwaladr Uni	2,973.76	3,005.68	2,874.11	2,831.81		31.91	-131.56	-42.30		1.07%	-4.38%	-1.47%
Cardiff And Vale Uni	1,905.01	1,913.89	1,809.96	1,766.21		8.88	-103.92	-43.76		0.47%	-5.43%	-2.42%
Cwm Taf Morgannwg UHB	3,322.50	3,370.52	3,193.36	3,147.47		48.02	-177.16	-45.90		1.45%	-5.26%	-1.44%
Hywel Dda	2,926.81	2,992.47	2,827.60	2,818.55		65.67	-164.87	-9.05		2.24%	-5.51%	-0.32%
Powys Teaching	2,013.53	2,033.21	1,944.90	1,872.12		19.68	-88.32	-72.78		0.98%	-4.34%	-3.74%
Swansea Bay UHB	2,979.93	3,008.86	2,879.90	2,815.91		28.93	-128.96	-63.99		0.97%	-4.29%	-2.22%
NHS Wales	2,788.87	2,820.93	2,680.59	2,641.04		32.06	-140.33	-39.56		1.15%	-4.97%	-1.48%

Quarterly trend line

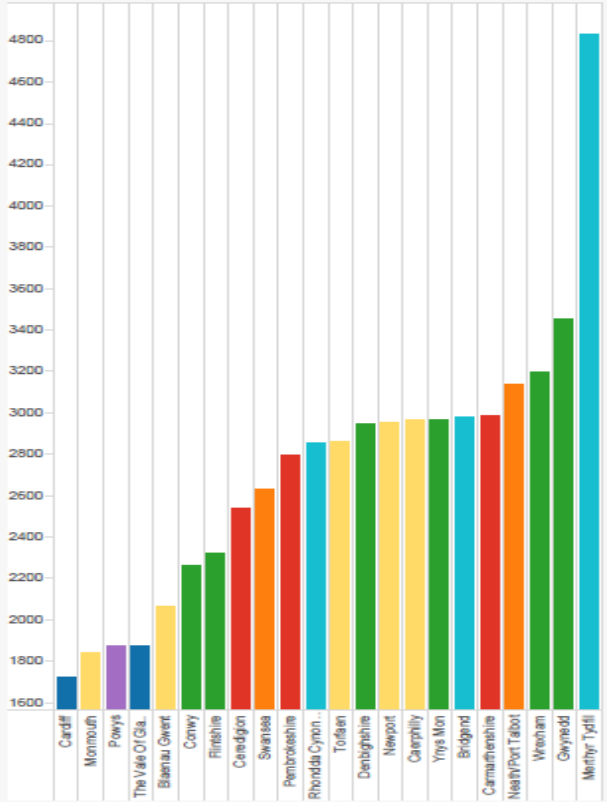
Lower values are closer to the threshold 1,888.96



Health Board data for the latest quarter - 2019/20 Qtr 1



Locality data for the latest quarter - 2019/20 Qtr 1



Primary & Community Care Assurance Report – Part B

Continuing NHS Healthcare Quarterly Report
July – October 2019

1. Purpose

This paper provides an overview of Continuing Health Care (CHC), Funded Nursing Care (FNC), and Joint Funded Care with local authorities. In line with National Framework this report focuses on:

- CHC strategy across the health and social care sector in North Wales.
- Consistency with the CHC National Framework 2014 including retrospective CHC claims
- Care Home quality
- Financial assurance
- Partnership working

Quarterly reporting to the Board (via the Quality Safety & Experience Committee) is required by Welsh Government (WG) to ensure there is scrutiny and accountability at a local level.

2. Background and context

For individuals eligible to receive it, Continuing Health Care (CHC) is an entitlement.

The Health Board is therefore responsible for ensuring consistent and accurate application of the CHC National Framework. The effective delivery of CHC is a key component of the Health Board's business and the Executive Director Primary Care and Community Services is responsible for monitoring performance and maintaining strategic oversight. CHC delivery within BCU is operationally devolved to Area Teams and the Mental Health and Learning Disability (MHLD) Division, with children's CHC hosted by the Central Area team.

The CHC National Framework (2014) is the current policy guidance. In July/ August 2019 WG undertook a consultation on an updated CHC National Framework. The outcome of the consultation is expected by the end of the year with a view to implementation from April 2020. It is anticipated that within the revised national framework new local and national reporting arrangements will be specified.

A National Complex Care Clinical Leads Group has been established reporting to the Health and Social Care National Commissioning Board.

CHC performance monitoring arrangements include:

- Internal audit programme
- Wales Audit office programme
- National self-assessment reporting

- National arrangements for individual HB case reviews

In 2018 BCU purchased a case management tool, BroadCare, to support case management and data intelligence for CHC. Since April 2019 BroadCare has been the main operational tool for local teams. Work continues to address outstanding issues relating to financial reconciliation and information technology so that by 2020 the Health Board routinely uses Broad Care as its primary source of business intelligence.

3. Strategic Approach

In April 2019 work supported by Price Waterhouse Cooper within BCU set out an ambition to significantly improve grip and control, to deliver cost efficiencies through standardising the CHC internal processes , improving management controls and developing more effective provider market management.

A number of key tasks were prioritised including implementing the “Checklist” across all teams; reviewing and standardising the FastTrack process; developing enhanced reporting and monitoring.

Use of the “Checklist” was mandated across the Health Board in June / July 2019 and a single FastTrack process was implemented in September 2019. Development of enhanced reporting and monitoring is underway and has commenced with national benchmarking data being generated and analysed.

A CHC Improvement Group has been established as part of the Health Board’s wider governance arrangements to develop clear and robust delivery and implementation plans. This is to ensure the organisation does not fail in its statutory duties and addresses unacceptable variations in service quality outcomes and patient experience.

During September/ October 2019 the Health Board started a new partnership with the National Commissioning Collaborative unit (NCCU), to redesign the way in which CHC services are procured and delivered. NCCU are working with BCUHB to review current CHC processes with a view to enhancing and streamlining them, ensuring that patients who meet the criteria for CHC funding are identified appropriately and funding agreements of suitable placements are as robust and timely as possible. It is acknowledged that we are building a process for the future and learning from what has already been achieved by the Mental Health & Learning Disabilities Division who have been working with NCCU for the past 18 months.

In dialogue with NCCU and in accepting their implementation timescales the Health Board understands there is a need for immediate additional support that is complimentary to the longer-term service redesign. It is proposed that the BCU led team will focus on 2 key priorities; firstly developing and enhancing skills and knowledge within the existing teams , learning from best practice and secondly the implementation of a care coordination model. The financial recovery group / finance and performance committee is overseeing the detail of the options being explored for additional support, which will complement the work underway with NCCU.

4. Performance and Assurance

4.1 CHC Framework

The devolvement of CHC services has brought about a greater understanding and ownership at a local level but there is evidence to suggest that there are variances in the way CHC services are accessed and a lack of robust assurance with regard to the quality of care in some areas. This situation has also impacted on the outright cost of CHC.

4.2 Retrospective CHC cases

The Health Board, via the Corporate CHC team, manages applications for retrospective reviews of CHC eligibility. These reviews are in respect of individuals who have contributed financially to care fees but who now believe the NHS should have funded their care in full. WG directed all Health Boards to adopt a nationally prescribed process to manage retrospective applications and BCU has fully implemented these procedures. (Further details are available in *'Continuing NHS Healthcare the National Framework for Implementation in Wales (2014)' Section 6: Retrospective Claims for Reimbursement).*

In addition WG supported a national programme hosted by Powys Health Board to manage the backlog of CHC retrospective reviews nationally. In June 2019 the Powys project came to a close and remaining cases were returned to their individual HB's. 41 cases at varying stages of completion were returned to BCU.

Remaining activity required included reviews, peer reviews, negotiation meetings with claimants and solicitors, ratification by Independent Chairs'. The breakdown of remaining work of the 41 cases as of 15th October 2019 is shown below.

Status (15.10.19)	**Number of cases**
Work required completed	18
Negotiation responses completed	8
Claimant/Negotiation Meetings scheduled	5
Awaiting Independent Chair ratification	4
Allocated for review	1
Independent Review Panel scheduled	3
Legal authority awaited	1
Response post-meeting	1
Total	**41**

The overall status of the retrospective cases managed as part of the project are 268 / 347 complex cases now completed or closed.

There has been national interest regarding the time it has taken for retrospective reviews to take place. The average time from activation to review completion is shown for the various phases of the project below.

***Completion date assumed to be same as review date where no eligibility agreed**

Phase	Average Days to Review	Average Days to Complete
Phase 2	275	494
Phase 2 - Alive	677	783
Phase 3	272	439
Phase 3 - Alive	652	716
Phase 4	480	619
Phase 5	480	559
Phase 6	465	511
Phase 7 - 17/18	396	352
Phase 7 - 18/19	185	238
Phase 7 - 19/20	N/A	N/A
Phase 7 - 20/21	N/A	N/A
Phase 7 - 21/22	N/A	N/A
Average All Phases	**478**	**588**

The 2014 Framework gives timelines Health Boards are expected to adhere to. The Powys team was commissioned nationally to support breaches and below are the current BCHUB breach details required by WG. The BCU retrospective team are reviewing all the returned cases and matching the anticipated work load against capacity to avoid further breaches .

	Review Dates Breached			Review Dates Not Breached		
Phase	Review Completed	Review Not Completed	Total Breached	Review Completed	Review Not Completed	Total Not Breached
Phase 2	11	2	**13**	0	0	**0**
Phase 2 - Alive	9	4	**13**	0	0	**0**
Phase 3	0	0	**0**	1	0	**1**
Phase 3 - Alive	5	6	**11**	8	0	**8**
Phase 4	39	6	**45**	13	0	**13**
Phase 5	33	4	**37**	1	0	**1**
Phase 6	11	17	**28**	1	0	**1**
Phase 7 - 17/18	5	4	**9**	0	1	**1**
Phase 7 - 18/19	3	10	**13**	1	2	**3**
Phase 7 - 19/20	0	0	**0**	0	2	**2**
Phase 7 - 20/21	0	0	**0**	0	0	**0**
Phase 7 - 21/22	0	0	**0**	0	0	**0**
Total All Phases	**116**	**53**	**169**	**25**	**5**	**30**

Once a retrospective claim has been reviewed and a claimant is found eligible for reimbursement there is clear scrutiny from WG regarding the timeliness of claimant's payments and impact on delays to the HB in terms of interest accrued to claimants.
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4.3 Care Home Quality

Our understanding of the quality of care in care homes comes from a variety of sources. Information is largely, but not exclusively derived from;

- HB contracts routine monitoring
- LA contracts routine monitoring
- Quarterly self-declarations by Care homes to the HB contracts team
- Local area professionals meetings/ quality circle reviews

- The Educational Assessment Tool completed by practice development nurses from the Area teams' in individual care homes**.**
- Individual patient reviews

Wider intelligence also comes from individual provider meetings, Care Inspectorate Wales, Health Inspectorate Wales or wider LA teams such as education.

It is recognised that more needs to be done to streamline information requests and subsequent analysis. Work to develop a single quality monitoring tool across health and social care is underway:

- HB contracts team are mapping the 700+ information requests required of a single care home from various agencies
- LA and HB contracts teams where ever possible are arranging joint visits
- In line with CIW requirement care homes now develop a single corrective action plan (CAP) in response to concerns and improvements identified by the Health Board and relevant local authority.

The previous Care Home RAG report was taken off line in July 2019 to review the purpose, function and reliability of the information held. A number of issues were identified that indicated it utilisation was no longer aligned to its intended purpose. A revised Care Home trend RAG report will be reintroduced as part of the wider piece of work described above. Information will be identified at an early stage to support operational decision making and conforms with relevant information sharing policies and procedures.

The fragility of the nursing home market remains a significant challenge and monitoring / compliance activity in this area is undertaken in partnership with HB Continuing Health Care and Local Authority (LA) colleagues. In Quarter 2, the heath contracting team undertook 11 full care home, on site, monitoring visits. The detail on issues and associated risk and actions for homes in increasing / escalating concerns are reported via the Area Teams monthly reports to the BCUHB quality and safety group.

Joint integrated professionals (JIMP) meetings are held quarterly and include LA commissioners, CHC area teams, Safeguarding, Community Care Home Practice Development Nurses and Care Inspectorate Wales (CIW). In this forum early indicators of quality concerns can be proactively addressed with providers in a coordinated approach to prevent a need for formal escalating concerns.

A significant amount of time since the last report has been spent by BCU staff participating in care home monitoring visits and actively involved in monitoring seven homes/ domiciliary care providers who are in increasing or escalating concerns. In the East area this included Coed Duon ,resulting in an emergency home closure widely reported at the time. All patients were safely transferred to alternative placements within 48 hours.

Practice development nurses in Area/ Divisional teams are responsible for planned and responsive care home training and development. This means that bespoke

responses to care homes have been developed. The Executive Director of nursing has resumed the lead for care homes which will facilitate a BCU wide approach integrated with other programmes of work. To this end the Executive Nurse Director is coordinating a BCU wide single care home action plan shaped by the HASCAS and Ockenden recommendations and the National care homes report from CIW/ HIW in 2018.

4.4 Finance

CHC financial data is reviewed through the CHC Operational Group, CHC Improvement Group and Finance and Planning Committee with the position at Month 6 set out below.

Budget Area	Annual Budget £ 000's	Month 6 YTD Budget £ 000's	Month 6 YTD Actual £ 000's	Month 6 YTD Variance £ 000's	Annual Forecast £ 000's	Full Year Effect Variance £ 000's
AX55 : CHC/FNC AREA EAST	20,649,498	10,063,971	9,575,995	-487,976	19,051,017	-1,598,481
AX35 : CHC AREA CENTRE	21,385,342	10,585,097	10,744,124	159,027	21,433,818	48,476
AX15 : CHC AREA WEST	19,426,521	9,429,092	9,714,539	285,447	19,732,373	305,852
CHC/FNC MENTAL HEALTH	34,417,044	16,873,611	17,398,639	525,028	34,938,197	521,153
CHC/FNC CHILDRENS	2,097,581	1,044,076	1,442,515	398,439	2,819,721	722,140
TOTAL	**97,975,986**	**47,995,847**	**48,875,813**	**879,966**	**97,975,127**	**-859**

4.5 Commissioned Care: contracts and fees

The BCU contracts team have now secured 92% of patients' placements into formal contracting arrangements to safeguard both the patients' placements and the organisation.

Type of Care	Total	Total Value £000's	Signed Contracts	Value Signed Contracts £000's	% of Numbers	% of £
Domiciliary Care	68	10,764	67	10,540	99%	98%
Nursing Home	138	44,490	118	35,912	86%	81%
Residential Home	28	927	27	927	96%	100%
Secure Hospital / Wards	19	7,675	19	7,675	100%	100%
Specialist Hospital / unit	18	4,177	18	4,177	100%	100%
Grand Total	**271**	**68,033**	**249**	**59,231**	**92%**	**87%**

The North Wales regional core contract for Care Homes, known as the Pre placement agreement (PPA) is in final draft and will strengthen these arrangements.

5. Partnership working

The BCUHB teams have been supporting the partnership agenda and are currently involved in the following :

- **Gwynedd Domiciliary Care project –**the development of a new Domiciliary Care framework agreement for the Gwynedd Local Authority (LA) Further work is ongoing to determine the financial implications of any new proposed approach before a HB commitment can be given.

  - **Tywyn project-** Community services staff from Gwynedd LA and BCU staff have looked at the scope for rationalising the administrative processes and practical care options for individuals.
  - **NWCIS community equipment-** East area are working in partnership of shared resources to ensure a single quality assurance process, value for money process and access to equipment process in Flintshire and Wrexham. This model has provided equity of services, improved quality of equipment service provision and financial savings.
  - **Agreement resolution process:** Working with all 6 North Wales Local Authorities Heads of Adult Social Care or delegated representatives to set out a local resolution process to minimise the risk of joint funding disputes arising and have a clear, timely pathway for local resolution for when complex scenarios arise to ensure the individual's care journey is not impeded

6 **Recommendations:** The committee is asked to :

- Note the overarching approach to improving quality and assurance supported by NCCU.
- Endorse the ongoing work to develop a single quality monitoring tool and a single care home action plan.
- Approve the report for submission to Welsh Government as mandated.

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Quality Safety & Experience Committee **19.11.19**	 ***To improve health and provide excellent care***

Report Title:	Occupational Health and Safety (OHS) Quarterly 2 Report 1st July – September 30th 2019
Report Author:	Mr Peter Bohan, Associate Director of Health, Safety and Equality
Responsible Director:	Mrs Sue Green, Executive Director of Workforce and Organisational Development
Public or In Committee	Public
Purpose of Report:	This report provides an overview of incidents, accidents, health and safety activity and training covering the period July 1st to September 30th 2019. The gap analysis of legislation has now been completed and a comprehensive action plan developed. The findings are further discussed within this paper. The action plan has been the focus of this Quarters work. Further updates on the gap analysis will be provided in Quarter 3 report.
Approval / Scrutiny Route Prior to Presentation:	Strategic Occupational Health and Safety Group.
Governance issues / risks:	A full review of legislative compliance has identified the current safety management systems within the Board requires significant work. The Strategic Occupational Health and Safety Group will provide assurance to the Board that reporting procedures and OHS structures can clearly evidence compliance in all service areas.
Financial Implications:	There will be cost implications in connection with the implementation of statutory requirements for example electrical testing, asbestos surveys etc. Failure to implement legal requirements may result ill health/accidents to staff, patients and others. This places BCUHB at risk of prosecutions, fines, lost time injuries, claims and reputation damage as a result of non-compliance.
Recommendation:	The Committee is asked to: 1. Note the position outlined in the Quarterly Report. 2. Support the proposed actions of the OHS, Security plans resulting from the gap analysis of legislative and security compliance.

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

Executive Summary

1. The Quarterly Occupational Health and Safety report aims to give an overview of incidents/accidents, training and Health and Safety (H&S) activities for the period 1st July to 30th September 2019.

2. Key issues to note:

- The gap analysis undertaken over a 6-week period from 17th June -31st July 2019 by the H&S Team, Occupational Health, Violence & Aggression (V&A) Case Manager and Manual Handling Manager provided results in Q2. The analysis of 31 pieces of Occupational Health and Safety (OHS) legislation, included site visits of 117 site-specific inspections. The OHS team had significant support from our trade union partners who visited a significant number of gap analysis reviews with the Team. Internal Audit who have provided feedback at the end of this report further evaluated the process. The audits identified that 15 pieces of legislation are deemed to be non-compliant 13 partially compliant and 3 fully compliant. The Occupational Health and Safety Team has now developed the action plan that relates to the outstanding findings in the gap analysis. The action plan for H&S Manual Handling and Security is in Appendix 1. This identifies key areas of work including policy, structure audit and review. The H&S Policy is now complete and will be provided to the Strategic OHS Group for approval and implementation.

- There have been 27 incidents reported under RIDDOR in Q2 an increase of 3 on Q1 with 9 reported in Central and 8 in West and 10 in East. Slips and trips have been the main cause of injury to staff this Quarter, followed by 7 injuries caused by the abuse of staff by patients and 5 patient/object handling incidents. There have been 3 needle-stick injuries which have potentially exposed staff to a Blood Borne Virus. However on investigation of donor bloods it was identified that the 2 of these cases did not have Hep C. We reported 1 occupational disease of occupational white finger vibration syndrome. Out of the 27 RIDDOR's reported, 25 of these were relating to staff and only 2 relate to the injury of patients.

- An Occupational Health Doctor's report was received by the Health and Safety Department that informed them that a member of staff had occupational vibration induced white finger. The risk assessment and health surveillance program undertaken as part of the gap analysis identified the issue and it was reported to the Health & Safety Executive (HSE) under RIDDOR as soon as the team had been made aware. The HSE lead for this area visited the Board on Friday 13th September. The HSE did not serve any improvement notices or charge the Board a fee for intervention as a result of the visit. The work undertaken by the H&S team, Estates and Mortuary staff gave the HSE assurance that the gap analysis provided clear indication of what where the H&S issues within the Health Board and we are clear on how we intend to address them.

3. Background and context

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

4. Health and Safety at Work etc. Act 1974

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

In promoting, stimulating and encouraging high standards of health and safety at work, the Act requires the governing bodies of all employing organisations to ensure:

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

Essentially, the HASWA law is based upon the principle that those who create risks to employees or others in the course of carrying out work activities are responsible for controlling those risks. Particular Regulations governing the management of health and safety in the work place are as follows:

5. Management of Health and Safety at Work Regulations 1999

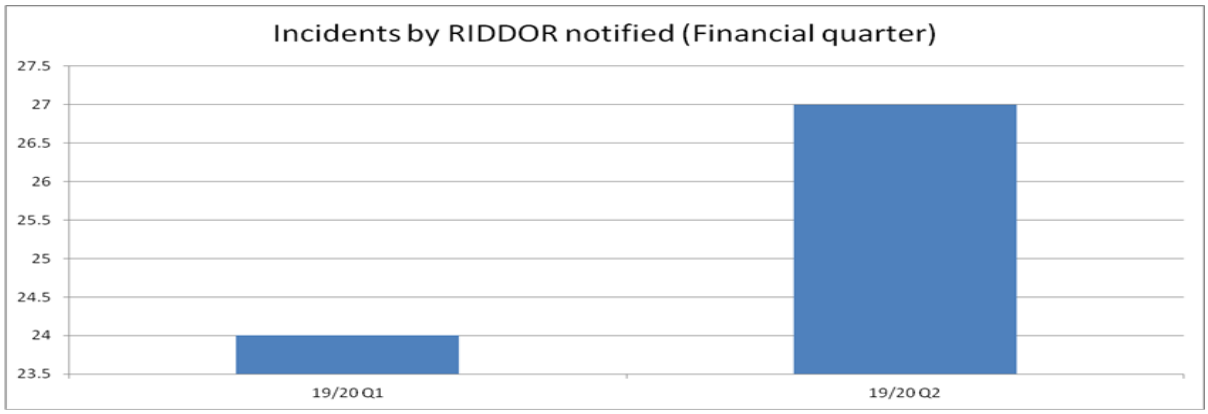
These regulations place a duty on employers to assess and manage risks to their employees and others arising from work activities. Under the Regulations, employers must also make arrangements to ensure the health and safety of the workplace, including having in place plans for responding to emergency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

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

This set of Regulations, commonly referred to as the RIDDOR Regulations, require employers and other people in charge of work premises to report and keep records of:

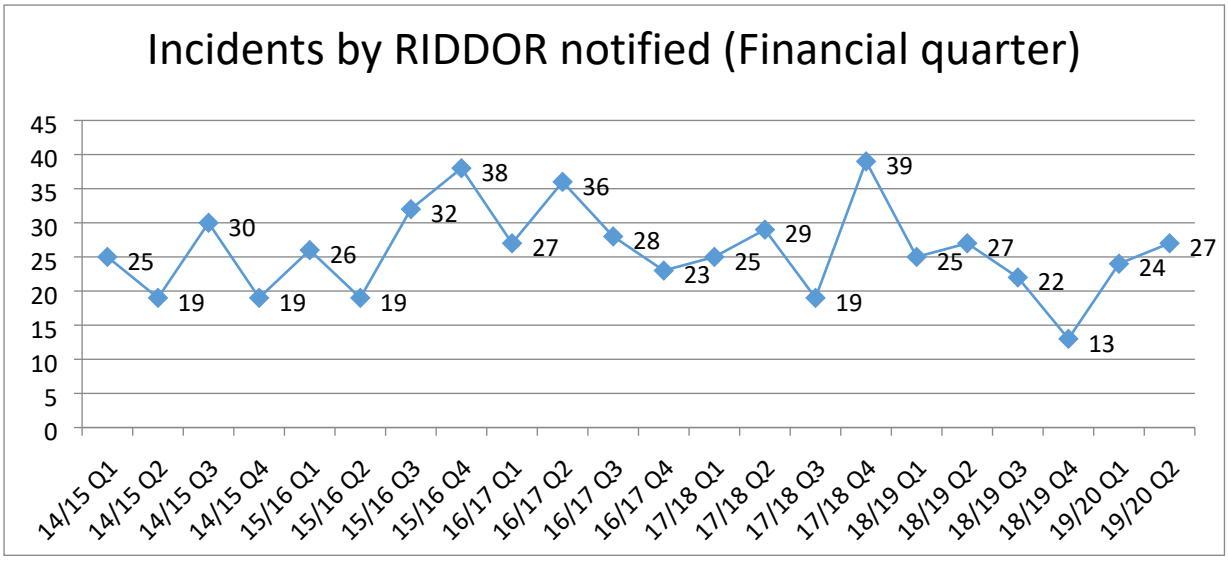
- Work-related accidents that cause deaths.
- Work-related accidents that cause certain serious injuries (major injuries), work related accidents resulting in over seven day absences
- Diagnosed cases of certain industrial diseases.
- Certain 'dangerous occurrences' (incidents with the potential to cause harm).

There have been 27 incidents reported under RIDDOR in Q2 an increase of 3 on Q1 with 9 reported in Central and 8 in West and 10 in East. Slips and trips have been the main cause of injury to staff this Quarter, followed by 7 injuries caused by the abuse of staff by patients and 5 patient/object handling incidents. There have been 3 needle-stick injuries which have potentially exposed staff to a Blood Borne Virus. However, on investigation of donor bloods it was identified that the 2 of these cases did not have Hep C. We reported 1 occupational disease of occupational white finger vibration syndrome. Out of the 27 RIDDOR's reported, 25 of these were relating to staff and only 2 relate to the injury of patients.



This table shows the Q1 2019/2020 and Q2 2019/2010 RIDDOR notified (rows section) against the financial Quarter.

Incidents by RIDDOR notified (Financial quarter) and Incident date (Financial quarter)					Total
19/20 Q1	1	5	18	0	24
19/20 Q2	0	1	11	15	27



Overall RIDDOR incidents:

RIDDOR Incidents by Detail and Region:	**BCUHB Central:**	**BCUHB East:**	**BCUHB West:**	**Total:**
Abuse of staff by patients:	0	2	3	**5**
Accident caused by some other means - Vibration:	1	0	0	**1**
Accidents caused by some other means - Collison with equipment:	0	1	1	**2**
Needle-stick Injury - Exposure to hazardous substance:	2	0	1	**3**
Accidents caused by object handling:	1	1	0	**2**
Accidents caused by patient handling:	3	1	1	**5**
Slips and Trips to non-workers:	0	2	0	**2**
Slip and Trips to staff:	2	3	2	**7**
Total	**10**	**10**	**7**	**27**

Root Cause Analysis (RCA) of RIDDOR incidents:

Hazard:	RCA completed:	RCA requested:	Root Causes, Lessons Learnt/Actions identified and implemented:
Abuse of staff by patients:	4	1	RCAs x 3 identified the Root Cause as the patient's unpredictable behaviour with no lessons learnt/actions identified. RCA x 1 identified that the Root Cause was the patient's unpredictable behaviour and that in Acute settings with abuse of staff by patients are investigated in relation to the management of the patient and not on the impact to staff/team.
Accident caused by some other means - Vibration:		1 Ongoing	A HSE visit identified that the work undertaken by staff across BCUHB was sufficient to avoid a cost for intervention or any improvement notices for the reported vibration white finger under RIDDOR. Further details in this report are provided.
Accident caused by some other means - Collison with equipment:	1	1	RCA x 1 identified that faulty equipment was the Root Cause and that: All equipment should be visually checked for faults regularly (implemented). A safe system of work is required for moving clinical equipment within the department (implemented).
Needle-stick Injury: Exposure to hazardous substance:	3	0	RCA x 2 identified no Root Causes with no lessons learnt/actions identified. RCA x 1 - The investigation is described below.
Accidents caused by object handling:	1	1	RCA x 1 identified the RCA as person error with no lessons learnt/actions identified.
Accidents caused by patient handling	2	3	RCA x 1 identified no Root causes and no lessons learnt/actions identified. RCA x1 identified a poor risk assessment as being a Root Cause and identified that a more robust one is required for similar circumstances (implemented).
Slips and Trips – non workers:	1	1	Welsh Government Closure form x 1 identified the Root Causes as not maintaining 1:1 care if this is the identified mitigation.

Slip and Trips – staff:	3	4	RCAs x 2 identified the Root Cause to be as follows; not fit for purpose flooring. Poor use of hazard signage. RCA x 1 identified that not wearing the correct Personal Protective Equipment (PPE) (shoe-wear) was the Root Cause and this has been rectified with correct footwear PPE.
Total	15	12	

The outstanding RCAs:

BCUHB Central:	4
BCUHB East:	8
BCUHB West:	0

A new and robust system is being implemented across BCUHB to ensure that all RIDDOR reportable incidents have a comprehensive investigation recorded on an RCA. The outstanding RCA's are in BCUHB East and BCUHB Central and further work is being carried out in these areas.

In East, the H&S Advisor is undertaking presentations with senior management in key areas to improve understanding of RIDDOR and the reporting and investigation requirements and responsibilities - Wrexham Maelor Hospital Management Team, Area East Risk and Safety Group and Mental Health. This includes the triggers for RIDDOR, the process and timescales for reporting, and the process and timescales for investigation/Root Cause Analysis. Attendees are asked to cascade the presentation and message to Management Teams and Services within their remit. When an incident is reported and a Root Cause Analysis is requested, the timescale for submission is stated, and the Advisor is monitoring progression. Support is offered where investigation is likely to be complex or require input from H&S.

In Central Acute, the H&S Advisor has met with the Managing Director for Ysbyty Glan Clwyd (YGC) to discuss the most appropriate action to progress this requirement and to ensure that the system implemented has senior management support. A system has been agreed and incidents are escalated to the Datix Handler and the Heads of Nursing are notified for Clinical areas. This requirement has also been escalated through the Quality, Safety and Patient Experience meeting, Heads of Department meeting and the H&S Group meeting. In Central Area the Risk and Safety Manager proactively works with the H&S Advisor to ensure that an RCA is carried out and these are monitored in the Area equivalent meetings. Additional training has been undertaken with ward managers and this will be extended further.

Out of the 27 RIDDORs reported, 15 Root Cause Analysis investigations had been carried out, with 12 still outstanding, 4 in BCUHB Central and 8 in BCUHB East. In relation to the slips and trips of staff, 2 out the 7 incidents had been investigated both have identified the root causes to be the environment and training. One of the patient falls that occurred in BCUHB East, have been thoroughly investigated via the 'Welsh Government' process and identified root causes and 'lessons learnt'; insufficient staff numbers and poor adherence/implementation of the identified mitigation in the falls assessments have been identified as issues to be addressed.

The majority of RIDDORS caused by the abuse of staff by patients have occurred in the Mental Health and Learning Disability Service and the associated RCA investigations have identified the unpredictability of the patients' behaviour as the root cause. Similar incidents that had previously occurred in this area had only been investigated in relation to the management of the abusive patient. They had not focused on the clinical environment, the safe systems of work, adherence to BCUHB procedures and the impact on the injured staff members or the effect on the Acute Team, as a whole. This RCA investigation also identified the lack of safe systems of work in relation to violence and aggression in this acute settings and in the ability to access help quickly and effectively on site and from North Wales Police.

Whilst support for the injured staff member was provided by Occupational Health immediately and effectively post-incident, accessing support for the effected Team was difficult but very effective once in place. The 1 RCA investigation that was carried out on a patient handling injury identified that an inadequate risk assessment was contributable and this was identified and implemented as a 'lesson learnt' in the Area West service. The 3 needle-stick injuries which potentially exposed staff to a Blood Borne Virus have all been investigated via the RCA investigation process, however only 1 identified any root causes other than 'person error'. The lack of safe systems of work in designated 'Standard Operating Procedures' for clinical treatment and associated Personal Protective Equipment were identified as potentially contributable to the incident. A very robust and thorough RCA is in process for the white finger vibration incident. The most robust and comprehensive RCAs that have been carried out this Quarter, have been carried out by personnel with formal health and safety expertise, or by staff who have attended BCUHB's health and safety training or similar training from outside the organisation.

7. Progress on Risk Management

The Health Board`s approach to risk management is underpinned by good governance, a dynamic, proactive, integrated and enterprise-wide focus which aims to foster the achievement of its objectives and priority areas as articulated in its three year plan. Staff are being encouraged to use risk management as a tool in driving continuous improvements in patient care, safety, experience and journey while improving the quality of decision making. The risk management team is currently liaising with and supporting Directorates/Divisions and Corporate services to regularly review and update their risks. There is ongoing drive to strengthen our risk management process and systems while leveraging sufficient clarity on the governance arrangements. As 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.

The Health Board is on a risk management improvement journey at the moment which is underpinned by a complete re-write of its risk management strategy, the implementation of a Gap Analysis and Training Needs Analysis within the widen context of identifying and addressing gaps and staff training needs in risk management. These will also enable the Health Board to strengthen its risk management improvement plan and deliver targeted support. The destination of the Health Board`s vision for risk management is an Enterprise Risk Management Model

which will be rolled out in the third year. BCU`s ambition in the first two years of this vision will seek to lay down the ground work and foundation on which to build a robust risk management architecture.

8. Claims

There were 16 claims in Q2 in relation to staff. The following examples have been provided by the Claims Department, which include a number of alleged events that resulted in claims and withdrawal of claims by staff members. A patient punched the wall next to the Claimant's head causing him to lose hearing in his left ear. Liability was denied and the Claimant was put to strict proof as the DATIX information regarding the incident did not corroborate with the Claimant's version of events. The denial was made on the basis that it was not foreseeable that a patient punching a wall next to the Claimant's head would cause any injury at all, let alone hearing loss and tinnitus. The Claimant withdrew his claim following BCUHB denial of liability.

Whilst walking into a hospital, the Claimant tripped on a large piece of plastic sheeting that was resting by a door in the corridor. Liability was admitted. The Claimant sustained a bruise/bump to the head that resolved in 1 week and a fracture to her elbow. The Claimant confirmed that she continues to have nuisance value symptoms nearly 1 year post accident. Our initial reserve for a permanent injury was £9,000. The Claimant made a Part 36 offer in the sum of £5,000. BCUHB made a counter offer in the sum of £4,000 that was accepted.

The Claimant went to assist a patient who was wandering toward the fire escape and attempting to exit the ward. As she attempted to steer him back towards the ward, he suddenly attacked her and landed a flurry of punches on her left arm, elbow and shoulder. Liability was denied on the basis that the incident was not foreseeable. The claim was withdrawn.

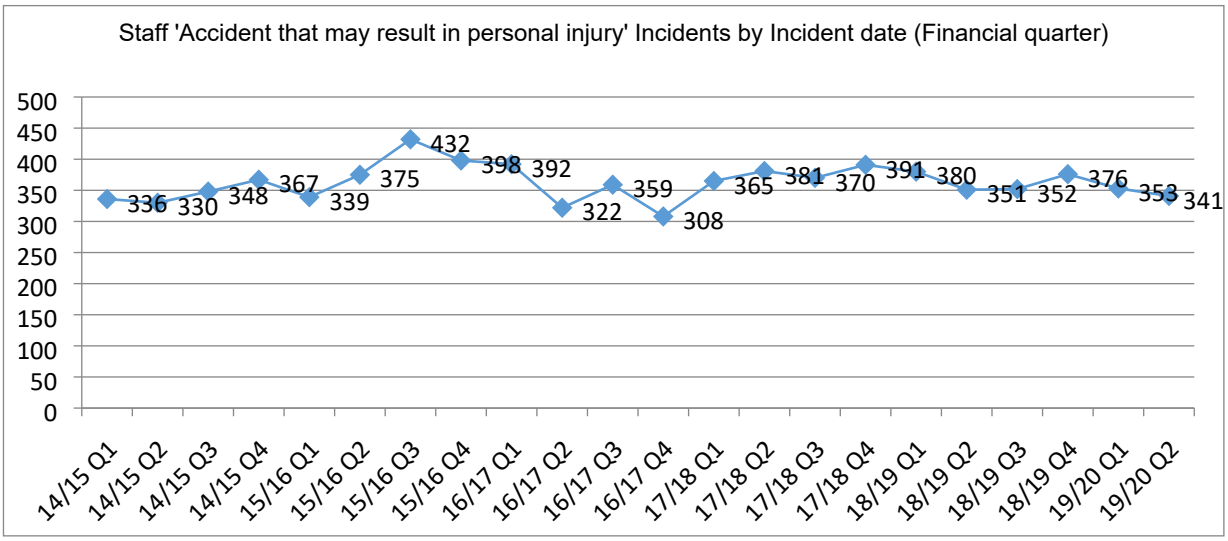
The Claimant was employed within the medical records department. Due to the absence of a colleague, he was re-deployed to deliver medical records to various departments throughout the hospital. Whilst carrying out this task the Claimant alleged that, he injured his back. There was no injury mentioned within the DATIX incident report form and the Claimant was put to strict proof in this report form. The Claimant withdrew his claim against the Health Board.

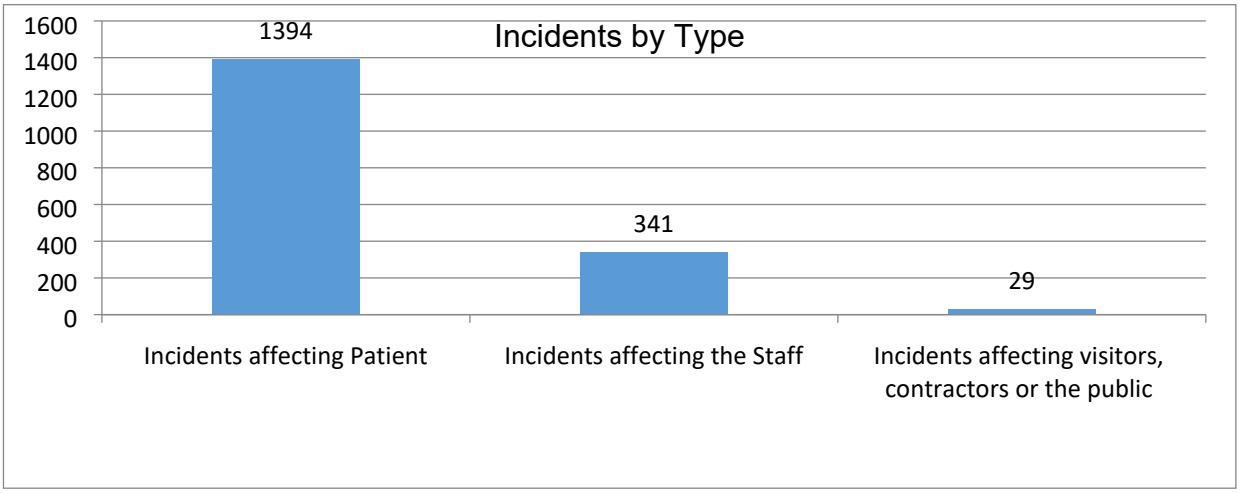
	Abuse etc. of Staff by patients	Accident caused by some other means	Exposure to electricity, hazardous substance, infection etc.	Injury caused by physical or mental strain	Lifting accidents	Needle stick injury or other incident connected with Sharps	Slips, trips, falls and collisions	Total
BCUHB Central	0	1	1	0	0	1	3	6
BCUHB East	0	0	1	1	1	0	3	6

BCUHB West	2	1	0	0	0	0	1	4
Total	2	2	2	1	1	1	7	16

9. Incidents

The Health Board utilises the DATIX system to record all incidents and near misses. An analysis of the data reported from 1st July – September 30th 2019 indicates that there have been 1,764 with the main Health and Safety related incidents are as follows.





Incidents affecting Staff

Incidents by Detail and Region	BCUHB Central	BCUHB East	BCUHB West	Total
Accident caused by some other means	43	36	32	111
Exposure to electricity, hazardous substance, infection etc.	8	11	7	26
Injury caused by physical or mental strain	18	16	7	41
Lifting accidents	5	4	1	10
Needle stick injury or other incident connected with Sharps	23	29	31	83
Slips, trips, falls and collisions	18	27	25	70
Total	115	123	103	341

Staff Needle-stick Incidents

Incidents by Adverse event and Region	BCUHB Central	BCUHB East	BCUHB West	Total
Accident of some other type or cause	2	1	4	7
Injury from clean sharps	2	6	5	13
Injury from dirty sharps	16	22	21	59
Sharps or needles found	3	0	1	4
Total	23	29	31	83

Of the 59 incidents reported as dirty sharps

Incidents by Location (exact) Top 5 and Region	BCUHB Central	BCUHB East	BCUHB West	Total
Emergency Department (secondary care)	1	1	5	7
Theatre B, Wrexham Maelor Hospital (WMH) (secondary care)	0	3	0	3
Outpatients (secondary care)	0	0	2	2
Gogarth, Ysbyty Gwynedd (YG(secondary care)	0	0	2	2
Theatre A, WMH (secondary care)	0	1	0	1
Total	1	5	9	15

Top 5 Contributory Factors	BCUHB Central	BCUHB East	BCUHB West	Total
Unsafe Sharps Storage	3	2	4	9
Failure to Follow Procedure	4	1	4	9
Lapse in Concentration	4	1	3	8
Other	0	0	3	3

Equipment Failure	1	0	2	3
Total	12	4	16	32

Staff Slip, Trip or Falls Incidents

Incidents by Adverse event and Region	BCUHB Central	BCUHB East	BCUHB West	Total
Accident of some other type or cause	8	12	7	27
Collision with an object	2	2	4	8
Fall from a height, bed or chair	0	3	2	5
Fall on level ground	4	6	9	19
Suspected fall	1	1	2	4
Tripped over an object	3	3	1	7
Total	18	27	25	70

9.1 Incidents Highlights

There have been 341 incidents recorded as affecting staff. The top four areas of concern in staff incidents/accidents included 111 accident caused by some other means, which includes incidents such as vehicle collisions, collisions with equipment and manual handling injuries, 83 needle stick incidents, 70 slips trips and falls, 41 injury caused by physical or mental strain this is due in general to patient handling or inanimate loads moving and handling activities. A number of Datix incidents required investigation by the H&S Advisors, the process has included attendance and support to a number of groups to look at risk assessments and solutions to the issues identified.

9.2 East

An incident recorded as accident caused by other means was a case where ordering of a blackout blinds to reduce light in the room for a Medical Secretary who was struggling with issues caused by a long-standing tumour behind the eye was rejected by a manager on a cost basis. The blackout blind was one of a number of recommendations made by the Manual Handling Team following a full assessment of need. This led to communication between the Health and Safety Advisor and the manager, with advice given to reconsider the balance of what is 'reasonably practicable'. He advised that the fitting of a blind could be viewed as a reasonable adjustment for the wellbeing of the individual. A system is now in place that when items are required to be signed off for staff welfare requirements; the Associate Director of H&S and Equality verifies the purchase of such products.

There was a number of manual handling incidents associated with the filling, movement and transport of laundry cages from the WMH site, via lorry to YGC. This was increasing risks of Musculoskeletal Disorders (MSDs), affecting working relationships and affecting laundry service. The two safety Advisors from Central and East worked closely with Portering and Estates Department to identify improvements in handling procedure, external environment and transport arrangements, to the satisfaction of all parties making safe handling a priority.

There were significant issues identified at Heddfan Adult Mental Health Unit with bedroom door frames and anti-barricade protection being damaged through a combination of poor design and patient aggression. This led to frequent repairs by Estates, accidental entrapment situations and closure of 4 rooms, impacting significantly on service delivery. Emergency meetings between leads from Estates, Mental Health, Health and Safety were held with risk assessments undertaken by Mental Health Management supported by the H&S Advisor. This has led to identification of funding for building improvements, mitigation for the situation in the interim and improvements were implemented to room breach protocols.

9.3 Central

Bryn Hesketh is a Dementia Assessment Unit (MH&LD) in Colwyn Bay. This area had 14 Datix incidents where staff have been injured; 5 are musculoskeletal and 9 are following physical assaults. The H&S Advisor has met with the Ward Manager and confirmed that the majority of these incidents relate to the care of one patient. The Ward Manager has undertaken a number of actions to reduce the risk to staff and is working closely with the Restricted Physical Intervention (RPI) team. The Manual Handling Team have booked to undertake some further training and the V&A Case Manager has offered support to staff. The Ward Manager is contacting the Wellbeing team for advice on how the team can be supported through this period. If funding is agreed then this patient will be moved to a more appropriate facility in Liverpool. Bryn Hesketh is a standalone building in Colwyn Bay and, in an emergency, trained additional staff are required to attend from the Ablett Unit which can significantly delay response times. There are plans at this time to move the unit onto the YGC site as part of the redevelopment of the Ablett Unit.

9.4 West

The Bryn Y Neuadd site had limited site management and many health and safety issues, for example security, traffic management, lone working etc. The H&S Advisor attends the site user group that has been set up to try to resolve these ongoing problems. One of which was gaining access to the decommissioned villas. The H&S Advisor is working closely with Estates West in developing an access permit for services to empty the villas and will be attending an Estates led ‘task and finish’ group to manage this access.

The H&S Advisor has supported the Catering Manager to escalated risks associated with the canteen flooring in Ysbyty Gwynedd which has been the cause of 2 RIDDOR reportable accidents. They reviewed the current risk on the site risk register and linked all associated incidents which will look at reducing risks in that area.

10. Violence and Aggression

A review of the incident data below has identified that Cemlyn A, Cefni hospital is the highest reporting area within BCUHB with 62 incidents in Q2. Contact has been made with the matron of Cemlyn who will explore the increased Datix reports as there are marked differences with comparable areas in Central (Bryn Hesketh 26 incidents Q2) and East (Gwanwyn 10 incidents Q2). A meeting with all three units is

required to include the Mental Health Centre for Aggression management team to discuss best practice and risk assessment processes.

Arrangements have been made with North Wales Police to attend a police training session to explain Obligatory Responses to Violence in Health Care. The purpose is to promote BCUHB's Case Management service this will take place in November 2019. V&A Case Manager has met with Mental Health & Learning and Development Division policy group to discuss embedding the Obligatory Responses to Violence into Healthcare process.

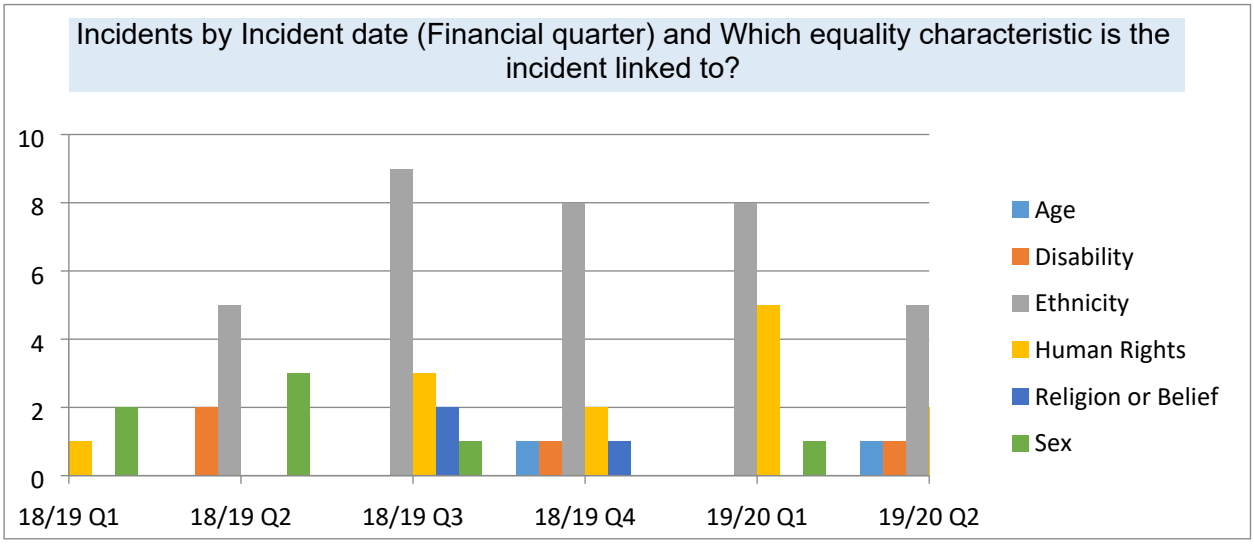
Datix incident reporting in relation to violence/aggression has a "pop up" information link in place to assist in the identification of incidents in which alleged perpetrator is believed to have mental health/learning disabilities related condition and formal police investigation is requested. Should the reporter complete the associated form this will assist police with the initial investigation and inform the V&A case management in order to offer support for staff.

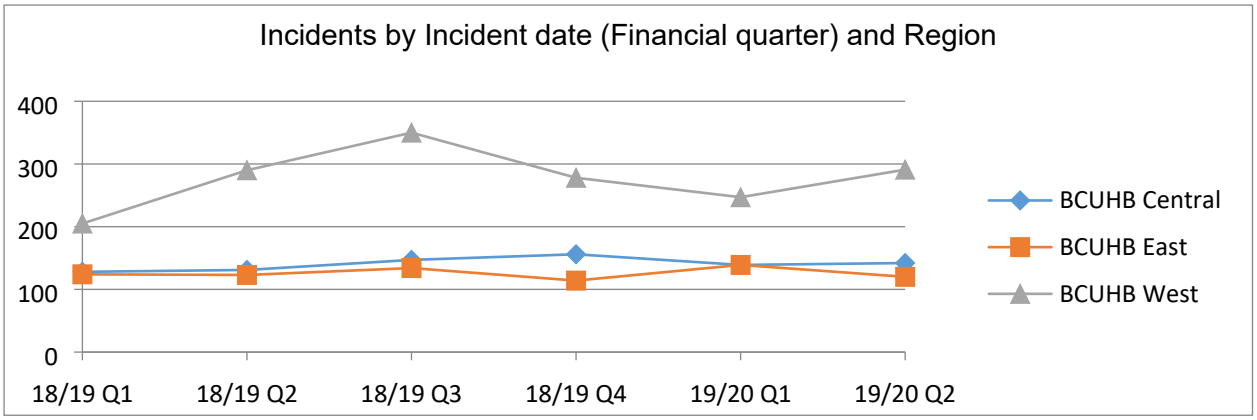
Obligatory response to Violence in Healthcare-work continues to progress in order that it achieves Welsh Health Office Circular status. The Obligatory Response to Violence in Healthcare will be "re-launched" when Circular status is achieved. BCUHB V&A Case Manager and Head of H&S are currently exploring how this reporting process can be achieved.

V&A Incidents "police called"			
18/19 Q1	37	19/20 Q1	32
18/19 Q2	46	19/20 Q2	46
18/19 Q3	31		
18/19 Q4	50		

V&A Incidents			
18/19 Q1	457	19/20 Q1	523
18/19 Q2	544	19/20 Q2	553
18/19 Q3	631		
18/19 Q4	548		

Area/Division	19/20 Q1	19/20 Q2
Division of Mental Health and Learning Disabilities	259	257
Specialist Medicine (Secondary)	99	126
Primary and Community Services (Area)	80	67
Children and Young People (Area)	11	32
Surgery (Secondary)	29	31
Therapies (Area)	10	8
North Wales Community Dental Service (Area)	3	7
Radiology (Secondary)	3	6
Women's and Maternal Care (Secondary)	4	5
Anaesthetics, Critical Care and Pain Management (Secondary)	1	4
Estates and Facilities (PandP)	6	3
Primary Care (Area)	5	3
Office of the Nurse Director (Corporate)	0	2
Cancer Services (Secondary)	2	1
Therapies and Health Science (Corporate)	0	1
Strategy (PandP)	8	0
Finance (Corporate)	1	0
Pathology (Secondary)	1	0
Pharmacy and Medicines Management (Area)	1	0
Public Health (Corporate)	1	0
Workforce and Organisational Development (Corporate)	1	0





All data is related to "Incidents affecting the staff/Abusive, violent, disruptive or self-harming behaviour" as listed on Datix.

V&A Management of Cases.

Case	Region	Division	Investigation Status.	Notes
Assault	West	Mental Health	No Further Action due to patient's mental health condition.	As result of this case, the V&A Case Manager and local district police inspector have arranged sessions with all officers to discuss the Obligatory Responses to Violence process.
Assault	West	Mental Health	No Further Action due to patient's mental health condition.	As above and in addition taken to Mental Health policy group.
Assault	West	Mental Health	On-going investigation	Awaiting police update.
Assault	East	Mental Health	On-going investigation	Police are attempting to locate the alleged offender.
Assault	East	Mental health	On-going investigation	After delay consultant agreed to supply information to police. Awaiting police response.
Threats to kill	East	Mental health	On-going investigation	Victim has arranged to provide statement to police but failed to provide. Medical workforce informed for support.
Assault	East	Mental Health	On-going investigation	Despite several attempt to contact the staff victim directly and via his line management there has been no contact.

Threats	East	Mental Health	Investigation complete. Patient charged. Court date Dec 2019	No contact from ward or victim until staff victim received court attendance letter. Case manager to attend Court with staff member.
Threats	Central	Mental health	On-going investigation	No contact from ward until 2 months after event - Obligatory response to Violence process not followed. Currently awaiting response from consultant to supply police with information to progress investigation.
Damage	Central	Mental Health	On-going investigation	No contact from ward until month after event- unfortunately in that time the relationship between ward and police has deteriorated. Although criminal damage, V&A case management has agreed to assist in very challenging circumstances.
Racial abuse	Central	Mental Health	On-going investigation	No contact from ward until one month after event. Written statement supplied to police Obligatory Responses to Violence process not followed. Due to staff, member shift pattern and V&A case manager non-availability. Meeting staff not possible until late October.
Indecency	West	Community Nursing West	Closed	Member of public thought to be engaging in lewd act near window of own property overlooking Health premises. Police investigate-no further action due to lack of evidence-staff not fully sure what was seen. Support given to victim and alternative solutions imposed to reflect lone worker entry to building.

In those cases where Obligatory Responses to Violence in Healthcare has not been followed the V&A Case Manager has attended at the unit to address managers explaining the process as well as attending the division's policy group in order to embed process.

11. Security Review

An initial security review was conducted across the organisation and included evaluation of policies and procedures related to the management of security within the Health Board; CCTV including the use of body worn camera's and the management and control of images including access and disclosure to third parties and access to images by individuals and enforcement. Additionally, the review included a measuring the compliance of BCUHB with Security Framework Document for NHS Trusts in Wales, review and evaluation of the post and role of the seconded North Wales Police demand reduction inspector and review of the scope and specification of third party security provider contract.

Preliminary findings identified a lack of policy, procedures and direction relating to security within the organisation particularly the absence of both security and CCTV policy. Furthermore, there was no identified Lead/Head of security within the health board and effectively security was divided into Estates (buildings and assets) and PSV (Patient, Staff and Visitors) and was facilitated by an external contractor. Hospital Management Teams (HMTs) were identified as responsible for the PSV element and Estates/Facilities function for the building and assets within their respective areas of responsibility; East, Central and West.

A comprehensive review document was compiled and presented to Strategic Occupational Health and Safety Group, from this document the initial action plan identified the following to be addressed as soon as possible;

1. Compose and complete Security Management Policy (including The Prevention and Control of Violence and Aggression through 'Obligatory Responses to Violence in Healthcare) stipulating roles and responsibilities of general users, key staff and management.
2. Compose and complete CCTV Management Policy including use of body worn camera's with the policy to include;
    a. Positioning of Camera's
    b. Quality of Images
    c. Recording and Retention of Images
    d. Access to and Disclosure of Images to Third Parties
    e. Access to Images by Individuals and Enforcement
3. Identify and review posts and positions of health board employees within the estates function currently conducting security related work activities with view to adopt into H&S/Security function
4. Conduct training needs analysis to establish levels of competence and/or gaps in personnel both external and internal within the security function of the health board.
5. Identify security service standards including training of both external security contractor and BCUHB staff who conduct security related work activities.

6. Identify, promote and communicate dedicated security head/lead for the organisation as required under Security Framework document for NHS Trusts in Wales.
7. Amend the role and responsibilities of Violence and Aggression Case Manager to include security responsibilities. (Current post holder has evolved with security elements to role that need to be adopted into the Job Description).
8. Review post and role of seconded North Wales Police Demand Reduction Inspector with view to review the effectiveness of support for BCUHB Security/V&A Officer.
9. Review and, where appropriate, amend current Lone Worker Policy stipulating roles and responsibilities of general users, key staff and management. Including monitoring devices and the use of, home visits, office based lone working and managers checklists.
10. Develop business case to establish Security / V&A Officers in each regional areas with additional officer specifically dedicated to the Mental Health and Learning Disability service.

The Security review requires clear roles and responsibilities to be defines with a specific action plan to be implemented (See Appendix 2).

12. North Wales Police Demand Reduction Inspector

This is the first report from the North Wales Police Demand Reduction Inspector the information will be further improved as we work closer over the coming months. The information below illustrates the demand placed on North Wales Police as a result of calls from the three District General Hospitals within BCUHB. *Figure 1:* identifies the number of contacts with North Wales Police is 571 with Wrexham Maelor being the largest contributor of demand on North Wales Police with 237 reported incidents.

Figure 1:

Hospital Incidents

Hospital	UNKNOWN	Wrexham Maelor	Ysbyty Glan Clwyd	Ysbyty Gwynedd
Event Count	3	237	147	187

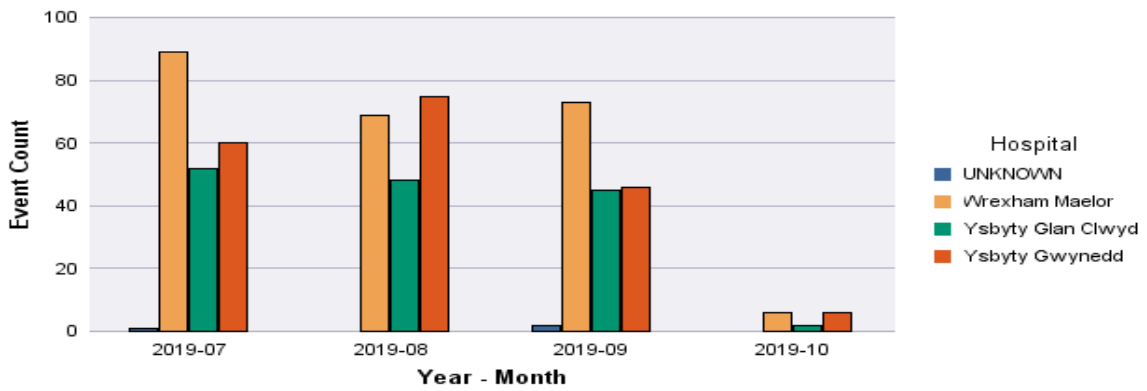


Figure 2: represents the types of calls that Police are responding to at the three District General Hospitals (DGHs). The most significant concerns are regarding safety. These types of events generally relate to patients leaving hospital premises

without letting people know or requests from Hospital Authorities asking for welfare checks to be conducted on patients because they again have absconded with cannulas still in situ.

Figure 2

	UNKNOWN	Wrexham Maelor	Ysbyty Glan Clwyd	Ysbyty Gwynedd
2019-07	1	89	52	60
2019-08		69	48	75
2019-09	2	73	45	46
2019-10		6	2	6
Sum:	3	237	147	187

Top 10 Incident Types

Initial Sub Type	Initial Type	Event Count
CONCERN_SAFETY	PSW	140
CONTACT_RECORD	ADMIN	127
COMMON_ASSAULT	CRIME	37
ABAN_CALL	ADMIN	34
MISPER_MED_RISK	PSW	32
MESSAGE_DELIVERY	ADMIN	26
SUS_CIRCS	PSW	22
ASB_NUIS_LOW	ASB	18
THREAT/CONS_MUR	CRIME	18
POL_GEN_RESACT	ADMIN	13
	Sum:	467

A review of BCUHB calls to the Police has identified that they are often inappropriate, discussions with relevant individuals and providing advice on lessons learnt is undertaken by the North Wales Demand and Reduction Inspector it is hoped that these inappropriate referrals cease. Work has continued with BCUHB staff in identifying the causation factors of such incidents and how these issues arise, the North Wales Demand and Reduction Inspector is exploring ways to mitigate these risks by attending sites and speaking to staff involved and providing recommendations. An Information Sharing Protocol now exists for all three Welsh Emergency Departments to identify frequent attenders. The network is now in place across the whole of North Wales.

