Bundle Quality, Safety & Experience Committee 28 January 2020

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

0 Note - Pre Meeting of Independent Members to take place at 09:00

1.0 OPENING BUSINESS AND EFFECTIVE GOVERNANCE

1.1 09:30 - QS20/1 Chair's Opening Remarks

1.2 QS20/2 Declarations of Interest

1.3 QS20/3 Apologies for Absence

1.4 09:32 - QS20/4 Minutes of Previous Meeting Held in Public on the 19.11.19 for Accuracy, Matters Arising and Review of Summary Action Log

QS20.4a Minutes QSE 19.11.19 Public V0.03.docx

QS20.4b Summary Action Log QSE Public.docx

1.5 09:42 - QS20/5 Minutes of Meeting of Joint Audit and Quality, Safety & Experience Committees Held in Public on the 5.11.19 - for information

QS20.5 Minutes JAQS 5.11.19 Public V0.03.docx

1.6 09:47 - QS20/6 Patient Story : Mrs Gill Harris

QS20.6 Patient story ICAN.DOCX

1.7 10:02 - QS20/7 Quality/Safety Awards and Achievements : Mrs Gill Harris

Verbal update

2.0 FOR DISCUSSION

2.1 10:07 - QS20/8 Annual Plan Monitoring Report - Dr Jill Newman

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

QS20.8a Annual Plan Progress Monitoring Report Coversheet.docx

QS20.8b Annual Plan Progress Monitoring Report Appendix 1 December 2019 FINAL.pdf

2.2 10:17 - QS20/9 Integrated Quality & Performance Report - Dr Jill Newman

Recommendation:
The Quality, Safety and Experience Committee is asked to scrutinise the report and to consider whether any area needs further escalation to be considered by the Board.

QS20.9a IQPR Coversheet.docx

QS20.9bIQPR Appendix 1 December 2019 FINAL.pdf

2.3 10:27 - QS20/10 Endoscopy Update : Mr Adrian Thomas

Recommendation:
The Committee is asked to continue to support the increased level of focus on the design and implementation of the recovery plan to address the core capacity improvement, backlog reduction and sustainable solutions for endoscopy services across BCUHB working closely with the National Endoscopy Programme Board and the Delivery Unit to deliver both shorter and longer tem plans.

QS20.10 Endoscopy Update January 2020 v1.0.docx

2.4 10:37 - QS20/11 Occupational Health & Safety Q3 Report : Mrs Sue Green

Recommendation:
The Committee is asked to:
1. Note the position outlined in the Quarterly Report.

QS20.11 Occupational Health and Safety Q3 Report_final reformatted.docx

2.5 10:47 - QS20/12 Patient Safety Report : Mrs Gill Harris

Recommendations:
The QSE Committee is asked to:
1. Note specific highlighted areas: overall patient safety incident reporting, Never Events, notable inquests (including 1 Prevention of Future Death Notice), overall complaints, Section 16 PSOW Report, upcoming significant claim and the safety alert non-compliance position.
2. Be aware of the possible triangulation between increase patient safety incidents, complaints, OTS and litigation and the further analysis into this now underway.
3. Note the ongoing work of the quality improvement collaboratives and planned improvement work: including review of various Health Board processes and implementation of the Datix IQ Cloud.
4. Note the increase in Welsh Risk Pool costs.
5. Receive this report and provide feedback on its evolved content and layout.

QS20.12 Patient Safety Report Q2 and Q3_reformatted.docx

2.6 11:07 - Comfort Break

2.7 11:17 - QS20/13 Mental Health and Learning Disabilities Exception Report : Mrs Lesley Singleton

Recommendation:
The Committee asked to:
1.Note progress made related to:
• Compliance with the Mental Health Measure, people classified as Delayed Transfers of Care (DToC) and people placed out of area
• Lessons Learned from incidents
• HIW outstanding actions
• Risk register: those managed through locality structures and those overseen by Divisional Directors
• Mental Health Strategy and plans for Quality Improvement

QS20.13 MH Exception Report 2020-01 Final.doc

2.8 11:32 - QS20/14 Development of Dementia Services : Mrs Gill Harris

Recommendation:
The QSE Committee is asked to accept the report submitted giving an update on the future of Dementia services with a focus on ensuring consistency across the Health Board

QS20.14a Dementia Update.docx

QS20.14b Dementia Update appendix 1.docx

QS20.14c update dementia appendix 2.pptx

2.9 11:47 - QS20/15 Serious Incidents Report : Mrs Gill Harris

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

QS20.15 Serious Incident report_reformatted.docx

2.10 11:57 - QS20/16 All-Wales Self-Assessment of Quality Governance Arrangements : Mrs Gill Harris

Recommendation:
The Quality, Safety and Experience Committee is asked to scrutinise the report and to consider whether any area needs further escalation to be considered by the Board.

QS20.16a Cwm Taf Self Assessment Coversheet.docx

QS20.16b Cwm Taf self assessment Appendix 1 final 060120.docx

2.11 12:07 - QS20/17 Healthcare Inspectorate Wales – the Health Board's position statement : Mrs Gill Harris

Recommendations:
The Committee is asked to:
1. Note the reports and appendices;
2. Approve the proposed tracker improvement actions.

QS20.17a HIW_amended 21.1.20.docx

QS20.17b HIW Appendix A- Corporate Nursing HIW Tracker Tool.docx

QS20.17c HIW Appendix B- Follow-up Inspection Wrexham Maelor BCUHB Emergency Department.pdf

QS20.17d HIW Appendix C- Hospital Inspection Glan Clwyd BCUHB Maternity Services.pdf

QS20.17e HIW Appendix D- HIW Standard Operating Procedure.pdf

QS20.17f HIW Appendix E- Corporate Nursing Response.docx

2.12 12:22 - QS20/18 Corporate Risk Register and Assurance Framework Report : Executive Leads

Recommendation:
The Quality, Safety and Experience 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) Consider and approve the reduction in the current risk score for CRRR13 from 16 to 12;
4) Approve the split of the Continuing Health Care and Potential inability of Care Homes to provide safe quality care risks, with the latter risk being newly formed and proposal for deescalation and management at Tier 2 by the Executive Director of Nursing and Midwifery;
5) Approve the new risk for escalation onto the Corporate Risk Register.

QS20.18 CRAF Report to QSE v2 amended 22.1.20.pdf

2.14 12:37 - QS20/20 General Medical Council Enhanced Monitoring of Medicine Training and Wrexham Maelor Hospital : Dr David Fearnley

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

QS20.20 GMC Enhanced Monitoring Medicine WMH V1.0.docx

3.0 FOR CONSENT

3.1 12:47 - QS20/21 Policies, Procedures or Other Written Control Documents for Approval

3.1.1 QS20/21.1 Review of Open Visiting Policy : Mrs Gill Harris

Recommendation:
The Committee is asked to approve the updated Open Visiting Policy

QS21.1a Open Visiting Policy report.docx

QS21.1b Open Visiting Policy Appendix 1.docx

QS21.1c Open Visiting Policy Appendix 2.docx

3.1.2 QS20/21.2 Nurse Staffing Levels Policy : Mrs Gill Harris

Recommendation:
The Committee is asked to approve the Nurse Staffing Levels Policy.

QS20.21.2a Nurse Staffing Levels Policy report.docx

QS20.21.2b Nurse Staffing Level Policy Appendix 1.docx

QS20.21.2c Nurse Staffing Levels Appendix 2 Workforce Planning template.xlsx

QS20.21.2d Nurse Staffing Levels Appendix 3 Triangulation of Patient Harm Incidents Report.xlsx

QS20.21.2f Nurse Staffing Levels Appendix 4 EQIA.docx

3.1.3 QS20/21.3 Clinical Audit Policy : Dr David Fearnley

Recommendation:
The Committee is asked to approve the draft policy and procedure document.

QS20.21.3a Clinical Audit Policy report.docx

QS20.21.3b Clinical Audit Policy Draft V1.15_Appendix 1.docx

QS20.21.3c Clinical Audit Policy EqIA v2_Appendix 2.doc

3.1.4 QS20/21.4 Mental Health and Learning Disabilities Division - Resubmission of Policies

Recommendation:
The Committee is asked to:
1. Approve the amended written control documents for implementation.

QS20.21.4a MHLDS WCDs Report.docx

QS20.21.4b Threats to the person in Forensic Establishments Policy Appendix 1.docx

QS20.21.4c Threats to the Person Procedures in Forensic Establishments EQIA Appendix 2.doc

QS20.21.4d Major Incident Protocol Appendix 3.doc

QS20.21.4e Major Incident Protocol EQIA Appendix 4.doc

QS20.21.4f Handcuff Policy MHLD 0041 Forensic Services Appendix 5.docx

QS20.21.4g Handcuff_Policy eqia Appendix 6.doc

3.1.5 13:02 - Lunch Break - attendees are reminded to bring their own lunch

3.2 13:22 - QS20/22 Quality Safety Group Assurance Report : Mrs Gill Harris

QS20.22 QSG assurance reports.doc

3.3 13:32 - QS20/23 Improvement Group (HASCAS & Ockenden) Chair's Assurance Report : Mrs Gill Harris

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

QS20.23 HASCAS Ockenden update report.docx

3.4 13:42 - QS20/24 Health and Social Care (Quality and Engagement) (Wales) Bill : Mrs Gill Harris

Recommendation:
The Quality, Safety and Experience Committee is asked to receive this report for information.

QS20.24 Quality Bill.docx

4.0 13:52 - FOR INFORMATION

4.1 QS20/26 Issues Discussed in Previous Private Session

Recommendation:
The Committee is asked to note the report

QS20.26 Private session items reported in public.docx

4.2 QS20/27 Documents Circulated to Members

5.12.19 APPMR for October
19.12.19 QSG Notes of November meeting
21.1.20 QSG Notes of December meeting

4.3 QS20/28 Issues of Significance to inform the Chair's Assurance Report

4.4 QS20/29 Date of Next Meeting

Tuesday 17.3.20

4.5 QS20/30 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."

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Quality, Safety and Experience (QSE) Committee

Minutes of the Meeting Held in public on 19.11.19 in The Boardroom, Carlton Court, St Asaph

Present:

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

In Attendance:

Mrs Deborah Carter	Associate Director of Quality Assurance
Mrs Michelle Denwood	Associate Director of Safeguarding (*part meeting)*
Mrs Kate Dunn	Head of Corporate Affairs
Dr David Fearnley	Executive Medical Director
Mr Steve Forsyth	Director of Nursing, Mental Health & Learning Disabilities (*part meeting)*
Mrs Sue Green	Executive Director of Workforce and Organisational Development (OD)
Mr Dave Harries	Head of Internal Audit
Ms Naomi Holder	Site Director of Nursing (*part meeting)*
Dr Melanie Maxwell	Senior Associate Medical Director / 1000 Clinical Lead
Dr Jill Newman	Director of Performance *(part meeting)*
Miss Teresa Owen	Executive Director of Public Health
Mrs Lesley Singleton	Director of Partnerships, Mental Health & Learning Disabilities (*part meeting)*
Dr Chris Stockport	Executive Director of Primary and Community Services
Mr Adrian Thomas	Executive Director of Therapies and Health Sciences
Mr Mark Wilkinson	Executive Director of Planning & Performance (*part meeting)*

Agenda Item Discussed	Action By
QS19/158 Chair's Opening Remarks The Chair welcomed everyone to the meeting. She reported that the deferred item listed on the agenda related to a requirement to update the Committee on learning and improvements from limited assurance audit reports. She would discuss further with the respective leads to ensure they were clear on what was expected.	LR
QS19/159 Declarations of Interest None raised	
QS19/160 Apologies for Absence Apologies were received from Mrs Gill Harris, Mrs Lyn Meadows, Mr Andy Roach and Mr Mark Thornton. It was noted that Mr Adrian Thomas would need to leave the meeting to Chair a national conference call.	

QS19/161 Minutes of Previous Meeting Held in Public on the 24th September 2019 for Accuracy, Matters Arising and Review of Summary Action Log **QS19/161.1** The minutes were approved as an accurate record. **QS19/161.2** A matter arising was raised in terms of the RAG rating for crude mortality rates within the Integrated Quality Performance Report. The discussion at the September meeting had queried whether the indicator should be green as it was higher than plan ie; 0.71% compared to plan of 0.7%. The Director of Performance clarified that for this indicator improved performance is to be below the plan level ie; mortality to be at or below 0.7% and therefore the report was correct. **QS19/161.3** Updates were recorded against the summary action log. The Chair was disappointed to note that there were several instances where updates had not been provided against actions at the time of publication of the papers. **QS19/161.4** The Committee noted that since the last meeting briefing notes had been provided for members on endoscopy and infection prevention.	
QS19/162 Patient Story **QS19/162.1** The Associate Director Quality Assurance presented the paper which related to the Community Care Collaborative Hub in Wrexham in January 2017. She felt that the paper told a positive story about responding to and meeting the needs of individuals and communities. **QS19/162.2** A discussion ensued. Members welcomed the feedback on the hub and enquired how the model was being rolled out and enhanced. The Director of Partnerships, Mental Health and Learning Disabilities (MHLDS) Division confirmed that the Division was taking learning from the early work of the hub to create sustainability and to build on this through the ICAN model. It was noted that a community hub was being established in Pwllheli from next week. The Independent Member (Trade Unions) suggested that information on such community schemes should be shared more widely with BCU staff as some may wish to get involved or volunteer. The Executive Director of Public Health supported the value of projects that were not purely health-based and that a partnership approach was essential. The Executive Director of Primary and Community Services felt that the story provided an excellent example of social medicine. Members also noted the clear links with criminal justice and that this type of project would also have unseen and unexpected benefits. *[Mr M Wilkinson joined the meeting]*	
QS19/164 Annual Plan Monitoring Report (APMR) *[Agenda item taken out of order at Chair's discretion]* **QS19/164.1** The Director of Performance presented the report for the period as at September 2019 which had already been discussed by the full Health Board, and indicated that the next report was due out within the next few days. It was confirmed that the revised schedule for Board and Committee meetings from April 2020 would	

address some of these sequencing issues but this would be revisited again to ensure the APMR was as timely as possible. It was also noted that future reports should reflect if the Board had already scrutinized it and that the recommendation be relevant. **QS19/164.2 It was resolved that** the Quality, Safety and Experience Committee note the report.	JN
QS19/165 Integrated Quality and Performance Report (IQPR) *[Agenda item taken out of order at Chair's discretion]* **QS19/165.1** The Chair suggested that as mental health, including child and adolescent services, were discrete items on the agenda these can be discussed when those items are presented. **QS19/165.2** The Director of Performance presented the report. She indicated that more detail on the infection prevention and control (IPC) element had been provided following the Committee's request for more granular information, and a breakdown as to whether infections were hospital or community acquired. The data showed the prevalence of community infections as a whole. The Associate Director of Quality Assurance reported there were a range of positive rates being sustained and the Director of Performance indicated that performance was in line with national trends. **QS19/165.3** A discussion ensued. A member raised the issue of 'corridor nursing' and whether this affected infection control. The Associate Director of Quality Assurance acknowledged the requirement to consider the wider nursing environment and ensure high quality cleaning processes were in place within all settings. She highlighted the challenge of multiple bed moves in terms of IPC. A continued resource issue in terms of antimicrobial pharmacists within the central area was also noted. The Chair noted that the East area was flagged as a major outlier in terms of long waits for psychological therapies but there was no supporting narrative to explain this. The Director of Performance stated that there were inconsistencies in how this data was captured and reported and that the exception reports would be refined as they developed. The Director of Partnerships (MHDLS) accepted there was an issue with the model in the East and that the Division had commissioned a review. She undertook to ensure that future exception reports within the IQPR provided explanatory narrative where a major outlier was identified, together with timelines for addressing this. **QS19/165.4** The Director of Performance reported that an attempt had been made to show more trends within the header bars of the report and confirmed that where there was a plan, performance was monitored against this and not the national target, with the arrows showing whether there had been a deterioration or improvement. The Chair found the executive and chapter summaries very helpful. The Director of Performance drew attention to the executive summary and the need to reflect the improvement in CAMHS although the recent investment had not yet had the full impact. She also noted that in terms of the revised national reporting framework it was looking likely that 'A Healthier Wales' indicators and improvement indicators would be utilised, and some existing indicators stood down.	LS

QS19/165.5 A wider point was made around the detail and frequency of the IQPR and APMR reports. The Chair noted that although the IQPR was dependent upon reporting dates, the APMR was not and therefore should be presented with the latest position. It was agreed that a schedule would be provided to clarify deadlines for data reporting and the committee submissions. This would provide members with information on what information had been reported to which Committees. **QS19/165.6** The appropriateness of the recommendation was considered and the Chair suggested amendments post-meeting. **It was resolved that** the Committee would be provided with a clear reporting schedule to ensure the most up to date information is provided to each Committee and reduce report duplication. *[Mr A Thomas left the meeting]*	JN
QS19/163 Quality and Safety Awards and Achievements The Committee was pleased to note a range of awards and achievements for the Health Board including • Radiographer of year for Wales • Radiography team of year (Ysbyty Glan Clwyd) • An advanced specialist nursing award from the Nursing Times • Student nurse award from the Nursing Times	
QS19/167 Advanced Paramedic Roles and the Development of Multidisciplinary Teamworking **QS19/167.1** The Executive Director of Primary and Community Services provided a verbal update on this joint venture between the Health Board and the Welsh Ambulance Services NHS Trust (WAST). He reported this was operational across 5 clusters with practices generally working in pairs with evidence of a good buddying system. An education framework had been commissioned to be delivered via GP training practices and a full evaluation would be undertaken on areas of patient experience, the design of the project, what worked well, areas for improvement and an economic evaluation. The Executive Director of Primary and Community Services confirmed that a memorandum of understanding had been agreed with Legal and Risk Services, and funding was secured through to the end of the first training cohort. **QS19/167.2** Members welcomed the update and felt the scheme was a good example of partnership working. The question was asked whether there could be influence over introducing advanced prescribers into other professions, and the Executive Director of Primary and Community Services indicated this was an evolving dialogue also linked to the Physician Associates work. The Executive Director of Workforce and OD added that she had had a discussion with Bangor University regarding the identification of teams who could benefit from having non-medical prescribers. *[Mr M Wilkinson left the meeting]*	

QS19/174 Children's Services - Healthcare Inspectorate Wales' Thematic Review *[Agenda item taken out of order at Chair's discretion]* **QS19/174.1** The Chair welcomed the clear and concise report. The Executive Director of Primary and Community Services reminded members that the report gave an all Wales picture as related to a thematic review, although some specific BCU inspections had been included. **QS19/174.2** A discussion ensued. A member referred to recommendations 32-33 relating to service models and thresholds between child and adult health services and enquired as to progress with undertaking a full review as indicated within the paper. The Executive Director of Primary and Community Services indicated that he was relatively comfortable with the approach within the larger services (eg; epilepsy, diabetes) but it was less clear how some of the more niche specialties could address this, as it was often more difficult to run specific multidisciplinary team clinics and more difficult to track. The Associate Director of Quality Assurance responded to another question regarding parents staying with children on paediatric wards and how the transition to an adult ward was handled. She confirmed there was guidance in place and invited members to share any examples of this not being followed. The Chair reported that on a recent visit to the Emergency Department (ED) in Ysbyty Glan Clwyd (YGC) a comment was made that parents were using ED as a quick access route to see a paediatrician. The Executive Director of Primary and Community Services accepted that this perception could exist but he was not aware of any examples being highlighted to him specifically. He acknowledged however that there were inappropriate ED attendances by both children and adults. The Executive Director of Workforce and OD referred to a successful project utilising health visitors and school nurses within the Single Integrated Clinical Assessment and Triage (SICAT) to divert paediatric 999 calls from EDs. The Executive Director of Public Health suggested that there were population and social reasons for increased ED attendances as very often the more vulnerable individuals without family or other support networks would turn to an ED facility for help. There would also be a cohort of the population who were not registered with a GP. A member noted that she was pleased to see that the paediatric area in the YGC ED was now protected. **QS19/174.3 It was resolved that** the Committee: 1. Note the progress that is being made to services for children, young people and their families. 2. Note the actions being undertaken to address the recommendations within the review.	
QS19/168 Infection Prevention : Second Safe Clean Care review by Jan Stevens (May 2019) **QS19/168.1** The Associate Director of Quality Assurance presented the report which summarised significant improvements noted by Jan Stevens since her initial visit in 2017, and also set out several recommendations around leadership, engagement with medical staff, isolation and personal protective equipment, prescribing, environment, post infection reviews, sustainability, communication and quantifying benefits.	

QS19/168.2 A discussion ensued. The Independent Member (Trade Union) referred to the recommendation for the continued reinforcement of not wearing lanyards and suggested that if this was also extended to non-clinical staff it may be easier to implement as a BCU-wide directive. The Associate Director of Quality Assurance acknowledged that the wearing of lanyards was a known IPC risk and that individuals within a close proximity of patients and wards should not be wearing them. The Executive Director of Workforce and OD wondered whether it would make better sense financially to procure an acceptable alternative on a large scale basis. On the basis of the discussion the Chair would include this matter within her report to Board. The Executive Director of Public Health alerted the Committee to a recent letter from the Chief Medical Officer regarding the strengthening of the health protection service and noted that elements of that work would support the role of IPC teams. The Chair felt that the review was positive and demonstrated what could be achieved with focus, and offered the Committee's support to those areas still requiring improvement. She asked that pressure be maintained on medical staff in particular to observe the bare below the elbow rule. **QS19/168.3** The appropriateness of the recommendation was considered and the Chair suggested amendments post-meeting. **It was resolved that** the Committee note the report and the resources required to address the recommendations and sustainability for Safe Clean Care campaign and that the Committee supported the withdrawal of using lanyards across the organisation.	LR
QS19/169 Corporate Risk Register and Assurance Framework Report **QS19/169.1** The extract of the Corporate Risk Register (CRR) which related to those risks allocated to the QSE Committee was received. The Chair highlighted that the CRR would be subject to further discussion at the Audit Committee workshop on the 2nd December 2019 but asked members if they were content with the current risk scores. **QS19/169.2** In terms of the separating out of the care home component from CRR03 (Continuing Health Care), the Associate Director of Quality Assurance indicated this had not yet taken place. Assurance was sought that any risks from the Health and Safety gap analysis had been appropriately escalated, and the Executive Director of Workforce and OD confirmed she was content that identified risks had been appropriately themed, with security having been scored as 20 and therefore being recommended as a new separate risk. She also noted that the target risk dates on the two Health and Safety risks may have been misunderstood within the teams and they should read 1st November 2020 not 2019. This would be amended within Datix. The Chair asked whether the external Police Support Officer role was at risk and the Executive Director of Workforce and OD responded that whilst the post itself was not currently at risk the way the funding was utilised may need to change and she would pick this up further within the Health and Safety report. The Chair also highlighted that there had been concerns flagged previously regarding the management and updating of CRR13 (mental health) and confirmed that the current risk score had reverted back to the August 2018 score.	SG

QS19/169.3 It was resolved that the Committee: 1. Note the current controls: 2. Having reviewed the actions in place agree that the risk scores remain appropriate for the presented risks – pending further consideration at the Audit Committee workshop 3. Approve the 2 risks (CRR20 and CRR21) for escalation onto the Corporate Risk Register.	
QS19/170 Listening and Learning from Patient and Service User Experience Report **QS19/170.1** The Associate Director of Quality Assurance reminded the Committee that the format of Listening and Learning reports had undergone a range of iterations and continued to evolve to try and better describe the mechanisms for feedback and how it is utilised to make improvements. She invited comments on the paper. **QS19/170.2** A discussion ensued. It was noted that there were consistently lower levels of feedback in the West area and the question asked why this was the case. The Associate Director of Quality Assurance stated that the other areas had had formal mechanisms for feedback for longer (IWantGreatCare in the East, and the early Patient Advice and Liaison Service – PALS - was piloted in Central) whereas the West area had only recently launched its PALS service. There were no underlying issues of concern it was just a case of now pushing ahead with PALS and encouraging feedback. It was reported that from December, patient feedback would be built into ward dashboards across all acute sites and there would be an opportunity to renew or refresh software as the current contract would come to an end in June 2020. A question was asked regarding the capture of primary care data and the Associate Director of Quality Assurance indicated that it was likely that comment cards would be utilised, together with the District Nursing teams to seek feedback. A member also raised the issue of obtaining the views and feedback from prisoners at HMP Berwyn and it was confirmed that BCU was looking to develop a bespoke method for this service. The Executive Medical Director welcomed the focus on carers but asked how wider family views were also sought. The Associate Director of Quality Assurance confirmed that cards and questionnaires were routinely offered to whole families, and that the Robin Volunteers also offered support in the use of tablets to provide feedback. In terms of out-patient services it was noted that there were some portable kiosks available however an options appraisal for a more consistent approach would be considered. A member noted that she was pleased to see Welsh language aspects coming out more strongly in the paper. **QS19/170.3 It was resolved that** the Committee note the report.	
QS19/171 Safeguarding and Protecting People at Risk of Harm *[Mrs Michelle Denwood joined the meeting]*	

QS19/171.1 The Associate Director of Safeguarding invited comments on the paper which provided an overview of safeguarding activity for the period April to September 2019. **QS19/171.2** A discussion ensued. A member noted that the report indicated that Deprivation of Liberty Safeguards (DoLS) had never been audited within BCUHB. This was acknowledged as not ideal and could be explained in part by the transfer of responsibility for safeguarding between the Offices of the Medical and Nurse Directors, however, it was confirmed that an internal audit review was shortly to commence. A question was raised regarding resourcing of the safeguarding teams and the Associate Director of Safeguarding confirmed there were currently a number of vacancies and challenges that were being pursued. She indicated that a key area of focus was around a review of job descriptions for the Best Interest Assessors (BIAs) and addressing cost implications from any revised bandings. In response to a comment regarding Adverse Childhood Experiences (ACEs) the Associate Director of Safeguarding accepted this was a challenging area as recent data had identified 126 children and young people with an ACE within one Local Authority area alone. A concern was raised that there was a decreasing trend in training compliance for Emergency Department (ED) medical staff across all acute sites. The Associate Director of Safeguarding recognised the challenges and confirmed that teams were engaging with EDs through walkabouts, in-house training, ICAN activity and other support. There was also close working with the MHLDS Division and engagement with HASCAS/Ockenden stakeholders. The Executive Director of Workforce and OD added that agency staff were also required to confirm they had undertaken the relevant training. The Executive Medical Director undertook to look at the uptake across various staff groups and provide a briefing note for Committee members ahead of the January meeting. **QS19/171.3** A member suggested that the terminology “non accidental injury” was no longer used across the system and instead “suspected physical injury” was referred to. She also noted that whilst the data provided the numbers examined, there was no profile nor outcome. The Associate Director of Safeguarding indicated that there was a whole range of further data and detail behind these high level figures. The Chair enquired as to why referral data within the paper was predominantly reported by area and did not include data regarding the referrer. The Associate Director of Safeguarding would work to provide details of referrals by both area and referrer in future reports. The Executive Director of Public Health raised a comment regarding benchmarking and the Associate Director of Safeguarding undertook to have a follow up conversation with her in order to inform future reports. The Chair commended the progress which was evident from the work of the safeguarding teams but asked that future reports be less numbers-focused and concentrate more on outcomes and learning. **QS19/171.4** The appropriateness of the recommendation was considered and the Chair suggested amendments post-meeting. **It was resolved that** the Committee noted the contents of the report and that future reports would address the feedback provided by members. *[Mrs M Denwood left the meeting]*	DF MD MD MD
QS19/175 Mental Health Services - Quality and Performance Assurance Report	

[*Mr Steve Forsyth joined the meeting]* **QS19/175.1** The Director of Nursing (MHLDS Division) firstly wished to inform the Committee that the Division had won the Nursing Time Awards Team of the Year. He felt that this was a great achievement and wished to record his thanks and recognition to all staff and partners concerned. It was suggested that a letter of congratulations be sent to the Division by the Committee Chair. **QS19/175.2** A discussion ensued. The Head of Internal Audit enquired how the outstanding actions from previous Healthcare Inspectorate Wales (HIW) inspections would be signed off as implemented The Director of Nursing confirmed this would be through the divisional 'QSEEL' group and then to the Quality Safety Group (QSG) with any necessary exception reporting to the QSE Committee. A summary of HIW actions was also incorporated within the biannual 'CLICH' reports to the Committee. The Executive Director of Workforce and OD referred to the later health and safety report which reported on work undertaken between the corporate health and safety team and the Division, and that there was work to do around the impact on staff of incidents involving patients. Reference was made to the report produced by Peter Lepping on this issue. The Director of Performance noted an improving position generally around delayed transfers of care, however, there were still a small number of patients who were experiencing very lengthy delays. A member commented that the location of the ICAN teams on acute sites was positive, but in terms of Ysbyty Glan Clwyd she felt it should be in closer proximity to the ED. The Director of Partnerships indicated the Division continued to work with the Hospital Management Team to ensure the most appropriate location taking into account safety aspects also. In response to a question from the Chair, the Director of Partnerships undertook to provide a briefing note ahead of the next meeting on the four locality thematic reviews undertaken in terms of confirmed suicides. **QS19/175.3** The Director of Partnerships concluded by stating that the Division was still addressing a lack of confidence in the service that has existed over the past three years but she felt there was now good traction on making progress. **QS19/175.4** The appropriateness of the recommendation was considered and the Chair suggested amendments post-meeting. **It was resolved that** the Committee noted the progress indicated within the report and the learning identified and that a briefing note would be provided to the Committee members on the locality thematic suicide reviews. *[Mr Steve Forsyth, Mrs Lesley Singleton and Dr Jill Newman left the meeting]*	LR LS
QS19/176 Mortality Surveillance Report April to September 2019 **QS19/176.1** The Chair reminded the Committee that feedback had been given on the mortality report submitted to the meeting in May 2019 as members had felt it lacked clarity and analysis and did not therefore provide sufficient assurance. She was disappointed to report that the Independent Members did not feel the content and format of this latest report had improved sufficiently for it to be formally considered at the meeting. This would be escalated in her Chair's report to Board.	LR

QS19/176.2 It was resolved that the Committee did not accept the report and the Committee Chair, Executive Medical Director and Senior Associate Medical Director meet to agree a way forward to ensuring an improved report be submitted to the January 2020 meeting.	DF/LR
QS19/179 Nurse Staffing Levels (Wales): Adult Acute Medical And Surgical Inpatient wards *[Agenda item taken out of order at Chair's discretion]* *[Ms Naomi Holder joined the meeting]* **QS19/179.1** The Associate Director of Quality Assurance reported there was positive recruitment and retention work ongoing with good numbers of nurses being recruited but acknowledged these were not always where most needed. She also indicated that there was a good upwards use of the nurse bank. **QS19/179.2** A discussion ensued. Reference was made to the statement within the paper to a reliance on a temporary workforce on some wards within Wrexham Maelor Hospital and a comment around the number of harms. The Site Director of Nursing confirmed that additional Band 4 roles had been introduced to supplement nursing vacancies and there was good evidence around the value of this role. She confirmed there was a 50% vacancy nursing rate in some areas and whilst this was not directly attributable to a rise in harm on certain wards, it could not be dismissed as a factor. In response to a question from a member, she also confirmed that crash teams were not staffed from within the regular complement. **QS19/179.3** A conversation was held regarding hotspots for recruitment and it was confirmed that there were very few vacancies within the community setting as a high proportion of newly qualified nurses were choosing to go straight into this area. Clarification was given regarding the conversion of a Band 5 to a Band 6 nurse in Ysbyty Gwynedd in that this was a short term solution via acting up, with a longer term intent to recruit. **QS19/179.4** The Committee Chair referred to the ongoing issue of nursing rotas and the management of the associated risk. The Associate Director of Quality Assurance confirmed that standardisation across the organisation remained the aim, and that the Executive Team and others were working very closely with matrons and nursing teams. The Executive Director of Workforce and OD confirmed there would be a report prepared for the Finance and Performance Committee. She referred to the recent extraordinary meeting of the Local Partnership Forum (LPF) where there had been a high level of nursing representatives who were positive and receptive to the proposed changes. It had been made clear that the organisation had paused its implementation of the changes, not abandoned them, and that there remained a commitment to move forward in partnership to ensure safety. The Committee acknowledged there was potential for other staff groups to also be affected.	

QS19/179.5 It was resolved that the Committee note the report.	
QS19/177 Primary and Community Care Assurance Report **QS19/177.1** The Executive Director of Primary and Community Services presented the report, highlighting that some of the data related to primary care as a whole and not just General Medical Services (GMS). He also drew members' attention to section 3.4 around performance and that the figures reflected the impact of the increased number of managed practices and the remedial work needed. Finally, he noted the positive achievement around prescribing indicators and that BCU had moved from 7th to 3rd within some datasets. **QS19/177.2** A discussion ensued. It was clarified that the performance issues ranged from contractors requiring some additional support to those with specific performance issues and concerns. It was also noted that the three listed suspensions were as a result of both General Medical Council (GMC) action and local concerns resulting in performers' list action at this stage. The Committee Chair referred to the under-delivery of Units of Dental Activity (UDAs) and the Executive Director of Primary and Community Services indicated the Board was trying to encourage a move to a new dental reform contract which didn't focus on UDAs, however, where practices currently under-performed on UDAs this was being addressed. In response to a question regarding themes from the joint Healthcare Inspectorate Wales and General Pharmaceutical Council visits, it was stated that access always featured but this was not specific to BCU. With regards to the introduction of the Quality Assurance and Improvement Framework (QAIF) it was felt that the focus within the paper was timely but indicated a significant amount of work. The Executive Director of Primary and Community Services was not aware of any significant issues across GMS pertaining to the new contract that would suggest the need to review the risk situation for primary care at this point in time. **QS19/177.3** The appropriateness of the recommendation was considered and the Chair suggested amendments post-meeting. **It was resolved** that the Committee noted the report and updates provided. **QS19/177.4** The Executive Director of Primary and Community Services then went on to present the second part of the agenda item which provided an overview of Continuing Health Care (CHC), Funded Nursing Care (FNC), and Joint Funded Care with local authorities. He confirmed there was a good alliance between BCU officers and the National Commissioning Collaborative Unit (NCCU) and that some of the current work was setting the direction of travel for the rest of Wales. He accepted that there was work to be done in terms of the initial assessment process for CHC which would need to be undertaken in partnership. Finally, he highlighted a current challenge relating to a care home provider which had written to its residents regarding a perceived funding gap.	

QS19/177.5 A discussion ensued. Members welcomed the approach but noted the importance of ensuring this focused on ensuring the right care for each individual as opposed to a cost cutting exercise and shifting of expenditure to Local Authorities. The importance of appropriate discharge was also stated. **QS19/177.6** The appropriateness of the recommendation was considered and the Chair suggested amendments post-meeting. **It was resolved that** the Committee note the contents of the report and approve for submission to Welsh Government.	
QS19/178 Occupational Health and Safety (OHS) Quarterly 2 Report 1st July to 30th September 2019 **QS19/178.1** The Executive Director of Workforce and OD presented the paper which provided an overview of incidents, accidents, health and safety activity and training for the given period. She highlighted that section 6 attempted to provide a greater level of detail around RIDDOR incidents, and that the improvement path for Root Cause Analysis (RCA) aimed to help the organisation understand what had happened and how to prevent a reoccurrence as this had not been as systematic and consistent as it could have been. Members were however informed that whilst there was room for improvement in terms of process and paperwork, RCA was undertaken in a timely fashion and by appropriate individuals. The investigation process was continually being redesigned and improved to ensure that lessons could be learnt from incidents. The Executive Director of Workforce and OD was mindful of the role of the Committee in ensuring quality was not adversely impacted when dealing with the impact of financial recovery. She informed members that a process had been put in place to ensure that any requisition for procurement that was essential to health and safety did not get halted as part of financial controls. Members' attention was drawn to the seconded role of Demand Reduction Inspector from the North Wales Police and that it had been reviewed to ensure it was more effective and was managed optimally. The Executive Director of Workforce and OD also referred to a visit by the Health and Safety Executive following the identification of a worker with vibration induced white finger. There was evidence of good multidisciplinary working on this matter and as a result no fine was given. Finally, it was reported that an audit report on the health and safety gap analysis had been produced which set out a range of helpful recommendations. In terms of the security action plan which was set out in an appendix to the report, it was noted that this would need to be revised in light of the gap analysis which would require longer a timescale. She indicated there was a risk in that the Board did not have the basic expected levels for security arrangements in place within some areas. **QS19/178.2** A discussion ensued. The Committee Chair was pleased to see human factors being built into the categorisation of incidents. She also commented that the abuse of staff by patients determined as unpredictable could in fact be predicted in many cases. In addition, she noted there was a high number of violence and aggression incidents reported (V&A) but wondered whether the threshold for categorising an incident as V&A was too low as the reporting profile was unusual for	

an organisation of this type. The Independent Member (Trade Union) also suggested that staff may not report each V&A incident as it was to a degree anticipated in certain scenarios – for example when caring for patients with dementia. **QS19/178.3** The appropriateness of the recommendation was considered and the Chair suggested amendments post-meeting. **It was resolved that** the Committee note the position reported and support the actions arising from the gap analysis, noting that the action plan was to be further reviewed.	
QS19/180 Policies, Procedures or Other Written Control Documents for Approval - Levels of Enhanced Care for Adult InPatients Policy **QS19/180.1** The Associate Director of Quality Assurance presented the policy for approval, confirming it was a refreshed policy resulting from a piece of work undertaken on All Wales basis. **QS19/180.2** Members made a range of comments: • The need to identify clear communication cascade for the policy • That the review of staff rostering arrangements should be referenced in the "documents to be read alongside this procedure" section • The need to build in associated training implications • The document needed more localisation for BCU • There were inconsistencies in formatting in terms of the use of bullet points or numbering as sub sections to paragraphs • The introduction section appeared to also include the purpose of the policy • The Committee welcomed the equality impact assessment which they found to be robust and appropriate. **QS19/180.3** The Independent Member (Trade Union) made a general comment that the ability to find relevant and latest policies on the BCU intranet remained an issue. **QS19/180.4 It was resolved that** the Associate Director of Quality Assurance arrange for the amendments to be made as early as possible and to seek Chair's Action for approval.	DC
QS19/181 Quality Safety Group Assurance Reports **QS19/181.1** The Associate Director of Quality Assurance presented the assurance reports from the September and October meetings. The Independent Member (Trade Union) noted the reference to an information governance incident within children's services. It was confirmed that despite significant data breaches no harm had been caused and the matter had been reported to the Information Commissioner's Office. The Committee Chair suggested that the Digital and Information Governance Committee should be sighted on this matter.	DC

QS19/181.2 A member expressed concern at the statement that there were significant pressures within the oncology service due to an inability to recruit**.** The Executive Director of Therapies and Health Sciences confirmed this was being actively addressed**.** The Associate Director of Quality Assurance also reassured members that the risks within women's services as set out in the paper were being addressed as a priority. In response to a question regarding the measles vaccination levels it was confirmed that the concern within the report was as at a given point in time and that the Executive Director of Public Health was not aware of a continued issue.	
QS19/182 Improvement Group (HASCAS & Ockenden) Chair's Assurance Report **QS19/182.1** The Committee Chair confirmed that she had met with key officers before this report had been finalised. She advised that in her view a number of the original recommendations could be closed down but that additional actions had been identified as a result of addressing the initial recommendation. It had been noted that the document was becoming more unmanageable as a result and it had been agreed that the format would be amended for the next Committee meeting in January. **QS19/182.2** The Associate Director of Quality Assurance indicated that many of the actions were now more mainstreamed and did not require such close monitoring, and in addition a number were due for closure in January 2020. She reiterated that managing the expectations of the stakeholders remained challenging. In terms of the actions that remained 'red' she noted that an audit had been identified for estates and a scoping exercise would be undertaken regarding clinical storage. The Committee Chair suggested that the latter may need to transfer over to the Digital and Information Governance Committee. This would be referenced within her Chair's Assurance Report to Board. *[Mrs S Green and Dr M Maxwell left the meeting]* **QS19/182.3 It was resolved that** the Committee note the progress against the recommendations to date.	DC LR
QS19/183 Issues Discussed in Previous In Committee Session It was resolved that the Committee note the information in public.	
QS19/184 Issues of Significance to inform the Chair's Assurance Report To be determined by the Chair.	

QS19/185 Date of Next Meeting Tuesday 28.1.20 @ 9.30am	
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."	

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. 19.11.19 It was confirmed briefing noted had been circulated.	September November Closed

21st May 2019				
D Carter	**QS19/70.2** Consider whether non-patient elements need separating from the CLIICH report in terms of category 'abuse of staff by patients', for next submission	Sept	24.9.19 discussions between teams ongoing as part of gap analysis. 30.10.19 The new Assistant Director of Service User Experience (who started with BCU in mid-October) is meeting with the Assistant Director of Health, Safety and Equality and will discuss how patient safety and staff safety incidents will be separated in the reports submitted to the committee, ensuring information to the committee is not lost and remains triangulated where appropriate. 19.11.19 The Chair confirmed she had met with the new Assistant Director for Patient Safety and this action would be addressed within the Patient Safety report in January.	January
~~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. 19.11.19 Further report requested for January. Meeting set up for January between QSE Chair and Office of Medical Director. 6.1.20 Meeting held and clarification/steer provided on how to improve and strengthen mortality reporting, with agreement the paper be deferred to the March meeting.	~~Closed~~ ~~November~~ ~~January~~ March
16th July 2019				

D Carter	**QS19/99.2** Include patient story re Welsh Language in the next Welsh Language monitoring report		13.9.19 As recommended by QSE, Head of Patient and Service User Experience for BCUHB has produced a Quality Assurance for Patient Stories Framework Sept 2019 to ensure that all Patient Stories are monitored. BCUHB has ensured adequate resources are in place to sustain the growth and development in capturing, monitoring and measuring quality improvements from patient stories. The Listening and Learning group will be the quality assurance measure to monitor reports and translate them into improvement work and celebrating best practice. The Listening and Learning Strategic forum for Patient and Service Experience' group (LLG) (LLE was stepped down for 6 months to review the function/purpose of the meetings and capture the correct attendees in alignment with QSE and 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.	~~Closed~~

			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. 19.11.19 Noted that the qualitative report re Welsh Language came to QSE as part of the IQPR reporting process. Timeframe for next report to be confirmed and whether the patient story had been included.	November January
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. 19.11.19 Committee agreed that this action could be closed.	Closed
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. 19.11.19 DC confirmed that this had been addressed within the mental health paper on the agenda.	November Closed
D Carter C Owen	**QS19/105.3**	November	13.9.19 The Head of Patient and Service User Experience is reviewing the report content detail	Closed

	Work to improve the analysis of data to show improvements within future Listening and Learning reports		and has requested a meeting with QSE Chair to discuss. 24.9.19 Committee agreed to reopen until next listening and learning report received. 12.11.19 Listening and Learning report agendered for discussion at November Committee meeting. Members' feedback invited on whether format addresses previous concerns. 19.11.19 Chair confirmed that she had met with the new Assistant Director for Patient Safety and agreed the format of future reports.	November Closed
A Thomas	**QS19/112.3** Follow up query from the May QSG report as to whether the related patient safety alert had been closed at the time, even though a Medical Devices Safety Officer was not in post.	Sept	24.9.19 AT reported that there was a lack of clarity. The CHC Chair accepted that the information was difficult to unpick retrospectively but was assured that the intention to appoint a Medical Devices Safety Officer was still ongoing. Committee agreed to keep action open. 19.11.19 AT confirmed there was a robust system around medical devices and this was an operational issue that should back through QSG, however, the Chair reminded members that the action had originated from the report from QSG. AT would take this action away again. 20.1.20. AT has had confirmation from the DGM of NWMCS that the MDSO function will be assigned to a member of staff within the Medical Devices team by the end of June 2020.	November January
24th September 2019				
J Newman	**QS19/129.1** Revisit the briefing note (against action QS19/101.1) on mapping of indicators to	Oct	19.11.19 JN indicated that there was a list within the IQPR of annual plan issues that came through QSE. The Chair reiterated that the	

	reflect members' comments re appropriateness and mapping to SPPH		action relates to having the briefing note refreshed to give the Committee confidence that it was monitoring the right annual plan elements. JN set out challenges in that whilst an overall action may be attributed to QSE there may be multiple milestones within that action which relate to another Committee – for example clinical coding. SG felt that an action shouldn't need to be deconstructed in order for it to be fully monitored. It was suggested that the Executive Director of Planning & Performance take the discussion through Exec Team.	January
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. 19.11.19 The Committee requested a formal report for the January meeting. 21.1.20 Paper submitted for January agenda.	 January Closed
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	19.11.19 The Committee were happy to close the action based on the improved reporting from the division.	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. 21.1.20 OHS report incorporates security issues.	 Closed
D Carter T Owen	**QS19/139.1**		19.11.19 TO suggested that six months would be appropriate for next report.	May 2020

	Ensure that next report from Women's Division includes detail of the reported clinical complex cases.			
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. 17.12.19 Chair's Action documentation signed off.	Closed
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	19.11.19 Lesley Singleton to follow up 21.1.20 Amended document resubmitted for January QSE Committee	December Closed
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	19.11.19 Lesley Singleton to follow up 21.1.20 Amended document resubmitted for January QSE Committee	December Closed
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	19.11.19 Lesley Singleton to follow up 21.1.20 Amended document resubmitted for January QSE Committee	December Closed
19th November 2019				
L Reid	**QS19/158** Discuss the requirements for future agenda items on progress against limited assurance audit reports	December	9.12.19 Chair confirmed that this item can be withdrawn from CoB	Closed
J Newman	**QS19/164.1** Review the sequencing and reporting of APMR reports to committee to ensure as timely as possible.	January		

L Singleton	**QS19/165.3** Ensure that future MHLDS exception reports within IQPR provided an explanatory narrative where a major outlier was identified, together with timelines to address.	January	21.1.20 S Forsyth confirmed this has been taken on board and actioned.	Closed
J Newman	**QS19/165.5** Consider reviewing an existing performance team reporting schedule to include information for committee members as to what data goes where and when	January		
L Reid	**QS19/168.2** Include matter of lanyards as a known IPC risk and the potential for large scale procurement within Chair's report	December	Completed.	Closed
S Green	**QS19/169.2** Arrange for CRR within Datix to be amended to reflect that the target risk dates for H&S risks should read 1.11.20 not 1.11.19	December	Completed, Datix has been amended.	Closed
D Fearnley	**QS19/171.2** Look at uptake against safeguarding training within various staff groups and provide a briefing note for circulation outside of the meeting.	January	19.1.20 Site Medical Directors have been asked to review safeguarding training for medical staff and report performance to the Executive Medical Director before end of January 2020. A briefing note will then be circulated to QSE members.	February
M Denwood	**QS19/171.3** Provide details of referrals by both area and referrer in future reports.	May 2020		
M Denwood	**QS19/171.3** Have a follow up discussion with the Executive Director of Public Health regarding benchmarking.	Dec 2019	31.12.19 meeting took place with the Executive Director of Public Health and Associate Director of Safeguarding to discuss benchmarking. It was agreed the annual National Safeguarding Maturity Matrix [SMM] provides the National benchmarking and peer performance Quality	Closed

			Assurance Tool to evidence our performance and Governance arrangements against other Health Boards and NHS organisations in Wales. The tool is evidenced based and is driven by safeguarding legislation, guidance and best practice principles. We await the final report as a result of the peer review activity which took place during November 2019. This will provide a National picture and the findings will be shared as an appendix to the Safeguarding Annual Report 2019/2020.	
M Denwood	**QS19/171.3** Work to ensure future reports are less numbers-focused and concentrate more on outcomes and learning.	May 2020		
L Reid	**QS19/175.1** Send a letter of congratulations on Nursing Time award for Team of the Year to the MHDLS Division	December	20.1.20 Committee Chair has drafted correspondence	
L Singleton	**QS19/175.2** Provide a briefing note for circulation outside of the meeting on 4 locality thematic reviews undertaken in terms of confirmed suicides	December	21.1.20 Briefing note circulated to members	Closed
L Reid	**QS19/176.1** Escalate concerns re mortality reporting to the Board via Chair's report	January	Completed	Closed
D Fearnley	**QS19/176.2** Arrange meeting with Committee Chair and report author(s) to agree future format and content of mortality reports.	January	Meeting held 6.1.20. Agreement reached.	Closed
D Carter	**QS19/180.4**	December	21.1.20 revised policy received and will be submitted to Chair for approval	January

	Arrange for amendments to be made to the Levels of Enhanced Care In-Patients Policy for submission for Chair's Action			
D Carter	**QS19/181.1** Check that the DIG Committee were sighted on the information governance breach within children's services as reported in QSG report.	December	All Information Governance (IG) incidents are captured and reported as part of the IG KPI reports which are reviewed at the operational IGG group and then formally submitted to DIG as a standing report. All serious incidents are categorised and severity assessed as part of this report and any lessons learnt or further actions required are also captured and documented. For any incident requiring external reporting to the Information Commissioners Office are detailed more extensively in these reports and the one in question from QSG is forming part of the IG KPI Report Q3 which will be presented in June.	Closed
D Carter	**QS19/182.1** Work to refresh the HASCAS / Ockenden reports to ensure more manageable	January	Refreshed report submitted for January meeting	Closed
L Reid	**QS19/182.2** Ensure that reference is made within Chair's report to Board that the DIG Committee may need to take responsibility for the action within HASCAS and Ockdenden report regarding an audit on clinical storage	January	Completed	Closed

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Joint Audit and Quality, Safety & Experience (QSE) Committees

Minutes of the Meeting Held on 5th November 2019 in the Boardroom, Ysbyty Gwynedd, Bangor

Present:

Cllr Medwyn Hughes	Independent Member (Joint Chair)
Mrs Lucy Reid	Independent Member (Joint Chair)
Mr John Cunliffe	Independent Member
Mrs Jacqueline Hughes	Independent Member
Mrs Lyn Meadows	Independent Member

In Attendance

Mrs Deborah Carter	Associate Director of Quality Assurance / Interim Director of Operations
Mr Andrew Doughton	Performance Audit Lead, Wales Audit Office
Mrs Kate Dunn	Head of Corporate Affairs
Dr David Fearnley	Executive Medical Director
Mr Dave Harries	Head of Internal Audit
Ms Sue Hill	Acting Executive Director of Finance
Dr Melanie Maxwell	Senior Associate Medical Director (part meeting)
Ms Dawn Sharp	Acting Board Secretary
Dr Chris Stockport	Executive Director of Primary and Community Services
Mr Adrian Thomas	Executive Director of Therapies and Healthcare Sciences

Agenda Item Discussed	Action By
JAQS19/1 Chairs' Welcome The Joint Chairs welcomed everyone to the meeting. It was noted that Dr Melanie Maxwell had been delayed and the agenda order would therefore be flexed.	
JAQS19/2 Declarations of Interest None made.	
JAQS19/3 Apologies for Absence Apologies were recorded for Cllr Cheryl Carlisle, Mrs Sue Green, Mrs Gill Harris, Miss Teresa Owen, Mr Mark Thornton and Mrs Amanda Hughes.	