Monthly meetings with area Hospital Directors and heads of nursing including mental health are now taking place, this ensures issues are addressed in a timely manner. A handover process for voluntary patients including Mental Health patients in Emergency Departments who are conveyed by the Police has been developed and is fully functioning in the West and is now going live in the Centre with implementation set for the East in February 2020. Implementation and review of the Missing Persons Policy in its entirety across the whole of the Health Board is being implemented with some areas not adhering to the Policy as they often have different owners. The Police Liaison Officer has also assisting and advising the Health Boards Estates Department with asset management Security advice as well as providing security advice to wards where they have difficult or demanding patients and also providing a visible presence when required.

13. Manual Handling

During Q2, the compliance levels for training were as follows:-

- Manual Handling Level 1, 2 yearly update can be completed via workbooks, e learning or attending a classroom session. This remains consistently high at 96%.

- Violence & aggression Level 1 (module A), a one-time only training session is 96%.
- Manual Handling Level 2, 2 yearly and can be completed via work based competency or attending a classroom session fell by 8% to 66%. This is due to changes in the ESR Team with staff group and not position numbers being entered. A plan to rectify this will be implemented in Q3.
- Violence & Aggression Level 2 (Module B & C), two yearly is classroom only based, this too fell by 5% to 62% and this is connected to the Electronic Staff Record (ESR) streamlining work being undertaken.

Through Q2 the Manual Handling Team has provided a total of 72 Manual Handling Level 2 sessions, 55 Violence & Aggression Level 2 sessions. The Did Not Attend (DNA) rate for V&A is continuing to be of concern at 25-30% for our training courses in the classroom. Level 1 Manual Handling had 5 sessions within the Lecture Theatres over the 3 main sites. The Team also provided a total of 111 sessions of competencies, where the Team are booked onto sessions within the hospital or community setting to update staff in the mandatory training, assisting current Champions and working alongside staff to ensure their current practice is safe for both patient and the employees.

The team also undertook 75 ergonomic risk assessments; these were mainly from staff experiencing difficulties with their works station and requesting advice on Display Screen Equipment (DSE). During the assessment advice is given for the sedentary worker on how to keep active at the desk, along with a leaflet containing exercises. Assessments also included staff returning to work with a musculoskeletal disorder. Workplace assessments to support staff and reduce the risks associated with MSDs, evaluate the task individual load and environment. Many staff are provided with additional support such as physiotherapy or signposted to other agencies for advice and support. In addition, patient assessments in hospital or their own home have been carried out by the team to ensure they support vulnerable complex patients. A database has been created to ensure follow-up via an email to staff whom have received an assessment, this is sent 3 months after an initial assessment has taken place, to monitor the effectiveness of the advice given.

There have been 18 Datix incidents regarding Manual Handling, of which 3 were highlighted as training issues, those incidents were investigated by the Manual Handling Team to retrain staff in the manoeuvre that may have caused the injury. A database has been created to ensure the incidents are followed up by Trainers to monitor the effectiveness of the intervention provided.

Currently there are 201 Manual Handling Champion across BCUHB, with the aim to have 1 Champion per 10 members of staff following an intense 2-day training programme. This will improve the standard of manual handling in all work areas. Champions will work with their peers in every day manoeuvres with patients and will likely reduce injuries and improve sickness from MSD's. Champions are to work close with their Housekeepers, to ensure all disposable equipment is replaced and available, along with creating an inventory for all manual handling equipment to ensure it is tracked and effectively maintained.

Bespoke Porters only Champions will be developed to target staff areas with higher sickness rates resulting from MSDs. Future training for Champions will commence in 2020 with Violence & Aggression Champions to be targeted later in 2020.

Work continues with the Manual Handling Action plan to update guidance and policies in Q3 (See appendix 1). Changes to future training in Level 2 Manual Handling is planned to include both a practical assessment, along with a classroom theory session and risk assessment to ensure the findings from the gap analysis are implemented

14. Training

The Corporate Health and Safety Team undertake a variety of internal training. There were 2 managing safely 2 day courses with only 8 attendees this was due to the work undertaken on the gap analysis (see below for details).

Training April 2019-June 2019	East	Central	West	Number of Sessions	Number of Attendees
Managing Safely					
No of Sessions	0	0	2	**2**	
No of attendees	0 1 cancelled	0	8		**8**
Combined Risk Assessment & COSHH					
No of Sessions	0	0	0	**0**	
No of attendees	0	0	0 1 cancelled		**0**
RIDDOR Awareness					
No of Sessions	0	0	0	**0**	
No of attendees	0	0	0 1 cancelled		**0**
			Total	**2**	
			Total		**8**

Course Subject	Number of sessions	Number of staff trained	Number of Cancelled Sessions
Managing Safely 2 Day Course	**2**	**8**	**1**
Risk Assessment & COSHH ½ Day	**0**	**0**	**1**
RIDDOR Awareness Training 1 ½ hrs	**0**	**0**	**1**
Total	**2**	**8**	**3**

15. Gap Analysis

The gap analysis undertaken over a 6-week period from 17th June -31st July 2019 by the H&S Team, Occupational Health, V&A Case Manager and Manual Handling Manager provided results in the exception report in Q2. The analysis of 31 pieces of Occupational Health and Safety (OHS) legislation, included site visits of 117 site specific inspections including Acute, Mental Health Community Services GP and HMP Berwyn (Wrexham). The OHS team had significant support from our trade union partners who visited a significant number of gap analysis reviews with the Team. Internal Audit who have provided feedback at the end of this report further evaluated the process. The audits identified that 15 pieces of legislation are deemed to be non-compliant 13 partially compliant and 3 fully compliant. The overall impression of safety management systems was that OH&S performance had become fragmented, with central control taking responsibility from sites with limited overall evidence of training, good quality risk assessments and safety management systems being implemented. Clear lines of responsibility and accountability are not being evidenced in a number of service areas.

There is serious concern over the management of key areas of the business including H&S training and level of competence, asbestos management, legionella, contractor management and control, stress management, permits to work systems, work at height, manual handling and control of substances hazardous to health. The lack of structure and systems makes the individuals who work for the Board and others who may be affected by its work activities at risk of serious harm. The risk leaves the Board open to enforcement action prosecution and fines for the most serious offences. A fundamental shift in the safety culture is needed to improve safety outcomes for staff, visitors, patients, contractors and volunteers. This report provides a clear plan and framework for action to firstly, identify hazards and then place suitable controls in place; this will require appropriate funding and a determined effort to change attitudes and behaviours.

The gap analysis report will support the Board and acknowledge the good work that has been undertaken and identifies additional work and evaluation to ensure the planning, organising and monitoring of the organisation's compliance with statutory health and safety obligations and duties can be clearly evidenced.

15.1 Key issues to note:

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

- Noise assessment and control.
- Clear lines of responsibility in relation to building management and control.
- Vehicle Driver safety.
- Lone Working.

The action plan is now being implemented with significant amount of work by a number of key players including Estates/Facilities, Occupational Health, Radiation, H&S, V&A Manager and Trade Union Partners to build the safety management system. This includes the development of Policies, protocols, audit systems and process to ensure that the H&S Culture is further improved. (See Appendix 3)

16. HSE Visit 13th September 2019

An Occupational Health Doctor's report was received by the Health and Safety Department on the 14th August 2019, which advised that a member of staff had vibration induced white finger. The risk assessment and health surveillance program undertaken as part of the gap analysis identified the issue and it was reported to the HSE under RIDDOR as soon as the Health and safety Team had been made aware. The staff member works as part of the Mortuary team and undertakes post mortem investigations using a Desoutter Cleancut autopsy saw to open and remove the cranium of a cadaver. An investigation into the incident was undertaken with immediate effect, with a risk assessment being completed and an assessment of the equipment including vibration levels undertaken by an external organisation at a cost of £4,000; this included Estates noise assessments and toolbox talks for staff. The levels identified within the mortuary where low and not deemed to be a significant risk, however areas such as grounds maintenance and estates will have higher levels of vibration.

Regular use of vibrating equipment can result in a range of occupational diseases including Hand-Arm Vibration Syndrome (HAVS), Vibration White Finger (VWF) or Carpal Tunnel Syndrome (CTS). The symptoms include tingling or pain in the digits, loss of sensitivity or grip, difficulty performing fine procedures (i.e. buttoning a shirt) and tips of fingers turning white. These symptoms may worsen in cold, damp weather or conditions. Daily levels of vibration above the exposure action value (EAV) for vibration magnitude require the Trust (employer) to take action to control exposure to employees. An increased exposure level gives an increased risk, meaning that employers need to take more action to reduce and control the risks to employees. Vibration is a common cause of injury within a range of workplaces. In the last ten years, over 10,000 claims for compensation have been made following injuries sustained through the frequent or prolonged use of vibrating equipment in the workplace. Employers have a duty to ensure that workers are provided with a safe working environment and safe working practices so that the risk of injury or illness is minimised.

The HSE lead for this area is Inspector Mhairi Duffy who visited the Board on Friday 13th September. The HSE did not serve notices or charge the Board a fee for intervention. The work undertaken by the whole H&S team Estates and Mortuary gave the HSE assurance that the gap analysis provided clear indication of what the where the H&S issues within the Health Board and we are clear on how we intend to address them. Sue Morgan (H&S Advisor) supported the teams in the

comprehensive plan developed over a very short period of time a system of evaluation, risk assessment, health surveillance and action plan. The systems now in place in Mortuary provided assurance that once the issue had been identified the Team worked tirelessly to get the best result possible for the staff and the Board and should be commended on this.

It is worth noting that Wrexham County Borough Council have recently been fined £150,000 and ordered to pay costs of nearly £11,000 after one of its workers was diagnosed with Vibration White Finger. Wrexham Magistrates' Court heard how a 57-year old man who was employed in the council's *'StreetScene'* department had been diagnosed with Hand Arm Vibration Syndrome (HAVS), also commonly known as Vibration White Finger, back in September 2015. When the HSE investigated the situation, it found that the council had failed to address the issue of HAVS after an audit in February 2011 that had identified a failure to assess the risk of vibration to employees. Upon further investigation, it was discovered that the council had developed a range of policies to tackle the risk of HAVS dating back to 2004, but it had failed to implement any of these. Speaking after the hearing HSE Inspector Mhairi Duffy said: *"This employee now suffers from a long-term, life changing illness. The council should have implemented the policy they devised following the audit in 2011. Workers' health should not be made worse by the work they do; all employees have the right to go home healthy at the end of the working day."* Following the council's adoption of health surveillance for users of vibrating tools, a further 11 cases of HAVS or Carpal Tunnel Syndrome have been diagnosed among employees.

Further evaluation work is required particularly in the Estates/Facilities Department across all service areas as there are a number of grounds maintenance staff actively working with vibrating equipment. The Estates Team have given assurances that this be looked at and the program rolled out across the whole patch. The Policy requires progressing and implementing by 1st November 2019 to ensure compliance with the legislation.

The inspector has followed up the visit to confirm via e-mail the following:-
'I was told that BCUHB had carried out a gap analysis earlier this year and had identified areas, including management of vibration, where action was found to be necessary. In order to avoid the risk of incurring a cost under the HSE FFI regime, to tell BCUHB something that it already knew and was dealing with, this investigation looked only at BCUHB's management of vibration within the mortuary – the area which was the subject of the RIDDOR. In the event of a future RIDDOR related to vibration it is likely that an investigation into the management of vibration across the health board will be investigated and, given the work was in progress at the time of my visit – would expect the board to be compliant in this area'.
HSE Inspector Mhairi Duffy

17. Audit Report into Gap Analysis and Governance

The objective of this review was to provide assurance that the gap analysis had been undertaken and completed within the time frame. The Internal Audit Department also sought to ensure the gap analysis was robust; consistently administered and the outputs of the analysis were accurately recorded. They also considered

documentation provided to the Health & Safety Advisors as part of the gap analysis and if reporting lines were in place within the Health Board concerning Health & Safety. The purpose being to provide assurance governance arrangements in situ. The scope of the gap analysis focused on a sample of meetings held by Health & Safety colleagues with relevant divisions / departments.The risks considered at the outset of the review were:

- Increased health and safety risk for the public and staff.
- Poor public image for the Health Board.
- Failure to comply with statutory requirements including legal repercussions such as legal fees and fines.

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the Health and Safety review is reasonable assurance. This confirmed the gap analysis was robust but further work on the questions within the analysis required further review and the governance systems being implemented need continual on-going work to be effective.

18. Safe Effective Quality Occupational Health Standards (SEQOSH)

The Occupational Health and Wellbeing service have commenced working towards the SEQOHS standards, which is a nationally recognised quality mark for Occupational Health Services. The Department has registered with the Royal College of Physicians to Faculty of Occupational Health Medicine and begun the self-assessment phase of the project completing a baseline assessment and action plan. Progress is being monitored in the form of a milestone via a Gantt chart (Appendix 4). Within the standards, there are six domains, each domain requires a robust evidence base with approximately 300 documents to demonstrate compliance.

The domains include the following:-
A. Business probity: which measures the integrity of the business and ensures that the business acts with financial probity.
B. Information governance: ensuring that adequate clinical records are maintained and that systems are in place to protect confidentiality.
C. People: ensuring that OH staff are competent to undertake their duties and that appropriate clinical governance arrangements are in place.
D. Facilities and equipment: assessing that the facilities and medical equipment are safe, accessible and appropriate for the services provided.
E. Relationships with purchasers: OH must demonstrate that it deals fairly and ethically with purchasers and is customer focused.
F. Relationships with workers: ensuring that the OH service deals fairly with workers in line with professional standards and respects and involves workers.

Substantial amounts of evidence including BCUHB policies, local policies and formal and informal feedback will be required. To date the service is 50% compliant with the standard. Once the self-assessment process is completed the data will be assessed by SEQOHS and any recommendations will be acted upon and a formal assessment visit can be undertaken, it is anticipated that this will be three months after the self-assessment is completed. It is likely the assessors will visit each Occupational

Health site. It is anticipated that the OH & Wellbeing Department will be submitting all evidence by February 2020 and looking for full accreditation by July 2020.

19. Conclusion

This report indicates that the systematic review of OHS Management will require continual work with the action plans for OH, H&S, Security and Manual Handling taking primary focus; further investment across the Health Board is required in all service areas. Work on Policies systems and processes are being implemented by Divisions/Services and the Occupational Health and Safety Team. A fundamental shift in safety culture is needed and an effective management system implementing based on the HSE framework plan, do, check, and act.

20. Recommendations

- Note the position outlined in the Quarterly Report.
- Support the proposed actions of the OHS, Security plans resulting from the gap analysis of legislative and security compliance.

The Quality Safety and Experience Committee is asked to note the position outlined in this report and support the recommendations.

Manual Handling Plan

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

No.	Manual Handling Plan	Resource	% Complete	02-Sep	30-Sep	28-Oct	25-Nov	23-Dec	20-Jan	17-Feb	16-Mar	13-Apr	11-May	08-Jun	06-Jul	03-Aug	31-Aug
1	**Identify Training needs for Manual handling Team**																
1.1	Ensure the Manual Handling Team gain the relevant recognised qualifications to effectively deliver both Load and Patient Handling courses for BCUHB. Course costing at £4,575 to ensure whole team gain qualification. Currently team are training without these recognised qualifications.	JBH, SR & PB															
1.2	Ensure the Manual Handling Team gain the relevant recognised qualification in Conflict Management to effectively deliver Violence & Aggression Modules B&C course for BCUHB. Course costing at £2,100 to ensure whole team gain qualification. Currently team are training without these recognised qualifications.	JBH, SR & PB															
1.3	Ensure the Manual Handling Manager and Manual Handling Advisor gain the relevant recognised qualification in Display Screen Equipment Training to effectively advise BCUHB employees who require ergonomic assessments. Course costing at £330 to ensure they gain the qualification. Currently offering advice without this recognised qualifications.	JBH, SR & PB															
2.0	**To deliver effective policies, procedures and structure to support manual handling.**																
2.1	Update the current Procedure for Manual Handling (WP55) to become a Policy for Manual Handling. To ensure it clearly identifies roles and responsibilities for all staff involved with the implementation of safe manual handling and include the roles and responsibilities of the Manual Handling Champions along with their Managers (Champions within Section 3). Policy to be clear on the organisation of the Manual Handling Team and contact details, along with all processes involved within Manual Handling.	JBH, MB & SL															
2.2	Review the procedure for emergency off the floor and equipment available across BCUHB. Lack of information over this procedure within WP55 and wide differences across BCUHB of equipment available and procedure used. When review completed, to create guidance and distribute throughout BCUHB.	GG & JB															
2.3	Update the Care Plan following the changes to the current Patient Handling Risk Assessment document used, due to the implementation of nursing e-docs in NHS Wales and the cross over to the new All Wales Patient Handling Risk Assessment and Safer Handling Plan. Advice given for the Manual Handling Care Plan to remain at the patient bedside, to ensure a quick visual guide on patients mobility and staff needed to manoeuvre a patient safely. Create a Generic Risk Assessment for all wards, as a requirement for this to remain at the bedside and concerns raised following Information Governance audits.	NL															
2.4	Update the current Procedure for the Larger Person (WP56) to become the Policy for the Larger Person. To ensure if clearly identifies the roles and responsibilities for all staff involved with the implementation of safe manual handling and guidance to ensure care with dignity for the larger patient. Policy to be clear on guidance for equipment available within BCUHB, when and how to hire in equipment via a easy how to guide. Information needed on what is already available and where this is stored. To include recommendations on what equipment should be made available in areas within BCUHB.	JBH, GG & JB															
2.5	Update the current procedure for the walking and falling patient, to ensure all BCUHB employees understand the safest way to guide a person to the floor by creating both a video of the manoeuvre along with poster information. Video to be used both for Manual Handling updates and to be added to the Staff App for wider audience.	GG & JB															
3.0	**To create a ratio of 1-10 for Patient Handling Champions through BCUHB**																

Manual Handling Plan

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3.1	Redevelop the current course for Patient Handling Champions to be rolled out in 2020 whilst continuing to train those booked in for this training on the current old programme. The intense 2 Day and the Half Day Refresher course content to be updated to ensure LOLER, TILEE and Manual Handling Operations Regulations (1992) are covered, in addition setting out roles and responsibilities of a Patient Handling Champion. These will also be added to the new Manual Handling Policy (2.1), to set out the role and responsibilities of Managers to ensure Champions can fulfil their training and their role.	JBH, MB, NL & GG															
3.2	Gather information from current Champion database, Champions are identified and what areas they cover. To include questions that will assist in developing Champions and information on how many competency updates they have completed.	JBH, MB, NL & GG															
3.3.	Set goals to and target to train all wards within Main Hospitals, along with Community hospital wards to be within the ratio of 1 Champion to 10 members of staff. To complete this, information needs to be gathered on total numbers of Level 2 Patient Halers within the ward and how many current Champions and invite direct to sessions planned for 2020.	MB, NL, GG															
3.4	Set goals and target all remainder areas after completing the main hospital and community hospital wards to be within the ratio of 1 Champion to 10 members of staff. To complete this, information needs to be gathered on total numbers of Level 2 Patient Handlers within these areas and invite direct to training in 2020	MB, NL & GG															
3.5	To develop Level 1 Load Handling Champions for Manager or supervisor assist in updating those employees that work twilight or nights and increase compliance for those groups often missed due to working hours of the Training Team. Load Champions to highlight the importance of TILEE and LOLER in their own work area ensuring this is fresher often.	JBH, MB & SL															
3.6	Monitor of Champions every 6 months through audit to ensure they are effective in their role, along with the creation of a database to ensure standard of Practical Assessments completed and Management support is given as per roles and responsibilities in Policy.	NL															
3.7	As part of the development of the Champion role, they would create an inventory for their own workplace on equipment in the are for manual handling, to highlight SWL and Safe numbers of staff. To take ownership of the Sling Register and ensure staff within their area understand LOLER and the importance of patient specific equipment and how to monitor this. Guidance will be given form the manual handling team, including templates to use for their own departments and to ensure all champions create this within 3 months of post.	NL															
3.8	To developed Champions courses for Porters only. To allow porters to discuss and work together in their department bringing a higher standard of patient handling and improve training within estates and facilities and for increased knowledge amongst themselves in load handling. To highlight the importance of TILEE and LOLER in their own work area and follow the roles and responsibilities set out within the Policy.	JBH & MB															

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4.0	**Ensure that the principles of Manual Handling are embedded within the organization to minimize the risks to all staff. Noted within gap analysis that staff are missing vital information on MHOR, LOLER, TILEE, Risk Assessments, Local Policy guidance and vital equipment information due to compact course content and reduced time to deliver . To ensure staff all receive the information needed to provide safe proactive and safety or patients, training needs to be redeveloped.**																
4.1	Current Load Handling courses are 1 hour, to ensure a practical session and increase knowledge in legislation, TILEE and Risk Assessments, along with increased DSE information and exercises for the Sedentary worker is given, this is to be increased to 2 hours and a new lesson plan to be created for 2020 and changes taken to the Mandatory Training Review Group Meeting for discussion and agreement.	JBH, JB & SL															
4.2	Current Patient Handling Refresher is a 2 hours classroom session or a 20 minute ward based competency (practical assessment), to ensure time to gain increase knowledge in legislation, TILEE and Risk Assessments, manual handling equipment along with increased DSE information and exercises for the Sedentary worker is given this should be changed from the current method. A 30 minute Practical Assessment to be carried out by Manual Handling Champion or Manual Handling Trainer within their workplace, followed by a 2 hour theory within the classroom to ensure updated on what was missing in the Gap analysis. For those areas where they would struggle to gain a workplace assessment, Competency sessions will be provided within the manual handling training rooms with a Manual Handling Trainer. All staff would need to attend the theory session after their practical assessment (3 month expiry), bringing a copy of their Assessment with them and following this they would be signed as competent through ESR upon completion of both sessions. New lesson plan to be created for 2020 and changes taken to the Mandatory Training Review Group Meeting for discussion and agreement.	JBH, MB & SL															
4.3	Be-spoke training for areas that cannot attend regular planned courses, working closely with estates and facilities in 2020 and assist with those who need to use other methods of to update their training.	JBH															
5.0	**Identify hotspots for MSD's and Back injuries through data of incidents and sickness and target these to reduce incidents.**																
5.1	Currently MSD's and Back pain account for 10.54% sickness overall from the last 12 months (April 2018-March 2019). Top 10 areas with high levels of MSD's or back pain reported on Datix or from Working Longer/Sickness Absence meeting and target them to reduce sickness and injuries by 1% in 6 months through Deep Dive in partnership with Occupational Health. Target X-Ray on each main site and to monitor effectiveness of intervention 3 months afterwards and roll out to other areas with high levels of sickness for intervention.	JBH, SJ, CJ															
5.2	Manual Handling Trainers to use Competency time and work in top 10 areas informed by Manager, monitor to see effectiveness of working alongside ward staff within manual handling tasks and see if any concerns over technique or offer any advice on training. Target 1 area per month and review effectiveness 3 months after.	JBH, MB, NL, SL, GG, JB															

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5.3	Create database for Datix received with a Manual Handling or MSD's. Ensure every Datix is answered and training offered if highlighted from the incident and follow up 3 months after training to review if effective intervention.	JBH															
5.4	Create new flowchart for Ergonomic Risk Assessments and ensure the process is appropriate, that equipment is only ordered when a documented need. Build a robust process to ensure all assessments are checked before being sent back to the individual, working close with procurement and Occupational Health.	JBH, PB															
5.5	Ensure all those with equipment advised following an Ergonomic Risk Assessment is followed up 3 months after and review effectiveness of intervention and equipment.	CJ															
6.0	**Identify equipment standards for Manual Handling Equipment**																
6.1	Highlight that not all sites across BCUHB have the same provider for LOLER checks, some using EMBE, some Estates and some areas buying in from Companies. One agreed Team should provide this throughout BCUHB to ensure the same standard is met and reduce the cost to private companies. A creation of a database to include all areas would enable a staff to find equipment, i.e. a hoist with a greater SWL, this would enable the information to be shared across sites and ease for LOLER checks on equipment.	JBH, ML, TC															
6.2	As in 3.7, Champions to have a Sling Register for their workplace for washable slings, currently this is with the Housekeeper. This is requested every 6 months (January and July) by the Manual Handling Team who then update the Sling Register within the database held on SharePoint. All slings were given a unique code and staff are advised to inform Manual Handling if a sling is taken out of use or a replacement and then updates as required. The Database enables the Team to access all slings throughout BCUHB, for when staff contact in need of a certain size urgently.	SL															
6.3	Ensure all staff are aware of the importance of adding information to Patient Specific equipment, Slide Sheets and Slings when attending training. Not all equipment is being marked and some areas using patient specific equipment for more that the named person. Information to be added to presentations and creation of reminder to be added to Weekly Bulletin for all staff, along with posters for Training Rooms.	GG															
6.4	Staff continuing to roll patients without the use of a Slide Sheet, or roll patients to insert a Slide Sheet which may be over use of handling and a cause of MSD's. Create a new video for this manoeuvre which is to be used within Manual Handling along with adding to the Staff App for wider audience.	NL & SL															
6.5	Creation of Slide Sheet workshops as a 30 minute session within hospitals using wards or seminar rooms with the use of a bed or trolley. This will allow staff a quick session on insertion of Slide Sheet without hands on to a patient, turning them with minimal hands on and removal of Slide Sheet without any hands on. This technique will reduce manual handling and effort required and may reduce MSD's caused from rounding's to patients and bed mobility assistance.	JBH, MB, NL, SL, GG, JB															
7.0	**Identify current equipment available for the larger person**																
7.1	Bariatric equipment provision differs across BCUHB and is very limited, not all areas have their own equipment. Ideally every ward should have the provision of a larger bed, chair and commode, but would need to see if a cost-to-save would benefit and an enquiry would be needed as to cost of hiring equipment for BCUHB against cost of purchasing equipment.	JBH & PW															

Manual Handling Plan

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7.2	Current process to gain access to equipment for the larger person is not the same throughout all areas and with no tracking system in place. Time consuming for staff who contact first Manual Handling, then Porters and ring around other wards trying to find equipment needed for a patient. All bariatric equipment should centrally stored to allow ease of access and tracked, to be taken on by EBME, Porters or HMT for out of hours? Manual Handling to create information via a flowchart on equipment for the larger person on how to access equipment, when to contact Manual Handling along with then and where to hire in.	JBH, JB & RT															
7.3	Ensure all staff aware to complete Referral forms found in policy (as per 2.4) and reliterate to staff on reasons for forms and what to expect form the Manual Handling Team. Create a database for these forms and ensure all referrals are answered and details updated onto the database, along with chart for the team on how to use database	JB															
7.4	Ensure there is provision for the evacuation of the larger person in the event of a fire. Current provisions of the evacuation mat used throughout BCUHB has a SWL of 160Kg and is inadequate to safely evacuate a larger person if they are unable to evacuate horizontally on their bed, as these patients are not always cared for on the ground floor and the bed size doesn't always fit through the door frame unless dismantled.	GaG, ST, JBH															

Key -

PB - Peter Bohan
JBH - Jillian Hughes
CJ - Carys Jones
MB - Meirion Beattie
NL - Nicola Lodge
SL - Sophie Lloyd
GG - Georgia Gainfort
JB - Joanne Burnham
PW - Phillip Williams
RT - Rod Taylor
GaG - Gareth Griffiths
ST - Simon Talbot
ML - Mel Lewis
TC - Tania Coppack

Project: Security Management Compliance & Action Plan
Date: September 2019
Version:
Project Lead: Steve Roscoe
Action Plan Owner: Steve Roscoe

BCUHB SECURITY INITIAL ACTION PLAN

Deliverables & Milestones:
From the findings of the BCUHB Security review conducted between July and August 2019, develop and implement an initial strategy and action plan to ensure compliance with Welsh Government Security Management Framework for NHS Trusts in Wales and associated legislative requirements and use as a foundation for further review of processes and procedures across all services and functions within the health board.

Measures:

Owner:
Project Lead**:** Steve Roscoe
Completion date: 01/05/2020

Date that actions are to be completed by:

Action	Action Owner	Action from the overarching action plan	Action Tasks	Comments & Action Update	Date Completed	31/10/2019	30/11/2019	31/12/2019	31/01/2020	28/02/2020	31/03/2020	30/04/2020	31/05/2020	30/06/2020	Anticipated Completion date is 01/07/2020					Revised date (dd/mm/yy)
1	Steve Roscoe	Compose and complete fit for purpose Security Management Policy (Including The Prevention and Control of Violence and Aggression through 'Obligatory Responses to Vioence in Healthcare'). Stipulating all security roles and responsibilities of General Users, Key Staff and Management.	1. Collate & review any and all previous policies, guidelines or instructions including internal audit documentation. 2. Collect, collate and review any and all job descriptions with roles and responsibilities related to Security and V&A. 3. Compose and complete draft Security Management Policy by 01 Nov 19.	1. No previous policies identified or located within organisation. 2. Job descriptions relating to 'Maintenanace Staff' (Estates) received and reviewed and found to have security related responsibilities within job role. 3. Systems and Security Manager position identified in the organisation - confirmed as on long term sick. Have arranged for meeting to be furnished with JD and discussion of the role to determine function. 4. Policy in process of being drafted.																

2	Steve Roscoe	Compose and complete CCTV Management Policy including use of body worn camera's with the policy to include; a. Positioning of Camera's b. Quality of Images c. Recording and Retention of Images d. Access to and Disclosure of Images to Third Parties e. Access to Images by Individuals and Enforcement	1. Collate and review any and all policies, guidelines and instructions including any internal audit documentation. 2. Liaise with Estates and IG functions to determine and review what, if anything is in place. 3. Liaise with Estates for comprehensive list of CCTV systems including location, type, monitored etc. 4. Confirm at each location who the responsible person. Liaise with current security provider and confirm policies and procedures, how they comply with BCUHB and use of body worn camera's.	1. Draft CCTV policy received from IG and found to be the start of a draft as opposed to an actual draft. 2. Liaison with Estates has not revealed any policy nor consistent guidelines in place with regards to SOP or other, however, 'Systems & Security Manager' appears to have led on copying of images but without appropriate recording of actions across organisation. 3. Estates requested to conduct full review of CCTV assets across the organisation including, types, locations, monitored or not monitored. 4. A selection and variation of sites were visited as part of Security Review were no specific responsible person(s) were identified relating to the use and management of CCTV on site. Awaiting response from Seamson Security regarding their policies/procedures including use of body worn camera's.															
3	Steve Roscoe	Identify and review posts and positions of health board employees within the estates function currently conducting security related work activities with view to adopt into H&S/Security function	1. Engage with Director of Estates with regards to justification and authority to consider adopt/transfer into H&S/Security function. 2. Compile appropriate JD including role, responsibilities and required competencies. 3. Develop and fit into H&S/Security structure/organagram.	Discussion to be had with Rod Taylor to establish opportunity and willingness to re-asign maintenance assistants into H&S/Security function.														

4	Steve Roscoe	Conduct training needs analysis to establish levels of competence and/or gaps in personnel both external and internal within the security function of the health board.	1. Review current job descriptions of all security related personnel and confirm qualification and certification/competence. 2. From results of TNA identify appropriate training provider for relevant security related training courses where required and confirm costings.	1. JD's of 'Maintenance Assistant' (Estates) received and reviewed. Found to be generic however mention of security related responsibilities within, additionally, those in the role were found to be conducting additional security related work without instruction, direction or authority - doing what they believed to be the 'right' thing. 2. No evidence of security qualification/certification/traiing of BCUHB staff conducting security related work activities. External security provider found to have all staff SIA licensed. 3. No evidence found to confirm BCUHB staff had recieved any or appropriate Conflict Resolution / V&A training. External provider to provide confirmation of level of training and be apprised of ORV. 4. NHS Health boards in South Wales requested to provide examples of criteria for securitry/V&A roles in order to determine appropriate levels of training for BCUHB staff.																
5	Sue Green	Identify, promote and communicate dedicated security head/lead for the organisation as required under Security Framework document for NHS Trusts in Wales.	1. Higher authority within BCUHB to appoint/recruit dedicated individual to fill role of Lead/Head of Security. 2. Job description to be compiled and agreed for specific individual or amendments to role and responsibilities within organisation to assume responsibilities.	1. JD compiled for presentation and recommendation for approval to Associate Director Health, Safety & Equalities with recommendation that consideration be given to amalgamation of Head of Health & Safety and Head of Security.															

6	Steve Roscoe	Develop and establish security service standards including training of both external security contractor and BCUHB staff who conduct security related work activities.	1. Policy. 2. Job Descriptions. 3. Governance structure. 4. Establish committee. 5. Training records. Risk Assessments	1. Currently limited evidence of standardised system in place for training staff. 2. Clarity on roles and responsibilities is required to be implemented. 3. No evidence of risk assessments in place.															
7		Amend the role and responsibilities of Violence and Aggression Case Manager to include security responsibilities. (Current post holder has evolved with security elements to role that need to be adopted into JD).	1. Review job description including role and responsibilities of V&A Case Manager to include additional security related duties expected within security function. 2. Upon completion and acceptance, promote and communicate the service in order organisation can fully comprehend the role.	1. JD reviewed along with current non-recorded working practices of post holder. (Currently V&A Post Holder deals mainly with security and safeguarding related issues by phone with an expectancy to act immediately - this has been generated by the working practices of himself and NWP Inspector developing their 'own service'.) 2. Ammended JD completed and forwarded to Associate Director Health, Safety and Equalities. 3. Findings of review identified BCUHB not compliant with 'Obligatory Responses to Violence in Healthcare' (ORV). 4. V&A Case Manager developing practice to promote the role and function to enable all elements within BCUHB to fully understand and comply.															

8	Steve Roscoe	Review post and role of seconded North Wales Police Demand Reduction Inspector with view to dissolve and replace with BCUHB Security/V&A Officer.	1. Review and evaluate incumbent current JD and responsibilities. 2. Evaluate effectiveness of role based on performance to establish VFM and if role could be effectively conducted with appropriately competent Security/V&A officer. 3. Consider role of North Wales Demand Reduction Inspector and if we could consider a more permanent position that suits the business needs of BCUHB.	1. NWP Demand Reduction Police Inspector interviewed as part of the Security Review. 2. Clearly define roles and responsibilities of NWP Demand Reduction Police Officer, identified no single point of contact for liaison/instruction/direction/support from BCUHB whilst working on BCUHB premises. 3. Consider findings of the security review and post holder role 'could be carried out by a BCUHB security officer' look to complete business case to security/V&A Officer to commence 01 Apr 2019.													
9	Steve Roscoe	Establish Security/V&A Officers in each regions of the organisation with additional officer specific to MH & LD function.	1. Develop and compile appropriate job description including role and responsibilities with defined chain of command. 2. Complete business case for positions using other health boards in NHS Wales as comparator.	1. Complete business case to request and justify establishing Secuirity/V&A officers in each region. 2. Copies of amalgamated Security/V&A JD's requested from South Wales Health Boards to look to align with their current practices. 3. JD being developed based on results from South Wales correspondence and findings of recent HSE inspection. 4. IN's issued at other Health Boards have been requested to share with BCUHB in order we can establish a fit for purpose function prior to expected HSE visit in 2020.													
10	Steve Roscoe	Review, revise and re-scope current scope/specification of third party security provider based on findings of the security review.	1. Develop an appropriate security structure/organagram of work force across BCUHB to facilitate the needs of the health board.. 2. Identify appropriate points of contact within BCUHB (Head of H&S/Security and BCUHB Security/V&A Officers in each region) as main point of contact for security management and monitoring to facilitate needs of external provider and BCUHB functions and services.	1. Appointing Head of H&S/Security and appropriate BCUHB Security/V&A Officers across all three regions would allow robust and transparent monitoring and management of security across the organisation. 2. If point 1 agreed, look to promote/communicate through appropriate channels and establish formal monitoring and management practice of the contract. 3. Informal managementpractices currently include weekly call with Samson Security Operations Manager with face to face monthly meeting at WMH. 4. Review of current scope/specification has been conducted and ammended scope in process of being written to capture failings of the current spec.													

11		Review and, where appropriate, amend current Lone Worker Policy stipulating roles and responsibilities of general users, key staff and management. Including monitoring devices and the use of, home visits, office based lone working and managers checklists.	1. Locate, review and scrutinise any current policies, guidelines and instructions relating to lone working across the organisation. 2. Identify owners and authors and engage to look to either amend or re-write where appropriate. 3. Identify any and all lone working devices being utilised within the organisation and review the procedures for all including monitoring of, associated cost, if any, and confirm fit for purpose with view to ideifying appropriate single device across the health board.	1. Initial findings confirm several thousand Reliance devices were procured by BCUHB however were discarded due to lack of use and failure to monitor. 2. Contact to be made with Systems & Security Manager to establish reasons for above and current location of devices. 3. To establish collaborative working with Sue Morgan (Health & Safety Advisor - Central) to establish current state of play relating to her work done on Lone Working so as not to duplicate work.															
12	Steve Roscoe	Establish appropriate Security related committee	1. Develop appropriate Terms of Reference. 2. Identify appropriate and relevant membership.	1. Identify appropriate personnel to form the key membership of the Group/Committee with support from Associate Director Health, Safety and Equalities. 2. Have completed suggested list of objectives that Security Commitee/Group would be expected to aspire and be working to achieve to support the Security Management Framework for NHS Trusts in Wales document. 3. Terms of reference to be drafted on confirmation of membership of the Group/Commitee with consideration to be amalgamated with Strategic Occupational Health and Safety Group for greater operational and financial efficiency.															

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

Compliant		
Partial Compliant		
Non Compliant		

No:	Deliverables & Milestones	Owner	H&S Advisor/Support	Measures	Start (dd/mm/yy)	End (dd/mm/yy)	Revised date (dd/mm/yy)	01/09/2019	01/10/2019	01/11/2019	01/12/2019	01/01/2020	01/02/2020	01/03/2020	01/04/2020	01/05/2020	01/06/2020	01/07/2020	01/08/2020	01/09/2020	01/10/2020
	WORKSTREAM 1																				
1a	**The Health and Safety at Work etc. Act 1974 and associated legislation.** The Health and Safety Policy provides a framework that defines individuals and corpoarte responsibilities for OHS with clear roles and resposnsibilities. The overaching legislation is an umbrella Act and regulations are made under the Act. The review of all elements of legislation will be completed with a suitable management framework completed in October 2020.	CEO/Sue Green Peter Bohan Associate Director of Health, Safety and Equality. Stephen Roscoe Head of H&S	All	Review of legislative compliance through gap analysis of 31 pieces of legislation.	September 1st 2019	August 31st 2020															
1b	**Control of Asbestos Regulations 2012.** 1. Ten asbestos re-surveys to be completed by Lucion Services to be compared with existing surveys. 2. The revised editions of the Asbestos Policy and Management Plan to be finalised and ratified. 3. Review how the schematic drawings are produced and the process for updating plans. 4. Review the system for data analysis of all asbestos surveys and action plans to ensure they are complete. Priority assessment undertaken with Estates staff to ensure they are accurate. 5. Identify how remote and local contractors are managed for asbestos to prevent their own exposure and that of others. 6. Updated Asbestos registers to be issued to all sites. 7. Annual asbestos surveys to be undertaken by Lucion Services and tracked for completion. 8. Permit to Work System to be fully implemented. 9. Asbestos Training Needs Analysis to be completed for relevant staff within BCUHB. 10. QR Code identification of asbestos stickers to be attached to all relevant areas BCUHB wide. Implement asbestos signage on ACM's in non-public areas and suitable signage to contact Estates in public areas to indicate were asbestos is present. 11. BCUHB intranet to be updated with the Policy, Management Plan and Asbestos registers. 12. Staff awareness programme to be implemented.	Rod Taylor	Susan Morgan/Gareth Griffiths.	Policy and guidance fit for purpose evidence of local management in all service areas. Review and audit against Policy undertaken. Asbestos Group reports into Strategic OHS Group of actions.	September 1st 2019	1st May 2020															
1c	**COSHH- Management of Water Systems.** 1. Update Corporate H&S Review template and H&S Self Assessment Template to ensure that actions are completed. 2. Ensure that engineering schematics are in place for all departments and kept up to date under Estates control. Consider CAD/database. 3. Departments to have information on all outlets and deadlegs, identification of high risk areas. 4. Departments to have a flushing and testing regime in place, defined in an SOP, with designated responsibilities and recording mechanism. 5. Water quality testing results and flushing to be logged on single system and shared with or accessible by departments/services - potential for dashboard/logging system. 6. Standardised result tracking, escalation and notification procedure in place, with appropriate escalation route for exception reporting. 7. Awareness and training programme in place to ensure all staff aware? Departmental Induction Checklist. 8. BCUHB Policy and Procedure in place and ratified, along with any department-level templates for SOPs and check sheets. 9. Water Safety Group provides assurance that the Policy is being effectively implemented across all sites. 10. AHUs/spaces with condensation/pooling.	Rod Taylor-Debra Carter	Sam Newitt	BCUHB is assured that the organisation is compliant with L8 guidance and risk assessments are in place for amber risks identified ensuring all actions are completed. A central data base is required to provide assurance that all flushing is taking place.	September 1st 2019	1st June 2020															
1d	**Working at Height Regulations 2005.** 1. Identify the requirements of the Working at Height Regulation 2005. 2. Identify current BCUHB Working at Height documentation/guidance. 3. Identify the local procedures for working at height for Estates. 4. Identify the training and competancy of BCUHB staff who work at height in Estates. How is that training organised, who provides it, is there refresher training and are training records kept? 5. Identify if there a documented process of risk assessment and method statements for working at height within Estates. 6. Identify if there is a Permit to Work System for working on roofs/fragile services. Who organises and supervises this? 7. Identify if there is a process of inspection of 'areas of working at height' - roofs, edge protection. Who carries out these inspections and how often? Is there a running programme? Is there a running programme of the fitting of edge protection pan BCUHB? 8. Identify the current system/process for checking working at height equipment in Estates - Scaffolding, Ladders, Step ladders, MEWPs and Trestles. Who carries out the inspections and what are the inspectors competency? 9. Identify the sytem in place for the management of contractors who work at height. Is a Permit to Work sysytem in place? Are risk assessments and method statements scrutininsed prior to the work commencing? If so, by whom? 10. Identify what local procedures are there for working at height for Facilities - deep clean team and linen staff. 11. Identify what local procedures are there for working at height for other services. 12. Identfy what is the training and competancy of BCUHB staff who work at height in Facilities - deep clean team and linen staff. How is that training organised, who provides it, is there refresher training and are training records kept? 13. Identify what is the training and co.mpetancy of BCUHB staff who work at height in all services. How is that training organised, who provides it, is there refresher training and are training records kept? 14. Identify how BCUHB staff are trained to work at height in relation to kickstools and stepladders etc. 15. Identify if there is a process of risk assessment for working at height activities? Is there a generic 'working at height' risk assessment template? 16. Identify what is the current system/process for checking working at height equipment in all services. Who carries out the inspections and what are the inspector's competancies? 17. Develop a BCUHB Working at Height Policy.	Rod Taylor	Clare Jones	Work at height requires a suitable policy system of implementation of permit to work process. Positive assurance that all staff and contractors are working to the Policy is in place. A program of inspection of ladders and regime to monitor system is required.	September 1st 2019	1st February 2020															

1e	**Non-notifiable Control of Contractors.** 1. Identify current guidance documents and absorb. 2. Arrange initial meeting with Tanya Coppack (Estates). 3. Contact Estates - Stephen Phillips. Contact Cardiff and glean additional information. 4. Write and introduce a Control of Contractors Policy. 5. Identify current tender process & evaluate. 6. Evaluate the current assessment of contractor requirements in respect of H&S, Insurance, competencies etc. Is the current system fit for purpose & robust? 7. Identify the current system for signing in / out and/or monitoring of contractors whilst on site. Currently there is no robust system in place. 8. Identify what the Local Induction involves or if one is carried out. 9. Who looks at RA's and signs off Method Statements (RAMS), and what skills, knowledge and understanding do those individuals have to assess those documents? 10. Identify the current Permit To Work processes, is it fit for purpose and implemented pan BCU?	Rod Taylor	Simon Talbot	Contractor management and control requires all contractors large and small to work to the Contractor Management Policy.The audit system will review if contractors have had local induction informed about emergency procedure and asbestos plans in the area they are working.	September 1st 2019	1st December 2019													
1g	**Vibration at Work Regulations 2005.** 1. Identification of all staff who are using vibrating or percussive equipment. 2. Staff awareness programme to be implemented. 3. Control of vibration BCUHB Policy and template risk assessment to be ratified. 4. Health surveillance programme for staff to be agreed and clarified in HS19 Staff Health Surveillance and Screening Procedure. 5. All identified departments to return their completed risk assessment to the Corporate H&S team. 6. Central register of all identified departments to be held by the Corporate H&S team and the Occupational Health department. 7. Purchasing policy to be clarified to ensure that vibration hazards are checked before equipment is purchased. 8. Staff awareness programme to be implemented including small group training and toolbox talks. 9. A review of the HSE visit and follow up all outstanding actions ensuring the HSE guidance is followed	Rod Taylor	Susan Morgan	The identification of staff who may be exposed to vibration equipment is required along with adequate assessments of such risks. Suitable controls and health surviellance programme.	September 1st 2019	1st December 2019													
	WORKSTREAM 2																		
2a	**Electricity at Work Regulations 1989.** 1. BCUHB Policy and Procedure in place and ratified - to include scope for non-estates agents/contractors, and staff responsibilities. 2. Risk Assessment/Evidence Based procedure and schedule for electrical testing, including individually owned items. 3. Centralised asset register with last and next testing date, capable of producing reports on all, overdue and upcoming (e.g. 3 months) test dates. 4. Procedure for installation, commissioning, inspection, maintenance and decommissioning of electrical equipment, including roles and responsibilities, equipment types, competency requirements, keyholder/lock-off/isolation procedure and SOP for Permit To Work System. Live/Dead Work. 5. Permit To Work System in place pan-BCUHB for mains/HV electrical work (internal/external agents). 6. Surveys/schematic records. 7. Testing/witnessing/manitenance.	Rod Taylor	Sam Newitt	Electricity safety policy will describe how the system for management of electrical installations working dead and electrical items will be tested.	September 1st 2019	1st June 2020													
2b	**Control of Noise at Work Regulation 2005** 1. Identify the requirements of the Noise at work Regulation 2005. 2. Identify the current BCUHB Noise Management documentation / guidance for Estates. 3. Identify the local procedures for the management of noise for Estates. Is there a procedure in place assessing the risk of noise? Is there a procedure in place for the creation of noise protection zones? Who is responsible for these procedures and ensures compliance with the procedures? 4. Identify what procedures there are for the checking of noise levels in Estate controlled areas. What equipment is used? Is it calibrated? Is the equipment operator trained and competant? Are training records kept? 5. Identify what procedures are in place for the selection of Estates equipment in relation to noise levels? Is identified equipment maintained and maintainenece records kept? 6. Identify what PPE is provided for Estates staff working within noise protection zones, or with noisy equipment. Is it personal and appropriate to the risk? Is training/instruction given to staff on the use of PPE? Is this documented and training records kept? 7. Identify what procedures are there for the checking of noise levels in Facility controlled areas. What equipment is used? Is it calibrated? Is the equipment operator trained and competant? Are training records kept? 8. Identify what procedures are in place for the selection of Facilities equipment in relation to noise levels. Is identified equipment maintained and maintainenece records kept? 9. Identify what health surveillance is in place. How is it managed? 10. Identify what noise assessments are carried out in the laundry in YGC. 11. Identify the local procedures for the management of noise for services. Is there a procedure in place assessing the risk of noise? Is there a procedure in place for the creation of noise protection zones in workshops? Who is responsible for these procedures and ensures compliance with the procedures? 12. Identify what the procedures there are for the checking of noise levels in relevant areas. What equipment is used? Is it calibrated? Is the equipment operator trained and competant? Are training records kept? 13. Identify what procedures are in place for the selection of equipment in relation to noise levels. Is identified equipment maintained and maintainenece records kept? 14. Identify what PPE is provided for staff working within noisy environments, or with noisy equipment. Is it personal and appropriate to the risk? Is training/instruction given to staff on the use of PPE? Is this documented and training records kept? 15. Identify the current BCUHB Noise Management documentation/guidance for services. 16.	Rod Taylor	Clare Jones	The Noise Policy will be used as a framework to identify those staff who may be at risk provide appropraite assessment and Health Survielance for staff identified at risk. Suitable controls require implementing and monitoring.	September 1st 2019	1st January 2020													
2c	**Workplace (Health Safety and Welfare Regulations) Workplace vehicular movement** 1. Identify who completes distribution / deliveries. 2. Fork Lift Truck operations - licensing? 3. Identify what RA's are in place for deliveries. 4. What procedures are in place for carrying of items in cars. 5. What RA's or controls are in place for delivery areas including pedestrianised walkways? 6. Identify if fleet vehicles have cameras. 7. Reversing warnings fitted - vulnerable persons? - What do we currently have? 8. Barrier controls? Banksmen / what training is provided? 9. What pre-checks take place? 10. Identify inspection, maintenance of fleet & records. 11. Compile a Driving at Work Policy 12. Welfare Policy to be finalised and ratified, this is to include space requirements and staff facilities (currently HS04 Procedure). 13. Hazard identification document to be reviewed and updated. 14. Relevant risk assessment templates to be completed. 15. Investigate room utilisation - what is currently in place to monitor room allocation and activity. 16. HMT's to complete a risk assessment of central site welfare facilities. 17. A review of the current training to identify any gaps and to implement any changes required	Rod Taylor	Simon Talbot/Susan Morgan/Stephen Roscoe	All vehicle management systems require a Driving at Work Policy and delivery areas require a specific risk assessment to be implemented. As part of the security review a Lone Working Policy will require implementing and monitored through an appropraite Audit system and consideration of additional equipment.	September 1st 2019	1st March 2020													

2d	**Occupational Health Surviellance.** 1. Health Surveillance - procedure redrafted, being consulted on, ratify for use and launch. 2. Final noise monitoring levels being undertaken. 3. Scope numbers of staff for audiometry screening and delivery method. 4. Conduct annual audiometry program. 5. Latex - procedure redrafted, consult on policy, ratify for use and launch. 6. Meet with procurement and quality clinical procurement group to consider latex products. 7. Vibration – policy being updated 8. Health surveillance for mortuary staff conducted. 9. Health surveillance for gardening estates staff to be conducted. 10. Night Workers - raise awareness of night-time workers assessments in January 2020 11. Immunisations – Pertussis campaign to commence November 2019 for Group 1 staff (predominantly midwifery).	Sarah Wynne Jones	Wendy Calveley	OH Surviellance is required in areas were there is a recognised ill health condition associated with the work activity substance or product. Ensure the range of questionaires targets high risk groups and audits the numbers of staff who are exposed. Implement suitable systems for testing which requires additional equipment and training will be required within OH Department.	September 1st 2019	1st Novemeber 2020	
2e	Manual Handling Regulations.A separate manual handling action plan is required to include. 1. The manual handling champion's course requires reviewing. Each manual handling champion should be is allocated 10 staff members per workplace to train, monitor and review. This will improve locally managed manual handling risks specific to the workplace. Additional support will be required to observe group sessions run by champions and annual update of training to aid the reduction of MSD's. Champions to collate an inventory of equipment used in their work areas to include LOLER requirements and ensure 6 monthly sling registers kept up to date. 2. The Policy will require updating to include simple to use guides on how to undertake TILE risk assessments and review of bariatric pathway and care plan process. **See Manual Handling Action Plan.**	Rod Taylor/Debra Carter	Jill Hughes/Steve Roscoe	The Manual Handling Policy will be evaluated as a framework to improve those at risk of MSD's in the workplace. Sickness absence and targeting of high risk areas is required to improve patient care increasing mobility and aiding staff in reducing harm. Bariatric patients require a suitable care plan and access to equipment in a timely manner.	September 1st 2019	1st March 2020	
	WORKSTREAM 3						
3a	**Control Of Substances Hazardous to Health 2002.** 1. COSHH policy to be finalised and ratified. 2. Risk assessment templates for known COSHH substances used in multiple areas to be provided by the Corporate Health and Safety team to ensure standardisation of documentation. This would include the most up to date version of the SDS. 3. Identify departments that are using substances that have a WEL / STL with support from the H&S leads. 4. Implement a monitoring system for these departments to include an inspection process from Corporate H&S. 5. Training to be reviewed and updated. This should be provided to ensure competent staff in teams using COSHH substances. These teams should be able to identify if the hazard can be eliminated or substituted for a less dangerous substance. 6. A review of Estates COSHH assessments looking specifically at substances such as wood, oil, mist, welding, diesel, dusts such as silica etc. 7. Identify the management of contractors COSHH assessments and how these are monitored and reviewed. 8. Establish if LEV is maintained via estates or do the departments arrange for their own Thorough Examination etc. 9. Review PPE including RPE is provided in line with policy and risk assessments. 10. Health Surveillance requirements to be clarified for example in relation to Occupational Asthma. 11. Identification of Biological agents and control measures required including areas such as drainage and macerators. 12. A specific review of dusts including Silica to be carried out by the Corporate H&S team	Rod Taylor	Susan Morgan	The COSHH risk assessment system requires centrally managing to avoid products being purchased at location that pose a risk to staff. Risk assessments clearly identify risks and controls effectively implemented.	September 1st 2019	1st August 2020	
3b	**Ionising Radiation.** 1. Meet Helen Hughes to discuss on 17.10.19. 2. To meet with Peter Hiles - Head of Radiation Physics and Dr. Julian McDonald - RPA for Radio istopes to discuss the GAP analysis workplan. 3. To attend the Local Radiation Committee Meeting - East - date to be confirmed. 2) To attend the Local Radiation Committee Meeting - Central - date to be confirmed. 3) To attend the Local Radiation Committee Meeting - West - date to be confirmed. 4. To observe at the Radiation Governance Meeting in YGC on 10/12/19.	Helen Hughes	Clare Jones	Ionising Radiation Policy implemented on all premises with local rules and risk assessments in place.	September 1st 2019	1st January 2020	
3c	**Confined Spaces.** 1. Policy for Safe Management of Work in Cofined Spaces. 2. Identification and risk assessment of all Confined Spaces. 3. Centralised Register of all Confined Spaces. 4. Permit To Work System in place for all work in Confined Spaces, with SOP for managing PTWs. 5. Contractor assurances in Control of Contractors Procedure, inc evacuation procedures, and RAMS. 6. TNA for relevant BCUHB staff. 7. Training Programme for BCUHB staff (supervisory, permit managers and tradesmen). 8. Monitoring and alarm systems.	Rod Taylor	Sam Newitt	A Confined Spaces policy to be implemented and clear identification and risk assessment of such areas of work. Permit to work system implemented in all service areas.	September 1st 2019	1st November 2020	
3d	**Stress Management.** 1. Gap analysis on stress conducted in June 2. Mental Wellbeing & Stress Management procedure redrafted, being consulted on, ratify for use and launch. 3. Revised individual and group stress risk assessment drafted for use 4. Mental Health World Day Conference 10th October 5. Triangulated approach for divisions commencing November a) Manager stress management training b) Staff wellness and you workshops c) Enrolling mental wellbeing champions 6. Workshop session at the staff health & wellbeing group in November to help inform longer-term strategy for 2020 onwards	Sarah Wynne Jones Peter Bohan	Jack Jackson	Stress management plan in place and simple to use risk assessment. All staff reffered to OH for stress have stress risk assesments in place. High risk areas are targeted and evidence reduction in stress sickness absence evidenced.	September 1st 2019	1st September 2020	
	WORKSTREAM 4 -						
4a	**Fire Safety Order 2005.** 1. Arrange an initial meeting with GWG. 2. Identify how actions identified in the site FRA are escalated. 3. Identify how site specific fire information and training is conducted and recorded. 4. Bariatric Evacuation Training - how is this achieved? 5. How is evacuation training delivered / monitored? 6. How is fire safety advice provided to contractors? 7. AlbaMat training - how is this achieved?	Rod Taylor	Simon Talbot	Fire Policy implemented in all services. Actions identified in risk assessment fully implemented along with fire drill undertaken.	September 1st 2019	1st July 2020	

4b	**The Provision and Use of Work Equipment Regulations (PUWER) 1998.** 1. Identify the requirements of the Use and Provision of Work Equipment Regulations. 2. Identify what current BCUHB documentation / guidance is there for the Use and Provision of Work Equipment. 3. Identify if the current documentation / guidance is fit for purpose. 4. Identify if there is a current risk assessment process in place for all work equipment. Estates, EBME, IT? 5. Identify if the equipment operators are provided with training / instruction and manufacturers guidance. 6. Identify if all departments/services have work equipment inventories kept locally? Do these inventories include maintenance schedules/checks? Do these inventories include staff training records and competencies? 7. Development of BCUHB Policy on PUWER.	Rod Taylor	Clare Jones	The PUWER policy to be implemented with inventory of equipment and maintenance records evidenced in all service areas.	September 1st 2019	1st March 2020														
4c	**Lifting Operations and Lifting Equipment Regulations (LOLER) 1998.** 1. LOLER Policy. 2. LOLER Procedure(s) for Estates, EBME, Nursing, Therapies and EBME, inc commisioning, maintenance, inpection, decommissioning. 3. Centralised register(s) with commission/decommision date, inspection and maintenance schedule, details of SWL and cycles (if counted). 4. TNA for BCUHB staff (to include Housekeepers). 5. Assurances for Contractors/Service Agents. 6. Manual Handling Guidance. 7. Manual Handling Training. 8. Manual Handling Audit Programme. 9. People Lifts. 10. Insurance inspection.	Rod Taylor	Sam Newitt/Jill Hughes	The LOLER Polcy is required to ensure all lifting equipment is suitable maintained in all service areas and specific risk assessments undertaken as required.	September 1st 2019	1st April 2020														
	WORKSTREAM 5																			
5a	**Management of H&S at Work Regulations 1999.** 1. Risk assessment guidelines HS03 to be reviewed and agreed. 2. Risk assessment template and guidance document to be finalised and agreed. 3. A suite of risk assessment templates to be produced by the Corporate H&S team that relate to specific hazards that may require technical input e.g. vibration and noise. 4. Risk assessment training to be reviewed and level of competence assessed. 5. Young worker risk assessment template to be reviewed and agreed. 6. New and expectant mothers risk assessment template to be reviewed and agreed. 7. HMT's to undertake a review of the facilities provided for new and expectant mothers. 8. A system for ensuring high risk activities have had a risk assessment to be established. 9. Establish a system to ensure that pre-contract reviews of risk assessments and method statements is undertaken	Peter Bohan	Susan Morgan	The risk assessment process should be integrated with the Risk Management Policy and a program of site specific risk assessments in all service areas. Adequate training is required for those undertaking the risk assessment process.	September 1st 2019	1st June 2020														
5b	**Corporate Manslaughter and Homicide Act 2007.** 1. TNA for Senior Managers down to Supervisors. 2. Align training requirement to recruitment procedure/probationary period for managers, plus requirement in Job Descriptions. 3. Source or write appropriate training for each determined level. 4. Secure funding if required - "big hit" and ongoing (? Bi-annual scheduled group booking may be sufficient and most cost-effective to cover all probationary periods for Senior managers). 5. Provide training to all identified levels. 6. Licensing for Doctors? In H&S Policy and HR Policy.	CEO/Sue Green Peter Bohan Associate Director of Health, Safety and Equality.	Sam Newitt	Specific training identified for senior leaders not just Board members requires implementing such as Directing Safely for staff above 8c. Additional training is required for staff who are responsible for safety management within the service areas.	September 1st 2019	1st May 2020														
	WORKSTREAM 6																			
6a	**The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013.** 1. Identify if there is a BCUHB Policy on Investigative Process and Management and if there is, does it include RIDDOR? 2. Liaise with Concerns re PTR01. Discuss the development of overarching policy to cover the investigation and management of all accidents, incidents, concerns and RIDDORs. 3. Identify and develop a new process for RCAs. 4. Identify all RIDDOR reporting guidance and procedures for inclusion in the BCUHB Policy on the Investigative Process and Management. 5. Develop a robust and effective process to ensure that any identified "lessons learnt" are implemented and shared pan BCU. 6. Audit sickness trends through Occupational Health to assess effectiveness of processes.	Peter Bohan	Clare Jones/Sam Newitt	RIDDOR guidance to be provided to staff and training. The OHS Team will review all incidents to ensure that they do not miss RIDDOR incidents.	September 1st 2019	1st March 2020														
6b	**Slips, trips and falls.** 1. Review ploicy and incorporate ground/premises management. 2. Determine requirement for scheduled inspection of all buildings and grounds and requirements for risk-based maintenance/rectification work, along with record-keeping for inspections. Rating system for prioritisation of works. 3. Reference requirement/periodicity of H&S Walkround Inspection for departments in BCUHB H&S Procedure. 4. Review requirement to specify periodicity in H&S Folder Contents Document. 5. Floor surfaces, cleaning, grounds, access routes/crossings, uniform policy, care plans, weather conditions/ice.	Rod Taylor-Debra Carter	Sam Newitt	The Slips, Trips and Falls Policy to be continually reviewed to ensure lessons are learned and reduction in numbers of staff who slip trip and fall is significantly reduced.	September 1st 2019	1st September 2019														
6c	**First Aid at Work Regulations 1989.** 1. Identify FA assessments in remote locations. 2. Identify how MHLD provide First Aid provision? 3. What is the frequency of the First Aid skills? 4. Who provides First Aid Training? 5. Is FA included in the Lone Working Policy? 6. Signage in place? 7. Appointed persons in place? 8. Are security staff First Aid trained?	Rod Taylor	Simon Talbot	The First Aid at work policy reqiuires developing to ensure suitable risk assessments are in place and emergency plans in place across all services.	September 1st 2019	1st August 2020														
	WORKSTREAM 7																			

7a	**Pressure Systems Safety Regulations 2000.** 1. Pressure Systems Policy to be completed and finalised. 2. Clarification of the training and competence required within the Estates Team to be included in the policy and records of this to be maintained by Estates. 3. Clarification of the competence required for installers and specialist contractors to be included in the policy and records of this to be maintained by Estates and included in the procurement process. 4. A database held by estates to evidence that a Written Scheme of Examination has been provided for all relevant systems. 5. Risk assessments to be completed for relevant systems which include the safe operating limits of the equipment and any protective devices installed. 6. A schedule of inspection and maintenance to be recorded centrally. 7. Ensure that a suitable database of Insurance checks is available to relevant staff and this has been updated and maintained.	Rod Taylor	Susan Morgan	A Pressure Systems guide is required to ensure there is a consistant appraoch to the management of pressure systems and this is evidenced at local sites.	September 1st 2019	1st May 2020
7b	**Management of Waste.** 1. Review the current Waste Management Policy ES03. 2. Review Waste Management training and information to managers. 3. Review auditing process for ISO14001. 4. Meeting with Ian Howard - BCUHBs Assistant Directorof Planning, Sustainability, Transport, Procurement and Planning. Invite sent for 21.11.19. 5. Review BCUHBs Waste Management Policy ES03. 6. Review Mandatory e-learning training on waste/environmental management 6 months post implementation. 7. Attend 3 ISO14001 audits per area.	Rod Taylor	Clare Jones	Waste Management Policy implemented and security of waste stores deemed to be appropraite.	September 1st 2019	1st Novemebr 2019
7c	**Personal Protective Equipment.** 1. Policy for PPE which includes Principles of Prevention, types of hazard (COSHH, Noise, Vibration, V&A, Fire, Head Protection, Electrical, Climate/Conditions, Falls etc). 2. Guidance documentation, to include element for risk assessment and selection of PPE. 4. Identify risk areas and what is currently in place. 5. Standard Operating Procedures to be reviewed.	Rod Taylor-Debra Carter	Sam Newitt	The PPE Policy in place and specific risk assessments identify hazards and control measures associated with the PPE.	September 1st 2019	1st March 2020
7d	**Gas Safety Regulations** 1. Identify contacts for Gas. Lease and property management - Chris Wilcocks. Maintenance and testing - Estate Managers. 2. Arrange to meet each area operations manager or attend one of their meetings. 3. Identify sites. 4. Produce a Gas Safety Policy. 5. What checks are in place for the verification of testers - audit system? 6. GP Practices - Community sites. 7. What are the emergency procedures - Lock off? 8. What provision is in place for Carbon Monoxide monitoring?	Rod Taylor	Simon Talbot	A gas safety Policy or guidance document is required to describe the system in place to manage gas safety and ensure annual checks of equipment can be evidenced in all service areas.	September 1st 2019	1st January 2020
7e	**Safey Representative and Communication systems.** 1. Meet with Trade Union Partners to discuss the role of Safety Reps within BCUHB. What support do they require fom the organisation? 2. Identify who are the Safety Reps within BCUHB? Where are they? What is their sphere of responsibility? What is their level of training? 3. Identify if the review has taken place of BCUHB's Trade Union Facilities Agreement. 4. Review the current BCUHB's Trade Union Facilities Agreement with Workforce. 5. Identify what is currently in place in relation to facility arrangements, time off for union duties, back fill arrangements.	Jan Tomlinson	Clare Jones	A safety represenatives guide is required and there should be clarity on numbers of safety representatives within service areas and their remit.	September 1st 2019	1st September 2020
	WORKSTREAM 8					
8a	**Sharps Safety Regualtions.** 1. Meeting with theatre managers to confirm safe removal of scalpels with disarmer pad or scalpel remover device. 2. Awareness information of safety products to be circulated. 3. Quarterly monitoring of statistics. 4. Identify an OH resource to support further actions in 2020.	Sarah Wynne Jones	Wendy Calverley	The Sharps Safety Policy procurement and systems to be constantly updated and reviewed to ensure high risk areas reduce the numbers and severity of sharps in the workplace. Proper RCA process that learns lessons implemented.	September 1st 2019	1st January 2020
8b	**The Health and Safety (Display Screen Equipment) Regulations 1992 (amended 2002).** 1. DSE policy to be finalised and ratified. 2. Review and update information on the H&S webpages in line with the Policy. 3. The return to work procedure for staff using DSE on their return to be clarified and agreed. 4. A flow chart for ordering new and replacement equipment to be completed. 5. A review to be undertaken of the self assessment procedure and the managers responsibilities is to be completed and outlined in the DSE Policy. 6. A structured training program for DSE users is to be agreed and implemented. 7. Clarification of the roles and responsibilities of the Occupational Health team, Manual Handling team and Health and Safety team to be given in the DSE Policy	Peter Bohan	Sue Morgan /Sarah Wynne Jones	The DSE Policy to be effectively implemented within service areas and individuals have appropriate assessment and controls in place. Fast track policy effectively implemented for staff to get physio service early.	September 1st 2019	1st September 2020
8c	**Safety Signs and Signals Regulations 1998.** 1. What signage do Estates use for Asbestos or other issues such as noise, goggles to be worn in areas etc. 2. What is the procurement process for signage cureently in place. 3. Is there a standars / size, location for signage - traffic areas when are they replaced. 4. Are there risk assessments for signage - traffic areas and processes to identify standard procedures. 5. Noise signage in place in plant rooms and zoning of areas for PPE. 6. What is the provision of signange for plant rooms and is it eefctive.	Rod Taylor	Simon Talbot	Ensure suitable safety are in place and guidance document available for staff when signs are purcahsed.	September 1st 2019	1st February 2020

8d	**CDM** 1. CDM Policy (notifiable and non-notifiable projects) which defines roles and responsibilities and references applicable Procedures. 2. Review Capital Projects Manual. 3. Audit Programme. 4. Safety File System - management control, updating, storage and security.	Neil Bradshaw	Sam Newitt/Steve Roscoe	The CDM Policy continually monitored and clear roles and responsibilities adhered to sample plans and ensure safety file delivered on work carried out and modifies or supports previous plans in place.	September 1st 2019	1st September 2020
8e	**Policy systems and document control.** The BCUHB Policy on Policies (PoP) will be launched in September 2019. Running parallel to this is the review and development of the new BCUHB Policies, Procedures, Guidance and other written control documentation internet page. The project aims to develop a central and authoritative location for the storage of all pan BCUHB WCDs. This will act as a point of assurance enabling the Health Board to review its internal control framework and provide further confidence in its operational working. The Occupational Health and Safety Policies will be used as a pilot in the development of the central control process required. The Occupational Health and Safety Policy will be provided to the Strategic OHS Group on the 1st November 2019.	Peter Bohan	Sara Jones/Bethan Wassle	Policy and guidance fit for purpose evidence of local mangagement in all service areas.	September 1st 2019	1st October 2020
8f	**Intranet site with self help guides.** The intranet site for Occupational Health and Safety requires easy helpful guidance and policies available that are agreed and controlled centrally as described above. Staff require simple self-help guides and information developing on what is required in a safety file and what an audit will be looking for.	Peter Bohan	All OHS Team to contribute Sara Jones to manage system.	Develop an effective intranet site that provides easy to access guidance for staff that is specific to BCUHB requirements.	September 1st 2019	1st September 2020
	WORKSTREAM 9					
9a	**Training Needs Analysis.** 1. A review of contractor induction to be undertaken and a system established to ensure this is carried out. 2. A review of the level of training for Board Executive Directors and Independent Members is required and a training program to be implemented. 3. A review of the level of training for Senior Staff including Area Directors / Associate Directors is required and a training program to be implemented. 4. A review of the level of training for H&S Leads (Champions?) is required and training program to be implemented. 5. A review of the level of training for Department Managers is required and a training program to be implemented. 6. Orientation and Workplace Induction training program to be updated and agreed	Peter Bohan	Susan Morgan	Undertake a TNA and all services are 85% compliant with the plans in place ensure the training is specific to the needs of the organisation.	September 1st 2019	1st July 2020
9b	**Audit system and Key Performance Indicators.** 1. Scrutinise Gap Analysis and applicable standards and canvas opinion re. suggested KPIs. 2. List of KPIs. 3. Determine data collection methods - risk registers , self-assessment, H&S Reviews, Datix, sickness data inc. time lost, type of illness/injury, turnover etc. 4. Implement data collection. 5. Validate data. 6. Design/procure core data collection and reporting system with dashboard funtionality. 7. Determine and document schedule and responsibilities for data collection and audit programme. 8. Implement audit programme.	Peter Bohan	Sam Newitt /Sara Jones	Ensur the audit system provides assurance that all safety risks are being managed a comprehensive KPI system is implemented and can be evidenced as improving safety performance and culture.	September 1st 2019	1st February 2020
9c	**SEQOSH accreditation.** 1. Appraise with detail in the self-assessment phase. 2. Complete a baseline assessment and action plan. 3. Monitor progress of the action plan. 4. Populate the web-based assessment. 5. Work towards assessment in 2020.	Peter Bohan - Sarah Wynne Jones	Janet Jones	Ensure SEQOSH systems are implemented and evidence of performance reviewed to maintain the quallity assured system.	September 1st 2019	1st October 2020
9d	**Health and Safety Leads.** 1. Identify who are the identified BCUHB Health and Safety Leads. What are their roles/seniority within their services and what health and safety responsibility to they have and what is their level of training? 2. Explore the concept of Health and Safety Champions. 3. Research other BCUHB champions - manual handling champions, staff mental health and wellbeing champions in relation to their development within BCUHB and their roles and responsibilities. 4. Explore level of required training? IOSH 4 day Managing Safely Course. NRCQ level 3 Managing Safely classroom, e-learning course?	Peter Bohan	Clare Jones	Ensure OHS Leads have the The Safety Leads require the skills and training necessary to support the OHS agenda. The Safety Leads group should be the focus of the actions required by the strategic OHS Group and should provide evidence of safety culture improvements in all service areas.	September 1st 2019	1st February 2020

Risk register

Key

1-3	Low Risk
4 – 6	Moderate Risk
7 – 14	High Risk
15 - 25	Extreme Risk

Risk ID	Date Raised	Raised by	Risk Score	Impact Level	Risk Description. There is a risk that…	Risk Reason. …because…	Risk Outcome/effect. …which will cause…	Planned Mitigating Action	Risk Owner	Impact (Drop Down)	Impact Score	Probability (Drop Down)	Probability Score	Date last Reviewed	Risk Status (Open/Accepted /Closed
R01			6	High						Moderate	3	Possible	2	19/12/18	accepted
R02			8	Critical						Major	4	Possible	2		Open
R03			8	High					Lisa Dugan	Moderate	2	Likely	4		Open
R04			20	Critical					Lisa Dugan	Major	4	Extremely Likely	5		CLOSED
R05			6	High					Lisa Dugan	Moderate	3	Possible	2		Open
R06			4	High						Major	4	Possible	1		Open
R07			12	High						Major	4	Likely	3		

Project: SEQOHS
Date: 10/10/2019
Version: 1
Project Lead: Janet Jones
Project team: **Occupational Health Team**

On track		
Delayed/deferred		
Deadline missed		

No:	Deliverables & Milestones	Owner	Measures	Estimated Duration	Start (dd/mm/yy)	End (dd/mm/yy)	Revised date (dd/mm/yy)	APRIL	MAY	JUNE	JULY	AUGUST	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEPT
											2019									2020					
	WORKSTREAM 1:- Stage 1 Pre Accreditation			39 weeks																					
1a	Registration & Application			2 weeks	Wed 17/04/19	delayed waiting for	See Risk 01																		
	Payment to SEQOHS	Janice Shawcross	Approved																						
	Review of Standards (Self Assessment)	Janet Jones		5 wks	Tue 7/05/19	Wed 12/06/19	31/11/2019																		
	- Note and act on gaps	Janet Jones	ensure all policies and procedure implemented, and up to date	5 wks	Tue 7/05/19	Wed 12/06/19	31/11/2019																		
	- Audit plan	Janet Jones	develop a policy to cover all audit processes within the service to	6 weeks	Tue 30/04/19	wed 12/06/19	31/10/2019																		
	- Cold chain Audit	Marian Addy	Review to ensure that the procedures outlined in Imms 04	4 weeks	01/12/2019	01/01/2020																			
	- Room Audit	Team Leads	Initial room audits completed in April Review	4 weeks	01/11/2019	01/12/2019																			
	- Calibration Audit	Team Leads	initial calibration audit completed in June -Review	4 weeks	01/01/2020	31/01/2020																			
	- Notes Audit	Claire Allen /Sandra Mayers	Review of previou saudit with changes to the audit process	4 weeks	17/09/2019	09/09/2019	30/11/2019																		
	Pre- Employment Audit	Eirian Williams	Compliant with SOP (currently procedure or local policy	4 weeks	21/08/2019	21/09/2019																			
	- Counselling audit	Jack Jackson	review planned by December1st	6 weeks	31/10/2019	01/12/2019																			
	Medicines management framework	Janet Jones	develop new medicines management SOP and check	2 weeks	17/09/2019	03/10/2019	21/10/2019																		
	electronic file containing all information about the service published in leaflets or on a website.	Geraint Blackwell	In process information being gathered.	3 weeks	02/10/2019	05/11/2019																			
	'An OH service must take reasonable steps to ensure that all of its staff are honest and trustworthy	East Janet Jones	Recruitment services confirming what checks are completed prior to commencing employment.	2 weeks	15/11/2019	30/11/2019																			
	'An OH service must take reasonable steps to ensure that all of its staff are honest and trustworthy	Central Kim Crichton	Recruitment services confirming what checks are completed prior to commencing employment.	2 weeks	15/11/2019	30/11/2019																			
	'An OH service must take reasonable steps to ensure that all of its staff are honest and trustworthy	West Wendy Calveley	Recruitment services confirming what checks are completed prior to commencing employment.	2 weeks	15/11/2019	30/11/2019																			
	Customer (Manager) feedback •Customer feedback, which sho	Janice Shawcross/Janet Jones	Smart survey to be set up to measure referrer satisfaction over a defined 2 week period. Rebecca Hubbard WOD to assisst with survey set up.	6 weeks	01/10/2019	15/11/2019																			
	Employee feedback	Janice Shawcross/Janet Jones	2 week snapshot period inOctober - clients to be sent a feedback form by post with addresed envelope for return.	4 weeks	15/10/2019	15/11/2019																			
	Collate results of employee and manager feedback.	Janice Shawcross	Devise a method of analysing feedback and identify areas of improvement.	4 weeks	15/11/2019	15/12/2019	Repeat in February and June																		
	Written procedure for budgetary control and auditing	Janice Shawcross/Sarah Wynne Jones	consider BCUHB standing financial instructions and procurement guide and develop local policy if needed.	2 weeks	15/10/2019	01/11/2019																			
	Demonstration of clear lines of budget responsibility including demonstration that income and expenditure are tracked	Janice Shawcross/Sarah Wynne Jones	consider BCUHB standing financial instructions and procurement guide and develop local policy if needed.	2 weeks	15/10/2019	01/11/2019																			

	SOP Transfer of records	Donna Piercy/Julie Firth	DP drafting from an example template and forwarding to JF for amendment	2 weeks	07/10/2019	17/10/2019	
	SOP nightworker assessment	Donna Piercy/Julie Firth	Developing a new protocol in line with industry guidance on fitness	3 weeks	17/10/2019	07/11/2019	
	Traffic Light Rating via SEQOHS self assessment tool			1 wk	Thu 13/06/19	Wed 19/06/19	04/11/2019
	Review of self assessment- Gap analysis			1 day	Thu 20/06/19	Thu 20/06/19	Nov
	Action Plan& Implement changes			1 week	Mon 01/07 /19	Mon 08/07/19	see risk 0201/12/19
1b	SEQOHS Knowledge Management System			12 wks	Tues 09/07/19	Tues 01/10/19	See Risk R02 01/12/19
1c	Training & Implementing changes		from gap analysis identify staff training needs	3 wks	Mon 02/12/19	Tues 24/12/19	January 1st
1d	or practice						
1e	Service Improvement review			2 wks	Tues 31 /12/19	Tues 14/01/20	
1f	Confirm able to demonstrate readiness / green light			Milestone	Wed 15/01/20	Wed 15/01/20	
	WORKSTREAM 2 :- Stage 2 Accreditation						
2a	**Stage B training: how to prepare for accreditation (mandatory)** - one free place per accreditation cycle included in membership fees; additional places £175+VAT	Janet Jones	attendance confirmed on 29 Jan 2020 at FOM 2 Lovibond Lane London SE10 9FY	1 day	29/01/2020	29/01/2020	Follow on dates delayed until after stgae 2 training
	SEQOHS Accreditation Readiness Assessment			1 wk	Thurs 30/01/20	Mon 3/02/20	
	Online SEQOHS Accreditation Submission			2 wks	Thurs 23/01/20	Thurs 06/02/20	
	Assessors Review of Evidence			12 wks	Mon 10/02/20	Mon 04/05/20	
	Monitor and respond to Assessors Feedback			3 weeks	Wed 1/04/20	Fri 24/04/20	
	Review			1 wk	Mon 27/04/20	Thurs 30/04/20	
	Action Plan			1 wk	Tues 05/05 20	Mon 11/05/20	
	Make changes			4 wks	Mon 11/05/20	Fri 05/06/20	
	Respond to Assessor			1 wk	Mon 8/06/20	Fri 12/06/2020	
	Go Ahead for Site Visit			Milestone	Fri 22/05/20	Fri 22/05/20	
	Site Assessments - At availability of assessors			1 wk			
	Assessors Report			3 wks			
	SEQOHS Quality Assurance Board			6 wks			
2b	Feedback			Milestone			

Quality Safety & Experience Committee **19.11.19**	GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board ***To improve health and provide excellent care***

Report Title:	Nurse Staffing Levels (Wales): Adult Acute Medical And Surgical Inpatient wards
Report Author:	Mrs Debra Hickman, Secondary Care Director of Nursing
Responsible Director:	Mrs Gill Harris, Deputy Chief Executive/Executive Director of Nursing & Midwifery
Public or In Committee	Public
Purpose of Report:	Formal Presentation of the biannual calculation of the Nurse staffing levels as directed by the Nurse Staffing Levels (Wales) Act 2016 for acute adult medical and surgical inpatient wards
Approval / Scrutiny Route Prior to Presentation:	As the Designated Person within the Health Board the Executive Director for Nursing & Midwifery is required to present
Governance issues / risks:	Issues of significance: 1. The number of Nursing vacancies within the Health Board 2. The Number of additional beds open due to ongoing capacity escalation management
Financial Implications:	None identified
Recommendation:	The Committee is asked to note and support the report.

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

3.To support children to have the best start in life		3. Involving those with an interest and seeking their views	
4.To work in partnership to support people – individuals, families, carers, communities - to achieve their own well-being		4.Putting resources into preventing problems occurring or getting worse	**x**
5.To improve the safety and quality of all services	**x**	5.Considering impact on all well-being goals together and on other bodies	
6.To respect people and their dignity	**x**		
7.To listen to people and learn from their experiences	**x**		
Special Measures Improvement Framework Theme/Expectation addressed by this paper Strategic and service planning			
Equality Impact Assessment			

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

Background:

In September 2016 the Nurse Staffing Levels (Wales) Act became law, requiring organisations across NHS Wales to calculate and monitor the number of nurses required to provide appropriate care for patients in acute inpatient settings as set out. In April 2018 the Act came into effect for Adult Acute Medical and Surgical wards.

The Act consists of 5 sections, 25A to E as specified below:

- 25A refers to the Health Board's overarching responsibility to have regard to providing sufficient nurses in all settings, allowing the nurses time to care for patients sensitively;
- 25B requires the Health Board's to calculate and take reasonable steps to maintain the nurse staffing level in all adult acute medical and surgical wards. The Health Board's is also required to inform patients of the nurse staffing level on those wards;
- 25C requires the Health Board to use a specific method to calculate the nurse staffing level in all adult acute medical and surgical wards;
- 25D relates to the statutory guidance released by the Welsh Government;
- 25E requires the Health Board to report their compliance in maintaining the nurse staffing level for each adult acute medical and surgical ward of which the Health Board is responsible for monitoring (see appendix 1)

Section 25A of the Act relates to the overarching responsibility placed upon each Health Board, requiring Health Boards and Trusts to ensure they have robust workforce plans, recruitment strategies, structures and processes in place to ensure appropriate nurse staffing levels across their organisations. Section 25B of the Act lays down specific and very detailed requirements in relation to the calculation and maintenance of the nurse staffing levels required for adult medical and surgical in-patient wards

To deliver safe quality patient care it is essential wards have optimal nurse staffing levels. It has been acknowledged that one of the contributory factors linking failures in care and patient safety were inadequate staffing levels (Francis 2013).The Board is mandated to receive a formal presentation of the staffing skill mix calculation for the wards as listed in appendix 1. 'Appropriate staffing plays an important part in the delivery of safe and effective health and care. Safe staffing can be a complex area and has to take account of multiple factors. It must be matched to patients' needs and is about skill-mix as well as numbers', Nursing Midwifery Council (NMC) (2016). The Chief Nursing Officers guidance reinforces a triangulated approach and no longer supports the use of predetermined 'multipliers' to the application of safe nurse staffing levels because of the complexities and multitude of factors associated.

The Nurse Safe Staffing Act (Wales) 2016, requires the Nurse staffing calculation to be undertaken bi-annually with documented evidence of a robust methodology, it also requires the Health Board to have due regard to providing sufficient nurses to allow time to sensitively care for patients and meet their health needs, ensuring that

all reasonable steps have been taken to maintain safe planned nurse staffing levels and mitigate shortfalls.

All of the acute adult medical and surgical inpatient wards have a 26.9% uplift for Band 5 Registered Nurses and above, Health Care Support Workers have an uplift of 22%.

Although the Band 7 Ward Sisters are not included in the care delivery numbers for their respective ward areas, due to the current vacancies they are often being rostered into the clinical care delivery numbers.

Methodology

This report covers the period November 2018 to October 2019. The following three stage approach has been used as the underpinning methodology for the calculations:

1. **Acuity**

   Dependency & occupancy data is routinely collected three times a day and recorded in the Health boards designated system. The information assists to support a dynamic assessment of staffing at coordinated intervals throughout each day and to inform the management of safe staffing levels. A record of mitigations taken is logged to provide supporting evidence of staffing management. The dependency data is extracted and submitted to the All Wales group on a bi annual basis for analysis and national benchmarking. Our latest submissions took place in January and June 2019 of which analysis was used to inform the current revised calculations.

2. **Quality and Professional Judgement (site level)**

   Nurse staffing review meetings with the Ward Sisters, Matron, Heads of Nursing, Site Directors of Nursing and Finance officers undertook a confirm and challenge approach reviewing the above evidence alongside:

   - capacity
   - current establishments - funded and actual
   - incidents
   - complaints / feedback
   - additional service demands

3. **Quality and Professional Judgement (BCU Acute Site comparison)**

   The above information has then been reviewed collectively with the Site Directors of Nursing, Secondary Care Director of Nursing and presented to the Executive Director of Nursing & Midwifery verifying the rationale for changes within establishments leading to final approval. Thus formulating a professional judgment of the staffing requirements for each medical and surgical adult inpatient area.

Outcomes:

A summary of Nurse staffing levels confirmed following the 2019 review for each site are included in Appendix 2. The staffing establishments have acknowledged the escalation beds that have been escalated for the last 12 months plus. The review noted the significant number of vacancies across all 3 of the acute sites, the challenges associated with this and the workforce optimisation plans to support. To support ongoing recruitment and retention initiatives, provide a level of stability and look to further strengthen clinical leadership, particularly in the more difficult to recruit to wards there has been a conversion of a Band 5 to a Band 6 post.

To support the vacancy gap, add stability to the workforce and to provide a further route of access to registered Nurse positions there has been an expansion of band 4 posts across the sites. It is recognised that this adjusts the overall skill mix, however is aimed to mitigate the current gap by providing a greater level of consistency, stability and wider skill mix than the traditional Health Care Support Worker role currently in the Health Board. Highlights from each of the site outcomes are given below.

Ysbyty Wrexham Maelor (YWM)

Has identified the need to increase Healthcare Support Workers (HCSW) numbers in the Acute Cardiac Unit, Surgical Assessment Unit, Erddig, Morris Bersham, Fleming, Lister and Pantomime ward predominantly on nights. This is predicated on the current escalation capacity, dependency of the patients, occupancy, stability of the current ward team and overall vacancies.

Additional Registrant requirements have been identified for Fleming ward, due to the instability in the current workforce for Pantomime due to escalation and dependency and occupancy for both wards alike.

Additional Band 4 roles are required for both Erddig and Morris ward due to vacancies and current reliance on temporary workforce the numbers of harms, although none are linked to staffing as direct causes.

Reduction in Registered Nurse (RN) requirements were noted on Pantomime, Prince of Wales and Lister ward, the latter of which plans are currently being developed to transition this area to support the revised Medical model as part of the unscheduled care programme.

Discussions with both Infection Prevention Lead and the Executive Director of Nursing & Midwifery have been held to support the change in use of Bromfield ward, which is an 8 bedded isolation facility, this is currently utilised as additional escalation capacity.

Ysbyty Glan Clywd (YGC)

Has identified the need to increase HCSW numbers for Wards 1, 4, 9, 12, 14 and 19. This is predicated on the dependency of the patients, increase in harms (none directly linked to staffing) and stability of the current ward teams and vacancies.

No additional registrant requirements have been identified across the inpatient acute medical or surgical areas, however recognising the number of wards with vacancies and where harms have been identified, the following wards have been identified as requiring movement from Band 5 to 6 posts on wards 1, 4, 5, 9 and 19 respectively.

Further Band 4 development roles have been identified on wards 2, 8, 9 and 19. Alongside these, there are also band 3 posts whereby a review of roles and requirements has currently being completed to ensure maximisation of the current workforce.

A recommendation has been made to review clinical specialities within the wards to ensure that skills sets are appropriate and are maximised, ensuring safe and effective pathways and outcomes for patients and development opportunities for the staff.

Activity on ward 1 Abergele site identified a reduced registrant requirement, this also supports the review of elective orthopaedic services on the Abergele site.

Ysbyty Gwynedd (YG)

Has identified the need for an increase in HCSW numbers for Hebog, Tryfan, Moelwyn and Dulas wards due to increases in both acuity, activity and harms (none directly linked to staffing).

A review of nursing input into both surgical pathways, cardiac and renal services has been recommended to ensure effective cross speciality working including effective utilisation Clinical Nurse Specialists currently in post.

Prysor ward is recommended to remain ‘as is’ currently following a further interrogation of acuity data in January 2020.

Further Band 4 development roles have been identified within Moelwyn and Enlli wards to support the RN vacancy gaps as identified for YWM & YGC sites respectively.

Wards identified as benefitting from conversion of an additional Band 5 to Band 6 role are Aran, Tryfan, Conwy, Dulas and Enlli wards again as described for YWM and YGC sites respectively.

Reduction in registrant numbers have been identified on Gogarth, Tegid and Dulas wards, with cross floor working between Glaslyn and Prysor wards to support the registrant deficit on Glasyln due to reductions in capacity, demand and acuity.

Conclusion:

All Staffing numbers as planned are displayed outside each ward, these are updated as planned requirements change to inform the public and wider Health Board workforce.

There are a number of work programmes in operation which are concentrating on the use and reduction of escalation beds, improved patient pathways and revised models of care to assist alleviating some of the current acute adult inpatient pressures.

Recruitment and retention remains a key feature with programmes looking to create stability in the current nursing workforce. We have seen our first increased outturn of newly qualified registered nurses all of whom we've offered substantive posts in their areas of choice. Recruitment initiatives continue to include attendance at local and National events, targeted social media use and overseas recruitment, all of which are contributing to stabilising the current workforce gaps.

References:

NMC (2016) Appropriate staffing in health and care settings https://www.nmc.org.uk/globalassets/sitedocuments/press/safe-staffing-position-statement.pdf.

Nurse staffing Levels (Wales) Act 2016: operational guidance http://www.assembly.wales/laid%20documents/pri-ld10028%20-%20safe%20nurse%20staffing%20levels%20(wales)%20bill/pri-ld10028-e.pdf

National Institute for Health and Clinical Excellence (NICE) on safe staffing. https://www.nice.org.uk/Guidance/SG1

Appendices

Appendix 1	Nurse Staffing Act – Act Wards
Appendix 2	Staffing summary current and proposed staffing following skills mix review
Appendix 3	Acuity Data

Appendix 1

Nurse Staffing Act
Act Wards

Ysbyty Glan Clwyd	Ysbyty Wrexham Maelor	Ysbyty Gwynedd
Abergele Ward 6	Bersham Stroke Unit	Aran – Medical
Ward 1	Bonney	Dulas
Ward 11 Respiratory	Cunliffe	Enlli - Orthopaedic
Ward 12 Renal & Diabetes	ENT	Ffrancon
Ward 19 COTE	Erddig Respiratory	Glaslyn
Ward 19a Gynae	Evington Ward	Glyder
Ward 2 CAU/SD	Fleming	Hebog
Ward 4 Cardiology	Lister	Moelwyn
Ward 5 ENT/Urology	Mason	Ogwen Orthopaedic Unit
Ward 7 Orthopaedics	Morris	Prysor
Ward 8 Colorectal	Prince Of Wales	Tegid - Urology/Colorectal
Ward 9 Gastro	Bromfield	Tryfan - Gastro
Ward 14 Stroke	Pantomime	Alaw

Appendix 2

Staffing summary current and proposed staffing following skills mix review

		Early		Late		Night	
		RN	HCSW	RN	HCSW	RN	HCSW
YWM	Current	67	43	68	38	48.5	24.5
	Proposed	66	43	66	42	47.5	31.5
YGC	Current	66	46	65	32	40	28
	Proposed	66	46	65	32	40	34
YG	Current	64	42	62	40	37.5	27
	Proposed	62.5	42	60.5	42	37	28

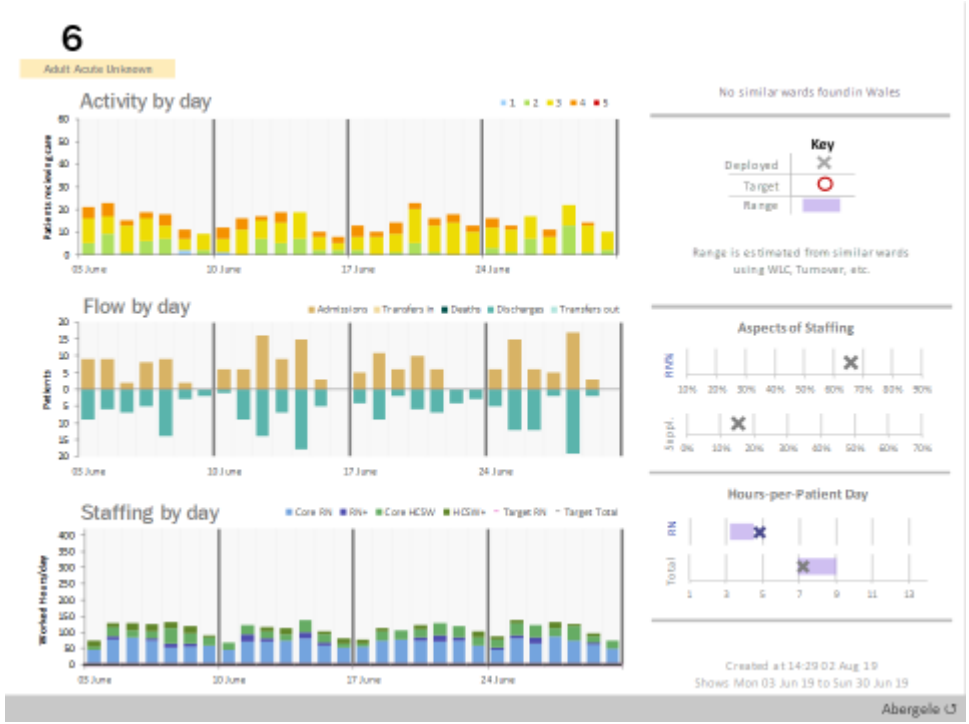
Appendix 3

Acuity Data

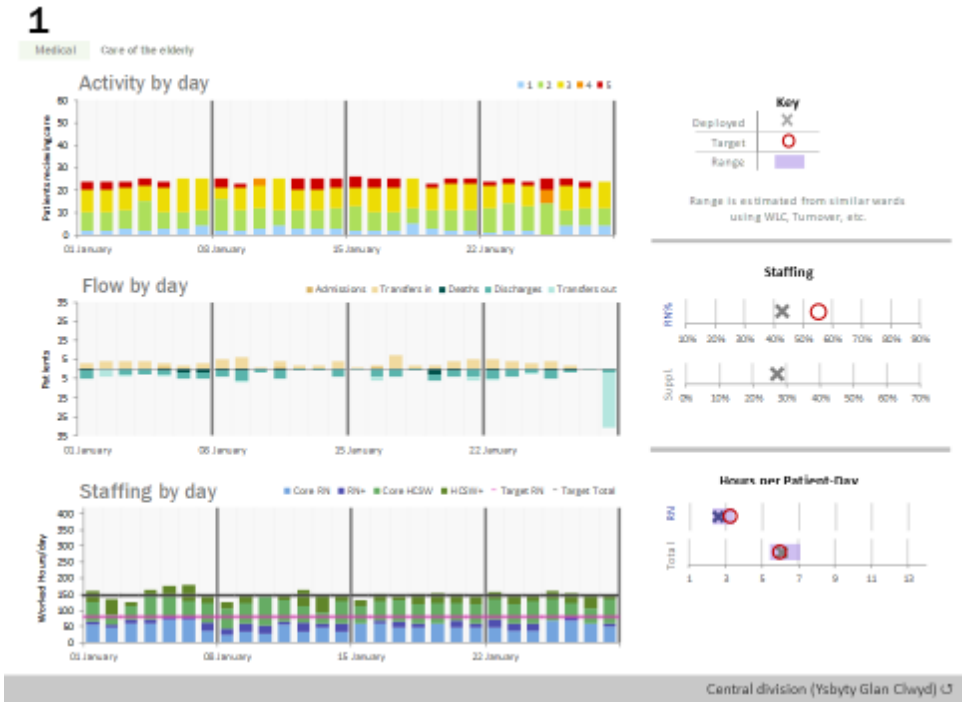
January 2019

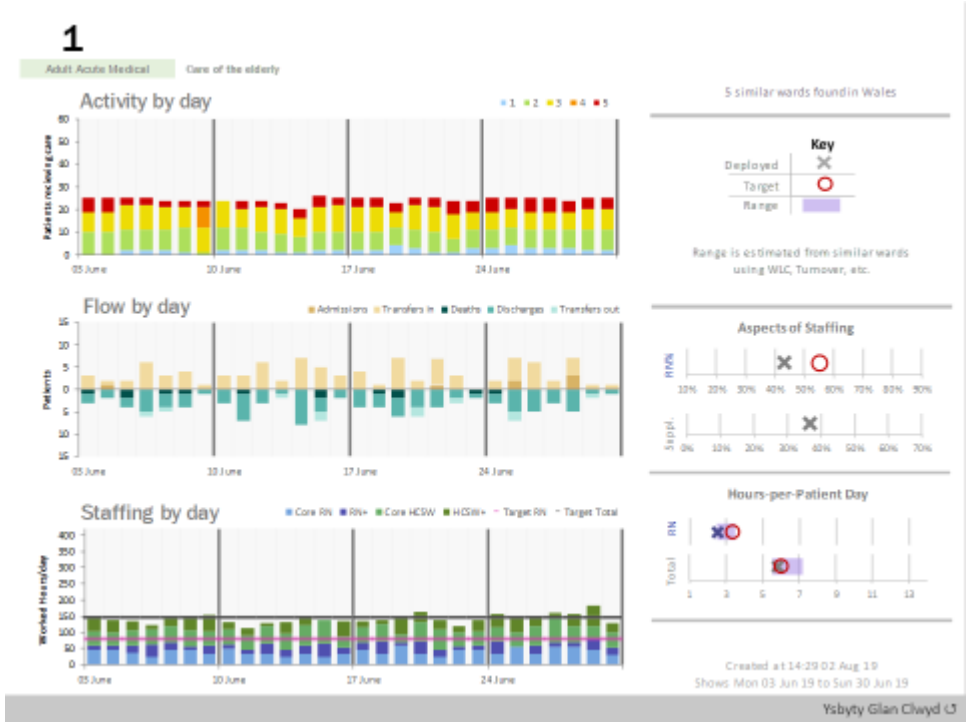
June 2019

Abergele

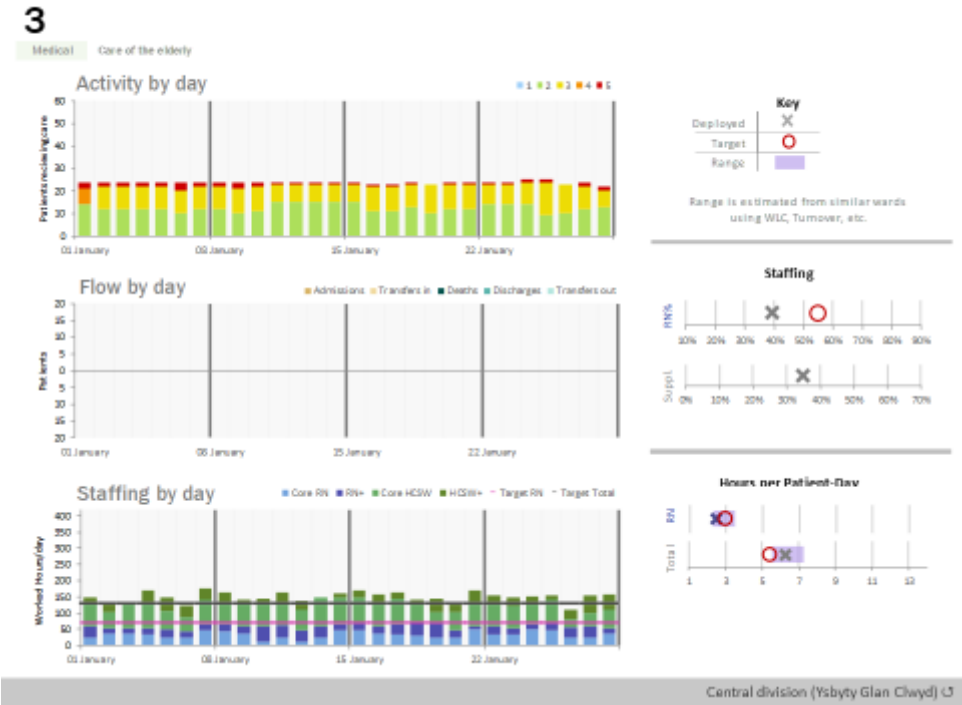


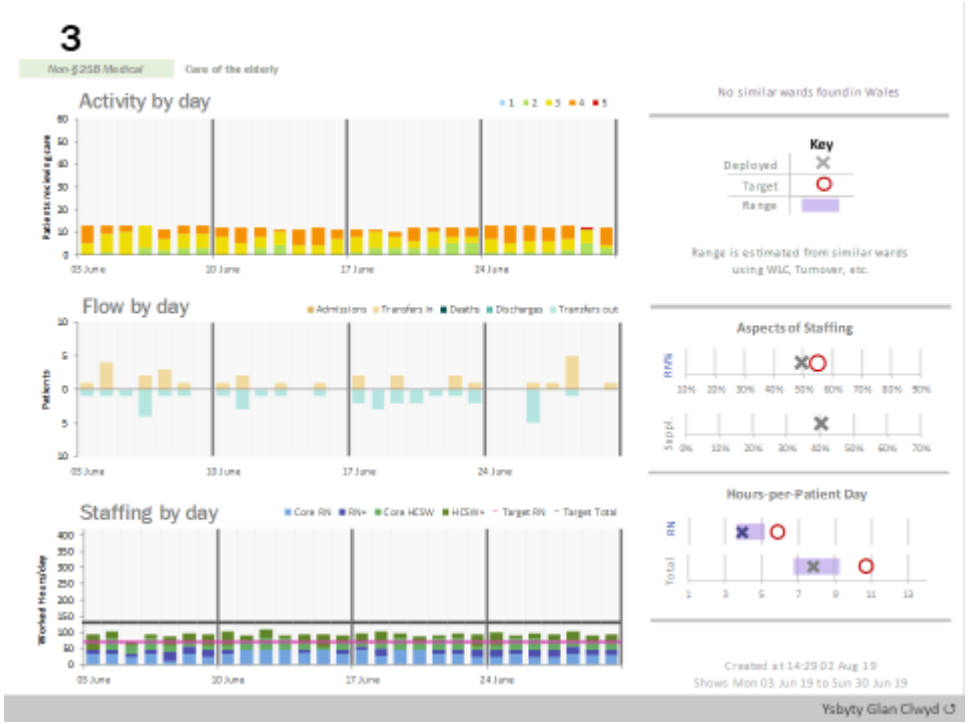
Ysbyty Glan Clwyd

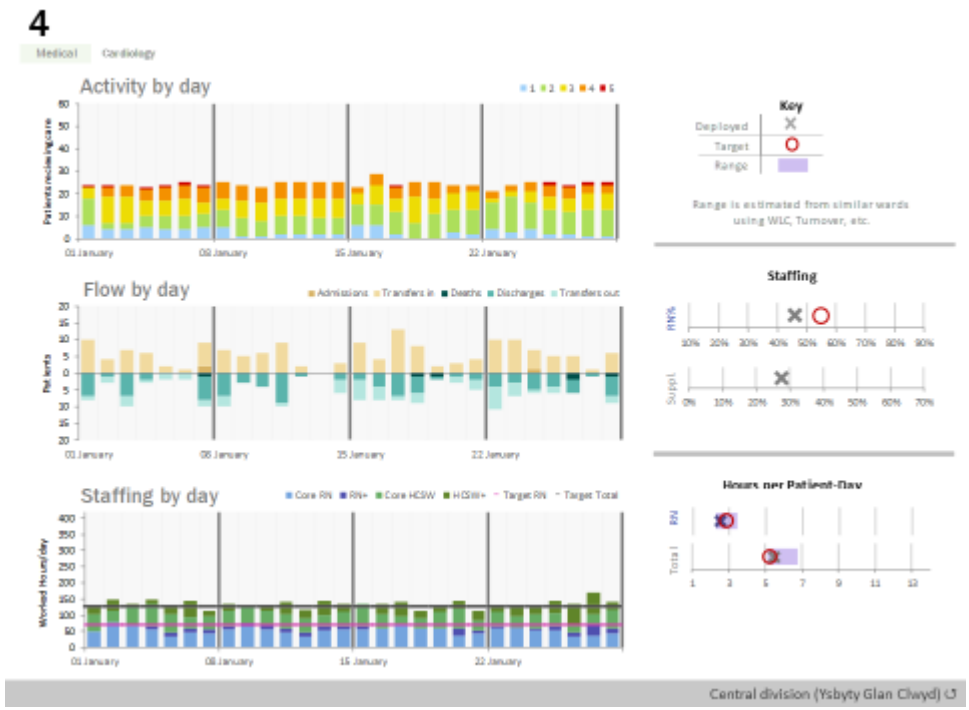




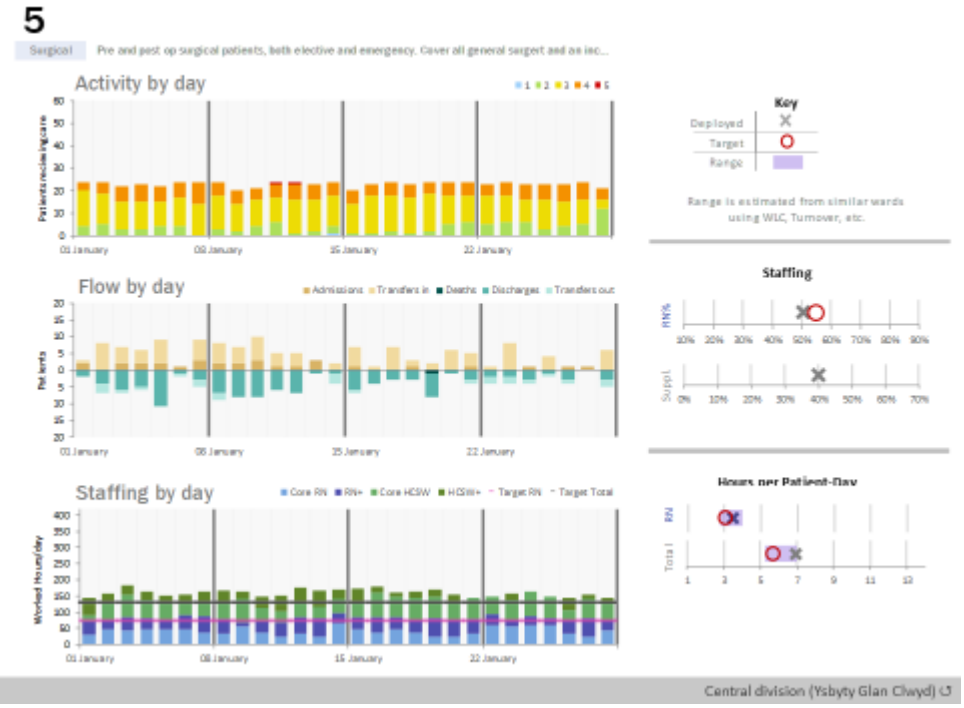
2b
Non-§258 Unknown
Medical Renal specialty, Care of the Elderly
Activity by day
1 2 3 4 5
Patients receiving care
05 June
10 June
17 June
24 June
Flow by day
Admissions Transfers in Deaths Discharges Transfers out
Patients
Staffing by day
Core RN RN+ Core HCSW HCSW+ Target RN Target Total
Worked Hours/day
6 similar wards found in Wales
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Aspects of Staffing
RMN
Suppl.
Hours-per-Patient Day
RN
Total
Created at 14:29 02 Aug 19
Shows Mon 03 Jun 19 to Sun 30 Jun 19
Ysbyty Glan Clwyd


3
Medical
Care of the elderly
Activity by day
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Flow by day
Staffing
Staffing by day
Hours per Patient-Day
Central division (Ysbyty Glan Clwyd)

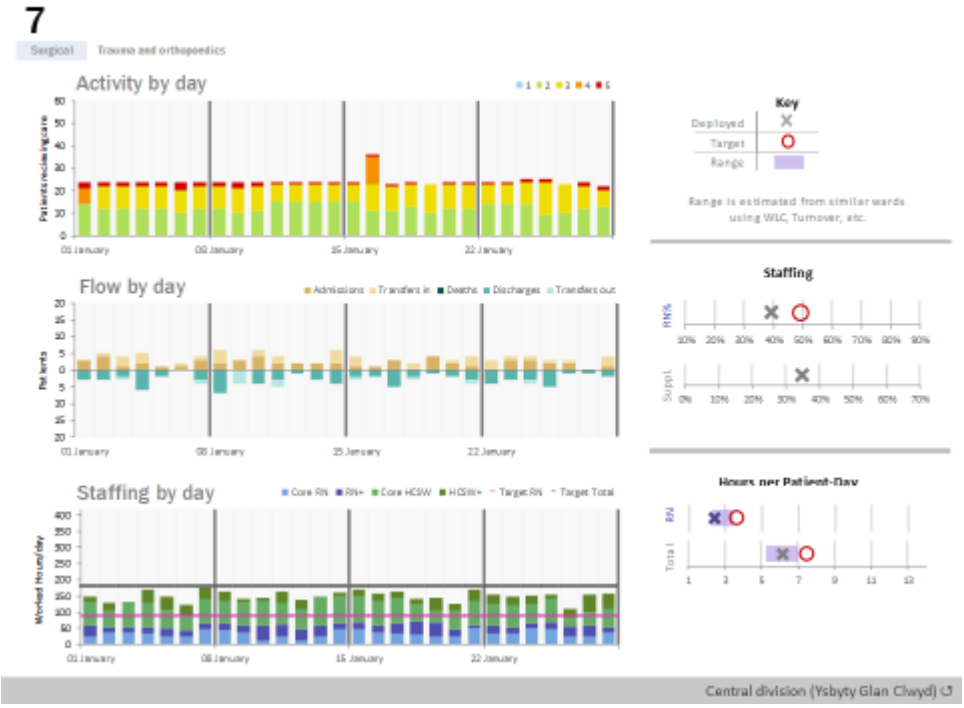

3
Non-§258 Medical
Care of the elderly
Activity by day
No similar wards found in Wales
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Flow by day
Aspects of Staffing
Staffing by day
Hours-per-Patient Day
Created at 14:29 02 Aug 19
Shows Mon 03 Jun 19 to Sun 30 Jun 19
Ysbyty Glan Clwyd


4
Medical
Cardiology
Activity by day
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Flow by day
Staffing
Staffing by day
Hours per Patient Day
Central division (Ysbyty Glan Clwyd)

4
Adult Acute Medical
Cardiology
Activity by day
3 similar wards found in Wales
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Flow by day
Aspects of Staffing
Staffing by day
Hours-per-Patient Day
Created at 14:29 02 Aug 19
Shows Mon 03 Jun 19 to Sun 30 Jun 19
Ysbyty Glan Clwyd


5
Surgical
Pre and post op surgical patients, both elective and emergency. Cover all general surgert and an inc...
Activity by day
Flow by day
Staffing by day
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Staffing
Hours per Patient-Day
Central division (Ysbyty Glan Clwyd)

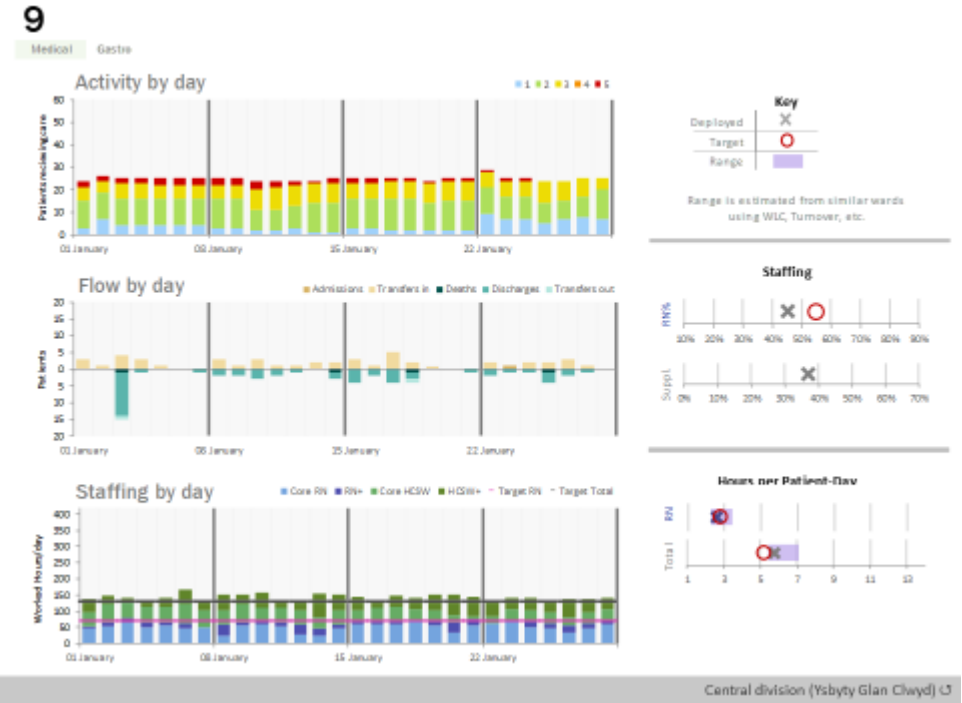
5
Adult Acute Unknown
Pre and post op surgical patients, both elective and emergency. Cover all genera...
6 similar wards found in Wales
Activity by day
Flow by day
Staffing by day
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Aspects of Staffing
Hours-per-Patient Day
Created at 14:29 02 Aug 19
Shows Mon 03 Jun 19 to Sun 30 Jun 19
Ysbyty Glan Clwyd

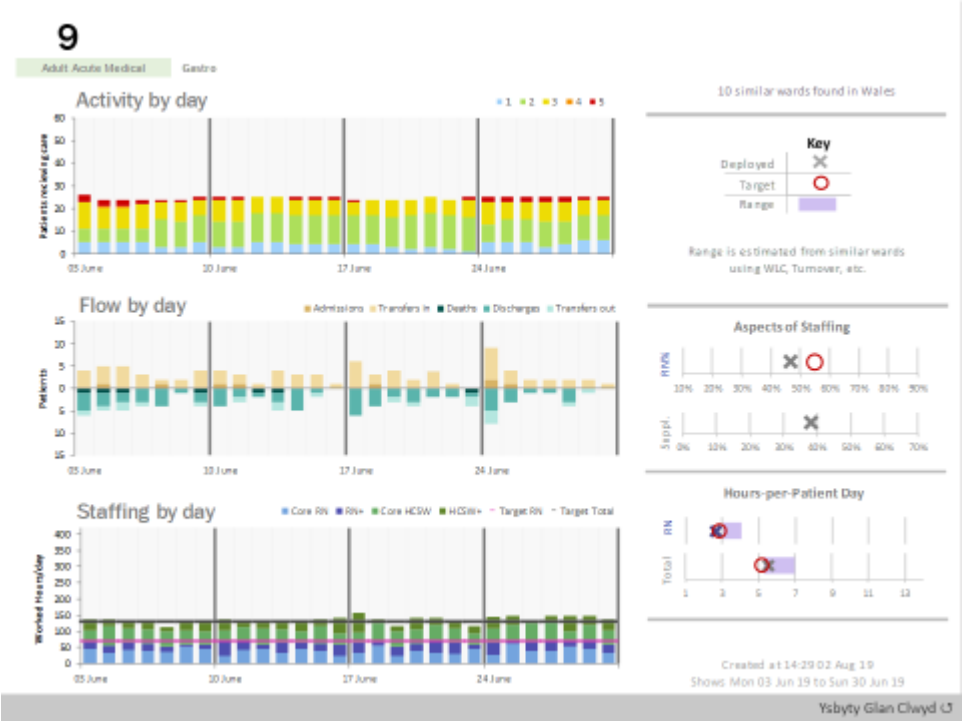

7
Surgical
Trauma and orthopaedics
Activity by day
Flow by day
Staffing by day
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Staffing
Hours per Patient Day
Central division (Ysbyty Glan Clwyd)

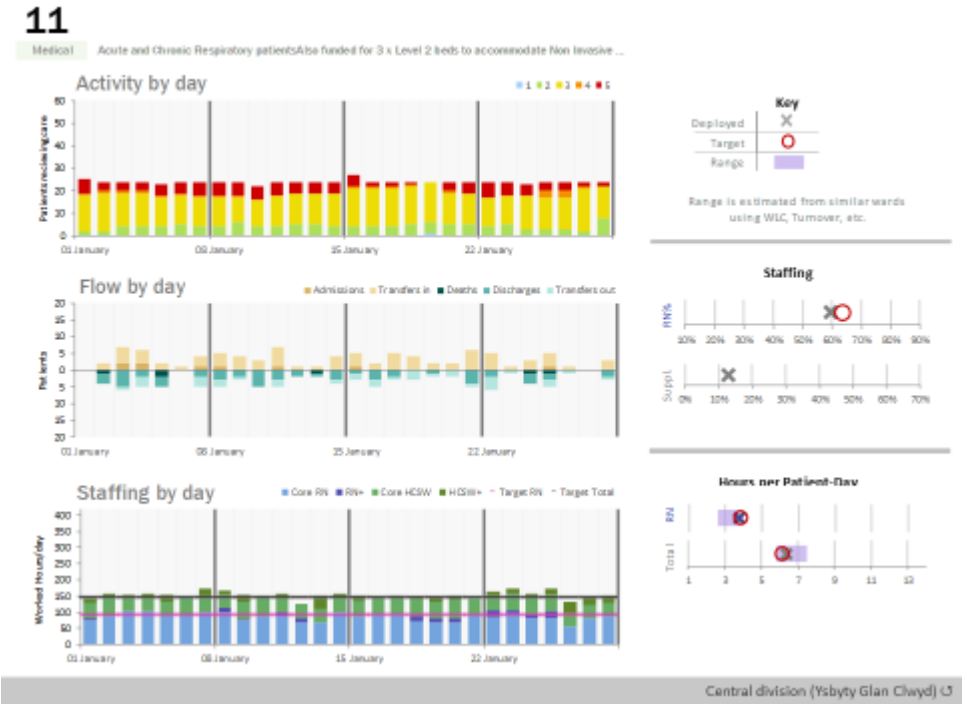
7
Adult Acute Unknown
Trauma and orthopaedics
3 similar wards found in Wales
Activity by day
Flow by day
Staffing by day
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Aspects of Staffing
Hours-per-Patient Day
Created at 14:29 02 Aug 19
Shows Mon 03 Jun 19 to Sun 30 Jun 19
Ysbyty Glan Clwyd