JAQS19/4 Minutes of Meeting Held on 6.11.18 for Approval of Accuracy, Matters Arising and Review of Action Log **JAQS19/4.1** The minutes were agreed as an accurate record. **JAQS19/4.2** With regards to the action log the QSE Committee Chair was of the view that she was not prepared to accept a recommendation to close an action without sufficient evidence that the action had been addressed. Once Dr Maxwell joined the meeting the action log was reviewed in detail but given the pressures of time it was agreed that the joint chairs would review outside of the meeting and confirm their acceptance or otherwise of the RAG status of each action, and recirculate.	MH LR
JAQS19/9 Briefing on Governance Review *[Agenda item taken out of order at Chairs' discretion]* **JAQS19/9.1** The QSE Committee Chair explained that she had requested a briefing paper as whilst she was aware that discussions regarding the governance review had been held within Audit Committee workshops, she was conscious that QSE Committee members had not been directly involved. She was also aware that the review had been referred to within the public domain but there had not been a specific position update. **JAQS19/9.2** The Acting Board Secretary presented the paper which summarised the work being undertaken to undertake a review of governance and risk arrangements across the organisation with a key intention to ensure there were clear reporting lines from any management groups to ensure timely and appropriate escalation. She also highlighted that consideration was being given to splitting the work of the Quality Safety Group (QSG) into three main areas of 1) quality and safety; 2) effectiveness and outcomes; 3) patient experience and co-production. The Acting Board Secretary reiterated that the proposals were still awaiting full consideration by the Executive Team. **JAQS19/9.3** The Audit Committee Vice-Chair referred to the proposal within the paper that executive led groups report into an appropriate scrutiny committee chaired by an Independent Member and noted that previously it had been widely accepted that the Board level committees were not scrutiny committees. He also was not aware of any discussion to date at the Finance and Performance (F&P) Committee regarding the potential need for an investment committee. He noted that whilst this may well reduce the burden on the F&P Committee it would increase the burden on Independent Members. The Acting Board Secretary indicated that the Executive Team would need to be clear what it wanted this forum/group to do, and that it may well not be a full committee. The Audit Committee Vice-Chair was also keen to ensure clarity on the role of existing and any new committees. **JAQS19/9.4** The Executive Medical Director was supportive of reducing unnecessary burden on committees whilst ensuring good governance. He also encouraged the use of digital solutions for sharing information. The QSE Committee Chair noted that the paper was a position update on the ongoing discussions and asked when the whole Board would be engaged in the process. The Acting Board Secretary suggested that	

initially there would be discussions at the Committee Business Management Group and within a future Board Workshop setting, ahead of consideration by full Board in public.

JAQS19/9.5 The Acting Executive Director of Finance enquired whether any benchmarking had been undertaken as to how other Health Boards aligned and structured their committee responsibilities. The Acting Board Secretary confirmed such benchmarking had been carried out in the past but not specific to this ongoing review. It was noted that All Wales QSE Committee Chairs had been asked to consider the matter and that the direction of travel of the BCUHB review was in line with arrangements in place elsewhere. Mr A Doughton concurred that generally Committee structures were similar across Wales although the size of BCUHB and its geography added a further challenge. He asked whether the proposal to split the QSG into three main areas of work would be replicated at divisional level. The QSE Committee Chair confirmed that the principle being considered was to ensure clear lines of reporting.

JAQS19/9.6 It was resolved that the Joint Audit and Quality, Safety & Experience Committee note the context and progress of the governance review and the emerging considerations and further updates would be provided to the Board going forwards.

[Dr M Maxwell joined the meeting]

JAQS19/5 Draft Clinical Audit Policy & Procedure

JAQS19/5.1 The QSE Committee Chair referred to the coversheet and suggested that the purpose of the paper was not to seek approval as that was the recommendation.

JAQS19/5.2 The Audit Committee Vice-Chair set out a range of specific comments:

- Para 6.4 roles and responsibilities – he was concerned that only the clinical audit lead was to review the action plan.
- Para 7.1 role of Audit Committee – he felt this was rather prescriptive. The Senior Associate Medical Director indicated that agreement had previously been reached to include the Welsh Government handbook wording. The Audit Committee Vice-Chair suggested the narrative could be softened to read “the role of the Audit Committee includes……”
- Para 7.5 Quality and Safety Groups – he suggested that this needed to clarify to where or whom risks should be escalated.
- Para 7.6 Clinical Audit and Improvement Groups (CIAG) – he enquired why this did not relate to the West area also. The Senior Associate Medical Director indicated that the CIAG function in the West was incorporated into their quality and safety site meetings. This variation was of concern. It was suggested that the policy should describe how the function was delivered, not necessarily how the groups were structured in different areas. This would be refreshed and reworded.
- Para 8 registration of audits – he asked how members would get assurance that the quality and safety groups were addressing the right priorities.
- He noted that the policy did not reference triggers to tier 3 audits, and did not define the Part A and Part B elements of national audits. This would be addressed.

JAQS19/5.3 A member asked that the policy make it clearer as to the consequences of a “must do” audit not being completed, and that any that were abandoned must be escalated with the reason clearly set out.

JAQS19/5.4 The Audit Committee Chair indicated that the lack of progress around implementation of clinical audit actions including the development of the policy would again be escalated to the Board, but he did not wish this to be seen as a reflection on the work of the clinical audit team. He was disappointed that the previous concerns had not been picked up adequately by the Executive Team. He also referred to the resources available to the team and the Executive Medical Director felt that a stock-take of resources going into the audit function was needed, including the ability of clinicians to take time to undertake audit and to ensure this was appropriately reflected in job plans. The Head of Internal Audit indicated he would be more than happy to input into the approach. **JAQS19/5.5** Members queried the relevance of some of the statements within the equality impact assessment (EQIA) which accompanied the policy and whether some of the impact would actually be positive rather than neutral. It was also noted that the equality diversity and human rights section within the policy document itself had been removed in error. **JAQS19/5.6** The QSE Committee Chair noted that the Policy stated that the corporate clinical audit annual plan would be agreed by the end of February each year, however, as the QSE Committee did not meet in the month of February it was agreed this would need to be reviewed in March. She also noted that the policy needed to be consistent in that the narrative needed to concur with the appendices and that there were still some typographical and grammatical errors within the policy. **JAQS19/5.7 It was resolved that** the Joint Audit and Quality, Safety & Experience Committee were not in a position to approve the policy. The comments and concerns would be followed up with a revised policy being submitted to Audit Committee on the 12th December.	MH LR MM
JAQS19/6 Draft Clinical Audit Reporting Templates **JAQS19/6.1** The QSE Committee Chair felt it was unclear what the templates were to be used for. The Senior Associate Medical Director confirmed that the aim was for the templates to provide an overview of audit activity including detail of those which had been added to the original plan, any audits abandoned and detail of those which had been completed. The templates would be supported by narrative to provide contextual detail. The Audit Committee Vice-Chair noted that they would need to meet the needs of both the Audit and QSE Committees as they had different and distinct roles in terms of monitoring the clinical audit plan. **JAQS19/6.2** The QSE Committee Chair enquired why the templates were laid out as site specific whereas audits were generally on a pathway or specialty level. The Executive Director of Therapies and Health Sciences indicated that site level did often improve ownership. The Performance Audit Lead (Wales Audit Office) concurred that site level detail was often helpful to identify variance. He suggested that members needed to consider the balance of information that the Joint Committees required, ensuring it was meaningful and able to give assurance whilst not providing too vast a level of detail. He suggested that the focus should be on the exception reports and those audits given limited assurance. The Associate Director of Quality Assurance / Interim Director of	

Operations added that it was often difficult to decouple methodology from the national audits. **JAQS19/6.3 It was resolved that** the feedback provided by the Joint Audit and Quality, Safety & Experience Committee on the draft templates would be considered further by the clinical audit team.	
JAQS19/7 Clinical Audit Report 2019 **JAQS19/7.1** The Senior Associate Medical Director apologised that resources had not allowed for a full-year report to have been prepared. The paper related to a number of audits delivered in the first six months of 2019-20. Members' attention was drawn to Section 2 on audit activity and that BCUHB had completed data submission for the majority of Tier 1(nationally mandated) audits. There were however resource challenges affecting participation with the following audits: • COPD / Asthma (East and West). • Fracture Liaison Service. • Vascular audit (Lower limb Angiography) **JAQS19/7.2** The Audit Committee Chair expressed concern at the lack of participation in Tier 1 audits. The Senior Associate Medical Director confirmed that the information required was available in the system and it was purely a capacity issue to extract and validate the data appropriately. The Audit Committee Vice-Chair again suggested that the Part A and B elements needed to be expanded upon to clarify and define. He also felt that the report should identify where BCUHB performance in terms of clinical audit activity differed from its peers. The QSE Committee Chair suggested that Table 2 (changes identified on Part A and B) needed to make it clear where BCUHB data was not submitted for the period but there was a recommendation or learning taken from the national report. She also noted that there were questions within the table rather than an explanatory narrative and this needed to be addressed in order for them to make sense. **JAQS19/7.3** A member referred to the governance issues and risks set out within the coversheet and sought assurance as to whether these were significant – for example was the respiratory service itself of concern or compliance with the related audit. The Senior Associate Medical Director indicated that as there was not the resource nor capacity to take part in the respiratory audit it wasn't possible to benchmark the service. This did not necessarily mean there was a concern or problem with the service but positive assurance could not be given. The Audit Committee Vice-Chair asked whether a priority could be given to undertaking a local respiratory audit in order to provide some level of assurance. The Executive Medical Director undertook to look into this and acknowledged that appropriate risk management processes were key to mitigating this assurance gap. **JAQS19/7.4** A discussion ensued around Table 1 (Tier 1- National Clinical Audit & Outcome Review Plan)**.** The Audit Committee Chair noted that the Board's compliance with submission of data had improved since last year. The QSE Committee Chair suggested it would be helpful for the table to have a single status column and also to indicate whether recommendations of the previous year's audit had been delivered.	MM MM DF MM

She noted that the report was very numbers rather than outcome focussed and that she would expect the compliance rate reported to relate to compliance against the standards being audited rather than compliance with the plan. **JAQS19/7.5** It was noted that a lack of leadership was referenced within the paper and the Associate Senior Medical Director indicated this again came back to capacity but that she hoped that as job plans evolved this would be addressed. It was agreed that the joint Chairs would prepare a note to encourage participation in audit. **JAQS19/7.6 It was resolved that** the feedback provided by the Joint Audit and Quality, Safety & Experience Committee would be considered and incorporated into future reports.	LR MH
JAQS19/8 Clinical Audit Plan Update **JAQS19/8.1** The Executive Medical Director confirmed that there was nothing significant to report, and implementation of the plan was progressing. The Head of Internal Audit added that the draft Internal Audit plan was subject to Audit Committee approval, and that he would welcome approval of the Clinical Audit policy as soon as possible. The Performance Audit Lead (Wales Audit Office) suggested that the organisation was at the forming and storming stages of clinical audit development, and that the challenges being made would strengthen and improve processes. He felt that the organisation was in a far more positive place than previously. **JAQS19/8.2** The Executive Medical Director wished to record his gratitude to Dr Melanie Maxwell for her work in developing the clinical audit agenda and for bringing the papers together.	
JAQS19/10 Date of Next Meeting To be arranged for November 2020	KD

Betsi Cadwaladr University Health Board
Patient's Stories Transcript Form

Who took the patient's story:	**Name:** Meinir Evans **Contact details:** Business Manager – Mental Health Transformation Rheolwr Busnes – Trawsffurfio Iechyd Meddwl Ffôn / Phone:07392 863 832 E-bost: Meinir.Evans@sirddinbych.gov.uk E-mail: Meinir.Evans@denbighshire.gov.uk
Sensitive issues to be aware of:	ICAN service is available daily between 7pm and 2am. On this occasion, the Police Officer who brought the patient into Emergency Department was aware of the ICAN service; if the officer had not been aware there would have been a delay in accessing provision resulting in unnecessary distress.
Brief summary of the story:	I am what is referred to as a 'service user'. A term I dislike as it brings negative connotations, a feeling of guilt, shame and a feeling, or knowledge that, I am a drain on the system. The aim is always to reduce numbers, eliminate us from the system, but to include us in the statistics that provide them with funding. It is also a system that dislikes to listen to our voice. The Society we live in dislikes my way of communicating, so label me as having a disability. Although not a mental illness, Society and ignorance creates one. In the DSM5 I would be classed as having an Autistic Spectrum Disorder, I call it Asperger's, but that title, the only one I could start to accept, was taken away from me in the new(ish) DSM5 manual. I call it the 'A' word, as it has always brought an air of shame and embarrassment. It is not as a result of this that I am a 'Service User' but as a result of forcing myself to be productive in a Society that doesn't accept me & be seen to succeed. To study to a high level, live independently, work in a graduate job and to function as much as I can, will take its toll. The toll on my mental health that I hide. I assert my hardest effort in life camouflaging the difficulties I have; getting up in the morning & walking out my front door are the hardest part of my day as I have to assert the 'me' where the 'A' word is hidden. By disguising, you may not see it, but I feel and battle of it every second of the day. I have the usual ignorance of people who question my living and battle to understand the solitary existence in a small quiet flat. Why am I living on my own? Why do I rarely socialise? What do I do when I am on my own? These are the questions I get, not in

	support, but in a slightly ‘sneery’ way. When I am on my own I am exhausted, in need of quiet, dimmed lights and simplicity to charge my energy ready to fight another day. Living the life I live takes its toll so, yes, I am a Service User. Unfortunately the extra battle I live is the ignorance of the Medical Model and its understanding of females on the autistic spectrum who have spent a life, and still spend their life, camouflaging the behaviours and difficulties that are there all through the day and often through the sleepless nights; those rejected by the Society that judges me. I have had to become an expert in my difficulties and the terms used to describe them as experts are far and few between, and most definitely not in the medical system. Although I have fought a brave battle to offer informed presentations, they refuse to listen and they refuse to help. But still I must be proactive in this Society and be independent as I know the alternative is even bleaker. So, although it is frowned upon, please forgive me if I go from crisis to crisis, some worse than others, particularly if there is ‘nothing you can do’. Forgive me if I spend a lot of time contemplating finishing this life within this Society; this harsh, unforgiving and ignorant Society. Forgive me if I am brought in to the failing and understaffed A&E, having been found on a bridge by another understaffed organisation, the Police, who, for their honesty I am grateful, ask when I got this (disease). Forgive me if I arrive deflated, exhausted with my conversation skills depleted, unable to explain myself in the 5 minutes I am given. By 11 at night, without ICAN, I would have been turfed out, exhausted, humiliated and reminded that I do not deserve help and there is nothing that can help me. When A&E are ready to dismiss, I am ready to run, but for the Police Officer who has taken the initiative to phone ahead to ICAN. So forgive me if I bolt out of the door when a face appears around the door and smiles to say she has come to find me. I am told by triage that ICAN is not for me, I demand it is and follow the person, I follow the smile still with police on my tail. The long walk along the corridors is relaxed and slow, me setting the pace and she occasionally turning, and smiling, and just giving me time. Time? Have they time to talk, to listen, to not judge, to not file me away as a waste of time, an unwanted statistic and a problem that does not fit neatly into a box? They sit and allow me to lead, allow me to talk, allow me curse, swear, vent anger and show my exhaustion. They remember the time of day and that a lack of food will fuel my mental health difficulties. They don’t assume and they don’t judge and they listen and wait, until I am further triaged. There is no time limit, no tick boxes and no requirements. I am Helen to them, and I am treated with respect. They look at me, not their watch. They dim the lights

	that are shouting at me and keep things quiet, when even the silence is shouting at me. One of my powers is I can pick a hole in any service; I see, I sense and I pick. This one I can't. I am not a number to them, have no diagnosis, no illness, no disease; I am me and I am treated as the expert in what I struggle with. This saved my life. It may sound dramatic but, in simple terms, it stopped me dying, being a statistic, a burden on the paper work and it removed me from your stretched and failing service. It imprinted a need to return, not in a client capacity but in a volunteer capacity. Why did I not know of this service, where did it come from and what is this uniqueness and sense of being human that it gave me. To return as a volunteer I expected judgement on my ability, my safeness in this environment and the ability to function in an important role. What others see as my deficit, they saw as a gift, a strength, a chance to help others in my unique way. I scrutinised the service, like an undercover cop but I saw no weaknesses, only strengths, acceptance and a genuine want to help. They took away the Medical Model, they took away the terms; service user, revolving door person, a drain on the system, an unwanted statistic and they saw my strengths my passion and my unique skills I could apply. I waited, and I watched, but I saw genuine people, people with a dream to help, to help those that are rejected and disliked. I was given the vision of ICAN and what we were there to do and that vision I wanted to be part of. To a 'service drainer' it is a dream to think that people think this way, the way I did and wanted others when supporting those who need us. To see the first individual, who needed our support, will stay with me forever, as will everyone that followed. To be there and listen and support is invaluable. My initial input was more a silent partner as my supervisor showed me the way. I sat and listened intently and questioned quietly just how we could help. We could help with time and listening and offering what others couldn't. To listen to a young lady with intensely complicated medical issues, developing into mental exhaustion and illness made me question what I could do? I could listen and I could tap into our common ground and I could be attentive to what she is missing that could help just a tiny bit. She read: I read and we talked about books, the lack of in that sad medical room and the book I could offer from the possessions I had with me. That look of appreciation and joy and, perhaps a beginning of her relaxing. To offer an ear to help her through the long painful hours she had ahead. I began to wonder how I could measure my input and whether I was help or hindrance but the measure came at the end when you caught that final glimpse in their eye, the one of hope and thanks for helping them through the worst. The comment from a

	client who was intent that she would take her life for her to look over her shoulder at me and say, “I will see you soon!” That astonishment when I can pay compliment to their intelligence, deep thinking, gentle and empathetic nature. When you can signpost them to something they can add value to. When I tell them that I now care and I see value in their life. The same way ICAN saw genuine value in my life to allow me to have input and a voice and to give passionately to a much needed service. From that bridge I transformed into a volunteer, a presentation giver and soon to be a TEDx speaker and conference speaker. Without ICAN, I would have returned to the bridge and jumped to my death.
Key themes emerging:	• Patient voice not being listened to • Terminology used to label patient • Needs of the individual not being recognised due to demand on the service • Different service after 7pm • Training for external agencies
Lessons learnt:	• Ensure people are listened to and respected, whilst having their individual needs understood • Further training and information for external agencies
Shared with:	Quality Safety and Experience Committee Listening and Learning from Experience Group
Proposed action:	Increase the patient voice being heard across the health service to ensure that ‘we listen to hear’. Strengthen awareness of individual’s health and support needs within the PALS service through variety of training. Increase collaborative approach in co-working with Mental Health and Learning disabilities services to include ICAN, CANIAD and Patient and Service User Experience. Training of individuals, teams and services to understand and promote the ICAN service to support patients in need, where appropriate. ICAN training has been planned for the PALS service. Strengthen relationships and referral awareness between PALS and ICAN services. PALS champion role identified to lead MHLD across PALS service ensuring one model approach across all regions.
Responsibility:	Business Manager – Mental Health Transformation ICAN service CANIAD Patient and Service User Experience

Cyfarfod a dyddiad: **Meeting and date:**	Quality, Safety & Experience Committee 28th January 2020
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Annual Plan Progress Monitoring Report (APPMR)
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Mr Mark Wilkinson Executive Director of Planning & Performance
Awdur yr Adroddiad **Report Author:**	Dr Jill Newman, Director of Performance
Craffu blaenorol: **Prior Scrutiny:**	The paper has been scrutinised and approved by the Executive Team and the Executive Director of Planning and Performance.
Atodiadau **Appendices:**	Appendix 1 - December 2019 report

Argymhelliad / Recommendation:

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

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

Sefyllfa / Situation:

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

Cefndir / Background:

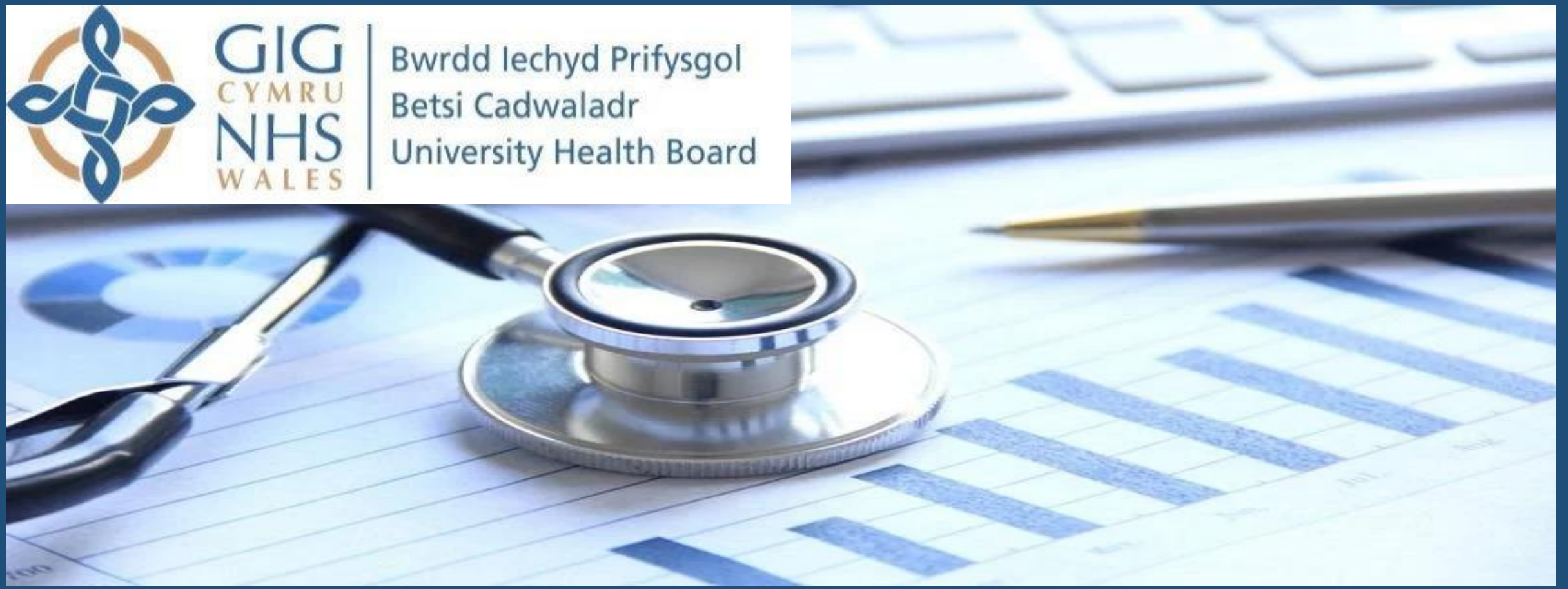
The operational plan has a number of key actions required to be delivered during 2019/20. The Executive lead reviews on a monthly basis progress against their areas for action and RAG-rates progress. Where an action is complete this is RAG rated purple, where on course to deliver the year end position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

Asesiad / Assessment
Strategy Implications Delivery of the operational plan actions is key to implementation of the Boards strategy **Financial Implications** Delivery of the operational plan within the budget set by the Health Board is part of ensuring resources are well-managed and care effectively provided within the allocated resources. **Risk Analysis** The RAG-rating reflects the risk to delivery of key actions **Impact Assessment** The operational plan has been Equality Impact Assessed.

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



December 2019

Table of Contents

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

December 2019

About this Report

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

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

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

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

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

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

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

December 2019

Programme Health Improvement & Health Inequalities Matrix

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

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

December 2019

Exception

AP002 Improve access to Children's weight management specialist services
Tier 3 business case by Q1 2020/21. Delay due to review of delivery models elsewhere to better inform the business case development.

AP008 Partnership plan for children progressed with a strong focus on Adverse Childhood Experiences
Work is continuing to progress positively, but has not yet reached the point of full implementation of the All Wales Neurodevelopment Pathway. As the milestone achievements have been delayed in full, but continuing to progress, this has been graded amber.

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	G	G	G			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	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	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	G	G	G			M
AP013	Develop and implement plans to support Primary care sustainability	Executive Director of Primary and Community Care		G	G	G	G	G	A	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	A	A	A			M
AP015	Implementation of RPB Learning Disability strategy	Executive Director of MH & LD		G	G	G	G	G	G	G	G			M
AP016	Plan and deliver digitally enabled transformation of community care	Executive Director of Primary & Community Care	G	G	A	A	A	A	A	A	G			M
AP017	Develop and Implement a Social prescribing model for North Wales	Executive Director of Primary & Community Care	G	G	G	G	G	G	G	G	G			M
AP018	Establish framework for assessment for CHC and individual packages of care for people with mental health needs or learning disabilities	Executive Director of MH & LD	G	G	P									M
AP019	Establish a local Gender Identity Team	Executive Director of Primary & Community Care	A	A	A	A	A	A	G	G	M			

Three Year Outlook and 2019/20 Annual Plan

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

December 2019

Exceptions

AP014 Model for Health & Wellbeing Centres

This work is progressing but is not as far progressed as was originally intended. Work is ongoing to make up lost time.

Quarterly assurance sampling

AP010 – Put in place Community Resource Team maturity matrix and support to progress each Community Resource Teams (CRT)

Maturity matrix has been agreed, and is now being reported albeit at an early stage.

AP013 – Develop and implement plans to support Primary care sustainability

Business case approved to further develop the professional healthcare workforce in medicines management Approved and being progressed

Workforce plan for Primary care developed First version of local workforce modelling tool has been populated, creating an initial workforce plan. More extensive work is now being undertaken to further refine and extend the modelling, incorporating national datasets and new ways of working. This will be a live plan, and will be coordinated within the PC Academy. Plan and business case developed for Clinical Triage by phone Initial local work on this has been completed, and a business case paused due to the need to align with similar work underway nationally, and greater BCU coordination of managed practices.

AP019 Establish a local Gender Identity Team

National programme, including Direct Enhanced Services (DES), implemented

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	R	R	R			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	A	A	A			
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	R	A	A			
AP024	Rheumatology service review	Executive Director of Primary & Community Care	G	G	A	A	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	A	A	A			
AP025	Implement year one plans for Endoscopy	Executive Director of Therapies & Health Sciences	G	G	A	R	R	R	R	A	A			
AP025	Systematic review and plans developed to address diagnostic service sustainability	Executive Director of Therapies & Health Sciences	G	G	A	R	R	A	A	A	A			M
AP025	Systematic review and plans developed to address service sustainability	Executive Director Nursing & Midwifery	G	G	A	A	A	A	A	G	A			M
AP026	Fully realise the benefits of the newly established SURNICC service	Executive Director Primary and Community Care		G	A	G	G	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	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	G	G	G			M

Three Year Outlook and 2019/20 Annual Plan

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

December 2019

AP021 Implement preferred service model for acute urology services
No further update.

AP022 Orthopaedic Plan enabling works (Estates)
Orthopaedic Plan went to Finance & Performance Committee in December 2019 and will go to Board on 23rd January 2020

AP023 Transform Eye Care Pathway
Successful tender evaluation has enabled contracts to be awarded to 6 primary care ODTs until the end of March 2020. However thete are significant risks in delivering this development given the non-reccurrent funding and the need for this to extend as a sustainable service change. The digital eye care procurement has been confirmed during December 2019 and work is moving to the implementation phase. However, capital allocation to support this is awaiting sign off of full business case by Welsh Government. The e-referral element is in the process of completing an options appraisal.

AP024 Rheumatology service review
Review now completed, and recommendations being progressed to implement.

AP025 Systematic Review and Plans developed to address sustainability for all planned care specialties:
Now being established as part of the Planned Care Improvement Group (PCIG). Recruitment is on-going on specific specialties and 3 consultants have been appointed in orthopaedics. RTT taskforce being reviewed and monitored through PCIG. Implementation of National Planned Care Delivery Programme recommendations being monitored through PCIG. OPD follow up capacity is still challenging to establish in some key specialties to reduce backlog, scrutiny is on-going on how it can be achieved

AP025 Endoscopy
Work is on-going to improve both theatre and outpatient utilisation

Quarterly Assurance Sampling
AP026 Fully realise the benefits of the newly established SURNICC service
Benefit Realisation has been undertaken

Programme Unscheduled Care Matrix

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

Three Year Outlook and 2019/20 Annual Plan

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

December 2019

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

AP031 Demand: Workforce shift to improve Care Closer to Home
Community Resource Teams (CRT) and Admission, Transfer, Discharge (ADT) in EDs across all three sites. Work continues through financial recovery works to improve the impact of these services to provide more care closer to home

AP033 Demand Improved Crisis intervention services for children
No Update
AP034 Flow: Emergency Medical Model
Milestone hit at Ysbyty Glan Clwyd (YGC) and Ysbyty Wrecsam Maelor (YMH). Ysbyty Gwynedd (YG) has opened the new ED unit but models of care are still being finalised to fully operationalise the space. Plans for these were implemented in December 2019.
AP034 Flow: Management of Outliers
Work to reduce outliers in Wrexham has been successful through achievement of new acute floor (AP034). Part of the gold level command and control has been focused on ensuring the patient is in the right bed, first time and supporting teams through making bed allocation decisions. Strategic plans in place to look at how we can use the Christmas period to re-balance patients in the Hospital as we are likely to be the lowest occupied on Christmas Eve.
AP038 Discharge Integrated Health & Social Care
AP038a – Ongoing work with local authorities, recognition there is a shortage in provision of package of care. RPB winter funding to support.
AP038b – Home First principles being embedded through financial recovery work, delays impacted by resource
AP038c – Long length of stay reviews in Acute and Community Hospitals is multi-agency and is identifying areas where community beds are inappropriately used and work is underway to ensure Home First approach is maximised as part of financial recovery work. Commenced in West late November.
AP038d – What matters conversations are happening but not consistently within 24 hours and further work is needed on discharge planning.

Quarterly Assurance Sampling

AP035 SAFER Implementation

SAFER principles in community hospitals is ongoing. Current focus on 'R' for review and long length of stay reviews have commenced in all community hospitals. Engaged with National 'Every Day Counts' work although delay to National agreement on discharge pathways and engaging with social care.

AP037 – Flow Early Pregnancy Service (emergency Gynaecology) Update

Service development will require submission of both a Revenue business and a Discretionary Capital Business case.
Discretionary capital case to be completed by March 2020 for consideration for 21/22 funding to secure funding for structural alterations required to East EGU
Revenue Business case – preferred options being completed which demonstrate need for additional revenue. Draft business case to be submitted to Womens F&P and Women's Board in February 2020.

AP039 – Stroke

There has been no change from what was reported in the previous APPMR of November 2019.

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	G	G	G			
AP042	Build on QI work to develop the BCU improvement system and delivery plan for efficient value based healthcare	Executive Director Workforce & Organisational Development	G	G	G	G	G	M	G	G	G			M
AP043	Deliver Year One Workforce Optimisation Objectives - reducing waste and avoidable variable/premium rate pay expenditure. Demonstrating value for money and responsible use of public funds	Executive Director Workforce & Organisational Development	A	A	A	A	A	M	A	A	A			M
AP044	Deliver year one Health & Safety Improvement programme, focussing on high risk / high impact priorities whilst creating the environment for a safety culture	Executive Director Workforce & Organisational Development	G	A	A	A	A	M	A	A	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	G	G	M			
AP046	Develop a Strategic Equality Plan for 2020-2024	Executive Director Workforce & Organisational Development	G	G	A	G	G	M	G	G	G			
AP047	Deliver Year One Leadership Development programme to priority triumvirates	Executive Director Workforce & Organisational Development	G	A	A	A	A	M	G	G	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	G	G	M			M
AP049	Provide 'one stop shop' enabling services for reconfiguration or workforce re-design linked to key priorities under Care Closer to Home; excellent hospital services	Executive Director Workforce & Organisational Development	A	A	A	A	A	M	A	A	A			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	G	G	M			M

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

December 2019

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

AP044 - Deliver year one Health & Safety Improvement programme, focussing on high risk / high impact priorities whilst creating the environment for a safety culture The gap analysis of legislative compliance has been completed in Q2. This objective remains amber as the review of 31 pieces of legislation indicated there was a lack of compliance in 15 pieces of legislation, partial compliance with 13 and fully compliant with only 3. Next Steps: comprehensive set of action plans has been developed to address the shortfalls in key areas of risks described above. The most significant risks are on the risk register and will be monitored by the Strategic Occupational Health & Safety Group. Plans to develop an accredited Occupational Health Service are underway through the Safe Effective Occupational Health Standards (SEQOSH), this will be implemented in June 2020. A comprehensive set of policies will form the basis of the next 12 months work that are realistic and clear on roles and responsibilities. Action plans are being completed as scheduled and Q3 report provided to QSE in January 2020 to track progress.

AP045 - Integrated Learning Programme: Establish strong links with HEIW to support the alignment of national and local education improvement programmes
The Workforce Modernisation Manager is a member of the HEIW all Wales Learning and Development Framework group, aims are to develop a single framework which will include the definition, educational level and competence of the workforce from support worker to consultant level practice. The group will develop a single, NHS Wales Learning and Development Framework for NHS Wales.
Attended HEIW N/W stakeholder event and established links and input to HEIW's IMTP and work related to the HEIW Workforce Strategy. Learning from this distributed within BCU to Heads of HR and to OD leads and will be shared at the BCU Education Governance group.

Workforce Modernisation Manager also sits on a number of other HEIW groups including: the Clinical Modernisation Group, All Wales Apprenticeship group, All Wales Careers group and the All Wales Primary Care Development band 1-4 group.
New BCU educational governance group set up, first meeting to be held on 20/1/20. Leads from HEIW identified and will be invited when required.

AP045c- Integrated Learning Programme: Develop an Apprenticeship Improvement Plan to enhance utilisation of apprenticeships across the organisation
Plan is developed and in progress, outcomes are well supported and many are completed (but they are an ongoing due to the nature of the work). Apprentices in the organisation have increased over recent months to 34, with several more in recruitment control.

AP045d - Integrated Learning Programme: Develop a plan to expand the Step into Work Scheme across the health and social care sector
Plan is in place:

- Placements commence Jan/Feb 2020
- 12 week placement (1 day per week)
- Participants to rotate (6 weeks) with a primary placement in either acute, community, managed practice, local nursing home (then rotate in all other areas)
- Agreement for placements from community hospital, acute hospital, managed practice
- Confirmed rotation with Clwyd Alyn/Pennaf

AP047a Year 1 Leadership Development Programme: Develop a robust succession planning programme that identifies future leaders within the organisation
Draft Matrix tool adopted from NHS Leadership Academy and is ready to be sent out for consultation.
Senior Director of Leadership from HEIW invited to next Senior Organisational Development Meeting to update on national process to ensure alignment.

AP047c Year 1 Leadership Development Programme: Develop a culture of compassionate, accountable and quality focused leadership and management capability at all levels including clinical leadership
A number of programmes implemented, supporting leaders at all levels in understanding and developing a compassionate leadership style and approach, including - ILM management programmes, A Step Into Management Programme, Ward Managers Programme and the Leading for Transformation Programme for Senior Leaders.
The Executive team are now fully engaged with various initiatives that provide consistent opportunities to communicate our purpose and vision into the organisation. These include participating in Seren Betsi Star staff recognition awards, taking part in Better Care Spending Well events designed to engage staff in effectiveness and efficiency conversations, contributing to the 'My Week' newsletter, engaging in leader walkabouts, acting as sponsors for our senior leadership development programme, Leading for Transformation, and actively participating in the programme's Dragons Den innovation events.
Senior Leadership Network launched - first session held in December 2019 - including executive representation and leaders at band 8D and above - session well received and focused on developing key relationships and networks at senior level. This programme will continue in 2020 on a quarterly basis

AP048b - Develop an integrated workforce development model for key staff groups with health and social care partners: Develop New Roles
W&OD dept are working closely with divisional leaders to develop staff in alternative roles and to develop and introduce new roles. OD department have developed a toolkit to support alternative roles. This has been used most recently to support the Cancer Clinical Nurse specialist competence review resulting in a competence framework for Cancer Clinical Nurse Specialists. BCUHB in association with Bangor University have been offering temporary development roles to newly qualified Physicians Associates. Towards the end of 2019 deputy medical director supported by W&OD colleagues has helped divisional managers towards securing permanent AP posts. This has been as part of M&D optimisation programmes and is providing a permanent solution to junior and middle grade M&D gaps.

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

AP050 – Develop and deliver year one of the Communications Strategy
Strategy has been developed and is awaiting sign off from the Board

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	G	G	G			M
AP063	Primary Care Project Pipeline	Executive Director Planning and Performance	G	G	G	G	G	G	G	G	G			M
AP064	Well-being Hubs	Executive Director Planning and Performance	G	G	A	A	A	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	R	Removed				
AP068	Orthopaedic Services	Executive Director Planning and Performance	G	G	G	G	G	G	G	G	G			M
AP069	Ablett Mental Health Unit	Executive Director Planning and Performance	G	G	G	G	A	R	R	G	G			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	A	A	A			M
AP072	Central Medical Records	Executive Director Planning and Performance	G	G	G	G	A	A	R	G	G			M
AP073	Residencies	Executive Director Planning and Performance	G	G	G	G	G	G	A	A	R			M
AP074	Integrated Care Fund (ICF) Schemes	Executive Director Planning and Performance	G	G	G	G	A	G	G	G	G			

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

December 2019

AP073 Residencies has moved from amber to red:

A useful meeting was held just before Christmas and the scope for a possible collaboration continues to be explored.

A draft business case has now been produced and is receiving its first review. There are a number of key issues to be resolved including:

- Given the previous procurement exercise, what is the current status of housing providers as preferred partners.
- Asset ownership.
- Balance sheet issues.

This is a proposed ground breaking partnership and an innovative financing approach. It will in all likelihood not be possible to progress a business case to Board by the end of March.

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	G	G	G			M
AP052	Completion of pilot studies to learn lessons to inform wider installation and utilisation of the Welsh Community Care Information System	Executive Medical Director	A	A	R	R	R	M	R	R	Moved to 2021/22			
AP053	Reconstitute the Welsh Emergency Department System upgrading the Emergency Department System in the East (phase 1) and extending instances to Central and West (phase 2 and 3)	Executive Medical Director	G	G	G	G	G	M	G	G	G			M
AP054	Phase 2 of a local Digital Health Record which will strengthen our investment and approach to the delivery of an electronic patient record	Executive Medical Director	G	G	G	G	G	M	G	G	G			
AP055	Support the identification of storage solution for Central Library	Executive Medical Director	A	A	A	A	A	M	G	G	G			
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	A	A	A			M
AP057	Delivery of information content to support flow/efficiency	Executive Medical Director	A	A	G	G	G	M	G	G	G			M
AP058	Rolling programmes of work to maintain / improve the digital infrastructure e.g. migration of telephone infrastructure from an end of life solution to one which is fully supported and capable of underpinning service change e.g. single call centre	Executive Medical Director	G	G	A	A	A	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	A	A	A			M
AP060	Support Eye Care Transformation	Executive Medical Director	G	G	G	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	A	A	A			

Three Year Outlook and 2019./20 Annual Plan

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

December 2019

AP056: Good Record Keeping/Management
Deputy Head of Health Records post (8b) has been recruited to internally and took up post in October. The Band 7 Project Manager requirement has been confirmed in principle and funding is being secured through the HASCAS & Ockenden Board. As soon as able to start the work, Mental Health Services will be the priority area - aim to complete this section by March 2020.

AP058: Deliver Capital Programme for 2019 2020 as defined within plans
The discretionary programme is progressing as planned with progress being made in all expected areas. The programme was subject to change control at the end of Quarter 2 via the Capital Programme Management Team to reflect the removal of the paging systems replacement project and emerging priorities for spend which include Health Records racking and Telephone Switches.

AP059: Provision of infrastructure and access to support Care Closer to Home
The group lead by BCU to facilitate standard access to "home networks" for community resource teams have identified 6 Work streams for the provision of ICT infrastructure; • Formalising IT Service Desk call logging procedures and service agreements • Federating Active Directory across 6 Local Authorities and implementing trust relations with BCUHB Nadex • Implementation of Wide Area Networks, Local Area Networks and Govroam wireless networks into required sites • Implementation of telephony solutions for each of the identified sites e.g. Interactive Voice Response call routing & Contact Centres as required • Implementation of shared managed print solutions for all partner organisations at sites • Deployment of Office 365 and MS Teams to enable collaborative working for the various partner organisations.
A capital business case is under development to enable work, data from CRT teams is required to complete. This is taking longer to gain than anticipated.

AP061: Cancer Tracker
The updated product is available within the organisation however this does not fully satisfy the requirements of Cancer Services, and appaers to offer lower functionality than is presently in use . National discussions are continuing to increase the functionality of the product. At this time Cancer Services have declined to adopt the current version available.

Programme Finance 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
AP075	Governance	EDN&M & Deputy CEO	Grey	Grey	M	A	A	M	A	A	A			
AP076	Grip and Control	Executive Director of Finance	Grey	Grey	M	A	G	M	A	A	A			
AP077	Planning	Executive Director of Finance	Grey	Grey	M	A	A	M	A	A	A			
AP078	Procurement	Executive Director of Finance	Grey	Grey	M	A	G	M	A	A	A			
AP079	Risk Management	Deputy CEO	Grey	Grey	Grey	Grey	Grey	M	G	G	G			

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

December 2019

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

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

AO077 - Planning
Performance against in-year financial plan (including savings programme) is being tracked.
Accurate forecasting and delivery of financial recovery actions are critical in driving the required reduction in expenditure by divisions over the last quarter of the year.
Planning cycle for future years is underway.
We are learning lessons from current year planning, in-year performance to date, and from the Financial Recovery programme to better inform future planning.

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

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

Cyfarfod a dyddiad: **Meeting and date:**	Quality, Safety and Experience Committee 28th January 2020
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Integrated Quality & Performance Report (IQPR)
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Mr Mark Wilkinson Executive Director of Planning & Performance
Awdur yr Adroddiad **Report Author:**	Dr Jill Newman, Director of Performance
Craffu blaenorol: **Prior Scrutiny:**	This paper has been scrutinised and approved by the Director of Performance.
Atodiadau **Appendices:**	Appendix 1 – IQPR December 2019

Argymhelliad / Recommendation:

The Quality, Safety and Experience Committee is asked to scrutinise the report and to consider whether any area needs further escalation to be considered by the Board.

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

Sefyllfa / Situation:

Please refer to Executive Summary contained within the IQPR

Cefndir / Background:

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.

Asesiad / Assessment
Strategy Implications The performance measures within the IQPR are aligned with the Annual Plan and identified as the key performance indicators in monitoring and managing the Health Board's strategy. **Financial Implications** The financial benefits arising from high quality safe care are recognised and the cost of poor performance both to the individual patient, staff morale, organisational reputation and financial cost is integral to improving the performance of the Health Board. **Risk Analysis** The RAG-rating reflects the performance against the Plan. Where there aren't Plan Profiles, the performance is measured against the national target. **Impact Assessment** The operational plan has been Equality Impact Assessed. The Quality, Safety and Experience Committee is asked to scrutinise the report and to consider whether any area needs further escalation to be considered by the Board.

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

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

December 2019

Table of Contents

Integrated Quality and Performance Report

Quality, Safety & Experience Committee Version

December 2019

About this Report

Section 1: Report Structure

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

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

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

An additional slide is provided this month on the actions being taken to address the backlog incidents requiring closure.
In addition to this report all committees are provided with a RAGP self-assessment of progress against the actions within the Annual Plan.