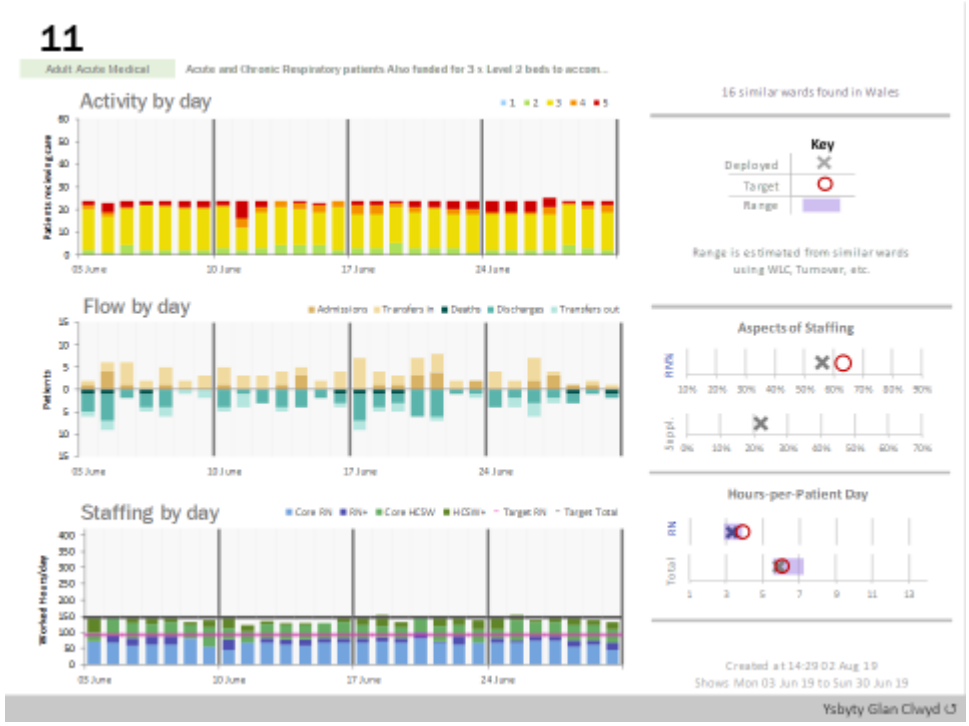
8
Surgical
General Surgical Ward - Colorectal Speciality
Activity by day
Flow by day
Staffing by day
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Staffing
Hours per Patient Day
Central division (Ysbyty Glan Clwyd)

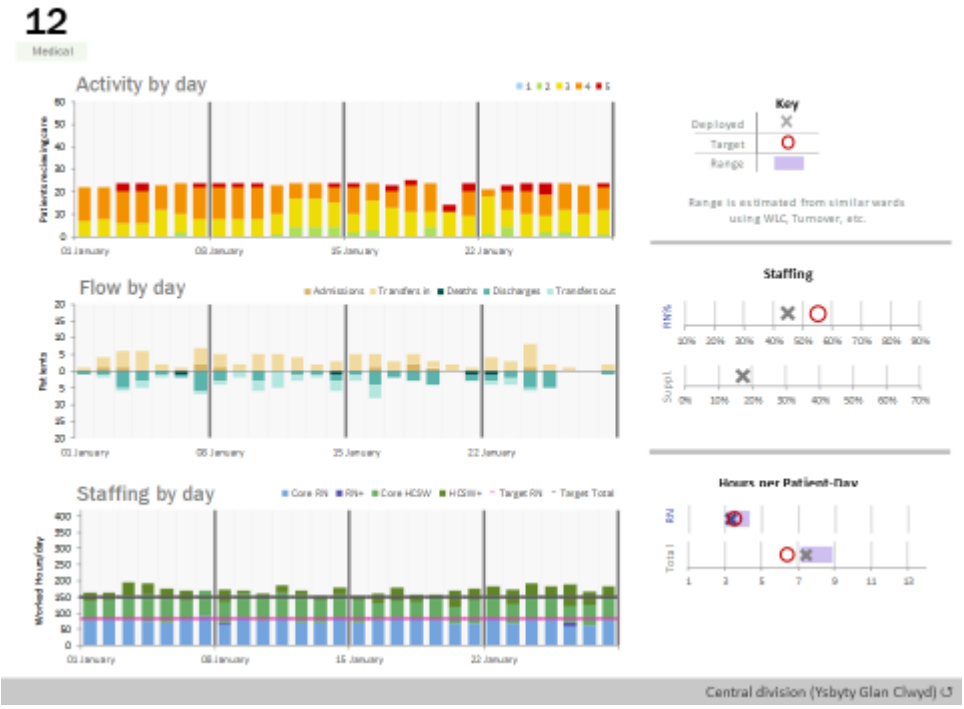
8
Adult Acute Unknown
General Surgical Ward - Colorectal Speciality
6 similar wards found in Wales
Activity by day
Flow by day
Staffing by day
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Aspects of Staffing
Hours-per-Patient Day
Created at 14:29 02 Aug 19
Shows Mon 03 Jun 19 to Sun 30 Jun 19
Ysbyty Glan Clwyd


9
Medical
Gastro
Activity by day
Flow by day
Staffing by day
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Staffing
Hours per Patient-Day
Central division (Ysbyty Glan Clwyd)

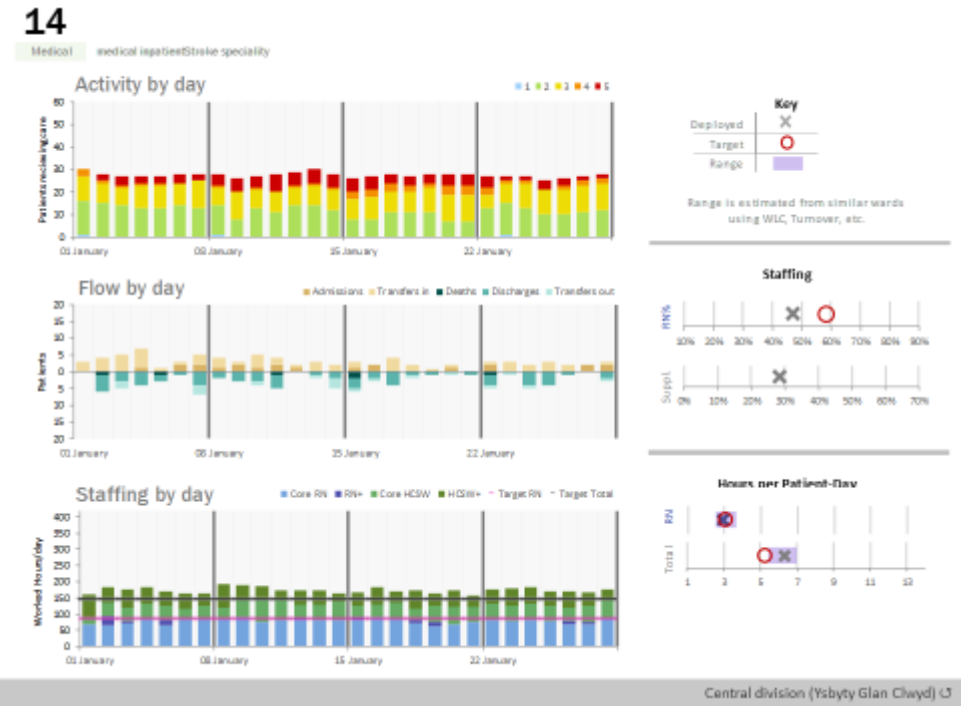

9
Adult Acute Medical
Gastro
10 similar wards found in Wales
Activity by day
Flow by day
Staffing by day
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Aspects of Staffing
Hours-per-Patient Day
Created at 14:29 02 Aug 19
Shows Mon 03 Jun 19 to Sun 30 Jun 19
Ysbyty Glan Clwyd


11
Medical
Acute and Chronic Respiratory patientsAlso funded for 3 x Level 2 beds to accommodate Non Invasive ...
Activity by day
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Flow by day
Staffing
Staffing by day
Hours per Patient-Day
Central division (Ysbyty Glan Clwyd)

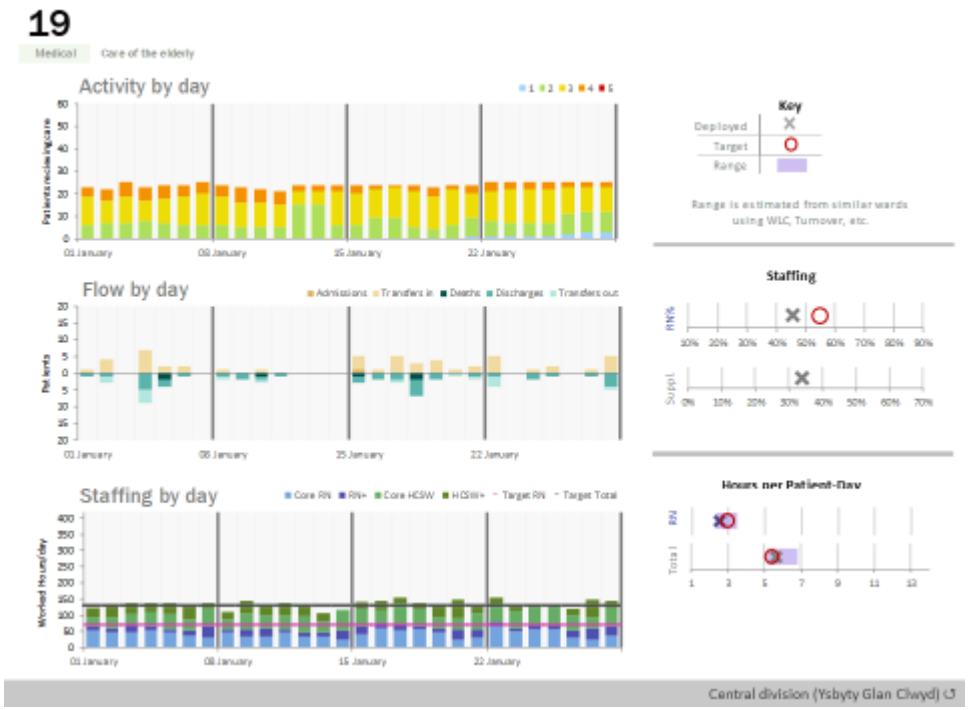

11
Adult Acute Medical
Acute and Chronic Respiratory patients Also funded for 3 x Level 2 beds to accom...
Activity by day
16 similar wards found in Wales
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Flow by day
Aspects of Staffing
Staffing by day
Hours-per-Patient Day
Created at 14:29 02 Aug 19
Shows Mon 03 Jun 19 to Sun 30 Jun 19
Ysbyty Glan Clwyd


12
Medical
Activity by day
Flow by day
Staffing by day
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Staffing
Hours per Patient-Day
Central division (Ysbyty Glan Clwyd)

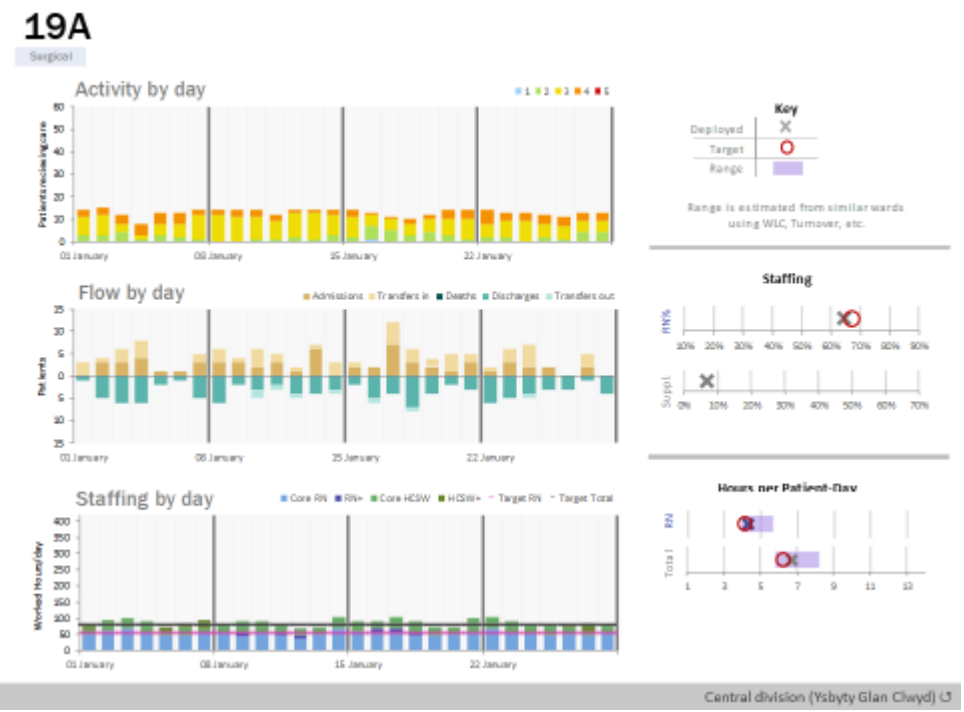
12
Adult Acute Medical
Activity by day
Flow by day
Staffing by day
7 similar wards found in Wales
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Aspects of Staffing
Hours-per-Patient Day
Created at 14:29 02 Aug 19
Shows Mon 03 Jun 19 to Sun 30 Jun 19
Ysbyty Glan Clwyd


14
Medical
medical inpatientStroke speciality
Activity by day
Flow by day
Staffing by day
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Staffing
Hours per Patient-Day
Central division (Ysbyty Glan Clwyd)

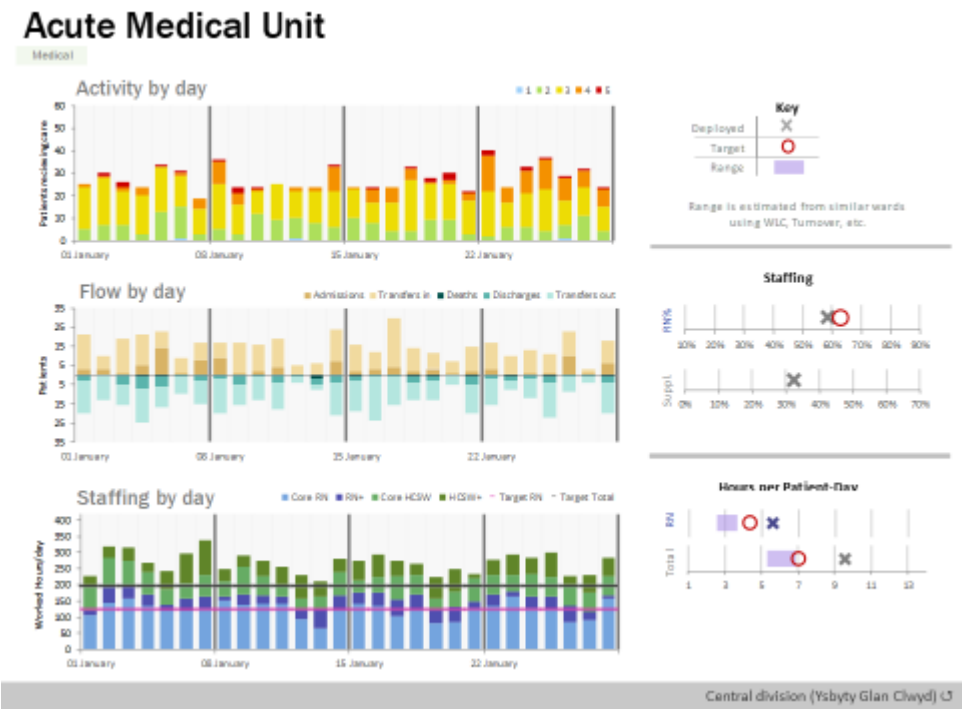
14
Adult Acute Medical
medical inpatient Stroke speciality
Activity by day
Flow by day
Staffing by day
3 similar wards foundin Wales
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Aspects of Staffing
Hours-per-Patient Day
Created at 14:29 02 Aug 19
Shows Mon 03 Jun 19 to Sun 30 Jun 19
Ysbyty Glan Clwyd

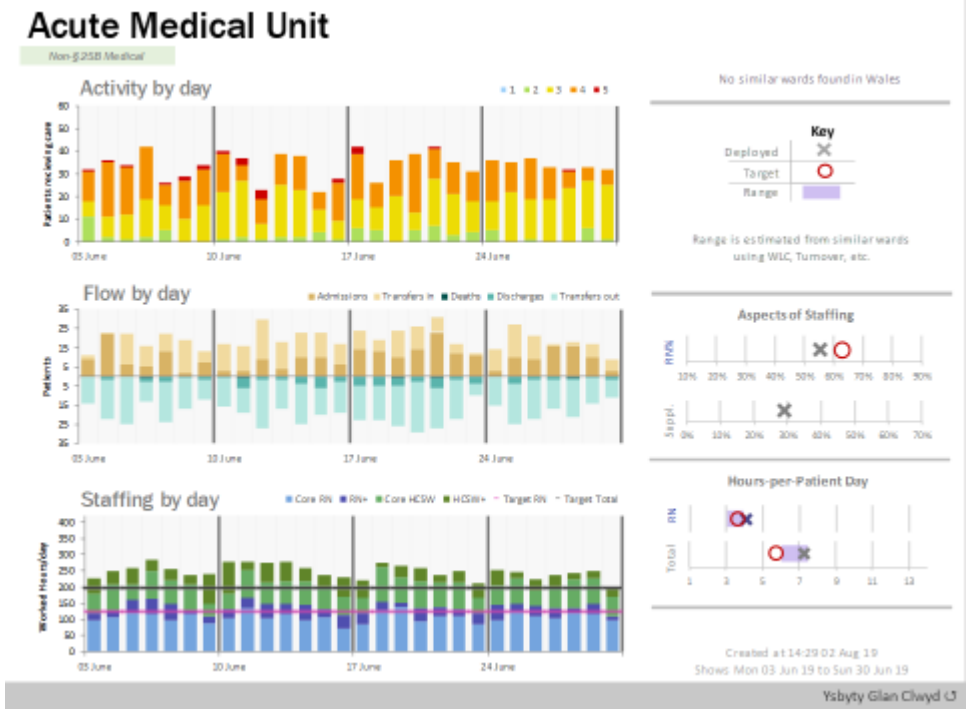

19
Medical
Care of the elderly
Activity by day
Flow by day
Staffing by day
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Staffing
Hours per Patient Day
Central division (Ysbyty Glan Clwyd)

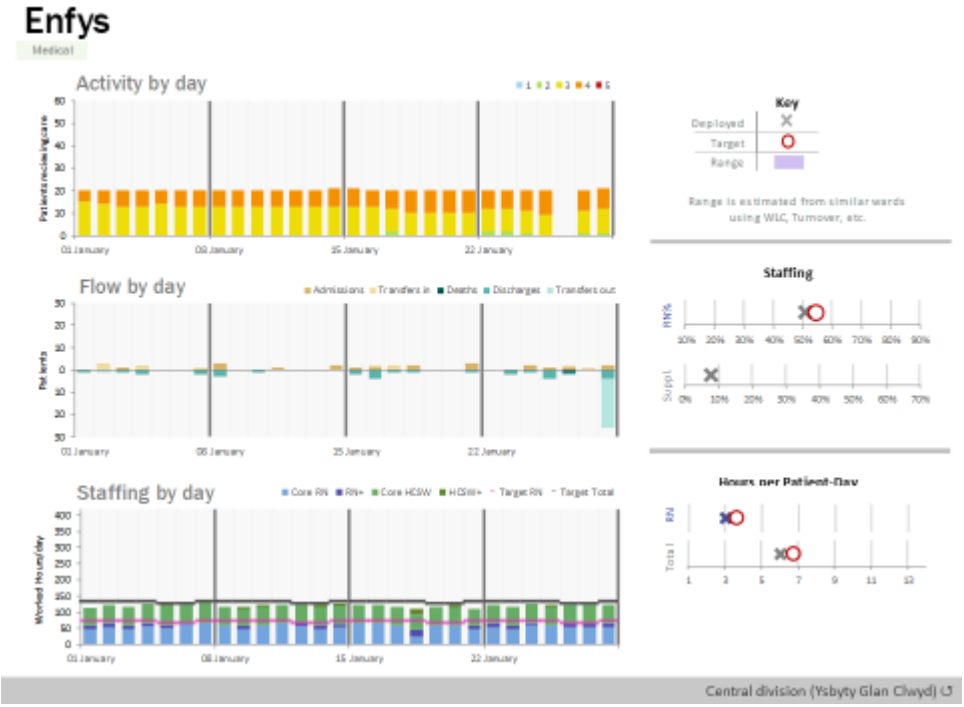
19
Adult Acute Medical
Care of the elderly
Activity by day
Flow by day
Staffing by day
5 similar wards foundin Wales
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Aspects of Staffing
Hours-per-Patient Day
Created at 14:29 02 Aug 19
Shows Mon 03 Jun 19 to Sun 30 Jun 19
Ysbyty Glan Clwyd

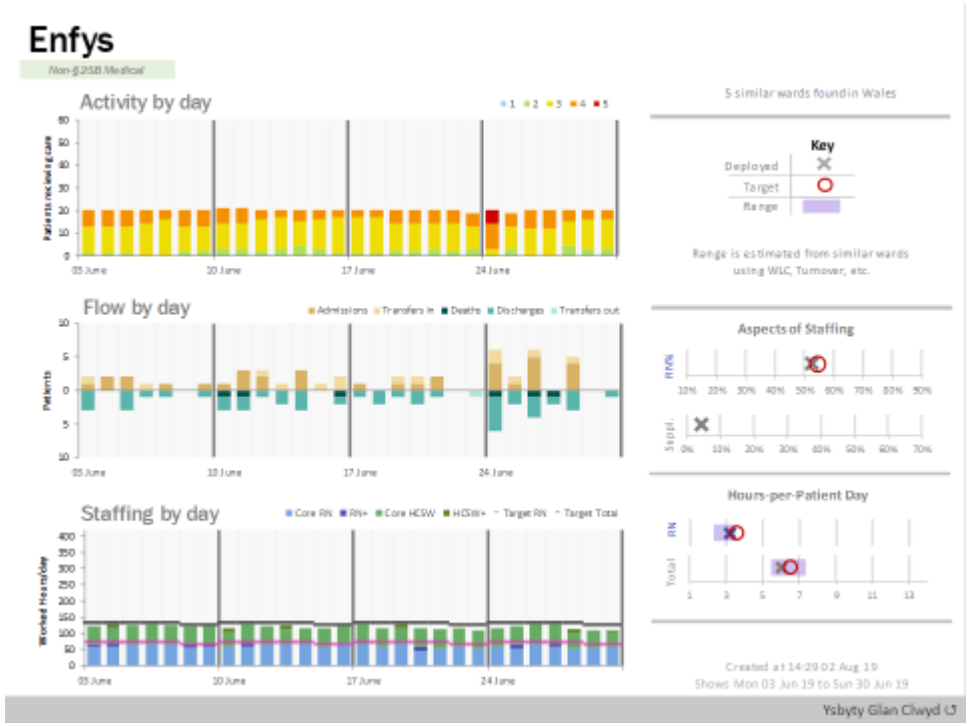

19A
Surgical
Activity by day
Flow by day
Staffing by day
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Staffing
Hours per Patient Day
Central division (Ysbyty Glan Clwyd)

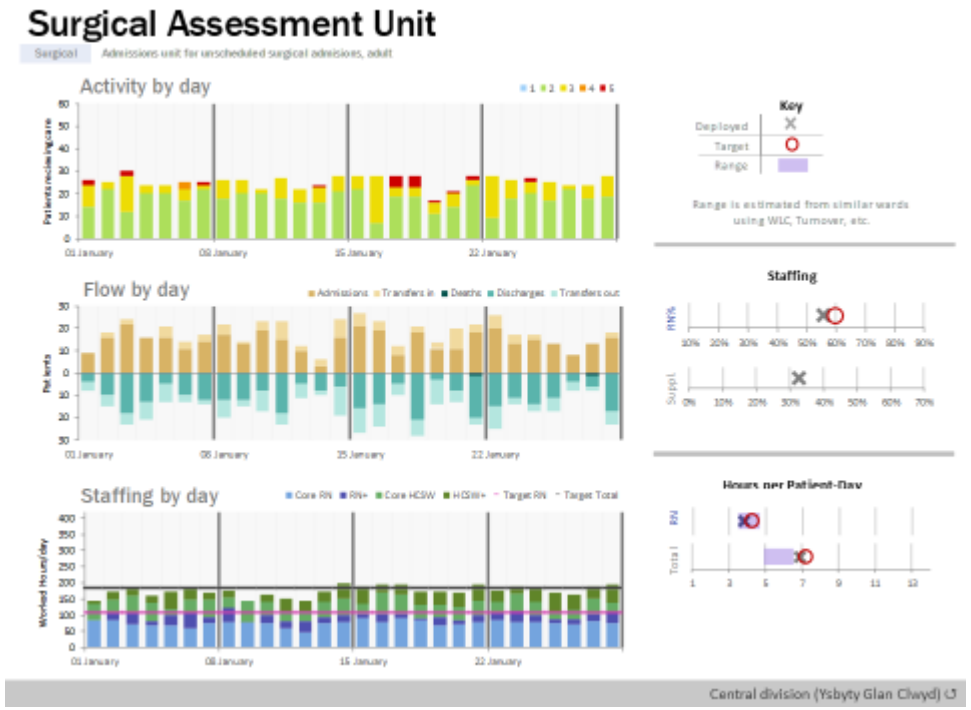
19A
Adult Acute Surgical
Activity by day
Flow by day
Staffing by day
No similar wards found in Wales
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Aspects of Staffing
Hours-per-Patient Day
Created at 14:29 02 Aug 19
Shows Mon 03 Jun 19 to Sun 30 Jun 19
Ysbyty Glan Clwyd

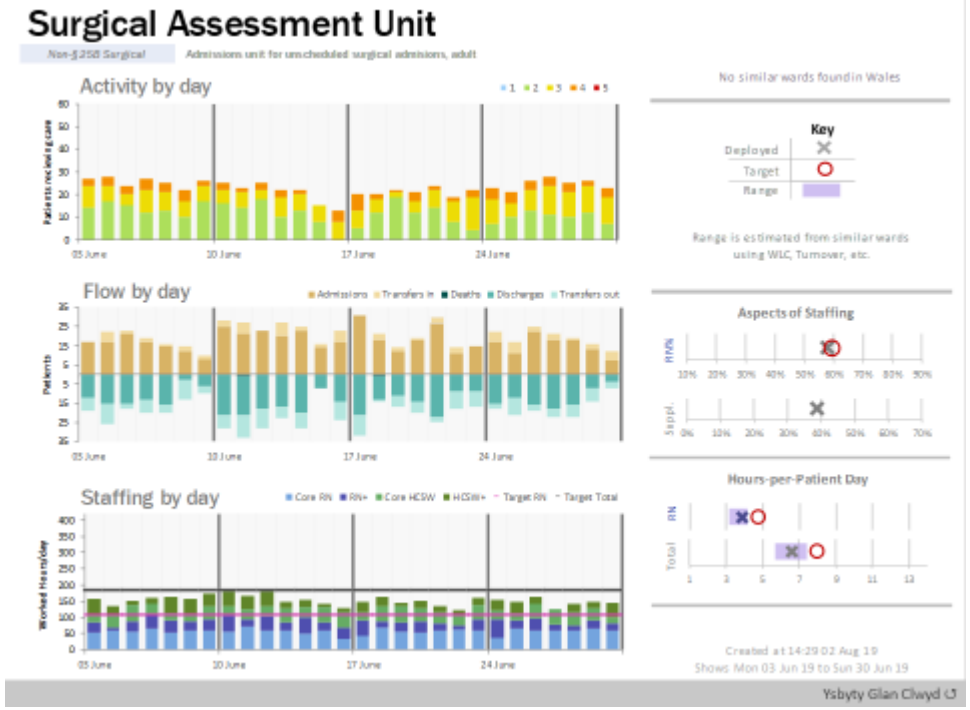

Acute Medical Unit
Medical
Activity by day
Flow by day
Staffing by day
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Staffing
Hours per Patient Day
Central division (Ysbyty Glan Clwyd)


Acute Medical Unit
Activity by day
Flow by day
Staffing by day
No similar wards foundin Wales
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Aspects of Staffing
Hours-per-Patient Day
Ysbyty Glan Clwyd

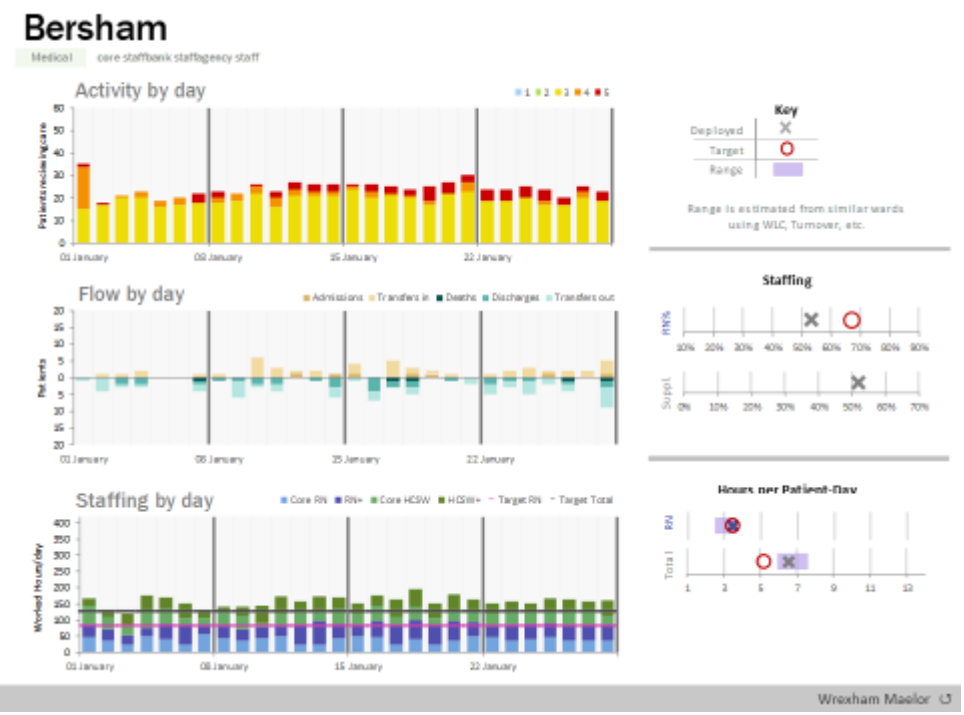

Enfys
Medical
Activity by day
Flow by day
Staffing by day
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Staffing
Hours per Patient Day
Central division (Ysbyty Glan Clwyd)

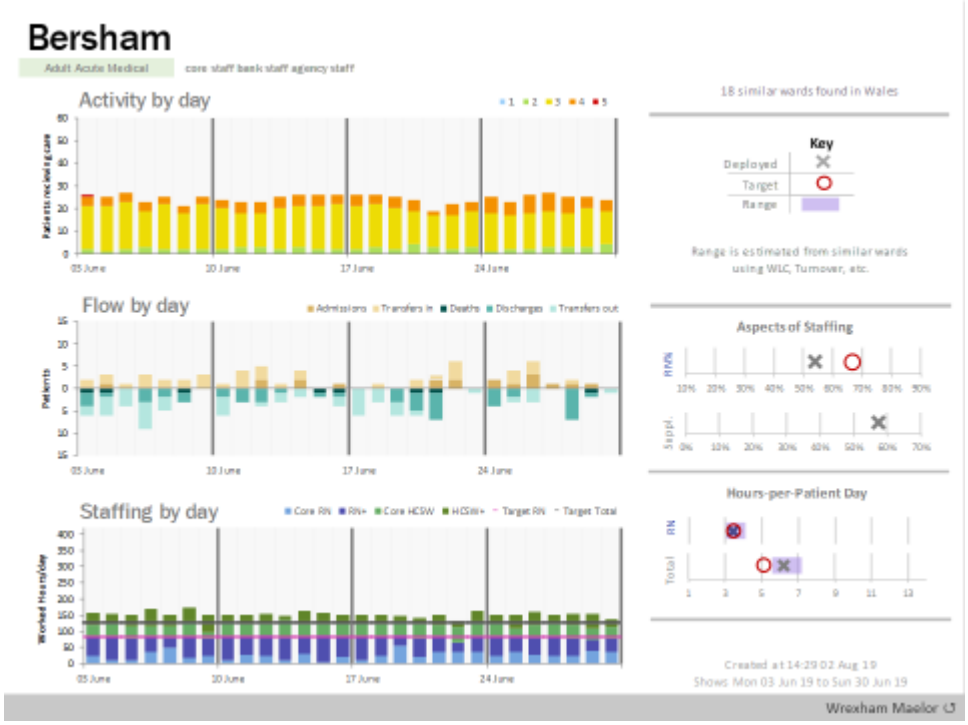

Enfys
Activity by day
Flow by day
Staffing by day
5 similar wards found in Wales
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Aspects of Staffing
Hours-per-Patient Day
Created at 14:29 02 Aug 19
Shows Mon 03 Jun 19 to Sun 30 Jun 19
Ysbyty Glan Clwyd

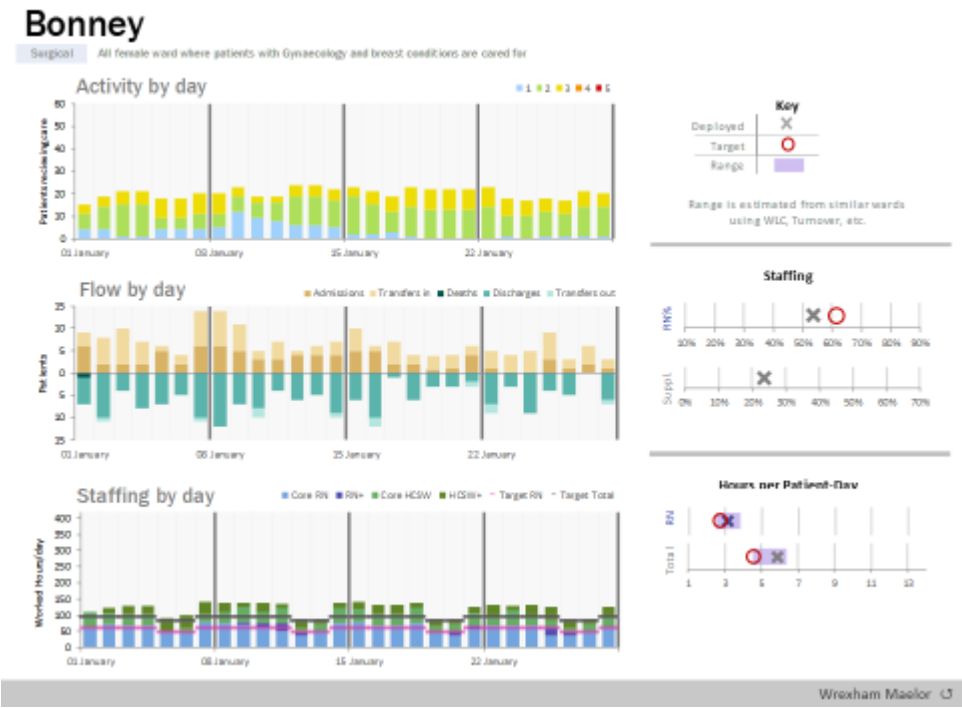

Surgical Assessment Unit
Surgical
Admissions unit for unscheduled surgical admissions, adult
Activity by day
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Flow by day
Admissions
Transfers in
Deaths
Discharges
Transfers out
Staffing
RN%
Suppl.
Staffing by day
Core RN
RN+
Core HCSW
HCSW+
Target RN
Target Total
Hours per Patient Day
RN
Total
Central division (Ysbyty Glan Clwyd)

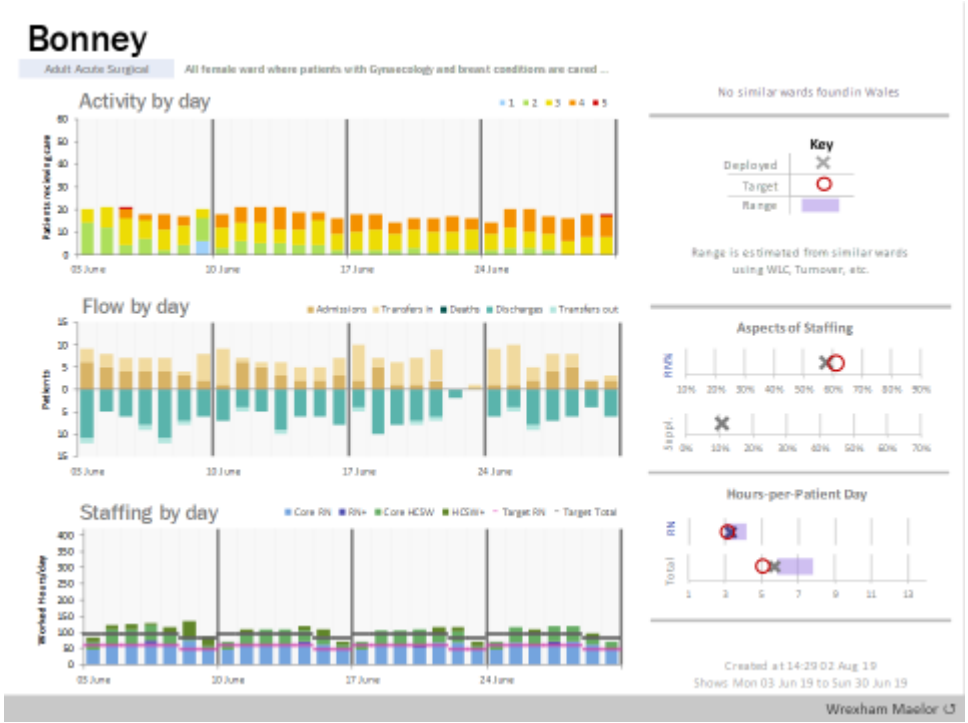

Surgical Assessment Unit
Non-§258 Surgical
Admissions unit for unscheduled surgical admissions, adult
Activity by day
No similar wards found in Wales
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Flow by day
Admissions
Transfers in
Deaths
Discharges
Transfers out
Aspects of Staffing
RN%
Suppl.
Staffing by day
Core RN
RN+
Core HCSW
HCSW+
Target RN
Target Total
Hours-per-Patient Day
RN
Total
Created at 14:29 02 Aug 19
Shows Mon 03 Jun 19 to Sun 30 Jun 19
Ysbyty Glan Clwyd

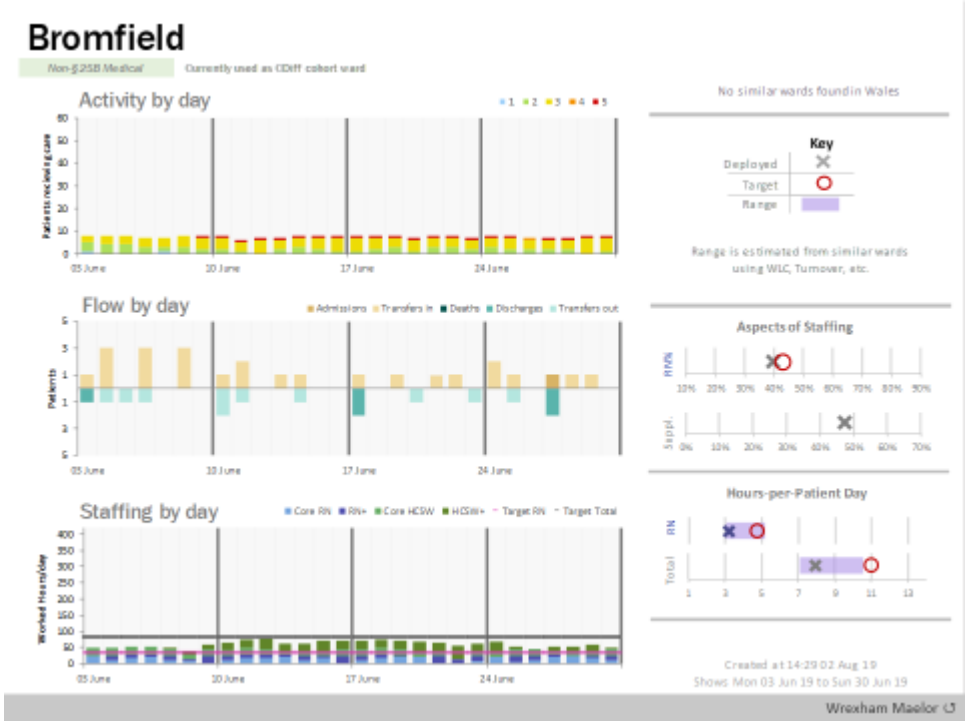
Ysbyty Wrexham Maelor

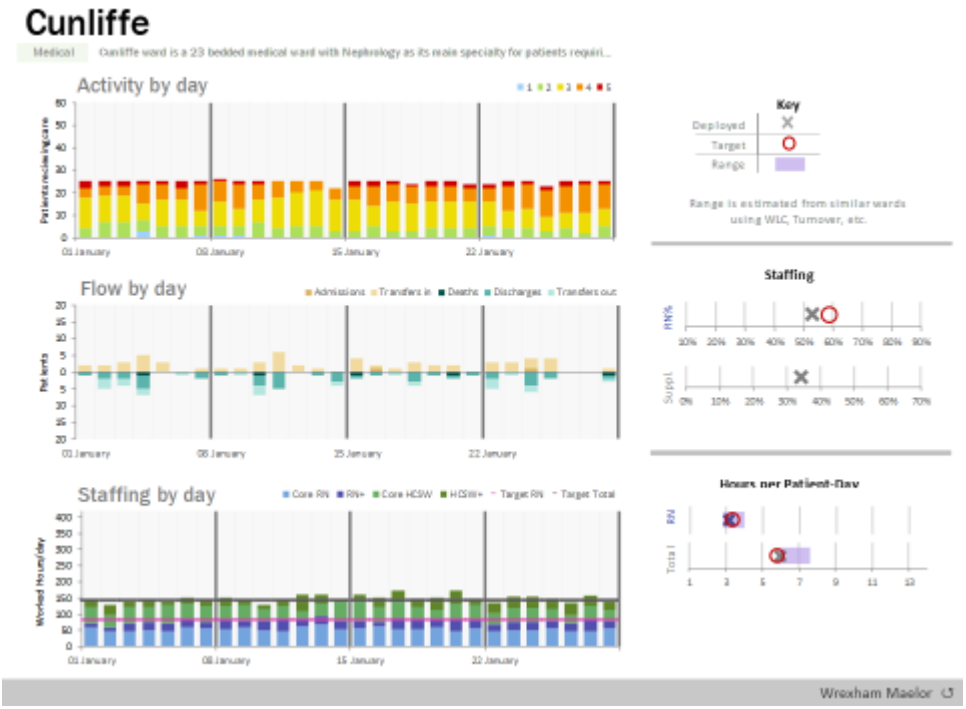


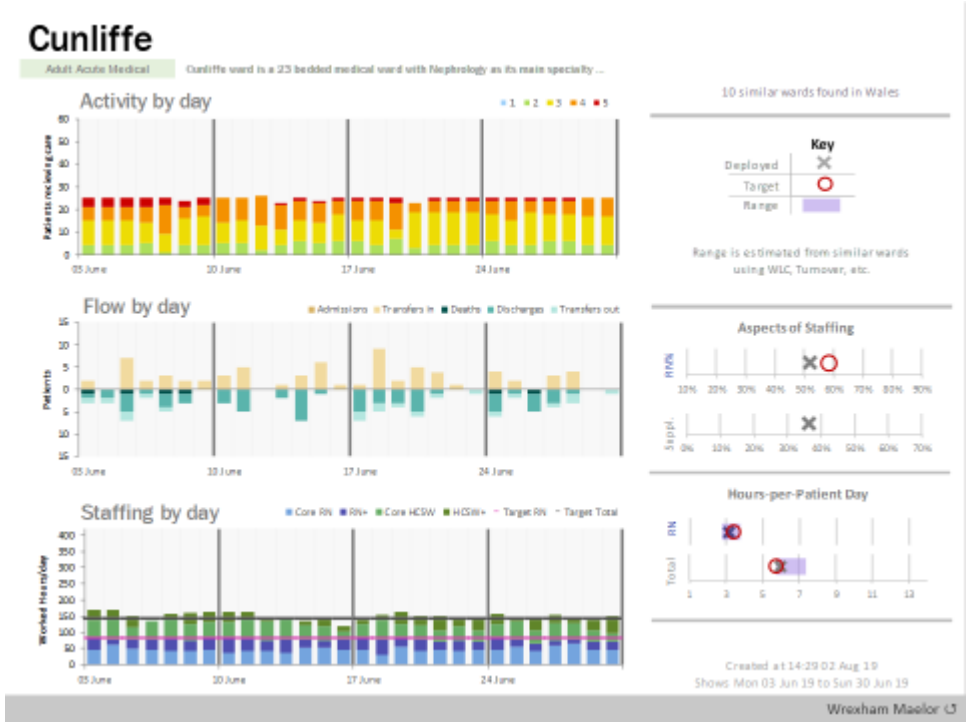


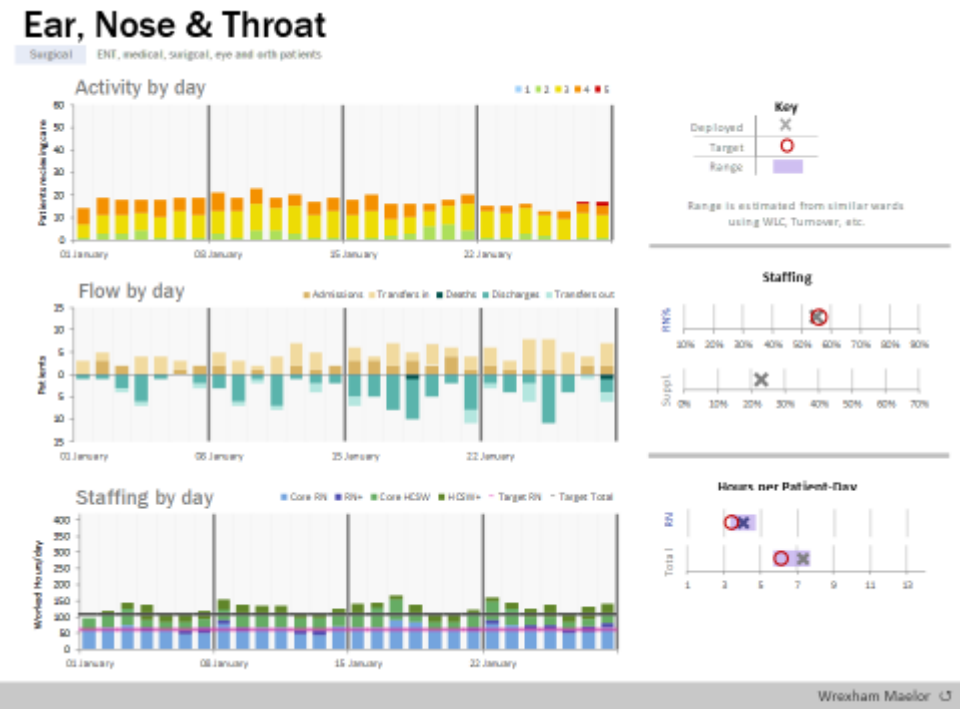

Bonney
Surgical
All female ward where patients with Gynaecology and breast conditions are cared for
Activity by day
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Flow by day
Staffing
Staffing by day
Hours per Patient Day
Wrexham Maelor

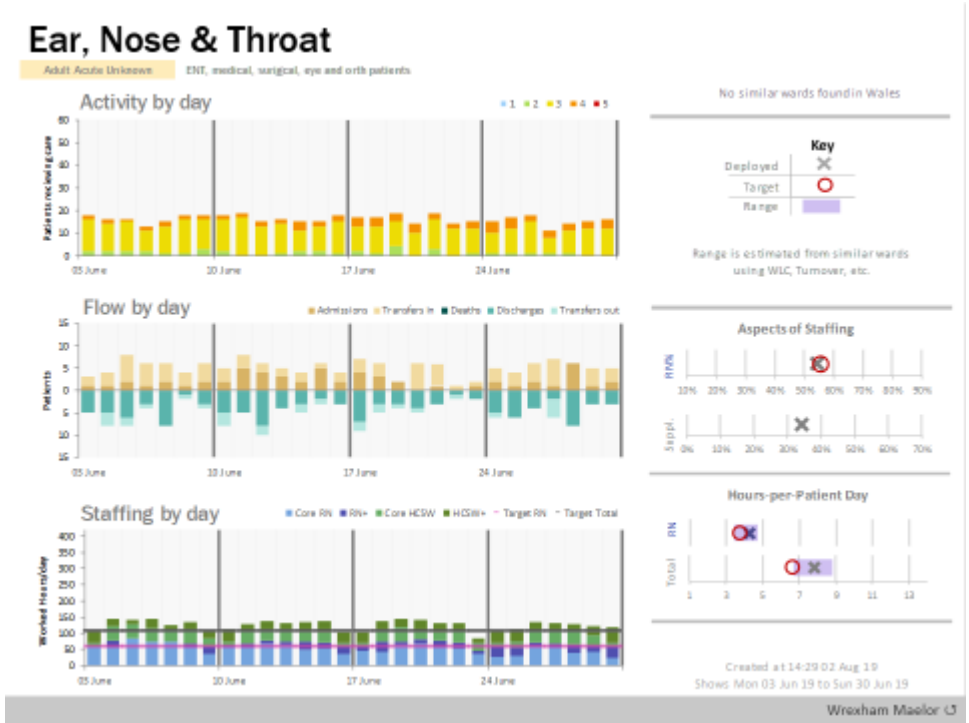

Bonney
Adult Acute Surgical
All female ward where patients with Gynaecology and breast conditions are cared ...
No similar wards found in Wales
Activity by day
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Flow by day
Aspects of Staffing
Staffing by day
Hours-per-Patient Day
Created at 14:29 02 Aug 19
Shows Mon 03 Jun 19 to Sun 30 Jun 19
Wrexham Maelor

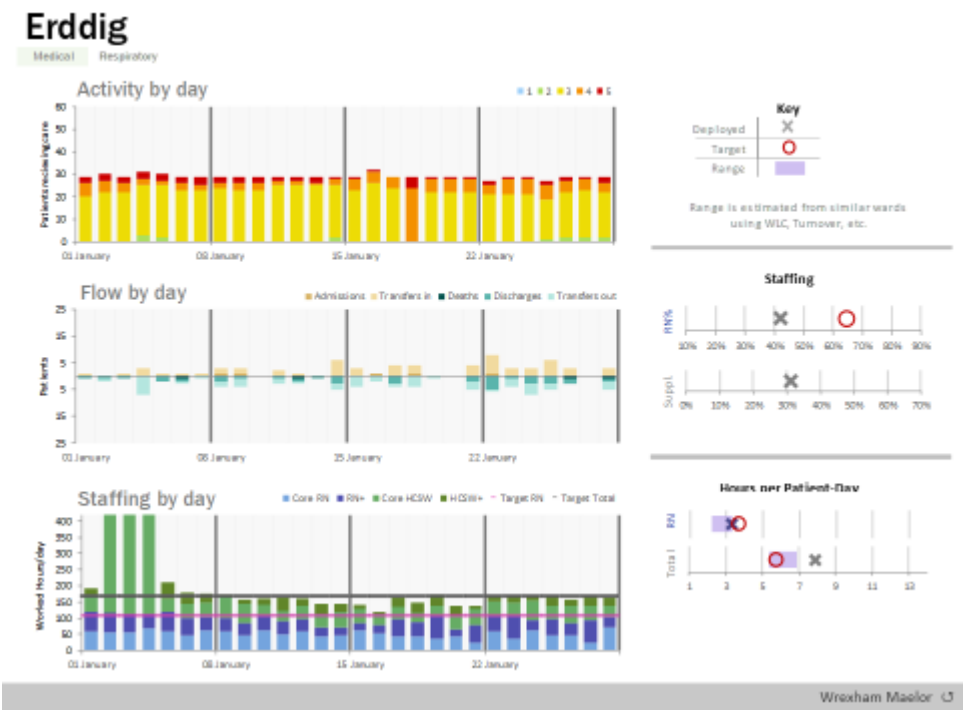

Bromfield
Non-§25B Medical
Currently used as CDiff cohort ward
Activity by day
1 2 3 4 5
Patients receiving care
05 June
10 June
17 June
24 June
Flow by day
Admissions Transfers in Deaths Discharges Transfers out
Patients
Staffing by day
Core RN RN+ Core HCSW HCSW+ Target RN Target Total
Worked Hours/day
No similar wards found in Wales
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Aspects of Staffing
RN%
Suppl.
Hours-per-Patient Day
RN
Total
Created at 14:29 02 Aug 19
Shows Mon 03 Jun 19 to Sun 30 Jun 19
Wrexham Maelor

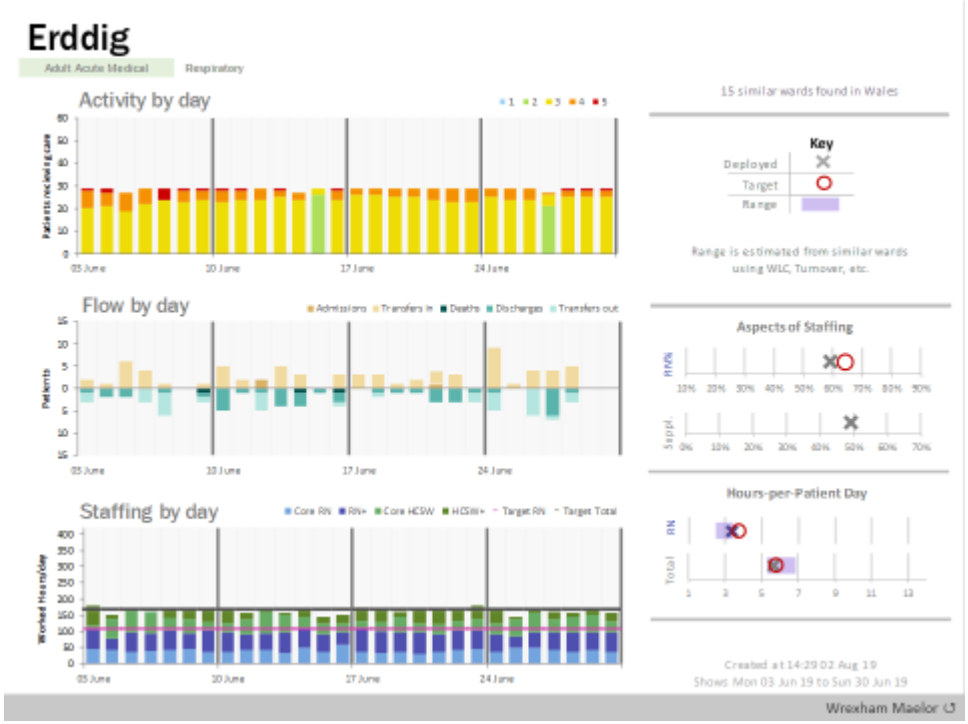

Cunliffe
Medical
Activity by day
Flow by day
Staffing by day
Key
Deployed
Target
Range
Staffing
Hours per Patient Day
Wrexham Maelor

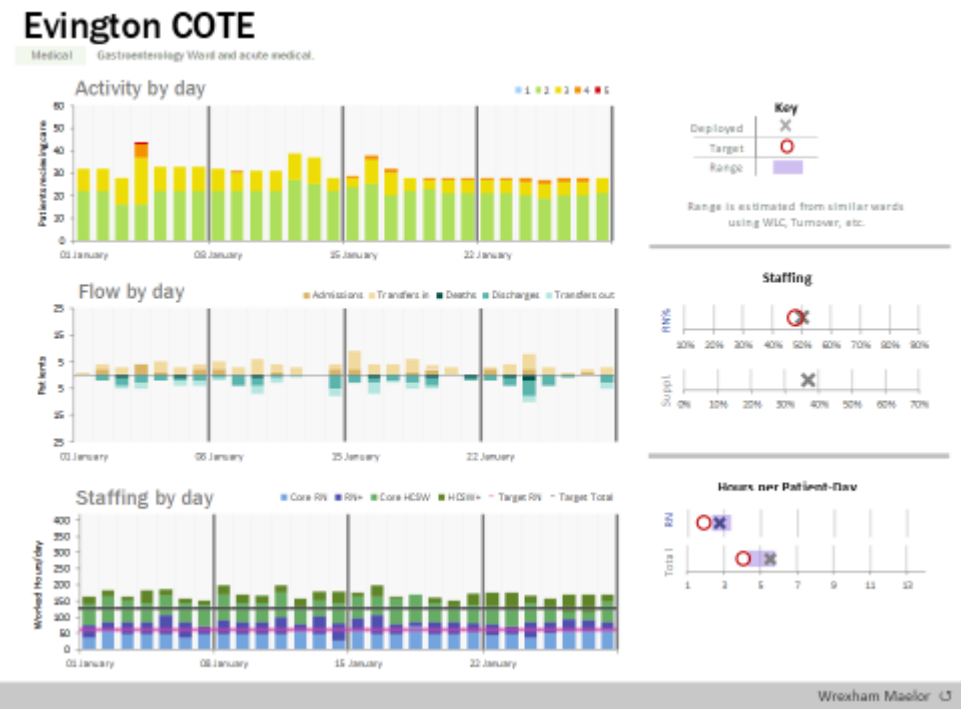

Cunliffe
Adult Acute Medical
Activity by day
Flow by day
Staffing by day
10 similar wards found in Wales
Key
Deployed
Target
Range
Aspects of Staffing
Hours-per-Patient Day
Wrexham Maelor

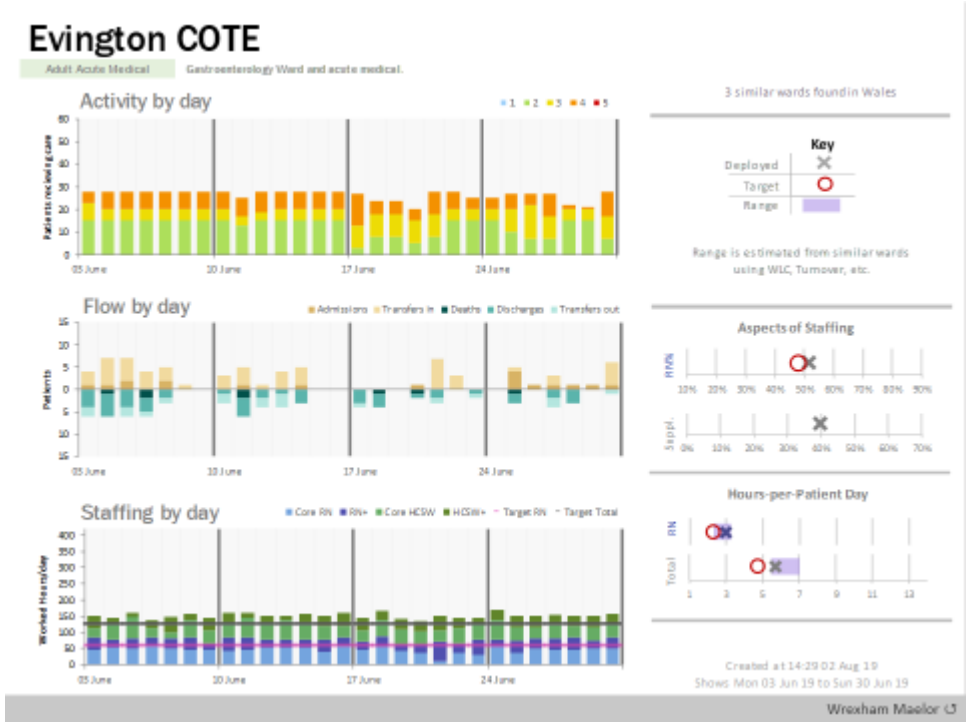

Ear, Nose & Throat
Surgical
ENT, medical, surgical, eye and orth patients
Activity by day
Flow by day
Staffing by day
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Staffing
Hours per Patient Day
Wrexham Maelor