Overall Summary

Graphic Summary

Improved

Code	Measure	Status	Annual Plan Profile	National Target
LFM060b	MHM1a - Assessments within 28 Days (CAMHS)	82.73% ↑	>= 80%	>= 80%
LFM061b	MHM1b - Therapy within 28 Days (CAMHS)	86.80% ↑	>= 80%	>= 80%
DFM005a	Flu Vaccination: 65's and Over	69.10% ↑	>= 60%	>= 75%
DFM005b	Flu Vaccination: Uner 65's at Risk	42.4% ↑	>= 30%	>= 55%

Of Most Concern

Code	Measure	Status	Annual Plan Profile	National Target
DFM058	26 Week Wait: Adult Specialist Mental Health Psychological Therapy	25.18% ↑	AP	>= 80%
DFM059	26 week Wait: Children and Young People Neurodevelopment Assessment	25.76% ↓	AP	>= 80%
DFM015	Sepsis Six Bundle: Emegrgency Department	48.15% ↑	>= 80%	Improve
DFM028	Crude Mortality Rate (Under 75 years of age)	0.77% ↓	<= 0.70%	Reduce

Grey = No Data available at the time of reporting

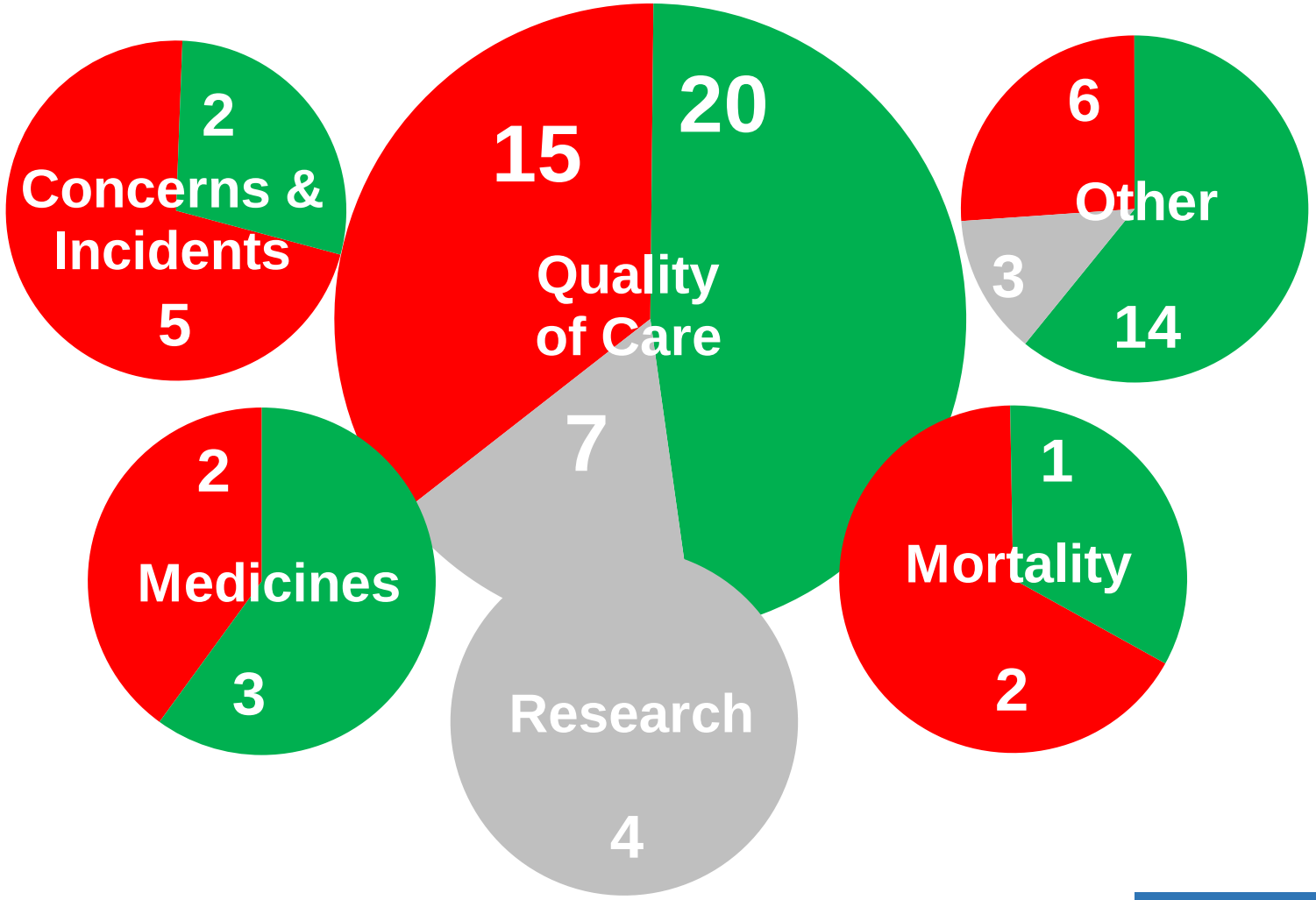
Integrated Quality and Performance Report
Quality, Safety & Experience Committee Version

December 2019

Executive Summary

The Committee are asked to note that while flu vaccination will continue to the end of the winter performance is presently the best in Wales. every effort is being made to improve further towards delivery of the targets despite some issues initially experienced with the distribution of vaccines.
The committee are also asked to recognise the improvement made in the delivery of the mental health measure in CAMHS with both assessment and therapy targets achieved for the first time this year. The assessment within 28 days has delivered the national target for 3 consecutive month and while continuing to be reported can be de-escalated from exception reporting next month.
The reports on psychological therapies and neurodevelopment indicators demonstrate the amount of work and investment required to improve delivery of services to both populations of patients.
The committee is asked to pay attention to the deterioration in infection prevention measures, with the present position indicating that for a number of infections the year end trajectory is now unlikely to be achieved. The committee should be aware that across Wales delivery of the trajectories is challenged and within BCU work is demonstrating that not all infections are health care acquired and a high proportion are classified as unavoidable.
The work of the sepsis collaborative to address the improvement in ED Performance is highlighted, noting that performance is lower in quarter 3 2019/20 than in the same period of the previous year.
The improvement in reporting of SUI is continuing with the backlog of overdue reports reduced to 37.
No new never effects are reported this month

Chapter 1 – Quality Graphic Summary



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

December 2019

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: Emergency Department	48.15%	>= 80%	Improve
DFM016	Preventable Hosptial Acquired Thrombsis	1	NIP	Reduce
DFM017	Opiod Average daily quantities per 1,000 patients	4,815	<=4,961	Reduce
DFM018	Antipsychotic Prescriptions for Over 65s	2,215	AP	Reduce

Code	Measure	Status	Annual Plan Profile	National Target
DFM019	Antibacterial Items per 1,000 STARPUS	259.8	<= 275.6	Reduce
DFM020	Combined 4 Antibacterial items prescribed	12.68	<= 14.33	Reduce
DFM022	Patient Safety Solutions Wales Alerts and Notices	1	<= 5	0
DFM023	Serious Incidents Assured within timescales	69.44%	>= 47%	>= 90%
LM023a	Serious Incidents: Patient Falls	12	<= 11	<= 11
LM023b	Serious Incidents: Pressure Ulcers	4	0	0
LM023c	Total Number of Healthcare Acquired Pressure Ulcers	516	AP	AP
DFM024	Total Number of New Never Events	0	0	0
DFM027	Universal Mortality Reviews within 28 Days	92.80%	>= 95%	>= 95%
DFM028	Crude Mortality Rate (Under 75 years of age)	0.77%	<= 0.70%	Reduce
DFM032	NICE Approved New Medicines made available Within 3 Months	99.40%	100%	100%

Chapter 1 – Quality Summary Page 2

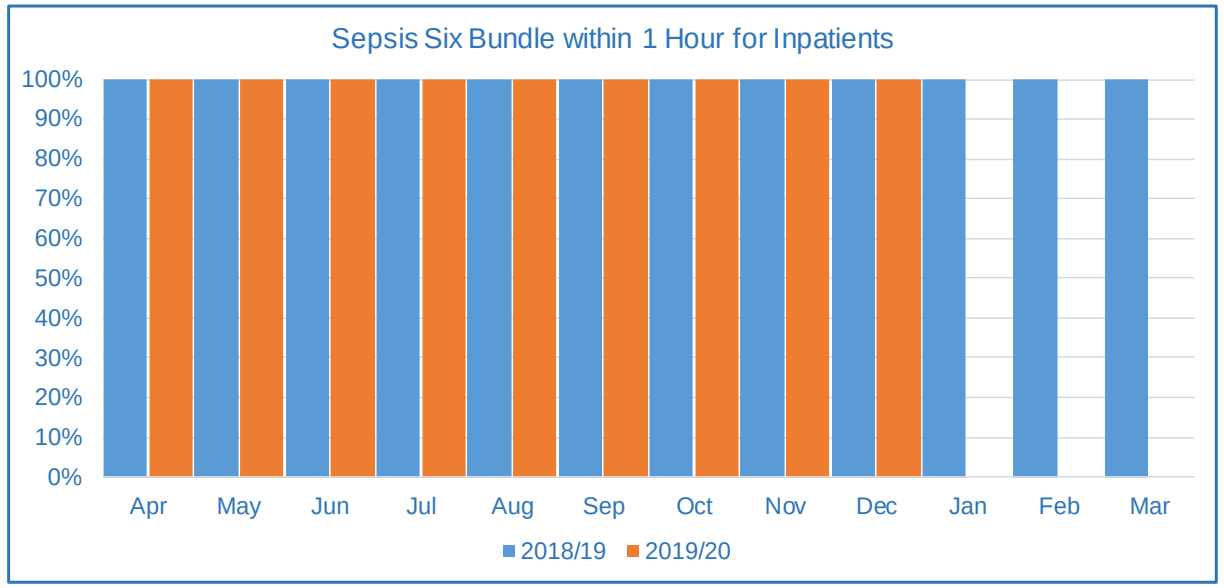
Code	Measure	Status		Annual Plan Profile	National Target
DFM033	Number of Clinical Research Studies				
DFM034	Number of Commercial Research Studies				
DFM035	Number recruited to clinical studies				
DFM036	Number recruited to commercial studies				
DFM037	Survey Results: Satisfaction with Health Services	6.17	↓	Improve	Improve
DFM038	Number of Postponed Procedures (Non-clinical)	2,239	↓	Reduce	Reduce
DFM039	Evidence of Responding to service user experience				
DFM040	Concerns Replies within 30 Days	55.20%	↓	>= 48%	>= 75%
DFM041	Over 65's with Dementia registered with GP	52.20%	↑	Improve	Improve
DFM042	Survey Results: Dignity and Respect	96.60%	↑	Improve	Improve
DFM043	Survey Results: Satisfaction with GP care	92.50%	↑	Improve	Improve

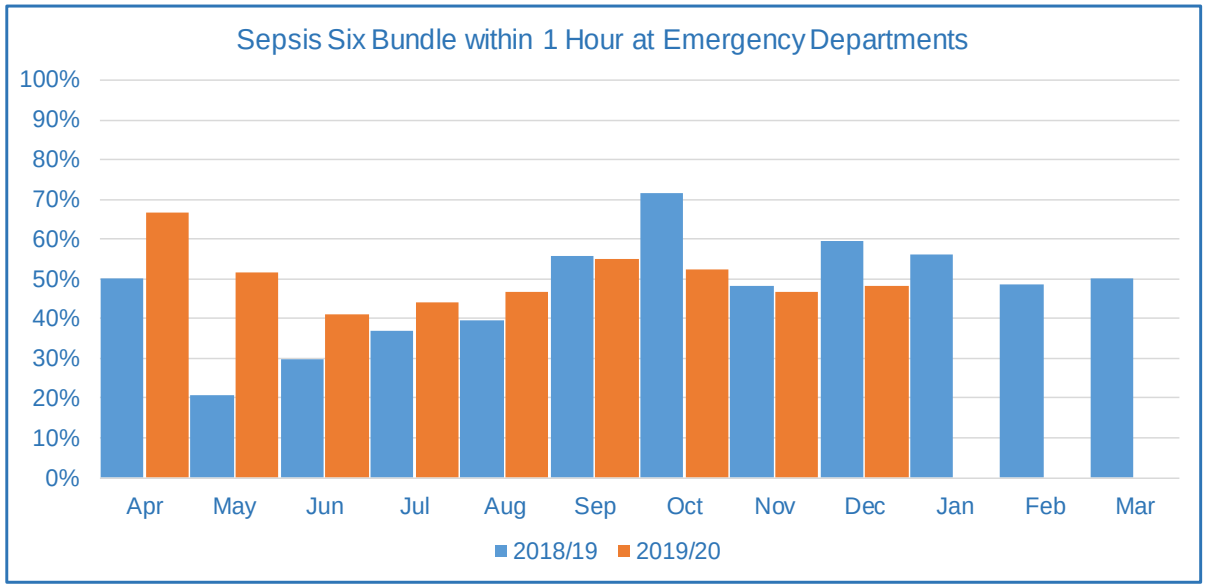
Code	Measure	Status		Annual Plan Profile	National Target
DFM044	Survey Results: Satisfaction with Hosptal Care	94.60%	↑	Improve	Improve
DFM045	NHS Staff Dementia Training	93.70%	↑	Improve	>= 85%
DFM046	GP Practice Dementia Training	18.90%	↓	Improve	Improve
DFM075	Qualitative Report: Advancing Equality	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)	86.00%	→	>= 95%	>= 95%
WGM002	Ward Staff Skill Mix (Nursing)	56.00%	→	>= 60%	>= 60%

Chapter 1 – Quality

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%	Dec-19	100%	→	0	100%	100%	100%	100%	-	100%	100%	100%	-	100%	100%	100%	-				
DFM015	Percentage of patients who presented to the Emergency Department with a positive sepsis screening who have received all elements of the 'Sepsis Six' first hour care bundle within one hour of positive screening	Improve	AP039	>= 80%	Dec-19	48.15%	↑	0	45.18%	66.21%	51.55%	44.78%	-	44.27%	53.13%	58.50%	-	52.36%	46.60%	48.15%	-				





Why we are where we are:

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

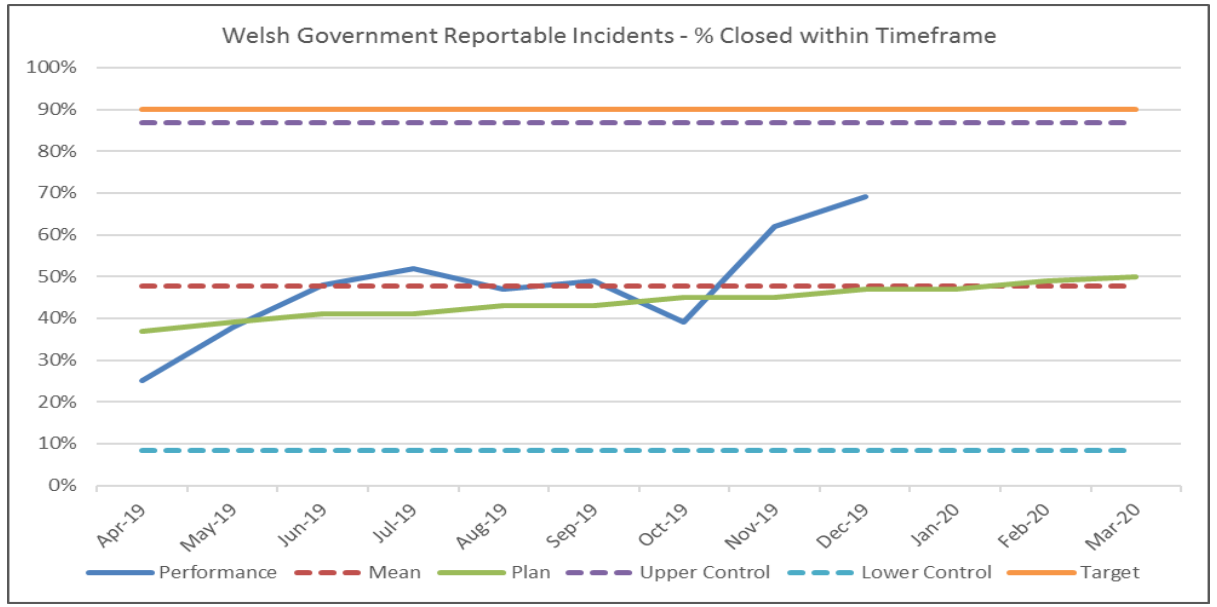
December 2019

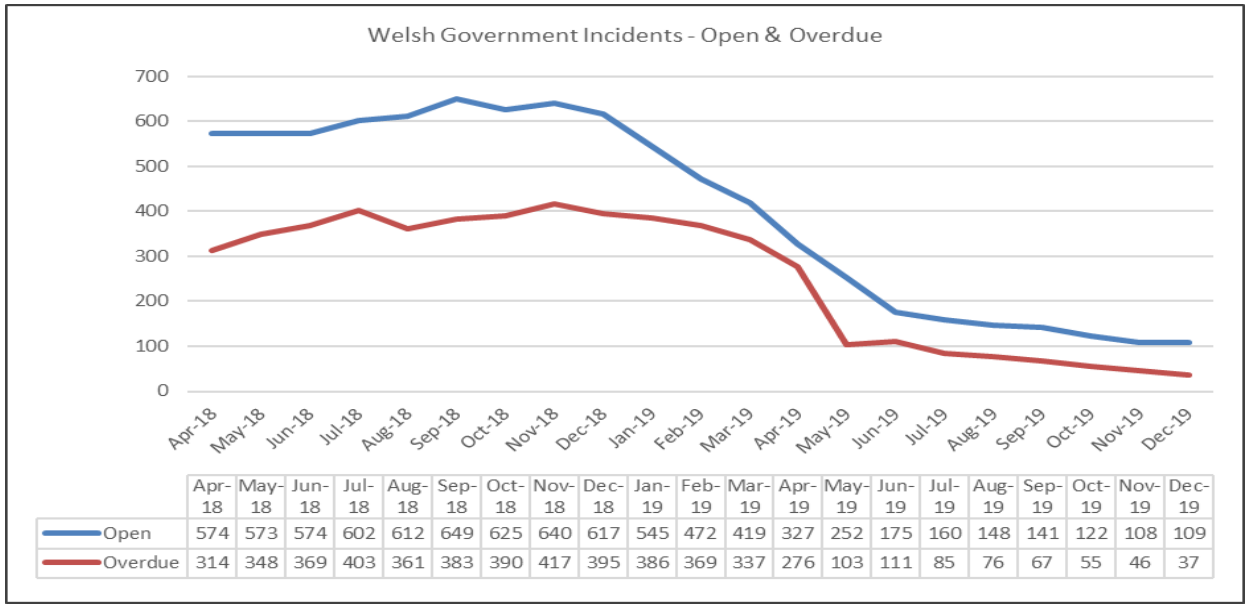
Sepsis Six Bundles

Actions	Outcomes	Timeline
1. Sepsis collaborative (Emergency Departments) • Sepsis collaborative is about supporting teams in the emergency department to work together local and across the health board to make improvements in sepsis management and share success with others to improve patient outcomes for sepsis in line with best practice. • Session 5 of the sepsis collaborative is scheduled to take place on 12th Feb 2020. This will be reviewed after this event to evaluate if further sessions will be held. • A reduction in Sepsis mortality is being seen now on some acute 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	Predicted April 2020
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. • Development work on the dashboard is now completed	provision of live data to inform staff of progress and help identify areas of weakness that need improvement	Completed November 2019
3. Introduction of DRIPS* meetings **DRIPS stands for data, review, improve, plot the dots and share** 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	Predicted April 2020

*Data, Review the cases, Improvements, Plot the dots, Share and celebrate

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	>= 47%	Dec-19	69.44%	↑	4th	22.22%	25.00%	38.24%	48.28%	-	51.52%	46.51%	51.60%	-	39.50%	62.16%	69.44%	-				-





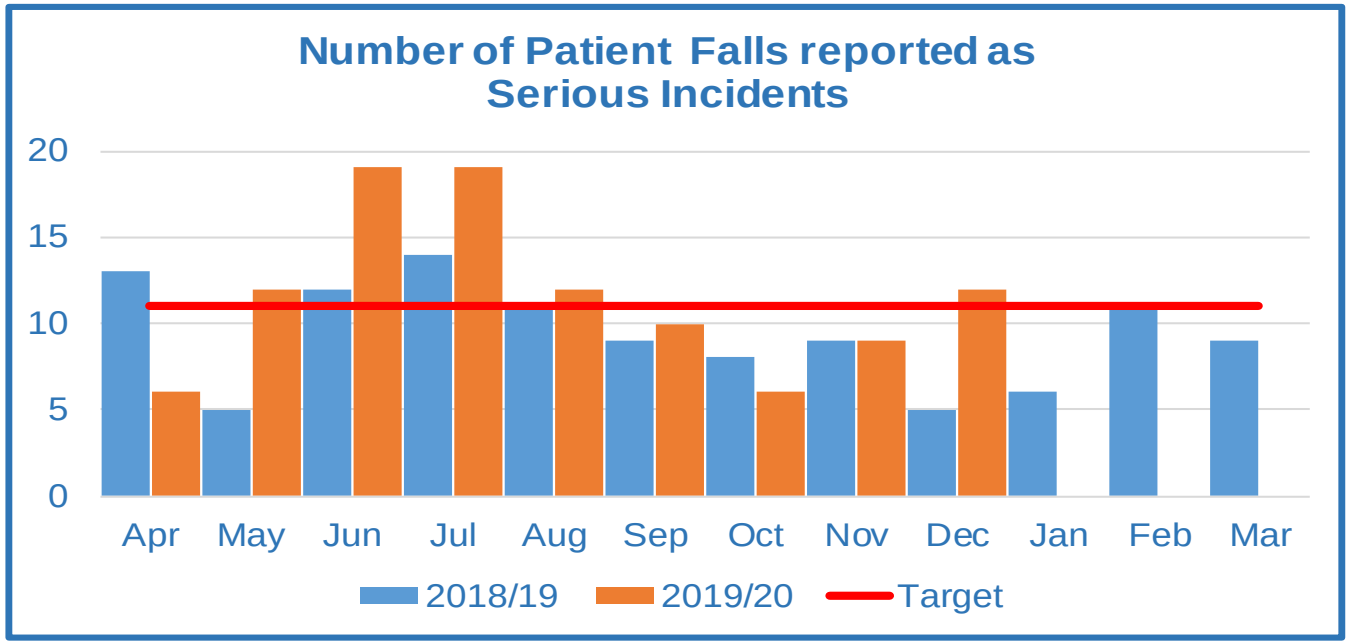
	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Open	574	573	574	602	612	649	625	640	617	545	472	419	327	252	175	160	148	141	122	108	109
Overdue	314	348	369	403	361	383	390	417	395	386	369	337	276	103	111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

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 8th January 2020 being 109, of which 37 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 Patient Safety and Experience has continued the scrutiny of open and overdue incidents, and divisions have continued their focus on timely completion. This focus will continue.	Continued focus and scrutiny has seen a sustained reduction in overdue closure forms and an improvement in timely completion.	Ongoing
2. A review of the procedures and processes for incidents is planned with a view to streamlining and simplifying. This will be done in co-production with divisions. The review will explore new processes, training and documentation.	Simpler process for staff to follow reducing delays	Review to start by March 2020
3. Implementation of the new All-Wales Concern System (replacement Datix system)	Simpler, improved and more accessible recording of investigations and learning and easier reporting to WG	National rollout during 2020-2021 (Welsh Government (WG) led programme)

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	Dec-19	12	↓	N/A	0	6	12	19	0	19	12	10	-	6	9	12	-				-



- **Harms resulting from patient falls in December 2019**:
- Total of **12** Falls reported for December 2019 increase from previous month (total 9 reported for November)
- 6 patients in Secondary care- 2 fractured neck of femurs, 1 subdural haematoma, 1 fracture wrist & 1 fracture to nose
- 2 patients in community inpatients-1 fractured neck of femur & 1 fracture to THR
- 3 patients in MHLD inpatients-2 fractured neck of femurs & 1 pubic rami
- 1 outpatient community hospital-1 fractured patella

Serious Incidents: Patient Falls

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

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	Dec-19	4	↑	N/A	52	3	4	2	-	2	6	2	-	10	10	4	-				-
LM023c	Total Number Healthcare Acquired Pressure Ulcers(All Grades)	AP	NIP	AP	Dec-19	516	↑	N/A	ND	508	452	543	-	550	502	482	-	539	536	516	-				-

Why we are where we are: Total of 4 HAPU reported as serious incidents for December 2019: 3 in Secondary care (Wrexham) 1 in community Clinic. Total number of HAPU (for all grades for the Health Board Inpatients, community patients in own home and care homes) 190 reduction on previous months.

Actions	Outcomes	Timeline
1Risk Assessments to be implemented as part of the introduction of revised booklet by 30th April 2020 in line with All wales implementation plan	Combined Risk Assessment and SSKIN* bundle will support identification and preventative intervention will reduce incidence of HAPU	30th April 2020

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

Chapter 1 – Quality Never Events

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
DFM024	Number of new never events	0	AP039	0	Dec-19	0	↑	2nd	1	0	0	0	-	0	0	1	-	2	1	0	-				-

Details on never events:

There were no new Never Events reported for the month of December.

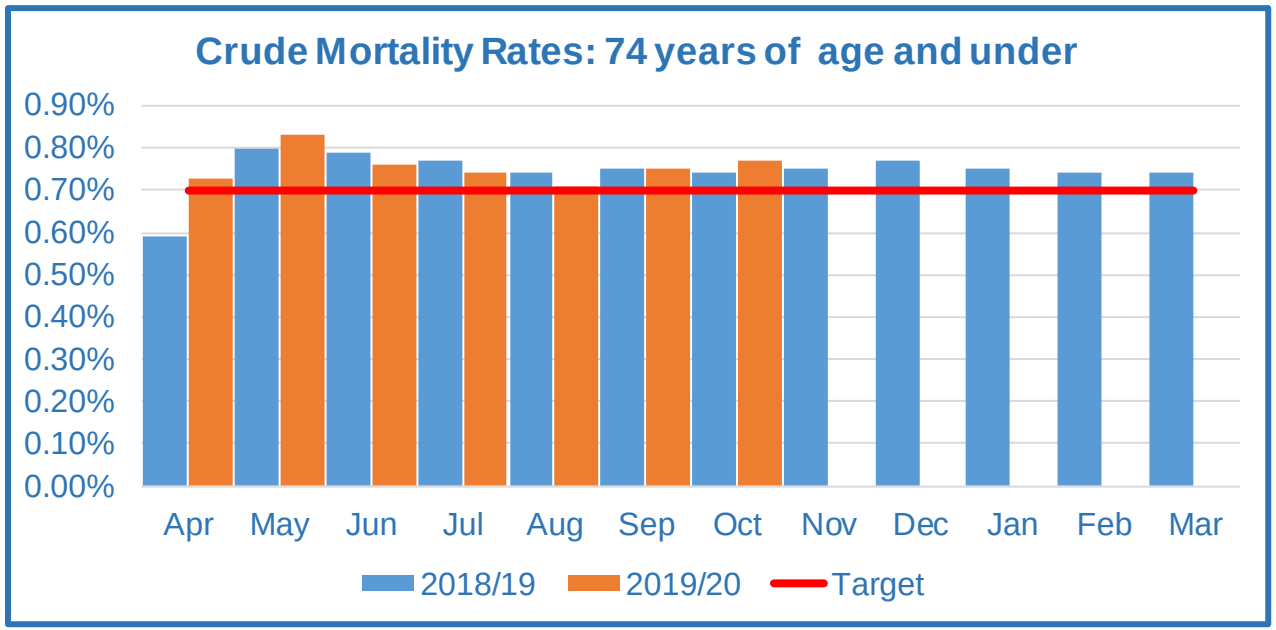
Currently the Health Board have 2 Never Events open and under investigation:

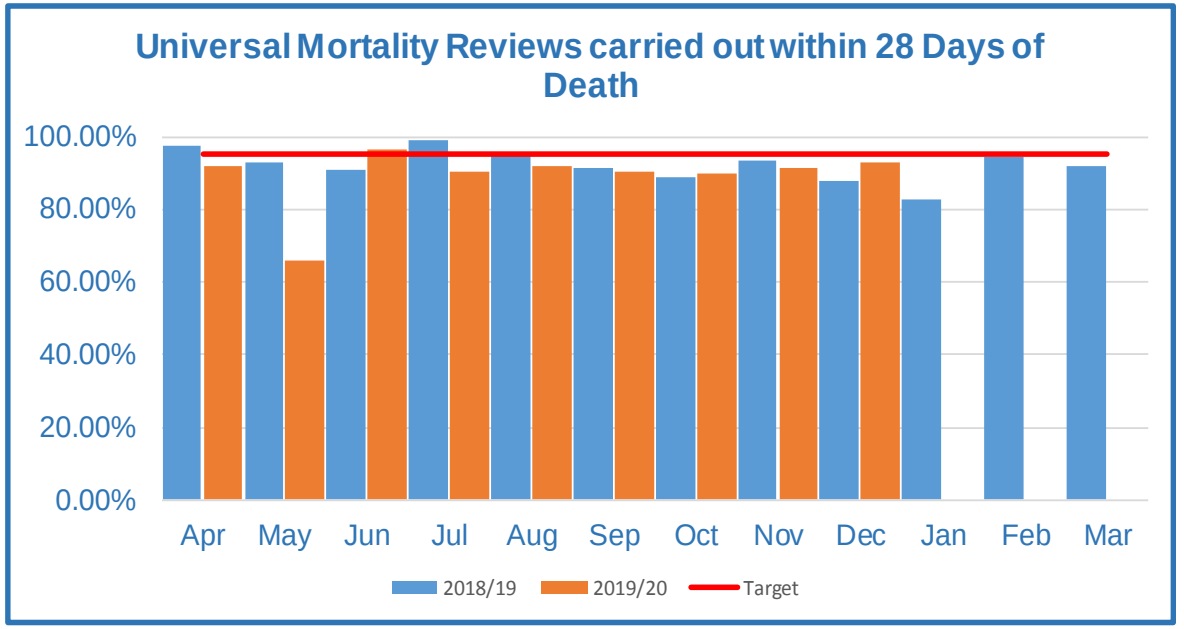
1) Retained foreign object post – operation. Reported 23.10.2019 - Serious incident review undertaken, chaired by Hospital Medical Director and supported by head of Patient Safety. Information from review to be fed into BCUHB's "PICC line" task and finish group. Action plan in development following recommendations.

2) Retained foreign object post – operation. Reported 21.11.2019 - Rapid review undertaken. Comprehensive investigation and review to follow. Secondary Care Medical Director will Chair the review.

Chapter 1 – Quality 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%	Dec-19	92.80%	↑	2nd	87.80%	92.10%	95.80%	96.70%	-	90.50%	91.70%	90.50%	-	89.60%	91.20%	92.80%	-				-
DFM028	Crude hospital mortality rate (74 years of age or less)	Reduce	AP039	<= 0.70%	Oct-19	0.77%	↓	4th	0.74%	0.73%	0.83%	0.76%	-	0.74%	0.71%	0.75%	-	0.77%			-				-

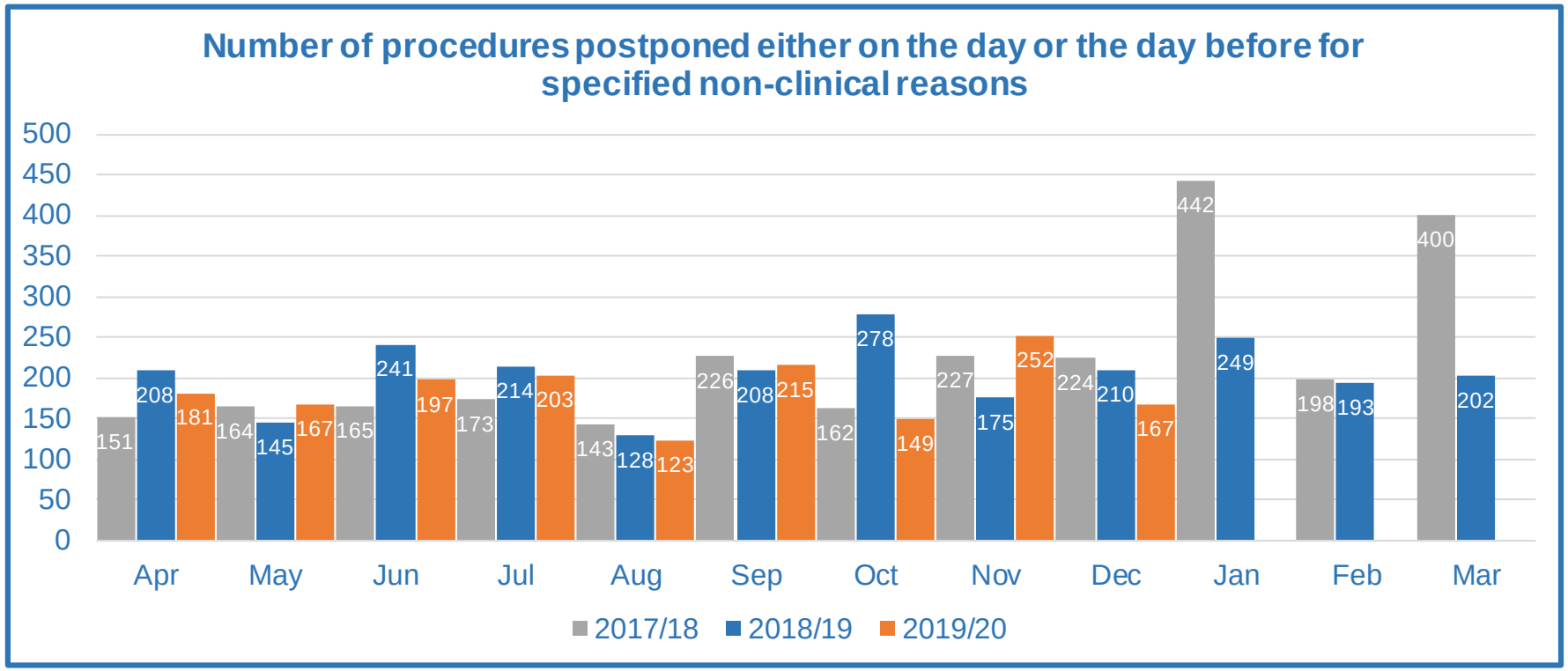




Why we are where we are: Crude mortality rate is a stable process with no special cause variation to suggest concern.
Universal Mortality review (UMR) performance is below target due to one DGH, Wrexham. This escalated to secondary care management team.
Work is progressing to move onto DATIX. Easier to track and manage, its anticipated this will address the performance deficit.
Medical Examiners are likely to come into post over the next 6 months. These will progressively take on review of all deaths for North Wales, with a national goal of April 2021. Together we anticipate to be above UMR target within next 6 months.

Actions	Outcomes	Timeline
1. Reduction in mortality through focussed improvement collaborative for Sepsis identified at the DGH Emergency Departments	• Improved compliance with sepsis six bundle • Downward shift in sepsis associated mortality	6 months
2. Reduction in mortality through focussed improvement collaborative on Acute Kidney Injury (AKI) arising in primary care	• All GPs complete Quality Improvement Training, at least to “Bronze” level- 1 year • Relevant Metrics established- 6-12 months • Engagement framework developed -6 months • At risk population identified and testing commenced on first step interventions- 6 months • Impact on AKI associated admissions and mortality expected to reduce over a 2 year period.	October 2020- 21
3. Mortality systems review with secondary care, to ensure alignment of process with strategic intent	• SBAR completed and meeting arranged with secondary care • Agree, Design and Implement over 6-12 months • DATIX system implemented across all areas • Achieve 95% target for UMR • Achieve review of all deaths within 6 weeks • Readiness of systems to receive referrals from Medical Examiners	6-12 Months
4. Learning From Deaths (LFD) policy	• Develop a LFD policy • Take through consultation and approval process • QSE	4-6 months
5. Extend systematic mortality review, in readiness for Medical Examiners	• All apply processes consistent with LFD policy • DATIX mortality review system established for all	18 months

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	Sep-19	2,239	↓	5th	2,796	2,242	ND	ND	-	2,236	2,227	2,239	-				-				-



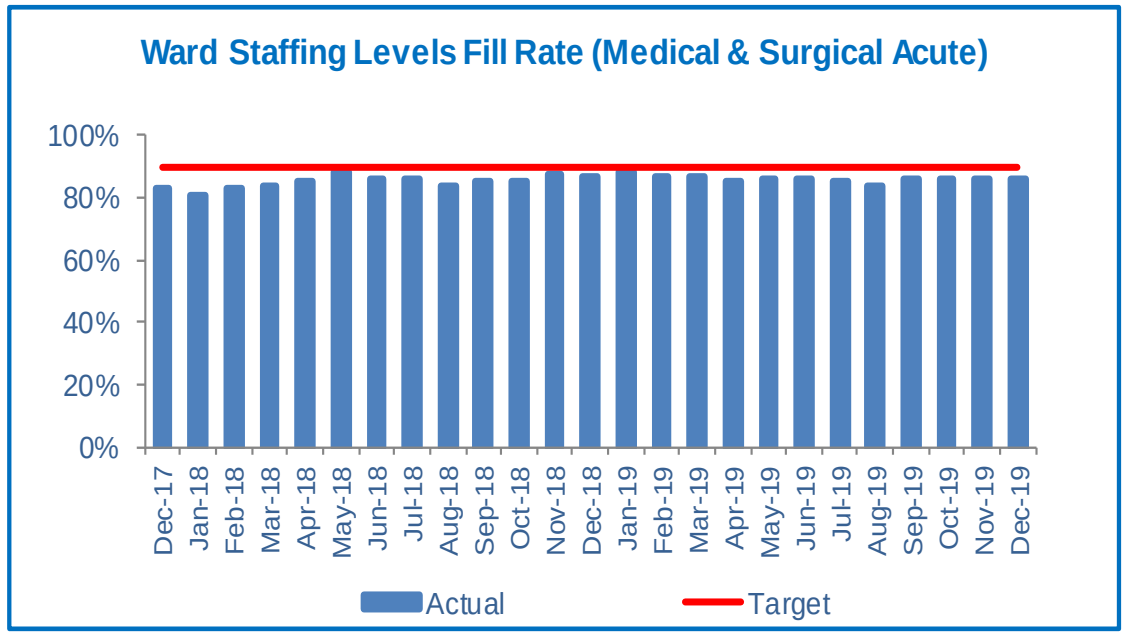
The measure is reported as rolling 12 months, whereas the graph illustrates number of postponed procedures per month

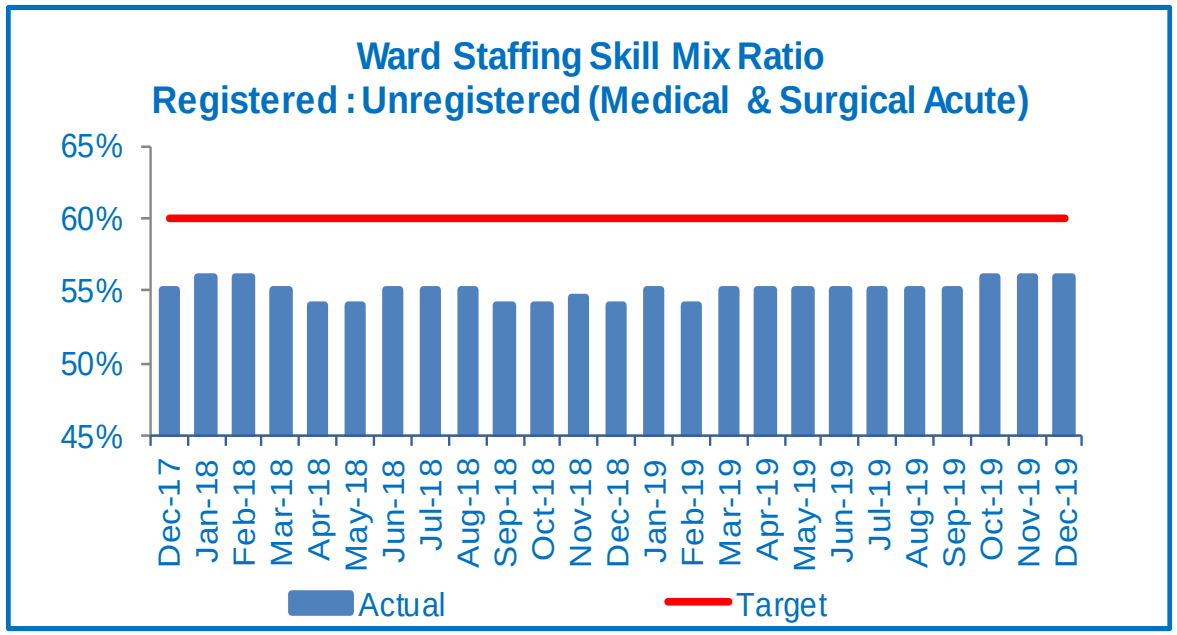
Actions	Outcomes	Timeline
1. Review of avoidable on the day cancellation as a part of weekly access meeting at site level. This is now part of weekly access agenda.	Better understanding of cancellations reasons by speciality to help manage cancellations.	30/01/2020 Avoidable cancellations are reviewed weekly as part of site level access meetings with agreed corrective actions.
2. 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
3. Improved Theatre scheduling process	Contribute to reduction in on the day cancellations to financial year benefit of 1,600	Theatre utilisation groups has been established at the 3 sites, along with the planning cells, work on reducing causes on theatre cancellations that are local to each site28/02/2020
4. Introduction and roll out of SMs messaging	Reduction in patient DNA	28/02/2020

Chapter 1 – Quality

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	Dec-19	86.00%	➡	N/A	87.00%	85.00%	86.00%	86.00%	-	85.00%	84.00%	86.00%	-	87.00%	86.00%	86.00%	-				-
WGM002	Ward Staff Skill Mix Ratio of Registered v Non-Registered Percentage	>= 60%	NIP	AP	Dec-19	56.00%	➡	N/A	54.00%	55.00%	55.00%	55.00%	-	55.00%	55.00%	55.00%	-	56.00%	56.00%	56.00%	-				-

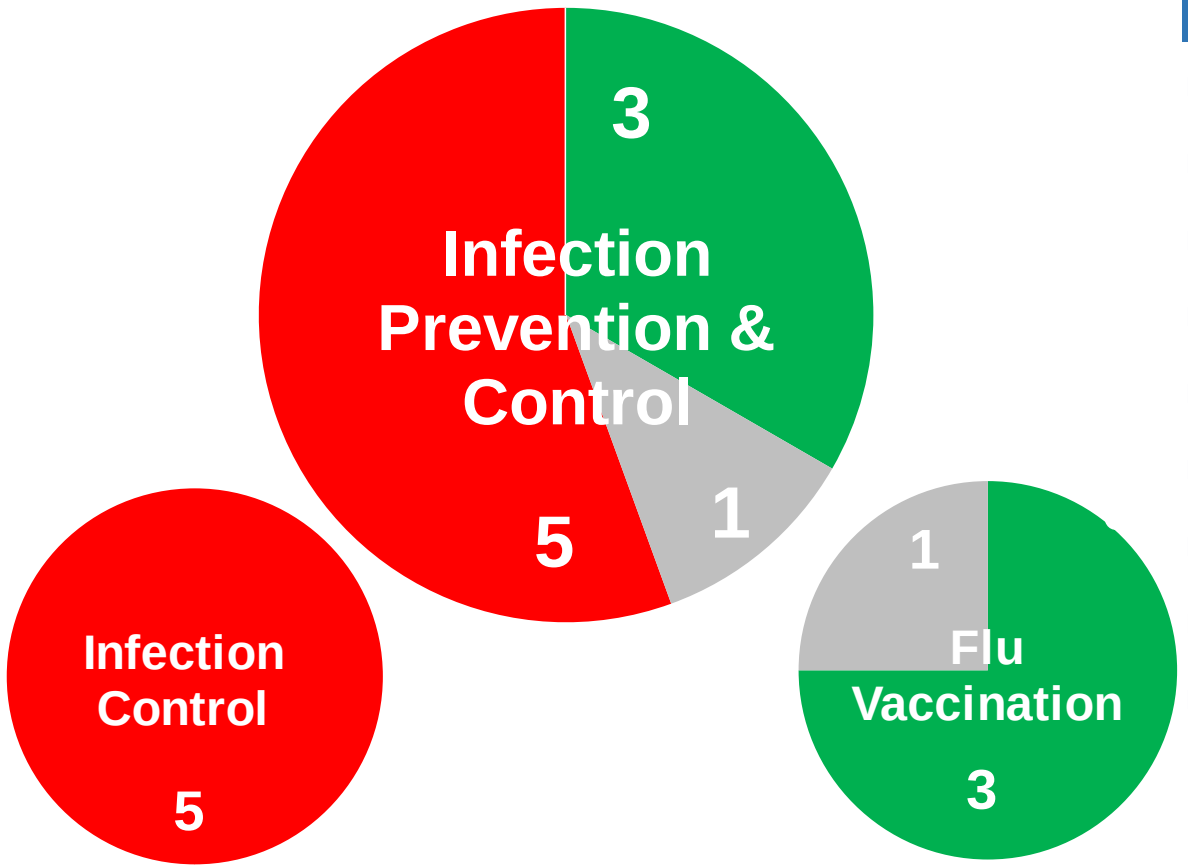




Actions	Outcomes	Timeline
1. Ongoing recruitment – including additional pipelines of: Band 4 role to support, overseas recruitment and targeted recruitment for hot spot areas. Bi-annual staffing reviews to be completed and monitored and triangulated with Harms data	Band 4 recruitment has been successful Offers made to 11 overseas Nurses due to start imminently Newly qualified due to complete March 2020 Staffing review completed Spring 2019, follow up review Autumn 2019	In progress Commence in post April 2020 Completed June & Nov 2019
2. Ongoing retention initiatives – including review of the preceptorship programme	Review of the HB preceptorship programme Introduction of a Buddy system to support New starters Review and analysis of Exit data Professional forums introduced	Commenced
3. Review of rostering effectiveness to ensure optimal staff deployment	Roster scrutiny meetings commenced – learning has been shared with teams. Ongoing monitoring using defined roster metrics.	Ongoing – monthly meetings
4. Promoting Staff wellbeing	Staff survey supported by Staff side colleagues Promotion of staff taken breaks and obtaining adequate hydration and nutrition whilst on duty Stress risk assessment completion for areas with high turnover/sickness	March 2020 February 2020 ongoing

Chapter 2 – Summary

Infection Control



Code	Measure	Status	Annual Plan Profile	National Target
DFM021a	Cumulative Rate: E.Coli	85.52 ↓	<= 67	<= 67
DFM021b	Cumulative Rate: S.Aureus	29.46 ↓	<= 20	<= 20
DFM021c	Cumulative Rate: C.Difficile	28.51 ↓	<= 22	<= 22.13
DFM021d	Cummulative Number: Klebsiella sp	113 ↓	<= 78	<= 106
DFM021e	Cumulative Number: P.aeruginosa	31 ↓	<= 18	<= 27
DFM005a	Flu Vaccination: 65's and Over	69.10% ↑	>= 60%	>= 75%
DFM005b	Flu Vaccination: Under 65's at Risk	42.40% ↑	>= 30%	>= 55%
DFM005c	Flu Vaccination: Pregnant Women			
DFM005d	Flu Vaccination: Health Care Workers	54.54% ↑	>= 30%	>= 60%

Chapter 2 – Infection Control Measures

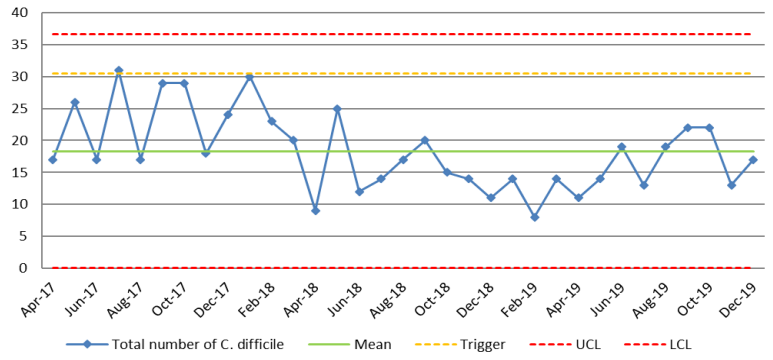
Code	Measure Description	National Target	Plan Ref	Plan Target	Current Period	Actual	Status	Wales Benchmark	Same Period Last Year	Apr-19	May-19	Jun-19	Qtr 1 19/20	Jul-19	Aug-19	Sep-19	Qtr 2 19/20	Oct-19	Nov-19	Dec-19	Qtr 3 19/20	Jan-20	Feb-20	Mar-20	Qtr 4 19/20
DFM021a	Cumulative rate of laboratory confirmed E.coli bacteraemia cases per 100,000 population	<= 67	AP039	<= 67	Dec-19	85.52	↓	3rd	84.12	97.85	83.59	88.38	-	83.77	85.63	83.39	-	83.04	83.11	85.52	-				-
DFM021b	Cumulative rate of laboratory confirmed S.aureus bacteraemias (MRSA and MSSA) cases per 100,000 population	<= 20	AP039	<= 20	Dec-19	29.46	↓	3rd	23.64	26.21	27.57	29.29	-	28.35	27.75	29.13	-	29.31	29.13	29.46	-				-
LM021b1	Cumulative Number of laboratory confirmed MRSA cases	0	AP039	0	Dec-19	7	↓	N/A	13	1	2	4	-	6	6	6	-	6	6	7	-				-
LM021b2	Cumulative Number of laboratory confirmed MSSA cases	<= 139	AP039	<= 101	Dec-19	148	↑	N/A	108	14	31	49	-	63	75	96	-	114	130	148	-				-
DFM021c	Cumulative rate of laboratory confirmed C.difficile cases per 100,000 population	<= 22.13	AP039	<= 22	Dec-19	28.51	↑	3rd	25.73	19.22	21.54	25.42	-	24.06	25.69	27.99	-	29.31	28.49	28.51	-				-
LM021c	Cumulative Number of laboratory confirmed C.difficile cases	<= 153	AP039	<= 112	Dec-19	150	↑	N/A	124	11	25	44	-	56	74	98	-	120	133	150	-				-
DFM021d	Cumulative Number of laboratory confirmed Klebsiela cases per 100,000 population	<= 106	AP039	<= 78	Dec-19	113	↑	6th	0	13	18	29	-	43	59	74	-	89	99	113	-				-
DFM021e	Cumulative Number of laboratory confirmed Aeruginosa cases per 100,000 population	<= 27	AP039	<= 18	Dec-19	31	↑	4th	0	1	3	6	-	11	13	19	-	24	27	31	-				-

Why we are where we are: Natural variation is expected.
An increase in Gram Negative/Multi Resistant Organisms (related to Urinary Tract Infections as a majority) and MSSA (skin related as a majority) 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 Infections in BCUHB are not Health Care Acquired or Hospital Onset (29%), however 54% have been in hospital in the previous 6 months where exposure MAY have taken place. On deep dive analysis on average 78% of these infections are UNAVOIDABLE.

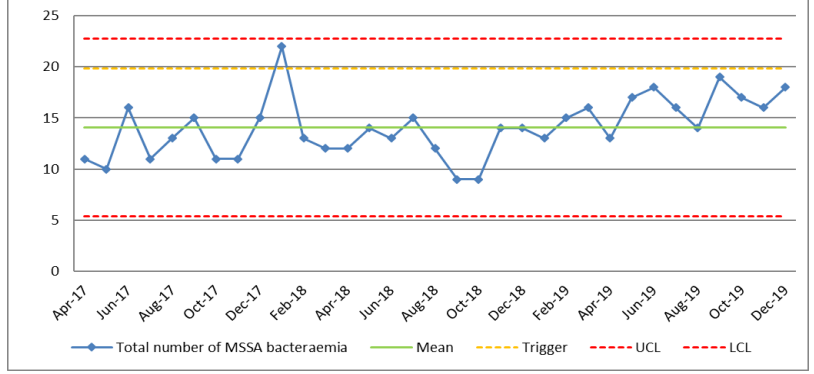
Chapter 2 – Infection Control

Graphs – Number of Infections identified

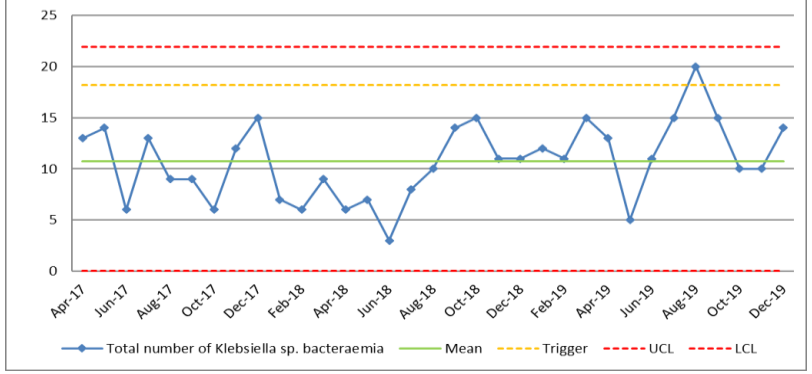
BCUHB
Total monthly number of C. difficile



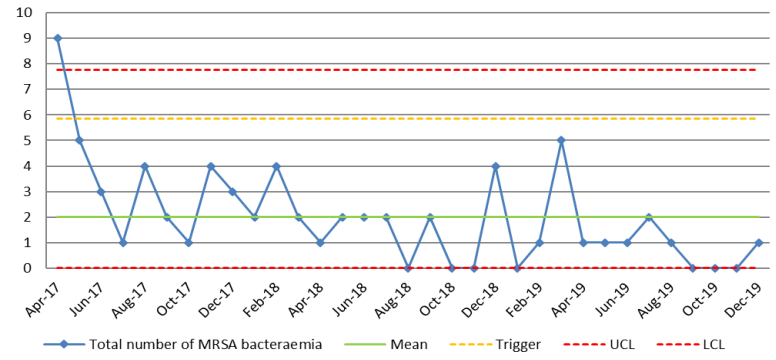
BCUHB
Total monthly number of MSSA bacteraemia



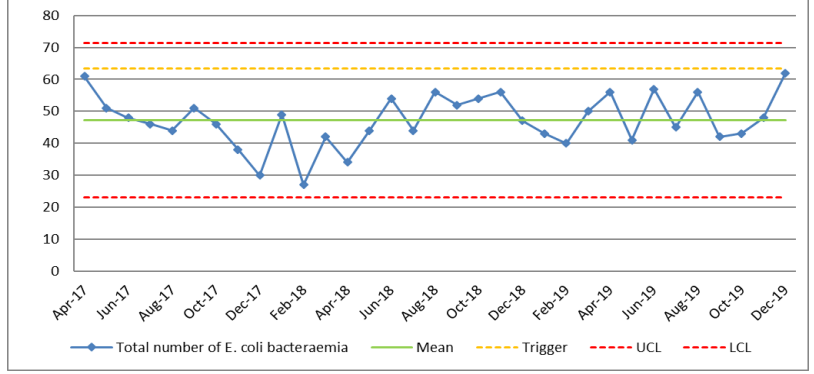
BCUHB
Total monthly number of Klebsiella sp. bacteraemia



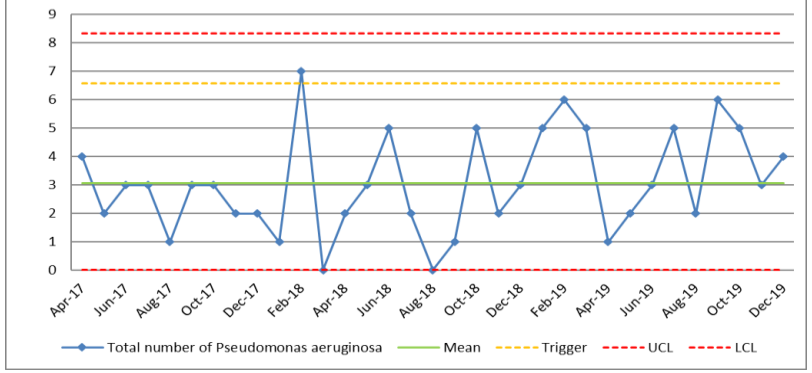
BCUHB
Total monthly number of MRSA bacteraemia



BCUHB
Total monthly number of E. coli bacteraemia

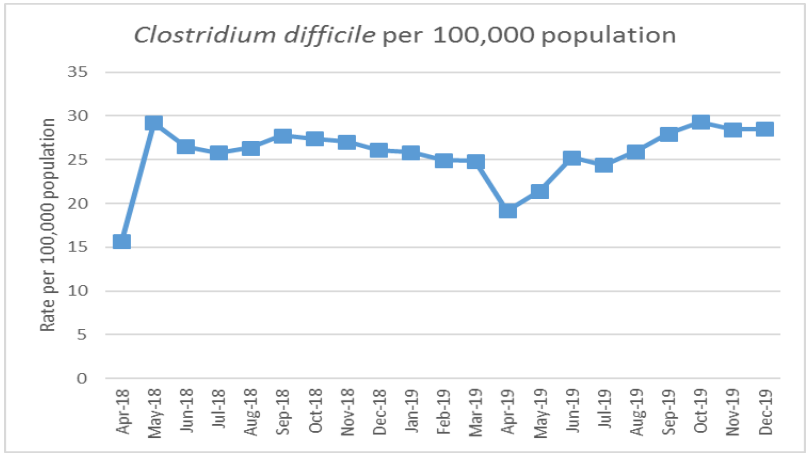


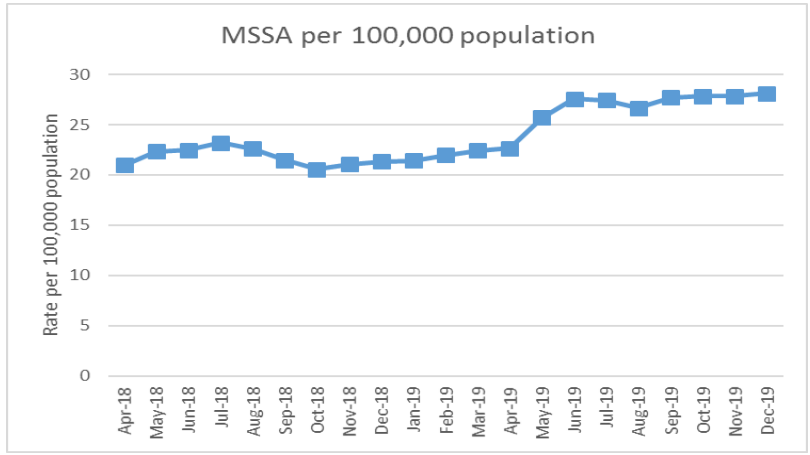
BCUHB
Total monthly number of Pseudomonas aeruginosa

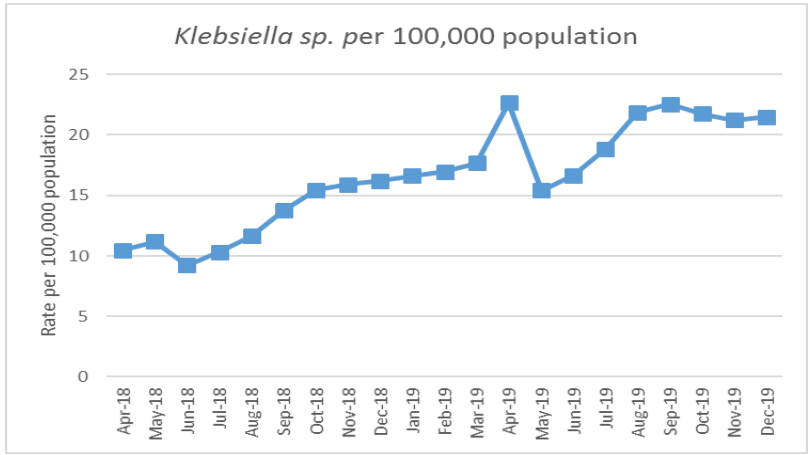


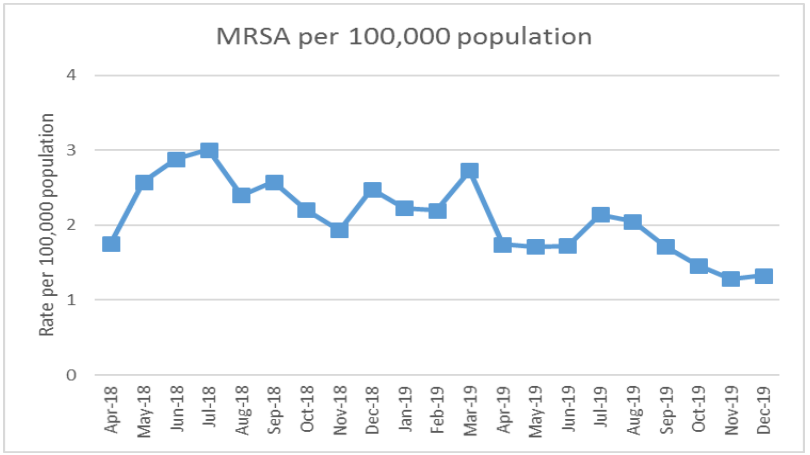
Chapter 2 – Infection Control

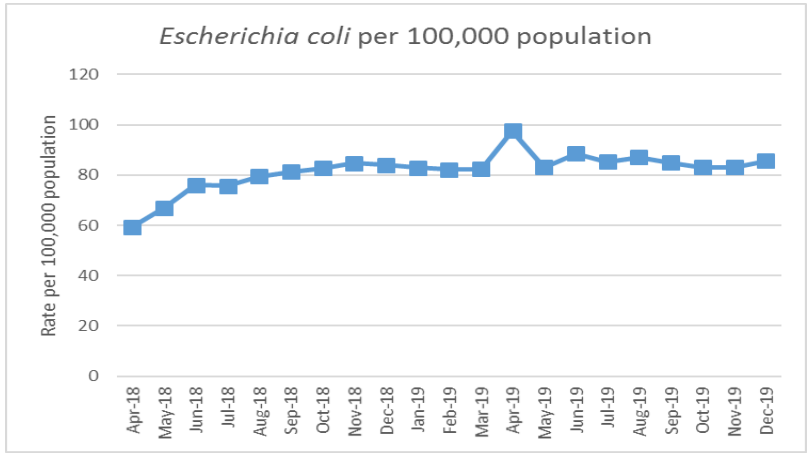
Graphs –Rate of infections

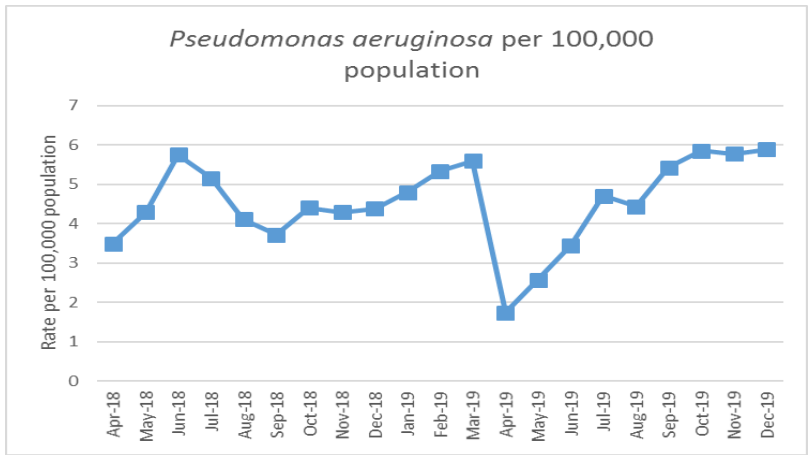






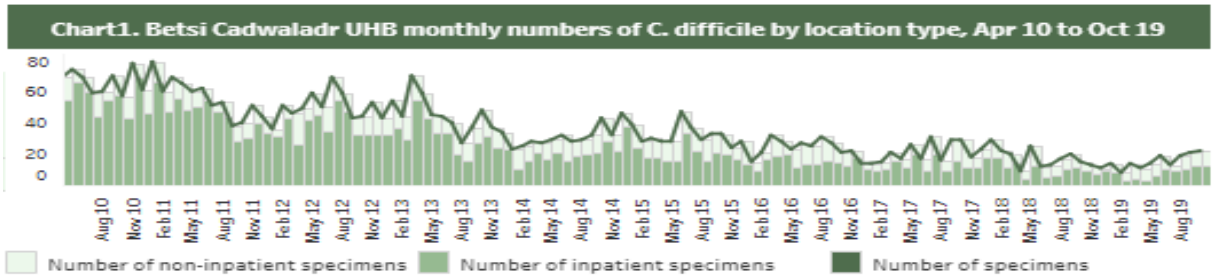


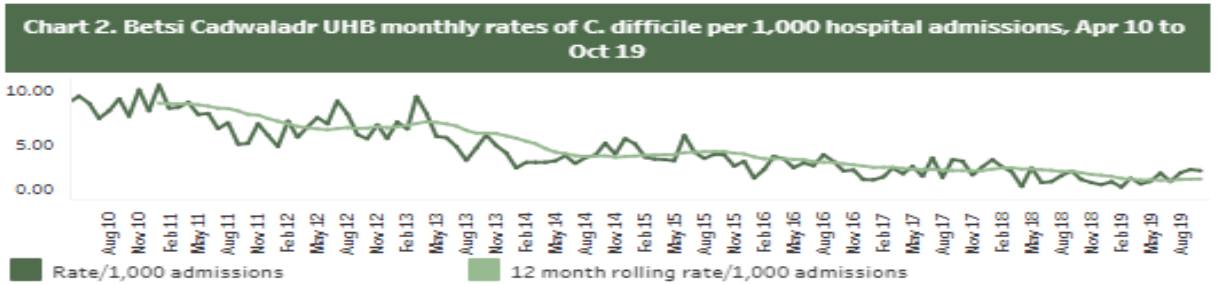


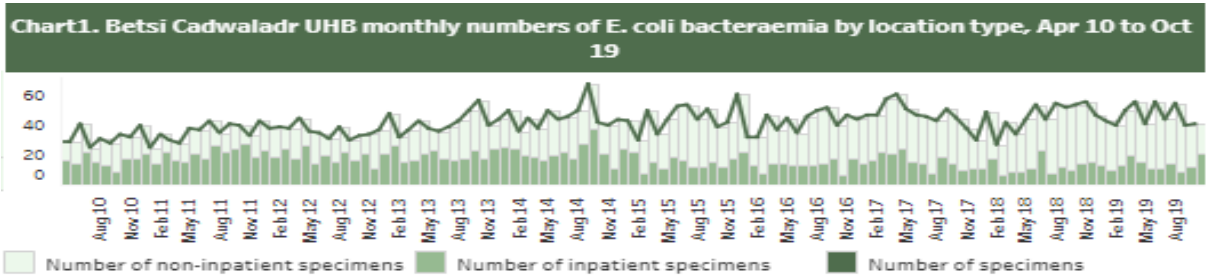


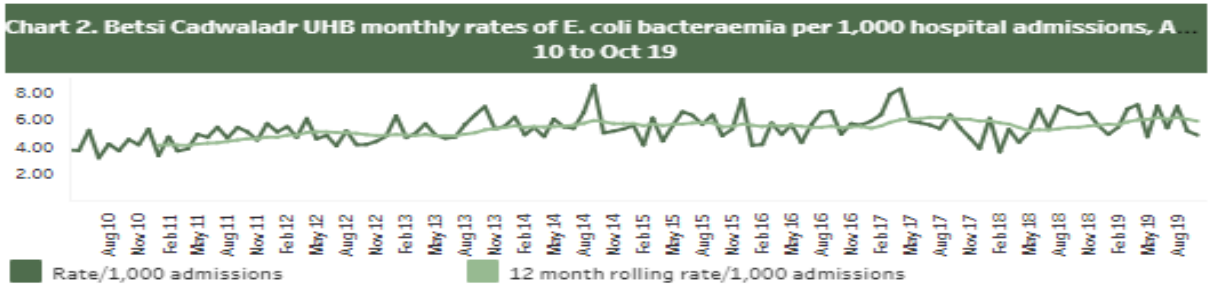
Chapter 2 – Infection Control Report - Page 1

Actions	Outcomes	Timeline
1. Continue with the weekly analysis and trends which includes every infection within the 6 trajectory organisms.	A one off sporicidal clean was implemented and a "back to basics" approach for cleaning in November. This was supported by a Safe Clean Care focus on decluttering and devices in Q3. A reduction was seen in November but has since increased in terms of those bacteria associated with gut and skin flora. The level of cleaning in November is not sustainable with vacancies and insufficient resources.	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. This is crucial in the Central Health Economy which continues to have the most numbers of infections which are Community Onset (75% compared to average 71%), and the most overall (41%) compared to East 32% and West 27%. Again this is reliant on appropriate resource and has been placed on the Risk Register. Considering that 78% of infections overall are UNAVOIDABLE, and 71% are Community Onset the Quality Improvement work needs to concentrate on where a difference can be made.	Continuous
3. 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. However less than 2% of patients in hospital during the audit had a Catheter Associated UTI (CAUTI) Work needs to be considered with the CHC, Continence Service and Quality Improvement to implement a Trail Without Catheter (TWOC) initiative and review of all devices to remove where possible, including urinary catheters. East has the highest numbers of infections in people with devices (44%), West 39% and Central 36%. Re audit Spring 2020.	Spring 2020
4. Increase the visibility of the IP team and senior clinicians in terms of quality support visits, audit and introduction of the Link Practitioner programme in September 2019.	Educational event took place on 6th December 2019. Timely support and actions to respond to any IPC gaps in practice, cleaning and the environment via Link communications and meetings. This has been a difficult Q3 with the numbers of positive Flu, RSV and Norovirus in addition to the other infections, particularly in Central where there has been significant difference in numbers (348) compared to East (274) and West (231) and in Influenza like illnesses. This has been compounded by absence in the IP team.	March 2020









Clostridium difficile (CDI)

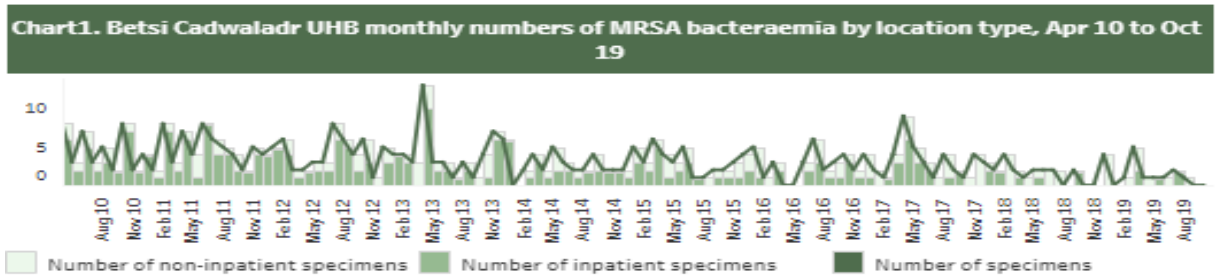
The Health Board is not likely to achieve the 2019/20 trajectory for Clostridium Difficile infection (CDI) with 150 infections to end of quarter 3 and a trajectory of 153. This is 12% less (19) than the target last year due to good reduction in 2018/19. In addition new molecular testing increases findings by 1-2%.
The IP team continue to follow up all CDI cases for a minimum of 4 weeks. 78% of patients had had antimicrobials. The highest numbers of CDI cases are in Central (45%) with the highest % from Care Homes (15%). The least in East (28%) which has a robust HPV programme, the most resource for Antimicrobial Stewardship and the most resource for Infection Prevention with a full time quality support post. Only 3% of cases were from Care Homes. Central has the least resource in terms of ratio.

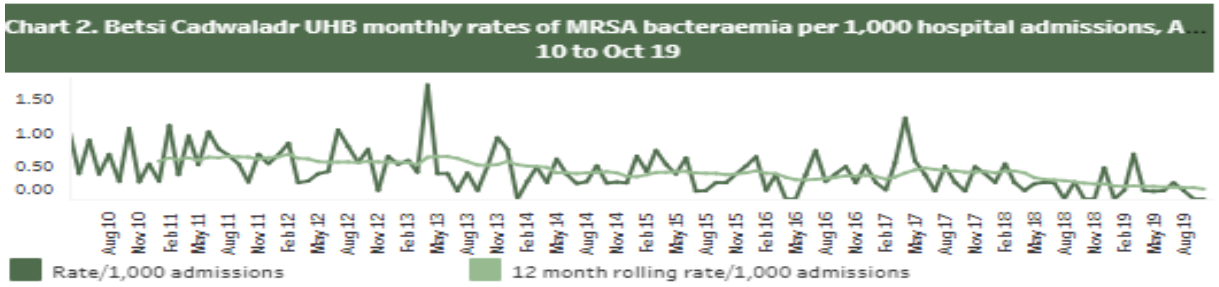
Escherichia coli

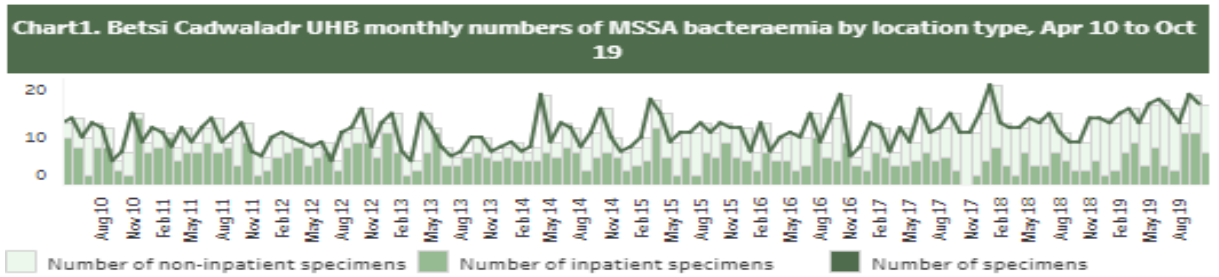
The Health Board is not likely to achieve the 2019/20 trajectory for E. coli Blood Stream Infections (BSIs) with 450 infections to end of quarter 3 and a trajectory of 467.

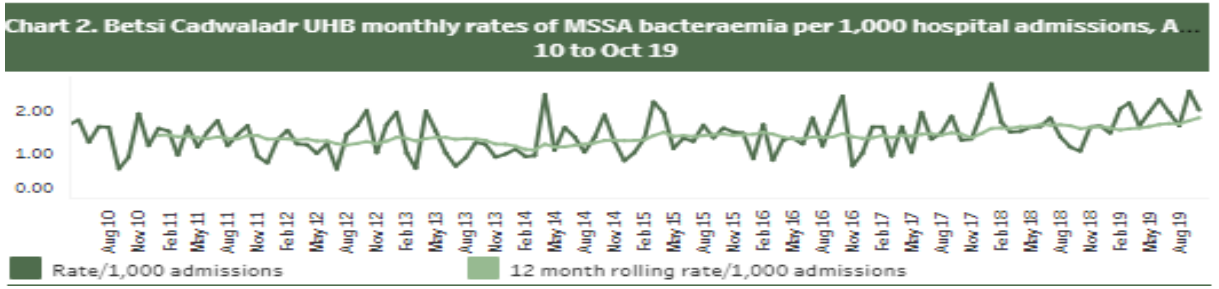
The majority of these are related to UTIs and many resistant to oral antimicrobials. These do not appear to be Catheter Device related. Again, the majority are in Central (40%) which has the least resource in terms of ratio of activity.

Chapter 2 – Infection Control Report – Page 3









MRSA bacteraemia

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

Only 3 were known to be MRSA positive on screening. Screening in Central and West needs improving. Screening is higher in East where they have seen the least amount of MRSA infections.

Work needs to continue to remove any unnecessary devices.

MSSA bacteraemia

The Health Board will not achieve the trajectory of 139 with 148 infections to date. The majority are community onset (82%) and again highest in Central. 68% were unavoidable.

Related to skin in a lot of cases, wound care and tissue viability antimicrobial stewardship is being considered by IP. Highest numbers in East which are thought to be wound related 58%, compared to 42% in Central and 31% in West.

In addition, 19% of Central cases are from Care Homes.

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

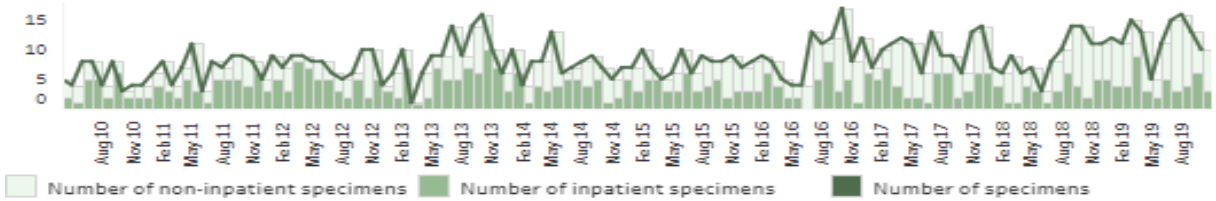
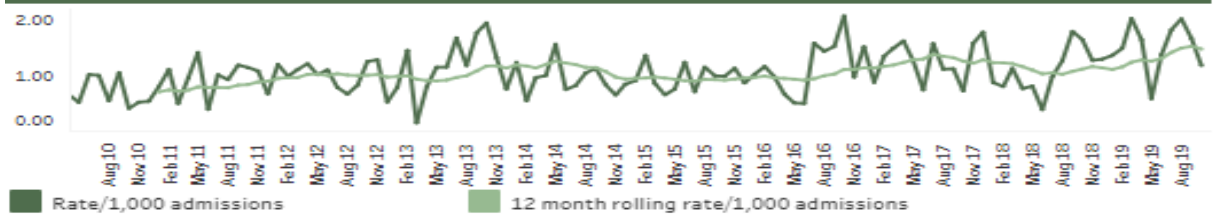


Chart 2. Betsi Cadwaladr UHB monthly rates of Klebsiella sp bacteraemia per 1,000 hospital admissions, Apr 10 to Oct 19



Klebsiella sp. bacteraemia

The Health Board is unlikely to achieve the trajectory of 113 with 106 to date. The majority of these are in the East and account for 16% of all their infections. East also have the highest numbers of devices which is also being considered and reviewed.

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

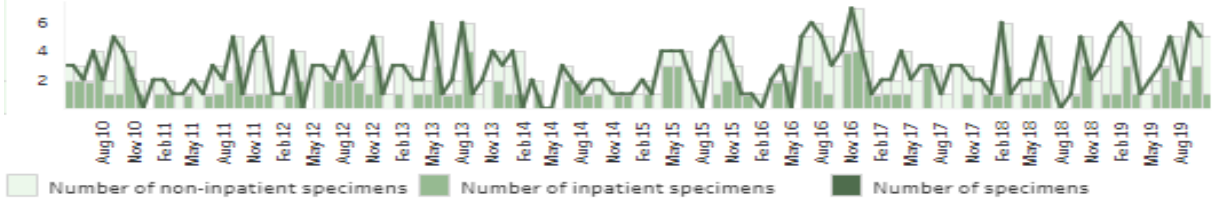
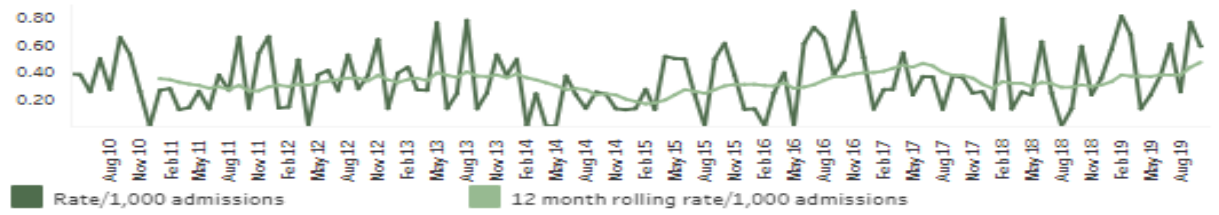


Chart 2. Betsi Cadwaladr UHB monthly rates of P. aeruginosa bacteraemia per 1,000 hospital admissions, Apr 10 to Oct 19



Pseudomonas aeruginosa bacteraemia

None related to water but unlikely to achieve trajectory of 31 with 27 to date. West has the highest numbers and resistance patterns. 76% are in those patients aged 65 years of age and over.

Chapter 2 – Infection Control

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
DFM005a	Uptake of the influenza vaccination among: a. 65 year olds and over	>= 75%	AP007	>= 60%	Dec-19	69.10%	↑	1st	68.00%	-	-	-	-	-	-	N/D	-	53.90%	65.90%	69.10%					-
DFM005b	Uptake of the influenza vaccination among: b. Under 65s in risk groups	>= 55%	AP007	>= 30%	Dec-19	42.40%	↑	1st	43.80%	-	-	-	-	-	-	N/D	-	19.80%	36.00%	42.40%					-
DFM005c	Uptake of the influenza vaccination among: c. Pregnant women	>= 75%	AP007	N/A	Mar-20				88.20%	-	-	-	-	-	-	-	-	-	-	-	-	-	-		-
DFM005d	Uptake of the influenza vaccination among: d. Health care workers	>= 60%	AP007	>= 30%	Dec-19	54.54%	↑	3rd	41.05%	-	-	-	-	-	-	N/D	-	41.06%	51.40%	54.54%					-

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

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

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

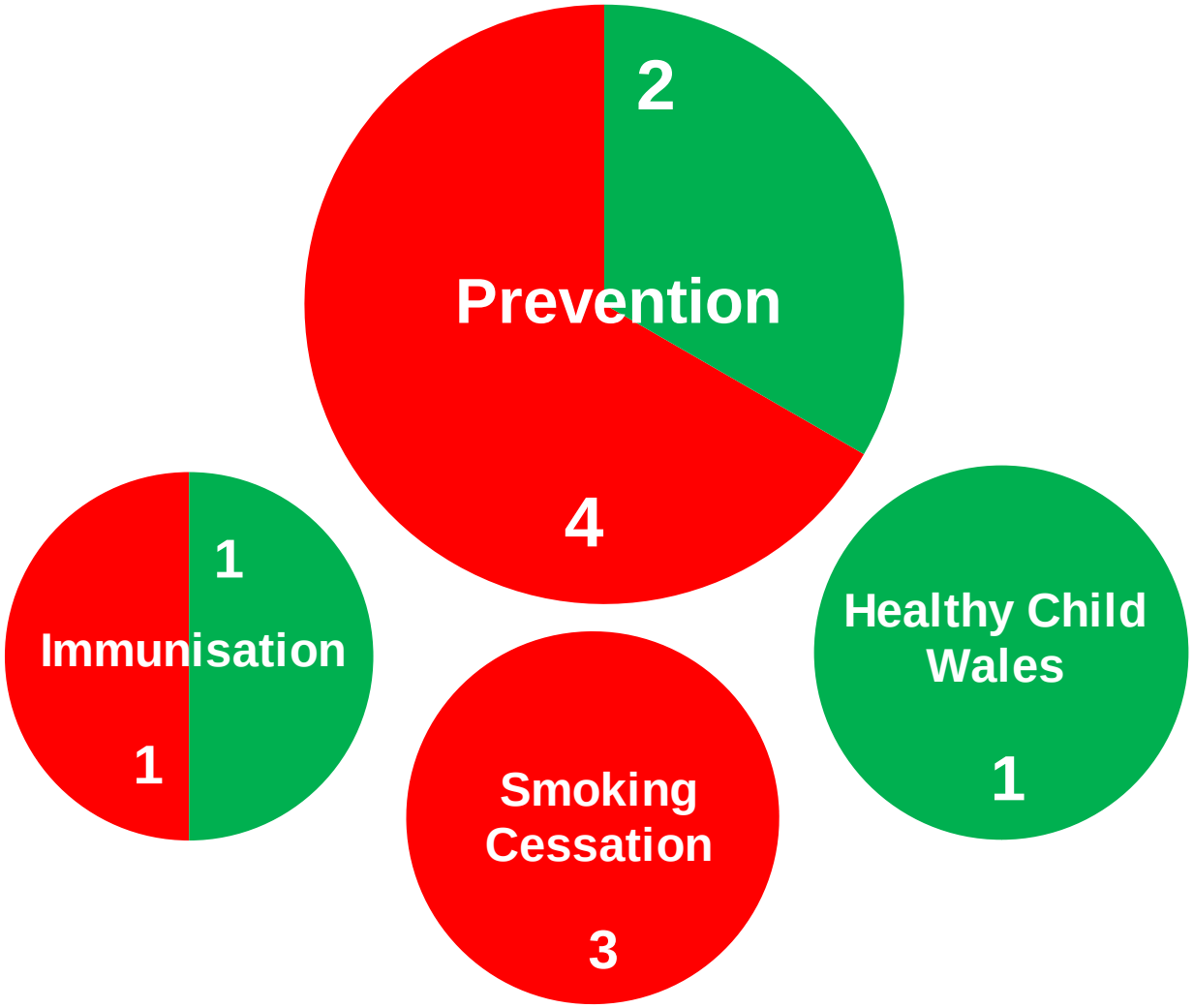
Chapter 2 – Infection Control Flu Vaccine Report

- **Why we are where we are:** The Flu vaccination campaign commenced in September, the active vaccination period will conclude on 31st March 2020.Currently Betsi Cadwaladr is the best performing Health Board in Wales in terms of flu vaccination.
- The aim for the 2019-20 campaign is to maximise uptake in eligible groups and to reduce variation in uptake at Area and Cluster level, data is being scrutinised and local leads informed of progress. To this end we have a Flu Vaccination Plan and Delivery Plan which includes a communications plan that are still being implemented with the aim of aspiring to reach the required targets by the end of March. Realistically we will fall a few % points short of the required targets.
- The 2019-20 Flu vaccination campaign has proved very challenging due to national vaccine supply issues affecting adults and children. This has impacted on the way GP practices have been able to deliver their practice campaign and combined with the usual problems of persuading individuals to be vaccinated the uptake is lower than where we would like it to be.
- GP practices have been asked to provide assurance to the health board on their plans to deliver the Flu vaccination campaign
- Uptake on pregnant women will be available in April 2020 following a Point of Delivery Audit being conducted in January 2020.

Actions	Outcomes	Timeline
1. Vaccination uptake data is being circulated to the Areas and Clusters for discussion locally	Maximise uptake in eligible groups and to reduce variation in uptake at Area and Cluster level and to ensure data accuracy	To continue until the end of March 2020
2. Contact lower uptake GP practices to ascertain if there are any technical issues affecting data submission	Technical issues are rectified so more accurate data is submitted for 2019-20. Increased scrutiny of Audit+ data	To continue until the end of March 2020
3. A flu Debrief and planning event is scheduled for February 2020	• Local early planning for the 2020-21 campaign will generate more targeted activities to improve performance	Date set for February 24th 2020
4. Communications to continue as planned	To raise awareness of the importance of the Flu vaccine and that it is not too late to be vaccinated	To continue until the end of March 2020

Chapter 2 – Summary

Prevention



Code	Measure	Status	Annual Plan Profile	National Target
DFM001	Smoking Cessation: Pregnant Women	10.70% ↑	Improve	Improve
DFM002	Immunisation: 3 doses of 6 in 1	95.30% ↓	>= 95%	>= 95%
DFM003	Immunisation: 2 doses of MMR	93.60% ↓	>= 95%	>= 95%
DFM004	Healthy Child Wales Programme	94.40% ↑	Improve	Improve
DFM006	Smoking Cessation: % Service Use	1.26% ↑	>= 3.9%	>= 5%
DFM007	Smoking Cessation: Validated as Quit	35.00% ↓	>= 38.0%	>= 40%

Chapter 3 – Prevention

Smoking Cessation

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: In August 2019 a number of unplanned absences through sickness were seen in the Stop Smoking Wales (SSW) and Help Me Quit (HMQ) for Baby services which impacted heavily on the number of quitters seen. The majority of staff who were off sick have now returned back to their normal hours.

The Stop Smoking Wales service transferred across to the Health Board on 01 October 19 and this will provide an opportunity for closer integration of smoking cessation services, particularly between hospital and community. This should start to have a positive impact on targets by end Q4.

Actions	Outcomes	Timeline
1. Transfer of services from Public Health to the BCUHB	Provides an opportunity to identify economies of scale between the various teams to increase the referrals and quit rates	A paper with a proposal to explore the integration of teams will be reviewed in quarter 4 of 2019/20
2. BCUHB Pharmacy are currently undertaking work to reduce the number of self-reporting quitters in the system, which are not recorded as a CO-validated quit, in favour of CO-validated quits.	This work should see a rise in overall CO-validated quits in Q3 and 4 given the footfall seen in pharmacy services.	Quarter 3 and 4

Chapter 3 – Prevention Immunisations

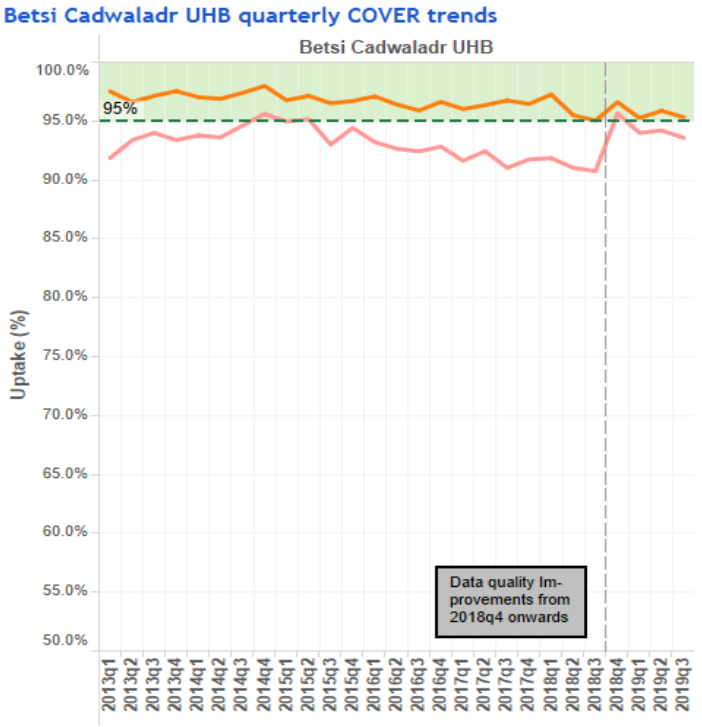
Code	Measure Description	National Target	Plan Ref	Plan Target	Current Period	Actual	Status	Wales Benchmark	Same Period Last Year	Apr-19	May-19	Jun-19	Qtr 1 19/20	Jul-19	Aug-19	Sep-19	Qtr 2 19/20	Oct-19	Nov-19	Dec-19	Qtr 3 19/20	Jan-20	Feb-20	Mar-20	Qtr 4 19/20
DFM002	Percentage of children who received 3 doses of the hexavalent '6 in 1' vaccine by age 1	>= 95%	AP006	>= 95%	Qtr 2 19/20	95.30%	⬇	4th	95.50%	-	-	-	95.90%	-	-	-	95.30%	-	-	-		-	-	-	
DFM003	Percentage of children who received 2 doses of the MMR vaccine by age 5	>= 95%	AP006	>= 95%	Qtr 2 19/20	93.60%	⬇	1st	91.00%	-	-	-	94.20%	-	-	-	93.60%	-	-	-		-	-	-	

Why we are where we are:

- As a health board we regularly achieved 95% in uptake for the 1 year olds but pockets of lower uptake exist across the area. A combination of vaccine hesitancy, no consent to vaccination, persistent defaulters are the cause of under vaccinated 1 year old children.
- As a health board we are slightly below the required 95% for the 2nd MMR at 5 years. The reasons above also apply to 5 year old children, notably parents or guardians are more likely to not keep appointments for children at 5 years old.
- Please note the dotted vertical line in the chart to the right, a recent review of the process by PHW to collect data from HBs identified an issue which meant data was being under reported. This has now been rectified, consequently the uptake has improved.
- In an effort to tighten up the appointment and recall process, an audit has taken place of the completed immunisation forms being returned to child health, training and support have been offered to ensure these forms are returned in a timely manner. A re-audit is underway to ensure processes are being adhered to so treatment queues are avoided.
- Data cleansing of records takes place on children missing any vaccine at 1,2,4 and 5 years to ensure data accuracy. I.e. information can be missing from children who move into the north Wales area.
- We have an Immunisation training scheme and circulate uptake data regularly to ensure immunisers are aware of the current uptake. Staff attending training are given top tips to focus on to maximise uptake i.e. do a catch up session, review processes, update notice boards.