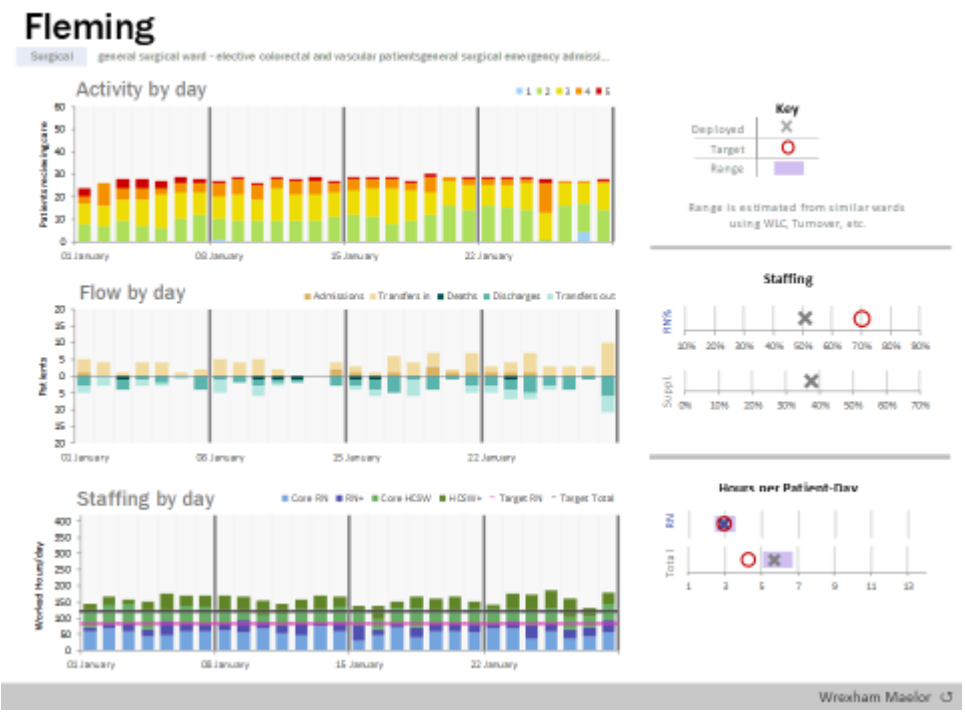

Ear, Nose & Throat
Adult Acute Unknown
ENT, medical, surgical, eye and orth patients
No similar wards foundin Wales
Activity by day
Flow by day
Staffing by day
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Aspects of Staffing
Hours-per-Patient Day
Created at 14:29 02 Aug 19
Shows Mon 03 Jun 19 to Sun 30 Jun 19
Wrexham Maelor

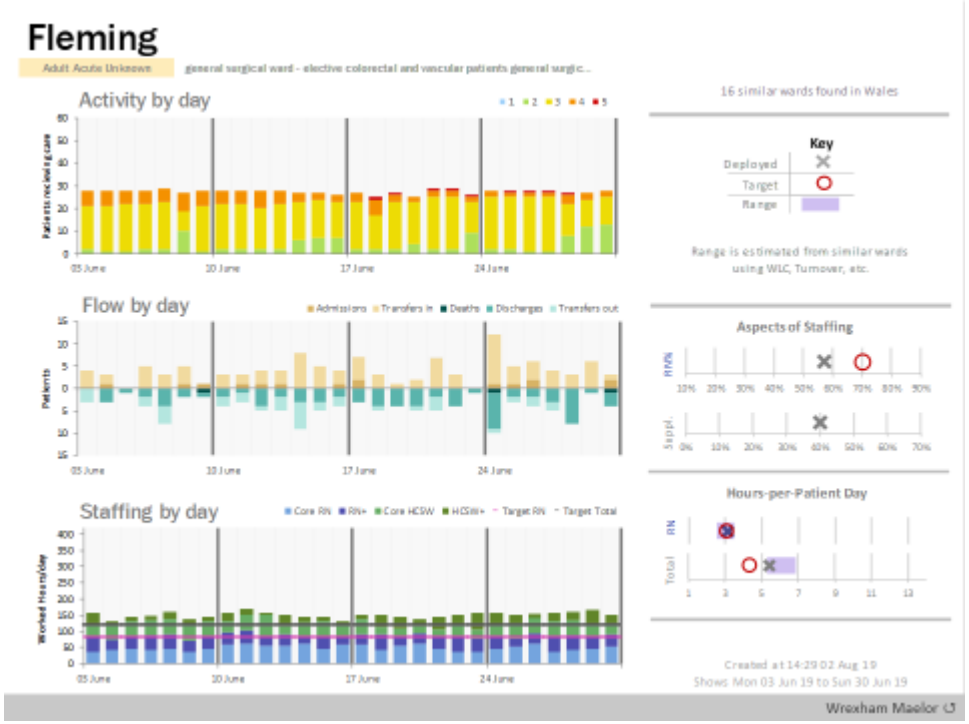

Erddig
Medical
Respiratory
Activity by day
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Flow by day
Staffing
Staffing by day
Hours per Patient Day
Wrexham Maelor


Erddig
Adult Acute Medical
Respiratory
Activity by day
15 similar wards found in Wales
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Flow by day
Aspects of Staffing
Staffing by day
Hours-per-Patient Day
Created at 14:29 02 Aug 19
Shows Mon 03 Jun 19 to Sun 30 Jun 19
Wrexham Maelor


Evington COTE
Medical
Gastroenterology Ward and acute medical.
Activity by day
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Flow by day
Staffing
Staffing by day
Hours per Patient Day
Wrexham Maelor


Evington COTE
Adult Acute Medical
Gastroenterology Ward and acute medical.
Activity by day
3 similar wards found in Wales
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Flow by day
Aspects of Staffing
Staffing by day
Hours-per-Patient Day
Wrexham Maelor


Fleming
Surgical
general surgical ward - elective colorectal and vascular patientsgeneral surgical emergency admissi...
Activity by day
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Flow by day
Staffing
Staffing by day
Hours per Patient Day
Wrexham Maelor


Fleming
Adult Acute Unknown
general surgical ward - elective colorectal and vascular patients general surgic...
16 similar wards found in Wales
Activity by day
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Flow by day
Aspects of Staffing
Staffing by day
Hours-per-Patient Day
Created at 14:29 02 Aug 19
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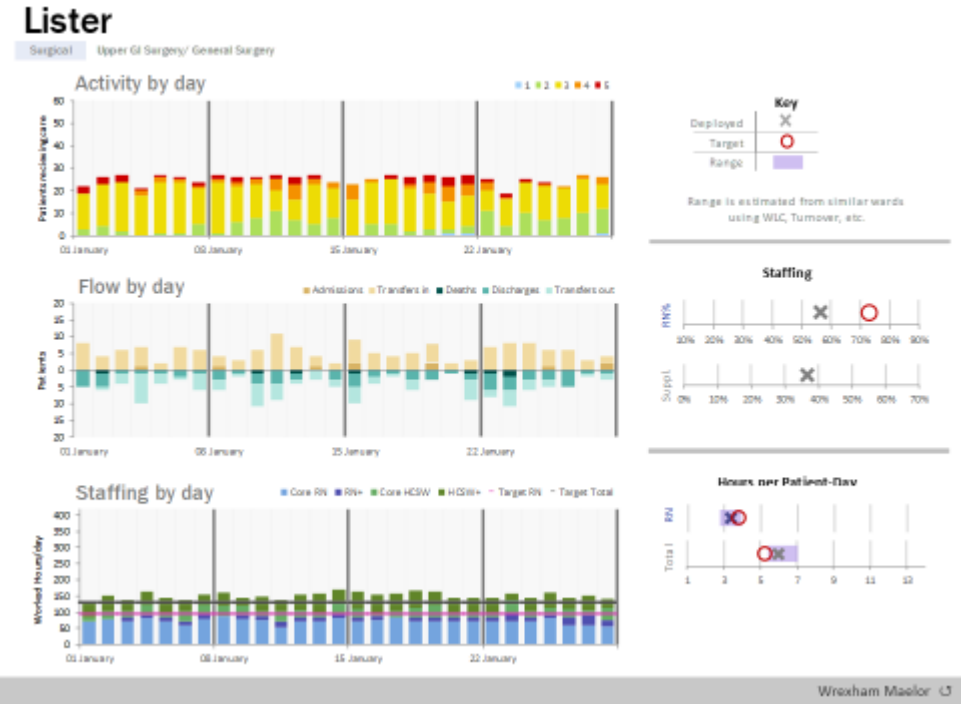
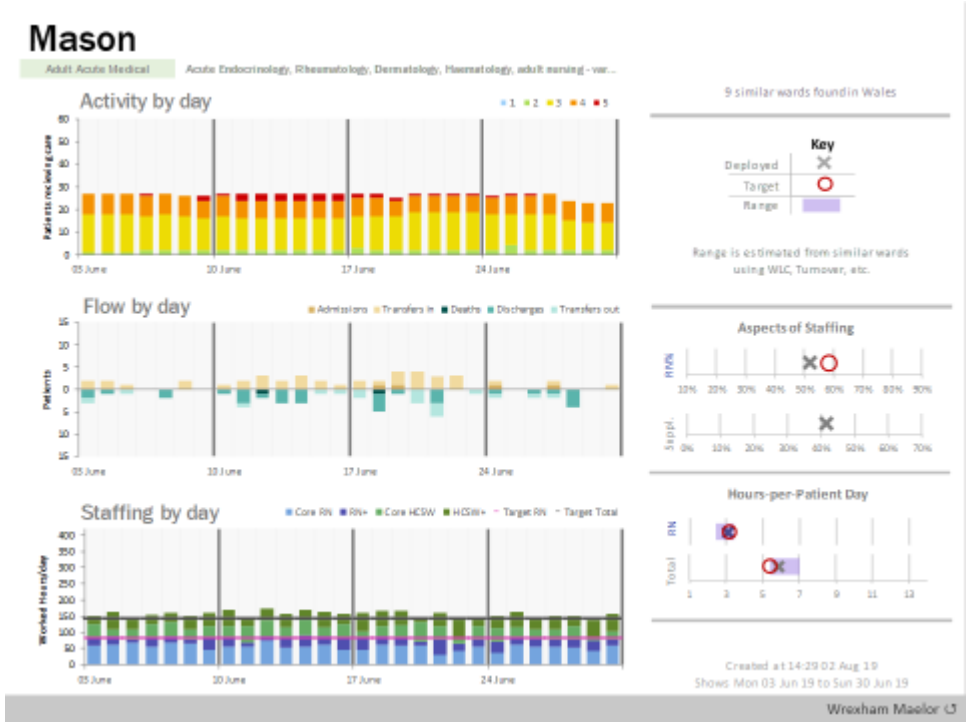
Wrexham Maelor

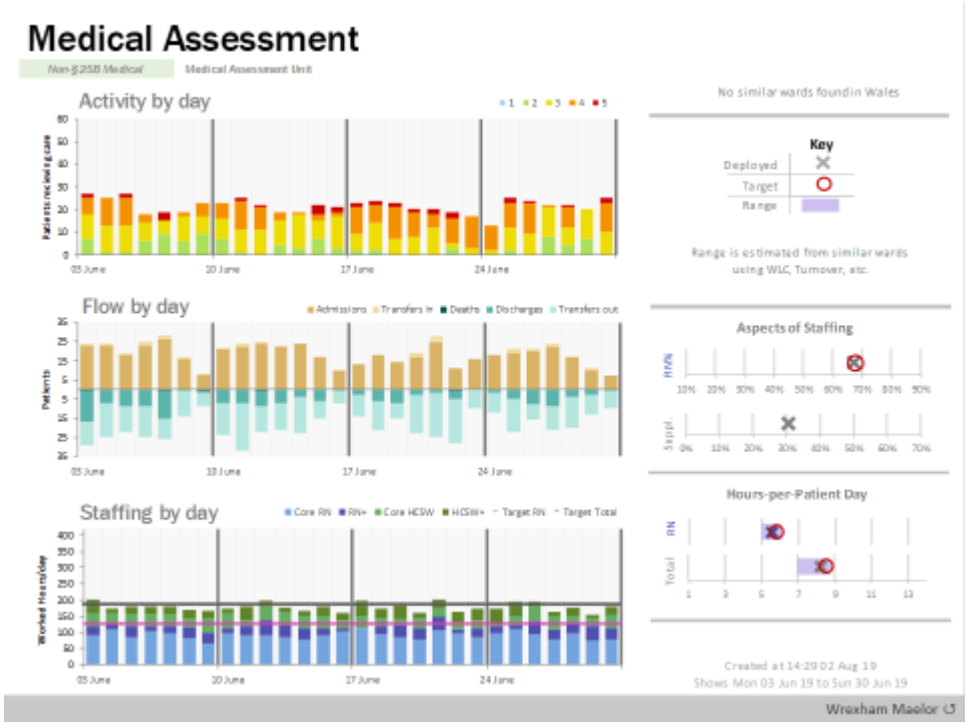

Lister
Surgical
Upper GI Surgery/ General Surgery
Activity by day
Flow by day
Staffing by day
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Staffing
Hours per Patient-Day
Wrexham Maelor

Lister
Adult Acute Unknown
Upper GI Surgery/ General Surgery
6 similar wards foundin Wales
Activity by day
Flow by day
Staffing by day
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Aspects of Staffing
Hours-per-Patient Day
Created at 14:29:02 Aug 19
Shows Mon 03 Jun 19 to Sun 30 Jun 19
Wrexham Maelor

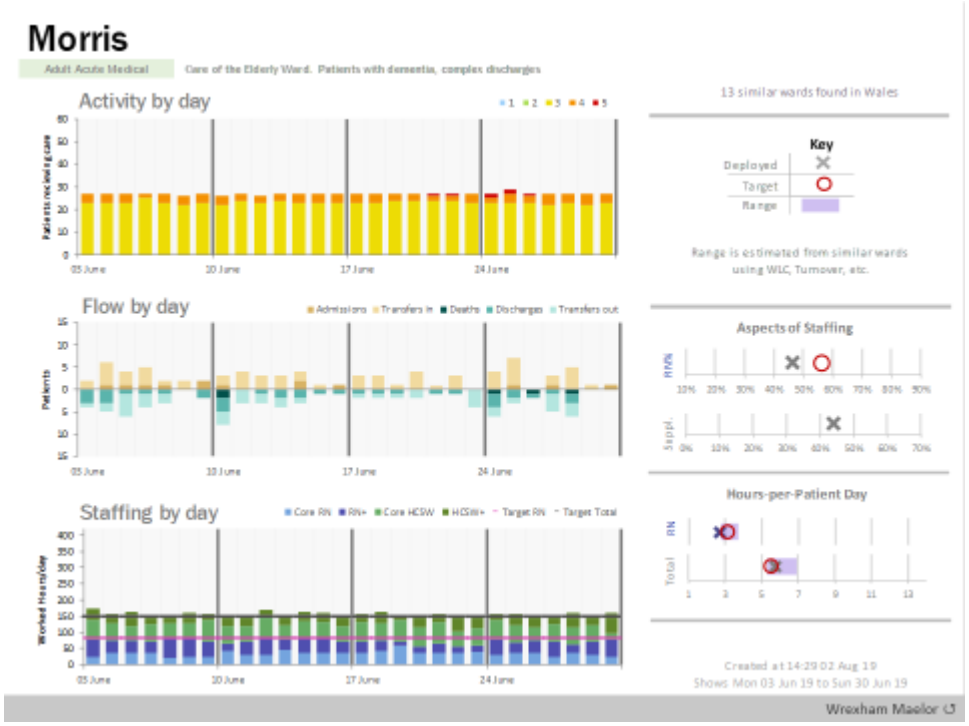
Mason
Medical
Acute Endocrinology, Rheumatology, Dermatology, Haematology, adult nursing - variety of ages and com...
Activity by day
Flow by day
Staffing by day
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Staffing
Hours per Patient-Day
Wrexham Maelor

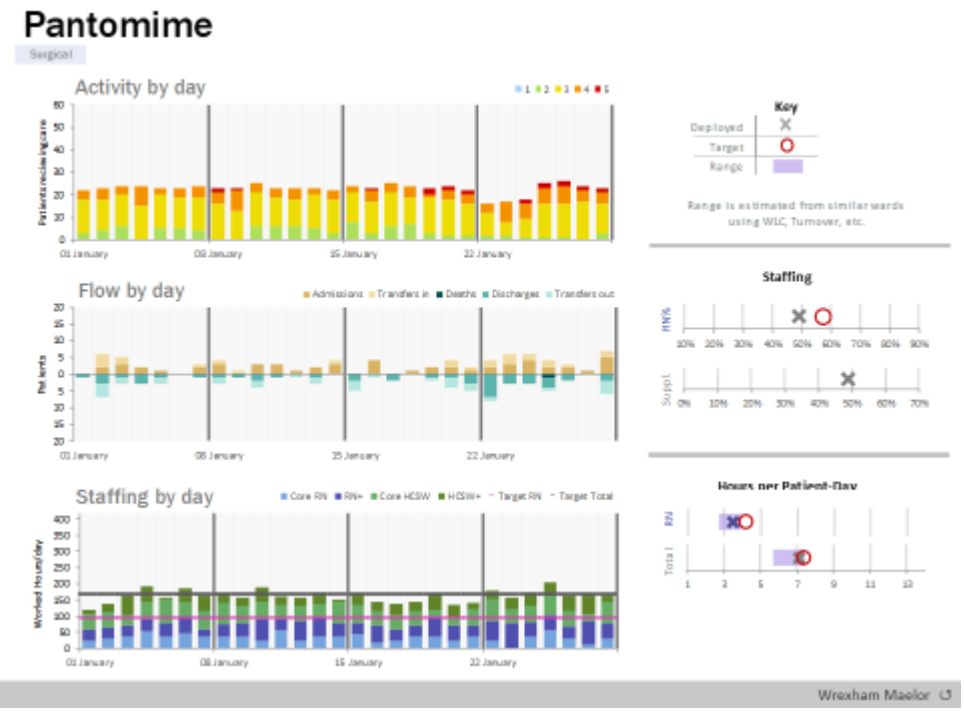

Mason
Adult Acute Medical
Acute Endocrinology, Rheumatology, Dermatology, Haematology, adult nursing - var...
Activity by day
Flow by day
Staffing by day
9 similar wards found in Wales
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Aspects of Staffing
Hours-per-Patient Day
Created at 14:29 02 Aug 19
Shows Mon 03 Jun 19 to Sun 30 Jun 19
Wrexham Maelor

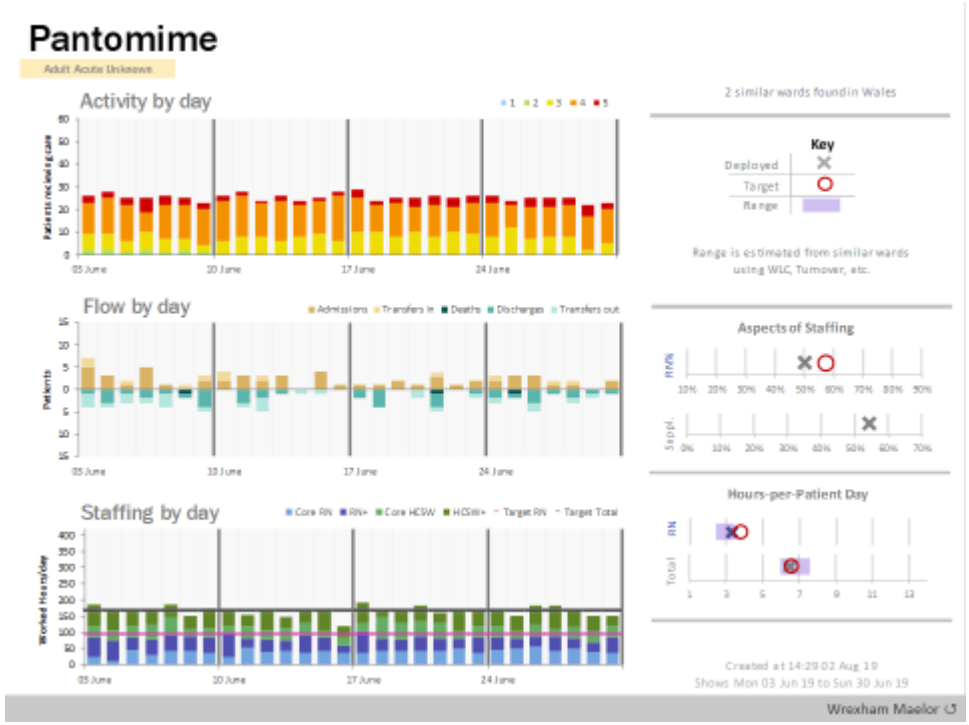
Medical Assessment
Medical
Medical Assessment Unit
Activity by day
Flow by day
Staffing by day
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Staffing
Hours per Patient Day
Wrexham Maelor

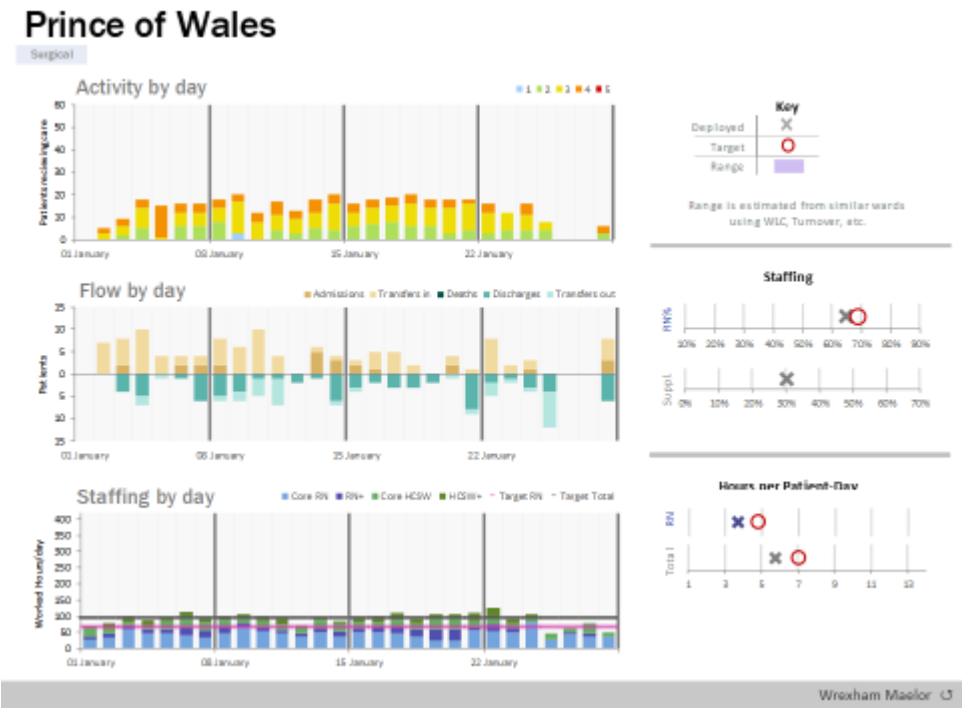

Medical Assessment
Non-ISB Medical
Medical Assessment Unit
Activity by day
Flow by day
Staffing by day
No similar wards foundin Wales
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Aspects of Staffing
Hours-per-Patient Day
Wrexham Maelor

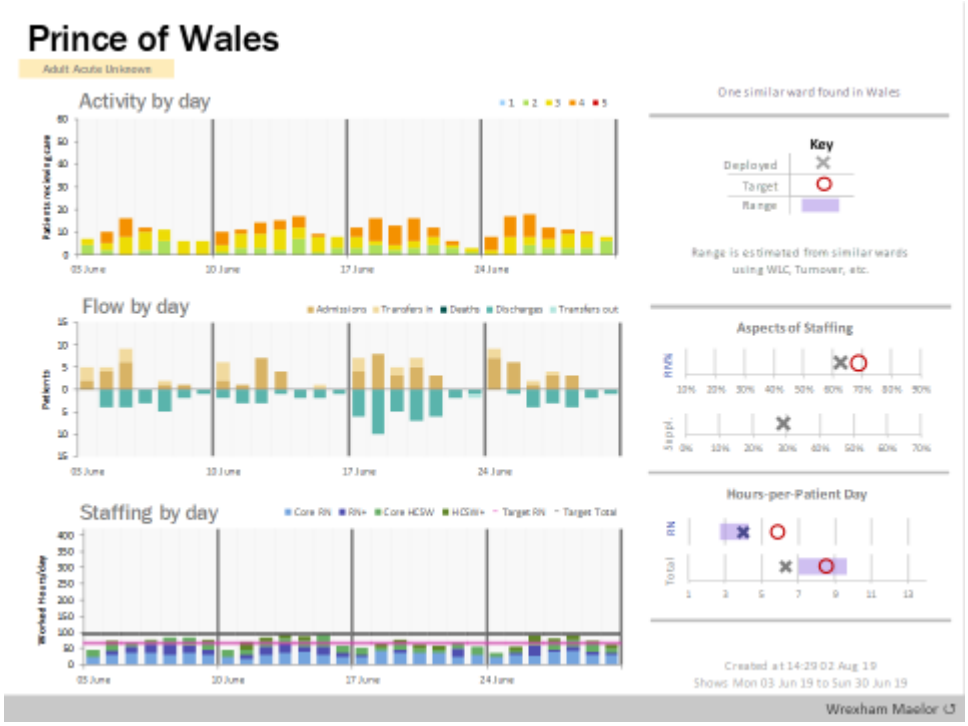
Morris
Medical
Care of the Elderly Ward. Patients with dementia, complex discharges
Activity by day
Flow by day
Staffing by day
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Staffing
Hours per Patient-Day
Wrexham Maelor

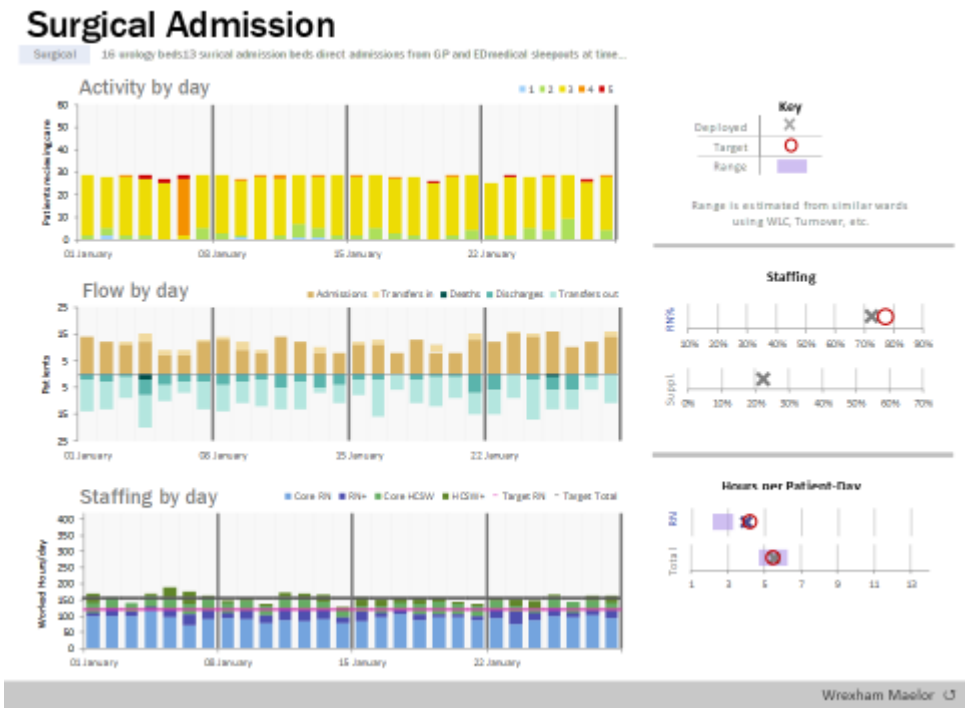

Morris
Adult Acute Medical
Care of the Elderly Ward. Patients with dementia, complex discharges
Activity by day
Flow by day
Staffing by day
13 similar wards found in Wales
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Aspects of Staffing
Hours-per-Patient Day
Wrexham Maelor

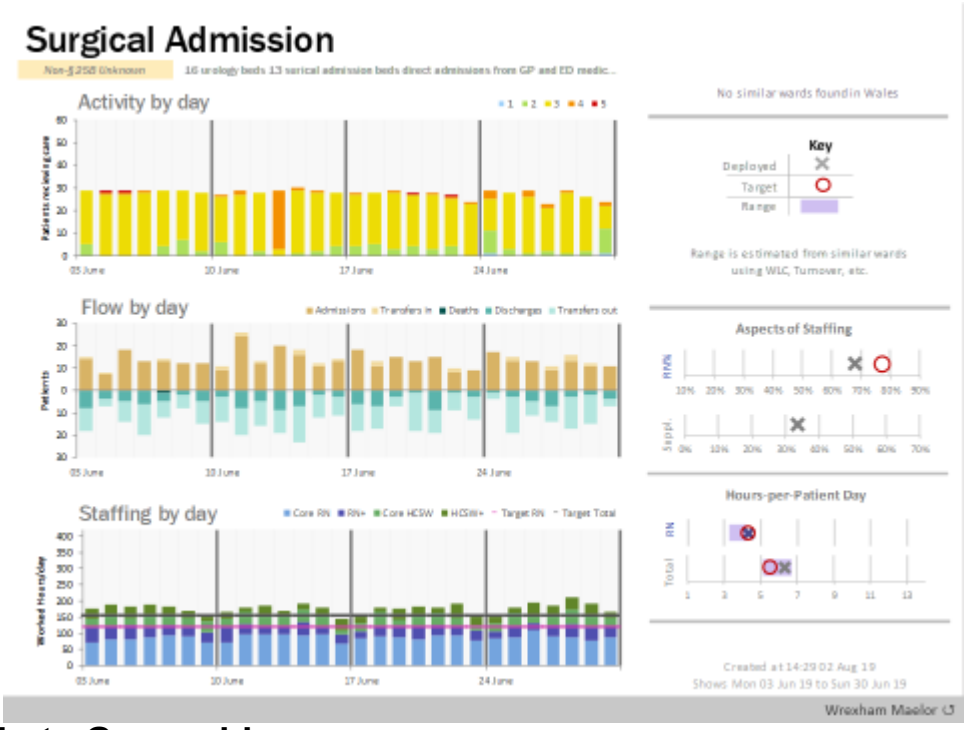

Pantomime
Surgical
Activity by day
Flow by day
Staffing by day
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Staffing
Hours per Patient-Day
Wrexham Maelor


Pantomime
Adult Acute Unknown
Activity by day
Flow by day
Staffing by day
2 similar wards found in Wales
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Aspects of Staffing
Hours-per-Patient Day
Wrexham Maelor

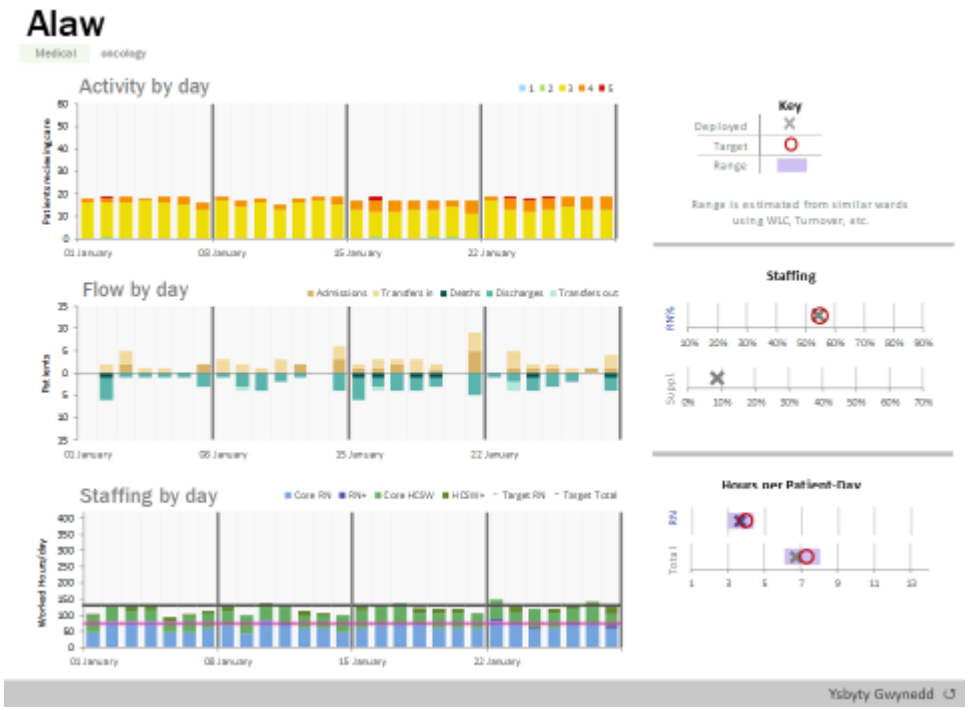

Prince of Wales
Surgical
Activity by day
Flow by day
Staffing by day
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Staffing
Hours per Patient Day
Wrexham Maelor

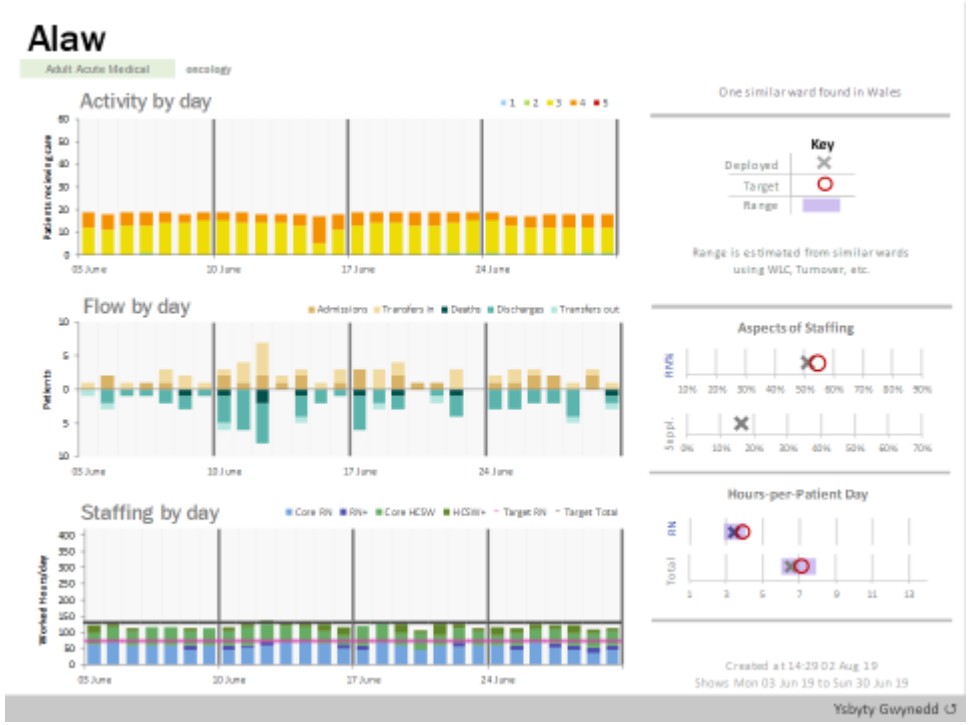

Prince of Wales
Adult Acute Unknown
Activity by day
Flow by day
Staffing by day
One similar ward found in Wales
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Aspects of Staffing
Hours-per-Patient Day
Created at 14:29:02 Aug 19
Shows Mon 03 Jun 19 to Sun 30 Jun 19
Wrexham Maelor

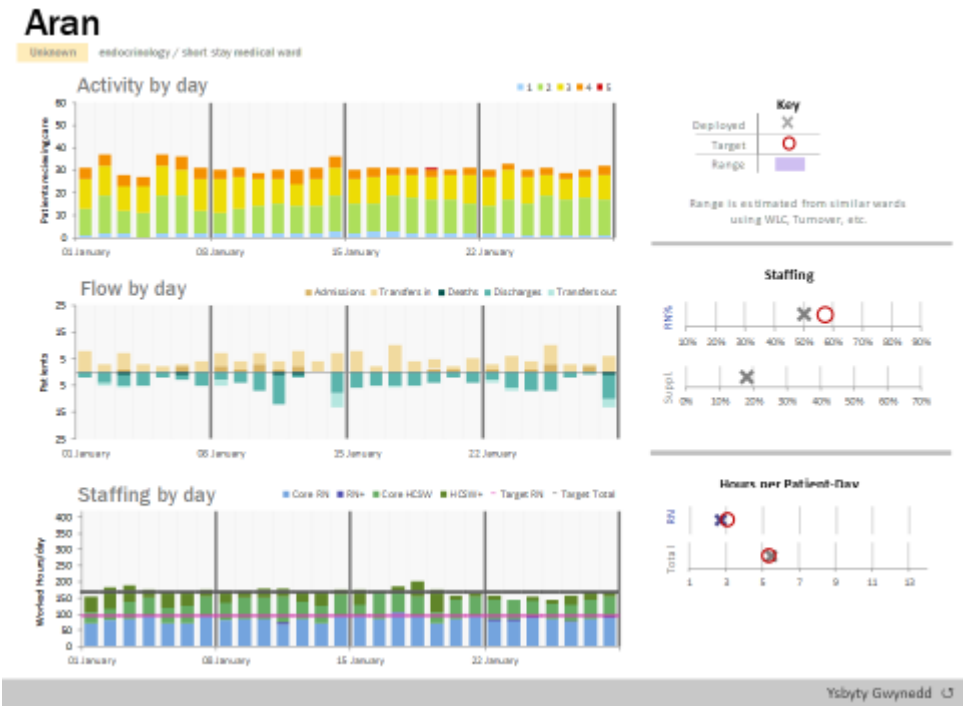


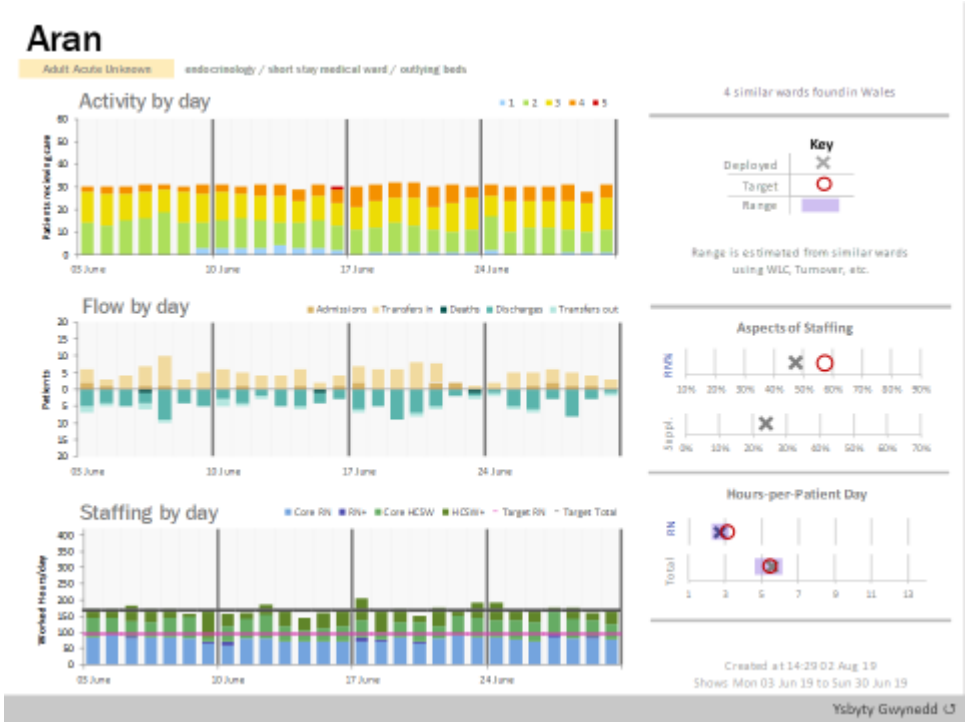


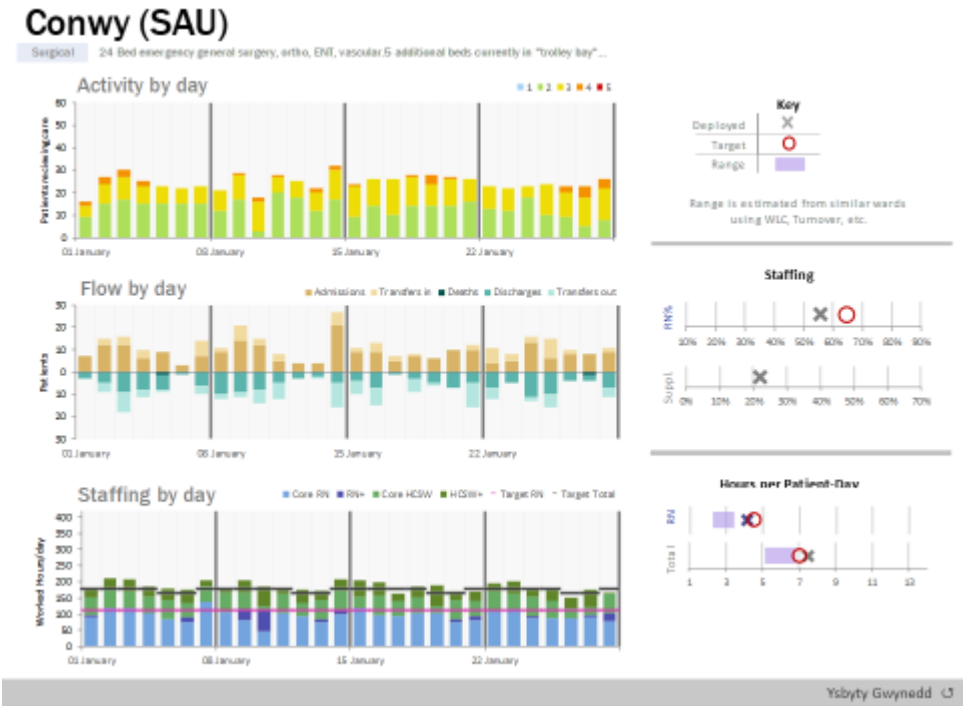
Ysbyty Gwynedd

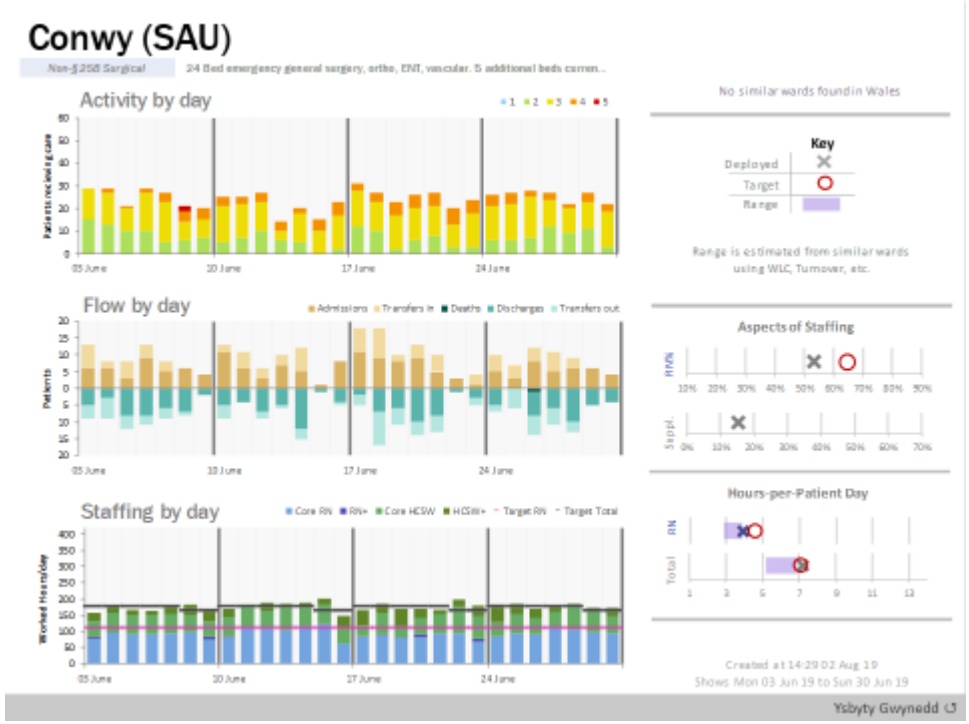

Alaw
Medical
oncology
Activity by day
Flow by day
Admissions
Transfers in
Deaths
Discharges
Transfers out
Staffing by day
Core RN
RN+
Core HCSW
HCSW+
Target RN
Target Total
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Staffing
Hours per Patient Day
Ysbyty Gwynedd


Alaw
Adult Acute Medical
oncology
Activity by day
Flow by day
Staffing by day
One similar ward found in Wales
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Aspects of Staffing
Hours-per-Patient Day
Created at 14:29 02 Aug 19
Shows Mon 03 Jun 19 to Sun 30 Jun 19
Ysbyty Gwynedd

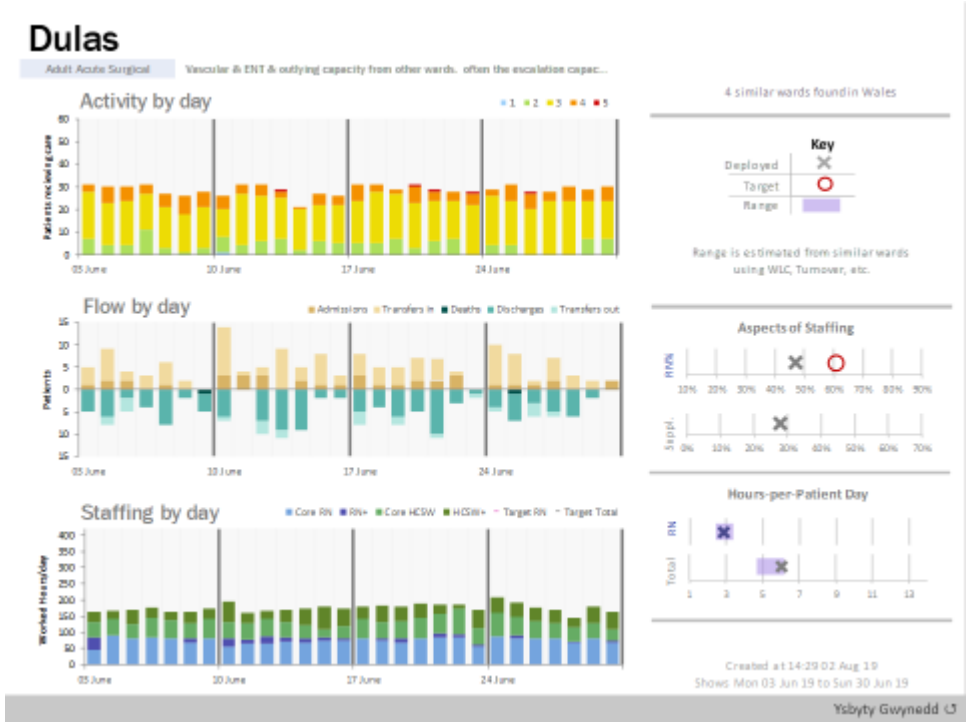

Aran
Activity by day
Flow by day
Staffing by day
Key
Deployed
Target
Range
Staffing
Hours per Patient Day
Ysbyty Gwynedd


Aran
Activity by day
Flow by day
Staffing by day
4 similar wards foundin Wales
Key
Deployed
Target
Range
Aspects of Staffing
Hours-per-Patient Day
Ysbyty Gwynedd


Conwy (SAU)
Activity by day
Flow by day
Staffing by day
Key
Deployed
Target
Range
Staffing
Hours per Patient Day
Ysbyty Gwynedd


Conwy (SAU)
Activity by day
Flow by day
Staffing by day
No similar wards foundin Wales
Key
Deployed
Target
Range
Aspects of Staffing
Hours-per-Patient Day
Ysbyty Gwynedd

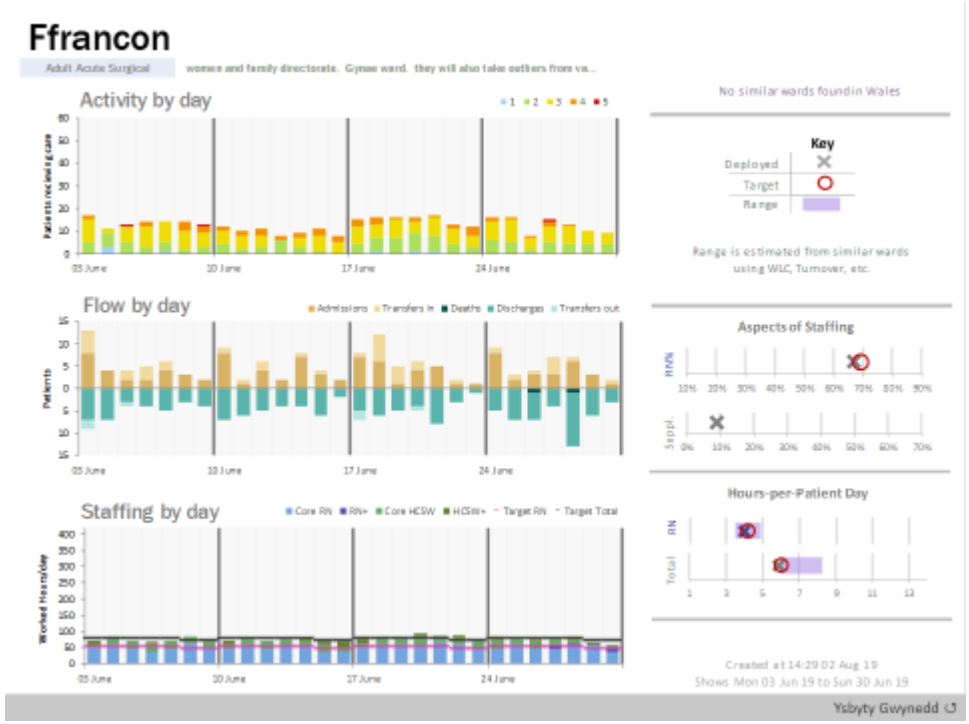
Dulas
Surgical
Vascular & ENT
Activity by day
Flow by day
Staffing by day
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Staffing
Hours per Patient Day
Ysbyty Gwynedd

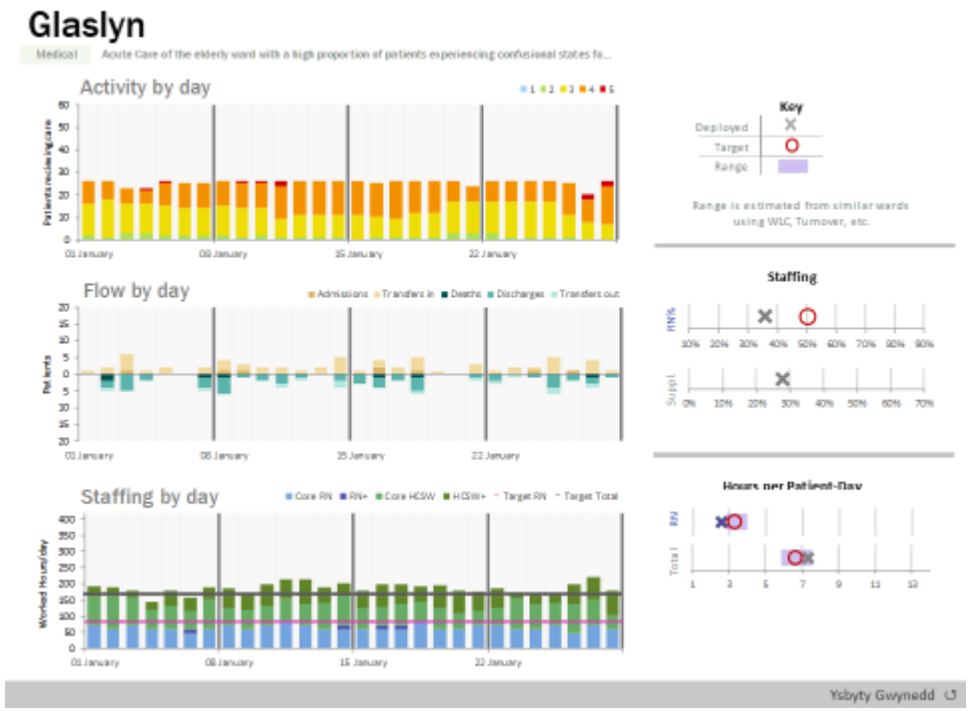

Dulas
Adult Acute Surgical
Vascular & ENT & outlying capacity from other wards. often the escalation capac...
4 similar wards foundin Wales
Activity by day
Flow by day
Staffing by day
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Aspects of Staffing
Hours-per-Patient Day
Created at 14:29 02 Aug 19
Shows Mon 03 Jun 19 to Sun 30 Jun 19
Ysbyty Gwynedd

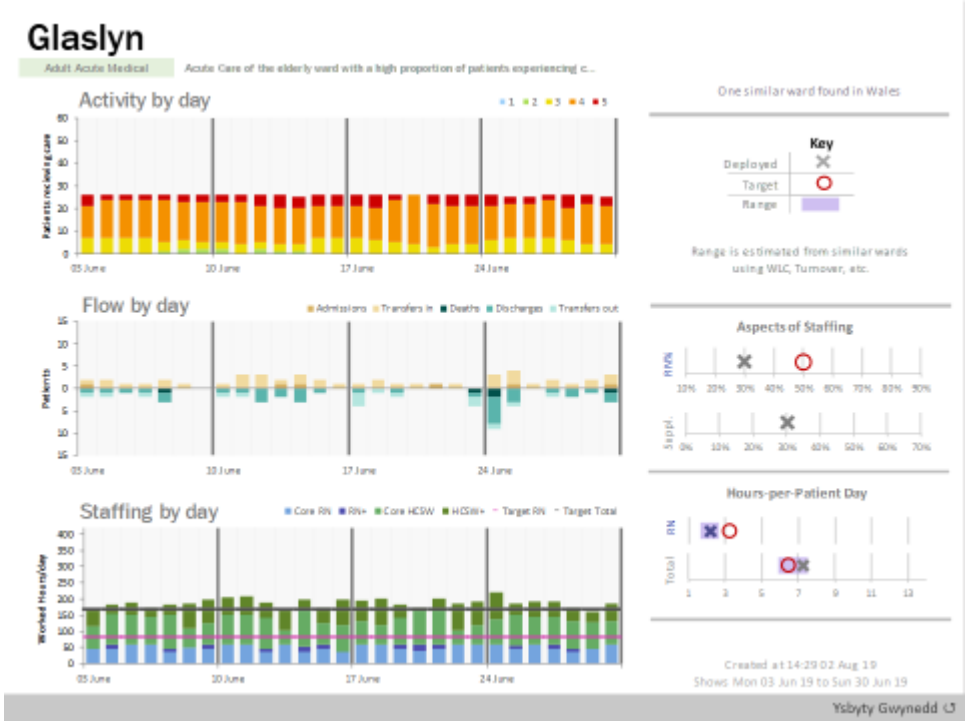
Enlli
Surgical
elective orthopaedic ward
Activity by day
Flow by day
Staffing by day
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Staffing
Hours per Patient Day
Ysbyty Gwynedd

Enlli
Adult Acute Surgical
elective orthopaedic ward
Activity by day
Flow by day
Staffing by day
One similar ward found in Wales
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Aspects of Staffing
Hours-per-Patient Day
Created at 14:29:02 Aug 19
Shows Mon 03 Jun 19 to Sun 30 Jun 19
Ysbyty Gwynedd

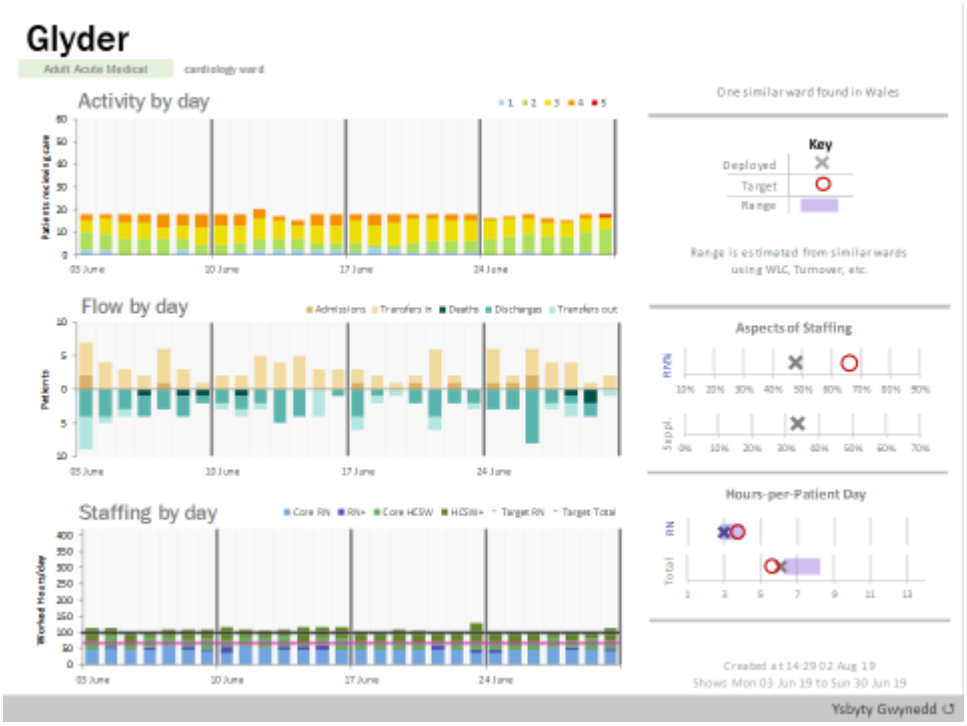
Ffrancon
Surgical
Activity by day
Flow by day
Staffing by day
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Staffing
Hours per Patient Day
Ysbyty Gwynedd


Ffrancon
Adult Acute Surgical
Activity by day
Flow by day
Staffing by day
No similar wards foundin Wales
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Aspects of Staffing
Hours-per-Patient Day
Created at 14:29:02 Aug 19
Shows Mon 03 Jun 19 to Sun 30 Jun 19
Ysbyty Gwynedd


Glaslyn
Medical
Acute Care of the elderly ward with a high proportion of patients experiencing confusional states fo...
Activity by day
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Flow by day
Staffing
Staffing by day
Hours per Patient-Day
Ysbyty Gwynedd


Glaslyn
Adult Acute Medical
Acute Care of the elderly ward with a high proportion of patients experiencing c...
Activity by day
One similar ward found in Wales
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Flow by day
Aspects of Staffing
Staffing by day
Hours-per-Patient Day
Created at 14:29 02 Aug 19
Shows Mon 03 Jun 19 to Sun 30 Jun 19
Ysbyty Gwynedd

Glyder
Medical
cardiology ward
Activity by day
Flow by day
Staffing by day
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Staffing
Hours per Patient Day
Ysbyty Gwynedd