5 in 1 at 1st birthday

2nd MMR at 5th birthday



Integrated Quality and Performance Report

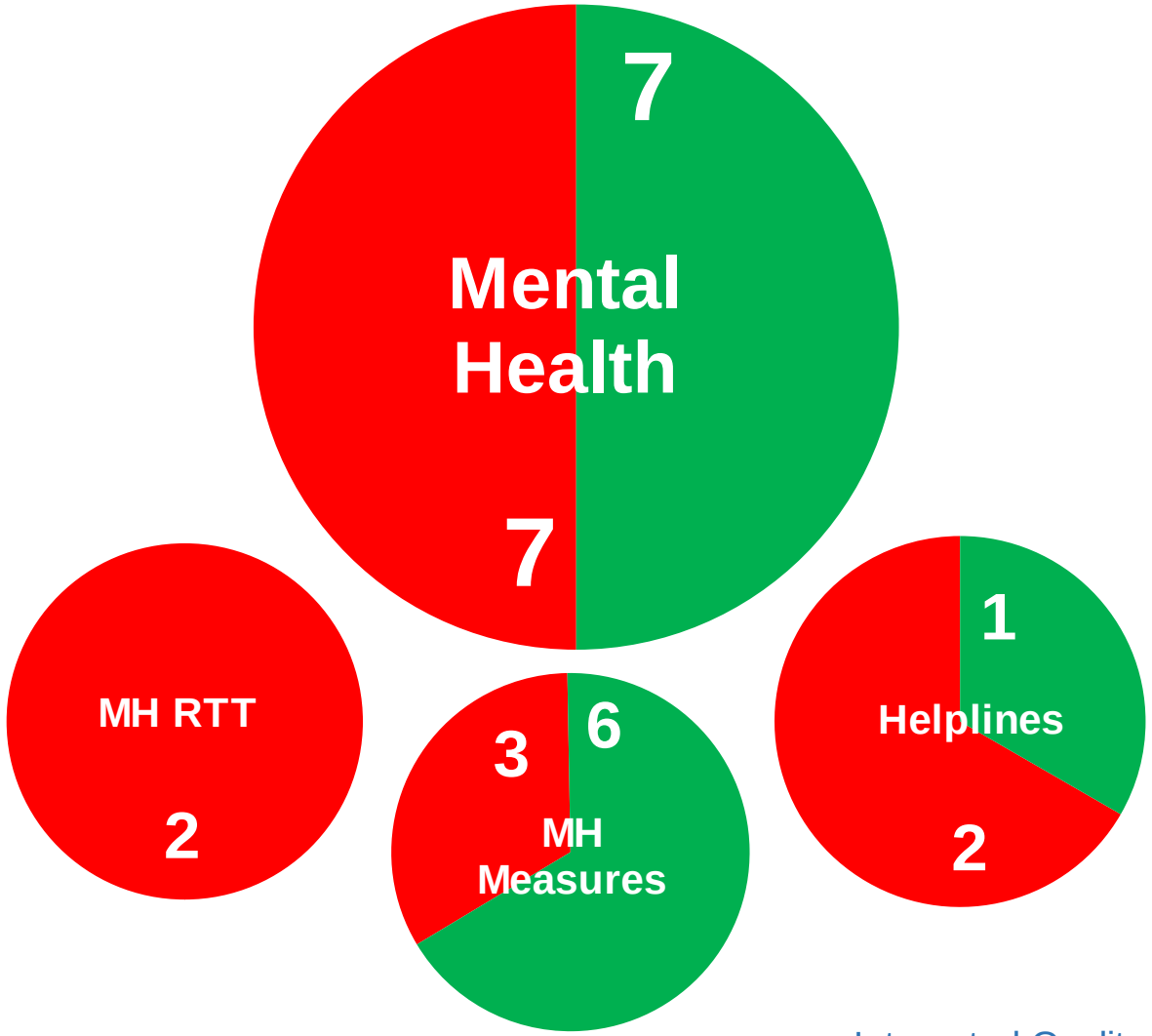
Quality, Safety & Experience Committee Version

December 2019

Chapter 3 – Prevention Immunisations

Actions	Outcomes	Timeline
1. Two additional immunisation nurses have been recruited to the Central and West areas to address inequality issues such as providing domiciliary vaccination to pre school children with a focus on administering MMR vaccine	Increase the uptake in hard to reach children who are persistent defaulters and support parents who are hesitant of their child receiving vaccines.	March 2020 to commence the domiciliary vaccination of pre school children
2. The MMR Action Plan is currently being updated to incorporate the recommendations from the national Measles Elimination Task Group Report. A BCUHB task group is ensuring all the recommendations are implemented	Increase the MMR uptake at every age using a more structured and consistent follow up of defaulters at an earlier opportunity.	Over the next 12 months improvements should be seen as the recommendations are implemented.
3. Immunisation training will include resources and support for staff to deal with parents that are vaccine hesitant or who do not consent to vaccination in line with the World Health Organisation recommendations	More knowledgeable confident staff who can support parents	Throughout the 2020 training programme
4. Focussed work on treatment queues for an immunisation appointment at GP practices	Treatment queues are generally caused by persistent defaulters or a clinic being cancelled. The aim is to reduce and remove all treatment queues at GP practices to ensure the appointment and recall process are timely. Combined with action one above we should see improvements.	July 2020

Chapter 4 - Summary



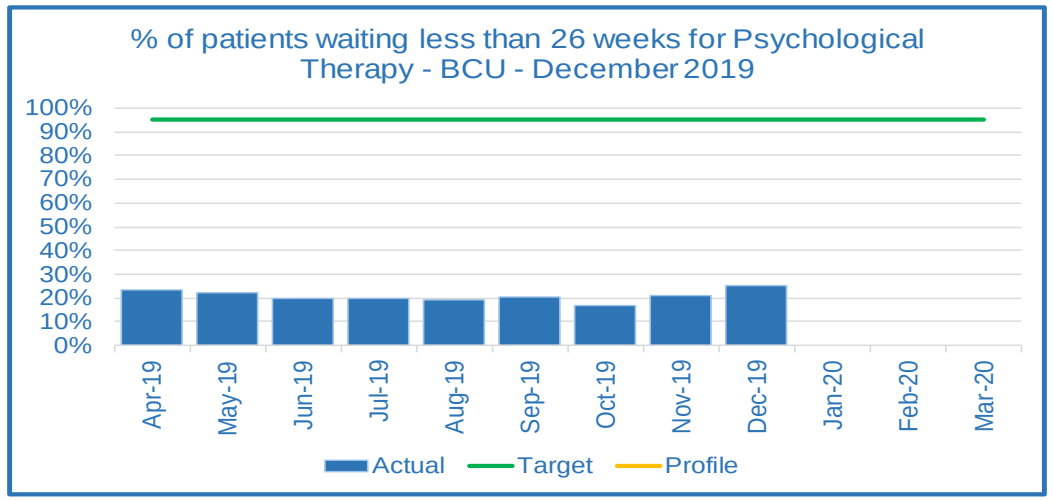
Mental Health

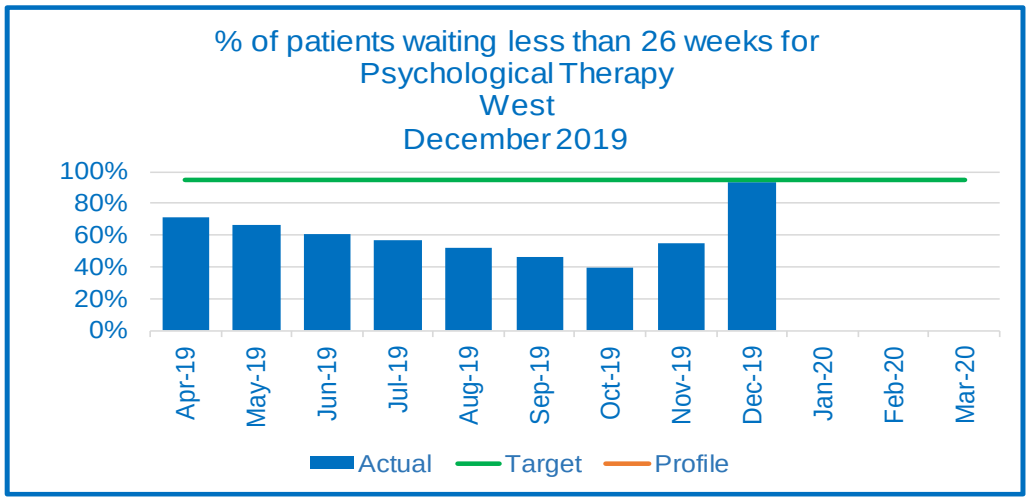
Code	Measure	Status	Annual Plan Profile	National Target
DFM058	26 Week Wait: Adult Specialist Mental Health Psychological Therapy	25.18% ↑	AP	>= 80%
DFM059	26 week Wait: Children and Young People Neurodevelopment Assessment	25.76% ↓	AP	>= 80%
DFM060	MHM1a - Assessments within 28 Days (Combined)	68.7% ↑	N/A	>= 80%
DFM061	MHM1b - Therapy within 28 Days (Combined)	74.2% ↓	N/A	>= 80%
DFM060a	MHM1a - Assessments within 28 Days (Adult)	67.33% ↑	>= 73%	>= 80%
DFM061b	MHM1b - Therapy within 28 Days (Adult)	72.21% ↓	>= 69%	>= 80%
DFM060b	MHM1a - Assessments within 28 Days (CAMHS)	82.73% ↑	>= 80%	>= 80%
DFM061b	MHM1b - Therapy within 28 Days (CAMHS)	86.80% ↑	>= 80%	>= 80%
DFM062	MH Independent Mental Health Advocacy (IMHA)	100% →	100%	100%
DFM082	MHM2 - Care Treatment Plans (CTP)	90.40% ↓	>= 89%	>= 90%
DFM083	MHM3 - Copy of Agreed plan within 10 Days	100% ↑	100%	100%
DFM079	Helplines: CALL	215.1 ↑	>= 212	Improve
DFM080	Helplines: Dementia	7.7 ↓	>= 9	Improve
DFM081	Helplines: DAN	41.8 ↓	>= 50	Improve

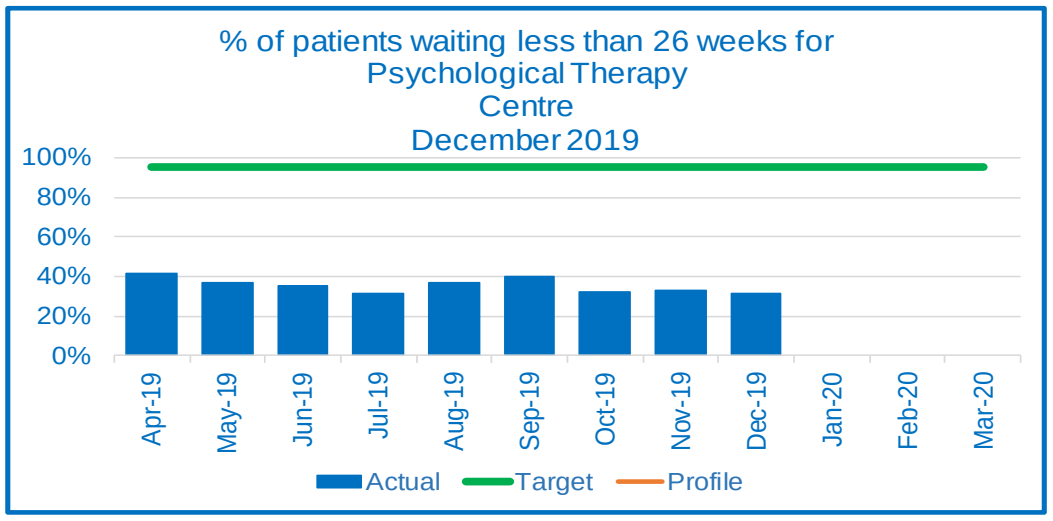
Chapter 4 – Mental Health

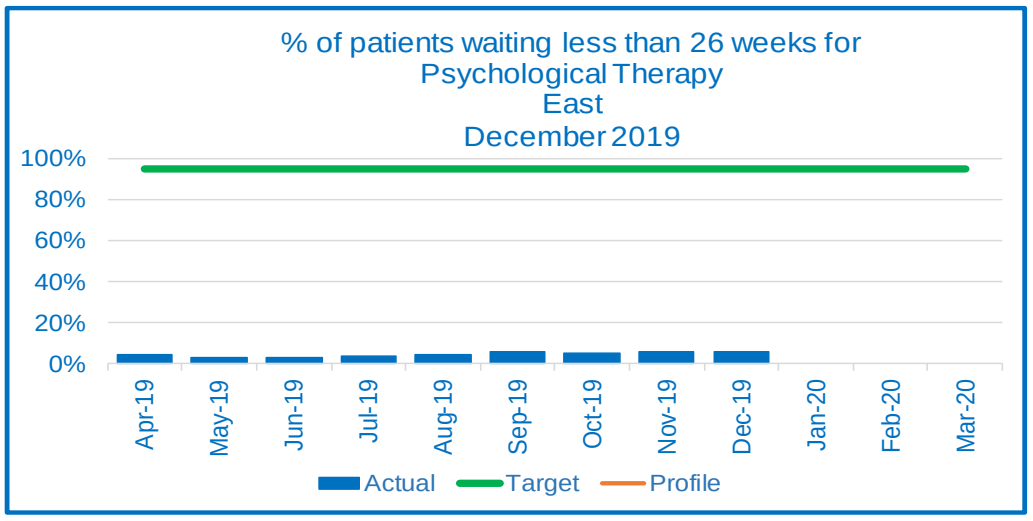
Psychological Therapy 26 Week Waits 40

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









Chapter 4 – Mental Health Psychological Therapy 26 Week Waits

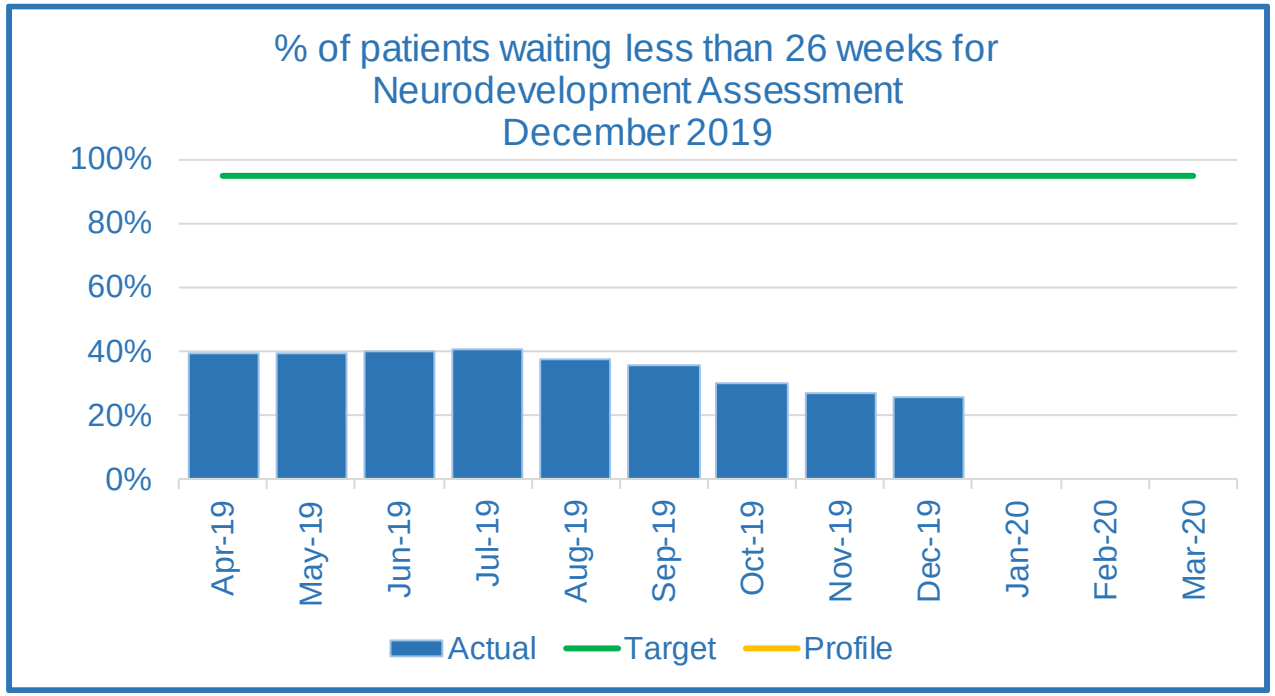
Actions	Outcomes	Timeline
1. Variances across BCU have been examined, and capacity and demand analysed.	1. East area significantly skewing regional collated figures. Performance across county areas vary due to a) the small workforce size, which means vacancies and sickness have a significant impact. b) The East area has a legacy backlog due to different pathway. East pathway/systemic issues now addressed. West & Central areas are comparable with rest of Wales.	Completed analysis. Ongoing monitoring. Anomalies in pathways being addressed ongoing.
2. All patients in the East area have now been reviewed, and all others over 6 months.	2. Over half Wrexham list found to be primary level of need.	Completed.
3. Coping skills groups have been set up in Wrexham primary care mental health services to meet need at primary care level.	3. Coping skills are ongoing in primary care and support is given across BCU to set up and continue groups in primary and secondary care.	Completed.
4. Pathways across all areas streamlined via SPOAA and team working.	5. People at risk are seen without delay and are not going on lists.	Completed.
5. Rolling out of DBT groups to increase access.	6. New DBT groups in Arfon set up, other groups in other areas are at risk due to MDT staffing issues.	Ongoing.
6. Small specialist workforce size. Ongoing recruitment and caseload management work.	7. Ynys Mon had vacancy May-Oct 19. Following psychologist recruitment waiting times in Ynys Mon Jan 2020 reduced from 22 months to 8 months. Conwy psychologist recruitment led to waiting time reduced from 25 months to 15.5 months. Following recruitment in North Meirionydd waiting times reduced by 9 months. Following recruitment in South Meirionydd waiting times reduced by 10 months. Denbigh remains a vacant post, but cover shared with Conwy. Conwy reduced waiting times by 10.5 months, 4 months reduction in Denbigh. Deeside waiting times have reduced 26 months over last 12 months following recruitment (34 months down to 8 months). Despite recruitment drives Conwy CBT therapist post remains unfilled. Numbers waiting in Wrexham reduced by 100 people and a 5 month reduction in waiting times.	Ongoing.

Actions	Outcomes	Timeline
7. MDT training, supervision and consultation offered on a weekly basis across all teams, and daily communication in MDTs to encourage MDT lower step psychological work as per Matrics Cymru guidance and the National Stepped Care psychological therapies model. This is longer term systemic work for sustainable change.	8. 100+ MDT staff have now been trained in CBT and DBT across all services. Impact will take time to show in specialist waiting times, and will require change in referral patterns and pathways.	Ongoing.
8. External psychological therapies review has now been completed.	9. Review recommendations to be taken forward in 2020.	Ongoing.
9. Short term waiting list initiative plan completed for Wrexham legacy backlog list and ready for outside tender.	10. Outside tender for Wrexham waiting list to proceed in early 2020. Should take 80 people off current 249 waiting in Wrexham, if appropriate tender.	Outside tender March 2020 1st intake.
10. Active monitoring and management of lists.	12. Reductions in all lists with exceptions only where posts are vacant.	Ongoing.

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	Dec-19	25.76%	⬇	6th	New 19/20	39.34%	39.53%	39.76%	-	40.62%	37.21%	35.55%	-	29.90%	26.84%	25.76%	-				-

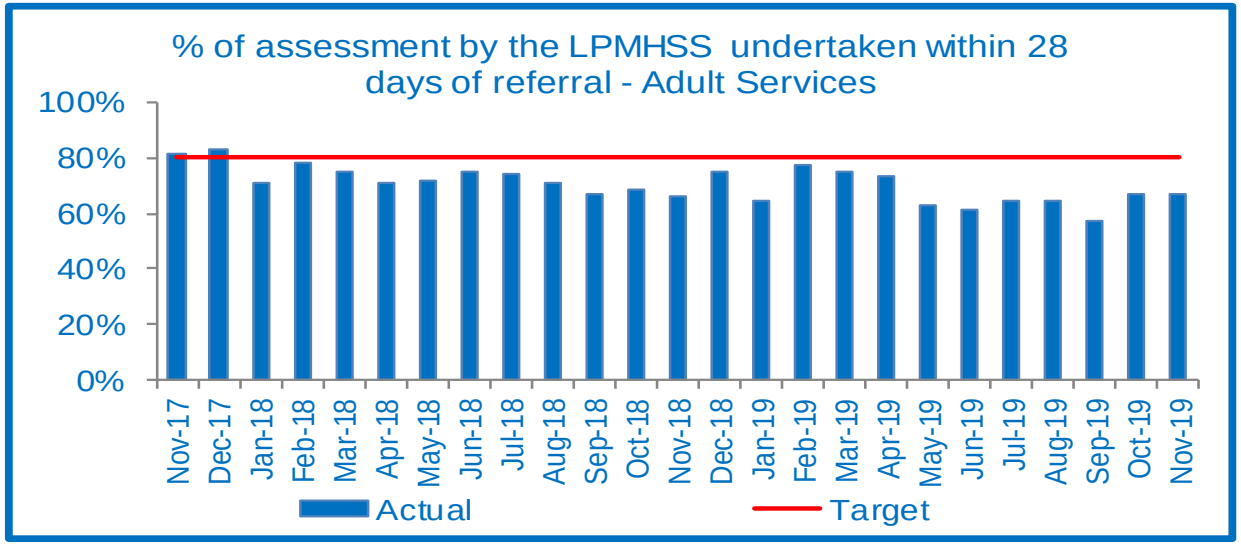


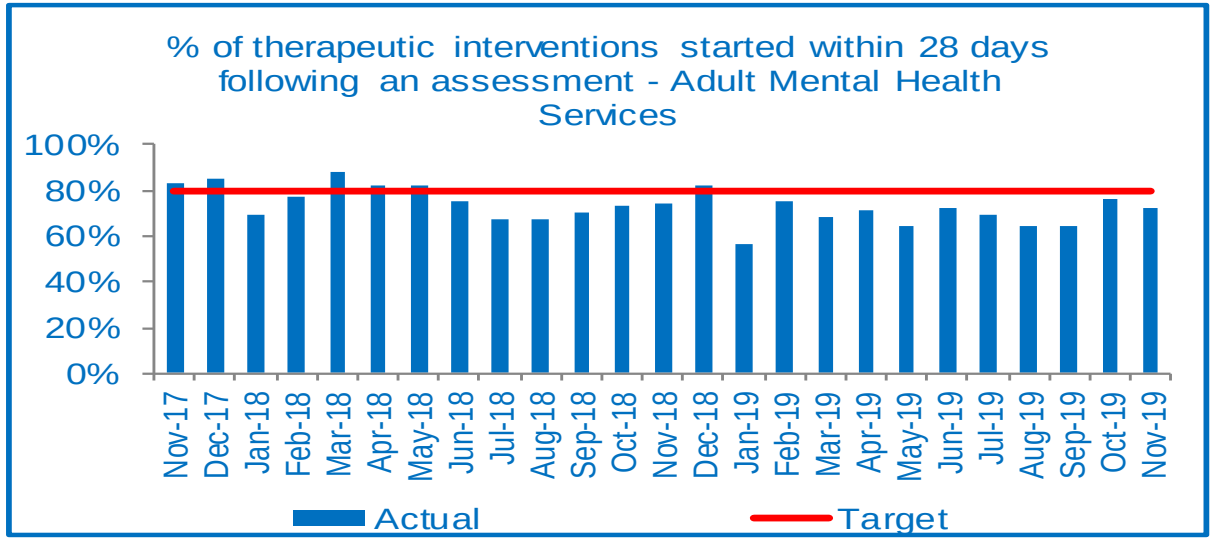
Why we are where we are: Demand for this service has exceeded funded capacity since the teams were first established in 2016/17. Reporting of this target became mandatory in April 2019. Demand has grown year on year for this service increasing 12% in 2017/18, 10% in 2018/19 and 20% YTD
In August the organisation learnt it was successful in obtaining additional Welsh Government funding to secure an increase in establishment to close the capacity demand gap from Jan 2020 and non recurrent funding to address the outstanding waiting list

Chapter 4 – Mental Health Neurodevelopment 26 Week Waits

Actions	Outcomes	Timeline
1. Regional Approach: The three areas have agreed and commissioned a regional approach to delivery and outcomes of the Welsh Government Funding Granted in Aug 2019	Establishment of Regional Group (Regional Neurodevelopment Steering Group {RNDSG} led by East Area). 5 Work streams established: 1) Model of Service, 2) Workforce, 3) Data recording, 4) Engagement and 5) Waiting List Recovery	Group established Jul 2019; Initial Plan sent to Area Exec in Aug 2019
2. Workforce: Recruitment, retention and development	A significant increase in workforce will occur as a result of the successful bid (22.4 wte, which is nearly 80% of the current team) It has been identified the roles, professions and JD require Recruitment process began Sept 19 To date (Jan 20) all posts have begun the recruitment process with the majority at the advert or	Recruitment began 2019 Sept, Starters planned Jan –Mar 2020 Repeat adverts currently in progress (no applicants)
3. Waiting List Recovery: Action to reduce current WL	1) An external tender was agreed after review of alternative options: New Tender developed Regional and sent to Procurement Delay in tender to be released Tender currently at advert closes Mid Jan 2020 2) Where possible current supplier capacity purchased to reduce WL 3) WL Peaked in Aug 2019 at 1905, Nov 2019 it was 1770	1)Tender completed by Mid Feb 2020 2) All current external supplier capacity used 3) Reviewed monthly
4. Model of Working: assurance of universal service offering	Review of current models has identified process consistent over the region, Professional groups applying the model did vary across the region, in part due to available staff and historic practice, The impact of this is being reviewed with the RNDSG work stream	Mar 2020, bid based on gap analysis in each team
5. Working with Partners: Addressing demand expectation and increasing joint working.	Links to Local Educational services required, has begun to establish clear expectations of diagnosis and requirement for assistance in the school setting. Specific Role developed for region to promote partnership working and user engagement	Recruitment process begun Jan 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	>= 73%	Nov-19	67.33%	↑	N/A	66.19%	73.26%	62.55%	61.61%	-	64.40%	64.80%	57.61%	-	67.13%	67.33%		-				-
LM061a	The percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS (Adult)	>= 80%	AP027	>= 69%	Nov-19	72.21%	↓	N/A	74.24%	71.22%	64.18%	72.21%	-	69.41%	64.00%	64.51%	-	76.45%	72.21%		-				-





Why we are where we are: Mental Health Recovery Plans for Part 1 are in place across all areas with a trajectory for compliance by March 2020. In order to achieve this, out of hour clinics have been established, additional resource secured from Welsh Government monies as part of the Waiting List Initiative, letters are being sent to patients on the waiting lists update them on the situation and providing them with essential contact details and a revised electronic booking systems has been introduced. There is an increased communication with GP practices of current waiting lists in relation to individual patients in addition to Team Manager attendance at Cluster Meetings and individual GP practices. Some areas have reconfigured the management structures to ensure a Lead for Primary Care (Part 1) at a Senior Level.

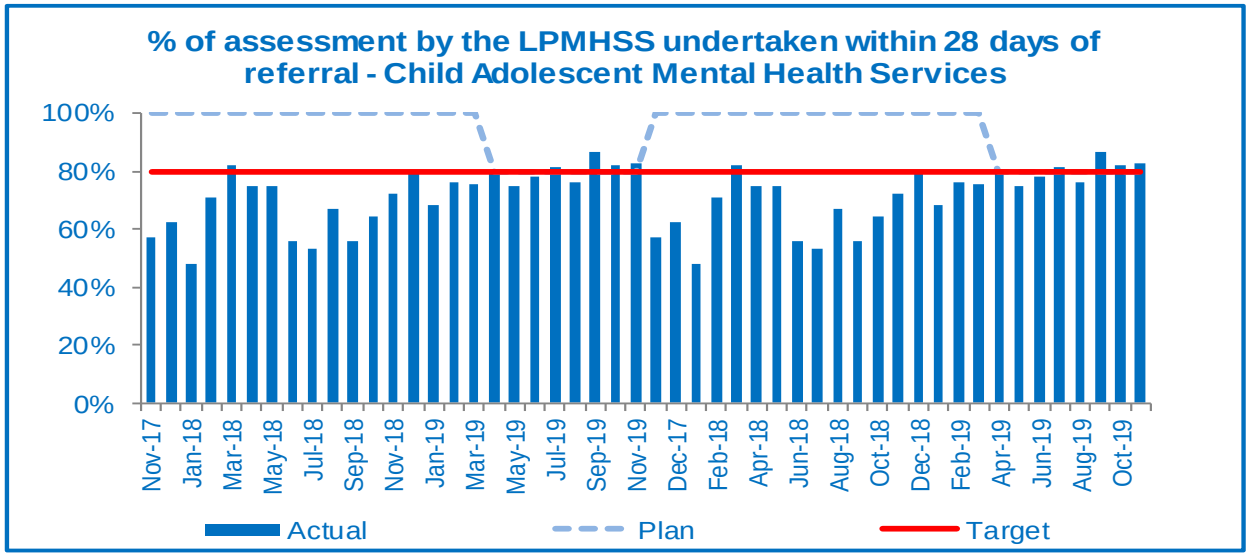
Chapter 4 – Mental Health

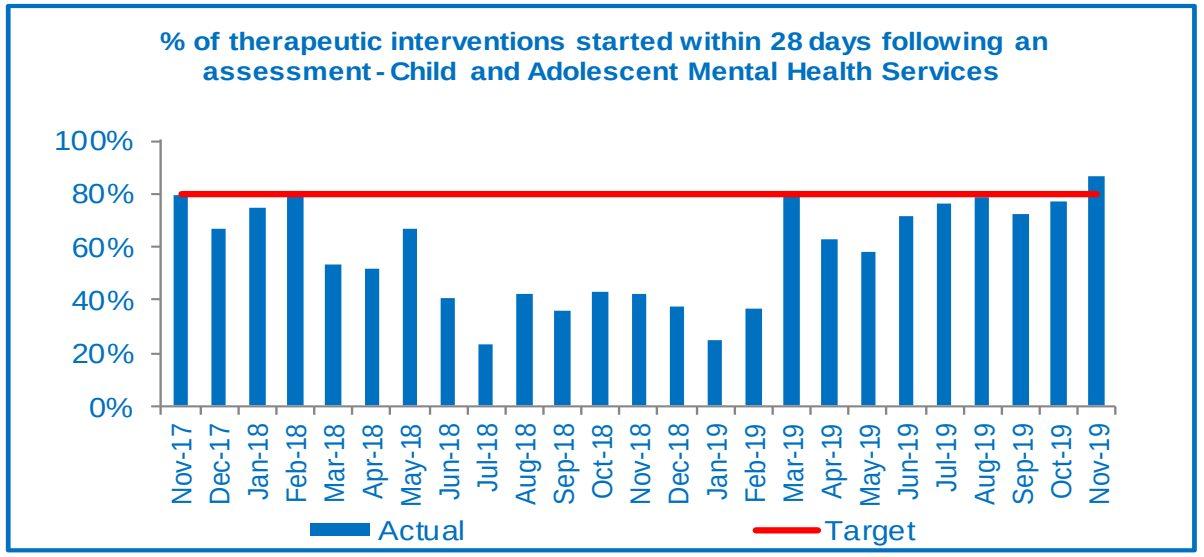
Actions	Outcomes	Timeline
1. Patients 'treated in turn' has been widely adopted which has had a negative impact on performance but, is clinically the right action for patients.	Proactive management of caseload to ensure patients are seen as quickly as possible. Improved quality and safety.	Backlog and waiting list trajectory to clear March 2020
2. Timely weekly reporting direct to area teams and a weekly 'deep dive' analysis to focus on potential breaches. We have also standardised intervention outcomes & reporting. Thus, ensuring Can Not Attend & Did Not Attend are accurately and timely recorded.	Correct & validated information ensuring Teams are timely informed and engaged and also can implement any remedial actions quickly.	Current and ongoing action
3. Mental Health Measure Lead(s) are supporting areas to increase focus and traction on specific issues and action plans. We have closer monitoring & scrutiny of referral activity which also informs the weekly targeted intervention meetings.	Correct & validated information. Teams timely informed and engaged.	The solution to target achievement is a complete service transformation which is currently been worked through via the strategy implementation.
4. We have undertaken piloting Threshold Assessment Grid, hold weekend & additional clinics and have strongly focused on recruitment and workforce issues such as: • Support Time Recovery 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	>= 80%	Nov-19	82.73%	↑	N/A	67.16%	80.15%	74.74%	78.00%	-	81.20%	75.80%	85.56%	-	81.70%	82.73%		-				-
LM061b	The percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS (CAMHS)	>= 80%	AP027	>= 80%	Nov-19	86.80%	↑	N/A	41.89%	63.24%	58.14%	71.64%	-	76.00%	79.00%	72.92%	-	76.92%	86.80%		-				-





Why we are where we are: Assessment target delivered for three consecutive months. Therapy target has seen improvement over last three months with delivery of target in November. Some delay in recruitment to additional posts as re-advertising required. Sustained delivery of targets to be met on completion of recruitment and training.

Chapter 4 – Mental Health

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, some posts have had to be re-advertised.	Development of Early Intervention teams and enhancement of core service to deliver Part 1 targets	Staff in post February 2020 – April 2020.
2.Recruitment of CAMHs Practitioners in GP Clusters following successful bid for Mental Health Service Improvement funding. Meetings arranged with GP Clusters	CAMHs Practitioner based in each GP Cluster to provide support and advice to manage demand appropriately	Staff in post in March 2020 – June 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 Delayed Transfers of Cares on the paediatric wards	Staff in post March 2020
4.CAMHs Improvement group established with focus on Action plan to be developed for CAMHs services following receipt of final report from Delivery Unit. Report and action plan received by MHAC and Board, update on action plan to be provided to Mental Health Act Committee /Quality, Safety & Experience Committee.	Clarity of Primary/Secondary Care thresholds/improved record keeping/improved communication with GPs/service specification clarity and consistency	Update to MHAC/QSE by end of March 2020
5.Weekly meetings held across the teams to assess demand and review capacity available in form of core staff availability, additional hours, bank and agency staff. Clinical prioritisation is robust, and alternative provisions to meet the need being established e.g. group interventions.	Understanding of current demands levels and capacity available to meet, identifying any gaps/anticipated breaches	Ongoing

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

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience Committee 28th January 2020
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Endoscopy Update
Cyfarwyddwr Cyfrifol: Responsible Director:	Adrian Thomas, Executive Director of Therapies and Health Science
Awdur yr Adroddiad Report Author:	Dr Kate Clark, Medical Director for Secondary Care
Craffu blaenorol: Prior Scrutiny:	None
Atodiadau Appendices:	Appendix 1. North Wales National Endoscopy Action Plan Appendix 2. JAG accreditation action plans – site specific

Argymhelliad / Recommendation:

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

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

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

Sefyllfa / Situation:

This paper provides an update on the previous papers presented to the Quality, Safety and Experience Committee in September and November 2019.

Cefndir / Background:

The Health Board is unable to provide sufficient capacity to meet the demands for endoscopy. This is multi-faceted relating to staffing, infrastructure as well as an increasing demand for the service. While some improvements have been seen it is clear that further work is required and potential transformational changes to the service delivery and clinical pathways to ensure that the future service is sustainable and fit for purpose. In recognition of these pressures across the country, Welsh Government created the National Endoscopy Board chaired by Simon Dean, deputy Chief executive NHS Wales this is mirrored locally by a North Wales Endoscopy Group.

The nationally directed endoscopy programme requires Health Boards to agree local action plans to deliver increased activity, improved infrastructure, recruitment and training over a 3 year period with the first phase requiring completion by April 2020. BCUHB has developed a Plan in response to the national actions, which was submitted for review to the National Endoscopy Board in December 2019. The Health Board Action plan is attached as Appendix 1.

As part of the Workforce, Training and Development national work-stream, Health Boards have been asked to review their endoscopy workforce to provide a map of current staffing and training profiles. The three Acute Hospital sites have completed a workforce survey which was submitted for review to the National Endoscopy Board in December 2019.

A national Demand and Capacity Tool has been developed by the national work-stream. BCUHB informatics colleagues and operational staff have completed the tool which has received positive feedback from the national group. The tool will enable Health Boards to better understand their current capacity, productivity and demand projections.

Following discussions with the Head of Planning for the NHS Wales Health Collaborative, a 5th workstream for service re-design has been agreed within the Health Board. This workstream will co-ordinate the 4 national groups and is being initially supported by NHS Wales Health Collaborative with indications that the national project may be able to fund a senior endoscopy network manager for a fixed term.

Health Boards are expected to continue to work towards achieving JAG accreditation. Each of the three Acute Hospital sites had a preparatory JAG Assessor visit in November 2019. No formal feedback has been received as yet. Ysbyty Glan Clwyd (YGC) and Ysybyty Gwynedd (YG) confirmed that the visits were positive. Action plans attached at Appendix 2 are those prepared following on from the Delivery Unit (DU) report in October 2018.

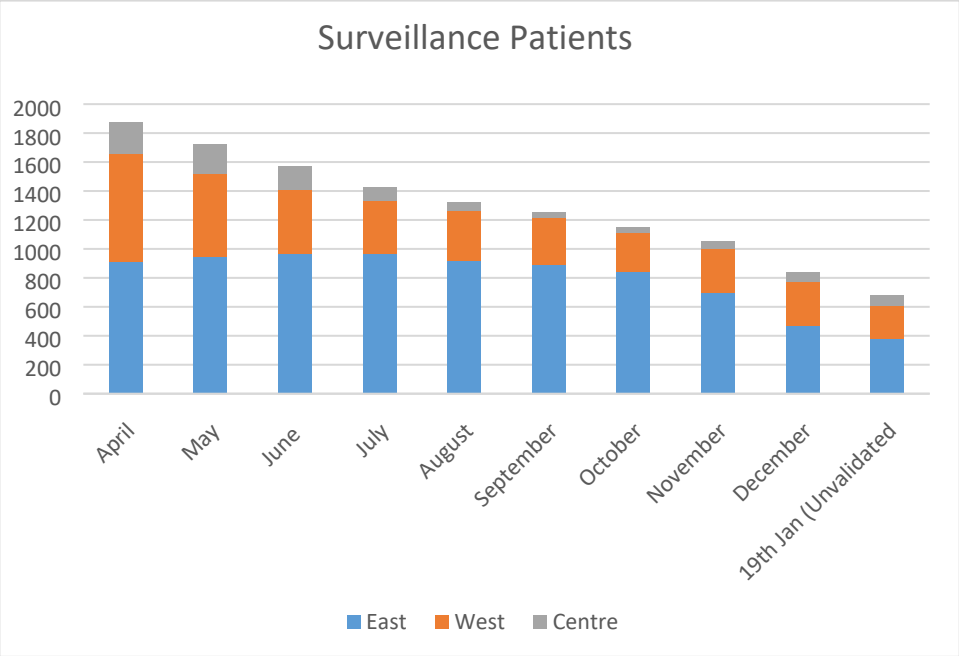
This paper does not specifically cover harms as this is included in the Harms Paper being presented to QSE today. Future incidents will be reported through DATIX and investigated as appropriate.
In respect of the order patient's are being invited for their endoscopy they are being seen by clinical priority and in turn.

Asesiad / Assessment & Analysis

Surveillance

At the end of December 2019 improvements in surveillance performance have continued. With an overall 55% reduction of the backlog from April 2019 and continuing reduction into January 2020. East continues to have the largest number of patients waiting and work continues to manage this. The numbers in Centre and West increased slightly during November and December as historically screening patients often fail to attend appointments over this time period. As a result a decision was made to switch a proportion of activity to the diagnostic waiting list to improve efficiency. Activity reverted to original plans from January.

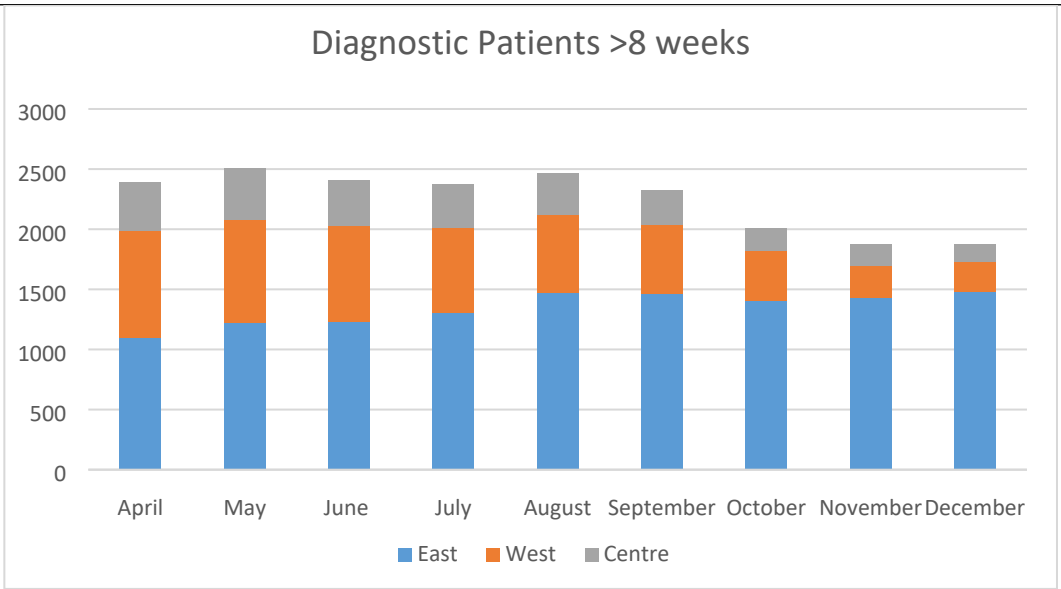
Surveillance										
	April	May	June	July	August	September	October	November	December	19th Jan (Unvalidated
East	913	942	966	968	917	890	846	699	472	380
West	746	573	447	364	347	327	264	304	304	229
Centre	220	206	159	91	60	41	37	50	65	71
Total	1879	1721	1572	1423	1324	1258	1147	1053	841	680



Diagnostic

As noted in previous reports, the health board is currently not meeting the 8 week diagnostic target. As a result of the capacity utilisation switch described above both Centre and West have seen reductions in the number of patients waiting.

Routine 8 weeks									
	April	May	June	July	August	September	October	November	December
East	1094	1226	1228	1305	1469	1460	1402	1434	1479
West	894	857	800	705	654	573	420	260	250
Centre	401	426	381	361	341	287	186	181	142
Total	2389	2509	2409	2371	2464	2320	2108	1875	1871



Activity

The Vanguard became operational for patients, mainly from Wrexham on the 3rd December for a few days and service was re-instated from 6th January 2020. Some concerns have been raised from patients travelling to the unit following use of bowel prep which necessitates urgent access to bathroom facilities, in addition some appointments have been cancelled at short notice, leaving little opportunity to re-book, which has led to only 60 of a potential 108 slots being filled. Cases have to meet specific criteria due to lack of some facilities within the Vanguard e.g. Entonox, and monitoring for glucose and INR. Further discussions are on-going to identify how this service can support East to increase the number of appointments offered. This includes consideration of re-siting the current Vanguard or an additional unit.

Insourcing has now been established on all 3 sites enabling regular weekend lists and additional weekday lists in Room 3 in Wrexham. We are also in the process of appointing additional pre-procedure nurses to triage and speak to patients. This will reduce cancellations on the day, through preparing patients for their scope and will improve our utilisation.

We are ringing patients 48 hours before their appointment at Wrexham Maelor Hospital (WMH) to further reduce the did not attend rate and are using planning cells to prospectively plan and address utilisation and productivity

Review of the current waiting list is under way to ensure maximal use of the Vanguard and insourced sessions, leaving more complex work for established sessions.

Strategy Implications

A national capacity and demand modelling exercise has been undertaken and this will be used to inform and agree future models of care and service delivery and future work will link to the National Endoscopy Programme
A business case has also been submitted to identify the resource required to address the current backlog.

Financial Implications

Aligned to the national work a further business case will be required to outline the transformational objectives and map to the current action plan (Appendix 1.)

Risk Analysis

There has been evidence of harm through delays in follow up and access to regular surveillance. This risk is being addressed through the work described in this paper and is also covered in the Harms Paper at this meeting. There continues to be a demand and capacity mis-match which will impart continued risk until the service delivery challenges can be overcome. The Health Board work as part of the national endoscopy programme aims to address this issue.

Legal and Compliance

Compliance with performance targets will continue to be reported and any incidents identified will be reported through DATIX and addressed through Putting Things Right processes.

Impact Assessment

Further work is required to fully assess the content of the action plans attached.

APPENDIX 1

Health Board: Betsi Cadwaladr University Health Board

Clinical Lead: Kate Clark, Secondary Care Medical Director

Managerial Lead: ……

Date:……

Work Stream	Immediate Phase (Dec 19)	Stabilisation Phase (March 21)	Sustainability Phase (March 23)	Notes
Demand and Capacity Please describe plans and progress to: • Increase activity • Improve productivity • Balance demand and capacity • Enable optimistion of screening	• Establishment of NEP posts funded via National Endoscopy Programme until March 2020 (YG and YGC only) • Additional POAC nurses via single cancer pathway funding • Insourcing non-recurrent capacity across all three Sites • Continue to support capacity shortfall via WLI • Planning cells in place to prospectively plan and address utilisation and productivity • 48 hours telephone calls to reduce DNAs at WXM • Review of need for lower level ventilation at YG and WXM as per sedation guidelines • Converting service lists at YGC to support bowel screening for BCUHB	• Business case developed and implemented to address workforce and capacity changes • Agreed approach to address sustainability gap for 2020/2021 • Review of partial booking system across all three Sites • Text reminder system at YGC	• Annual Action Plan developed in conjuction with annual planning process • Development of pan BCUHB strategic plan for Endoscopy	

	• Additional Sunday lists at YGC to support delayed patients in the East			
Facilities and Infrastructure Please describe plans and progress to: • Achieve and/or maintain JAG acreditation • Upload data to the National Endoscopy Database • Enable electronic referrals, vetting and validation • Enable uploading results onto the Welsh Clinical Portal • Ensure approprite capital investment and inclusion in the IMTP	• Estates improvement work carried out to improve patient confidentiality at YGC • Estates improvement work carried out at WXM due to age and risks with current infastructure • Risk assessment on use of Entinox at YG • On site centralisation of decontamination at YG	• Development of electronic internal referrals with informatics • look at options for endoscopy reporting tools to include scheduling modules. Agree and implement infrastructure changes (including low level ventilation) where appropriate to enable use of Entinox at YG and WXM • Assessment of Estate and Equipment for Endoscopy and Decontamination across all three Sites and develop Options Appraisal • Develop Asset Register for each of the three Sites • Business case developed to refurbish Endoscopy Unit at YGC • Capital programme refurbishment work at WXM to commence • Work towards JAG acreditation for YGC and WXM • Seek JAG accreditation for YG	• System and hardware upgrade (including additional server) to improve IT functionality • Implementation of WPAS and WCP for electronic referrals and results upload • Seek JAG Accreditation for YGC and WXM	
Clinical Pathways Please describe plans and progress to: • Retrospectively implement new	• BSG guidelines implemented for new additions to the surveillance waiting list • Review output from demand and capacity	• Plans in place to retrospectively implement BSG guidelines surveillance	• Retrospectively implement new BSG surveillance guidelines • Develop clear pathway to implement surveillance via	

BSG surveillance guidelines • Use FIT in the symptomatic service		• Identify capacity and skills within Primary Care and Pathology Services • Review use of genetics for reduction in surveillance demand for screening services	Genetics and FIT based on outcome from review of capacity and skills in Primary Care and Pathology Services	
Workforce Please describe plans and progress to: • Increase the number of endoscopists • Increase capacity for screening colonoscopy • Ensure appropriate skill mix	• Map the local endoscopy workforce • Ensure reference to the development of sustainable endoscopy services within the BCUHB Annual Plan • Establishment of NEP posts funded via National Endoscopy Programme until March 2020 • Additional POAC nurses via single cancer pathway funding	• Understand current capacity, productivity and demand projections in order to establish future staffing needs for endoscopy and bowel screening • Develop a Workforce Plan for Executive sign off that: -Explores opportunities for different roles / skill mix through the provision of a modern workforce within each of the three Units -Reviews the competencies and skills required -Describes the trainer and training requirements including non-medical 'accelerated training' for BCUHB staff where appropriate -Proposes a phased timeline for implementation • Develop and implement a Business Case to address workforce and capacity changes informed by the Workforce Plan above • Scope a training programme to upskill current endoscopists to undertake screening and ensuring that consultant	• Implement local actions to recruit, train and retain staff as part of the Workforce Plan • BCUHB able to cope with the anticipated increase in bowel screening referrals	

		staff are able to maintain their skills and competencies • Revise and / or develop new Job Descriptions • Implement local workforce actions to recruit, train and retain staff as part of the Workforce Plan • Appointment of a Bowel Screening Co-ordinator across all three Sites to support operational teams with data requirements • Work to ensure sustainability of the additional POAC nurse posts. Workforce requirements should be based on capacity and demand projections • Secure current temporary and seconded SSP hours at YG to permanent • Recruit vacant BSW admin posts at YG and WXM		
Comments….. Plan will be reviewed in January by North wales Endoscopy board to track progress and amend/update as needed.				

Appendix 2

Site updates against DU Recommendations October 2018

Ysbyty Gwynedd

Action Plan following Delivery Unit Observations during October 2018

Target Area Identified *(where specific performance standards have not been met)*	**Performance Concern** *(examples of where the performance standards have not been met)*	**Expected Standard of Performance** *(detail what performance standard is expected – what should it look like)*	**Agreed Improvement actions** *(who/what actions need to be taken to meet expected standard of performance)*	**Owner / Support** *(detail what support is required and agreed to achieve the expected standard of performance)*	**Review Notes** *(improvements made inc. Date and any future review dates)*	**Current status**	**RAG status**
JAG accreditation **(R1)**	No performance concern. Recognition that the process for JAG accreditation can be burdensome and therefore a clear plan is required to detail balanced workload	The site will progress towards JAG accreditation	* JAG accreditation current compliance to be established through an action tracker * EUG meeting cycle of business to be amended to support the required audits, QI and policy/procedure requirements. * Establishing areas of work and channel through an EUG action plan for review and delivery *Establish endoscopy planning cell for monitoring of site performance	Karen Mottart (chair of EUG), Jonathan Sutton (Clinical lead for Gastroenterology), Joanna Elis-Williams (Deputy General Manager)	Endoscopy Planning Cell established in February 2019. Monitoring of capacity and Demand for RTT, Surveillance and Cancer pathways. Procedure booking, procedure efficiencies, Unit concerns and risks are all discussed on a weekly basis. EUG cycle of business and terms of reference supports the progressing of JAG requirements.	**04.09.19**: visit to be arranged with JAG team (Debbie Johnson lead) to arrange visit to site to informally review preparation 4 members of staff have been trained by JAG on accreditation process. **11.11.19** An informal YG site visit has been agreed with Debbie Johnson from JAG on 25th November 2019. In view of this, the site JAG action plan has been updated with GRS standards being grouped into key work areas for the team to progress (allowing break out task groups to work on specific areas of work without duplication). Performance data and unit information/evidence is being compiled to demonstrate current	

					JAG action plan developed which matches GRS domains to provide clear cross over of achievement / actions A detailed business case for the endoscopy service in YG was developed in February 2019. The achievement of a sustainable service is dependent on the approval of this business case which was submitted to the Secondary Care team in March 2019. This detailed the staffing requirements from 2019 to 2022. Additional resource is also required for equipment provision (see R2). Please see below for demonstration of performance improvement which has been driven by the Endoscopy planning cell.	evidence levels for the visit. The YG Endoscopy service sustainability business case is being updated into the new business case format to be resubmitted following its previous submission to the Secondary Care team in March 2019 (concern has been raised due to the potential inability to complete timely recruitment of 20/21 sustainability solutions due to being in Q3 without an approved business case – certain workforce recruitment areas which have been stalled are delaying improvements within 19/20. Moreover, there is a potential need for insourcing in 20/21 should progression with the sustainable service business case not occur – the case has been included within West region IMTP developments). 20.01.20: Visit completed by Debbie Johnson in November 2019. Awaiting feedback following visit. Informal verbal feedback on the day was supportive of the site applying for JAG accreditation within Q1 of 2020/21 but this would require the sustainable service business case being progressed and service recruitment taking place for 2020/21 to show workforce and performance plan for year.	

Equipment purchase **(R2)**	Proactively manage equipment purchase scheduling	All rooms required for endoscopy are compatible with the requirements for the procedures undertaken.	• Asset register for the Unit to be reviewed • A 5 year capital programme spreadsheet to be developed for the Unit • Business Cases developed for the staged replacement of equipment	Tina Macphail-Owen (Matron) Joanna Elis-Williams (Deputy General Manager)	Asset register review has been completed and presented to the EUG	**04.09.19** Prioritised capital equipment has been received and will be submitted alongside the medical directorate prioritisation capital spreadsheet to site on 06/09/19 **11.11.19** Capital bids for the endoscopy service in YG have been submitted to the site's capital planning process for 20/21. The purchase of 3 new scope guides for the unit has been entered to the North Wales secondary care bidding process as the second priority for the YG site. A further scope guide is being purchased by BSW for the YG service through monies in 19/20. However, significant concern remains with the current stack systems, which although remain in service contract are regularly failing and causing on the day cancellations, DATIX incidents and general disruption to lists.	

Endoscopy Department – Wrexham Maelor Hospital

Action Plan following Delivery Unit Observations during October 2018

Target Area Identified *(where specific performance standards have not been met)*	**Performance Concern** *(examples of where the performance standards have not been met)*	**Expected Standard of Performance** *(detail what performance standard is expected – what should it look like)*	**Agreed Improvement actions** *(who/what actions need to be taken to meet expected standard of performance)*	**Owner / Support** *(detail what support is required and agreed to achieve the expected standard of performance)*	**Review Date**	**Review Notes** *(improvements made inc. Date and any future review dates)*	**Current status**
Reception and booking area ***(R1)***	No visual displays to identify Endoscopy reception which could cause delays to patients 'checking in'	Clear signage for patients should be displayed ensuring a smooth patient flow	Temporary signs introduced.	N/A	N/A	Signage of the whole unit will be reviewed following refurbishment.	Action complete 11.11.19 - Estates have been asked to take down some of the old day case unit signs, all signs have been reviewed to ensure they are bilingual).
Protocols for discharging patients ***(R2)***	Occasional communication issues regarding contacting relatives for collection of patients resulting in poor patient flow out of department	Consistent good patient flow protocols when discharging patients	Reviewing discharge process and discuss with Nursing staff.	Nursing / R Hayward		Discussed with nursing team to ensure process is adhered too.	Action complete and will continue to be monitored. 11.11.19 - No further issues identified with discharge process.