Glyder
Adult Acute Medical
cardiology ward
Activity by day
Flow by day
Staffing by day
One similar ward found in Wales
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Aspects of Staffing
Hours-per-Patient Day
Created at 14:29 02 Aug 19
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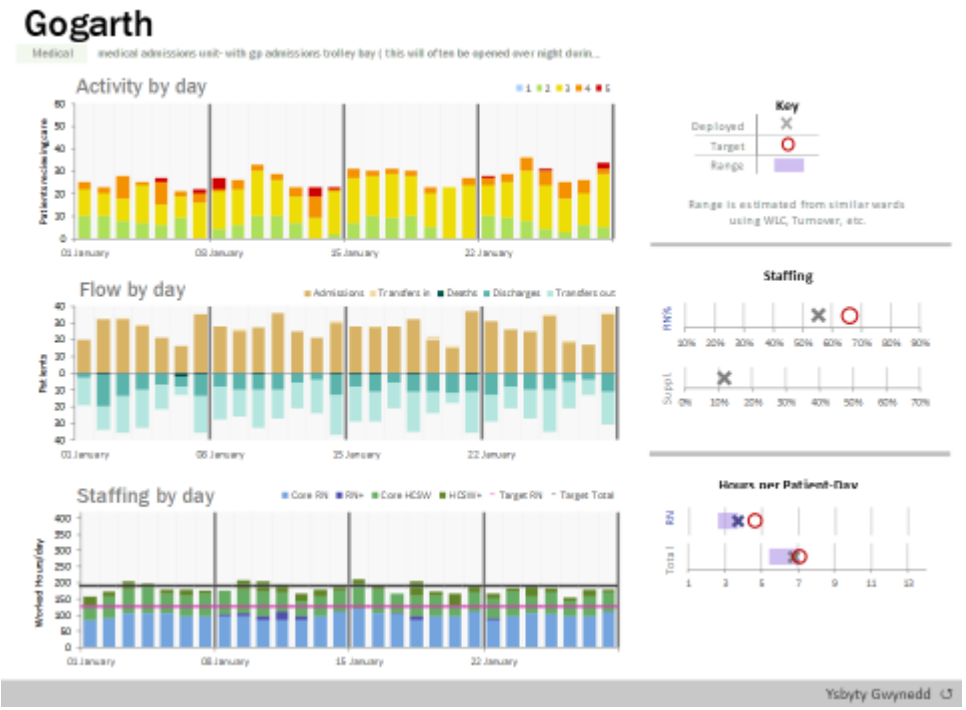
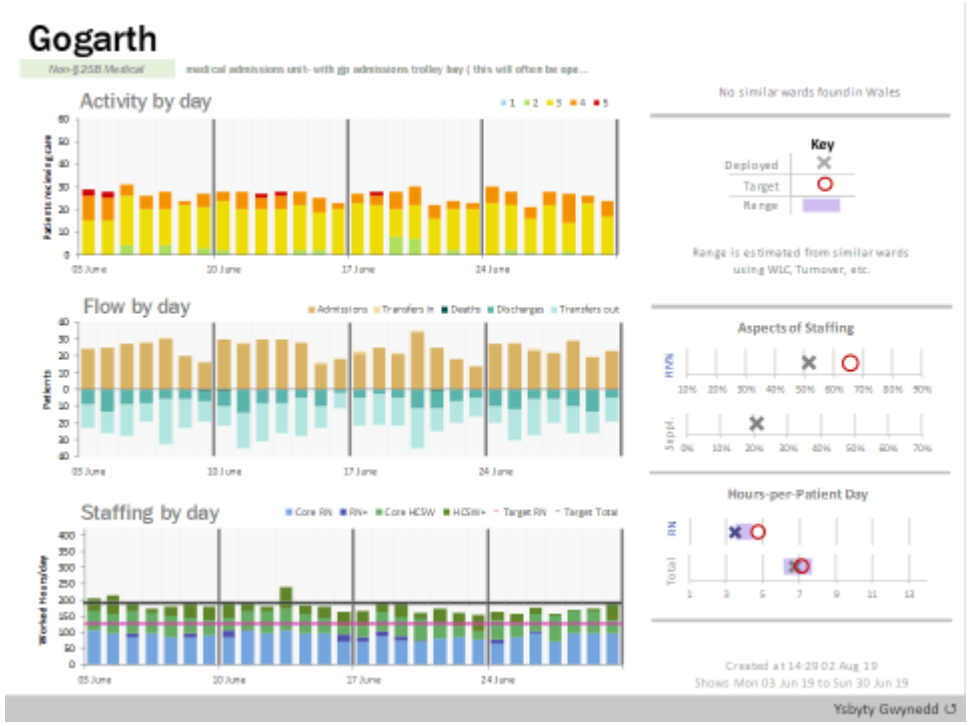
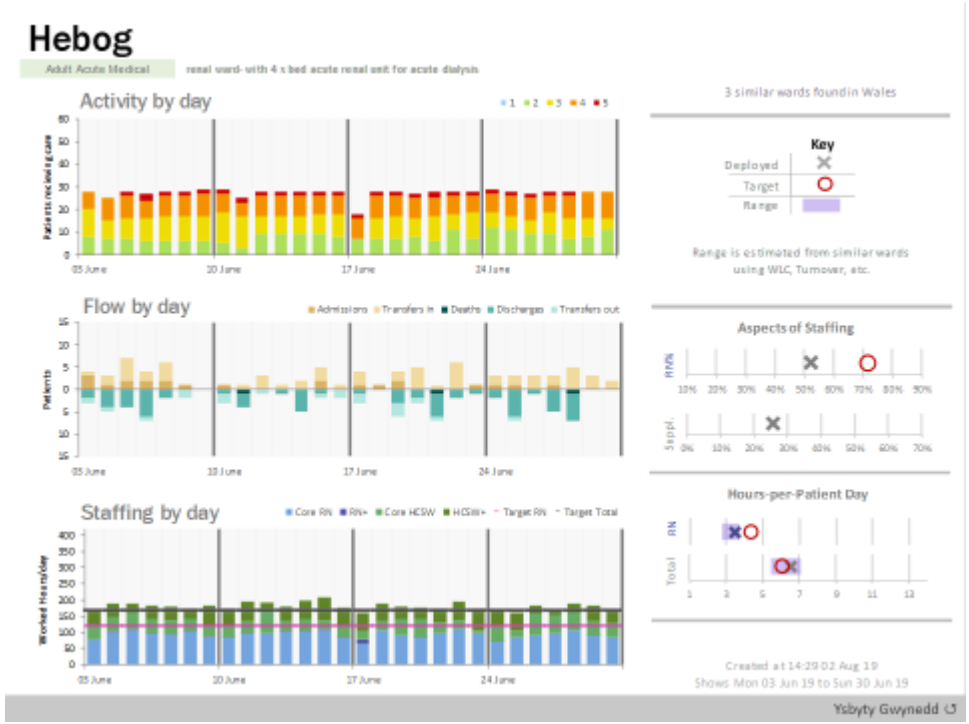
Ysbyty Gwynedd


Gogarth
Activity by day
Flow by day
Staffing by day
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Staffing
Hours per Patient-Day
Ysbyty Gwynedd


Gogarth
Activity by day
Flow by day
Staffing by day
No similar wards foundin Wales
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Aspects of Staffing
Hours-per-Patient Day
Ysbyty Gwynedd

Hebog
Medical
renal ward- with 4 x bed acute renal unit for acute dialysis
Activity by day
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Flow by day
Staffing
Staffing by day
Hours per Patient-Day
Ysbyty Gwynedd


Hebog
Adult Acute Medical
renal ward- with 4 x bed acute renal unit for acute dialysis
3 similar wards found in Wales
Activity by day
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Flow by day
Aspects of Staffing
Staffing by day
Hours-per-Patient Day
Created at 14:29 02 Aug 19
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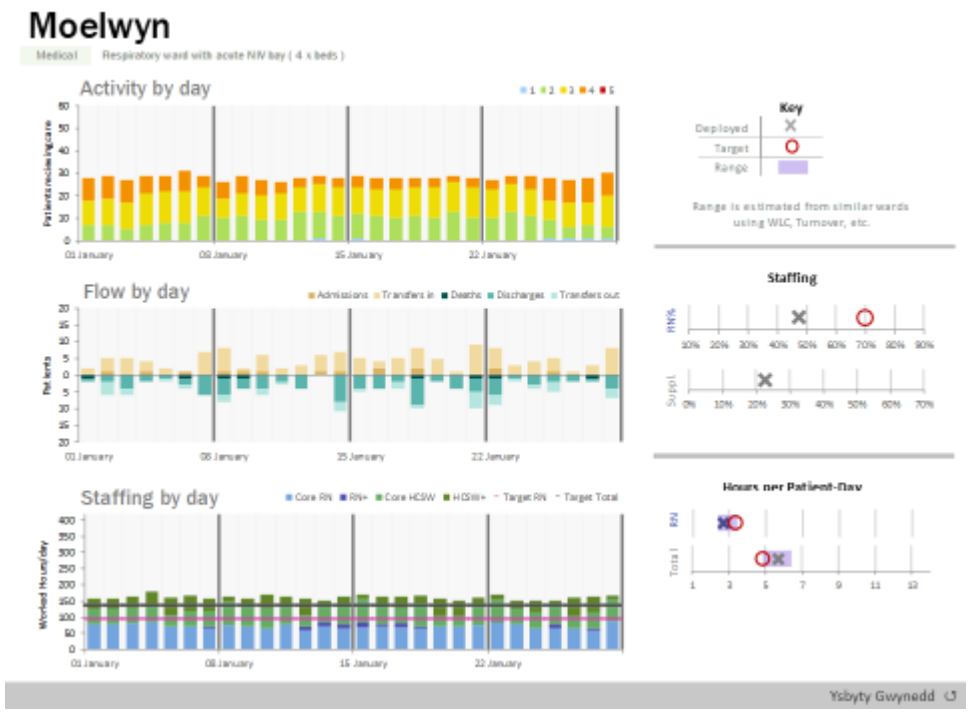
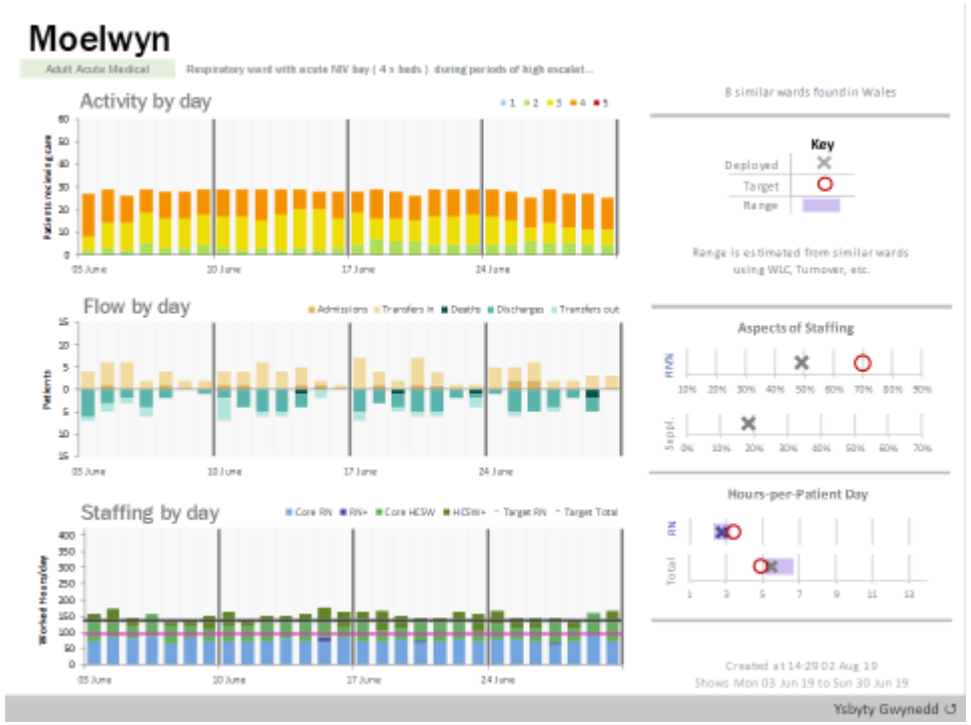
Ysbyty Gwynedd


Moelwyn
Medical
Respiratory ward with acute NIV bay (4 x beds)
Activity by day
Flow by day
Staffing by day
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Staffing
Hours per Patient Day
Ysbyty Gwynedd


Moelwyn
Adult Acute Medical
Activity by day
Flow by day
Staffing by day
8 similar wards found in Wales
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Aspects of Staffing
Hours-per-Patient Day
Created at 14:29 02 Aug 19
Shows Mon 03 Jun 19 to Sun 30 Jun 19
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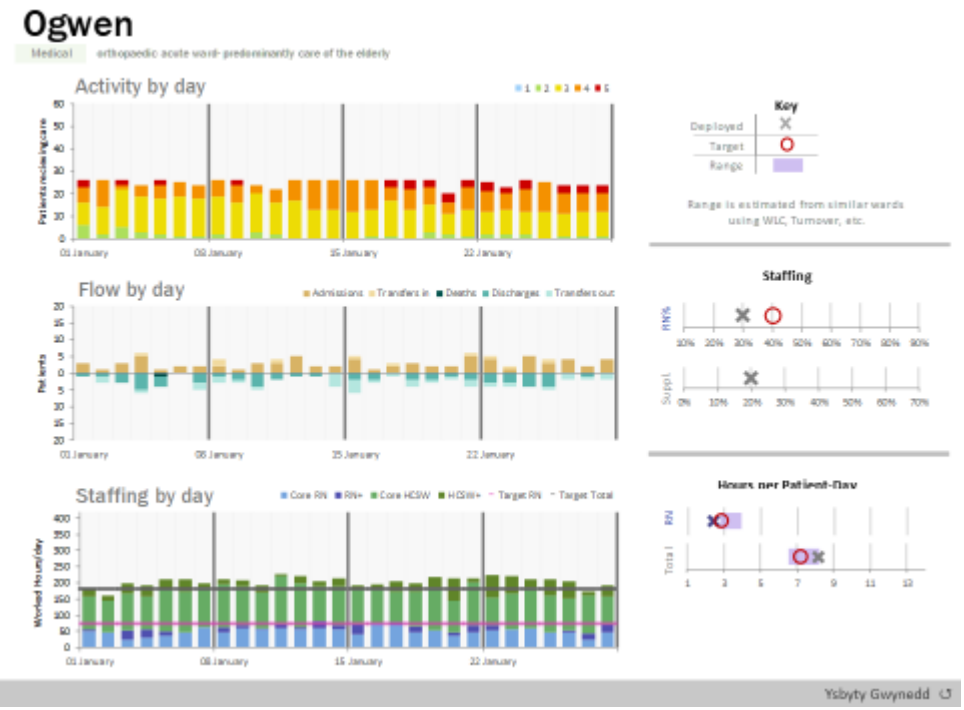
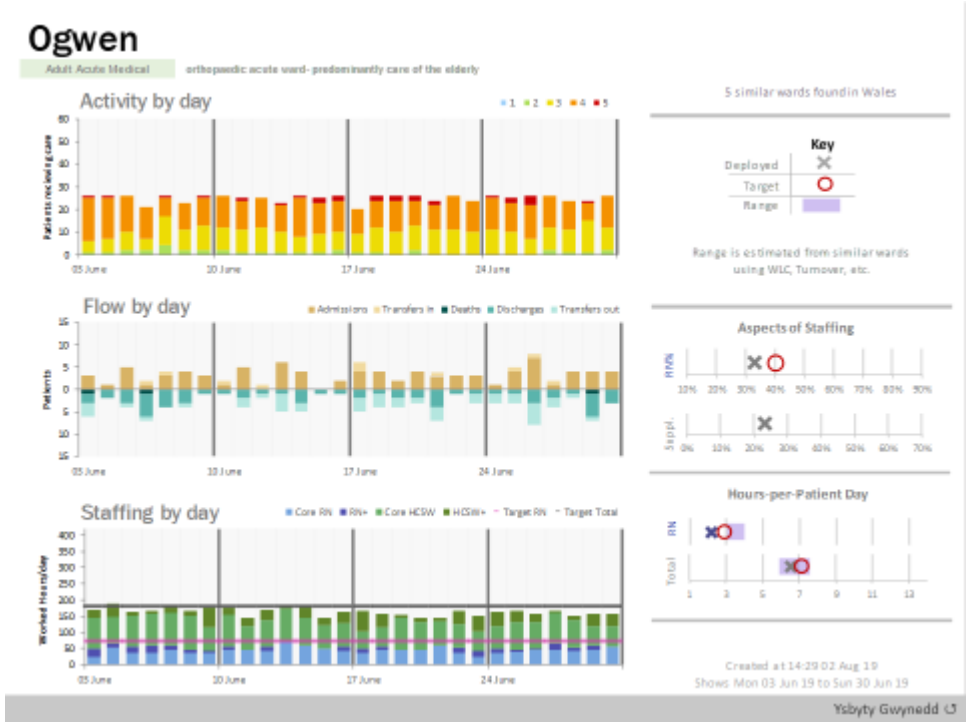
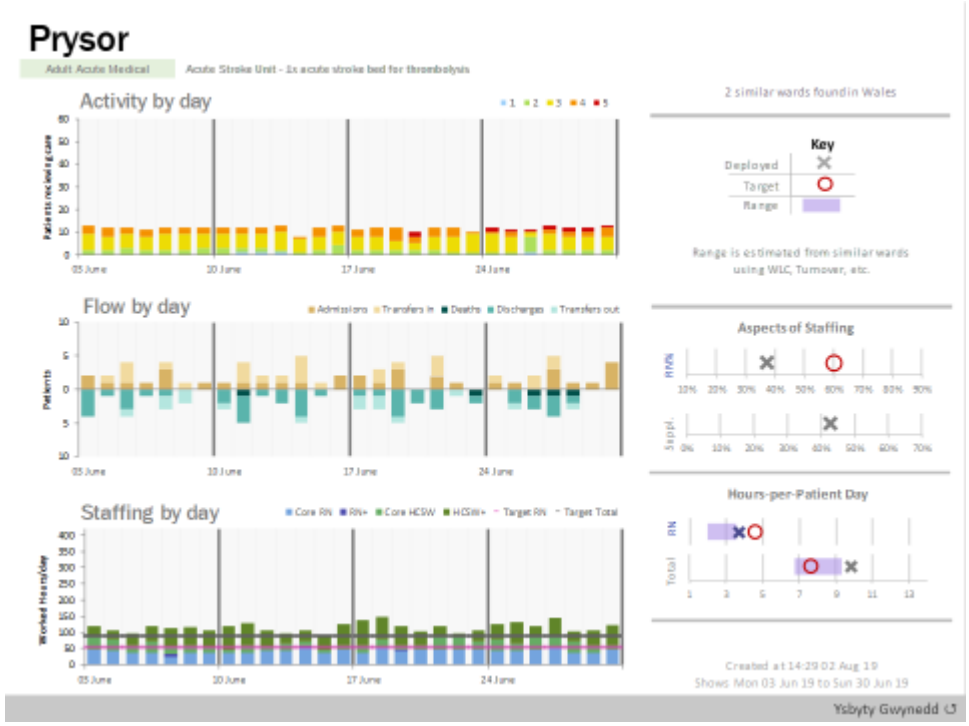
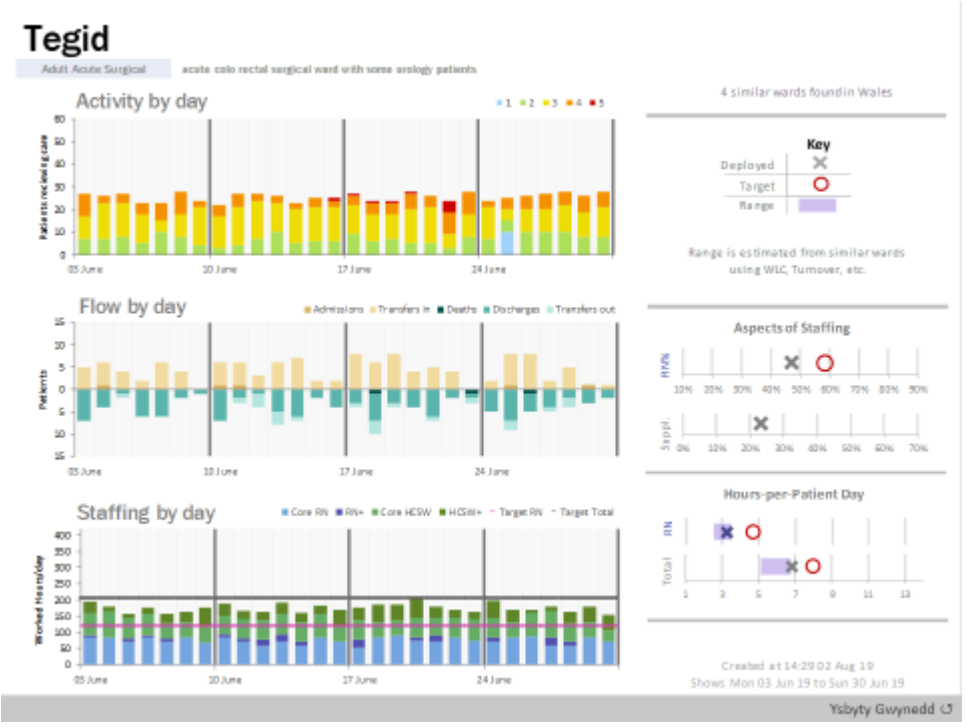

Ogwen
Medical
orthopaedic acute ward- predominantly care of the elderly
Activity by day
Flow by day
Staffing by day
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Staffing
Hours per Patient Day
Ysbyty Gwynedd


Ogwen
Adult Acute Medical
orthopaedic acute ward- predominantly care of the elderly
5 similar wards found in Wales
Activity by day
Flow by day
Staffing by day
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Aspects of Staffing
Hours-per-Patient Day
Created at 14:29 02 Aug 19
Shows Mon 03 Jun 19 to Sun 30 Jun 19
Ysbyty Gwynedd

Prysor
Medical
Acute Stroke Unit - 1x acute stroke bed for thrombolysis
Activity by day
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Flow by day
Staffing
Staffing by day
Hours per Patient Day
Ysbyty Gwynedd


Prysor
Adult Acute Medical
Acute Stroke Unit - 1x acute stroke bed for thrombolysis
2 similar wards found in Wales
Activity by day
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Flow by day
Aspects of Staffing
Staffing by day
Hours-per-Patient Day
Created at 14:29 02 Aug 19
Shows Mon 03 Jun 19 to Sun 30 Jun 19
Ysbyty Gwynedd

Tegid
Surgical
acute colo rectal surgical ward
Activity by day
Flow by day
Staffing by day
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Staffing
Hours per Patient-Day
Ysbyty Gwynedd


Tegid
Adult Acute Surgical
acute colo rectal surgical ward with some urology patients
4 similar wards found in Wales
Activity by day
Flow by day
Staffing by day
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Aspects of Staffing
Hours-per-Patient Day
Created at 14:29 02 Aug 19
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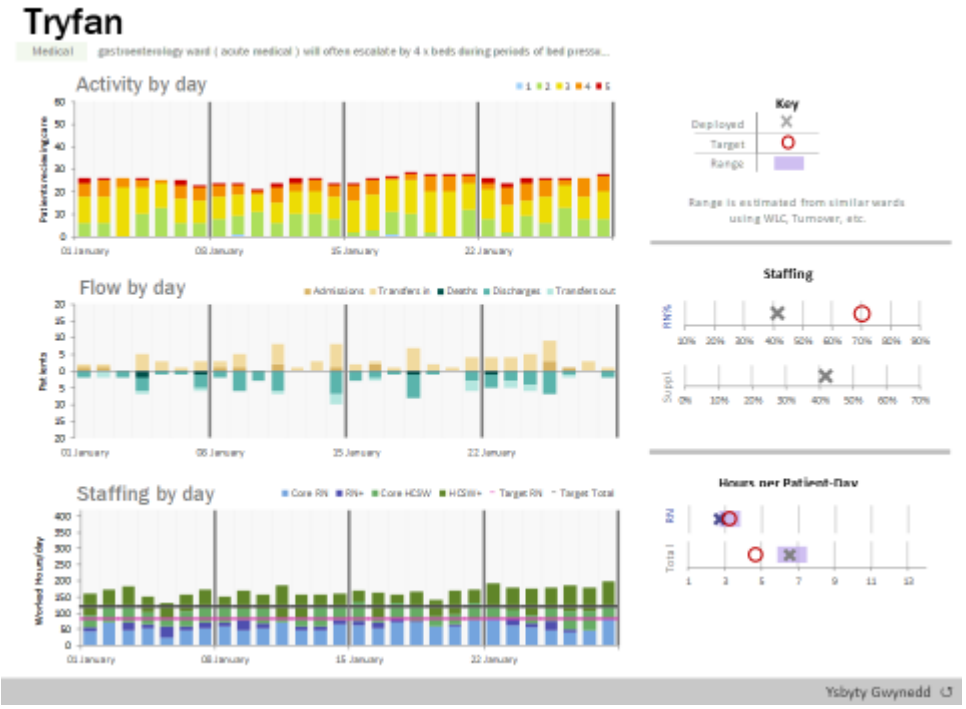
Ysbyty Gwynedd


Tryfan
Medical
gastroenterology ward (acute medical) will often escalate by 4 x beds during periods of bed pressu...
Activity by day
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Flow by day
Admissions
Transfers in
Deaths
Discharges
Transfers out
Staffing
Staffing by day
Core RN
RN+
Core HCSW
HCSW+
Target RN
Target Total
Hours per Patient Day
Ysbyty Gwynedd

Tryfan
Adult Acute Medical
gastroenterology ward (acute medical) will often escalate by 4 x beds during p...
Activity by day
7 similar wards foundin Wales
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Flow by day
Admissions
Transfers in
Deaths
Discharges
Transfers out
Aspects of Staffing
Staffing by day
Core RN
RN+
Core HCSW
HCSW+
Target RN
Target Total
Hours-per-Patient Day
Created at 14:29 02 Aug 19
Shows Mon 03 Jun 19 to Sun 30 Jun 19
Ysbyty Gwynedd

Quality, Safety & Experience Committee **19.11.19**	 ***To improve health and provide excellent care***

Report Title:	Policies, Procedures or Other Written Control Documents for Approval
Report Author:	Authors are detailed on the respective title page
Responsible Director:	Responsible directors are detailed on the respective title page
Public or In Committee	Public
Purpose of Report:	To seek Committee level approval for new or revised policies and written control documents.
Approval / Scrutiny Route Prior to Presentation:	In accordance with the Policy for the Management of Health Board Wide Policies, Procedures and other Written Control Documents, authors are responsible for ensuring that appropriate consultation has taken place with the relevant individuals and groups. Each policy was considered by the Quality Safety Group (QSG) with detail of prior scrutiny being set out on the respective title pages. The QSG was supportive of recommending each of the following written control documents to the QSE Committee for approval.

Title	New or Revised	Summary of Revisions
Levels of Enhanced Care for Adult In Patients Policy – *QSG Chair's Action taken*.	New	-

Governance issues / risks:	BCUHB has a statutory duty to ensure that appropriate written control documents are in place to comply with legislation, enabling staff to fulfil their roles safely and competently. Up to date and easy to follow policies and written control documents minimise risk to patients, visitors, employees and the Health Board. They help to ensure that statutory requirements, standards and regulations are understood, and provide a framework to monitor compliance. This ensures the Health Board provides a robust and clear governance framework within which service delivery and operational activity can occur.
Financial Implications:	Authors have a responsibility to consider any training and resource implications that are identified as a result of implementation of the policy

	and to set out who is responsible for the training programme as documented within the Health Board's Policy on Policies.
Recommendation:	The Committee is asked to approve the attached written control document for implementation within BCUHB.

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

Special Measures Improvement Framework Theme/Expectation addressed by this paper

Policy development will support the special measures theme of Leadership & Governance

Equality Impact Assessment

Each of the attached written control documents have been subject to EQIA screening – copies of which are appended. Where appropriate, support on completing the EQIA has been sought from the BCU equalities team.

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

Levels of Enhanced Care for Adult Inpatients

POLICY

Date to be reviewed:		No of pages:	
Author(s):	Tracey Harris Jane Lucy Julie Smith	Author(s) title:	Lead Nurse- Clinical Governance Clinical Governance Nurse Associate Director- Quality Improvement- Secondary Care
Responsible dept / director:	Executive Director of Nursing BCUHB		
Approved by:	Professional Advisory Group		
Date approved:	July 2019		
Date activated (live):	October 2019		

Documents to be read alongside this procedure:	BCUHB Falls Care Pathway and related guidance Mental Capacity Act (2005) and Code of Practice Mental Health Act 1983 and Mental Health Act 2007 Health and Safety at Work Act (1974) Nurse Staffing Levels Wales Act (2016) Statutory guidance Welsh Government; National Institute of Clinical Excellence, NICE publication 'Safe Staffing for nursing in adult inpatient wards in acute hospitals' (2014) Missing Persons Procedure Deprivation of Liberty Safeguards Self-harm Guidance Adults at Risk Procedure AC002 MHLD Therapeutic Engagement and Observation Policy
Purpose of Issue / Description of current changes: The Policy sets out the standards of practice for delivering the correct levels of enhanced care to maintain the safety of adult inpatients and increase social interaction/therapeutic advantages This Policy provides structure for determining level of enhanced care and lines of responsibility for those involved in the decision making, delivery and management of enhanced levels of care	

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1.0 Introduction

Betsi Cadwaladr University Health Board is committed to improving standards of care by the delivery of a service that is of the highest quality possible. This includes ensuring there is a system of monitoring in place applicable to patient need and responsive to fluctuations of risk, whilst cost effective and efficient. Nurse staffing ratios/establishments have traditionally reflected bed occupancy not dependency or acuity of patients. Levels of observation may have an impact on the standard staffing and skill mix numbers and require extra controls, reporting and additional staffing. The Welsh Levels of Care is a key component to implementing the Nurse Staffing Act (2016) in practice, forming one third of the triangulation method that Health Boards are required to use when calculating their Nurse staffing levels. The Act makes it clear that any workforce planning tools to be used must be evidence-based and specific to the Welsh context. The Welsh Levels of Care will give a consistent, standardised approach when establishing the acuity of patients on adult medical and surgical wards. The Welsh Levels of Care consists of 5 levels of acuity ranging from; Level 1 where the patient's condition is stable and predictable, requiring routine nursing care; to Level 5 where the patient is highly unstable and at risk, requiring an intense level of continuous nursing care on a 1:1 basis.

The enhanced observation levels of enhanced care therefore will 'dovetail' with the all Wales level of care to provide a seamless approach in the terminology used to reflect levels of input required for patients with a risk assessment process to support decision making

The objective of this policy is to provide a framework for enhanced levels of observation in Acute Adult inpatient settings where patients may be considered "at risk" of harm to themselves or others (e.g. risk of falls or due to dementia or confused state, patient may present a risk to others through violent or aggressive behaviour).

There are a number of situations where patients may require increased support, observation or intervention, for example:

1.1 The patient is undergoing an intervention that requires frequent clinical monitoring.

1.2 The patient is acutely physically ill and / or requires frequent clinical observation. (*e.g.: to prevent falls or harm)*

1.3 The patient is acutely mentally ill and at risk of self-harm.

1.4 The patient is likely to wander and/or abscond and is at risk to him/herself.

1.5 The patient is confused / agitated / aggressive / violent towards others.

1.6 The patient may have learning disabilities and need additional support.

Above examples are not an exhaustive list and each case must be considered on an ongoing individual basis.

2.0 Scope

2.1 In Scope

This Policy will apply to all adult inpatient groups in Secondary Care and community ward settings across the organisation. The Policy will apply to all staff working across BCUHB in these locations, including temporary employees, agency staff, bank workers, contractors, locum staff, carers, volunteers, visitors/family members and any other person who may be affected by its undertaking.

2.2 Out of Scope

Mental Health & Learning Disabilities Division

3.0 Purpose

The purpose of this Policy is to ensure that the assessment of all adult patients at risk who may require enhanced care have the appropriate level of supervision and observation available to them.

The level of enhanced care is an integral part of the therapeutic care plan, to ensure the sensitive monitoring of the patients behaviour and mental state, and identify factors that may exacerbate or inhibit challenging behaviours; whilst at the same time, fostering therapeutic relationship and using the least reactive means possible.

The level of enhanced care should never interfere or compromise any planned treatment or therapy for a patient. It is to inform professional judgment and assist the member of staff with decision-making that is required to support patients who may require enhanced care to keep them safe.

This document provides clear instruction of how these observations and levels of enhanced care must be identified, implemented and evaluated to ensure that safe, personal and effective care is provided to all patients assessed as needing it.

To ensure that 1:1 nursing is not the immediate solution to every clinical scenario. Care Provision is guided following an enhanced care individual risk assessment (see Appendix 1) before any decision regarding resource is made.

To ensure that resources are allocated appropriately through a robust and a dynamic ongoing risk assessment process.

To reflect and support other related policies that are integral to patient safety, liberty and patient experience.

To ensure that appropriate control and safety measures have been considered or put in place through the following measures:

3.1. Discussion with the patient, family and carers as appropriate.

3.2 Moving or locating the patient closer to the nurses station within the ward for closer observation or consider using a side room to minimise stimulation and to enable rest, or if they are causing a disturbance to other patients or causing distress.

3.3 Assessment of Mental Capacity and where appropriate Deprivation of Liberty Safeguards (DoLS) requiring authorisation e.g. If patient lacks capacity and is at risk of leaving the department and wards.

3.4 Utilising patient safety equipment, only after appropriate enhanced care risk assessments (see Appendix 1) have been made and recorded within patient nursing documentation, such as, profiling low bed, bed rails / safety bumpers, safety mittens to prevent cannulae, tubes and catheters from being dislodged. Where there are a number of patients of the same sex on a ward who may require close observation, to consider the benefits of cohorting (moving into same room) and using a 'bay –watch' approach. This should be supported by the bay tagging methodology that means the nurse appointed to work in the bay should not leave the bay, including delivering care behind curtains until he or she has tagged another member of staff to take over (see Appendix 4).

3.5 Review of skill mix, patient acuity and availability of staff on shift to meet the needs of patients' requiring enhanced observation.

3.6 Utilisation of a Behavioural chart (see Appendix 3) and that consideration has been made for diversion therapy at certain times during the day.

3.7 Ensuring and maintaining a safe environment, to include risk assessment is performed for potential ligature points in certain circumstances / areas as appropriate. Ensure ward environmental generic risk assessments are reviewed and updated to minimise risk.

3.8 Sensitively discuss with the patient's family the possibility of their support during visiting times and by offering flexible visiting to enable family/friends to stagger their visits. (hyperlink to open visiting policy)

3.9 Utilisation of staff from other wards to back fill staff to enable support for patients requiring enhanced observation.

4.0 Observation Levels

The decision to implement a type of enhanced care is made following a holistic risk and multidisciplinary assessment of the patient's physical and psychological state as well as social and environmental factors at that moment in time. This needs to be clearly documented with the rationale for the level of observations clearly stated and an appropriate observer identified. This must be documented in the Risk Scoring Tool/Plan of Care Chart (see Appendix 2), whilst taking account of observations of behaviour (see Appendix 3).This process can be supported by accessing 'Delirium 10' that provides person, relationship centred guidelines for individuals with dementia and delirium where appropriate. http://howis.wales.nhs.uk/sitesplus/861/page/74098

Observation can be defined as "regarding the patient attentively" whilst minimising the extent to which they feel they are under supervision. Encouraging communication, listening and conveying to the patient that they are valued and cared for are important components of skilled observation. The need to observe the patient must be balanced against the need to maintain the patients' privacy and dignity. Additionally, effective communication with family at visiting time is important- update them on impact of close supervision, levels of distress etc.

The levels of enhanced care are broken down to five levels to help facilitate decision-making:

Level 1: BLUE

Patient identified as:

Having no risks, routine care to be maintained. No further assessment is required unless condition deteriorates, or any change in clinical treatment plan.

Level 2: GREEN

This level means that the patient must be observed at specific intervals agreed by the Nurse-in-charge and where possible, agreed in collaboration with the patient, carers and/or family as appropriate. This level of support is indicated where the risk level is low, (there is no acute or overt risk of harm to self or others) and the patient is deemed safe between checks or has capacity to summon support where necessary.

It is anticipated that Level 2 (Green) will only be used for a limited period. The timeframes decided by the team must be specified and clearly recorded, as well as realistic and achievable for the staff involved. The recommended interventions to consider are:

- Additional family support – open visiting
- Medications review with Doctor and Pharmacist
- Communicate and escalate at safety huddle
- Maintain intentional rounding observation
- Consider allocation of bed

However, based on clinical assessments, other interventions may be considered for this level of enhanced care.

Level 3: YELLOW

For Level 3 (Yellow), the patient is identified as being at an increased risk of harm. This means they are at risk of one or more types of harm e.g. falls, moderate confusion or challenging behaviour. All Level 2 (Green) interventions will be utilised, but they are not deemed as sufficient enough in providing safe care to the patient, which leads to utilising Level 3 (Yellow) enhanced care interventions.

For Level 3 (Yellow), the patient must be visible within line of sight. There should be consideration of placing the patient close to staff so that they can respond immediately should an incident occur or be likely to occur. All patients should be offered the option of attendance/support by staff to use bathroom/toilets; however, the patient may choose some degree of privacy, if this is the case, it must be clearly stated and documented in their care plan.

A regular summary of the patient's condition, care and treatment must be entered on the Risk Scoring Tool/Plan of Care Chart (see Appendix 2).This must include changes in mental health, physical, psychological and social behaviour, pertinent development and significant events. This assessment should take place daily and/or on any change in condition or treatment plan.

For patients who require cohorting, a nurse or support worker will be present in the bay area at ALL times and should have clear observation of each patient requiring cohorting care. The nurse present must be able to respond quickly to any concerns observed and must ensure continuous engagement with the patient(s). If for any reason, the nurse has to leave the bay, they must ensure another nurse temporarily takes over their role and they must provide a handover before leaving (see Appendix 4).

The recommended interventions to consider are:

- All interventions listed under Level 2: Intermittent Observation GREEN
- Relocation of patient in area of high visibility
- Cohorting of patients
- Commence patient engagement activities
- Consider DOLS application or Mental Health Assessment (if appropriate)
- Consider use of bed/chair sensor alarm

Level 4: AMBER

Within eyesight, this level means the patient is unstable with an unpredictable condition. There is history of moderate confusion. Has sustained a fall within the last 12 months.
The existing or longer-term plan of care may be postponed, while alternate urgent treatments and interventions are put in place to avoid any further deterioration, or protect the patient.
The patient's condition may change rapidly and therefore high levels of observation and supervision are in place, or provided on a continuous basis for the majority of the day.
There is regular senior clinical review.
The work to deliver care is multifaceted with a number of highly skilled interventions and technical procedures interspersed with numerous tasks to provide full personal care.
Acutely unwell with elevated NEWS and requires additional nursing care.

The recommended interventions to consider are:

- All interventions listed under Level 3: Yellow
- Discuss with family regarding their input in delivery of care
- If family are unable to assist look at existing staffing levels and consider cohorting if more than 1 patient requires enhanced care
- Review frequency of NEWS and timing of observations

Level 5: Continuous observation: RED

Continuous observation (RED), the patient must be subject to close proximity, constant, uninterrupted observation. Actual distance or proximity must be determined by an assessment of the patient's condition. Following an assessment, the patient may be allowed some degree of privacy (e.g. use of bathroom/toilet/when visitors present), though this must be clearly stated in the care plan. This level of enhanced care requires dedicated 1-1 care.

Such patients include those who are at high risk of falls, at high risk of removing clinical devices, have acute mental health problems or patients whose physical condition is likely to deteriorate to such an extent that they are likely to need a higher level of care such as HDU or Intensive Care. Environmental factors should be considered to maintain patient safety, (e.g. including removing equipment/instruments that may cause harm to self or others, positioning of furniture to reduce falls, consideration of noise/lighting levels).

All interventions at Level 2 (Green) and Level 3 (Yellow) must be utilised (where appropriate) as well as the recommended interventions at Level 4 (Amber).

The recommended interventions to consider at Level 5 (Red) are:

- All patients requiring continuous observation must have 1-1 care implemented
- Family members or carers can manage non-clinical elements of providing 1-1 care. These elements must be clearly explained to them and documented
- Consider DOLS application
- Consider support or advice from Specialist services/nurses

	Level of Enhanced Care	Inclusion criteria
T0	***Level 1:***	• Having no Risks, routine care to be maintained
	Level 2:	• At low risk of falls and no history of falls • Occasional episodes of mild confusion. Very occasional restlessness but no evidence of challenging behaviour • Low risk of deterioration • No history of self-harm
	Level 3:	• At risk of falls but no previous history of falls • Occasional moderate confusion • Frequent episodes of agitation, or attempting to leave clinical area • Fluctuating NEWS and requires additional nursing care
	Level 4:	• Patient is unstable with an unpredictable condition • Moderate confusion • Has sustained a fall within the last 12 months • The existing or longer term plan of care may be postponed, whilst alternative urgent treatments and interventions are put in place to avoid any further deterioration, or protect the patient

		• The patient's condition may change rapidly and therefore high levels of observation and supervision are in place, or provided on a continuous basis for the majority of the day • There is regular senior clinical review • The work to deliver care is multifaceted with a number of highly skilled interventions and technical procedures interspersed with numerous tasks to provide full personal care • Acutely unwell with elevated NEWS and requires additional nursing care
	Level 5:	• Significant risk of falls/or has sustained a recent fall • Severe confusion with regular episodes of agitation and challenging behaviour • Acutely unwell requiring constant clinical care to maintain safety • Safety concerns e.g. severe alcohol withdrawal • Unstable mental health • At risk of harm: suicidal intent or/and serious self-harm incident has occurred

5.0 Assessing the level of enhanced observation (as above)

5.1 A full-enhanced care risk assessment must be undertaken on a daily basis and communicated to all members of the multi-disciplinary team involved in the patients care. (Appendix 1).

6.0 Roles and Responsibilities

Multi-Disciplinary Team members

- Where the decision to implement 1-1 care is taken, this must be made by the multidisciplinary team. However, in situations when prompt action is required, the Nurse-in-charge can implement a heightened level of observation ideally in discussion with another registered nurse
- When patients are transferred to the care of another provider, the MDT must consider how the risks in relation to direct observations and 1-1 care can be safely met. This may involve temporarily deploying staff to undertake direct observations in another ward/department
- Ensure that the patient's needs for a certain level of enhanced care is reviewed daily and on change of conditions/needs

Director of Nursing/Head of Nursing

- Responsible for the overall safe and supportive care of the patients within their hospital
- Responsible for providing overall assurance for implementation and monitoring of the Policy
- This policy will also be monitored in Directorate Governance for incident trends where patients have sustained an injury due to any of the reasons for a patient requiring enhanced care that are outlined in the introduction of the policy

Matrons

- Responsible for ensuring all patients requiring 1-1 care or cohorting have risks identified in line with the individual Enhanced Levels Care Tool. The nurse on the ward must discuss the level with them when they receive a request for bank/agency shift
- Provide leadership for delivery of the implementation of the guidance in their area of responsibility

- Ensuring implementation in a timely manner of care plans devised following environmental and patient risk assessments
- Manage and take into account staffing skill mix, current patient acuity on the ward and patient risks in conjunction with Nurse-in-charge. (see Nurse Staffing Escalation Policy, hyperlink) The level of enhanced care scores should be reflected on the Safe Care Dashboard to inform safe daily operational practice across the site
- Frequency visits

Nurse in Charge

- Ensure an individual Enhanced Care Risk Assessment is completed, (see Appendix 1) for all patients deemed at risk. The Risk Assessment must be completed prior to implementing 1-1 care. The Risk Assessment must be completed within 12 hours of admission or on transfer to another ward or unit
- Manage and take into account staffing skill mix, current patient acuity on the ward and patient risks in conjunction with Matron (see Nurse Staffing Escalation Policy- hyperlink)
- Coordinating the multidisciplinary team assessments which will determine the level of enhanced care required
- Ensure that the individual delegated to undertake 1-1 care or cohorting has the appropriate skills/training and is provided with a full handover on the patient's condition and the rationale for this level of care. Ensure allocated nurse understands the 'bay tagging' methodology
- Ensure staff carry out risk assessments which are kept up to date, are acted upon and escalated when appropriate
- Ensure that support and assistance from other members of the team are available as required
- Ensure that nursing documentation and Datix is completed and any incident/concern is reported as necessary via appropriate Health Board reporting system
- Ensure that the patient understands why 1-1 care and cohorting is being given. If they do not have capacity, it is essential that relatives and carers are kept informed
- Ensure that the patient/relatives/carers are involved with the decision making as appropriate
- Ensure that staff providing 1-1 care and cohorting are aware that where the needs of the patient are being met, they may also be asked to assist with other patient care as instructed by Nurse-in-charge
- Ensure that enhanced care at all levels on the Scoring Tool/Plan of Care Chart (see Appendix 2) are recorded detailing all interventions undertaken with the patient
- Review (minimum of 3 times daily) the clinical condition of the patient and need to remain on a high level of enhanced care (e.g. 1-1 care or cohorting)
- Communicate to all staff on duty which patients are subject to enhanced care and at what level of observation they require (e.g. 1-1 care, cohorting, patient placed in "visible" area)
- Ensure that those undertaking dedicated 1-1 care and cohorting are offered breaks at regular intervals
- Ensure that all staff attend the handover for the shift to enable them to work across the ward if needed and be aware of potential risks identified
- Staff must hand over the baton to the nurse who is taking over the management of the patient

Carers and Relatives

- Carers and relatives play an important role in the process of information gathering and assessment. They should be kept informed of changes to the level of enhanced care required and be offered explanations about the reasons for that level. The rules of confidentiality

continue to apply and this should be discussed with the patient before discussing with carers/relatives (where appropriate)

- Carers and relatives who know the patient well and are aware of the patient's risks and needs can, at times, help and may on occasions be more appropriate than the professional staff to provide 1-1 care depending on their own and the patient's wishes. The leaflet, 'Partnership in Care' should be given and explained to carers and relatives, and reinforced with this leaflet (see Appendix 5)
- If a carer or relative undertakes the role of proving the non-clinical elements of 1-1 care, it remains the responsibility of the professional staff to ensure the patient's safety is maintained
- Carers/relatives are to be informed of the level of enhanced care identified, as well as the level of information that will be required for the appropriate staff member to complete the care plan during their period of observation. They must be informed who to report to when concerns arise, when leaving the patient/ward, as well as being offered the opportunity to take regular breaks
- It must never be assumed that the carer/relatives will undertake the role of providing any level of enhanced care. It is important to note that this may not always be appropriate based on the reason for the patient requiring enhanced care (e.g. suicidal risks)

Observer (volunteer, carer or relative)

- Undertake the delegated enhanced care and any interventions in accordance with this guidance utilising the relevant documentation
- Must hand over information pertaining to the care of patients when one observer/care provider is replaced with another
- Be familiar with the ward/department and potential risks in the environment
- Consider approaches/interventions that have been effective for the patient in similar situations in the past, such as distraction, diversion and de-escalation techniques. All patients on level 2 or 3 (Green or Yellow) to consider commencement of engagement activities (where appropriate)
- There must be clear instructions for the types of care provision that carers or relatives can undertake; all of which should be non-clinical and within the realms of providing safe care by non-clinical staff

7.0 Carrying out observation

NB All staff should be aware that the person carrying out the observations should offer therapeutic engagement and interventions. Staff should also aim to empower the patient and not restrict their movement unnecessarily.

7.1 Observation usually involves a number of nurses, with care being handed over at intervals. Excellent communication amongst staff must be maintained.

- At the beginning of each shift, the nurse-in-charge shall inform and ensure that all members of the ward team, who are involved in observations with a patient, understand the procedure, in terms of who is being observed at what level, and why via ward safety briefing
- Before taking over the patient's observation, each nurse will have familiarised themselves with the patient plan of care, current risks and individual needs

7.2 The member of staff undertaking observation:

- Should take an active role in engaging positively with the patient
- Should be appropriately briefed about the patient's history, background, specific risk factors and particular needs
- Should be familiar with the ward, the ward policy for emergency procedures and potential risk in the environment
- Should be approachable, listen to the patient, know when self-disclosure and the therapeutic use of silence are appropriate and be able to convey to the patient that they are valued

8.0 Record Keeping

8.1 To maintain patient records in line with NMC/GMC record keeping guidance, and stored as per local policy.

8.2 The observation levels prescribed will be recorded in the patient record. An individualised observation record and plan of care should also be drawn up with the involvement of the patient where appropriate. (see Appendix 2 & 3)

9.0 Review / termination of enhanced observation

- The patient's condition and the need to continue enhanced observation should be undertaken and reviewed on each shift by the Sister / Charge Nurse / Shift Leader and discussed with the Matron or appropriate senior nurse
- Patients may require different levels throughout the 24hr day e.g. level 3 during the day stepping down to level 2 overnight
- When it is deemed no longer necessary to provide greater care, all decisions should be clearly documented onto the risk assessment
- The relatives / carer must be notified of the decision and the rationale must be communicated and documented appropriately

10.0 Training & Support

- Staff will be issued with a training pack for cascading to the teams, this will include examples of Enhanced Care Risk Assessment, Risk Scoring Tool/Plan of Care and Behavioural Chart (see Appendix 1, 2 & 3)
- All Staff caring for patients receiving enhanced care will have received training
- At the beginning of span of duty, staff will receive a Partnership in Care: Nurse Pocket Guide (see Appendix 6) outlining roles and responsibilities of providing enhanced care. The Nurse Pocket Guide will be returned to the nurse station at the end of the shift/episode of care

11.0 Process for Monitoring Effective Implementation

The use of all temporary staff and associated costs will be monitored monthly using information collected by the Ward Manager and monitored by Matron and Divisional/Directorate Head of Nursing. This should demonstrate that the correct escalation procedures were put in place for

those patients who were in need of enhanced care, and to confirm the procedure for approving temporary staff was followed.

12.0 Audit Process

Audit Process Criterion	Lead	Monitoring method	Frequency	Committee/Group
Duties (Accountabilities)	Author of Policy	Policy Review	1 year	PAG
Audit of enhanced care assessment and resources	Divisional/Directorate Heads of Nursing	Finance aspect of Accountability Meetings	Annual	Site/Divisional Finance & Performance Group
Incidence of falls and trends for patients requiring enhanced care.	Divisional /Site Governance Lead	Incidents	Quarterly	Local Q&S Groups
Incidence of patient absconsion	Divisional /Site Governance Lead Incidents	Incidents	Quarterly	Local Q&S Groups

13.0 Personnel involved in the development of the policy:

Name	Title
Sharon Pierce	**Interim Lead Nurse Clinical Governance, West**
Janette Hamilton	**Lead Nurse Clinical Governance, West**
Tracey Radcliffe	**Lead Nurse Clinical Governance, Central**
Eleri Evans	**Head of Nursing, West**

References & bibliography

- Mental Capacity Act 2005, Code of Practice (2007). The Stationery Office. London
- NICE National guidance for patient observation issued by the National Institute for Health and Clinical Excellence (2006).
- NMC Record keeping

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Appendix 1

Hospital Number : _____

Ward: _____

ENHANCED CARE RISK ASSESSMENT (To be done within 12 hrs of admission or transfer to new ward)

Risk of Falls	At risk of getting up unaided or attempting to leave the ward	An episode of increasing disorientation/delirium/ Dementia	Psychological Factors	Other clinical risks
Patient not deemed as a falls risk as per initial risk assessment	Patient is independently mobile around ward area	No identified disorientation or delirium	No previous self-harm	Clinically stable
0	0	0	0	0
Patient identified as being at low risk of falls and no history of actual inpatient falls	Patient at risk of getting up unaided or attempting to leave the ward	Occasional episodes of mild to moderate disorientation. Patient requires regular reassurance and reorientation to ward area.	Previous self-harm and not generating concern. None this episode	Patient at low risk of deterioration
1	1	1	1	1
Patient identified as at being at risk of falls	Patient showing signs of trying to leave ward	Frequent episodes of agitation and occasional moderate disorientation.	Previous self-harm generating on-going concern .Low mood. Background history of mental health issues	Fluctuating NEWS and requires additional nursing care
2	2	2	2	2
Patient identified as being at risk of falls with one or more of the following: An actual fall has occurred, or within the last 12 months. Patient is impulsive and/or non-compliant in using nurse call bell. YELLOW level of interventions have not made patient safe	Patient is showing signs of attempting to stand unaided or to leave the ward.	Consistent moderate disorientation. Frequently agitated and restless or requires regular reassurance and reorientation to the ward environment. • At risk of pulling out an indwelling device. • Unable to make needs known.	Poor compliance with medications and or treatment Previous suicide attempts Patient expressing harmful behaviours to self or others. Patient expressing hopelessness	Patient is acutely unwell with elevated NEWS score and requires additional nursing care to maintain patient safety.
3	3	3	3	3
Patient is identified at significant risk of falls with serious harm and one or more of the following is present: All AMBER actions have been attempted but risk remains. An actual fall with harm has occurred.	Patient is wandering and/or standing unaided and attempting to leave the ward.	Severe disorientation with regular episodes of agitation, violent behaviour and/or aggression towards staff, other patients or relatives.	Patient is a current risk to self Admission because of self-harm / suicide risk. Irrational behaviour Attempted to harm others Patient is removing critical physiological support Public health issues involved	Patient requires 1:1 care to maintain safety e.g. severe alcohol withdrawal, airway compromised Patient needs continuous enhanced observation/intervention
4	4	4	4	4

Note: If, in your professional judgment, you feel that a patient requires enhanced care observations, then please provide enhanced care. Please follow specialist advice.

Score	Level of Observation		Menu of Possible Intervention
No Risk Level 1	Usual ward based observation		No need for further assessment unless condition deteriorates, or any change in clinical treatment plan
<5 Level 2 Some Risk	Intermittent Observation		Additional family support, open visiting times. Review Medications with Doctors and Pharmacists. Communicate and escalate at safety brief. Maintain intentional rounding. Consider location of allocated bed.
5-10 Level 3 Increased Risk	High Visibility Use of bed/chair sensor alarms if appropriate		Relocation of patients to area of high visibility. Cohorting of at risk patients. Request additional family support, open visiting. Commence patient engagement activities. Review medication with Doctors and Pharmacists.
11-15 Level 4 Moderate Risk	Within Eyesight		Relocation of patient in area of high visibility. Cohorting of at risk patients. Request additional family support. Commence patient engagement activities. Consider DOLS application or Mental Health Assessment. Review medication with Doctor and Pharmacist. Consider use of bed/chair sensor alarms if patient appropriate.
> 16 Level 5 High Risk	Continuous Observation		Implement 1:1 asking family first if appropriate, if they can assist with this. If family are unable to help look at existing staffing levels. If staffing levels cannot be achieved, escalate to Matron. Communicate and escalate safety-brief. Commence patient engagement activities. Review medication with Doctor and Pharmacist.

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Appendix 2

Risk Scoring Tool/ Plan of care

Reason for enhanced observation request as elicited from Risk Assessment (Appendix 1). PLEASE COMPLETE POINTS 1 – 5 BELOW

Risk detail	Score: Day 1	Score: Day 2	Score: Day 3	Score: Day 4	Score: Day 5	Score: Day 6	Score: Day 7
Risk of falls							
Risk of getting up unaided or attempting to leave the ward							
Episode of increasing confusion/delirium/dementia							
Psychological factors							
Other Clinical risk score							
Overall score (based on totals above)							

Level of Observation required	Document plan of care listing interventions from menu of possible interventions on assessment tool.	Date and sign	Review date	Reason why

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Appendix 3

Behaviour Recording Chart

ABC Behaviour Recording Chart for:

Date:

Activating Event What happened just before the behaviour occurred? For example, where was the person? Who was near him? What was he doing? **Had a request been made of him?** **What was said?** **Did he want something specific?** **Had an activity just ended?** **What were you doing? How was his mood?**	**BEHAVIOUR** What exactly did he do? How long did it last? (If more than on behaviour occurred list all – and what order they happened)	**CONSEQUENCE** What happened immediately after the behaviour? Please provide a step-by-step description of the exact events that occurred. e.g. Was anything taken from/given to him? Did he 'escape' from doing something? Has the environment changed in some way? **How did he respond to your reaction?** **Was there anyone else around who responded, or showed a reaction?**	Time, Print & Sign (If untrained needs to be countersigned by trained staff at end of shift)

Bay Watch/ Bay Tagging

Bay Watch

Definition: Where a number of patients of the same sex on a ward who require close supervision are cohorted into the same bay

Bay Tagging

Definition: Bay tagging is a method for ensuring that a bay of high falls risk patients has continuous nursing presence to try to reduce the risk of patients falling due to lack of supervision. The main point of Bay Tagging is that the nurse appointed to work in the bay cannot leave until **he or she has "tagged" another** staff member to take over. If a person in a bay has to go behind the curtains with a patient, wherever possible they should ask another person to tag them and oversee the bay.

Below is the methodology to be used on the ward to achieve this:

- Assignment of designated bay will be given at safety brief. The designated bay is allocated a colour
- The staff members will then wear the appropriate coloured badge to match the bay where patients are cohorted
- Staff assigned to the designated bay must not leave the bay until they have tagged another member of staff
- To tag another member of staff you must give them your coloured badge and they are then responsible for that bay of patients

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Appendix 5

Partnership in Care Leaflet

If you have a carer's sheet, "This is me" leaflet or any other log of what your relative's personal preferences or needs are, please bring it in.

We will help by continuing any activities they like, and keep a log. If there are certain objects that will help the patient adjust to a new environment, please discuss with a member of staff.

We will review their Partnership in Care needs daily to see if supervised observation is still needed. Please ask us if you want to know about this each time you visit. Please be assured if Partnership observation is not medically needed, you are still welcome to provide it on an informal basis.

If you choose to spend some time in hospital to provide Partnership in Care, free or reduced parking costs are available. Please ask a member of staff for further details.

You can visit any time and you can provide Partnership in Care at any time, day or night – it's up to you what you do and how long you want to do it for. You are always welcome.

Please talk to us if you have any questions or concerns. You may wish to complete a "Partnership in Care" form or a "Friends and Family" card. We will use your comments to help improve our partnership.

Partnership in Care

Working together with relatives and carers to provide safe, personal and effective care for vulnerable patients

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Appendix 6

Partnership in Care: Nurse Pocket Guide

1:1 – Partnership in Care: Nurse Pocket Card

Care: You must assist in providing care to Patients including mouth care, pressure care, feeding, hygiene & toileting needs.

Breaks: You must be offered a break at least every 2 hours.
Patient care must be carefully handed over to another staff
Member who will undertake that role until you can return.

Your wellbeing: Alert Senior Staff member if you are feeling fatigue as a result of continuous observation; you may be relieved for a short period of time if appropriate.

Limitations: Recognise your own limitations and seek assistance when appropriate. Remain calm at all times.

Continuous Observation: In some instances, you will be asked to carry out continuous observations. You should not be involved in other clinical duties in the clinical environment; unless requested by the Nurse in charge.

You **MUST NOT** use mobile phones, headsets or personal computers while providing Partnership in care.

You **MUST NOT** eat or drink while providing care

BUILD A PARTNERSHIP WITH PATIENTS AND RELATIVES

1:1 – Partnership in Care : Nurse Pocket Card

Team: You are expected to work as part of the ward team and rotate to other duties during the span of a shift.

Familiarise: Receive orientation of ward, polices/procedures if you have not worked on that ward for the past 3 months.

Care Plans: You must read the care plans for the Patients in your care, including their history and any specific risk factors. Refer to “This is me” leaflet if present.

Activity log history: Must review previous activity logs for continuation with familiar activities/stimulation with patients.