Answer phone / nurse assessment area ***(R3)***	Confidentiality in the reception area as answer phone can be clearly heard even with the door closed	Confidentiality to be maintained at all times within the department	There is no alternative accommodation at present. Nursing staff reminded to ensure door is closed and answer machine is turned down to its lowest sound setting	Estates / R Hayward		This will be reviewed as a requirement for any further refurbishment of the unit. Chairs have been removed from this side of the waiting room and radio licence has been approved for the waiting area.	Action complete. 11.11.19 - Radio now in place, with some of the changes in the unit there is a potential for this office to be moved in the near future).
Rebooking of patients	Patients with incomplete forms or queries being rebooked	Patient to attend agreed appointment date and not be rebooked due to communication with nurse	The re-introduction of the pre-assessment service will alleviate a number of these queries.	Nursing staff / R Hayward			Ongoing dependent on nurse vacancies. Band 2 admin telephone call introduced. Text reminder service introduced. **20.01.20** Single cancer pathway funding for pre-assessment nurse, post awaiting advertisement.
Preparation of notes	Only utilisation of 1 trolley	Use of several trolleys to allow forward preparation of notes for lists	Only one trolley required – locked cupboard and notes room available.				
Booking centre ***(R4)***	Significant weaknesses in	Seamless booking process with	• Embed new management	T.Lisin		• Daily checkpoint	Ongoing

	quality of booking process with poor attention to details	patients being booked on correct lists and in correct order	within Directorate • Review of SOPS/processes • Weekly meetings with clerks • Two weekly 1:1 with clerks • Action plan and targets set and agreed with booking staff			meetings introduced • Planning cell introduced to look at cancellations, utilisation • Band 2 bank helping until permanent post appointed to.	11.11.19 - Cancellation rate has improved due to the actions taken, aim to keep below 10%.
Review use of room 1 – Modular **(R5)**	Issues raised were portering; location and patient flow; removal of monitors; procedure limitations; isolation of room; decontamination		Meetings with portering managers to ensure portering support. Ensure the facility works as best as it can with the resource that we have. Lists are reviewed to ensure best flow possible and equipment has been reviewed.	Nursing / R Hayward	Continue to review	At the end of May there will be two procedure rooms back in use on the unit and the modular will not be required unless used as a third procedure room.	This has been postponed due to verification of air handling unit, awaiting date from Estates. Should be opening from 18.09.19 11.11.19 - The 2 refurbished procedure rooms opened w/c 28/10/19 in the main unit, the modular unit will now be used for the weekday insourcing. **20.01.20** the modular room is currently being used as a third

							room for the insourcing and an additional HCA is on duty to assist with the issues around location.
Improvement patient information pre appointment **(R6)**	Lack of patient information being provided to patient from GP	Patients to be fully informed of procedure prior to appointment	Review of current patient paperwork already completed. Printed paperwork has been costed and is currently having final check before order.	R Hayward / Senior Sister		Awaiting quote for new patient documentation. Aug 19 received. Order being raised. Order rejected and resubmitted.	Raised at Endoscopy Steering Group. Further discussions to take place with primary care. **20.01.20** new paperwork now in place.
Patient pathway **(R7)**	Current patient pathway is overly complicated with non-value added steps.	Ensure a patient pathway does not include non-value added steps	Pathway reviewed. (pathway shown on report did not reflect our current pathway)	Nursing / R Hayward			Completed. Pathway will also improve significantly when both procedure rooms are back in the main unit.

Endoscopy Department - Ysbyty Glan Clwyd

Action Plan following DU visit 2019 update v4 Oct 19

Action number	Required Action	Target Date	Owner	Update/comments	RAG status
DU Recommendation 1 - Review confidentiality issue in the waiting area - it was reported that there had been concerns over confidentiality in the area as the assessment rooms were not sound proofed and therefore staff had been concerned that patient/relative consultations may be overheard. A TV had been purchased however this is not a satisfactory solution.					
1.1	Remind all staff that the rooms are not sound proofed and to bear this in mind when conversations are being held.	Jul-19	Nicky Roberts, Unit Manager	Completed and message reinforced during regular team meetings/handovers.	
1.2	Hold initial scoping meeting to discuss redevelopment of endoscopy unit.	Aug-19	Mark Andrews, General Manager	Scoping meeting held 5.8.19 (minutes available if required)	
1.3	Establish project board to progress the redevelopment/refurbishment of the endoscopy unit.	Sep-19	Mark Andrews, General Manager	First project board meeting to be arranged in September. Arrangements underway. First project board meeting now scheduled for October due to annual leave commitments of key members. Arranged for 7.10.19 and monthly thereafter. First meeting did not go ahead due to annual leave and meeting not being quorate. Impromptu smaller meeting held about smaller more immediate changes that can be made to the unit. See point 1.12. First project board meeting now scheduled for 4.11.19.	
1.4	Dr Ian Finnie to be asked to provide expert knowledge/experience/advice to the board as required.	Sep-19	Mark Andrews, General Manager	MA to invite IAF	

1.5	Obtain projected capacity figures for the next 5, 7 and 10+ years to inform design of new unit to ensure future proofing.	Sep-19	Mark Andrews, General Manager	MA to ask Wendy Hooson, planning department, for these calculations. WH currently pulling together these figures - to be provided by end September. After further discussion these figures are not available. Therefore current D&C figures to be used factoring in growth rate. Unit to be designed with 3 rooms but design remaining space flexibly to allow for fourth room to be commissioned in due course when required. Demand and capacity exercise currently being undertaken using a national standard tool which should help to inform future capacity requirements.	
1.6	Need to understand strategic intention for centralised decontamination of the YGC site as this will inform the new design/footprint of the unit.	Oct-19	Mark Andrews, General Manager	MA to link with HMT. Initial discussions held but no clear direction available to date. Design options for the new unit will contain plans for including and excluding decon. This issue is being discussed at the BCUHB strategic decontamination group.	
1.7	Undertake a survey of the current endoscopy unit to ensure it is fit/suitable for refurbishment.	Sep-19	Neil Bradshaw, Director of Capital Planning	Mark Lewis, Gleeds allocated as project link for this project. Initial discussions held and plans underway to carry out survey and to decide what changes can be made to the unit in the interim to try to meet JAG recommendations.	
1.8	Undertake initial design work for the new unit. This will quickly inform whether (a) decon needs to be moved out, (b) can the unit accommodate 3 or 4 procedures rooms, (c) enable financial calculations to be undertaken. Meetings with Project management and architect commenced in Dec 2019 and are continuing monthly until design is confirmed.	March - 20	Neil Bradshaw, Director of Capital Planning		

1.9	Upon completion of the initial design work, calculate indicative cost of business case which will then determine funding route/next steps.	Mar-20	Neil Bradshaw, Director of Capital Planning	Target date changed to Mar 20.	
1.10	Upon completion of point 1.9 above, create BJC (business justification case).	Mar-20	Mark Andrews, General Manager	Target date changes to Mar 20.	
1.11	Ensure refurbishment/redevelopment of the endoscopy unit is on the directorate risk register	Aug-19	Tracy Sellar, Deputy General Manager	Completed.	
1.12	Investigate any temporary changes that can be made to the unit to improve the environment in the short term.	Dec-19	Rachel Langford Jones, Lead Manager	Completed	
1.13	Once temporary changes agreed, complete business case to secure funding.	Dec-19	Rachel Langford Jones, Lead Manager	Completed	
1.14	Seek advice from JAG professionals at upcoming JAG visit in November to ascertain what improvements they suggest whilst the capital refurbishment is awaited.	Feb-20	Tracy Sellar, Deputy General Manager	Visiting JAG rep suggested to continue with the minor improvements in December which are ow complete but to rapidly progress the planning for the unit refurbishment.	

Action number	Required Action	Target Date	Owner	Update/comments	RAG status
DU Recommendation 2 - Continue review of cancelled and did not attend patients - It was observed that only 71% of patients arrived for their appointment. Of the 29% of patients who did not arrive, various reasons for not attending were given; it was observed that an audit of patients cancelling had been commenced recently, the results of this audit should be shared and actions agreed and carried out.					
2.1	Establish a weekly endoscopy planning cell meeting which will include robust review of CNA and DNA rates	May-19	Rachel Langford Jones, Lead Manager	Started in May 19	
2.2	Strengthen the endoscopy administration team to provide more robust and resilient cover.	Jan -20	Rachel Langford Jones, Lead Manager	**Completed** Band 4 team leader appointed. All vacancies filled except for one part time post which is currently going through the recruitment process - expect to be appointed by Nov 19. Ad hoc experienced bank support is available when required to ensure workload is managed efficiently. Delays with recruitment - interviews now planned w/c 21.10.19. Expect to be fully complimented by Jan 20.	
2.3	Review administration processes to ensure efficient processes are in place.	Aug-19	Rachel Langford Jones, Lead Manager	**Completed** New Speciality Manager appointed who is experienced in booking/outpatients/day case field. Administration processes have been reviewed and SOPs created, new processes introduced, processes changed to introduce more efficient ways of working etc. Ongoing review and re-assessment will be built into regular team meetings etc. All clerks are now trained in all roles within the department thus providing more resilient/robust cross cover.	
2.4	Following work undertaken in points 2.2 and 2.3 above, booking further in advance for patient appointments.	Aug-19	Rachel Langford Jones, Lead Manager	**Completed** Patient appointments now being booked further in advance which allows more efficient booking, backfilling of cancellations etc.	

2.5	Introduction of partial booking for routine and surveillance patients.	Aug-19	Rachel Langford Jones, Lead Manager	**Completed** As the department are now able to book further ahead, partial booking has been introduced. This ensures that patient appointments are mutually agreed theoretically reducing the number of CNAs and DNAs.	
2.6	Enhance recording of CNA dates and reasons.	Aug-19	Donna Pope, Speciality Manager	**Completed** Introduction of bespoke form to record all CNA communications with patients. Start date 19.8.19. Audit of these forms at the end of pilot period of one month to ascertain (a) reasons for cancellations (b) date of advice of cancellation - is it enough notice to backfill slot and (c.) whether slot was refilled. Results of audit to be fed back at planning cell early Oct 19. Following completion of the audit, the reasons for cancellation have been reviewed and amendments on WPAS were requested and are now available for selection by the team. To support the continual reduction of CNAs the team are pending a start date to introduce a text remainder service for patients to start taking bowel prep and for their appointment.	
2.7	Tracking of CNA and DNA reasons on a monthly basis through the planning cell.	Ongoing	Rachel Langford Jones, Lead Manager	**Completed** Trend data available and shared at weekly planning cell. Ongoing monitoring underway to determine whether interventions are successful. Quarterly CNA/ DNA historic data reviewed at the planning cell to highlight themes and trend.	
2.8	Rewording of endoscopy appointment letter.	Jan-20	Donna Pope, Speciality Manager	**Completed** Rewording of the cancellation paragraph in the appointment letter. Current letter asked patients to give 5 days' notice - this to be increased to 8 to allow more potential to refill any cancelled slot. Also paragraph to be reworded to be more concise as it is currently quite lengthy. Changes underway and should be in place by end Sept 19. This has not yet been done as the department is only 2-3 weeks ahead with partial booking. Need to be further ahead before this letter is changed. Target date changed to Jan 20.	

2.9	Text reminder service to be piloted for endoscopy appointments.	Sep-19	IT	Introduction of pilot 3-6 month text reminder scheme to be introduced in the hope of reducing CNAs and DNAs. Initial conversations held, date of implementation to be agreed. Plans progressing - still on track to implement before end Sept 19. IT issues have delayed this implementation - now expected Feb 20	

Action number	Required Action	Target Date	Owner	Update/comments	RAG status
DU Recommendation 3 - Review endoscopist options and skills mix to fill sessions					
3.1	Review of protected weekly inpatient slots to determine whether capacity exceeds demand.	Sep-19	Tracy Sellar, Deputy General Manager	**Completed** Currently 16 slots are reserved for IP work (before a/l and s/l). Audit to be undertaken commencing 19.8.19 for 1 month to determine whether all slots are consistently utilised. Audit completed. Results document available. Current IP slot capacity pa = 704. Indicative demand following 4 week audit = 650 pa. No change planned to current IP slot capacity, especially as the winter months are ahead and IP capacity will enable flow.	
3.2	Analysis/review of number of current sessions to be undertaken.	Sep-19	Tracy Sellar, Deputy General Manager	**Completed** Full analysis of lists/operators carried (document available). Further discussion with lead endoscopist required to ascertain if operators with lists less than 12 points can be increased.	
3.3	Review of lists involving endoscopists with less than 12 points per list to be undertaken with lead endoscopist.	Sep-19	Tracy Sellar, Deputy General Manager	**Completed** Undertake review in September - meeting to be arranged. TS/AB/MA met 25.10.19 to review operators/points/lists (document available). One change made to Dr Miric template. Templates to be re-reviewed in Jan 20 with information regarding start and finish times available also. This will additional meaningful discussion.	

3.4	Undertake D&C exercise for EUS procedures to determine whether 2 lists per week are still required.	Aug-19	Tracy Sellar, Deputy General Manager	**Completed**. Data shows 2 lists per week still required. 232 procedures carried out April 18 to March 19. 3 procedures per list. = 78 lists required. 42 weeks per year x 2 lists per week - 84 lists available per year. Allowing for DNA and last minute CNA, D=C. To be reviewed in 3 months' time to re-assess demand to determine whether any change.	
3.5	Monitor start and finish times and feed this information into regular reviews of operator points on list	Ongoing	Tracy Sellar, Deputy General Manager	This information to be used to inform discussion re number of points on list. For example, If operators have less than 12 points but constantly finish early, then review points on list. AB also has asked the National Endoscopy Programme team about distribution of points on list comparing mornings and afternoons. Audit to be undertaken for November initially - possibly extend to end December if required.	

Action number	Required Action	Target Date	Owner	Update/comments	RAG status
DU Recommendation 4 - Review sedation rates within department - the DU would recommend looking at the sedation rates as these seemed high compared to the other units.					
4.1	Ascertain whether information regarding sedation rates % can be extracted from Unisoft.	Aug-19	Nicky Roberts, Unit Manager	At present it cannot be extracted due to the IT issues preventing the software upgrade. A solution has been identified to proceed with the upgrade however a revenue cost of approx. £4,500 has been identified and until this expenditure is released by finance this cannot be progressed. When the software is upgraded non sedation rates can be extracted from the system on a regular basis which will allow us to calculate sedation rates. Purchase of the hardware has been refused as a result of heightened financial controls. Funding agreed and order placed for up-grades	

4.2	Obtain sedation rates % from YG and WX (if these are recorded).	Aug-19	Nicky Roberts, Unit Manager	Numbers of patients sedated is not easily obtainable from the three sites. YGC cannot extract this information from Unisoft without the £4500 upgrade as detailed above. YG advise that this data is collated by looking at individual Clinician's data which, after generation, is sent to JAG where it is monitored by the Local Endoscopy Lead.	
4.3	If sedation rate information cannot be extracted from Unisoft commence audit on 1.9.19 of all patients sedated.	Sep-19	Nicky Roberts, Unit Manager	Confirmed sedation rates cannot be extracted from Unisoft therefore audit planned to commence 1.9.19	
4.4	Link with colleagues from other hospitals to ascertain whether their units routinely record sedation rates % (ask ID Group nursing colleagues) and if so contact hospitals for their rates.	Sep-19	Nicky Roberts, Unit Manager	Endoscopy staff to speak to ID Group colleagues on the next weekend - 17th and 18th September. NR reported back that the feedback received was that other units do not monitor sedation numbers as it is patient choice.	
4.5	Contact DU for advice on obtaining comparative data or information re national standards.	Aug-19	Tracy Sellar, Deputy General Manager	Tracy Sellar contacted Christine Owens 16.8.19. Christine to provide as much information/advice as possible. CO has forwarded some information however this information does not state how many patients per head of population should be sedated, nor are there target rates of any kind.	
4.6	Upon receipt of comparative data, undertake analysis and review process with lead clinician, unit manager	Oct-19	Tracy Sellar, Deputy General Manager	Once data compiled, Tracy Sellar to organise review. Full review not possible. Email correspondence received from Dr Baghomiam explaining comparison work done previously compared to external studies. Email of explanation send to the DU. 13.9.19. 16.9.19 response received from DU who advise they are happy with the review/comparison work undertaken by the clinicians.	
4.7	Secure funding for the IT upgrade which will provide enhanced features in Unisoft.	Sep-19	Mark Andrews, General Manager	Funding approved	

4.8	Review JAG comfort scores for unit	Sep-19	Tracy Sellar, Deputy General Manager	Nicky Roberts sending comfort scores by endoscopist and user to Tracy Sellar.	

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience (QSE) Committee 28th January 2020
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Occupational Health and Safety (OHS) Quarter 3 Report [1st October– 30th December 2019]
Cyfarwyddwr Cyfrifol: Responsible Director:	Mrs Sue Green - Executive Director of Workforce and Organisational Development
Awdur yr Adroddiad Report Author:	Mr Pete Bohan - Associate Director of Health, Safety and Equality
Craffu blaenorol: Prior Scrutiny:	Strategic Occupational Health &Safety Group – 10th January 2020
Atodiadau Appendices:	Appendix 1 – Quarter 3 Occupational Health and Safety Report [Further appendices referenced in the report available upon request]

Argymhelliad / Recommendation:

The Committee is asked to:

1. Note the position outlined in the Quarterly Report.

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

Sefyllfa / Situation:

Following the introduction of revised Health and Safety governance arrangements, this report sets out the progress against the occupational Health and Safety Improvement Plan and performance against the key requirements.

This is the 3rd Report produced and progress continues to be made in terms of integrating all aspects of Occupational Health and Safety.

The work being undertaken by the Strategic Occupational Health and Safety Group is significant in reviewing the delivery of the Improvement Plan and there is considerable support for the work being undertaken lead by the relevant teams in Corporate Health and Safety; Estates and Facilities and Nursing and Quality.

Of significance is work currently being undertaken to co-ordinate a business case as part of the financial planning for 2020/21. This case sets out the cost benefit case for investment in essential work required to meet a number of legislative and regulatory requirements.

Cefndir / Background:

The Quarter 3 2019/20 report is attached at Appendix 1.

Asesiad / Assessment
Strategy Implications The Occupational Health and Safety Improvement Plan is a 3 year plan under the Workforce Strategy. It is a key enabler for delivery of the Health Board's legislative and regulatory responsivities. **Financial Implications** There are no direct cost implications arising from this report. However, a business case is being developed as part of the financial planning for 2020/21 in conjunction with Estates and Facilities. This business case covers a number of measures to support delivery of effective Health and Safety management and operational effectiveness. There will be cost implications for failing to reduce or mitigate risks associated with Occupational Health and Safety in terms of fines prosecutions, lost time injuries and claims against the Board. **Risk Analysis** A full review of legislative compliance has identified the current safety management systems within the Board requires significant work. There are significant risks in areas including asbestos, legionella, fire, electrical safety, noise / vibration, contractor management/control and Security/Violence and Aggression. 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. ***Legal and Compliance*** A number of elements within this report and in the business case being developed include measures to address breaches in legislative requirements e.g. Security and CCTV/Information governance ***Impact Assessment*** Impact Assessments are undertaken against each of the headings under the improvement plan and escalated to the Strategic Occupational Health and Safety Group as appropriate.

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Appendix 1

Occupational Health and Safety (OHS)
Quarterly 3 Report 1st October–December 30th 2019

Executive Summary

1. The Quarterly Occupational Health and Safety report aims to give an overview of incidents/accidents, training and Health and Safety activities for the period 1st October to 31st December 2019.

2. Key issues to note:

- The gap analysis action plan is being undertaken to ensure significant risks are being effectively managed. The Occupational Health and Safety Team has now developed a 12 month action plan that relates to the outstanding findings of the gap analysis. The action plan includes key areas of risk including, contractor management and control, work at height, vibration and noise, asbestos, legionella water safety, driver safety, security, manual handling and incident reporting procedures to ensure when things do go wrong we learn lessons. The H&S Policy is now complete and has been provided to the Strategic OHS Group for approval and implementation at QSE.

- There have been 23 incidents reported under RIDDOR in Q3, a decrease of 4 on Q2, with 8 reported in Central, 8 in West and 7 in East. Patient and object handling have been the main cause of injury to staff this quarter with 7 related incidents reported, followed by slips and trips with 6 related incidents. Injuries to staff from abuse by patients has reduced, with four incidents being reported compared to seven in Q2. BCUHB have had 2 incidents which have been reported under RIDDOR as 'Dangerous Occurrences', a chemical and a gas supply pipework explosion in East described below. The 23 incidents reported to the Health and Safety Executive (HSE) in Q3, 18 related to staff and three to the injury of patients, which is one more than Q2.

- On Monday 16th December, one of the two steam generating boilers based at the Hospital Sterilisation and Disinfection Unit (HSDU) in Wrexham Technology Park suffered a catastrophic failure within the gas supply pipework. This resulted in substantial damage to the boiler and the attached ducting. There were two members of staff working on the boiler at the time and in the vicinity but they were unharmed. There were no obvious signs of damage to the building. The staff members have been supported and offered occupational health assessments. The loss of this boiler together with the time delay in assessing the other boiler for any defects has resulted in significant disruption to HSDU's processes with theatre sets being sent to YGC and Countess of Chester. This incident has been reported to the Health and Safety Executive (HSE) by the Corporate H&S Team under RIDDOR as a Dangerous Occurrence. A Root Cause Analysis is currently being carried out by Estates with additional work to be done in relation to what Business

Continuity plans were in place. The HSE plan to visit early January to review procedures including policy, systems and maintenance procedures in place at the time.

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.

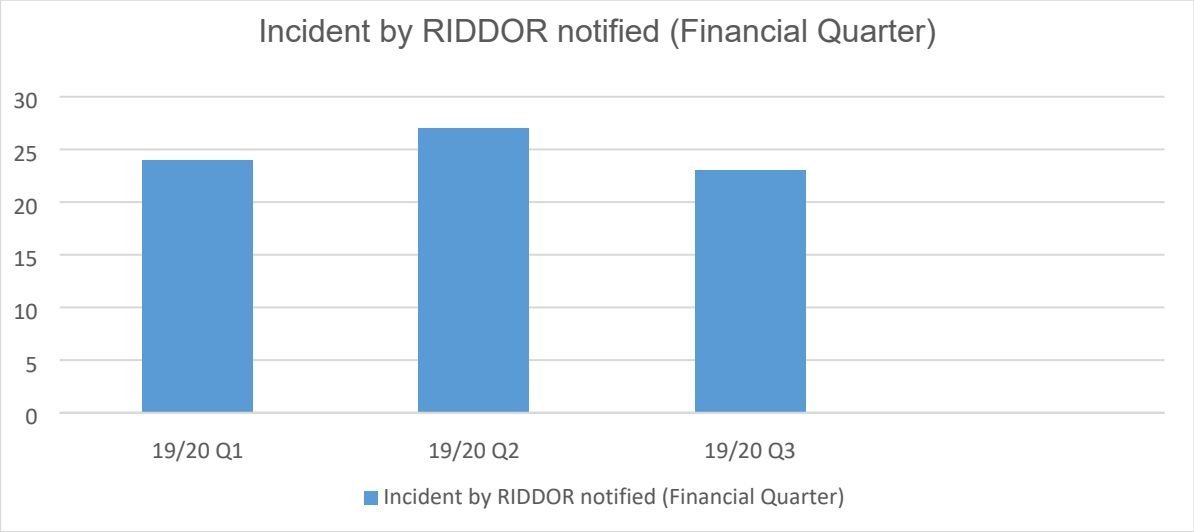
Employees must also notify their employer of any serious or immediate danger to health and safety, or any shortcomings in health and safety arrangements.

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

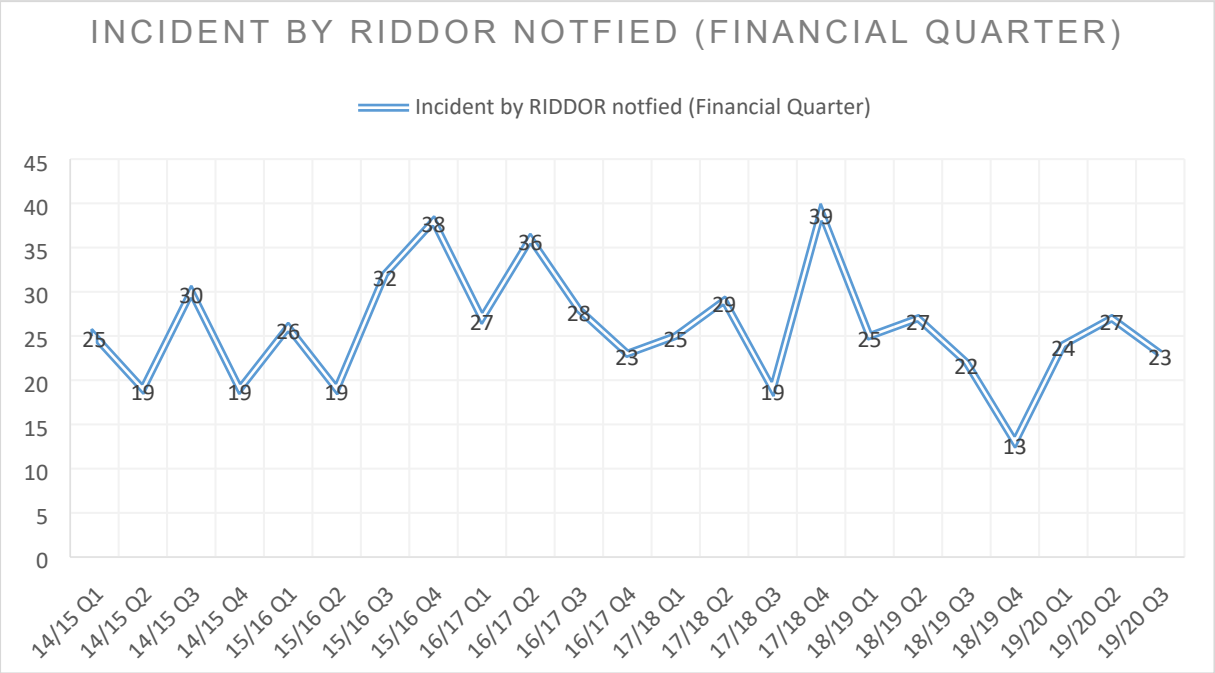
This set of Regulations, commonly referred to as the RIDDOR Regulations, require employers and other people in charge of work premises to report and keep records of:

- 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 23 incidents reported under RIDDOR in Q3, a decrease of 4 from Q2, with 8 reported in Central, 8 in West and 7 in East. Patient and object handling have been the main cause of injury to staff this quarter with seven related incidents reported, followed by slips and trips with 6 related incidents. Injuries to staff from abuse by patients has reduced, with four incidents being reported compared to seven in Q2. We have had two incidents, which have been reported under RIDDOR as 'Dangerous Occurrences', a chemical release and a gas supply pipework explosion in East. The 23 incidents reported to the Health and Safety Executive (HSE) in Q3, 18 related to staff and three to the injury of patients, which is one more than during Q2. Thirteen incidents were reported within the statutory timescales and 10 outside them, due to lack of information available at the time.



The table above shows the Q1 2019/2020, Q2 2019/2020 and Q3 2019/2020 RIDDOR notified (rows section) against the Financial Quarter.



The table above shows the Quarter RIDDOR notified (row sections) against the Financial Quarter since 2014/15.

RIDDOR Incidents by Detail and Region:	**BCUHB Central:**	**BCUHB East:**	**BCUHB West:**	**Total:**
Abuse of staff by patients:	1	2	1	**4**
Accident caused by some other means – Chemical release & gas explosion:	0	2	0	**2**
Accidents caused by some other means - Collison with equipment:	1	0	0	**1**
Needle-stick Injury - Exposure to hazardous substance:	0	0	0	**0**
Accidents caused by object handling:	1	2	1	**4**
Accidents caused by patient handling:	2	0	1	**3**
Slips and Trips to non-workers:	1	0	2	**3**
Slip and Trips to staff:	2	1	3	**6**
Total	**8**	**7**	**8**	**23**

The table above shows the overall RIDDOR incidents 2019/2020.

Hazard:	RCA completed:	RCA requested:	Root Causes, Lessons Learnt/Actions identified and implemented:
Abuse of staff by patients:	3	1	RCA x 3 - completed and no lessons learnt identified. RCA x 1 - requested, out of agreed time limits, Divisional Director has been informed
Accident caused by some other means - Chemical Release:	1	0	RCA x 1- undertaken, with actions/lessons learnt identified and implementation commenced.
Accident caused by some other means - Gas Explosion:	0	1	RCA x 1 - requested on 19/12/19 and reassurance has been received that it is in progress.
Accident caused by some other means - Collison with equipment:	0	1	RCA x 1 – requested, out of agreed time limits, Head of Nursing has been informed.
Accidents caused by object handling:	3	1	RCA x 1 – no lessons learnt identified. RCA x 2 – undertaken with actions/lessons learnt identified – no confirmation to date as to whether they have been implemented. RCA x 1 – requested 27/12/19.
Accidents caused by patient handling:	3	0	RCA x 2 – undertaken, with actions/lessons learnt identified and implementation commenced. RCA 1 – undertaken, with actions/lessons learnt – no confirmation to date as to whether they have been implemented.
Slips and Trips – non workers:	0	3	Welsh Government Investigations x 3 – in progress.
Slip and Trips – staff:	3	3	RCA x 1 - undertaken, with actions/lessons learnt identified and implementation commenced. RCAs x2 – undertaken, with action/lessons learnt identified – no

			confirmation to date as to whether they have been implemented. RCAs x 3 - requested on 19/12/19, 24/12/19 & 27/12/19 and reassurance has been received that they are progress.
Total	13	10	

The table above shows a breakdown of the Root Cause Analysis of RIDDOR incidents 2019/2020.

BCUHB Central:	3
BCUHB East:	3
BCUHB West:	3

The table above shows the outstanding Root Cause Analysis by Area 2019/2020:

Division/Area:	**No:**
Estates and Facilities:	4
Mental Health and Learning Disabilities:	3
Radiology:	1
Secondary Care:	8
Primary Care:	**1**
Informatics/Health Records:	**1**
Area West:	**2**
Area Central:	**3**

The table above shows the overall RIDDOR incidents by Division/Area 2019/2020.

Division/Area	Completed	Commenced	Not completed but still within agreed time limit	Not completed and outside the agreed time limit
Estates and Facilities	2	2	0	0
Mental Health and Learning Disabilities	1	0	1	1
Radiology	1	0	0	0
Secondary Care	3	3	1	1
Primary Care	0	0	1	0
Informatics/Health records	1	0	0	0
Area West	1	1	0	0

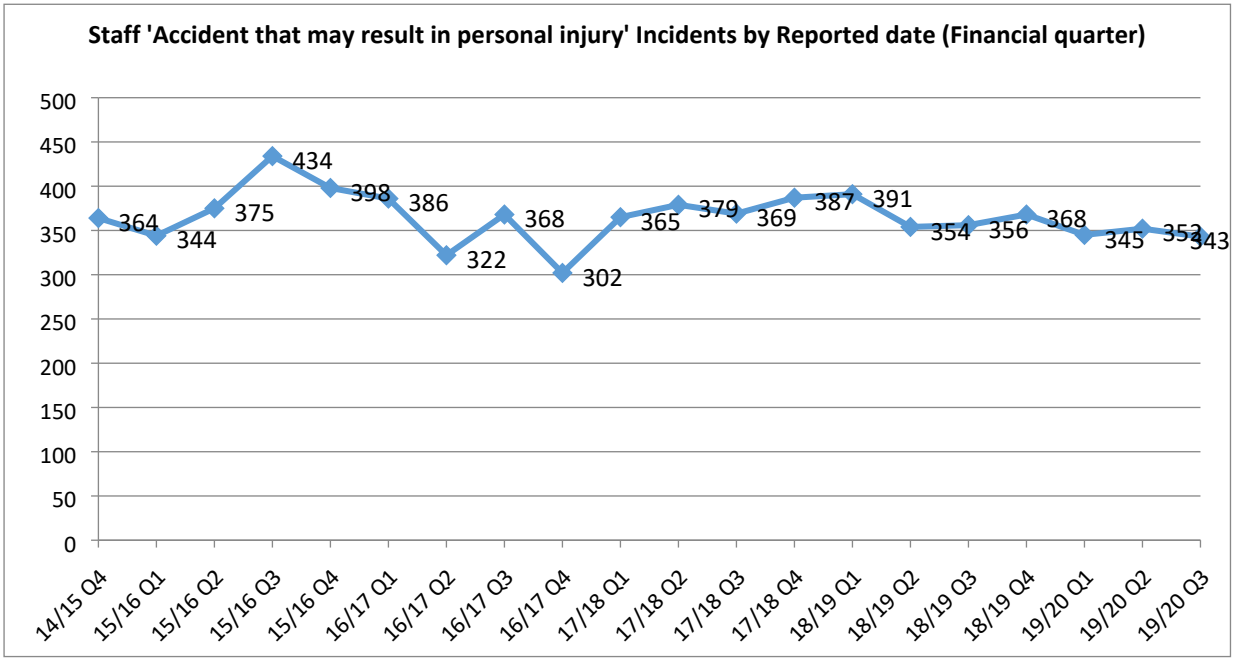
Area Central	3	0	0	0

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, BCUHB Central and BCUHB West and further work is being carried out in these areas.

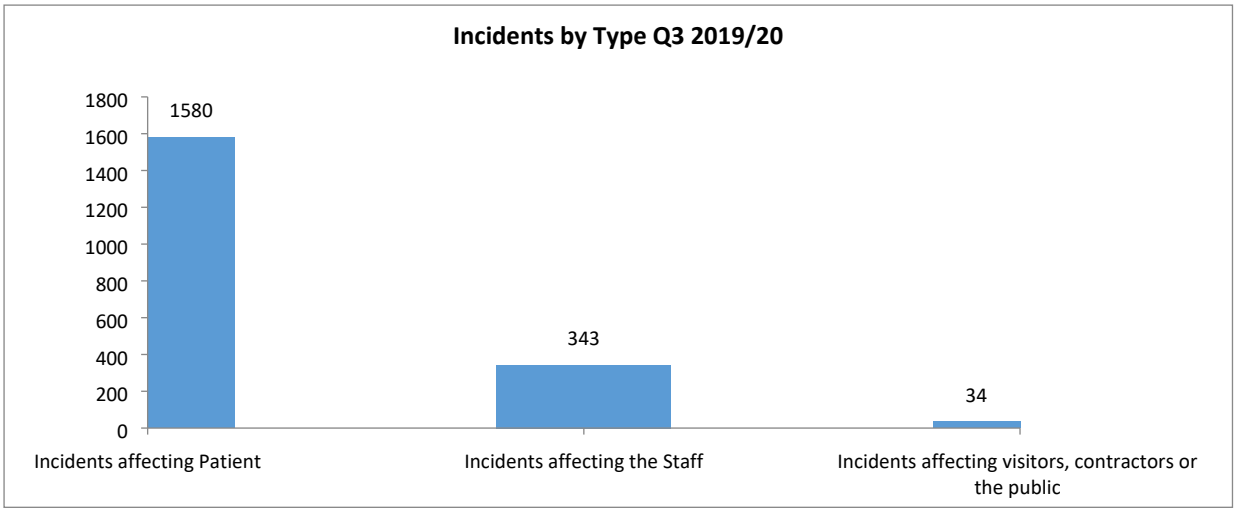
The RIDDOR incident related to the boiler at Wrexham may have had an effect on theatre lists but at the time of this report could not be confirmed. Engineers and assessors were quickly on site and BCU Estates are waiting for the full report on the probable cause. Early indication from the boiler manufacturers is, at this stage, thought to have been failure of a relay system allowing the boiler to fire without purging the flue, causing built up gas in the flue to combust. Estates have responded well to the incident, with thorough investigation and use of experts, and planning to re-engineer to improve future safety of the system. A meeting will be held prior to the HSE visit in early January 2020.

7. Incidents

The Health Board utilises the DATIX system to record all incidents and near misses. An analysis of the data reported from 1st October – December 31st 2019 indicates that there have been 1,957 with the main Health and Safety related incidents are as follows.



The above table shows the total number of staff accidents in Q3 2019/2020



The above table shows the total incidents recorded in Q3.

Incidents affecting Staff - by Detail & Region	BCUHB Central	BCUHB East	BCUHB West	Total
Accident caused by some other means	27	38	39	104
Exposure to electricity, hazardous substance, infection etc	14	6	8	28
Injury caused by physical or mental strain	14	6	8	28
Lifting accidents	14	7	2	23
Needle stick injury or other incident connected with Sharps	33	28	25	86
Slips, trips, falls and collisions	22	25	27	74
Total	124	110	109	343

Staff Needle Stick Incidents - by Adverse event & Region	BCUHB Central	BCUHB East	BCUHB West	Total
Accident of some other type or cause	3	1	2	6
Injury from clean sharps	2	5	1	8
Injury from dirty sharps	24	19	20	63
Sharps or needles found	4	3	2	9
Total	33	28	25	86

The above table shows the number of Needle stick incidents occurring in Q3 including 63 incidents reported as dirty sharps.

Injury from dirty sharps by Location (exact) & Region - Top 5	BCUHB Central	BCUHB East	BCUHB West	Total
Emergency Department (secondary care)	1	1	1	3

Outpatients (secondary care)	1	0	1	2
Theatre B, WM (secondary care)	0	2	0	2
Theatre A, WM (secondary care)	0	2	0	2
Labour, YG (secondary care)	0	0	2	2
Total	2	5	4	11

Injury from dirty sharps by Contributory factors & Region (Top 5)	BCUHB Central	BCUHB East	BCUHB West	Total
Lapse in Concentration	6	1	4	11
Other	0	1	3	4
Operator Error	1	1	1	3
Failure to Follow Procedure	1	0	2	3
Judgement	0	1	2	3
Total	8	4	12	24

Staff Slips, Trips & Falls or Collision Incidents

Incidents by Adverse event & Region	BCUHB Central	BCUHB East	BCUHB West	Total
Accident of some other type or cause	9	3	5	17
Collision with an object	5	8	5	18
Fall down Steps	1	1	0	2
Fall from a height, bed or chair	2	2	1	5
Fall on level ground	3	9	10	22
Slips on ice or snow	0	1	0	1
Suspected fall	0	1	2	3
Tripped over an object	2	0	4	6
Total	22	25	27	74

7.1 Incidents Highlights

The top four areas of concern in staff incidents / accidents included 104 accident caused by some other means. This includes incidents such as vehicle collisions, collisions with equipment and manual handling injuries, 86 needle stick incidents, 74 slips trips and falls, 28 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.

7.2 West

The H&S Advisor is carrying out all the Root Cause Analysis (RCA) investigations as part of the gap analysis work to develop an improved, more robust RCA process. Once completed, the H&S Advisor will work closely with the management team to ensure that the actions/ lessons learnt are implemented in a timely manner and shared as appropriate. There have been some good news stories in Q3 regarding

the actions / lessons learnt from RCAs which have been carried out. For instance, the RCA that was carried out following the chemical spillage in East has resulted in a complete review of the Control of Substances Hazardous to Health (COSHH) and the Dangerous Substances and Explosive Atmosphere Regulations (DSEAR) management by Operational Estates pan BCUHB, with significant involvement by the 3 area Environmental Officers; a programme of workplace inspections to be carried out in all Estates Compounds.

The RCAs looking into staff slip, trip and falls, which resulted in injury, have identified shortfalls such as insufficient risk assessments of working areas or manual handling activities with limited safe systems of work, poor maintenance contracts for associated equipment or adherence to the correct application of Personal Protective Equipment. All these shortfalls are now being addressed pan BCUHB through the gap analysis work. The RCAs carried out into incident involving abuse of staff by patients have not identified any actions/lessons learnt which could help prevent further incident occurring. This is an area that requires attention and support for the services affected.

7.3 East

There have been two significant Dangerous Occurrences in the East region, which necessitated reporting to the HSE under RIDDOR. The first was an accidental chemical release (chlorine gas) caused during an attempt by Operational Estates to consolidate COSHH products and improve conditions on site. This was picked up by staff and triggered an alarm system, resulting in attendance by the Fire Service, who ventilated the area and made safe. Thorough investigations by H&S and Estates highlighted some weak COSHH management, which is being comprehensively addressed by Operational Estates with attention to all regions, and with involvement from H&S. Good practice was also noted in the emergency response and situation management, the approach to investigation, and action planning following investigation. HSE have not expressed an interest from the information submitted to them. Secondly the gas boiler incident described in the RIDDOR section above.

Working with H&S, Surgical in East have trialled Quantitative Face Fit Testing as an alternative to Qualitative Testing, in an attempt to improve face fit rate, quality of testing, speed and convenience. This uses a particulate sensing machine to compare air inside the mask to the ambient air and give a measured protection factor for each mask tested with each individual, the aim being to focus on individual protection for the RPE user. The initial feedback from the demonstrations and testing are positive, and this is now with HONs for Surgical to evaluate and consider clinical, H&S and cost benefit. Infection Prevention have been included in conversations with H&S around this methodology.

There has been significant involvement with Mental Health & Learning Disabilities (MH&LD) during this quarter, related to Anti-Ligature Strategy, self-harm prevention and engineering requirements in mental health inpatient facilities. This has led to improvements in procedures, with further work planned. It is noted that MH&LD are liaising with colleagues in other LHBs and Trusts on benchmarking, good practice

and management tools to provide a reasoned and evidence-based strategy. H&S have been involved in discussion and risk assessment with Matrons in the Wrexham Maelor Hospital regarding anti-ligature strategy for patients being cared for on acute Wards who may be at risk of suicide. It is hoped that the liaison with MH&LD will help provide further useful information to inform this.

There are four services in East identified as potentially having staff at risk from Hand Arm Vibration Syndrome. Assessment and measurement is being managed by Occupational Health and the Advisor for Central, with local liaison and some assessment of risk being coordinated by the local H&S Advisor.

7.4 Central

The area with the highest number of data incidents (18) in central relating to incidents affecting staff reported in Q3 at the Bryn Hesketh Unit. These are predominantly due to violence and aggression incidents and ongoing support is available to this unit. There have been seven reported incidents relating to staff in the laundry, one of which has been investigated with the Health and Safety Advisor and a Root Cause Analysis carried out. During this incident, the staff member's leg was caught by the arm of the blanket-folding machine, which had been activated whilst they were removing a jammed item of linen. This was not RIDDOR reportable as the injury was minor and there was no lost time; but it was considered to be a serious near miss. Recommendations have included changes to the current isolating procedures for equipment, relocation of the control unit, the completion of a Standard Operating Procedure for removing jammed linen, staff training and a suitable risk assessment.

Four reports have now been received from HAVi our external consultant who are reviewing the levels of noise in specific areas and vibration levels of equipment which may result in Hand Arm Vibration. These include the noise and vibration assessments for Estates (Central), the Mortuary and the noise only assessments for the Laundry and Catering. A meeting has been held with HAVi to discuss the initial reports and to look at the potential use of HAVi meters/ watches within the Estates team; these will monitor the extent of exposure of staff in real time. The risk assessments for the Estates team have been completed with the manufacturer's information and these will be updated for Central with the accurate results. The report for the Estates East team is due to be provided in early January.

The noise assessment in the Laundry has shown the noise level readings were in general higher than those recorded in 2015 and the logarithmic average noise level has been calculated to be above the lower exposure action value of 80 Dba due to some higher noise zones in the work area. An initial meeting has been held with the Laundry Management Team to discuss the results and the current risk assessment will be updated with a revised action plan; both are then to be agreed in the next meeting with HAVi. The noise assessment of the catering dishwashing area has confirmed that no further controls are required for this area. An assessment of vibrating equipment is being scheduled with HAVi for the Maxillo-facial Laboratory Team where manufacturer's data for the equipment used is not available. This is

likely to commence in January 2020. HAVi have been requested to provide a summary report of all of the findings to date and a further meeting is planned for the 17th of January to plan future work and prioritisation.

8. Manual Handling

During Q3 the Manual Handling Team has provided training for BCUHB employees and external students at local universities. This has included Manual Handling Level 1 & 2, along with Modules B&C in Violence & Aggression totalling 2,310 attendees.

- 354 attended Level 2 Classroom
- 181 attended Level 2 Competency
- 12 sessions for Orientation, offering 240 places
- 601 Students from Bangor and Glyndwr Universities
- 191 Competencies completed by Manual Handling Champions
- 60 Champions completed Level 2 Champion refresher training
- 283 Level 1 Manual Handling through Mandatory Training Days
- 590 in modules B&C in Violence & Aggression.

There have been 38 ergonomic risk assessments undertaken in Q3, these were mainly from staff experiencing difficulties with their works station and requesting advice on DSE equipment. 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 Disorders (MSD); advice on their manual handling work activities takes place ensuring they are safe, reducing further risks, many staff are signposted to other agencies for advice. Patient assessments are undertaken in hospital or patients own homes, these cases are often complex and need considerable work. A database has been created to ensure a 3 month follow-up system is in place. The process will monitor the effect of the advice given and ensure equipment is used effectively.

There have been 41 Datix incidents that relate to Manual Handling, with 14 highlighted as training issues, as a result training has been offered and visits implemented by the Manual Handling Team to retrain staff in the areas identified. A deep dive was completed with Occupational Health for YGC Mortuary following the identification of a member of staff being identified as having Hand Arm Vibration Syndrome (HAVs) and advice was offered to reduce likelihood of MSD's in their daily practice.

Work continues to develop Manual Handling Champions with the aim to have 1 Champion per 10 members of staff following an intense 2-day training programme. The program will improve the standard of manual handling as the Champion will work with their peers in every day manoeuvres with patients and in effect reduce injuries and improve sickness from MSD's, along with improving the manual handling given to patients. Champions are to work closely with their Housekeeper, to ensure all disposable equipment is replaced and always available along with creating an inventory for all manual handling equipment available in their environment with the

assistance of the Manual Handling Team. A new 2-day Champions course will commence in January 2020 offered in the three main sites each month with 36 places being available. A bespoke Porters only Champions course has been offered to Estates & Facilities, however this was not completed in West and Central. The session did take place in East, with seven attending and they will be followed up in the New Year to review progress.

Work continues with the Manual Handling action plan with work on the Policies being a priority. Close communication has taken place with the All Wales Manual Handling Group to ensure the Manual handling Passport is utilized to guide the updated policies. Due to the findings from the gap analysis which identified poor knowledge of legislation, policies and procedures in manual handling, Level 2 Manual Handling training will include a practical session and classroom theory session.

An SBAR was created for the manual handling training team raising the concern regarding the lack of accreditation in training certification of team members. Prices are being sought from three providers to provide specific training to ensure competence of the Team. An external training provider is being sought for implementation in the New Year.

9. Training

The Corporate Health and Safety Team undertake a variety of internal training. There were 8 managing safely 2 day courses with 65 staff attending, a significant increase in attendance on previous months. There were 8 attendees on the risk assessment COSHH courses (see below for details).

Training Oct 2019-Dec 2019	East	Central	West	Number of Sessions	Number of Attendees
Managing Safely					
No of Sessions	3	3	2	8	
No of attendees	9	27	29		65
Combined Risk Assessment & COSHH					
No of Sessions	1	0	0	1	
No of attendees	8	0	0		8
RIDDOR Awareness					
No of Sessions	0	0	0	0	
	0	0	0		0
			Total	9	
			Total		73

Course Subject	Number of sessions	Number of staff trained	Number of Cancelled Sessions
Managing Safely 2 Day Course	**8**	**65**	**1**
Risk Assessment & COSHH ½ Day	**2**	**8**	**1**
RIDDOR Awareness Training 1 ½ hrs	**3**	**0**	**3**
Total	**13**	**73**	**5**

10. Security
10.1 Background

Security Management within BCUHB has historically been the responsibility of a number of services and there has been a number of attempts to centralise the system over many years. In 2017, The Executive Medical Director of BCUHB commissioned Prof Peter Lepping to prepare a report to inform BCUHB how to reduce and prevent patient and visitor violence (PVV) against staff across all services of the BCUHB. The report included a review of the available evidence-based literature and estimates of the current level of PVV in North Wales and its impact on staff. It concluded that there was underlying risks to staff with a significant costs incurred due to lost time incidents and increased sickness absence rates. A subsequent security review in August 2019 identified a shortfall in systems and processes to provide assurance that security was effectively managed in all service areas. The level of security management did not equate to the expanding scope and increasing complexity of the security agenda with a lack of a clear security framework or designated post for Head of Security or staff within BCUHB, a clear management structure was not clearly evidenced within BCUHB.

BCUHB currently deals with approximately 3,746 Violence and Aggression (V&A) cases per year and this is supported by a part time staff member. This number has increased significantly year on year and is expected to continue to do so. There is a contracted member of staff (part time) from North Wales Police who works to reduce demand on Police Services. His contract will finish in March 2020. The number of violent cases reported to North Wales Police including physical assaults for the period 1st April 2018 to 31st March 2019 was 1,964, at this juncture it is expected that this figure will show an increase by 31st March 2020.

The manual handling team currently provides training to all new starters to the organisation at induction on a monthly basis. Additionally, further mandatory training is conducted across the health board to facilitate the needs of 17,000+ employees in addition to patient handling and movement and the V&A related training including

Restrictive Physical Interventions (RPI). RPI (historically known as Control and Restraint) in mental health is delivered specifically to their own staff. There are Estates maintenance people who, without formal authority, act as security with limited formal training, this poses a risk to patients and BCUHB as a body corporate.

10.2 Findings

Following the preliminary security review, in August 2019 an appropriate action plan has been compiled to address the areas of concern identified in order to ensure a more comprehensive security function across the organisation and establish a robust and compliant security management process. This includes the development of policies, protocols, procedures, guidelines and instructions to ensure the security function can be appropriately established and therefore further improved.

This has included significant work on the security management plan, particularly in the development of draft security policy, which was previously not present within the Health Board. This policy has now been drafted and disseminated for comment. All comments are being collated and the Policy will be completed by March 2020. Furthermore, it has been identified that the Violence and Aggression Case Managers role and responsibilities within BCUHB has evolved significantly with a more prominent focus on security related matters. This was found to be more significant since the departure of previous security related employees within the organisation who have not been replaced. A revised V&A case worker job description has been drafted to fit the role and its responsibilities of the post holder.

Other posts within the organisation identified as conducting ‘security related’ actions and responsibilities within BCUHB were realised within the estates function. Initial discussions with Director of Estates have provisionally identified those staff members would be best re-deployed within a recognised security function falling under the command and control of the Associate director of Health, Safety and Equality. Further discussions will look to be held in early 2020 to establish an appropriate way forward and a date for this action to be agreed and to be implemented.

Substantial work has been carried out to develop a draft Closed Circuit Television Policy which, as with the Security Management Policy, has been disseminated to appropriate key stakeholders for comment. This has proven to be an extensive and difficult task particularly regarding recent changes to The Data Protection Act (DPA) 2018 and General Data Protection Regulations (GDPR) 2018. This was further exacerbated due to not knowing the full extent of CCTV assets across the organisation. Hardware, including cameras, hard drives and storage devices, were not comprehensively recorded or registered. Whilst a piece of work by estates has been conducted to realise this deficiency, there are still gaps of information that need to be confirmed to completely establish what assets are being used in all service areas to confirm their compliance with the aforementioned legislation.

There is a serious concern regarding the current practices and procedures for the downloading and disclosure of images to third parties. Whilst protocols do exist, they have proven to be inconsistent across the organisation and, in the main, non-

compliant with statutory requirements. Local advice and direction has resulted in limited establishment of appropriate registering and audit trails of images, this has seen in some cases CCTV being used in disciplinary procedures. It is apparent that further dialogue and a more collaborative approach to completing the CCTV operating procedures will need to be undertaken with Information Governance to ensure appropriate documentation is developed that meets requirements of GDPR 2018. Whilst producing the CCTV policy it was confirmed that those persons within the organisation having access to CCTV systems had little or no training in the use and management of CCTV systems. A provisional training needs analysis has been conducted with a view to determining what training is required for compliance with DPA / GDPR and identifying suitable providers and associated costs.

External security services remain with Samson Security providing that service. Where the review identified the current service of limited hours across three acute sites, it was further identified that Ysbyty Gwynedd fund additional hours from their budget to meet what they perceive to be their additional needs outside the agreed times. This is a local arrangement with Samson.

A subsequent updated security specification has been drafted to consider the provision of 24/7 security service across the organisation. This has been distributed to appropriate key stakeholders and will look to be discussed early 2020 as a potential option. Meetings have taken place with Samson Security, however these have been less frequent as initially agreed and has had limited engagement from Hospital Management Teams. Recent developments and departure of Samson Regional Manager have been a factor however, a new Regional Manager has been appointed and meeting has been arranged for January 2020.

Meetings have been conducted with Samson at Executive and Associate Director level to discuss the contract, the management of and financial aspects particularly relating to Ad Hoc requests for additional security provision. This identified an issue with invoices and as a result further engagement will be conducted with shared services/procurement to fully realise the financial elements and account management of the contract. It is apparent the splitting of Estates/Assets and Patient, Staff and Visitors (PSV) is problematic as the priority should be focused on violence against staff and this will be addressed early 2020.

Key issues to note as part of security review requiring further work include:

- Establish full asset register of CCTV hardware including;
  Cameras (types/standard/resolution)
  Monitors (Positioning and location/registered and authorised viewers)
  Hard drives/recording devices (Compliant with DPA / GDPR)
  Training standards (SIA or other organisation accredited)
  Register of third parties with access to systems and authority to record/download
- Agreement of security specification for organisations needs
- Transfer of estates staff with security responsibilities to H&S function
- Development of appropriate security related risk assessments

- Appropriately staffed security service in BCUHB
- Provision of an appropriate contract for external support 24/7 in high risk areas of BCUHB

10.3. Security Summary

Currently BCUHB have established that the existing security provision by external provider is inadequate highlighted by the lack of physical resource at each acute hospital and the level of numbers of incidents recorded. A sole security guard for the support of patients, staff and visitors over a limited period does not address nor facilitate the needs of the acute hospital nor does it afford support in the event of having to de-escalate a situation or in the restraint of an offender, be they patient, staff or visitor. The role of the V&A Case Manager has evolved extensively over the years with a much greater demand for support and resource both from a security perspective as well as support to staff post incidents of violence and aggression. There have been extensive changes to the Data Protection Act and General Data Protection Regulations it has become apparent that the use and management of CCTV within BCUHB is of serious concern including the level of competence and training of staff CCTV responsibilities.

11. Violence and Aggression

The numbers and volume of V&A and Security related issues is increasing along with hate crime and violence, both verbal and physical assault is a serious area for concern and continues to increase across the health board. Whilst there is a clear commitment to promote security, married with desire of staff to have support, direction and guidance there is limited capacity to deliver this service. The legislative framework and an increased focus on security through the all Wales, regional and partnership working has increased demand in key areas such as:-

- Evidence identified through the security gap analysis
- Security Policy requiring implementation
- Increased public interest, scrutiny and challenge
- Sickness absence rates relating to stress anxiety and depression at 29.9% which may relate in some cases to V&A
- Moral and ethical duty to protect the workforce from violence.
- Legislation increasing through the obligatory response to crime.

Examples of incidents include Cemlyn Ward, Cefni Hospital which remains the highest reporting area within BCUHB with 54 incidents in Q3 however this quarter has seen a reduction of 8 incidents from the 62 that were reported in Q2. Following discussions with Matrons of Cefni, Bryn Hesketh & Gwanwyn, it was decided that contact be made with the Consultant Nurse (dementia care specialist) to visit each unit to assess acuity using NPI (Neuropsychiatric Inventory Questionnaire) and Dementia Rating Scale. This is to provide a clearer picture of the client group on each unit and then review the DATIX / Safeguarding reports, use of Bank staff, supervision/PADR compliance. The V&A Case Manager has, in partnership with the North Wales Police Demand Reduction Inspector, seconded to BCUHB, attended North Wales Police HQ and delivered 4 training and awareness sessions of Obligatory Responses to Violence in Healthcare (ORV) to the following;

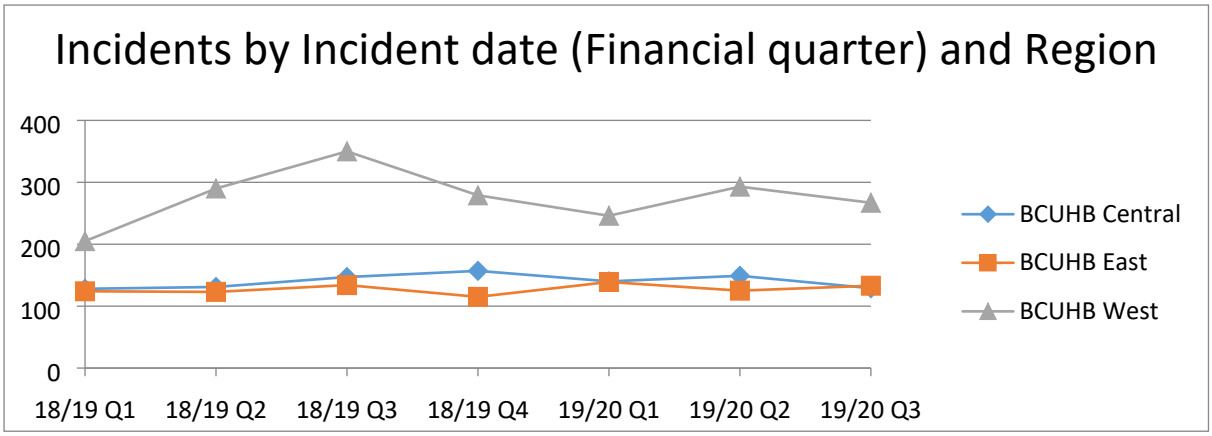
Role	Police Officers	Sgt	PCSO	Others (police staff)
Numbers	39 (1 detective)	3	8	13

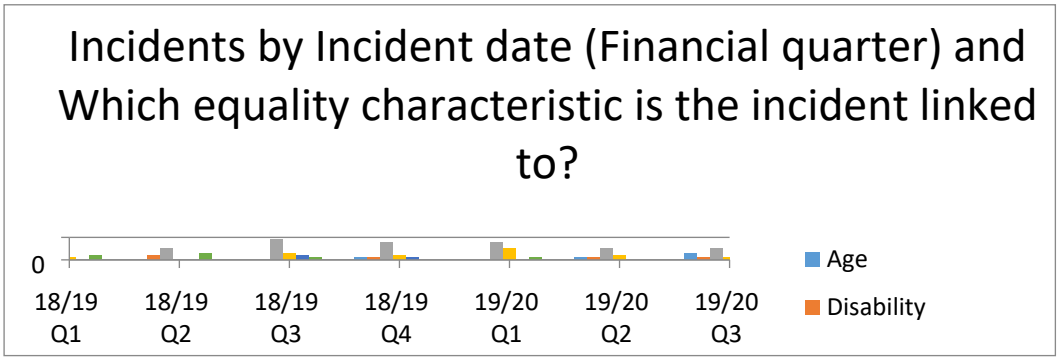
The sessions have focussed upon greater partnership working in respect to NHS staff workplace assaults/abuse and the ORV agreement. Feedback from North Wales Police has thus far been positive and has led to better and more structured communication/contact with investigating officers who respond to staff workplace assaults and the V&A Case Manager. Subsequently, an officer within the central area has now been tasked with developing a "Preventative Policing Plan" to better inform police officers regarding aspects of the Obligatory Responses to Violence in Healthcare (ORV). Additional training sessions are scheduled for 2020.

Regrettably at this juncture, little progress has been made with Mental Health Division following attendance at Mental Health Policy Group in embedding the ORV agreement. Of note, there has been one occasion where police have requested information in accordance with ORV whereby mental health services were unable to supply due to lack of knowledge leading to delay in assault investigation. The All Wales Case Management meeting will be held in early January 2020 where each Health Board will be expected to return to the NHS Anti-Violence Collaborative regarding progress with implementation of ORV. It is worthy of note that BCUHB has progressed further than other health boards in the NHS which is positive.
The data below describes "Incidents affecting the staff/Abusive, violent, disruptive or self-harming behaviour" as listed on Datix.

V&A Incidents			
18/19 Q1	457	19/20 Q1	523
18/19 Q2	544	19/20 Q2	553
18/19 Q3	631	19/20 Q3	529
18/19 Q4	548		
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	19/20 Q3	31
18/19 Q4	50		

Area/Division	19/20 Q1	19/20 Q2	19/20 Q3
Division of Mental Health and Learning Disabilities	259	257	287
Specialist Medicine (Secondary)	99	126	91
Primary and Community Services (Area)	80	67	60
Children and Young People (Area)	11	32	17
Surgery (Secondary)	29	31	29
Therapies (Area)	10	8	12
North Wales Community Dental Service (Area)	3	7	6
Radiology (Secondary)	3	6	5
Women's and Maternal Care (Secondary)	4	5	4
Anaesthetics, Critical Care and Pain Management (Secondary)	1	4	9
Estates and Facilities (PandP)	6	3	3
Primary Care (Area)	5	3	2
Office of the Nurse Director (Corporate)	0	2	0
Cancer Services (Secondary)	2	1	2
Therapies and Health Science (Corporate)	0	1	0
Strategy (PandP)	8	0	0
Finance (Corporate)	1	0	1
Pathology (Secondary)	1	0	1
Pharmacy and Medicines Management (Area)	1	0	0
Public Health (Corporate)	1	0	0
Workforce and Organisational Development (Corporate)	1	0	0





V&A Management of Cases.

Case	Region	Division	Investigation Status.	Notes: Information on current status
Assault (DB1)	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. Completed 18 PC's & 2 Sgt's have been supplied with required information session.
Assault (DB2)	West	Mental Health	No Further Action due to patient's mental health condition.	As above and in addition taken to Mental Health policy group. Completed 18 PC's & 2 Sgt's have been supplied with required information session. No progress with mental health division.
Assault (DB3)	West	Mental Health	On-going investigation	Awaiting police update. Police unable to locate suspect-address supplied by BCUHB-Suspect thought to be in Devon area.
Assault (DB4)	East	Mental Health	On-going investigation	Police are attempting to locate the alleged offender. Police continue to search for suspect.
Assault (DB5)	East	Mental health	On-going investigation	After delay consultant agreed to supply information to police. Awaiting police response. Police arranging interview with suspect-awaiting police update.
Threats to kill (DB6)	East	Mental health	On-going investigation	Victim has arranged to provide statement to police but failed to provide. Medical workforce informed for support. Police report difficulties with obtaining victim statement-Victim does not wish to engage with case management service. Awaiting police update.
Assault (DB7)	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.

				No contact from victim- victim has given statement to police progressing –awaiting update.
Threats (DB8)	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. Court Date 20&21 Dec. Case set for retrial due to Jury not being able to agree result. De-briefing planned to explore how ward can engaged in ORV process at earlier time and to support staff attending court prior to date as it transpired six staff attended court and some were clearly unprepared to give evidence. Consultant attended court-had ORV process been followed there would have not been a need for consultant's attendance. Meeting arrangements to be made with Mental health medical director to explore solutions.
Threats (DB9)	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. Consultant responds following 3 months delay- information supplied to police awaiting police update.
Damage (DB10)	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. Awaiting response from consultant (on Leave)
Racial abuse (DB11)	Central	Mental Health	Closed	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. Following some good partnership working and excellent assistance from mental health, ward police were able to interview patient. No further action to be taken due to no third party witness. Staff victim understandably disappointed but pleased that robust investigation conducted and support which led to speedier conclusion.

Indecency DB (12)	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.

Incidents reported to V&A Case Manager Q3				
Assault (DB13)	Central	CMHS	Closed	No further action due to patient age, mental health, no injury sustained. Staff pleased full police investigation was conducted. De brief with ward conducted.
Damage (DB14)	East	Mental health	On-going investigation	Police awaiting ward manager to supply statement
Assault (DB15)	West	ED	On-going investigation	Patient assaulted police officer in clinical area. No BCUHB staff victims- potential witnesses.
Public order (DB16)	West	ED	On-going investigation	Male patient charged with a racially aggravated Public Order offence and committed to Crown Court for sentencing.
Assault (DB17)	West	ED	Closed	8 weeks prison term. Fast tracked due to patient having no fixed abode.
Assault (DB18)	Central	ED	On-going investigation	Police statement taken from victim. Awaiting statement to be taken by BCUHB witness
Assault (DB19)	Central	Mental health	On-going investigation	Ward failed to make contact with Case manager until 5 weeks after incident. ORV process not followed. Delays in investigation process.
Administer noxious substances DB(20)	Central	Mental health	On-going investigation	Ward take 2 days to inform Case manager. ORV process not followed. Delays in investigation process. Evidence lost due to ward staff & management not being aware of ORV. Suspect interviewed by police & on bail. Awaiting forensic examinations.
Assault DB (21)	West	Mental health	On-going investigation	ORV process not followed. Police contact case manager rather than ward to request information as direct result of information session following lesson learnt (DB1 &DB2).Relevant information now supplied to police-awaiting police update.
Public Order DB(22)	Central	ED	On-going investigation	ORV process not followed. Police contact case manager rather than ward. Incident yet to be reported on Datix. Case manager able to trace staff involved and statement now supplied to police.
Assault DB(23)	West	Mental health	Closed	Ward manager reported incident to police despite staff member not wishing to pursue formal complaint of assault, as she believed patient was unwell and “assault” was result of accident. Advice supplied to ward manger.

Assault DB(24)	West	Mental Health	On-going investigation	Case Manager to meet staff victim. ORV process followed
DB (25)	West	Mental health	On-going investigation	ORV process not followed-Case Manager inform 4 weeks after event. Case Manager to meet staff victims.
DB(26)	West	Mental Health	On-going investigation	Case Manager to meet staff victim. ORV process followed
DB(27)	West	Mental Health	On-going investigation	Case Manager to meet staff victim. ORV process followed

12. North Wales Police Demand Reduction Inspector

Since the North Wales Police Demand Reduction Inspectors initial report for Q2 a meeting has been conducted with the Executive Director Workforce and Organisational Development and Associate Director of Health, Safety and Equality where it was agreed Demand Reduction Inspector would work to Head of Health and Safety. The Head of H&S will develop further the V&A Case Manager and the Police Demand Reduction Inspector roles and defined responsibilities to better establish operational efficiencies.

The below statistics illustrate the demand placed on North Wales Police as a result of calls from the three District General Hospitals within the Betsi Cadwaladr University Health Board.

As can be seen from *Figure 1*: the cumulative Q3 figures for calls from the three district Hospitals to North Wales Police is 157 with Wrexham Maelor being the biggest demand contributor to North Wales Police.

Figure 1:

Hospital Incidents

Hospital	UNKNOWN	Wrexham Maelor	Ysbyty Glan Clwyd	Ysbyty Gwynedd
Event Count	1	157	107	118

Figure 2: Represents the types of calls that Police are responding to at the three DGH's. 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
2019-10		65	44	49
2019-11		60	43	41
2019-12	1	32	20	28
Sum:	1	157	107	118

Top 10 Incident Types

Initial Sub Type	Initial Type	Event Count
CONTACT_RECORD	ADMIN	81
CONCERN_SAFETY	PSW	77
MISPER_MED_RISK	PSW	27
COMMON_ASSAULT	CRIME	22
ABAN_CALL	ADMIN	21
SUS_CIRCS	PSW	21
MESSAGE_DELIVERY	ADMIN	15
ASB_NUIS_LOW	ASB	12
RTC	TRANSPORT	12
PUBLIC_ORD_CRIME	CRIME	11
	Sum:	299

As in the previous quarter a review of BCUHB calls to the Police has identified that there stilll remains occassions when inappropriate calls are made to the Police requesting assistance with various clinically based patient incidents. Appropriate

discussion with line managers and members of staff have been carried out to discuss the issues reported and provide advice on lessons learnt. The aformentioned discussions have also been recipricated from a Police perspective where issues have arisen due to Police actions relating to visits by North Wales Police officers to BCUHB premises .

During Q3 the following activities have been conducted;

- In conjunction with the BCUHB V&A Case Manager, reviewed and advised on on-going Criminal investigations where Health Board staff have been the Victims of Crime.
- Together with the BCUHB V&A Case Manager, delivered Obligatory Response to Violence training to North Wales Police Offciers and support staff including Mental Health Clinicians who are to be based in the Police Control room.
- Worked with BCUHB Safeguarding Team and partners to develop and implement a patient on patient protocol on behalf of the North Wales safeguaridng board .
- Obtained a Community Protection Notice in relation to a frequent attender at two acute sites in North Wales.
- Security audits and provided relevant advice following requests from business areas and datix submissions from staff .

13. Gap Analysis

The action plan (Appendix i) is now being implemented with significant amount of work being undertaken by a number of key players including Estates/Facilities, Occupational Health, Radiation, EBMA, Manual Handling Team, H&S, V&A Case 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. This has included significant work on the Control of Contractors (CofC), with a draft procedure presented to the Senior Estates Officers at a recent group meeting. It was identified that at least three full time equivalent posts may be needed to administer the system. Software programmes are available, some used by other NHS trusts, that provide cloud based document control, induction information, site specific information and booking in controls and following one recent demonstration, if introduced, will provide a level of assurance to the board that any current or proposed manual system could never achieve based on our topographical layout. The Driving at Work Policy has been reviewed and a draft risk assessment relating to deliveries and unloading areas is being implemented. Meetings are being held with colleagues from Expenses, Lease vehicles (Shared Services) and pool car use to ensure all aspects of the policy can be implemented. This includes enquiring if the current expenses company Selenity have the facility to control the ‘Duty of Care’ process (which is currently in place for expenses and lease car holders) to include pool car users as they are the risk group and account for over 5 million of our business miles each year. There is ‘possibly’ a draft All Wales Driving at Work policy and this needs to be followed up. One large

piece of work is to identify the location / owner of every pool car and the division / function responsible within BCU as this is currently unknown.

The asbestos action plan has been updated following a meeting with Estates. The Permit to Work system has been out on trial, with changes to be agreed at the next Asbestos Management Group (AMG). The Estates team have had a demonstration of the MiCAD system and the asbestos re-inspections has commenced. An initial meeting to progress the actions required for Pressure Systems has been agreed and will take place in January 2020. Estates have confirmed that the Competent Person for pressure systems is outsourced and that this person undertakes the written scheme of work, hold the asset registers and undertakes the inspections. The identification of teams who are using vibrating equipment has been completed (within current knowledge). These teams have all been notified of the requirement to complete a risk assessment and a template risk assessment has been provided. The Health Surveillance Standard Operating Procedure for HAVs has been drafted and work is being undertaken to complete the draft Policy.

A demonstration was held for the Sypol COSHH management system in December. This system is currently being considered for implementation across the Estates team, with consideration for this to then be utilised across BCUHB. This will be a significant step for compliance for the Estates Team and management of substances across all service areas. The DSE actions are progressing with the flow chart for ordering new and replacement equipment being completed, a new standard office chair being sourced by procurement to ensure safe and consistent purchasing is undertaken. The return to work procedure has been completed and work has commenced on the DSE Policy and risk assessment template.

The Work at Height Regulations 2005, The Control of Noise at Work Regulations 2005 and The Management and Provision of Work Equipment Regulations 1998 are being reviewed. The H&S Team have identified what procedures, processes and training is currently in place for managing these hazards; currently there are many variations on similar themes. Based on best practice the H&S Team are working to develop pan-BCUHB policies and guidance to ensure that a standardised process is in place for their management. For instance, a draft noise risk assessment template and process is being trialled via the BCUHB Leads with the plan to implementing a new BCUHB policy by the end of January 2020. In relation to Waste Management, the development of the pan-BCUHB Environmental and Sustainability Strategy is being implemented.

In support of compliance with the Ionising Radiation Regulations, ‘local rules’ are being further developed and audits undertaken at local community sites. RIDDOR reporting/Root Cause Analysis (RCA) processes are being further developed with the Associate Director of Patient Safety and Experience to develop a new stand-alone, pan-BCUHB Incident and Investigation Policy. A review of training to develop pan-BCUHB Health and Safety Champions is being undertaken to strengthen and promote health, safety and welfare throughout the organisation. A meeting has also

been arranged with our Trade Union Safety Representative partners to discuss strengthening partnership working/approaches in all aspects of health and safety.

A draft Policy is being developed for Construction (Design and Management) Regulations 2015, as the LHB does not currently have a Policy. CDM is concerned with safe management of all construction projects and safe operation throughout the lifespan of the construction. There are specific roles, each having specific duties in law.

There are 3 main agencies within BCUHB commissioning construction and installation projects:

- Operational Estates
- Capital Planning
- Informatics

There may be a number of other specialist services commissioning construction work, and the Policy aims to raise awareness and provide guidance on correct management for all services commissioning or undertaking construction work. Awareness and procedures are varied – Capital Planning and Operational Estates have the greatest awareness and procedures which fit well with CDM, and H&S are in consultation with these services. Outside of these services awareness of CDM is very low and significant further consultation will be required to introduce and enact correct procedures. This may incur a training need for identified staff, and template tools to be able to manage projects safely and effectively with minimal risk to construction workers, staff and service users. It is anticipated that the Policy will be released within Q4, with implementation and development work continuing throughout 2020.

H&S have reviewed the ES02 Policy for the Management of Safe Water Systems and Procedure in line with HSE Approved Code of Practice L8 – “Legionnaire’s Disease – the control of legionella bacteria in water systems”, and are also now attending the Water Safety Group. While the Policy and Procedure are robust and require only minor updates (comments have been submitted to Estates), there are risks associated with poor representation at the Water Safety Group, which was not quorate at its last meeting due to lack of Clinical and Microbiology representation. John Peet has written to group members to emphasise the importance of correct representation at this group. The Group will escalate the risk if this is not addressed.

EBME and the Medical Devices Group had escalated that eight hoists on the Ysbyty Glan Clwyd site were now obsolete and non-compliant with the statutory requirement for Thorough Examination as part of the Lifting Operations and Lifting Equipment Regulations (LOLER). EBME had been pursuing funding since July 2019 however this had not been successful. This risk was escalated through the YGC H&S Meeting and to the January Strategic OH&S Meeting. It has now been identified that funding has now been confirmed and the hoists have been ordered.

Key issues to note as part of the gap analysis requiring further work include:

- 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.
- Electrical safety.

14. Occupational Health

The service have commenced working towards the Safe Effective Quality Occupational Health Standards (SEQOHS) standards, which is the national recognised quality mark for Occupational Health. They are continuing to self-assess and benchmark with the SEQOHS and are engaged in gathering the required evidence. Substantial amounts of evidence including BCUHB policies, local policies and formal and informal feedback will be required. To date the service is approximately 65% complete. When the self-assessment process is completed, the uploaded evidence will be assessed by SEQOHS accreditors and any recommendations acted upon before a formal assessment can be completed. The Team are aiming to complete and upload the evidence for consideration by the assessors by the end of February 2020. It is anticipated that the assessors will then take 3 months to review the evidence during which time they are likely to make recommendations before proceeding to the assessment phase likely to be in July 2020.

15. Health & Safety Prosecutions by the HSE

It is worth noting that the HSE continues to increase fines against organisations who are non-compliant with the law. The case described below is in relation to a prosecution for failing to comply with an enforcement notice:
Westminster Magistrates' Court heard that, between May 2018 and February 2019, the Health and Safety Executive (HSE) carried out a series of inspections at a construction site at South Woodford, London following health and safety concerns raised at the site. During the inspections, the site manager and company Director Mr Tahir Ahmed was served with two Prohibition Notices and his company, 'All Type Electrical and Building Limited', were served with two Prohibition Notices and two

Improvement Notices. All Type Electrical and Building Limited's Improvement Notice for competent advice was not complied with. The company pleaded to breaching Regulation 15(2) of the Construction (Design and Management) Regulations 2015; and Section 21 of The Health and Safety at Work etc. Act 1974. The company was ordered to pay a fine of £60,000 plus a surcharge of £170 and full costs of £5,216.46

Mr Ahmed pleaded guilty to breaching Section 21 of The Health and Safety at Work etc. Act 1974. He was sentenced to 18 weeks' imprisonment suspended for 12 months, 180 hours of unpaid work, and was ordered to pay a surcharge of £115, and full costs of £5,060.69.

Prosecutions undertaken (provisional figures for 2018/19)

- 394 cases were prosecuted by HSE
- 364 of the 394 cases had a conviction secured (for at least one offence) where a verdict was reached in 2018/19; a conviction rate of 92%.

Sentencing outcomes (provisional figures for 2018/19)

- £54.5 million in fines were issued to duty holders found guilty of health and safety offences. The average fine per case was £150,000
- The single largest fine in this period was £3 million and a total of 36 cases received fines of £500,000 or more.
- 11,040 enforcement notices were issued by HSE and local authorities

Prosecutions in 2019
In 2019 the largest fine was following a refinery explosion which killed four workers and injured a fifth. Chevron were fined £5 million with costs of £1 million.

16. Conclusion

This report indicates that the systematic review of H&S Management will require continual work with the action plans for 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 but this will take considerable time to embed. A fundamental shift in safety culture is needed and an effective management system implementing based on the HSE framework plan, do, check, and act.

Cyfarfod a dyddiad: **Meeting and date:**	Quality, Safety and Experience Committee 28th January 2020
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Patient Safety Report – Q2 and Q3 2019/20
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Mrs Gill Harris, Executive Director of Nursing and Midwifery/Deputy CEO
Awdur yr Adroddiad **Report Authors:**	Matthew Joyes, Assistant Director of Patient Safety and Experience Kath Clarke, Head of Patient Safety Carolyn Owen, Head of Patient Experience Anne Hall, Head of Complaints Diane Read, Head of Quality Improvement
Craffu blaenorol: **Prior Scrutiny:**	Review by the responsible director
Atodiadau **Appendices:**	Appendix 1 – Q2 and Q3 report

Argymhelliad / Recommendation:

The QSE Committee is asked to:

1. Note specific highlighted areas: overall patient safety incident reporting, Never Events, notable inquests (including 1 Prevention of Future Death Notice), overall complaints, Section 16 PSOW Report, upcoming significant claim and the safety alert non-compliance position.
2. Be aware of the possible triangulation between increase patient safety incidents, complaints, OTS and litigation and the further analysis into this now underway.
3. Note the ongoing work of the quality improvement collaboratives and planned improvement work: including review of various Health Board processes and implementation of the Datix IQ Cloud.
4. Note the increase in Welsh Risk Pool costs.
5. Receive this report and provide feedback on its evolved content and layout.

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

Sefyllfa / Situation:

The Quality, Safety and Experience Committee is the delegated Health Board committee with responsibility for seeking assurance on patient safety. This report provides the committee with information and analysis on significant patient safety issues arsing during the quarter under review, alongside longer-term trend data, and information on the safety improvements underway. This report replaces the former CLICH Report and as it is the first iteration, covers a period of two quarters.

Cefndir / Background:

This new format report is designed to offer improved information and analysis in relation to patient safety, in order to improve the assurance received by the committee. The period under review is

primarily July 2019 to December 2019 (inclusive); however, longer-term data for the previous 30 months (allowing period on period comparison over two years) has been included in the graphs to provide a better longitudinal view and to enable the use of statistical process control (SPC) charts.
Asesiad / Assessment & Analysis
Assessment and analysis is included within the report including a breakdown of incidents by division/site, details of the most common type of reported serious incidents and a high-level summary of identified learning.

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Appendix 1

Patient Safety Report Q1 and Q2 2019/20

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

1. INTRODUCTION

1.1 Patient safety is focused on the prevention of harm to patients by improving the way in which care is delivered so that errors are prevented, learning occurs from the errors that do occur and a culture of safety is fostered that involves health care professionals, partner organisations, patients and their carers/families.

1.2 This report provides the Quality, Safety and Experience Committee with information and analysis on significant patient safety issue arsing during the quarter under review, alongside longer-term trend data, and information on the safety improvements underway. The aim is to provide the committee with assurance on the Health Board's work to improve patient safety. This report replaces the former CLICH Report and as it is the first iteration, covers a period of two quarters.

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

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

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

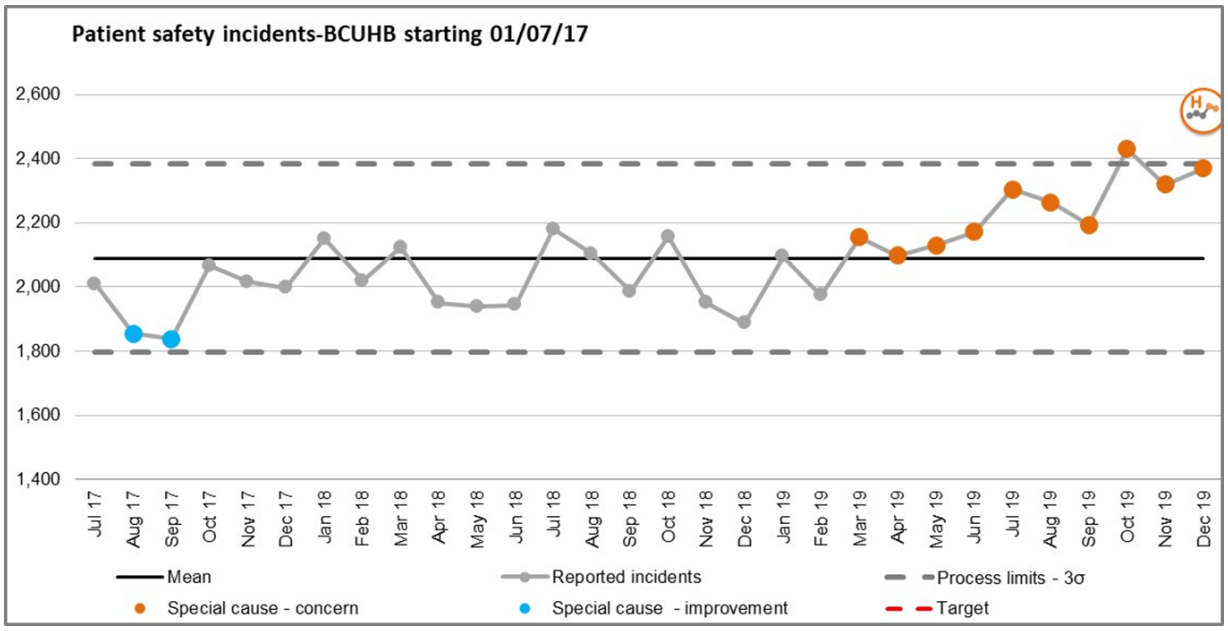
Variation			Assurance		
					
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling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

1.5 There are two sections of this report that may include incidents that affect employees and members of the public, as well as patients; these are serious incidents and liability claims. As the Patient Safety and Experience Department manage these matters, they are included in this report to provide an overall view of these areas; however, relevant information is also included in the Occupational Health and Safety Report.

2. PATIENT SAFETY INCIDENTS

2.1 Patient safety incidents are any unintended or unexpected incidents, which could have, or did, lead to harm for one or more patients receiving healthcare. Incidents are reported on Datix, the integrated risk and safety management system used by the Health Board.

2.2 During the two quarters under review, 13,878 patient safety incidents were reported. The data for the previous 30 months (allowing period on period comparison over two years) shows a statistically significant shift which requires further review (and is now underway). This shift reflects a similar shift seen in complaints, and possibly partly seen in litigation and On the Spot (OTS) concerns, however a link cannot be drawn until the further analysis mentioned is complete. The shift is not reflected in the number of serious incidents.



2.3 The Patient Safety and Experience Department is planning a comprehensive review of the incident process (including serious incidents) and this will be conducted in co-production with divisions and other stakeholders. This work is planned to commence in March 2020 (due to the various other reviews underway as detailed in this report). Running parallel to this will be the development and implementation of the new Datix IQ Cloud system and implementation of the anticipated Duty of Candour and a new national Serious Incident Framework (currently under review by Welsh Government).

3. SERIOUS INCIDENTS

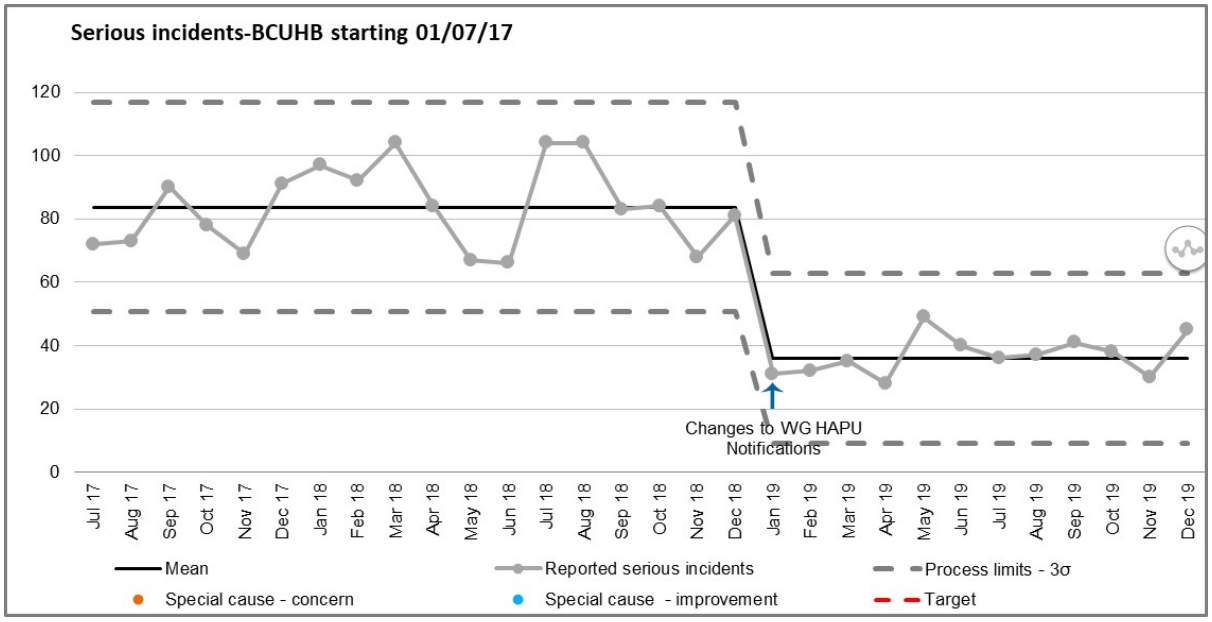
3.1 A serious incident is defined as an incident (not exclusively a patient safety incident) that occurred in relation to NHS funded services and care resulting in:

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

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

- Grade 0 - Concerns currently and commonly referred to as a 'no surprise' and/or where it is initially unclear whether a serious incident has occurred will be graded 0. Unless further information is received, the Welsh Government will automatically close the incident after 3 days and no further correspondence with the Welsh Government is required.
- Grade 1 - It is expected that a comprehensive investigation will need to be completed by the Health Board within 2 calendar months. In order to close this incident the Welsh Government require confirmation that an appropriate investigation has been undertaken, has been reported to an appropriate committee, an action plan developed and where relevant has identified any actions for wider learning and dissemination. A closure/update report form is completed and submitted for this purpose.
- Grade 2 - This will follow a similar process to the above. A comprehensive investigation is required, and in some cases the incident may be referred for independent external review by Health Inspectorate Wales (HIW) or another regulatory body. Grade 2 incidents will be subject to ongoing monitoring by Welsh Government and final agreement through its Patient Safety Committee that the incident has been investigated appropriately and thoroughly before closure. Examples of such incidents could include mental health homicides, maternal deaths, clusters of similar incidents and never events.

3.3 During quarter 2 and quarter 3, 227 serious incidents were reported.



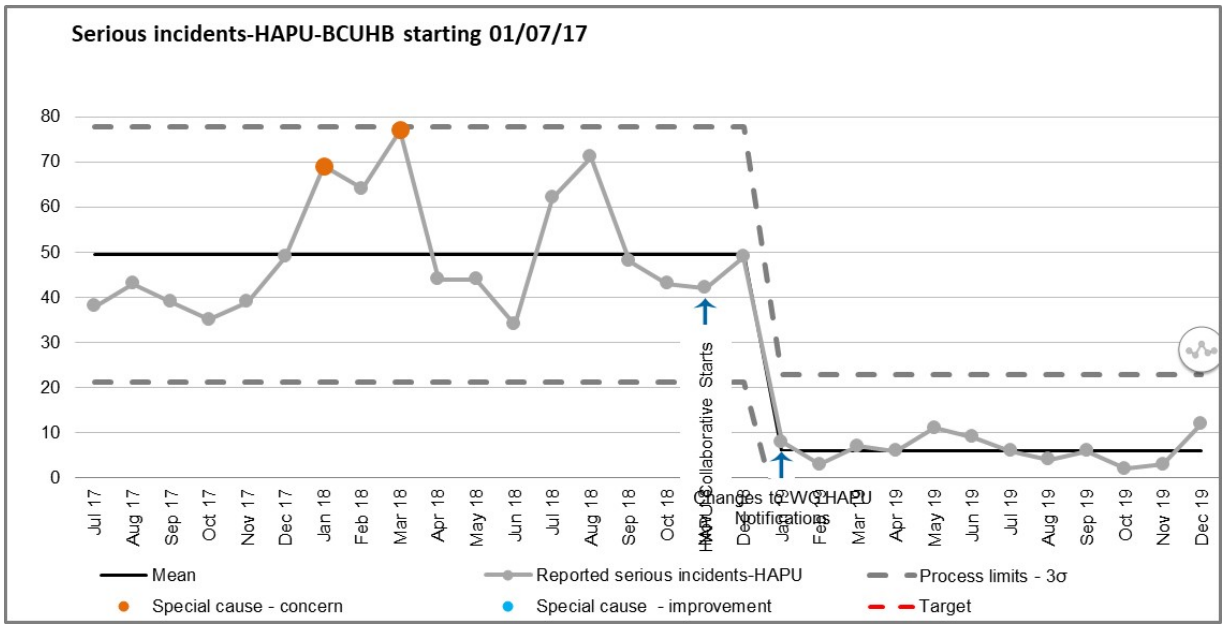
	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Q1 19/20	Q2 19/20	Q3 19/20
East Acute	33	31	47	27	41	20	20	13	23	15
Central Acute	23	20	18	18	8	13	7	7	12	11
West Acute	16	26	34	19	24	24	15	22	9	5
East Area	56	51	69	44	54	48	6	12	6	9
Central Area	48	46	55	44	74	47	8	12	12	15
West Area	19	13	31	25	39	27	4	5	7	5
Women's	4	1	4	5	8	2	2	1	4	2
Radiology	0	1	0	0	0	1	0	0	2	0
MH & LD	50	56	36	41	53	57	39	47	48	55
								Changes to WG HAPU Notifications in Jan 2019		

3.4 The most common categories of reported serious incidents include:

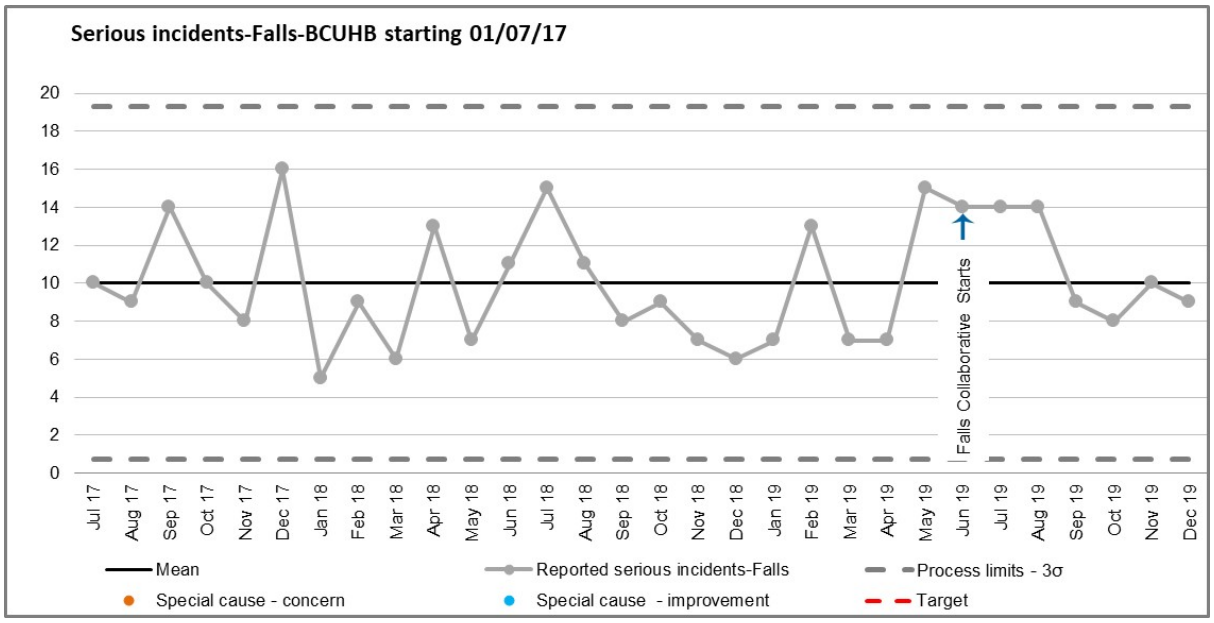
- Unexpected death whilst under the care of a health professional – the significant predominance of these incidents are deaths reported by the Mental Health and Learning Disability Division who are required to report all unexpected deaths of patients open to services. This is regardless of whether the death was contributed to by healthcare services (as per the national Serious Incident Framework);
- Healthcare Acquired Pressure Ulcer (HAPU);
- Patient falls resulting in severe harm or death.

3.5 In relation to serious incidents, Healthcare Acquired Pressure Ulcers (HAPU) and falls have been identified as safety improvement priorities for the Health Board. The

following charts outline performance in relation to these two areas of focus and the later section of this report details safety improvement activity.



The number of HAPUs reported as a serious incident have noticeably reduced, however this is largely due to the revised Welsh Government reporting process (January 2019) which now requires determining a HAPU as a serious incident on completion of the investigation. This is different to other categories and potentially means incidents occurring at the end of the quarter may be upgraded to a serious incident. Taking into account this change, the most recent data shows common cause variation.



The number of falls reported shows common cause variation over the last 30 months.

The Mental Health and Learning Disability Division is undertaking a thematic review of deaths, to complement its serious incident and mortality review processes, and this will be summarised in this report when complete.

3.6 At the time of writing, 99 serious incidents remain open with Welsh Government of which 33 are overdue. Of these, the predominance of overdue incidents relate to Ysbyty Glan Clwyd (6), Central Area (8), Mental Health, and Learning Disability (7). All divisions have seen and continue to see a reduction in overdue incidents. A small number of incidents are overdue by twelve months (4) and these mostly relate to matters subject to police investigation. A number (8) are overdue by 6-12 months and a larger number (12) are overdue by 3-6 months. There has been significant reduction over the last 12 months and divisional governance teams are taking focused action to reduce this further.

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

3.8 A key focus of the Patient Safety and Experience Department in 2020 will be developing a learning framework and associated tools that support an emerging learning culture. Work is underway currently to develop initial basic tools including a new Patient Safety and Experience Newsletter and Online Learning Portal to support the sharing of learning across the Health Board. The PTR1a concerns procedure is currently under review into a single, simplified and easier to read document alongside the process reviews mentioned throughout this report.

4. NEVER EVENTS

4.1 Never Events are defined as Serious Incidents that are wholly preventable because guidance or safety recommendations are available at a national level and should have been implemented by all healthcare providers. The Welsh Government issues a list of serious incidents that are deemed to be Never Events. Each Never Event type has the potential to cause serious patient harm or death. However, serious harm or death does not need to have happened as a result of a specific incident for that incident to be categorised as a Never Event. Never Events require full investigation under the Serious Incident Framework.

4.2 During quarter 2 and 3, 5 Never Events were reported as follows:

Division	Ward/Team	Type of Event	Description	Harm
Wrexham Maelor Hospital	Fleming Ward	Retained foreign object post-operation	Retained PICC[1] line guidewire and incorrect end connection	Minor
Ysbyty Glan Clwyd	Theatre B	Wrong site surgery	Removal of gallbladder instead of kidney	Major
Ysbyty Glan Clwyd	ITU	Retained foreign object post-operation	Retained PICC line	Moderate
Ysbyty Glan Clwyd	Theatre F	Wrong route administration of medication	Spinal block[2] completed on incorrect side	Minor
Wrexham Maelor Hospital	Endoscopy	Wrong site surgery	Patient underwent unnecessary endoscopies	Major

4.3 Since July 2017, the Health Board has reported 16 Never Events. Therefore the number of recent incidents is noticeable. The serious incident investigations are ongoing but at this stage, there does not appear to be a consistent underlying theme or recurring issue. Once all individual investigations are completed, the Patient Safety and Experience Department will conduct a thematic review to provide assurance around this.

5. INQUESTS

5.1 During quarter 2 and quarter 3, the Health Board was involved in 155 inquests.

5.2 One Prevention of Future Deaths (Regulation 28) Notice was received by the Health Board from HM Coroner for North Wales (East and Central). This related to the inquest touching the death of Mr Peter Andrew Connelly, with the coroner raising concerns in relation to the delay in treatment as a result of pressures at Wrexham Maelor Hospital's Emergency Department. The response is due by 16 January 2020.

5.3 The Health Board was also involved in a further significant inquest that did not result in a Prevention of Future Deaths (Regulation 28) Notice. This related to the inquest touching the death of Mrs Samantha Brousas. Mrs Brousas waited three hours in an ambulance outside of the Wrexham Maelor Hospital Emergency Department before being admitted due to pressures. The expert witness medical evidence for HM Coroner noted that the delay did not contribute to Mrs Brousas' death. A Prevention

[1] PICC - Peripherally inserted central catheter, can be used to allow medication, fluids, nutrition or antibiotics to be given intravenously (administered directly to a vein). In addition it can also be used to take blood samples which reduces the need for multiple needle punctures in the arm.

[2] Spinal anaesthetic, also known as a spinal block, is administered by injecting drugs into an area called the subarachnoid space near the spinal cord.