Experience: You must have the knowledge and experience of caring for patients with high risk conditions/behaviours. If there are any concerns, please discuss with Nurse in charge.

Handover: You must receive a comprehensive handover of each patient and be given a written handover sheet.

Patient engagement & communication: You must complete a 24-hour Risk scoring tool/Behaviour Log / Plan of care for each patient. You must engage with the Patient: use distraction, diversion and de-escalation skills as required. Utilise activity resource boxes.

Appendix 7

Initial Approval Form

BCUHB-wide Policy Initial Approval Form
This form should be completed and approval obtained before you start producing your policy document. The Equality Impact Assessment should also have been started and any Welsh Language Scheme requirements (See Welsh Language Scheme) considered. **To be completed by document author(s)/group.**

Policy Title: Transfer of Adult Patients	
Brief Summary: This procedure document provides direction and guidance for staff to ensure the safe and appropriate transfer of adult patients between wards and departments across the Health Board, or externally to the Health Board.	
Reason for the review:	**Tick to indicate**
Aligning services/changing service (ie re-organisation):	
Amendments to documentation needed:	
New/amended legislation:	
Review date approaching:	
Supporting National guidelines, policies, legislation, standards:	✓
Other:	
Document(s) this will replace: New Procedure. **Previous organisation policy/procedures (S) – Name/number:**	
Responsible Department: Area that is responsible for creating, updating, monitoring the document/elements the document specifies: Corporate Nursing.	
Responsible Executive Director/Director: Secondary Care Nurse Director NB. Your Executive Director is ultimately responsible for this document, so it is important that they are aware of the document's production.	
Has the responsible Executive Director/Director approved the instigation of this document? **Yes:** ✓ **No:** ❒ **If no, please state why** **Will they be informed?** **Yes:** ❒ **No:** ❒	
If no, please state why:	

Responsible Author: (ie nominated by the Executive Director/Director)
Julie Smith, Associate Nurse Director, QI , Secondary Care, Tracey Harris, Lead nurse, Clinical Governance (East)

Working Group: (please detail who is involved)

Tracey Radcliffe- Lead Nurse Clinical Governance- Central
Eleri Evans- Head of Nursing – West
Sharon Pierce- Interim Lead Nurse- Governance, West
Janette Hamilton, Lead Nurse Governance- West

Engagement to take place with relevant stakeholders (please ensure you detail exactly who you are engaging with): Professional Advisory Group and Senior Directors of Nursing.

Method of engagement (for the draft document)

Meeting: ✓
Email: ✓

Union representative must be consulted for all Workforce/HR related Policies

Yes: ❒ **No:** ✓
If no, please state why
N/A

Local Counter Fraud
Certain policy documents require input from your Local Counter Fraud Specialists. If your document content involves patient or staff claim forms or other financial records please ensure your draft document is sent to Karl.Woodward@wales.nhs.uk as part of the consultation process.. Please tick here if this is the case:

Yes: ❒ **No:** ✓
If no, please state why
N/A

Welsh Language
If your document will impact on patient /user experience please ensure you send your draft document to: Eleri.Hughes-Jones@wales.nhs.uk (Welsh Language Services Manager). Please tick here if this is the case:

Yes: ✓ **No:** ❒
If no, please state why

Resource implications associated with implementing this Policy:
Financial: Nil
Training / staff time: Yes

Have these been discussed/resolved within your Division/Directorate/Corporate Department? **Yes:** ✓ **No:** ❒ **Details:** Discussion at existing local and Health Board wide meetings such as Matrons, Ward Managers, Quality & Safety	
Timescales envisaged – please give details. An action plan can be submitted for further clarification: Equality Impact Assessment screening and produce final draft version: The Equality Impact Assessment Approval and endorsement: Implementation: Training:	
Monitoring arrangements. Please detail here how the document / process within the document will be monitored: **Audit and datix reviews**	
Is this an All Wales document? tick if applicable: ❒	
What are the legislative or statutory elements of this document?	
Approval: where do you envisage this Policy will be approved?	Executive Team ❒ Committee ✓ Board ❒
Please state which Committee (if applicable): PAG	
Any additional comments regarding the Policy:	
Details: To support the launch of the procedure document - raising awareness and implementation across the Health Board.	

Please return this form to: Liz.Jones5@wales.nhs.uk

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EQUALITY IMPACT ASSESSMENT FORMS

PARTS A and B: SCREENING AND OUTCOME REPORT

Introduction:
These forms have been designed to enable you to record, and provide evidence of how you have considered the needs of all people (including service users, their carers and our staff) who may be affected by what you are writing or proposing, whether this is:

- a policy, protocol, guideline or other written control document;
- a strategy or other planning document e.g. your annual operating plan;
- any change to the way we deliver services e.g. a service review;
- a decision that is related to any of the above e.g. commissioning a new service or decommissioning an existing service.

This is not optional: Equality Impact Assessment is a specific legal requirement on public sector organisations under equalities legislation and failure to comply could result in a legal challenge to a decision or strategy. More importantly, equality impact assessment helps to inform better decision-making and policy development leading to improved services for patients. **This form should not be completed by an individual alone, but should form part of a working group approach.**

The Forms:
You must complete:

- **Part A** – this is the Initial Screening that is always undertaken and consists of Forms 1 to 3; these forms are designed to enable you to make an initial assessment of the potential impact of what you are doing, and decide whether or not you will need to proceed to a Full Impact Assessment (Part C);

AND

- **Part B** – this is the Outcome Report and Action Plan (Form 4) you will need to complete whether or not you proceed to a Full Impact Assessment;

Together, these forms will help to provide evidence of your Impact Assessment and how you have shown “due regard” to the duties.

You may also need to complete **Part C** (see separate Form) – if parts A and B indicate you need to undertake a Full Impact Assessment. This enables you to fully consider all the evidence that is available (including engagement with the people affected by your document or proposals) to tell you whether your document or proposal will affect people differently. It also gives you the opportunity to consider what changes you may need to make to eliminate or mitigate any adverse or negative impact you have identified.

Remember that these forms may be subject to external scrutiny e.g. under a Freedom of Information request.

Once completed, the EqIA Forms should accompany your document or proposal when it is submitted to the appropriate body for approval.

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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?	**Levels of Enhanced Care for Adult Inpatients POLICY**
2.	Provide a brief description, including the aims and objectives of what you are assessing.	Betsi Cadwaladr University Health Board is committed to improving standards of care by the delivery of a service that is of the highest quality possible. This includes ensuring there is a system of monitoring in place applicable to patient need and responsive to alterations in risk, whilst also cost effective and efficient. Nurse staffing ratios/establishments have traditionally reflected bed occupancy not dependency or acuity of patients. Levels of observation may have an impact on the standard staffing and skill mix numbers and require extra controls, reporting and additional staffing
3.	Who is responsible for the document/work you are assessing – i.e. who has the authority to agree/approve any changes you identify are necessary?	Associate Nurse Director of Quality Improvement Secondary Care Nurse Director
4.	Is the Policy related to, or influenced by, other Policies/areas of work?	BCUHB Falls Care Pathway and related guidance Mental Capacity Act 2005 and Code of Practice Mental Health Act 1983, Mental Health Act 2007 and Code of Practice Health and Safety at Work etc. Act 1974 Nurse Staffing Levels (Wales) Act 2016 Mental Health (Wales) Measure 2010 National Institute of Clinical Excellence, NICE publication ‘Safe Staffing for nursing in adult inpatient wards in acute hospitals’ (2014) Missing persons procedure Deprivation of Liberty Safeguards Self-harm guidance

5.	Who are the key Stakeholders i.e. who will be affected by your document or proposals?	Patients Clients Staff Visitors
6.	What might help/hinder the success of whatever you are doing, for example communication, training etc?	Inability to release staff to receive adequate training leading to insufficiently prepared staff. Inadequate and insufficient resource material provided to staff A training and resource pack has been prepared for staff in all inpatient adult settings that sets out key components of the policy to include risk assessment, planning, implementation and evaluation of the care put in place. A series of drop in sessions will be arranged for key trainers, as well as communicated via Health Board sources and key meetings

Form 2: Considering the potential impact of your document, proposals etc in relation to equality and human rights

Characteristic or other factor to be considered	Potential Impact by Group. Is it:-		Please detail here, for each characteristic listed on the left:- (1) any Reports, Statistics, Websites, links etc. that are relevant to your document/proposal and have been used to inform your assessment; and/or (2) any information gained during engagement with service users or staff; and/or any other information that has informed your assessment of Potential Impact. Previous incidents have informed the need to ensure adequate risk assessment of patients requiring additional observation in the prevention of incidents e.g. falls/deterioration of vital signs or patients suffering dementia
	Positive (+) Negative (-) Neutral (**N**) No Impact/Not applicable (**N/a**)	High Medium or Low	
Age	+	High	This will be used for all patients requiring additional observation. Older people are more likely to need close observation if risk of falls, suffer dementia.
Disability	+	M	Patients with learning disabilities often need close supervision. Also from a mental health perspective, patients will be positively supported where there is potential risk of self-harm.
Gender Reassignment	+	M	The proportion of people with dementia who identify as LGBTQ is increasing because, more people are identifying as such and as the ageing population increases we are and will continue to see a larger number of LGBT people with dementia The Equality Act 2010, which includes Gender reassignment. BCUHB document, 'Understanding, Reflecting and Responding to Transgender, Issues in Dementia Care – a Reflective Model for Health Care Staff
Marriage & Civil Partnership	No impact		This will have no impact on marriage or civil partnership
Pregnancy & Maternity	+	M	Will positively support patients who potentially are physiologically compromised, this includes patients who have an acute illness whilst pregnant and in the post- partum phase
Race / Ethnicity	No impact		This will have no impact on race or ethnicity
Religion or Belief	No impact		This will have no impact on religion or belief
Sex	+	M	A larger proportion of women form part of the aging population than males

Sexual Orientation	+	M	As above. The proportion of people with dementia who identify as LGBTQ is increasing because, more people are identifying as such and as the ageing population increases we are and will continue to see a larger number of LGBT people with dementia . More positive on women than men
Welsh Language	+	H	Patient information leaflet will be available in welsh in accordance with statutory duties under the Welsh Language (Wales) Measure 2011
Human Rights	+	H	Closer observation will protect dignity and respect the rights of patients under the Human Rights Act 1998. In particular, Article 2, Right to life (by reducing the occurrence of life threatening falls), Article 3, Freedom from inhuman or degrading treatment and Article 5, Right to liberty and security (via the appropriate assessment and approval for DoLs)

Guidance on completing Form 2: For each of the characteristics listed, and considering the aims and objectives you detailed in Q2 on Form 1, you need to consider whether your document or proposal likely to affect people differently, and if so, will this be in a positive or negative way? For example, you need to decide:

- will it affect men and women differently?
- will it affect disabled and non-disabled people differently?
- will it affect people in different age groups differently? - and so on covering all the protected characteristics.

Use your judgement to indicate the scale of any impact identified. The factors used to determine an overall assessment for each characteristic should include consideration of scale and proportionality as well as potential impact.

Form 3: Assessing Impact Against the General Equality Duty

As a public sector organisation, we are bound by the three elements of the "General Duty". This means that we need to consider whether (if relevant) the policy or proposal will affect our ability to:- • Eliminate unlawful discrimination, harassment and victimisation; • Advance equality of opportunity; and • Foster good relations between different groups	
1. Describe here (if relevant) how you are ensuring your policy or proposal does not unlawfully discriminate, harass or victimise	The document does not treat individuals any differently regardless of their sex, religious beliefs, disability etc.
2. Describe here how your policy or proposal could better advance equality of opportunity (if relevant)	This policy ensures consideration of individual need, dependency or acuity of patients to inform nurse-staffing ratios rather than bed occupancy and therefore may advance equality

	of opportunity for some protected characteristic groups' e.g. older people, disabled people and for patients with cognitive impairment
3. Describe here how your policy or proposal might be used to foster good relations between different groups (if relevant)	Encourage and support inter-relationship between the multidisciplinary team in the assessment and management of patients requiring enhanced observation. Will also foster a culture of developing therapeutic relationship with family members in the support of the patient/client

Part B:

Form 4 (i): Outcome Report

Organisation:	BETSI CADWALADR UNIVERSITY HEALTH BOARD

1. What is being assessed? (Copy from Form 1)	**Levels of Enhanced Care for Adult Inpatients POLICY**

2. Brief Aims and Objectives: (Copy from Form 1)	Betsi Cadwaladr University Health Board is committed to improving standards of care by the delivery of a service that is of the highest quality possible. This includes ensuring there is a system of monitoring in place applicable to patient need and responsive to alterations in risk, whilst also cost effective and efficient. Nurse staffing ratios/establishments have traditionally reflected bed occupancy not dependency or acuity of patients. Levels of observation may have an impact on the standard staffing and skill mix numbers and require extra controls, reporting and additional staffing

3a. Could the impact of your decision/policy be discriminatory under equality legislation?	Yes	No X
3b. Could any of the protected groups be negatively affected?	Yes	No X
3c. Is your decision or policy of high significance?	Yes	No X

4. Did the decision scoring on Form 3, coupled with your answers to the 3 questions above indicate that you need to proceed to a Full Impact Assessment?	Yes	No X
	Record here the reason(s) for your decision i.e. what did Forms 2 & 3 indicate in terms of positive and negative impact for each characteristic? The document does not treat individuals any differently regardless of their sex, religious beliefs, disability etc. and will have a positive effect	

5. If you answered 'no' above, are there any issues to be addressed e.g. mitigating any identified minor negative impact?	Yes	X
	Record Details:	

6. Are monitoring arrangements in place so that you can measure what actually happens after you implement your document or proposal?	Yes X	No
	How is it being monitored?	Policy re-launch across the Health Board communicated to senior staff and ward managers to ensure risk assessments are completed appropriately Assurance will be sought regarding the utilisation of the policy in line with safe staffing bill and maintaining effective rostering Part of Secondary Care Audit Programme
	Who is responsible?	Site Directors of Nursing
	What information is being used?	E.g. will you be using existing reports/data or do you need to gather your own information? Datix reports and complaints
	When will the EqIA be reviewed? (Usually the same date the policy is reviewed)	Same time as Document review

7. Where will your decision or policy be forwarded for approval?	Professional Advisory Group, BCU Quality & Safety Group and the Quality, Safety & Experience Committee

8. Describe here what engagement you have undertaken with stakeholders including staff and service users to help inform the assessment	Pan BCU Task and Finish Group, which included Governance Lead Nurses and Quality Improvement Associate Nurse Director. Tabled at Site Directors of Nursing meeting and Professional Advisory Group

9. Names of all parties involved in undertaking this Equality Impact Assessment:	Name	Title/Role
	Julie Smith	Associate Nurse Director - Quality Improvement. Secondary Care. BCUHB
	Tracey Harris	Head of Nursing Governance and Quality (East)
Please Note: The Action Plan below forms an integral part of this Outcome Report		

Form 4 (ii): Action Plan
This template details any actions that are planned following the completion of EqIA including those aimed at reducing or eliminating the effects of potential or actual negative impact identified.

	Proposed Actions	Who is responsible for this action?	When will this be done by?
1. If the assessment indicates significant potential negative impact such that you cannot proceed, please give reasons and any alternative action(s) agreed:	N/A		
2. What changes are you proposing to make to your document or proposal as a result of the EqIA?	None.		
3a. Where negative impacts on certain groups have been identified, what actions are you taking or are proposed to mitigate these impacts? Are these already in place?	N/A		
3b. Where negative impacts on certain groups have been identified, and you are proceeding without mitigating them, describe here why you believe this is justified.	N/A		
4. Provide details of any actions taken or planned to advance equality of opportunity as a result of this assessment.	N/A		

Quality, Safety & Experience Committee 19.11.19	GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board *To improve health and provide excellent care*

Advisory Group Chair's Report

Name of Advisory Group:	Quality and Safety Group

Meeting date:	11th September 2019

Name of Chair:	Deborah Carter, Associate Director of Quality Assurance

Responsible Director:	Deborah Carter, Associate Director of Quality Assurance

Summary of key items discussed:	**<u>Ward Accreditation (WA) / Hospital Acquired Pressure Ulcers/ Falls collaborative update – Deborah Carter</u>** To date 60+ wards have been visited, validation criteria and overview is detailed in the report. Common themes are being identified and mainly already known. Celebration event is scheduled to take place and aims to provide share feedback/learning and examples of positive outcomes. Going forward looking to refresh the standards in 2020, going for gold roadshows have commenced attending wards/areas. ED – working up framework to start doing WA visits in the departments, for which the delivery unit have agreed to support. Update on HAPU and Fall collaboratives demonstrating improvements in areas of focus. **<u>Controlled Drug Local Intelligence Network annual report</u>** The Controlled Drugs Local Intelligence Network (CD LIN) undertakes and provides oversight, scrutiny and a governance function in relation to the safe management of Controlled Drugs across North Wales. The annual report summarises the key work undertaken during 2018/19 and highlights the following national risks associated with CD use for BCU, namely: • Opioid medicine procurement shortages

	• Prescription governance - CD prescriptions not including prescriber identifiable information. National action needed to allow tracking of individual CD prescribing practice. Pharmacy team are working on remedial actions and will provide further updates. **<u>Mental Health</u>** Steve Forsyth informed the group that the following positive items are happening within the division: - Suicide awareness week – offered free staff training - Nurse staffing awards – 2 finalists - Proposal for WG serious untoward incidents managements been put forward with positive feedback Updated the group on the ongoing work in line with staffing optimisation plan
Key advice / feedback for the QSE:	**Risks to highlight:** <u>West</u> The findings into the information governance incident within children's identified there was no harm caused but significant learning. The full report will be brought to the October meeting <u>Childrens services</u> Key risks include ability to meet the mental health measure (MHM) treatment targets and the Neurodevelopment waiting lists targets which will be mitigated with new WG monies. YG medical staffing is an issue but has been mitigated with a recruitment drive and additional resource. <u>Central –</u> Primary care recruitment of GPs and clinical staff is still an issue with a number of mitigations being put in place – **score 15** The issue relating to patients with E-coli bacteraemia, many of which are presenting at A&E. These could represent revolving door patients as we still see a tendency on wards to over diagnose UTI in the elderly based on dipsticks. Further work being undertaken Estates issues have the potential to not support the bioburden reduction and walkabout assessments of the sites are taking place. <u>HMP Berwyn update</u> Notice to be starting in Dec 2019 to include men on remand, which is a risk for the Health board in relation to this group on a number of levels. There are issues relating to facilities to support this

	group of men and discussions are ongoing to manage. <u>East</u> Lack of funded pharmacy resource for MH in Wrexham – **score 25 – being reviewed as previous mitigations had been in place** <u>Womens – Fiona Giraud</u> National data shows women's as an outlier for post-partum haemorrhages. This relates to BCU practice of measuring actual blood loss as opposed to estimating blood loss for all births which is different to other HBs, now received their information and will responding with additional questions. <u>Secondary Care</u> Ligature risk incidents in Wrexham, all sites asked to review with estates – the enhanced care policy has been approved through PAG, and will be launched next month, which will support the work Oncology service - significant pressure due to inability to recruit. Working through ways to mitigate for which KC talked through some options. – **Score 20.** This is being added to the NWCS risk register <u>Mental Health</u> There is long term sickness absence within the West triumvirate Head of ops and interim posts – **score 16** Continued scrutiny over Cefni in relation to safeguarding and the improvement plan going through safeguarding and NWP – **score 15** Most areas raised that there have been delays in recruitment due to internal scrutiny process with posts being put on hold or rejected, which will be raised as a risk next month. Adrian Thomas discussed the need to complete as much detail as possible on the applications to support the process
Special Measures Improvement Framework Theme/Expectation addressed	Leadership and Governance
Planned business for the next meeting:	To be determined from cycle of business

Date of next meeting:	Friday 4th October 2019

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

Quality, Safety & Experience Committee 19.11.19	GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board *To improve health and provide excellent care*

Advisory Group Chair's Report

Name of Advisory Group:	Quality and Safety Group (QSG)

Meeting date:	4th October 2019

Name of Chair:	Deborah Carter, Associate Director of Quality Assurance

Responsible Director:	Deborah Carter, Associate Director of Quality Assurance

Summary of key items discussed:	**Neonatal death review report update** Fiona Giraud gave an overview that Public Health Wales were asked to complete a review with executive support, the start had been delayed due to completion of data collection but has now been completed, and the draft report will be presented to the Women's QSG in November, then onward to QSG. **Root cause analysis report – data protection incident** The analysis was completed to investigate information governance breaches related to record keeping and missing/mislaid child health records in the West by one member of staff. Report sets out actions to implement improvements to prevent re-occurrence of breaches. Investigation identified poor ways of tracking records and issues with filing, for which a standard operating procedure has been developed and staff being given information governance training. As improvements were being put in place they were also testing if any harm was caused to children or families, with letters being issued to 290 families to ask if families had any concerns? From these there were 21 enquiries, 20 of which were from different services within area team, and only 1 related to appointment to child within community team (this did not result in any harm). Positively a lot of the children involved were also using other

	services, so issues were picked up during other appointments. Incident was reported to the ICO office and support given by them, the issued 27 questions requesting more detail. Responses were provided from the investigation with no additional feedback being received. There may yet be potential for the Health Board to receive a financial penalty or an enforcement notice. DC stressed concern about the poor Datix compliance and reporting of this matter, as well as the root cause outcome, she advised that the incident team would provide training and support.
Key advice / feedback for the QSE:	**Risks to highlight:** **<u>Secondary Care</u>** • Haematology – extensive work has identified a locum being identified to fill the post, who has an interest in haemophilia. There are also issues with storage of stem cells in West, exploring an outside storage option, the team are working on plan for how this would work. There is also the potential for out-sourced work to be brought back from Liverpool = **score 20** • Emergency Department records in WMH – the Zylab system that contains scanned ED attendance cards is currently inaccessible from 2009-2019. Risk assessment completed and ongoing discussion with the company regarding retrieval and ongoing maintenance, information can be accessed through other mechanisms although it may not be as detailed. The risk has been assessed as minimal with no incidents being reported. **<u>West – Chris Lynes</u>** Escalated the risk in relation to the delays in recruitment resulting from the new internal processes of scrutiny, which will be added to risk register - score of 16. Main impact is resulting in there being very limited booking clerks to support clinics for Rheumatology and sexual health and causing clinics to be cancelled, they are currently looking to move staff around sites and have been asked to do an admin review in the meantime. **<u>Womens</u>** • Clinical Outcome Measures published in services contracted by BCUHB and provided at Countess of Chester Hospital – score 16. Work has commenced to review contract and approach being developed

	• Lack of scan capacity to meet national recommendations for reduced fetal movements and growth restriction in babies (GAP Programme) – score 16 • Potential for delayed Gynaecology care and referral to treatment timeframes will not be met - score 9 **Estates & Facilities** • HASCAS rec 11 – assessments of the environment and needed maintenance has taken place and the results are going to be reported to exec team next week **Mental Health** • Heddfan doors – issue has now been going on for nearly a year with a high number of associated risks being identified, patients have been moved out of area and the bed capacity reduced, solution identified and capital ring fenced. Issue was found to be with a key component not included in the original fit and now being fitted on the decommissioned doors for tests, with a business continuity plan being followed– **score 15** **Children** • Measles – increasing, and there are low levels of vaccination available currently. Being reviewed urgently • Consultation of proposed changes to acute nursing rosters has now ended with feedback from staff being collated and submitted, a number of staff have raised concerns about the changes.
Special Measures Improvement Framework Theme/Expectation addressed	Leadership and governance
Planned business for the next meeting:	To be determined from cycle of business
Date of next meeting:	Friday 8th November 2019

Quality, Safety & Experience Committee **19.11.19**	GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board ***To improve health and provide excellent care***

Report Title:	Progress report of Recommendations arising from HASCAS independent investigation and Ockenden governance review
Report Author:	Claire Brennan, Head of Office, Executive Nurse Director
Responsible Director:	Mrs Deborah Carter, Associate Director of Quality Assurance and Interim Director of Operations
Public or In Committee	Public
Purpose of Report:	The paper provides the progress update against the recommendations arising from both the HASCAS independent investigation and the Ockenden governance review
Approval / Scrutiny Route Prior to Presentation:	HASCAS & Ockenden Improvement Group
Governance issues / risks:	Additional resources required have been identified to support 3 of recommendations in order to progress the work further to deliver improvements and fully address the recommendations.
Financial Implications:	Executive Team have agreed the funding for the required additional posts to support progress of the relevant recommendations.
Recommendation:	To note the progress against the recommendations to date

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

4.To work in partnership to support people – individuals, families, carer's, communities - to achieve their own well-being	√	4.Putting resources into preventing problems occurring or getting worse	√
5.To improve the safety and quality of all services	√	5.Considering impact on all well-being goals together and on other bodies	√
6.To respect people and their dignity	√		
7.To listen to people and learn from their experiences	√		
Special Measures Improvement Framework Theme/Expectation addressed by this paper Governance & Leadership Mental Health Services			
Equality Impact Assessment *n/a*			

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

Executive Summary

HASCAS & Ockenden Recommendations status

The Quality, Safety & Experience Committee meeting on 24th September received a report on the progress of the HASCAS & Ockenden recommendations, the attached report is an updated version to reflect progress where this has been made during this period between meetings.

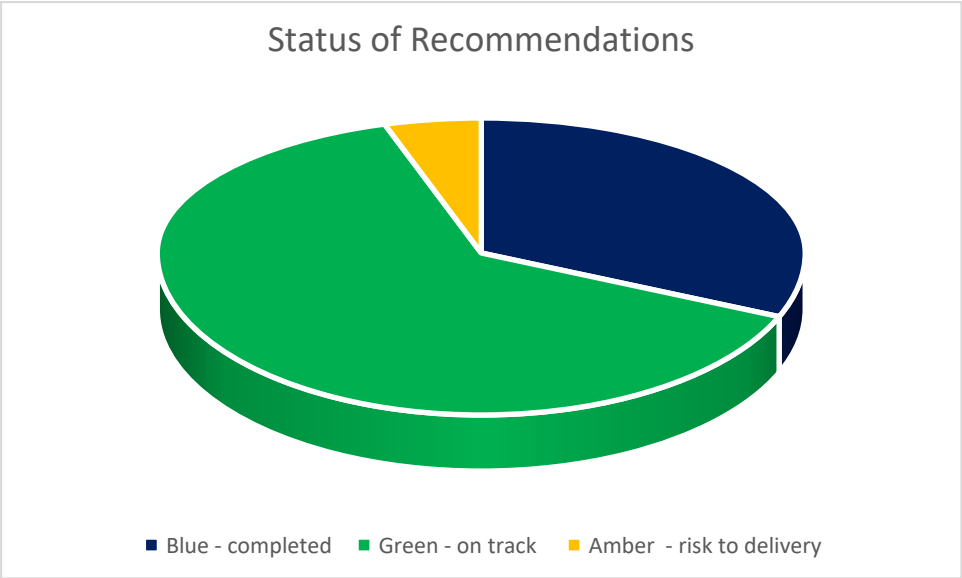
A meeting was held on 11th November between Director of Operations / Associate Director of Quality Assurance and Head of Office for Executive Nurse Director with Independent Members Mrs L Reid and Mr J Cunliffe to reflect on the format of the current report. The requirement for a more concise and clear reporting template was discussed to provide details of the evidence and assurance from actions undertaken, which had subsequently led to recommendations being closed. There was also acknowledgement for the need to clearly identify where recommendations were closed in terms of addressing the recommendation but that ongoing monitoring is undertaken by a relevant working group.

The status of the total 35 recommendations for both HASCAS & Ockenden is detailed below;

- 22 are reporting green, as on track to achieve delivery, some of these recommendations are almost due to complete and any that are proposed for closure will be formally reviewed at the Improvement Group meeting on 18th November and shared with Stakeholder Group members;
- 2 are reporting amber, where work is progressing but some additional focus or support is required to address some challenges that is impacting on timely progress;
- 11 recommendations have now been completed; these are relation to;
  - HASCAS 3: Care Homes & Service Integration
  - HASCAS 4: Safeguarding training
  - HASCAS 5: Safeguarding Informatics & Documentation
  - HASCAS 6: Safeguarding Policies & Procedures
  - HASCAS 7: Tracking of Adults at Risk across NW
  - HASCAS 13: Restrictive Practice Guidance.
  - Ockenden 2d: Recruitment of the second Consultant Nurse for Dementia
  - Ockenden 4b & 4c: Staff Surveys
  - Ockenden 10: Reviewing External Reviews
  - Ockenden 14: Board Development and prescribed disengagement.

As work continues to progress, further recommendations will progress to full implementation / closure over the next month, which will be formally signed off at the Improvement Group meeting on 18th November. Stakeholders will continue to undertake tests of assurance of the actions that are confirmed as having been implemented.

Graph 1 shows the status of the recommendations to date.



Graph 1

Improvement Group

The Improvement Group continues to meet bi-monthly to monitor progress and scrutinise any risks to delivery and mitigating actions. The last meeting was held on Monday 16th September, chaired by the Deputy Chief Executive, however, the meeting was not quorate in respect of the core membership. The meeting received the monthly highlight reports and discussions took place with the operational leads present; Ockenden recommendation 2 (Integrated Reporting) was proposed as being fully implemented but as the group was not quorate this will be formally signed off at the next Improvement Group meeting on 18th November. It is also anticipated that a number of other recommendations will also be considered for sign off at the November meeting.

For recommendations that are signed off as fully implemented, operational leads have confirmed that activity continues to embed and monitor the work implemented in response to the recommendations and report any further updates or challenges if they arise.

In addition to the bi-monthly Improvement Group meetings, additional one to one meetings have been established between the operational leads and the Acting Executive Director of Nursing. These meetings enable a more in-depth review of progress and issues of each recommendation; to identify any areas that are not progressing at the anticipated pace and agree required actions and any support to address barriers.

Stakeholder Group

The Stakeholder Group has met 6 times since its inception in October 2018. The most recent meeting was held on 29th October.

A number of stakeholders continue to be in contact with the operational leads for the recommendations they expressed an interest to support. The following are examples

of some of the activities that stakeholder members have actively engaged in, relating to the work of recommendations as follows;

- In relation to safeguarding activity, stakeholder members were invited to engage with a Level 3 Mental Health & Learning Disability (MHLD) training event and asked to engage with the process, attend, and provide constructive comments and feedback in relation to the event and package content. Stakeholder member Mr J Gallanders provided a report detailing feedback from the training, which set out some key issues with regards to safeguarding training for both BCUHB staff and agency / bank staff. This report was received by the Stakeholder Group meeting and presented by Mr Gallanders and the Associate Director of Safeguarding Michelle Denwood.
- Stakeholder member invited to engage with the revision of the Deprivation of Liberty Safeguards (DoLS) structure, consultation and review.
- Stakeholder members were invited and included on interview panels
- Some stakeholder Group members have undertaken visits to establishments, including Mental Health units and also end of life care facilities on Bryn Hesketh and Cefni. A second and more recent visit to Bryn Hesketh by two stakeholder members commended the photo wall within the end of life suite on the unit, which was donated by a staff member with an interest in photography, and printed onto washable vinyl with the support of third sector organisation. Stakeholders described the artwork as fantastic, better than they could have imagined and which has transformed the unit.
- A member attended the first day of the 5 day aggression training course with the Positive Intervention and Clinical Support Services team.

Operational leads have formally acknowledged the valuable contribution from the engagement and involvement that stakeholders are making in supporting the progress of actions.

To date, the Stakeholder Group has received presentations to highlight the work being undertaken to progress actions in the following areas;

- End of Life Care;
- Dementia Care in Emergency Departments;
- Restrictive Practice Guidance
- Neurological conditions (pathways)
- Estates Older Person's Mental Health (OPMH) including anti-ligature and Ablett Redevelopment
- Draft Integrated pathway supporting access to health care for patients with a diagnosis of dementia, from referral to discharge

Stakeholder Group members have previously agreed to identify future topics for presentation that they wished to receive going forward.

HASCAS & Ockenden Recommendations – update report for Quality, Safety & Experience Committee 19th November 2019

Recommendation	Current position	Progress update	Risks
HASCAS 1: Integrated Care Pathways Operational Lead: Reena Cartmell Associate Director of Nursing *'An integrated service review is required to map the needs of the older adult and those with dementia across north Wales. This review needs to involve all stakeholders (from the statutory, independent and voluntary sectors) and those with performance responsibilities. The review should include all care and treatment settings (not just those) confined to mental health and older adult services) in order to ensure that all interventions are integrated and that patients, service users and their families do not encounter service barriers that prevent them from receiving access to the care, treatment and support that they need'.* **Ockenden 1: Integrated Service Model for Older People and those with Dementia** Operational Lead: Reena Cartmell Associate Director of Nursing *"The patient pathway for service users of older people's mental health was fragmented from the 'birth' of BCUHB in 2009 and remains fragmented today from the perspective of many service users, service user representatives and carers (as of the end of 2017).* *As of the end of 2017 there has been insufficient evidence seen by the Ockenden review team that the patient pathway and the systems, structures and processes of governance underpinning service provision for vulnerable older people at BCUHB is improving. The current service model remains fragmented with multiple service providers across health, social care, the voluntary sector and other independent sectors.* *There will be the need for extensive multi-agency working between BCUHB and a range of partners with continuing oversight by the BCUHB Board and Welsh Government as this work progresses".* **Ockenden 12: Older Persons Long Term Clinical Strategy** Operational Lead: Reena Cartmell Associate Director of Nursing *Develop a clear plan for the clinical services of older people to improve training across the workforce, set*		It is important to note that BCUHB's response to the HASCAS and Ockenden recommendations and all clinical actions will support the wider strategic programmes for older persons, such as the North Wales Regional Plan (Area Plan) and the Integrated Care Fund (ICF) revenue plan. The HASCAS and Ockenden recommendations will therefore inform wider work streams under the North Wales Regional Partnership Board (NWRPB) and the North Wales Social Care and Wellbeing Services Improvement Collaborative, particularly dovetailing with the Dementia Strategy. Integrated care pathways affects all aspects of service delivery, the work programme ahead is therefore interweaved into other recommendations such as HASCAS 2 (Dementia Strategy), HASCAS 3 (Integrated Care Homes). In addition the direction of travel for BCUHB is to request via Quality & Safety Group (QSG) that the Integrated Pathways for Older People (IPOPs) framework be endorsed to inform the wider clinical strategy for the Health Board. ***Logic Models***: Three logic models have been developed to demonstrate the outcomes, measurable outputs and a list of activities required to achieve the overall objectives of the HASCAS and Ockenden recommendations (HASCAS 1, Ockenden 1 and Ockenden 12). Former implementation plans have been translated into the logic models, and are now used as our baseline for delivery. In total, there are eight specific actions to be achieved in this combined programme of work for the older person, these include: 1. An Integrated Service Gap Analysis 2. Defined Integrated CRT Care Pathways 3. BCUHB Care Pathways for older persons and Dementia *4. A North Wales Integrated OPMH Improvement Hub* *5. An Annual Audit and Reporting Schedule* *6. BCUHB wide set of clinical standards and procedures* 7. A BCUHB training programme for our workforce *8. Single Care Home Action Plan* Actions 4, 5, 6 and 8 highlighted above in italics are all completed. • ***Action 1: Integrated Service Gap Analysis***: A meeting took place in July 2019 with the Director of Primary Care and Associate Director of Nursing to agree a way forward for the development of an older person's service gap analysis through the support and engagement of Area Directors. Since this approach was agreed, the gap analysis methodology required presentation across the region and dates set within each of the Areas/ Divisions quality meetings. A model and framework of the gap analysis has been developed and shared with all Area Nurse Directors. Each Area is expected to arrange a partnership event to undertake the analysis of their older person's services identifying what works well and not so well following the IPOPs. This will attempt to identify opportunities for improvement and further integration. Feedback is due in December 2019. A representative from WG presented IPOPs to BCUHB on 18th October 2019 and offered to deliver IPOPs training in early 2020. The gap analysis should complement this future framework but ultimately is required to inform BCUHBs wider clinical strategy. • ***Action 2: Integrated Community Resource Teams (CRTs)***: As part of the evolving service model of community resource teams, BCUHB is looking to define the care pathways for older persons to join up primary, secondary and mental health care services. Care Homes are also an integral part of this work as monitored under the Care Inspectorate Wales (CIW) / Healthcare Inspectorate Wales (HIW) Action Plan (November, 2018) questions 4 and 5: "*The CRT work stream must incorporate access*	Timescale to achieve review of a broad range of services - Joint and clear action plan including milestones and timelines to be developed. Progress regularly reported to Improvement Group Workforce capacity and resource for transformation (reducing duplication / conflicting agendas) - Ensure joint responsibility of translating strategy into action via an improvement sub-group and map out all forums/groups involved. Sustainability and differing standards of quality and safety of services (across health, social care, third sector and commissioned services) - Design a set of agreed principles in partnership along with quality and safety standards to inform the model of care and strategy Awaiting outcome of regional service gap analysis for the NW Integrated Service Model. • Work taking place with the RPB to develop the wider service model based on the IPOPs approach, which will include the findings of the gap analysis.

Blue = Fully implemented Green = on track to deliver Amber = risk to delivery

Recommendation	Current position	Progress update	Risks
clinical standards and uniformity with a solid foundation of evidenced based policies and procedures		*for care homes. This will be achieved by developing a partnership approach i.e. a care pathway between CRT's and care homes whereby mutual goals and objectives are agreed in order to improve the patient experience and promote seamless services*". This specific action has been subsumed into BCUHB's newly launched 'Single Care Home Action Plan' and area teams are responsible for the development and delivery of these pathways, with feedback due in December 2019. ICF work is also underway to develop CRTs and service specifications for primary and secondary care. The OPMH Quality and Workforce Group are also addressing this through their forum. • ***Action 3: BCUHB Pathways:*** The main care pathways under development include: – ***'Meeting the Physical Health Needs of People Admitted to an Older Person Mental Health (OPMH) Ward'.*** The aim is to integrate clinical pathways between physical health and OPMH. An improvement programme of work has developed with support from consultant psychiatry and medical staff to review and revise the clinical pathways between Emergency Department (ED) and Care of the Elderly (COTE). Outcome measures are being developed in order to help measure service change. The Improvement plan will also be shared with the OPMH Quality and Workforce Group for support, spread and sustainability purposes. The proposed pathway above was approved at the QSG meeting held on 19th September 2019 and was operationalised from 1st October 2019. – ***End of Life (EoL) Pathway***; meetings held between Improvement Lead and Head of Nursing for Palliative Care in May 2019. Work has been ongoing to review and refine end of life pathways across primary and secondary care, including care homes. The EoL framework for OPMH wards was approved at the QSG meeting held on 19th September 2019 and operational from 1st October 2019. – ***Emergency Department (ED), Acute Medical Unit (AMU), Surgical Assessment Unit (SAU) pathways*** under early discussions; meeting held between Improvement Lead and Head of Nursing for ED. Significant amounts of work are progressing in relation to admissions to hospitals discharge processes. Task and finish groups are established in each locality. The West Area team have drafted version 1 of an "*Integrated Pathway Supporting Access to Health Care for patients with a diagnosis of Dementia from referral to discharge*". Consultation of the draft document is underway with teams across each area for further input and standardisation. The lead matron for this pathway presented the draft document to the Stakeholder Group on 29th October 2019 for feedback and is also sharing with the BCUHB Dementia Strategy Group for wider consultation prior to presentation at QSG. – ***Advanced Nurse Practitioners (ANP):*** To support the above development; clinical teams from Care of the Elderly Services and OPMH have met to determine the service changes required to further support OPMH patients. This has resulted in the identification and support for additional ward based clinical sessions for physical assessment by appointing Advanced Nurse Practitioners (ANP) to assess the physical health needs of older persons on mental health wards and the development of an integrated pathway for rapid response, however, challenges have been experienced in recruiting to these posts. • ***Action 4: An OPMH Improvement Hub***: This year (2019), the mental health division have successfully established a 'Quality and Workforce' group that addresses service improvements for the OPMH patient group. HASCAS recommendation 3 is just one example of how the group have embraced the 'Single Care Home Action Plan' and are in the process of addressing action no.8 which is to map out and clearly define the referral process for older persons living in care homes who require mental health	Challenges experienced in recruiting to ANP position • Agreement confirmed to increase the hours / sessions for advertisement in addition to the possibility of a job share; to attract a suitable candidate

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		services' support, across all six local authority regions in North Wales. This action is completed. • ***Action 5: Audit and Reporting Schedule***: A mapping exercise of current mandatory audits that relate to older persons' services across BCUHB has taken place. However, in order to address HASCAS recommendation 1 i.e. '*an annual audit and reporting schedule for older persons and those with dementia'* further consideration has been required. The outputs expected, as seen across all logic models relating to HASCAS and Ockenden (recommendations 1, 2 & 3), provides a future benchmark in terms of which internal audits are necessary. In preparation for this, the Improvement Lead for HASCAS recommendations 1 & 3 is in the process of designing an audit in relation to safe discharges of older persons into care home settings. This relates to HASCAS recommendation 3 but dovetails with HASCAS recommendation 1 due to the care pathways that are under development across the service. The audit will commence in January 2020 with Care Forum Wales to capture qualitative data from a service users / carers' perspective. The audit will also incorporate lessons learnt from the Welsh Audit Office Report 2017 that reviewed BCUHB's discharge processes. We are pleased to further report that following discussions with the BCUHB Audit Team, 'older persons services' will now feature systematically within the health boards 'Annual Audit Cycle'. One audit per annum will be supported by corporate nursing and these will be based on the Quality Standards concerning care of the older person as published by NICE, seven of which (quality standards) will be relaunched across BCUHB in early 2020. • ***Action 6: Clinical Standards*** BCUHB's Dementia Nurse Consultants are currently mapping out all clinical standards / policies in relation to Dementia care. The clinical standards and procedures for the Older Person will be developed via the IPOPs work programme (Gap Analysis). In addition, seven Quality Standards relating to older persons, published by NICE will be relaunched in early 2020 across BCUHB to promote older persons standards of care, quality and consistency. These include: i) Learning disability: care and support of people growing older (QS187) ii) Dementia (QS184) iii) Falls in older people (QS86) iv) Mental wellbeing and independence for older people (QS137) v) Mental Wellbeing in over 65s: Occupational Therapy and physical activity intervention (PH16) vi) Home care for older people (QS123) vii) Mental wellbeing of older people in care homes (QS50) • **Action 7) Training Programme**: Dementia training features within BCUHB's Clinical Dementia Strategy and training to date is operationalised effectively across the organisation. BCUHB are also working with Bangor University to develop a model of 'scholars' to train the workforce on the health related needs of older persons. This is an exciting pilot project that the improvement lead is progressing which will require endorsement by QSG and the executive board. Glyndwr University are also in the process of mapping training opportunities for our clinical staff with an interest in older persons. The above plans will also compliment and include BCUHB's wider strategies in relation to 'Living Healthier, Staying Well', a 'Healthier Wales' and 'North Wales Dementia Strategy'.	

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		• **Action 8) A Single Care Home Action Plan**: A 4 hour 'getting to know you' event with care home and clinical health board staff was held on the 12th, 13th and 14th of March 2019 across West, Central and East areas. The CEO of Care Forum Wales supported the events. Report published internally and shared with care home attendees and CIW. The action plan was developed as a direct response to, and includes recommendations from the following: – CIW/HIW Review of healthcare support provided by Betsi Cadwaladr Health Board for older people living in care homes in North Wales (November 2018). – Independent Investigation into the Care and Treatment Provided on Tawel Fan Ward: a Lessons for Learning Report, HASCAS (May 2018), (Recommendation 3). – Review of the Governance Arrangements relating to the care of patients on Tawel Fan ward prior to its closure on 20th December 2013 and governance arrangements in Older People's Mental Health at BCUHB from December 2013 to the current time, Donna Ockenden (June 2018). – BCUHB's Living Healthier, Staying Well Draft Framework for Care Closer to Home. – North Wales Social Care and Wellbeing Service Improvement Collaborative, Market Shaping Statement; Care Homes for Older People in North Wales (2018). – BCUHB Care Home Partnership Event (March 2019). The implementation of the action plan will be monitored with local area teams responsible for updating the action plans, providing evidence of achievements that are consistent to local needs. Each action will evidence the application of stakeholder's engagement / service user involvement in the design of all action plans. Key practice issues that relate to the workforce. Timescales for completion. Lead person(s) for management and delivery and Quality Impact Assessments. Feedback is due in December 2019, to date all 23 actions are progressing well, many are completed, and others are in progress. CIW (2018) actions have been reported through corporate services in readiness for QSG in December 2019. **In Summary:** The findings of the older person's gap analysis, along with the bullet points listed above, will help inform the direction and design of both the integrated service model and clinical strategy for older persons. Whilst the aforementioned and significant work is underway, the improvement lead will continue to engage with stakeholders to consult on the various pathways, with the inclusion of the patient experience service. Engagement to date indicates that 'care outcomes' are considered central to an integrated service model and so this will feature prominently within the forthcoming safe discharge audit to care homes with nursing.	
HASCAS 2 : Dementia Strategy Operational Lead: Chris Lynes, Area Nurse Director (West) *BCUHB is required to develop a detailed and costed action plan to support the implementation of its Dementia Strategy; the plan should be developed in partnership with the Regional Partnership Board response to the Welsh Government's new Dementia Plan. This work should be undertaken in conjunction with (HASCAS) Recommendation 1. The action plan should incorporate the consequent implications and requirements for all clinical services (not just the mental health directorate) in all care and treatment settings (community, primary and secondary care).*		The NWRPB are developing an integrated North Wales Dementia Strategy for the 6 Local Authorities and BCUHB, setting out joint aims and objectives. A Dementia Strategy Group for North Wales has been established with BCUHB representation. In addition, BCUHB set up its own strategic working group in July 2019 in order to maintain oversight and governance of all Dementia work streams. • ***Logic Model:*** The logic model for HASCAS 2 has been refined with clearer outcomes, measurable outputs and a list of activities required to achieve the overall desired impact. The former implementation plan has therefore been translated into this logic model, and is now used as our baseline. There are seven main outputs to be achieved within the programme of work, these include: 1. A Costed Action Plan for Non-Medical Therapies. *2. A Performance Managed Dementia Strategy Implementation Programme.* *3. BCUHB Dementia Training Programme.*	Timescales pose a risk to delivery in respect of achieving such a broad range of service reviews. - Joint and clear action plans including milestones and timelines will be developed through logic models and KPIs with progress regularly reported to Improvement Group Workforce capacity and resource for transformation (reducing duplication / conflicting agendas). - Ensure joint responsibility of translating strategy into action via an improvement 'working group' and map out all forums/groups involved.

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Ockenden 8: Dementia Strategy *The dementia strategy should be developed to work across all relevant clinical services across BCUHB not just within the MH&LD division. The dementia strategy should incorporate care across home, primary care and secondary care.*		4. *Clearly defined Dementia Care Pathways across community, primary and secondary services.* 5. *Evidence based policies and procedures that set clinical standards in Dementia* 6. *Dementia Governance Framework* 7. *Independent Consultation.* Actions 4, 5, 6 and 8 highlighted above in italics are all completed • ***Action 1: A Costed Action Plan for Non-Medical Therapies***: BCUHB's response to the 'Dementia Therapies Action Plan' has been drafted which outlines the evidence based practice to support the need for additional therapies. A task and finish group has been established and held meetings in June and September to date. A draft plan has now been developed which highlights current resources and proposed staffing with a supportive document attached to highlight the rationale of the various therapy proposals. The plan has been submitted to the finance department to identify costings and a phased 3-year plan is under consideration to demonstrate how the services will be delivered. This may require a new model of care and further work is ongoing in relation to obtaining stakeholder engagement. This action also dovetails with the work of HASCAS recommendation 10 to reduce the use of antipsychotic medication. The therapies task and finish group are due to meet in early November to review the 3-year plan proposals. This work stream has now been subsumed into the BCUHB Clinical Dementia Strategy Group. • ***Action 2: A Performance Managed Dementia Strategy Implementation Programme***: A BCUHB Dementia Strategy Group was established in July 2019 to oversee all health board work streams in relation to Dementia An initial gap analysis has taken place that reviews how the current 'BCUHB Dementia Plan' meets with the WG (2018) Dementia Action Plan for Wales. The group also intend to provide input into the wider regional 'Area Plan' by supporting the development of the NWRPB Dementia Strategy for North Wales. A mapping exercise of all Dementia services across BCUHB has taken place and information shared with the project lead for the North Wales Dementia Strategy on 6th September 2019. A BCUHB Clinical Strategy Group has now been established with agreed Terms of Reference and governance structure. First meeting with members was held on 22nd October 2019. The strategic group has now subsumed all work programmes under the previous HASCAS working group. Handover documents presented 24/10/19. Long-term clinical plan to inform the under early development with five key themes to be addressed by operational groups across BCUHB. • ***Action 3: BCUHB Dementia Training Programme***: BCUHB will continue to train staff as 'dementia friends' champions and actively run sessions to support this. There are now 10 dementia friendly communities across North Wales however it is recognised that this needs to be scaled up. There are a further 9 dementia friendly communities which are working through the foundation criteria to become accredited by the Alzheimer's society. Dementia friends' awareness sessions will also be included in all BCUHB mandatory dementia training. BCUHB will have representation in every dementia supportive community project group. A project plan will be developed to outline the above ambitions with clear measurable outcomes, timescales and a governance structure. Whilst this program of work remains ongoing, BCUHB also intend to assess the capacity and capability of the workforce with strategic and board oversight via the BCUHB Dementia	Sustainability and differing standards of quality and safety of services (across health, social care, third sector and commissioned services). - Design a set of agreed principles in partnership along with quality and safety standards to inform the model of care and strategy. Establishing a strategic group for BCUHB • Realigned to Deputy Director of Nursing (TH) to take forward, working up a TOR, Governance Structure and membership. Long-term clinical plan to inform the programme and its implementation under early development.

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		Strategy Group, which will focus upon sufficient training, recruitment and retention of staffing (dovetailing with Ockenden recommendation 1). The Dementia training and dementia friends needs to be progressed together as mandatory for all new starters. Local areas need to ensure allocated resource available to dedicate to dementia awareness for clinical staff and map their progress utilising the Dementia Support Workers and trainers in all areas, ensuring records on ESR, which will be facilitated by all sites. This has been raised as an issue as the current model is not sustainable, educational resources need to be available to support training in all areas. The progress on distressed behaviours need to be considered in the existing developed program by the BCU IPAC wide team as this is accredited and modular and already has a trust wide remit utilised predominantly in MH (previously known as violence and aggression). The West Area are bench-marking the Alzheimer society work program for dementia assessments in care homes, whereby BCHBU has commissioned beds and from this, key elements will be identified that can be utilised for care homes commissioned to look after BCU patients, develop a model to include basic antipsychotic awareness and the practice development team will deliver this, this will need replication over all areas. Also all care homes must provide a base line of training for staff and should keep records of which patients are known delirium or on antipsychotics. • ***Action 4: Dementia Care Pathways***: Working alongside HASCAS 1 and Ockenden 1, the BCUHB 'Dementia Friendly Organisation Action Plan' will apply evidenced based practice such as the 'King's Fund National Quality Standards' for the Dementia supportive and enabling environments. The action plan is scheduled for completion by end of Q4 2019-20 – further upscaling to be shared across all BCUHB pan wide services to ensure implementation is consistent within both primary and secondary care, such as the mental health liaison service within general hospitals. The 29 recommendations from the Royal College of Psychiatrists National Audit of Dementia in general hospitals is pivotal within 'BCUHB's Dementia Friendly Organisational Plan' and we will continue to adopt the principles of the 'John's Campaign' in all work streams to this effect. In agreement with Bradford University, BCUHB has innovated the use of dementia care mapping as a measure of cultural change and published this work in an international peer reviewed social research journal. Furthermore, accessing information will play a key part in the Dementia care pathways. The action required, as seen within the context of HASCAS 2, is to ensure readily available information for patients, carers and representatives about services available, ensuring most up to date information is accessible on the BCUHB intranet. Referrals are now routinely made to the Carers Trust for any individual with a diagnosis of dementia, from BCUHB's memory clinics. A scoping exercise will be taken forward via the HASCAS/Ockenden working group to review all current BCUHB information ensuring that present and future public information is compliant with 'Accessible Communication' standards as per action 8 of the Welsh Government Audiology Framework for Action. Dementia Helpline has been launched across BCUHB providing 24hr advice, information and support. The above work streams will now be subsumed into the BCUHB Dementia Clinical Strategy Group.	

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		• ***Action 5: Evidence Based Policies and Clinical Standards****:* A BCUHB wide systematic approach in reviewing all current policies relating to older people and those with Dementia (dovetails with Ockenden 12 and Ockenden 3, is currently in early development. Review of clinical policies is to be supported by the Dementia Nurse Consultants, with University support. A review and report on key policies moving forward has been produced, there will be a Dementia policy inclusion for all policy and procedure developers / leads which is in current draft format. It will be expected that all developers and policy reviewers consider all vulnerable groups when developing any policy or guidance, making Dementia a key consideration. This will need to go through the process of being added into the policy for polices guidance; it will be the responsibility of areas to consider this in all policy development. • ***Action 6: Dementia Governance Framework:*** A single point of governance that underpin all service provision and encourages continuous improvement, lessons learnt and the BCUHB Dementia Strategy Group will oversee transparent reporting from ward to board level. BCUHB are also in the process of establishing a third sector partner's group with Alzheimer's Society and the Carers Trust to shadow all BCUHB's Dementia transformation work. A task and finish group is in the process of being established in response to BCUHB's Dementia Audit Plan (2018-2020) to undertake audits and all future reporting from 'ward to board'. BCUHB have launched a 'dementia feedback toolkit' for service users. This will be developed further by involving community services and expecting services to undertake their own performance management arrangements to report directly to Area Directors. The work streams under BCUHB's Dementia Friendly Organisation Plan will also be included within the audit process. ***In summary:*** The Executive Nurse Director for BCUHB has confirmed that the current stakeholders and audit groups can provide independent oversight for the programmes of work listed above. In addition, WG have also newly advertised an All Wales Dementia Allied Health Practitioner Consultant post who will be approached to give advice and support to health boards and local authorities to enable the delivery of person-centred care and drive forward service improvements. This post forms part of the All Wales Dementia Action Plan. BCUHB are required to subsume this programme of work and to develop it alongside the North Wales Social Care and Wellbeing Service Improvement Collaborative who are project managing the development of a North Wales Dementia Strategy. A mapping exercise is underway to scope all Integrated Care Fund programmes that are currently providing transformational work across BCUHB in relation to Dementia.	
HASCAS 8: Evaluation of Revised Safeguarding Structures / Ockenden 6: Safeguarding Structures Operational Lead: Michelle Denwood, Associate Director of Safeguarding *BCUHB will evaluate the effectiveness of its new safeguarding structure in the fourth quarter of 2018/2019. This will be overseen by Welsh Government.*	Expected to be fully implemented by December 2019	• The Senior Safeguarding Structure is being implemented with pace. • The two posts for Head of Adults at Risk and Head of Adults at Risk for MHLD within the Safeguarding Structure have now been recruited to and are now in post. This will strengthen strategic oversight in these key areas. • The Business Support Team have successfully recruited to one of two vacant Band 3 posts, further recruitment will take place on 18th November 2019. This will strengthen the central administration function. • Due to internal and external staff movement into alternative posts, further vacancies have arisen; Senior Team Manager West, interviews are due to take place on 20th November with start dates expected to be around February 2020. • The position of Business Manager is vacant which allows for the job description to be reviewed and recruitment to take place.	Secondment to the Adult at Risk / Dementia Lead was recalled back to MH&LD, which now remains a key vacancy in the safeguarding structure. Subsequently due to the Health Board's financial constraints, there is a risk that the appointment to the Adult at Risk / Dementia Lead (Band 8a) will not be recruited to which will impact on service delivery and recruitment to full safeguarding structure. • A JD will be submitted to vacancy control panel with clearly identified risks and clarity on key role responsibilities with identified risk

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		• The Named Doctor Adults at Risk job description, implementation and engagement requires further action to progress. The Executive Medical Director has informed the Associate Director of Safeguarding that unfortunately due to financial challenge he cannot provide a date to progress this position. • As part of the organisational update, the second phase of safeguarding job descriptions are in the process of being reviewed to ensure they are fit for purpose. • A full evaluation of the existing 2017 Organisational Change Policy Safeguarding Structure is to be finalised and reported to QSG in December 2019. • A 7-day on call / flexible working arrangement has been costed to support Safeguarding service delivery. Job descriptions are being refreshed to reflect this for clinical staff and will be implemented once financial approval has been gained, and the consultation complete.	assessment and clarity on activities which will not be undertaken without the post.
HASCAS 9: Clinical Records Operational Lead: Dylan Williams, Chief Information Officer *Restructure and redesign of paper records archiving and retrieval systems*	Expected to be fully implemented March 2020	• Deputy Head of Health Records is now in post. • Funding for the B7 Project Manager post has been confirmed by the Executive Team and with the confirmation of the funding in place, recruitment is underway. Once this post is appointed to, Mental Health services will be the priority area. The work programme for this post is expected to be completed by March 2020. • Confirmation given that responsibility for the management of all patient records is within the remit of the Executive Medical Director. • Health records policy (HR1) has been redesigned to take account of transition to digital records and is being reviewed by Head of Information Governance prior to submission to Patient Records Group for approval in November. • Following a meeting held with the Clinical Audit lead, agreement has been reached to include checks for co-mingling within the annual clinical audit of case notes, this will be resource matched by support from within the Health Records service. This action is now complete. • The Service is now live in Central and East with new processes and a digitised approach to collating and providing responses via secure web services, including comprehensive commingling checks being carried out. Capacity within the team is being evaluated prior to roll out to West as the number of requests have increased to 400 on the two sites per month, from 300 over three sites per month – this is in part due to it now being easier to make a request and partly due to drawing all requests made to BCU in through the new centralised service. It is expected however that additional resources will be required to complete the roll out and take on the next steps to be fully compliant with the ICO recommendations. • Safeguarding also recognise the fundamental importance of good record keeping in Patient Safety. Whilst responsibility for implementing this recommendation sits with the Chief Information Officer, Corporate Safeguarding are undertaking activity which supports this, including conducting an audit of the use of purple dividers, and their application within MHLD, Secondary Care and Primary Care clinical records. • Corporate Safeguarding have requested that this activity form part of the 2019-2020 Internal Audit cycle for which a response is awaited. • Record keeping training is delivered by Safeguarding, which reflects on the importance of good record keeping, and its role in Safeguarding. This message will also be shared through the Safeguarding Bulletin and the Safeguarding Homepage. • Corporate Safeguarding are implementing the Lead Practitioner role after an initial pilot. The Lead Practitioner role will include the oversight of the content, quality and standards of Safeguarding record keeping and documentation.	Benchmarking work cannot commence until additional project manager resource appointed.

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HASCAS & Ockenden Recommendations – update report for Quality, Safety & Experience Committee 19th November 2019

Recommendation	Current position	Progress update	Risks
HASCAS 10: Prescribing and Monitoring of Anti-psychotic medication Operational Lead: Berwyn Owen, Chief Pharmacist *A) The updated BCUHB 2017 antipsychotic prescribing guidance will be kept under review and be subject to a full audit within a 12 month period of the publication of this report.* *B) BCUHB will continue to work with care homes across North Wales to provide practical clinical advice, guidance and training so that residents with behaviours that challenge can be supported and kept safe with the minimal amount of anti-psychotic medication possible. The effectiveness of this should be built into the antipsychotic prescribing guidance audit.*	Expected to be fully implemented by end of November 2019	• Antipsychotic prescribing audit has been completed for people with dementia on OPMH wards, in accordance with the BCUHB MM010 guidance. • Primary care report has been completed and results are currently being collated and an action plan agreed. • Results from both audits will be presented to OPMH clinicians and disseminated to other staff on 25th November and an action plan agreed for the HB. • CAIR (checklist for antipsychotic initiation and review form) has been developed and distributed to all OPMH and Community Mental Health Teams (CMHT) across MH&LD division, however there is limited uptake to date. Reminders sent to secondary care MH staff to use the CAIR form for patients who have started on antipsychotics. Further audits will be undertaken to monitor completion of the forms. Discussions are underway with the Medical Director to consider embedding within core documentation. Presentation of the audit in November will demonstrate the benefit of using the form. Consideration is being given to simplify the tool to encourage use. • Care Home sub group of primary care pharmacists met in July and CAIR forms have been circulated to raise awareness for care home staff. • A community pharmacy care homes National Enhanced Service (NES) is in place to monitor antipsychotic use in care homes and increase the number of pharmacies signed up to the NES. • Discussions to be held with the Programme Manager for HASCAS recommendation 3 regarding the pilot of an Adverse Drug Reaction (ADRe profile) tool for use within care homes which has demonstrated a significant reduction in falls in Swansea to align with work ongoing for HASCAS recommendation 3 (Care Homes & Service Integration). • Training plan to include training for care home staff on the use of medication for people with dementia, including antipsychotics, has been agreed and planning is in progress with the Dementia Consultant Nurse. • Older Person's Mental Health services are partnering with people affected by dementia, academics from Bangor University, Clinical Psychology services and the Positive Interventions Clinical Support service to develop a training module exploring behaviour change in dementia. The module will support staff to understand that many changes are caused by unmet needs for the person to feel safe, understood and valued. The aim is that staff will acquire the skills to effectively identify trigger factors and ways of responding. As part of the module staff will acquire knowledge about the safe use of antipsychotic medication and introduced to an approach aimed at reducing the prescribing of these medications. • Costed therapies action plan to include pharmacy role in reducing inappropriate psychotropic use. Business case in progress to support resources required to implement HASCAS recommendation to address lack of pharmacy support for ward staff around medication reviews.	Lack of pharmacy staff to deliver training for safe use of antipsychotic and support review • Resource requirement to support implementation of recommendations. • Business case in progress to support resources required to implement HASCAS recommendations. • Presentation distributed including care home subgroup. Community pharmacist uptake of the NES for care homes has been minimal so far. Care homes not trained to deliver care that reduces need for antipsychotics • Work in progress to deliver MDT module for staff on behaviour in dementia – pharmacy to provide medication education session. Additional resource required to support data analysis work has been approved by the Executive Team and funding confirmed.
HASCAS 11: Evidence Based Practice Operational Lead: Dawn Sharp, Deputy Board Secretary *BCUHB will conduct a review of all clinical policies to determine the ratification processes that were conducted together with an assessment of the appropriateness of content and currency; this will include all hard copy policy documentation still retained in clinical areas, and all electronic documentation held currently on the BCUHB intranet.*	Expected to be fully implemented by December 2019	• The new external BCUHB website is now live. The basic structure has been agreed (document categories) and sent out to all governance leads for comment / consultation. A statement of a commitment to the promotion of equality of opportunity and treating the Welsh language no less favourably than English has been drafted and circulated to Welsh Language leads for review. This will sit on the front Policies page and provide guidance to readers on accessing their chosen document bilingually. • A request has been submitted to the Executive Medical Director for the identification of a second *clinical/medic* governance lead in addition to the existing non clinical lead. This is to ensure sufficient medical/clinical oversight to the page set up and migration. • Confirmation has been provide to the Integrated Care Pathway Lead that Care Pathways will be included. Support has been offered to accommodate migration.	Reduction in administration staff within OBS could lead to delays in transfer of policies to new site. • Following redeployment of resources for other corporate support, recruitment is now underway for additional secretarial support for Interim Acute Services Director.

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		• Meeting scheduled with Informatics 19/11/19 to develop a SharePoint Database that will enable smart reporting and efficient document management / version control. • A document quality 'checklist' has been developed and disseminated to Governance Leads as well as signposting in the all staff Corporate Bulletin to raise awareness of the mandatory requirements for document quality. • Staff continue to be reminded of the importance that all clinical WCDs are developed using a person centred approach and that the evidence base in relation to older adults and/or those with dementia must be specified -if necessary separate clinical WCDs should be developed with input from experts. • EqIA mandatory requirement awareness for all pan BCUHB WCDs remains a key message. Additionally, Office of the Board Secretary staff to screen EqIAs prior to review at Quality & Safety Group, Quality, Safety and Experience Committee and prior to document upload. Though it should be recognised that these checks are administrative and any clinical or operational content remains the responsibility of the responsible directorate. Knowledge and understanding of the impacts that are (or should be) documented in the EqIA will be limited to the reviewer's knowledge of the subject documented. • The IG list of documents has been finalised for transfer and requires a final quality check prior to uploading. • Individual and group sessions continue to be held with governance leads. • OBS have reviewed and adapted the Welsh Government Integrated Screening Tool. This will provide a one stop screening tool that encompasses all relative areas of impact (Finance, Environment, EqIA, Children, Data Protection etc.). Where further assessment is required, the tool will point the author to the applicable full screening assessment / BCUHB lead. This document will pre-empt issues and ensure all factors have been taken into consideration prior to any proposed service change. Relevant Service/Speciality leads will be consulted on the document once complete. • Due to the volume of clinical documentation, a meeting has been scheduled for the 6/11/19 with Corporate Nursing, Secondary Care and OBS to plan a phased migration that will target most accessed documents.	
HASCAS 12 Deprivation of Liberties (DoLs) Operational Lead: Michelle Denwood, Associate Director of Safeguarding *BCUHB will conduct a formal audit and provide a progress report in relation to the 2017-2018 action plan. This will include a review of any barriers to implementation (such as office accommodation) together with a timed and resourced action plan to ensure full implementation can be taken forward in 2018-2019.* **Ockenden 9: Deprivation of Liberties** *BCUHB will complete a review of the 2017-18 DoLS work plan*	Expected to be fully implemented by December 2019	• With regards to DoLs signatory activity, the role and responsibility of this role has previously been held by the Office of the Medical Director. Since the transfer of this responsibility to the Office of the Nurse Director and Corporate Safeguarding Team, the number of signatories has risen to approximately 40 with improved activity and governance. • The 6th vacant Best Interest Assessor (BIA) post was to follow the recruitment process. These posts are critical due to the high activity which is both challenging and complex. Unfortunately, as the posts have been banded higher than the intended budget, the 6th post has not commenced recruitment due to budget restraints. • An evaluation of new working practices will be carried out including the Mental Capacity Documentation Pilot and the Signatories training package. This will be reported to the Safeguarding Performance Group (SGPG) on 16th October, and QSG in December 2019. • The DoLs activity during the period of 2017-18 has been reviewed. Based upon the outcome of this activity and the evaluation of 2018-19 activity, an action plan will be produced. An options paper to commence discussions relating to the revised structure of the DoLs team, to reduce risk and increase activity will be completed. The timing for this activity has been amended due to the recent Supreme Court Judgement relating to 16-17 year olds. A paper detailing this judgement was presented to QSG in November 2019.	The implementation of a revised DoLS structure, due to the recognition of the organisational demands and the required service delivery based upon the annual data of applications, training statistics, and findings within reviews will have a cost pressure as the service is under resourced. *Financial constraints affecting the recruitment of the 6th BIA* The current resource cannot maintain the demand, high risk and complexity of cases. Formal options paper will be presented to QSG setting out the mitigations and future proposals in an attempt to reduce the risk.

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		It should be noted that DoLS has a Tier 2 entry on the Corporate Risk Register with a Risk Rating of 16 and states that: *BCUHB is at risk of unlawfully depriving adults of their liberty due to the Case Law of Cheshire West, which widened the parameters based on the acid test. The results extended the definition of the Deprivation of Liberty legislation and how it applies to vulnerable adults.* *Supreme Court Judgement relating to 16-17 year olds requires a task & finish group to support implementation.* *BCUHB has also seen a continuous increase in Court of Protection Activity (COP).*	
HASCAS 14: Care Advance Directives Operational Lead: Dr Melanie Maxwell, Associate Medical Director *BCUHB will conduct an audit to establish how many patients and their families have advance directive documentation within their clinical records together with care plans in relation to choice and preference about end of life care*	Expected to be fully implemented by end of December 2019	• The monitoring process which commenced in November 2018 is ongoing and continues to capture data on End of Life paperwork for inpatient deaths, this includes 'What Matters', future care plans, Advance Care Plans (ACP), treatment escalation plans (TEP), care decisions, DNACPR etc. This will provide baseline data for improvement work and also enable the identification of patients for more in-depth review. • End of life case note reviews for inpatient notes were held in April and May with clinical staff from palliative care and mental health teams, based on the 5 priorities of care for the dying person. Results have been analysed and an audit report was finalised. Out of date guidance was found in critical care and a meeting between palliative care and critical care leads arranged for September to update documentation so it is fit for purpose and meets priority of care recommendations. • Initial findings demonstrated that documentation of care was poor and difficult to follow. However, there was some evidence of good care being delivered and anticipatory prescribing but the need for end of life conversations to be held earlier. There was no evidence of obvious inequity of care between patients with or without a diagnosis of dementia. There was evidence that the involvement of specialist palliative care appeared to lead to earlier implementation of appropriate end of life care (EoLC). • • Baseline audit actions identified, including the need to review priorities of care documentation across critical care, this was delayed awaiting updated national guidance and a meeting has been arranged between site Clinical Leads for Organ Donation and Specialist Palliative Care service. • Data submitted to the National Audit for Care at End of Life which includes a carers' survey.	Capacity to complete the national end of life audit • Palliative care lead established, sites have been requested to identify generalist consultants to lead site audits. Clinicians were identified and data was submitted on time.
HASCAS 15: End of Life Care Environment Operational Lead: Dr Melanie Maxwell, Associate Medical Director *Improve end of life environment on OPMH wards and associated guidance training*		• The End of Life (EoL) / OPMH pathway has been developed alongside a standard operating procedure (SOP), an MDT / relatives joint risk assessment and a dedicated training module. The draft SOP was presented to Stakeholder Group in January 2019 for their input and minor amendments made from stakeholder feedback. Further changes were made following discussion at the HASCAS EoLC Task & Finish Group which included valuable comments from two members of the stakeholder group who are also members of the Task & Finish Group. The SOP includes real time audit of the process. The low number of deaths on an OPMH ward makes this realistic. The SOP identifies when DATIX is to be used. • Three deaths on OPMH wards recently with care showing learning into practice and families satisfied with the care received. • Relative rooms developed on each OPMH 'organic' ward are in the final stages of upgrading with décor and furniture.	Staff not being released for training. • Training is mandated on OPMH wards for Registered Nurses. • 68% registered nurses on OPMH wards attended training. Going forward missed staff will be prioritised.

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Recommendation	Current position	Progress update	Risks
		• First round of bespoke EoLC training programme with Consultant Psychiatrists and ward managers has concluded. Evaluation of training very positive, 68% registered OPMH nurses attended. Interest expressed from other groups e.g. Adult psychiatry. • Strategic and Operational Delivery Group for Palliative and EoLC chaired by Executive Director of Primary Care will meet on 18th November. Operational group will be formed to move the work forward, the spread and sustainability of actions on these recommendations will move to this once functional. • Second stakeholder group held – update on progress and plans to transfer work to operational group discussed. Positive report that Hydref Ward manager had encouraged lay stakeholder visits to the ward which is considered an assurance of an open culture. • Two stakeholder members have visited	
Ockenden 2a: Quality Impact Assessment Operational Lead: Dawn Sharp, Deputy Board Secretary *QIAs (where the clinical implication of financial savings plans are assessed by Executive members of the BCUHB board) were 'still in the process of refinement' (as of Spring 2017). Evidence is required of focussed Board attention going forward.*	Proposed as fully implemented – to be formally agreed by the Improvement Group	• An update to HASCAS / Ockenden Improvement Group in January confirmed that a system is in place for Quality Impact Assessment (QIA) of savings schemes and progress will be measured from samples of completed QIAs and a record of outcomes and as part of the internal audit programme 2019/20. The audit is now timetabled for Q3. • The draft audit brief was issued for approval on 7th October for Executive sign off. • Once the audit brief has been approved and audit commenced it is proposed that this recommendation is reviewed for approval by the Improvement Group on 18th November and signed off as fully being implemented and moved to a "business as usual process" and expectation.	
Ockenden 2b: Integrated Reporting Operational Lead: Dawn Sharp, Deputy Board Secretary *There is a need for further urgent and sustained Board attention to full integration of the systems, structures and processes underpinning financial, corporate and clinical governance and the Board will need to assure itself that it has effective integration and timely oversight and scrutiny of workforce planning, financial planning, performance and quality going forward.*	Proposed as fully implemented – to be formally agreed by the Improvement Group	• The interim accountability framework was ratified by the Audit Committee in May 2019. Two cycles of Health Economy reviewed introduced through this framework have been completed. • Learning from the first review resulted in an amendment of the process for the second cycle undertaken in June 2019. The outcomes of the reviews have been fed back in the form of notes, action log, decision tracker and risk log. • The Q1 2019/20 review took place at the beginning of August 2019 with the mechanism expanded to include both the 3 health economy reviews and reviews for the pan-BCU services of Women's, North Wales Managed Clinical Services and review of the work on the clinical services strategy. The effectiveness of the interim accountability framework will be required post the quarter 3 reviews set for February 2020 with an intent to formalise the Performance Framework from 2020-2023 planning cycle. • The annual operating plan actions are being monitored with progress reported to committees of the Board on a monthly basis using the peer reviewed self-assessments. On a quarterly basis a random sample of the underpinning evidence takes place to ensure consistency in rating between the Executive Lead for each Action. This was completed at the end of June 2019 and included in the July Annual Plan Monitoring Report presented to the Finance and Performance Committee for scrutiny. • Due to the significant oversight by the Board, as well as subcommittees (QSE and F&P) and also the Special Measures task & finish Group, it is proposed that this recommendation is approved as fully implemented where robust governance structures provide the relevant level of monitoring and scrutiny. This will be formally reviewed at the Improvement Group meeting on 18th November. Ongoing reporting will continue through the above groups.	
Ockenden 3: Policy Review Operational Lead: Dawn Sharp, Deputy Board Secretary	Expected to be fully implemented	• This recommendation dovetails with HASCAS Recommendation 11 (above) and will be progressed in tandem with the other recommendations in the report relating to corporate governance.	Clinical staff not being aware of the transfer of key policies to the new site

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Recommendation	Current position	Progress update	Risks
Ensure a review of all clinical policies within all BCUHB divisions to include quality checks on how the policies and guidelines were ratified, their due date of review and a full understanding of those policies that are overdue for review. *This review will need to be undertaken of all BCUHB policies held on the intranet and a BCUHB Board 'amnesty' announced for submission of all paper copies of policies and guidance held within individual clinical areas in hospitals and across the community. Once an appropriate archive of these policies are created they should be destroyed so that they cannot be returned to clinical practice as a 'work around solution' to lack of access to policies and guidance electronically.* *BCUHB should then undertake a comprehensive review of all existing BCUHB policies to ensure the needs of older adults are specifically considered within all relevant policies.*	by December 2019	• Under the sponsorship of the Executive Director of Nursing and Midwifery, and with the Deputy Board Secretary acting as the operational lead, a programme of work commenced in July 2017 to review existing arrangements for the creation, cascade, access and storage of policies, guidance documents, protocols, and other written control documents. • The breadth, volume and complexity of the work was recognised and it was agreed that in order to progress the work successfully, governance/policy leads would need to be identified in each Directorate. This was achieved in Autumn 2017 and an initial training session was held with the leads in November 2017 to outline the requirements to review all policies and procedures both clinical and non-clinical within their remit and bring them up to date, or confirm that they remained extant. In doing so leads were asked to identify current locations of all policies to be removed both, in paper copy or online, on the Health Board's intranet pages. • In relation of BCU wide clinical policies the Corporate Nursing Team have undertaken a clinical policies mapping exercise to determine the location and current status of all clinical policies. These clinical policies have been risk assessed in terms of prioritising those that require urgent review under the direction of the Executive Clinical Directors. In line with the existing policy on policies the Quality, Safety and Experience Committee of the Board must approve clinical policies. From August 2018 an additional step has been added to the ratification and approval process with all new or refreshed clinical polices being scrutinised by the Quality and Safety Group to ensure they are fit for purpose and are evidence based.	• Targeted communication plan for each transfer to be agreed with the leads. Redirect system to be in place (from existing location) where possible Resources to review policies and bring them up to date (across the wider organisation) • Meetings continue to take place with leads to agree the programme of transfer of documentation to the new site and to prepare communication plans and identify any issues
Ockenden 2c Workforce Development Operational Lead: Sue Green, Executive Director of Workforce & Organisational Development *BCUHB will need to provide significant amounts of targeted workforce and organisational development support in the form of extra team members to support the MH&LD and specifically OPMH with recruitment and retention expertise across medical, nursing and support services going forward. The MH&LD will need to utilise this support to creatively explore different ways of working and new and effective ways of recruiting and retaining staff. There will need to be efficient, timely and effective recruitment processes in place at all times to support MH&LD going forward.*		• A number of nursing student graduates are due to qualify in March 2020 who will be eligible for registration within the MHLD Division. Work is ongoing to recruit to fill substantive posts. • WG funds have been allocated in year for the recruitment of additional Band 6 and Band 7 posts to support the Mental Health Measure. These posts are currently being progressed through the TRAC recruitment system. • A dashboard is developed to monitor workforce performance for the MH&LD division. Improvements can be seen in areas of turnover and time to hire. • Progress monitoring against Q2 workforce objectives. WOD teams are working with Assistant Director (Nursing) to improve retention in identified wards and examine exit interview data. Mental Health establishment control processes embedded and functioning well. • Workforce Improvement Group established which includes monitoring progress on Mental Health workforce objectives. • A continued focus remains on engaging frontline staff and operational managers in training to develop skills and processes that are required to understand service demand and capacity, in order to improve flow within the Community Mental Health Teams (CMHT). Work continues to build on current learning and will be used to support further improvements in the delivery of care within the current system and also the work of our Quality & Workforce Group to redesign services. • Revised clinical leadership and management structure is now in place within MH&LD division with dedicated project management support to enable triumvirates to engage with the Quality Improvement Governance Plan and produce Divisional Action Plans. • Since the launch of the Together for Mental Health Strategy, Local Implementation Teams (LITs) have been established across the 6 counties supported by Quality & Workforce Groups that work collaboratively to ensure vertical read across, and understanding of how the work of the LITs and other organisations and networks impact	

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		on service provision across the whole system. The Quality & Workforce Groups are tasked with developing clinical service models across secondary care.	
Ockenden 4a: Staff Engagement Operational Lead: Sue Green, Executive Director of Workforce & Organisational Development *The BCUHB board and the MH&LD divisional senior management team is recommended first to ask front line staff 'what does the term 'staff engagement' mean to you, 'what would effective staff engagement look like for you?' and then to develop a system of bespoke meaningful and sustained staff engagement first across mental health and specifically older persons mental health. The Board may then wish to consider how effective their engagement is with staff across BCUHB and decide whether a new Board approach is required to staff engagement across the whole of BCUHB*		• The Staff Engagement strategy approved in 2016 identified key activities and achievements required to successfully realise the strategy and the Health Board have received six monthly updates on progress and achievements since the launch. One of the elements included in the strategy was the adoption of a tool which would give the Health Board the ability to measure staff engagement on an ongoing basis. • The 'Go Engage' tool developed by Wrightington, Wigan and Leigh NHS Foundation Trust has been rebranded and implemented for BCUHB as 'ByddwchynFalch / BeProud' in order to maintain consistency with the Proud of theme adopted as part of the staff engagement strategy. The tool offers: – a simple way to understand the science behind staff engagement in terms of cause and effect – Clear practical recommendations to improve staff engagement – Regular trend analysis – not a once a year/two years snapshot in time. – Ability to act quickly on data, two week turnaround from close of survey to presentation of results – Organisational and team level diagnosis of culture • BeProud Staff engagement pulse surveys are sent out quarterly over the course of the year, every single member of staff will have the opportunity to take part. Feedback received is used to inform actions to support and engage staff each year, such as recognition schemes, engagement programmes, listening events and health & wellbeing initiatives. The Pulse survey measures a range of areas that may engage or disengage staff in work, based on the 9 enablers of engagement. The survey highlights how effective work relationships are, how clear staff are about their roles and the direction of the organisation, how recognised and valued staff feel and how fairly they are treated at work. • The overall response rate for the first BeProud Pulse Surveys was 20% and indicated that 50.93% of respondents reported feeling positive about the standard of service provided by the Health Board and 54.64% would recommend BCUHB as a place to work. • The 'Be Proud' Pioneer Programme is specifically aimed at teams to improve and sustain staff engagement so that they can better understand challenges and barriers to engagement and provide support to build improved engagement behaviours. The programme runs over a 26 week period and starts with a cultural team survey and comprises workshops for 2.5 days, 3 action learning sets and a celebration event. • As part of the ongoing priority work relating to the HASCAS / Ockenden recommendations and in an effort to support unscheduled care, teams were nominated from 10 priority areas to undertake the first Pioneer Team Programme which commenced in March 2019. Cohort 2 started their Pioneer journey on the 19th June 2019 and will run until 12th December 2019 and cohort 3 is being planned for October start date and teams have been identified for this cohort which includes a number of teams from the MHLD division. • Regular cohorts of pioneers will continue and is part of the mainstream Organisational Development portfolio, engagement and improvement and also forms part of the workforce objectives and strategy. This part of the recommendation has been met. • There has been positive engagement with the Action Learning Sets within which the Pioneers have been taught the process of action learning and recognise the benefits of using it collectively to solve problems and remove barriers. These sessions are also an opportunity to update their peers on their progress so far, and gain useful feedback.	

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Recommendation	Current position	Progress update	Risks
Ockenden 4d: Clinical Engagement Operational Lead: Sue Green, Executive Director of Workforce & Organisational Development *BCUHB must take urgent and sustained steps to ensure the continued involvement of all clinical colleagues in the leadership and management of BCUHB*		• A third Medical and Dental conference was held on 22nd October which reviewed all the points raised at the previous two conferences and to provide an update on actions taken to address topics that were raised. • Clinical Leadership meetings are established on a quarterly basis, with the third due to be held on 26th November. • The 3D (Discover, Debate, Deliver) Framework is a flexible staff listening methodology widely used throughout the Health Board by Staff Engagement Ambassadors and anyone who wishes to access the comprehensive and interactive toolkit, which is available on-line and bilingually on request. The toolkit includes flowcharts, question banks, templates and all relevant information for utilising 3D. • Collating case studies and outcomes, using the 'You Said, We Did / What Happened Next' approach, forms an integral part of the 3D toolkit for feedback and to also capture progress and impact during and after any event. Case studies and outcomes are available on the BCUHB intranet pages and emphasise how flexible 3D can be to fit around specific service needs. • The promotion of 3D has been undertaken widely across Senior Leadership Teams as well as holding roadshows, team away days, site visits and was included as part of the first BCUHB Annual Medical and Dental Conference held in partnership with NHS Wales Confederation and BMA Wales. The toolkit is also integrated into Leadership & Management Programmes, included in relevant Senior Leadership Masterclasses as well as being included in the Quality Improvement (QI) Hub. • Close links continue to be made with other initiatives across the Health Board such as Mental Health & Well-being Champions, Today ICAN and the Improving Quality Together (IQT) team. The aim is to build better relationships and become better connected with colleagues from across the Health Board to bring about positive change and increase staff satisfaction, which in-turn has a direct impact on our patients • 3D (as well as other internal engagement tools) is also an integral part of the Be Proud Pioneer team toolkit. • The Generation 15 Ward Manager programme was designed in 2015 to develop management and leadership skills and competencies to enable individuals to build effective capability within their roles as clinical leaders. It provides practical skills and tools which enables the Ward Manager to manage and lead their team effectively in order to improve patient outcomes. This programme has been refreshed and is now called the **Ward Managers Development Programme** following feedback and consultation with the Executive Director of Nursing, Deputy Director of Nursing and the corporate nursing team. Two cohorts have been undertaken in March and July. • Building on the Ward Manager Leadership Development Programme the first cohort of matrons will commence the **Matron Leadership Development programme** in November 2019. • A bespoke leadership development programme 'Leading for Transformation' is in place delivered by external provider Carter Corson Business Psychologists. The programme supports the ambition to develop an engaging, inclusive and compassionate leadership style across the organisation through enhancing the capability of leaders to deliver results, by better engaging with their staff at an individual and team level, as well as with partners and stakeholders across sites, sectors and services. • All development programmes are mainstreamed into the Organisational Development team's work on an ongoing basis. Programmes are evaluated in conjunction with clinical leaders, refreshed and adapted as necessary to ensure programmes meet the needs of clinical managers. The establishment of the Senior Leadership Network will bring together the most senior clinical and business leaders to develop relationships, encourage active and constructive debate and develop a cohesive team to ensure organisational and service objectives and improvements are met.	

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Ockenden 5: Partnership Working Operational Lead: Sally Baxter, Assistant Director Health Strategy *BCUHB needs to work effectively at a strategic level with the voluntary sector and a wide range of multi-agency partners to develop, provide and sustain services to older people and older people with mental health needs and dementia across North Wales.*	Expected to be fully implemented by end of December 2019	• The Executive Management Team at the meeting on 5th June supported the proposal to devolve the centrally held Voluntary Organisation budget and establish a commissioning forum. This will support local ownership, management and decision-making in relation to these budgets and services and increase assurance and governance in relation to service expectation and outcomes for the relevant population across all such grants and contracts. There has been some initial positive recognition in respect of this proposal from some representatives of the third sector, raised during discussions on the refresh and review of strategic working with the sector which are currently underway. • A designated MH commissioning post has been appointed to and commenced in the role. • A paper was presented to the Strategy, Partnerships & Population Health Committee in September providing feedback from the series of engagement events held earlier in the year and confirming the proposed principles. Following discussion with Independent Members the draft strategic framework has been prepared and is being shared with third sector and internal colleagues for any further feedback and amendment prior to sign off. • Further contact has been made with some voluntary sector forums again to discuss the principles in the draft paper, which were received positively.	Complexity of the Health Board presents challenges in developing a fully embedded approach – Develop a set of principles to be adopted across the Health Board Partnership approaches differ across the 6 counties – Ensure corporate arrangements are supportive of and link closely with county based arrangements Objectives need review and refresh to reflect the wider strategic approach – Include wider strategic development within objectives
Ockenden 7: Concerns Management Operational Lead: Deborah Carter, Associate Director Quality Assurance *Whilst it is acknowledged that on many occasions since 2009, BCUHB has made an effort to improve the timeliness of responses to concerns in line with the requirement of Putting Things Right (2011) this has not yet been sustained on an ongoing and long term basis.* *It is clear that the BCUHB Board have very little knowledge of the **actual** everyday experience of families, service users and service user representatives who try to make complaints to BCUHB as an organisation. Service user representatives also raised the reluctance of families and service users to complain and the fear they have of complaining.*	Expected to be fully implemented by End of March 2020	• Work continues to progress to respond to the actions identified to better manage concerns in a timely and effective manner. • A bilingual online complaints form is live and has had input from the Community Health Councils. In addition, complainant feedback forms are now included with every complaint response as from 4th November 2019 • Revised trajectories that have been identified to deliver real time management of complaints and incidents continue to be monitored via weekly incident review meetings. The current position against trajectories is as follows; – No WG incidents overdue by end of June 2019 – **55** as at 28th October – No complaints graded as 1 or 2 overdue – **99** overdue as at 28th October – No more than 15 complaints graded as level 3 overdue – **78** overdue as at 28th October – No more than 30 complaints graded as 4/5 overdue – **0** overdue as at 28th October – No more than 5 complaints overdue by over 6 months and must be grade 5 – **1** overdue as at 28th October linked to a police investigation and so cannot be progressed • The number of open and overdue incidents continues to reduce and as at the end of October 2019 there were 3,976 open, of which 2,091 are overdue • There has also been a decrease in the overall number of open Welsh Government closure forms from 419 in March 2019, of which 345 were overdue to 122 in October 2019 (of which 55 are overdue). • A revised approach to weekly scrutiny of all complaints has been implemented, led by a single lead for corporate complaints with each division including all complaints over 2 months as well as open AM / MP complaints. • Review and refresh of policies and procedures for concerns, complaints and incidents to be undertaken following the appointment of a new Assistant Director of Service User Experience. • The Patient & Service User Experience Improvement Strategy 2019-2020 is progressing well with clear measures monitored and reported to Assistant Director of Service User Experience.	Capacity within divisions to complete investigation and report writing for Concerns (against operational priorities) – Trajectories developed by division to deliver required deadlines by week commencing June 17th currently under review Quality of historic information to support robust learning – Training and support in place for investigation of new cases. Corporate team offering support to divisions to review historic cases, identify learning and move to closure

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		• Following successful recruitment process, the full complement of Patient Advice & Liaison Service (PALS) officers are now in place. The PALS service will support members of the public, staff, patients, carers and their families, to address any issues they have efficiently and promptly. The draft Patient Advice and Liaison Support officers' operational model is now live. • Customer care training and recording of patient stories is being delivered across BCUHB with excellent participation, evaluation feedback. Quality & Safety meetings have introduced patient stories as an opening agenda to address key learning from patient's individual experiences. The next stage is to develop a patient story library on the BCUHB website accommodating varying methods including audio, video and narrative.	
Ockenden 11: Estates OPMH Operational Lead: Rod Taylor, Director of Estates & Facilities *BCUHB should prepare a detailed estates inventory across the care settings for all of older people including but not limited to OPMH. Firstly this should include clarity and specificity of all outstanding estates issues including outstanding repairs and estates issues raised as concerns with internal audits and external reviews and inspections.* *The estates inventory should be prepared for each ward, clinic, department, inpatient unit and hospital department where care is provided to older people and older people with mental health issues. This includes where care is provided to people with dementia.* *The estates inventory should include for each area an audit based on the work for Enhancing the Healing Environment.*		A number of actions have been completed for work stream 1, as follows; • A multi Directorate / Divisional working group that includes Operational Estates, Estate Development and Mental Health and Learning Disabilities is established with agreed Terms of Reference which will be updated as the work streams progress. • A site-by-site schedule (inventory) of outstanding repairs and maintenance work for MH&LD buildings has been completed. Work is continuing through Operational Estates to complete any outstanding jobs and the schedule is updated monthly to monitor progress and report to the group. • A detailed inventory of previous External Audits and Inspections by HIW & CHC relating to MH&LD OPMH facilities has been prepared and all outstanding actions are now completed. • Funding of £200k has been identified in the 2019/20 Revenue budget setting process to undertake additional repairs and maintenance in MH&LD establishments and to commence the assessment of a Safe Healing Environment. Procurement and planning will now be undertaken for this work to support work stream 2. • As part of Estates and Facilities budget setting process for 2019/20, bids have been submitted for an additional £200k of recurring revenue funding to address any remaining outstanding repair / planned maintenance work within MH&LD buildings. • The project group have identified the requirement for Project Management capacity to support the project and actions required in Work stream 2 – funding has now been confirmed by the Executive Team to recruit to this additional resource. Work stream 2 commenced in April 2019 and is tasked with developing the Enhancing the Healing Environment (EHE) assessment across all wards within MH&LD OPMH facilities. • Funding has been agreed by the Executive Team for additional project management capacity which will now enable the ward assessment work.	Capital and Revenue funding to undertake identified works – Revenue funding bids have been included within Estates and Facilities budget cost pressures for 2019/20
Ockenden 13: Culture Change Operational Lead: Sue Green, Executive Director of Workforce & Organisational Development *There will need to be sustained, visible (in clinical areas), stable leadership within MH&LD division over a longer period of time to ensure that the culture within mental health and specifically OPMH continues to develop in a positive way.* *The cultural change that is necessary towards dementia needs to happen across BCUHB and to happen from Board to Ward. This cultural change needs to happen not just within MH&LD but everywhere within BCUHB where care and treatment*		• The national Staff Survey Project Group continues to implement approaches that develop and build an "in-house" ongoing sustainable approach to measuring colleague experiences as agreed by the Welsh Partnership Forum in November 2018 and in line with Welsh Government strategies. The new approach will help develop the NHS Wales culture so that colleagues regularly give and receive feedback. • The Organisational Improvement Plan has been developed following a number of staff engagement events held during December 2018, as well as drawing on data from the qualitative element of the staff survey. The Improvement Plan was approved by Board in March 2019 and a number of improvement actions have since been met. As the organisation approaches the end of the first quarter, a process is in place to feedback these outcomes to our staff through as many communication channels as possible. The Organisational Development team have worked closely with the Communications team to develop a Communication Strategy to support this.	

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may be provided to persons with dementia, their families and friends.		• Furthermore, the Organisational Development team engaged with and supported divisional managers to ensure divisional improvement plans are drafted and discussed with staff locally and worked up into final plans. Staff engagement events were held locally to further inform and develop local plans. All divisions are progressing their improvement plans and developing their communication approach to ensure staff receive feedback on local actions. The '*You Said, We Did*' template has been shared with divisions but any local communications channels can be used to update staff. The Workforce Improvement Group will monitor progress against the Divisional Improvement plans. • As part of the Quality Improvement and Governance Programme (QIGP), a Quality Improvement Strategy will be developed through an established collaborative task & finish group in consultation with staff, partners and people with lived experience of using our services which will continue to meet monthly to ensure the production of an MHLD Quality Strategy. The 10 themes of the QIGP have been fully mapped out for actions which are reviewed in 90 day cycle meetings. • The Strategy aims to provide assurance to stakeholders of our continued determination to focus on delivering high quality patient care and challenging ourselves to achieve the highest of standards. • The Health Board is strengthening its offer of skilled level dementia training for clinical staff. Current training is aligned to the 'Good Work' framework and we are developing our modules further by placing additional emphasis on the important role of the carer. To support this work is underway with TIDE, an involvement network for carers of people living with dementia, hosted by the Life Story Network CIC. Its mission is to be the voice, friend and future of all carers and former carers of people with dementia. TIDE is supporting carers to share their experiences by training them to acquire appropriate skills and competencies in delivering training. The project is overseen by the Consultant Nurse for dementia. • As part of the celebrations for the 70th anniversary of the NHS last year, all members of the Executive Team participated in a 'Back to the Floor' initiative to celebrate with staff, families and volunteers the incredible work conducted by our staff and volunteers on a daily basis. Further to this, a proposal has been made to continue with a rolling programme of a refreshed approach 'Walk in my Shoes' for all Executives and Senior Leaders. This will involve each member of the Executive Team undertaking a 'shift' of a minimum half day within a range of services, both patient facing and non-patient facing such as catering, estates and administrative services. The aim is to undertake a shift which presents an opportunity for high visibility or within hard to reach/remote areas such as community teams. The whole ethos of the shift will be to integrate with the team and undertake tasks that the team would normally perform on a day to day basis. This will not only improve visibility but will also allow staff to get to know Executives/Senior leaders on a more personal level.	

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The actions undertaken in response to the following recommendations have been reviewed and signed off by the HASCAS & Ockenden Improvement Group as now being closed. Assurance is provided by the operational leads that ongoing monitoring and oversight will be undertaken via the relevant working group for each recommendation.

Recommendation	Current position	Progress update	Risks
HASCAS 3: Care Homes and Service Integration Operational Lead: Reena Cartmell Associate Director of Nursing *The current Care Home work streams need to be incorporated into a single action plan, which in turn should dovetail into the pre-existing BCUHB mental health and dementia strategies.*	Closed with ongoing monitoring by the corporate nursing department	The Improvement Group for the HASCAS & Ockenden recommendations held on 31st July 2019 formally approved that this recommendation was fully implemented, with the agreement that the identified actions have been delivered to address the objectives set out in the HASCAS report as previously reported. The following activity has been undertaken to ensure that this recommendation has been fulfilled. • ***Logic Model:*** The logic model for HASCAS recommendation 3 has been refined with clearer outcomes, measurable outputs and a list of activities required to achieve the overall desired impact. The former implementation plan has therefore been translated into this logic model, and is now used as our baseline. There are three main outputs to be achieved within the programme of work, these include: 1. Action plans based on engagement with the care home sector. 2. A single care home action plan that supports the implementation of the BCUHB Dementia Strategy and pre-existing BCUHB 'Together for Mental Health' Strategy. 3. Integrated Training programmes for BCUHB to include Care Home Staff. • ***Care Home Event***: A series of 4 hour 'getting to know you' events with care home and clinical health board staff were held on four days throughout March 2019 across West, Central and East areas. BCUHB hosted the event, supported by the CEO of Care Forum Wales, which were delivered within a world café approach to generate ideas on how to improve working partnerships for patient centred care and to discuss ways to improve relations, safer discharges, and celebrating successes in older person's services. Area Nurse Directors have reviewed the recommendations provided and considered how to develop (both immediately and long term) action plans for their local regions. Feedback to all partners who attended the events have been provided, and the programme manager for this work stream has co-ordinated all responses and shared with Care Inspectorate Wales (CIW) in March 2019. • ***Single Care Home Action Plan:*** The 'BCUHB Single Care Home Action Plan' was launched in July 2019 in order to incorporate all current care home work-streams into a single plan, which in turn will dovetail into other pre-existing BCUHB Mental Health and Dementia Strategies. The action plan has been developed as a direct response to the following requirements: – CIW / HIW Review of healthcare support provided by BCUHB for older people living in care homes in North Wales (November 2018). – Independent Investigation into the Care and Treatment Provided on Tawel Fan Ward: a Lessons for Learning Report, HASCAS (May 2018), (Recommendation 3). – Review of the Governance Arrangements relating to the care of patients on Tawel Fan ward prior to its closure on 20th December 2013 and governance arrangements in Older People's Mental Health at Betsi Cadwaladr University Health Board (BCUHB) from December 2013 to the current time, Donna Ockenden (June 2018). – BCUHB's Living Healthier, Staying Well Draft Framework for Care Closer to Home. – North Wales Social Care and Wellbeing Service Improvement Collaborative, Market Shaping Statement; Care Homes for Older People in North Wales (2018). – BCUHB Care Home Partnership Event (March 2019). The '*BCUHB Single Care Home Action Plan'* will be overseen by BCUHB's Corporate Nursing Department. Progress will be monitored and updates requested on a quarterly basis. Any new and emerging BCUHB care home work-streams will be added to, and form part of this integrated process at a local level. The aim of the action plan is to bring	Timescales pose a rise to delivery in respect of achieving such a broad range of service reviews. - Joint and clear action plans including milestones and timelines will be developed through logic models and KPIs with progress regularly reported to Improvement Group Workforce capacity and resource for transformation (reducing duplication / conflicting agendas). - Ensure joint responsibility of translating strategy into action via an improvement 'working group' and map out all forums/groups involved. Sustainability and differing standards of quality and safety of services (across health, social care, third sector and commissioned services). - Design a set of agreed principles in partnership along with quality and safety standards to inform the model of care and strategy.

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Recommendation	Current position	Progress update	Risks
		together all ongoing service re-design initiatives, and to capture evidence of improvements through a single framework of governance. Local area teams are responsible for updating the action plans, providing evidence of achievements with actions that are relative to local needs. Area Nurse Directors will therefore assume overall responsibility for the delivery of action plans. The drafted BCUHB priorities for the older persons have also been incorporated and mapped through a consultation process to help drive forward the older person's agenda for the health board. The priorities are based on the IPOP (Integrated Pathways for Older Persons) initiative with 7 key themes. Output measures are also identified with desired outcomes made clear. It is expected that each action will evidence the application of the following factors: – Stakeholder's engagement / service user involvement in the design of all action plans. – Key practice issues that relate to the workforce. – Timescales for completion. – Lead person(s) for management and delivery. – Quality Impact Assessments. A strategic review of progress and completion date is aimed for April 2020. The above achievements were presented to the HASCAS Improvement group meeting held on 28th July 2019 where it was approved that the requirements of the recommendation is fully implemented. However it is acknowledged that there is considerable progress required to implement the actions across Health Board in the forthcoming months. The stakeholder group have also been sighted on the development of the single care home action plan. • ***Integrated Training Programme***: A long-term training schedule for BCUHB to include Care Home staff in its design and delivery, in relation to the care of older person and those with Dementia remains under development. This work stream will be completed within the remit of Ockenden recommendation 12; Long Term Clinical Plan. The improvement lead has met with Bangor University and recent undertook a scoping exercise, which identified opportunities for BCUHB to work with the University to develop specific training and education. • ***Presentations***: The Programme Manager for this work stream delivered a successful presentation to the East, Central and West Partnership Forums to raise awareness of BCUHB's progress made against HASCAS recommendation 3. The partnership forums have provided the opportunity to move action plans forward, restoring confidence with wider stakeholders in relation to BCUHB supporting North Wales care homes (with nursing) and in doing so illustrating the consultation process and benefits of working in partnership. The Flintshire's 50+ Action Group also warmly received the same presentation in June 2019 and a further presentation will be offered to the Carer's Strategy Group in September 2019.	
HASCAS 4 Safeguarding Training Operational Lead: Michelle Denwood, Associate Director Safeguarding *BCUHB will revise its safeguarding training programme to ensure it is up to date and fit for purpose. The updated training programme will*	Closed with ongoing monitoring via the Safeguarding Reporting framework	• The Improvement Group for the HASCAS & Ockenden recommendations held on 28th May 2019 formally approved that this recommendation was fully implemented, with the agreement that the identified actions have been delivered to address the objectives set out in the HASCAS report as previously reported. • The following activity has been undertaken to ensure that this recommendation has been fulfilled:	

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HASCAS & Ockenden Recommendations – update report for Quality, Safety & Experience Committee 19th November 2019

Recommendation	Current position	Progress update	Risks
incorporate all relevant legislation and national guidance *BCUHB will engage with all prior safeguarding course attendees to ensure that they are in receipt if the correct and updated guidance. The responsibility for this will be overseen by the relevant BCUHB Executive Director with responsibility placed on all clinical service managers from all of the clinical divisions within the organisation* *BCUHB has not been able to ensure staff attend safeguarding training sessions in the numbers required. there are multiple factors involved which will require a detailed and timed action plan with external oversight.*		– All existing safeguarding training packages have been refreshed and updated to ensure that packages are in line with current legislation. – National recognition has been received for the Ask and Act Training - VAWDASV (Domestic Abuse) which has been accepted as a National Training package for Wales. – A learning environment has been led and embedded by Corporate Safeguarding, through the Safeguarding Bulletin, which targets education, learning and updates relating to legislation, policy and procedures. – A robust analysis of training compliance occurs through the refreshed Safeguarding Reporting Framework and into Area/Secondary Care /Divisional governance forums. – Training Reports are undertaken and areas of low compliance within Safeguarding Training are identified and scrutinised. Underperforming areas are reported via the Safeguarding Reporting Framework and into Area / Secondary Care / Divisional governance forums. • Whilst this recommendation has been recognised as implemented, the important role of Training in embedding good safeguarding practice is recognised, and activity will continue in this high priority area.	
HASCAS 5 Safeguarding Informatics and Documentation Operational Lead: Michelle Denwood, Associate Director Safeguarding *BCUHB has conducted an audit on the compliance of filing safeguarding information in patients' casenotes. BCUHB will ensure that the consequent recommendations it set in relation to informatics in its BCUHB Corporate Safeguarding Team Safeguarding and Protections of People at Risk of Harm Annual Report 2017-18 are implemented namely;* • *The use of the dividers to be re-iterated in safeguarding training, briefings, and other communication activities and a key annual audit activity;* • *Process of secure storage of strategy minutes of strategy meetings and outcomes of referrals to be revisited at safeguarding forums with legislative guidance from Information Governance;* • *Team and ward managers to continue to include safeguarding documentation in team meetings and safety briefs.* *BCUHB will reconsider how clinical teams should record safeguarding information and the quality of the information provided.*	Closed with ongoing monitoring via the Corporate safeguarding team	• The Improvement Group for the HASCAS & Ockenden recommendations held on 28th May 2019 formally approved that this recommendation was fully implemented, with the agreement that the identified actions have been delivered to address the objectives set out in the HASCAS report as previously reported. • The following activity has been undertaken to ensure that this recommendation has been fulfilled: – The Health Records department has worked alongside the Associate Director of Safeguarding to support the review and amendment of the safe storage of safeguarding information in clinical records in line with the Social Services & Well-Being Wales Act and GDPR. – Good Record Keeping (GRK) training has been delivered, which incorporates a sign off element for safeguarding to ensure that records are correct. – Initial scoping work has been completed to review the approach for the transition to digitalisation system from paper records by the Health Records Department. – The Health Records Service have completed actions with the following deliverables: (i) Good Record Keeping Training explicitly includes a section on filing safeguarding information; (ii) Communications cascaded on Things You Need To Know (TYNTK) to remind staff of the importance of appropriately filing 'safeguarding' information; (iii) Supplier of the safeguarding divider (for the case note folders) are being updated to reference updated Safeguarding terminology, and to include the Harm agenda. A list of documents which are to be included behind the divider has been set out. • The GRK Training and communications from the action above are being used to strengthen the HR1 Policy for appropriate filing of safeguarding information – this is being prepared in line with a full review of HR1 in light of GDPR. Work has been undertaken with MHLD colleagues to ascertain their use of the safeguarding divider, remind them of their responsibilities in its use, and ask for assurance of appropriate use. • In order to assure progress in this area, internal audit are scheduled to undertake a records management audit and a review of the implementation of safeguarding documentation. This has been included within the planned works for 2019-20. • Level 3 Record Management training is included within the Safeguarding Training portfolio. This package incorporates the safe storage of safeguarding information.	Digital informatics and the management of clinical records remains an organisational risk, based upon the challenges relating to the availability of different systems of which do not support the identification of risk or sharing of information.

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Recommendation	Current position	Progress update	Risks
		• When areas / departments identify high levels of safeguarding activity, a review of record management takes place, this also includes where cases are discussed and supervision and support is provided. • The Safeguarding Bulletin has a 'Learning' theme once a quarter and these Bulletins specifically highlight education, legislation and policy and procedure updates. • The monthly Safeguarding Bulletins provide reference, advice and guidance relating to records management and remains a key activity of dissemination of information by Teams and Ward managers. • Whilst this recommendation has been recognised as implemented, the important role of Good Record Management in embedding good safeguarding practice is recognised, and activity will continue in this high priority area.	
HASCAS 6 Safeguarding Policies & Procedures Operational Lead: Michelle Denwood, Associate Director Safeguarding *The BCUHB Corporate Safeguarding Team Safeguarding and Protection of People at Risk of Harm Annual Report 2017-2018 identified that there were priority actions required in relation to safeguarding policies and procedures. This investigation recommends that these priority actions are incorporated into the action plan consequent to the publication of this report. The actions are;* • *To identify those policies, procedures and SOPs that firmly sit within the Safeguarding remit and those that should be the responsibility with internal and external partners* • *Agree a priority list and activity timeframe to review documents within the parameters of corporate safeguarding* • *Provide safeguarding expert advice to internal and external partners in order that those documents are reviewed appropriately and in line with local and national policy band legislative safeguarding frameworks;* • *Agree a governance structure and reporting framework for all safeguarding policies, procedures and SOPs;* • *Update and maintain the Safeguarding Policy webpage;* • *Continue to actively participate in the Policy and Procedure sub group of the Regional Safeguarding Boards*	Closed with ongoing monitoring via the Safeguarding Governance & Performance Group	• The Improvement Group for the HASCAS & Ockenden recommendations held on 28th May 2019 formally approved that this recommendation was fully implemented, with the agreement that the identified actions have been delivered to address the objectives set out in the HASCAS report as previously reported. • The following activity has been undertaken to ensure that this recommendation has been fulfilled: – Good progress has been made in the management and control of Safeguarding policies. All policies and procedures within Corporate Safeguarding have been identified and a register has been implemented which manages version control and the publishing of policies in a timely and accurate way. – To ensure the governance structure is in place and in accordance with organisational procedure the Safeguarding Business Manager is linking in with the Board Secretary and the Policy on Policies (PoP) and their work on developing a central repository as part of this process. – A priority list has been identified with a full review of Phase 1 completed. The following procedures and guidance were requested for approval at QSG following ratification at the Safeguarding Governance and Performance Group on 31 January 2019. ▪ The Adult at Risk Procedure – ratified for publication and builds on the guidance issued by Welsh Government. (HASCAS 8.3) ▪ Safeguarding Supervision Procedure – BCUHB Supervision ▪ Female Genital Mutilation (FGM) Standard Operating Procedure ▪ Best Interest Meeting Guidance – Deprivation of Liberty Safeguards (DoLS) • In addition, to the above policies, the following processes were approved at Safeguarding Governance and Performance Group in January 2019 and subsequently implemented: – Procedural Response to Unexpected Death in Childhood (PRUDIC) which have been published in line with National guidance. – Safeguarding Team; Area Domestic Abuse Workplace Safety Group. Terms of Reference (ToR) – Safeguarding Supervision Procedure – Safeguarding Only Supervision • Full engagement takes place across the organisation and with participation at the North Wales Safeguarding Adult Training Sub Group, this ensures internal and external expertise to be captured.	

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HASCAS & Ockenden Recommendations – update report for Quality, Safety & Experience Committee 19th November 2019

Recommendation	Current position	Progress update	Risks
HASCAS 7: Tracking of Adults at Risk across North Wales Operational Lead: Michelle Denwood, Associate Director of Safeguarding *BCUHB will work with multi-agency partners through the North Wales Adult Safeguarding Board, to determine and make recommendations regarding the development of local safeguarding systems to track an individual's safeguarding history as they move through health and social care services across North Wales in order to ensure ongoing continuity of protection for that individual.*	Closed with ongoing monitoring via the NW Safeguarding Adult Board	• The Improvement Group for the HASCAS & Ockenden recommendations held on 28th May 2019 formally approved that this recommendation was fully implemented, with the agreement that the identified actions have been delivered to address the objectives set out in the HASCAS report as previously reported. • The following activity has been undertaken to ensure that this recommendation has been fulfilled: – BCUHB worked in collaboration with North Wales Safeguarding Adult Board to coordinate a Task and Finish Group for shared learning with regard documentation and communication. – This Task and Finish Group has now been disbanded due to completion as agreed by the North Wales Safeguarding Adult Board. – The Lead Practitioner programme has been developed in collaboration with the North Wales Safeguarding Adults Board (NWSAB). Over 70 key BCUHB staff have been identified to participate in the pilot and undertake the Lead Practitioner training, which will be implemented by July 2019. – This programme represents a major change in how Adults at Risk are coordinated and managed across the Health Board and will result in a more individualised and improved experience for the patient. • The programme will continue to be rolled out, implementation is a priority for 2019-20.	
HASCAS 13: Restrictive Practice Guidance Operational Lead: Steve Forsyth Director of Nursing MH&LD *BCUHB will provide assurance that all older adults and those with dementia are in receipt of lawful and safe interventions in relation to restrictive practice management across all care and treatment settings within the BCUHB provision.*	Closed with ongoing monitoring via the Quality, Safety, Effectiveness, Experience, Leadership Group	The Improvement Group for the HASCAS & Ockenden recommendations held 28th May 2019 formally approved that this recommendation was fully implemented, with the agreement that the identified actions have been delivered to address the objectives set out in the HASCAS report as previously reported. The following activity has been undertaken to ensure that this recommendation has been fulfilled: • The 2 recently developed policies relating to the positive reduction of challenging behaviours and physical restraint, have both been subject to governance scrutiny and review and are fully ratified and operational. • Training in proactive approaches has begun in earnest with a full schedule of training dates available for all clinical areas where a training need has been identified. Moreover, the corporate training team are receiving ongoing support from the Positive Interventions Clinical Support Service (PICSS) team and are on track to being able to independently to deliver this training to the wider organisation by the end of the calendar year. • Training in the use of Datix to report incidents of restrictive physical intervention is included. • Within the MHLD division, BCUHB PICU staff (Tryweryn) together with Caniad recently showcased to the Leaders Collaborative conference a number of initiatives being introduced to the wards – these included new ideas and approaches in reducing restrictive practices, improved co-production and a revised all Wales training syllabus in the prevention and management of behaviours which challenge. Furthermore, the excellent work being carried out by Tryweryn staff and Caniad has been shortlisted for the 2019 Nursing Times Awards'. An update was provided to the Improvement Group meeting held on 16th September that highlighted performance of draft Mental Health benchmarking data that demonstrated the Health Board is significantly improving the number of restraints per 10,000 occupied bed days for both adults and OPMH. The Improvement Group noted that this was a very positive development against a key performance metric	

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HASCAS & Ockenden Recommendations – update report for Quality, Safety & Experience Committee 19th November 2019

Recommendation	Current position	Progress update	Risks
Ockenden 2d: Appointment of a second Consultant Nurse in Dementia Operational Lead: Chris Lynes, Area Nurse Director (West) *There is currently only one Consultant Nurse in Dementia for the whole of BCUHB. With the currently extensive work plan this single post-holder is already likely to be stretched very thinly. Going forward there will not be sufficient Consultant Nurse resource to even begin to get to grips with the recommendations arising from this review and the HASCAS investigation. BCUHB should take active steps to appoint a second Consultant Nurse in Dementia.*	Closed	• Recruitment process for the second Consultant Nurse in Dementia post has been successful and the candidate Suzie Southey commenced in post on 1st July, this role will include a focus on Acute Care, End of Life Care and Primary Care.	
Ockenden 4b & 4c: Staff Surveys Operational Lead: Sue Green, Executive Director of Workforce & Organisational Development *The Ockenden review team was informed that the NHS staff survey across Wales is completed every 3 years and is next due in 2019. WG may wish to consider an annual staff survey in line with that carried out in England.* *Aside from any potential decision by WG, the BCUHB Board should commence a formal annual BCUHB staff survey starting with the all Wales staff survey at BCUHB on an annual basis from 2020.*	Closed with ongoing monitoring via the Workforce Improvement Group	The Improvement Group for the HASCAS & Ockenden recommendations held on 31st July 2019 formally approved that this recommendation was fully implemented, with the agreement that the identified actions have been delivered to address the objectives set out in the HASCAS report as previously reported. The following activity has been undertaken to ensure that this recommendation has been fulfilled: • The 2018 NHS Wales annual staff survey has been undertaken and the results revealed a number of positive improvements since the 2013 and 2016 survey. • The Organisational Survey has been redesigned and tailored to the Health Board's needs with additional Wellbeing and Equality & Diversity questions. The results of the first BeProud organisational engagement survey report saw a 20.29% response rate, which equates to 1400 individuals from a range of disciplines across the Health Board. These results from the first quarterly survey were presented to the Executive Team on 31st July. Plans are in place to carry out 4 surveys a year with a different random sample each time. • Draft organisational and divisional plans were approved at the Health Board meeting on 28th March 2019. Monitoring progress against the organisational improvement plan and divisional improvement plans will take place through the Workforce Improvement Group. • It is important to note that the survey content, administration and execution is under complete review nationally. The Cabinet Secretary has been clear of the expectation that staff locally need to be involved in driving the change and improvements required to improve experiences at work. NHS Wales has historically facilitated pan-organisational surveys bi-annually. These have been contracted out to organisations who have provided pan-NHS Wales and organisational reports. There has also been access to the results database to allow more localised interrogation of the data, but this has not allowed organisations to drill down fully to team and departmental level in a meaningful way. It has been confirmed that a national NHS Staff Survey will next take place in 2020. • In addition, as part of the 'Be Proud' Pioneer Programme, surveys are undertaken locally in teams to establish an engagement baseline measure which the pioneers are working on to develop local improvement plans that focus on the three lowest scores within their survey. Each team takes ownership to agree which engagement tools they will use to make improvements. At the end of 26 weeks another team survey is undertaken and comparisons are made against the first survey. All ten teams have fully engaged with the programme and the response to the programme by the Pioneers and their teams has been excellent and very encouraging.	

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HASCAS & Ockenden Recommendations – update report for Quality, Safety & Experience Committee 19th November 2019

Recommendation	Current position	Progress update	Risks
Ockenden 10: Reviewing external reviews Operational Lead: Dawn Sharp, Deputy Board Secretary *BCUHB needs to undertake a review of all external reviews (including those by HIW, the NHS Delivery Unit and others) where any findings, recommendations and requirement may have concerned older people and specifically the care of older people with mental health concerns.* *The exercise needs to be completed across all Divisions and all sites by the end of the second quarter 2018/2019, (the end of September 2018) and reported to the BCUHB Board by November 2018.*	Closed with ongoing monitoring by the Quality & Safety Group	The Improvement Group for the HASCAS & Ockenden recommendations held on 31st July 2019 formally approved that this recommendation was fully implemented, with the agreement that the identified actions have been delivered to address the objectives set out in the HASCAS report as previously reported. The following activity has been undertaken to ensure that this recommendation has been fulfilled; • Following the review undertaken by the Corporate Nursing Team to strengthen assurances, the BCU / HIW management plan was introduced to provide additional assurance processes continues to be implemented. • All open / outstanding actions arising from these inspection reports continue to be monitored/managed on a monthly basis by the Quality and Safety Group.	
Ockenden 14: Board Development Operational Lead: Dawn Sharp, Deputy Board Secretary *The work of Swaffer and the WHO/ United Nations should be introduced to the Board in a Board seminar/ Development day in the second quarter of 2018-19 and a programme of introduction to the whole of BCUHB should commence in the third quarter of 2018- 19 with reports to the Board on the introduction and utilisation of 'Prescribed Dis-engagement' every quarter.*	Closed	• The Executive Director of Nursing and Midwifery determined that this ambition would be best met by the full Board participating within a dementia friendly awareness session which was delivered on 10th January 2019. • At the Improvement Group meeting held on 29th January it was formally approved that this recommendation was fully implemented as the action has been completed for required Board members. Following on from this, the Executive Director of workforce & Organisational Development agreed to take forward an action to consider how to incorporate dementia awareness sessions into the Health Board's induction programme. • A dementia friendly awareness session for senior managers as members of the Executive Management Group took place on 3rd July. • This will form part of any new board member's formal induction	

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Quality, Safety & Experience Committee **19.11.19**	GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board To improve health and provide excellent care

Report Title:	Summary of In Committee business to be reported in public
Report Author:	Mrs Kate Dunn, Head of Corporate Affairs
Responsible Director:	Mrs Deborah Carter, Director of Quality Assurance / Interim Director of Operations
Public or In Committee	Public
Purpose of Report:	Standing Order 6.5.3 requires the Board to formally report any decisions taken in private session to the next meeting of the Board in public session. This principle is also applied to Committee meetings.
Approval / Scrutiny Route Prior to Presentation:	The issues listed below were considered by the Committee at its private in committee meeting on 24.9.19 • Executive briefings • Briefing on endoscopy services • Briefing on follow up delays
Governance issues / risks:	None identified
Financial Implications:	None identified
Recommendation:	The Committee is asked to: 1. Note the information in public.

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

3.To support children to have the best start in life	✓	3. Involving those with an interest and seeking their views	✓
4.To work in partnership to support people – individuals, families, carers, communities - to achieve their own well-being	✓	4.Putting resources into preventing problems occurring or getting worse	✓
5.To improve the safety and quality of all services	✓	5.Considering impact on all well-being goals together and on other bodies	✓
6.To respect people and their dignity	✓		
7.To listen to people and learn from their experiences	✓		
Special Measures Improvement Framework Theme/Expectation addressed by this paper Governance			
Equality Impact Assessment No equality impact assessment is considered necessary for this paper.			

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