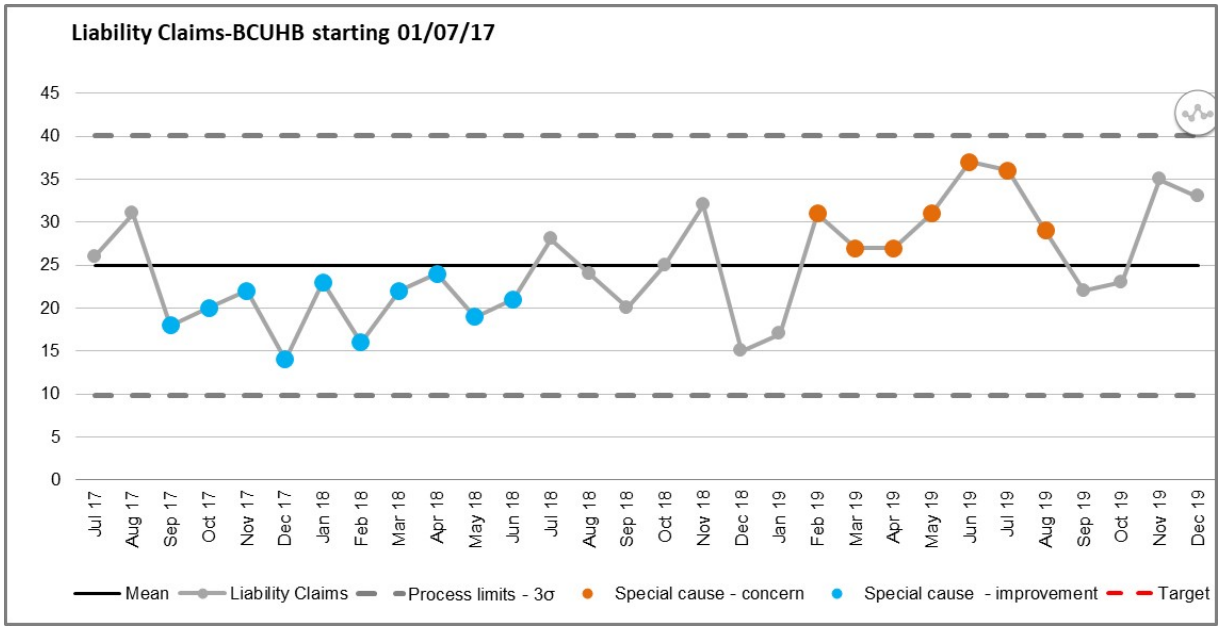
of Future Deaths (Regulation 28) Notice was issued to the Welsh Ambulance Service Trust in relation to pre-alert procedures.

5.4 The Patient Safety and Experience Department is planning a comprehensive review of the inquest process and this will be conducted in co-production with divisions and other stakeholders. This work is planned to commence in summer 2020 (due to the various other reviews underway as detailed in this report). Running parallel to this will be the development and implementation of the new Datix IQ Cloud system.

5.5 The Assistant Director of Patient Safety and Experience is meeting local Coroners in January/February 2020 to continue the good relationships between them and the Health Board.

6. LITIGATION

6.1 During quarter 2 and quarter 3, 178 claims or potential claims were received against the Health Board. Of these, 158 related to clinical negligence and 20 related to personal injury.



6.2 During quarter 2 and quarter 3, 138 claims were closed. Of these, 117 related to clinical negligence and 21 related to personal injury. The total costs for these closed claims amounted to £8,337,377.09 before reimbursement from the Welsh Risk Pool. The most significant claims related to:

- Delays in delivery of twins and failure to recognise complications resulting in one child suffering brain damage (Women's and Maternal Care, 2002) - £2,176,171.71.
- Failure to appropriately monitor and test a patient suffering from ulcerative colitis (Ysbyty Gwynedd, 2005) - £238,568.71.
- Baby born with hypoxia contributed to by a failure to conduct foetal monitoring and recognise complications (Wrexham Maelor Hospital, 2008) - £3,117,594.50.

- Failure to diagnose broken vertebrae (Wrexham Maelor Hospital, 2011) - £103,619.83.
- The extent of clamping/dissecting during lap cholecystectomy was excessive and has resulted in damage and bowel leakage (Ysbyty Glan Clwyd, 2012) - £208,324.36.
- Complications from surgery resulting in the patient experiencing mental illness and subsequently dying by suicide (Ysbyty Glan Clwyd, 2012) - £416,101.29.
- Catheter was fitted during surgery which damaged the claimant's artificial urinary sphincter cuff and urethra (Ysbyty Glan Clwyd, 2014) - £311,153.60.
- Pain and suffering since tension-free vaginal tape procedure (Ysbyty Glan Clwyd, 2009) - £119,295.15.
- Death of a patient (Mental Health and Learning Disabilities) - £205,256.22.
- Treatment and management of patient, who was discharged from MAU, being later re-admitted and did not recover whilst in ICU (Wrexham Maelor Hospital, 2008) - £87,924.70.
- Patient went in for surgery for a pelvic floor repair and vaginal hysterectomy to alleviate prolapse; vaginal hysterectomy was not performed leaving patient in pain and discomfort and a requirement for further surgery (Women’s and Maternal Care, September 2011) - £93,169.46.
- Failure to appropriately diagnose prostate and bladder cancer resulting in claimant not receiving treatment in a timely manner (Ysbyty Glan Clwyd, 2009) - £137,021.06.
- Failure to diagnose bicornuate uterus and perform an earlier electric caesarean section (Women’s and Maternal Care, 2014) - £136,800.00.
- Failure to diagnose an intra cranial bleed (Ysbyty Gwynedd, December 2016) - £138,082.60.

6.3 Between February 2019 and August 2019, there is special cause variation in the number of claims received. This has been reviewed and no immediate themes or hot spots have been identified. It may indicate the emergence of an increase in claims and this will be closely monitored. The number of reported patient safety incidents and complaints have both increased around this same period however the increase in litigation is unlikely to be connected as claims often follow several months later.

6.4 All settled claims over £25,000 require completion of a Learning from Events Report. This records the findings of investigation and any actions taken and is jointly developed by the claims manager and relevant clinical lead. This report must be submitted to the Welsh Risk Pool in order to reclaim costs.

6.5 The Welsh Risk Pool (WRP) arrangements require that individual NHS bodies meet the first £25,000 of any claim or loss. Thereafter the NHS bodies can submit a reimbursement request to the WRP for consideration and approval. The WRP administers the risk pooling arrangements and meets the cost of financial losses over £25,000. All Health Boards and Trusts across Wales have been advised by the Welsh Risk Pool that the annual revenue allocation from the Welsh Government is not sufficient to meet the value of forecast in year expenditure and that it is likely additional contributions will be required. The current forecast predicts an additional cost to this Health Board of £2.836m in addition to the contribution already made,

creating a significant impact on the overall financial position. The Finance Division is aware and national discussions are underway, however this figure succinctly reflects the increasing costs arising from liability claims across the NHS.

6.6 One significant claim is likely to be settled in the immediate comings months following on from complications of labour (brain damage causing cerebral palsy in 2006). It was alleged that the Health Board failed to identify a developing pathological cardiotocography (CTG) and to seek appropriate obstetric assistance. It was also alleged that there was a failure to discontinue the syntocinon infusion in the face of pathological CTG. Liability was agreed on an 80/20 basis in August 2018 and settlement negotiations are ongoing. Counsel is assisting and advising the Health Board concerning the counter schedule given the value of £20-26 million.

6.7 The Patient Safety and Experience Department is planning a comprehensive review of the claims process and this will be conducted in co-production with divisions and other stakeholders including Legal and Risk Services from the NHS Wales Shared Services Partnership. This work is planned to commence in summer 2020 (due to the various other reviews underway as detailed in this report). Running parallel to this will be the development and implementation of the new Datix IQ Cloud system.

7. SAFETY ALERTS

7.1 At the time of writing, the Health Board is non-complaint against two National Patient Safety Alerts.

Alert	Issue Date	Deadline Date	All Wales Position	Narrative
Supporting the introduction of the National Safety Standards for Invasive Procedures (NatSSips)	28/09/2016	28/09/2017	7 of 9 compliant	Secondary Care Quality and Safety Committee (20/11/2019) received a compliance template now being reviewed by their Medical Director.
The safe storage of medicines: Cupboards	04/04/2016	26/0/2016	3 of 9 compliant	Nationally this now agreed for inclusion on the annual audit plan. This is scheduled to be run each June, and audit compliance with the elements of the notice.

7.2 The Patient Safety and Experience Department is planning a comprehensive review of the safety alerts process and this will be conducted in co-production with divisions and other stakeholders. This work is planned to commence in summer 2020 (due to the various other reviews underway as detailed in this report). Running parallel to this will be the development and implementation of the new Datix IQ Cloud system.

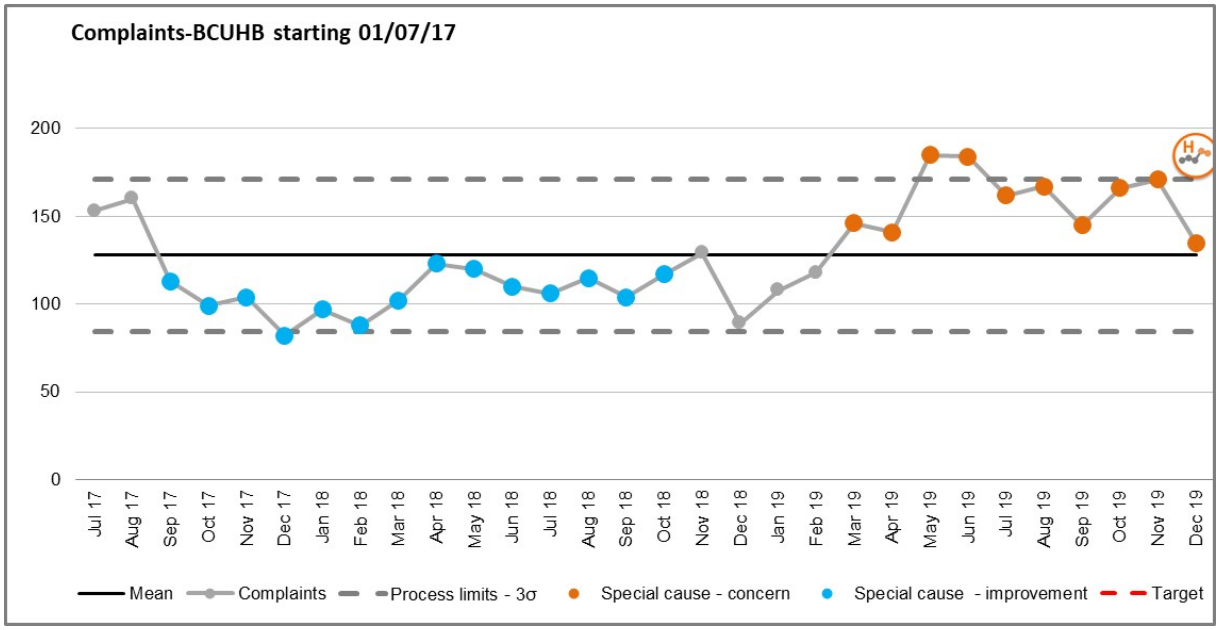
8. COMPLAINTS

8.1 Complaints are received and responded to in accordance with the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 (commonly known as Putting Things Right – PTR) and/or Health Board policy and procedure. Detailed thematic review of complaints data will be included in the Patient Experience Report (formerly the Listening and Learning Report). Information is included in this report to enable triangulation of patient safety issues arising from complaints.

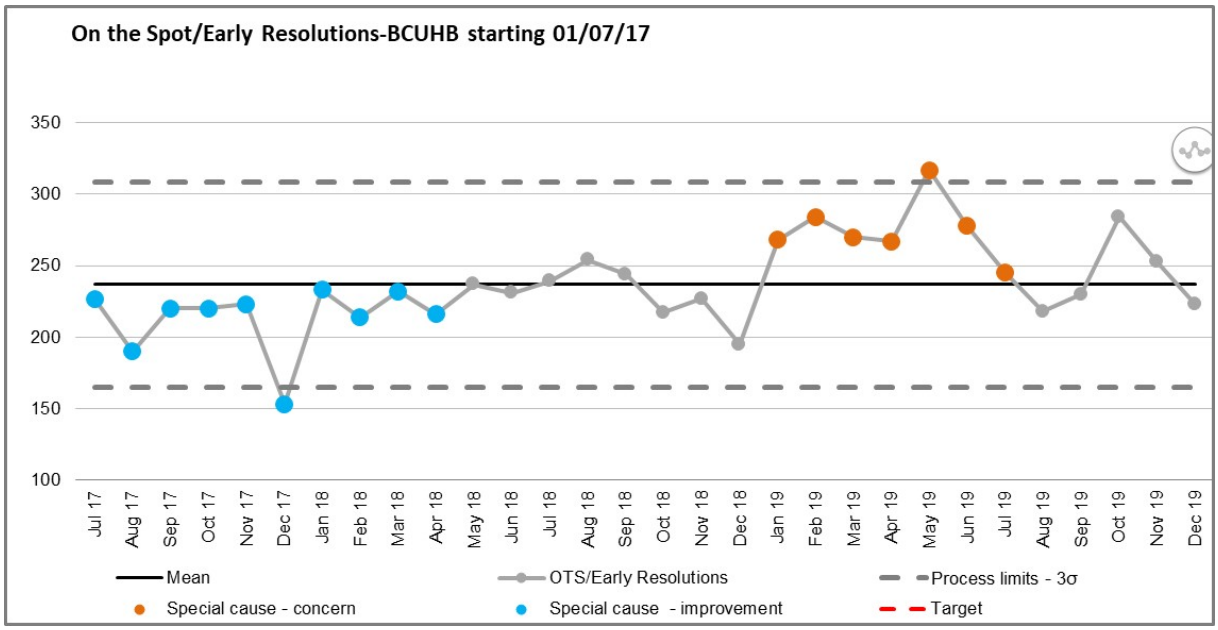
8.2 The Patient Safety and Experience Department is planning a comprehensive review of the complaints process and this will be conducted in co-production with divisions, patients and carers and other stakeholders including the Community Health Council (CHC) and Public Services Ombudsman for Wales (PSOW). This work is planned to commence in February 2020 and will include review of the redress process. Running parallel to this will be the development and implementation of the new Datix IQ Cloud system.

8.3 During quarter 2 and 3, 946 complaints were received. In respect of complaints performance, 96% of complaints were acknowledged within 2 working days and 48% of complaints were closed within 30 working days against an agreed target with Welsh Government of 60% by the end of March 2020 (at the time of writing the latest validated data was up to 31 October 2019). At the time of writing, 71 complaints were overdue of which 44 related to Secondary Care (17 West, 16 Central, 11 East). Other divisions with a number of overdue complaints includes Central Area (8), Women's and Maternity (7) and East Area (6).

8.4 The data for the previous 30 months (allowing period on period comparison over two years) shows a statistically significant shift which requires further review (and is now underway). The shift identified is partly reflected in On the Spot (OTS) concerns (see below) but this has now returned to a more normal rate, and has not been reflected in enquiries from the Ombudsman (see below). This shift also reflects a similar shift seen in reported patient safety incidents however a link cannot be drawn until the further analysis mentioned is complete.

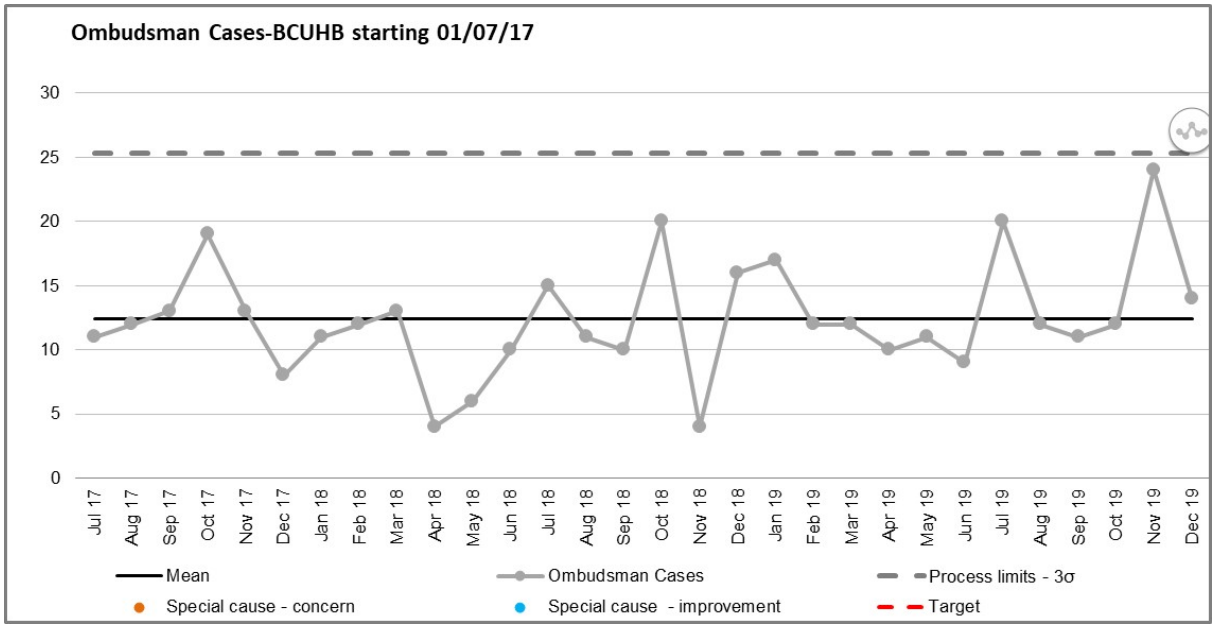


8.5 Complaints raised at the point of service delivery, and resolved satisfactorily within an agreed timeframe (ideally one working day), are referred to as “On the Spot” (OTS) concerns or “Early Resolution” concerns. These concerns are dealt with outside of the PTR process for complaints. During quarter 2 and 3, 1,453 OTS concerns were received. Where a concern cannot be resolved on the spot it will be upgraded to a formal complaint. Some OTS/Early Resolution concerns are recorded by the Central Secondary Care Governance Team within the Datix PALS module due to a pilot project and these are excluded from the data below; the Head of Patient Experience is undertaking work to standardise practice.



8.6 The Public Services Ombudsman of Wales (PSOW) has legal powers to look into complaints about public services and independent care providers in Wales. During quarter 2 and 3, 93 Ombudsman enquiries were received. The Ombudsman closed

77 enquiries during the quarters under review and awarded penalties against the Health Board totalling £12,275.



8.7 During quarter 2 and 3, 1 Section 16 Report was received by the Health Board relating to a complaint in the Mental Health and Learning Disability Division. A Section 16 Report is a case which the Ombudsman considers has public interest and will be published openly. The primary issue arising from this was strengthening the contract management arrangements in cases where both the Heath Board and local authority has co-commissioned packages of care. The division has developed an action plan in response to the Ombudsman's findings and this includes a letter of apology to the family of the patient. This is the only Section 16 Report received by the Health Board since 2017.

8.8 The Ombudsman, Nick Bennett, met with the Chief Executive on 20 December 2019 for their annual meeting following his annual letter to the Health Board. No issues or concerns have arisen from that meeting.

8.9 The Assistant Director of Patient Safety and Experience met with the local PSOW Improvement and Investigation Officer on 12 November 2019 and no issues or concern arose. The number of complaints to the Ombudsman has decreased and the Health Board intervention and resolution rate is broadly in line with other health boards. The Assistant Director of Patient Safety and Experience also met (along with the Head of Complaints) the new PSOW Complaints Standards Authority team on 06 December 2019. This new team is part of the Ombudsman's new powers and the team are working to standardise complaint handling across Wales, focusing initially in 2020 on local authorities. Following the meeting, the Health Board will seek opportunities to participate in this training during 2020 alongside our local authority partners (where possible).

9. SAFETY IMPROVEMENT

9.1 **Healthcare Acquired Pressure Ulcers (HAPU):** The HAPU collaborative commenced in late November 2018, with two cohorts of wards from across the Health Board. Through a focused approach to pressure area care (with support of an expert faculty and the application of quality improvement methodology) the cohorts were able to determine through testing, the standards for the Health Board for pressure area care in the ward setting, effectively creating 'always events' for pressure area care. Early indication of the wards actively testing interventions are positive. HAPU launch events were held across the Health Board in May 2019 and were attended by over 130 staff. During each of these sessions, the following improvements (as identified by the cohort wards) were presented / launched:

- Staff "know your ulcers" quiz – this will improve staff knowledge of identifying Pressure Ulcers;
- New look tissue viability intranet page – this has provided staff with easier access to documentation and learning aids, etc;
- Improve Datix reporting including using an SBAR format in open narrative, plus the ability to report more than 1 pressure ulcer for 1 patient;
- "Are you Chair Aware" (as developed by Ceiriog Ward, Chirk) to help staff identify if patient chairs are suitable / not causing harm;
- Overview/introduction of the new tissue viability risk assessment Purpose T as part of the all Wales documentation standardisation.

The HAPU Masterclasses (to launch the Purpose T and corresponding documentation) were originally scheduled for July 2019 but were postponed to September 2019 due to a delay in receiving the All Wales Welsh Health Circular which will confirm the All Wales launch date for Purpose T (and the package of other risk assessments). The September events were attended by over 200 staff who left understanding how to complete the new All Wales Risk Assessments as follows:

- Continence risk assessment;
- Falls bone health multifactorial assessment;
- WASS;
- Manual Handling Assessment;
- Purpose T Assessment and pathway;
- SKINN bundle.

9.2 The Tissue Viability Nursing (TVN) Team are developing the Datix Root Cause Analysis (RCA) process for spread pan- Health Board to ensure improved reporting and analysis of Healthcare Acquired Pressure Ulcers. The HAPU collaborative has developed short videos of ward team members demonstrating how to check the patients armchair to ensure it meets the required pressure relieving properties and the application of the Health Board non-concordant policy and the impact on patients with cognitive impairment and the resulting quality improvement work in one of our community hospitals. All are available via the Staff App, Ward Accreditation intranet page and the BCUQI Hub. The TVN and QI Team will continue to work and support

the HAPU cohort wards to develop their quality improvement initiatives and continue to share/spread these initiatives pan- Health Board. We are awaiting a date for roll out of All Wales Purpose T documentation as part of the Health Board risk assessment booklet.

9.3 **Falls Collaborative:** By applying similar methodology as used with the HAPU collaborative, the Inpatient Falls Collaborative commenced in June 2019 with one cohort of wards identified through analysis of falls data. The collaborative aim is to reduce falls by 30% by April 2020 for our cohort wards. The collaborative aspire to achieve this aim by implementation of individual interventions for patients following an individual risk assessment. The faculty compromises of the Quality Improvement Team (Corporate Nursing) and subject experts which include Physiotherapist, Occupational Therapist, Dementia Consultant Nurse, Medical Consultant, community falls lead with technical support from a data analyst.

To date, the cohort wards have attended three masterclasses and a presentation day, during which they:

- Received falls training from the Health Board Falls Prevention Community Clinical Lead and Clinical Specialist Physiotherapist. This training ensured that all members of the collaborative have the same knowledge base;
- Received training around sustainability and how to ensure change is sustained post completion of the collaborative;
- Reviewed own wards (last 6 months of) Datix incidents to identify trends / themes for areas of targeted quality improvement;
- Tested quality improvement initiatives to reduce falls, enhance staff knowledge and improve incident reporting on Datix which include:
    - Improved falls intranet page;
    - Documentation: Multifactorial Assessment (incl. Lying and Standing BP) & Falls Policy;
    - Educational Resources: Staff Mandatory E Learning;
    - Patient exercise programme;
    - Baywatch;
    - Illuminous tape on patient frames;
    - Staff, patients & public: App development;
    - DATIX (SBAR reporting);
    - Post Falls Management;
    - Measles spots & clock;
    - New call bells in day rooms;
    - Falling Leaf – above bed board symbol;
    - Health Board solution for appropriate footwear;
    - Enhanced Observation Policy awareness;
    - Discussions at Safety Brief;
    - Medicines reconciliation.

The collaborative is improving access to online resources, updating the Falls Policy; planning masterclasses/launch events to be held in early 2020 to share and spread the quality improvement work developed during the collaborative and awaiting a

date for roll out of All Wales Multifactorial Assessment as part of the Health Board risk assessment booklet.

10. CONCLUSION AND RECOMMENDATIONS

10.1 This report provides the Quality, Safety and Experience Committee with information and analysis on significant patient safety issue arsing during the quarter under review, alongside longer-term trend data, and information on the safety improvements underway. The aim is to provide the committee with assurance on the Health Board's work to improve patient safety. This report replaces the former CLICH Report and as it is the first iteration, covers a period of two quarters.

10.2 The QSE Committee is asked to note specific highlighted areas: overall patient safety incident reporting, Never Events, notable inquests (including 1 Prevention of Future Death Notice), overall complaints, Section 16 PSOW Report, upcoming significant claim and the safety alert non-compliance position. The QSE Committee is also asked to be aware of the possible triangulation between increase patient safety incidents, complaints, OTS and litigation and the further analysis into this now underway.

10.3 The QSE Committee is asked to note the ongoing work of the quality improvement collaboratives and planned improvement work: including review of various Health Board processes and implementation of the Datix IQ Cloud.

10.4 The QSE Committee is asked to note the increase in Welsh Risk Pool costs.

10.5 The QSE Committee is asked to receive this report and provide feedback on its evolved content and layout.

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety & Experience Committee #28/01/2020
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Mental Health and Learning Disabilities Exception Report
Cyfarwyddwr Cyfrifol: Responsible Director:	Steve Forsyth, Director of Nursing, Service Delivery & Operations Lesley Singleton, Acting Director
Awdur yr Adroddiad Report Author:	Adrian Jones, Assistant Director of Nursing
Craffu blaenorol: Prior Scrutiny:	Divisional Directors MHLD
Atodiadau Appendices:	

Argymhelliad / Recommendation:

The Committee asked to:
1.Note progress made related to:

- Compliance with the Mental Health Measure, people classified as Delayed Transfers of Care (DToC) and people placed out of area
- Lessons Learned from incidents
- HIW outstanding actions
- Risk register: those managed through locality structures and those overseen by Divisional Directors
- Mental Health Strategy and plans for Quality Improvement

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

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

Sefyllfa / Situation:
This is an exception report for MHLD to highlight to QSE progress made against key Quality & Safety indicators, performance and an update on key elements of the Mental Health Strategy development
Cefndir / Background:
This report forms part of regular updates to QSE but greater emphasis has been placed on those key items of progress and assurance
Asesiad / Assessment & Analysis
Strategy Implications This report outlines key improvements as highlighted in the Mental Health Strategy plus Health Board requirements in Welsh Government reporting particularly the Mental Health Measure **Financial Implications** A financial assessment has not been included within this exception report. **Risk Analysis** The report provides an update to QSE on the risk register and those risks managed through local governance arrangements. **Legal and Compliance** This particular report provides data on compliance with the Mental Health Measure and reporting on SUI management **Impact Assessment** There are no proposed service change within this report; all policy follows due process for EQIA.

Mental Health and Learning Disability Services

1.0 Purpose of exception report

To provide the committee members with an exception report on the quality and performance assurance metrics in place within Mental Health and Learning Disability Services.

2.0 Summary of Significant Quality and Safety Issues

Heddfan Bedroom Doors, Heddfan Unit

QSE updated in November 2019 on the position relating to the Heddfan bedroom doors. Since this time, new door closures are in the process of being installed, doorframe/door repairs undertaken, just 1 door remains out of operation, scheduled for repair January 2020.

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.

Conwy Community Mental Health Team

An internal MHLD Division review will commence for Conwy CMHT and report February 2020 and QSE 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:

- Silver award for Foelas Ward – BCUHB Ward Accreditation
- Silver award for Cefni Ward – BCUHB Ward Accreditation
- Silver award for Cynnydd Ward – BCUHB Ward Accreditation
- In 2019, positive media coverage of our MHLD services outnumbered negative coverage by a factor of 4:1.

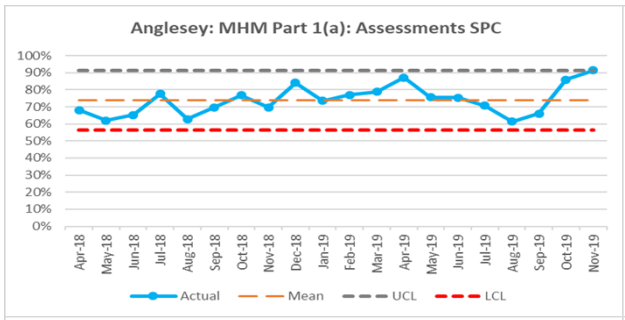
2.2 Performance: Mental Health (Wales) Measure, Delayed Transfer of Care & Out of Area Placements

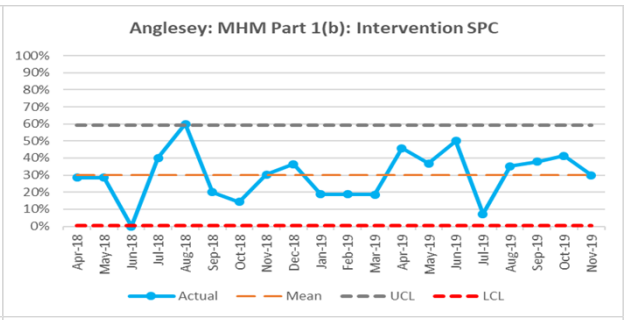
Mental Health Measure

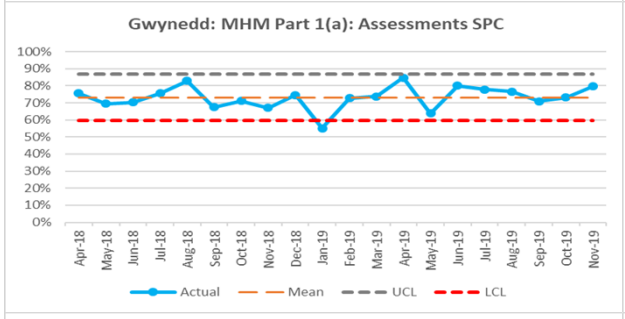
The MHLD Division continues to work on achieving the target across all teams. Overall, Part 1a, and b remains non-compliant but there are signs of some parts of the Measure improving. It should be noted that the validated position always provide data one month in arrears. For Part 2, the continued attention, 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. Apart from October 2019, Part 3 remains compliant.

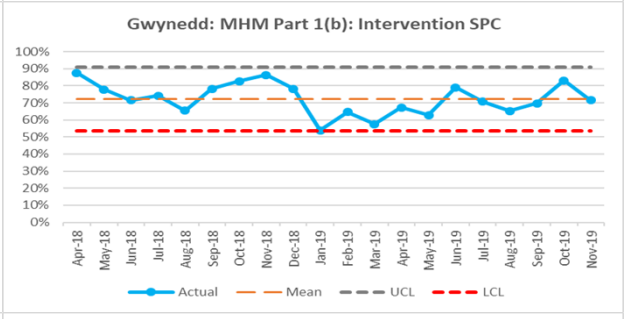
Mental Health Recovery Plans for Part 1 are in place across all areas with a trajectory for compliance by March 2020. In order to achieve this, out of hour clinics have been established, additional resource secured from Welsh Government monies as part of the Waiting List Initiative, letters and phone calls are being sent/made to people on the waiting lists updating them on the situation and providing them with essential contact details and a revised electronic booking systems has been introduced. There is an increased communication with GP practices of current waiting lists in relation to individual people in addition to Team Manager Attendance at Cluster Meetings and individual GP practices. Some areas have reconfigured the management structures to ensure a Lead for Primary Care (Part 1) at a Senior Level.

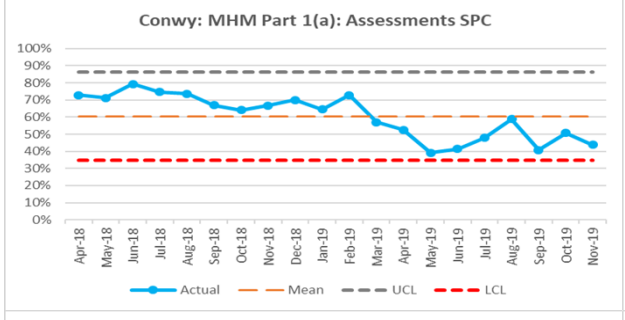
Actions	Outcomes	Timeline
1. Patients 'treated in turn' has been widely adopted which has had a negative impact on performance but, is clinically the right action for patients.	Proactive management of caseload to ensure patients are seen as quickly as possible. Improved quality and safety.	Backlog and 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.

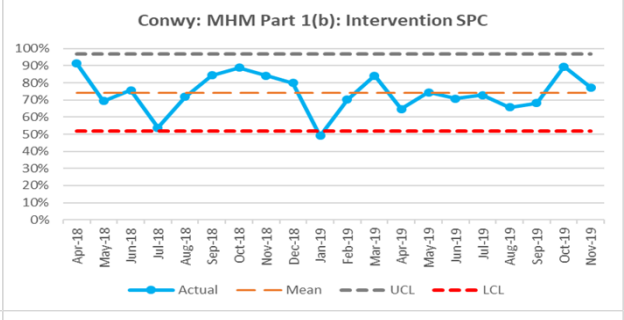

Anglesey: MHM Part 1(a): Assessments SPC
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Apr-18 May-18 Jun-18 Jul-18 Aug-18 Sep-18 Oct-18 Nov-18 Dec-18 Jan-19 Feb-19 Mar-19 Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19 Nov-19
Actual
Mean
UCL
LCL

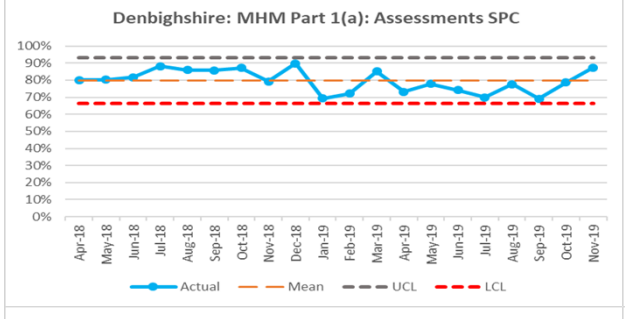

Anglesey: MHM Part 1(b): Intervention SPC
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Apr-18 May-18 Jun-18 Jul-18 Aug-18 Sep-18 Oct-18 Nov-18 Dec-18 Jan-19 Feb-19 Mar-19 Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19 Nov-19
Actual
Mean
UCL
LCL

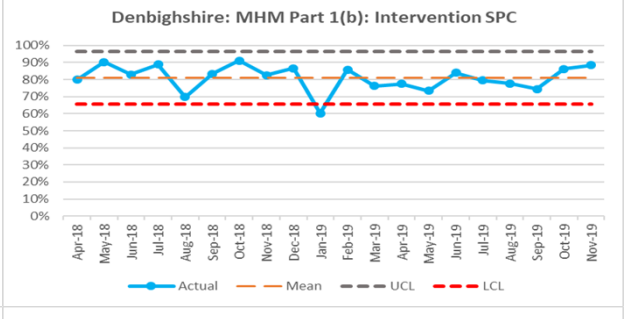

Gwynedd: MHM Part 1(a): Assessments SPC
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Apr-18 May-18 Jun-18 Jul-18 Aug-18 Sep-18 Oct-18 Nov-18 Dec-18 Jan-19 Feb-19 Mar-19 Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19 Nov-19
Actual
Mean
UCL
LCL

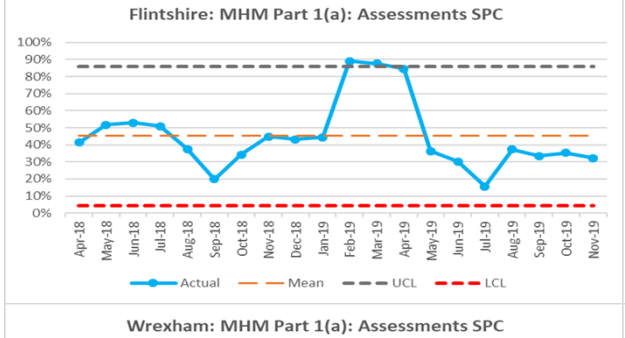

Gwynedd: MHM Part 1(b): Intervention SPC
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Apr-18 May-18 Jun-18 Jul-18 Aug-18 Sep-18 Oct-18 Nov-18 Dec-18 Jan-19 Feb-19 Mar-19 Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19 Nov-19
Actual
Mean
UCL
LCL

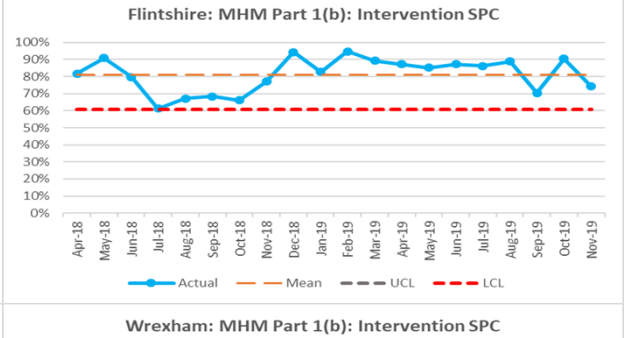

Conwy: MHM Part 1(a): Assessments SPC
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Apr-18 May-18 Jun-18 Jul-18 Aug-18 Sep-18 Oct-18 Nov-18 Dec-18 Jan-19 Feb-19 Mar-19 Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19 Nov-19
Actual
Mean
UCL
LCL

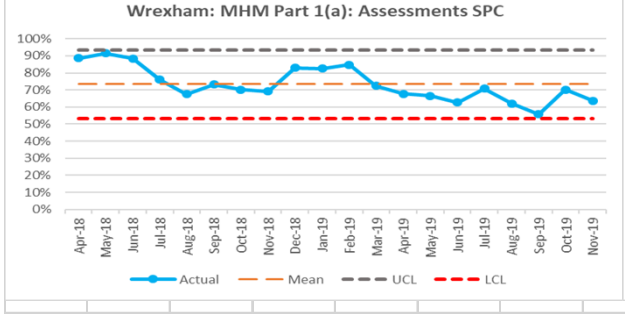

Conwy: MHM Part 1(b): Intervention SPC
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Apr-18 May-18 Jun-18 Jul-18 Aug-18 Sep-18 Oct-18 Nov-18 Dec-18 Jan-19 Feb-19 Mar-19 Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19 Nov-19
Actual
Mean
UCL
LCL

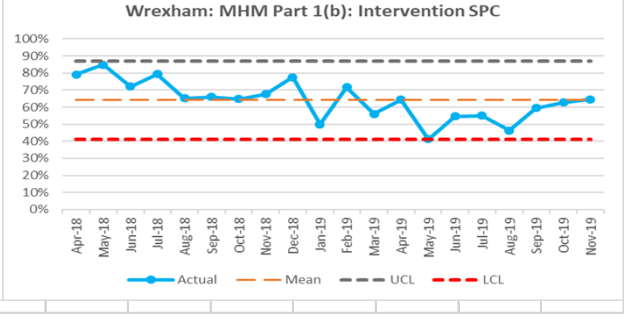

Denbighshire: MHM Part 1(a): Assessments SPC
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Apr-18 May-18 Jun-18 Jul-18 Aug-18 Sep-18 Oct-18 Nov-18 Dec-18 Jan-19 Feb-19 Mar-19 Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19 Nov-19
Actual
Mean
UCL
LCL

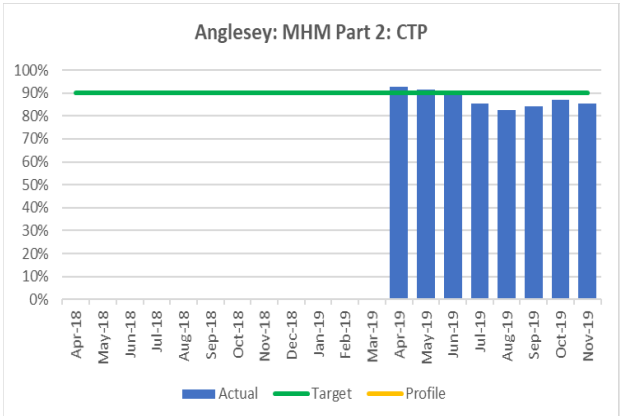

Denbighshire: MHM Part 1(b): Intervention SPC
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Apr-18 May-18 Jun-18 Jul-18 Aug-18 Sep-18 Oct-18 Nov-18 Dec-18 Jan-19 Feb-19 Mar-19 Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19 Nov-19
Actual
Mean
UCL
LCL

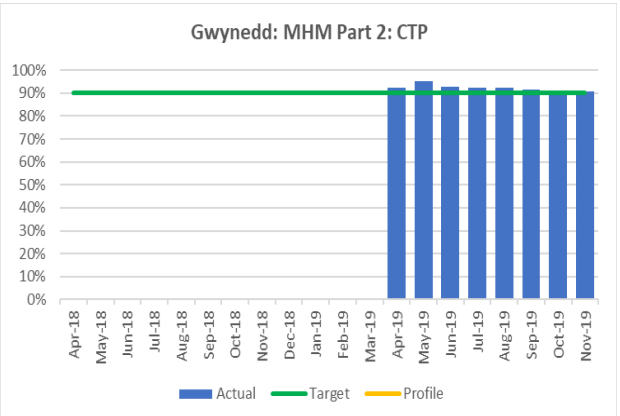

Flintshire: MHM Part 1(a): Assessments SPC
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Apr-18 May-18 Jun-18 Jul-18 Aug-18 Sep-18 Oct-18 Nov-18 Dec-18 Jan-19 Feb-19 Mar-19 Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19 Nov-19
Actual
Mean
UCL
LCL

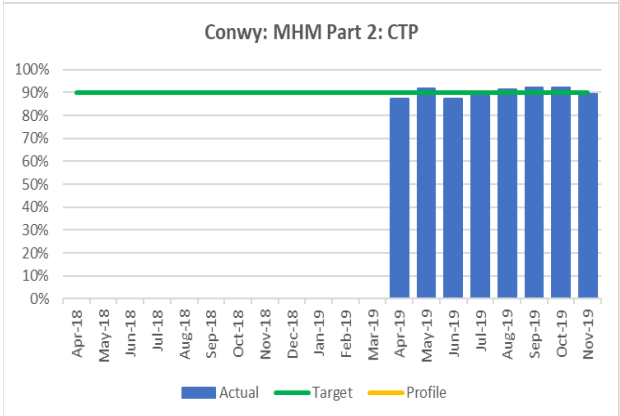

Flintshire: MHM Part 1(b): Intervention SPC
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Apr-18 May-18 Jun-18 Jul-18 Aug-18 Sep-18 Oct-18 Nov-18 Dec-18 Jan-19 Feb-19 Mar-19 Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19 Nov-19
Actual
Mean
UCL
LCL

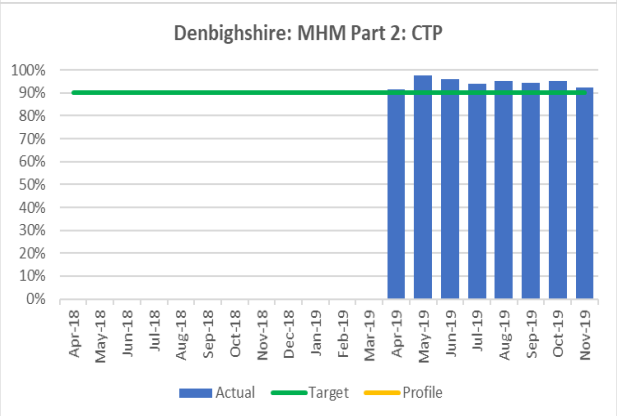

Wrexham: MHM Part 1(a): Assessments SPC
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Apr-18 May-18 Jun-18 Jul-18 Aug-18 Sep-18 Oct-18 Nov-18 Dec-18 Jan-19 Feb-19 Mar-19 Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19 Nov-19
Actual
Mean
UCL
LCL

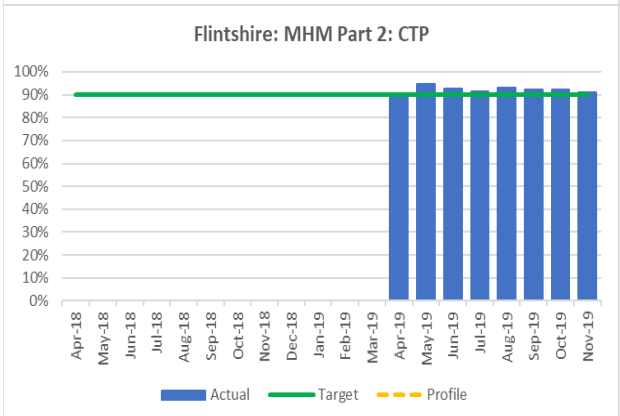

Wrexham: MHM Part 1(b): Intervention SPC
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Apr-18 May-18 Jun-18 Jul-18 Aug-18 Sep-18 Oct-18 Nov-18 Dec-18 Jan-19 Feb-19 Mar-19 Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19 Nov-19
Actual
Mean
UCL
LCL

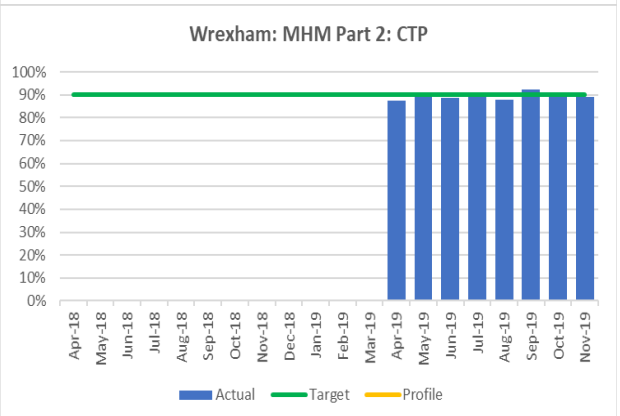


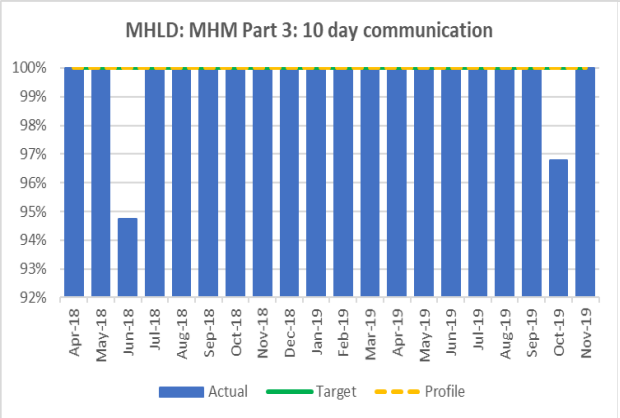








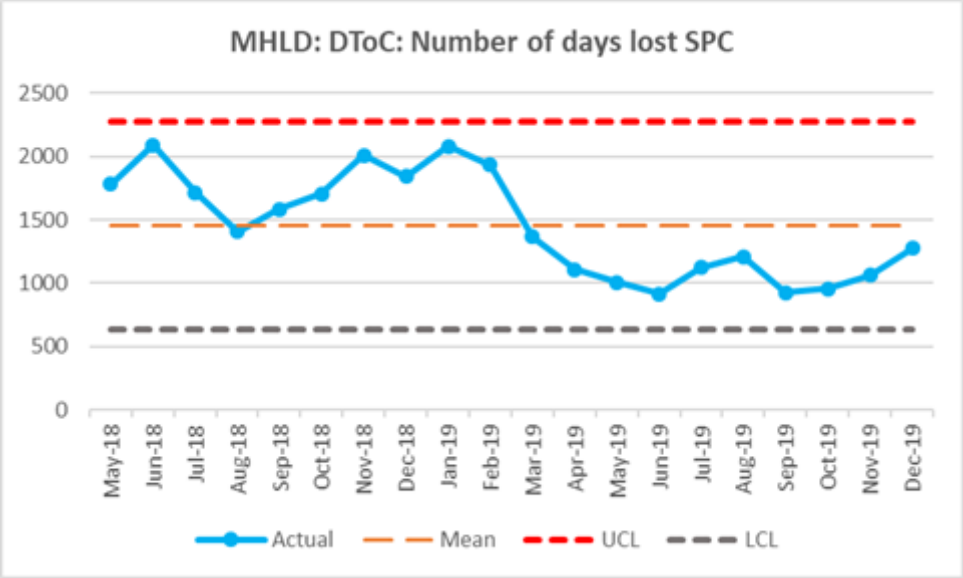


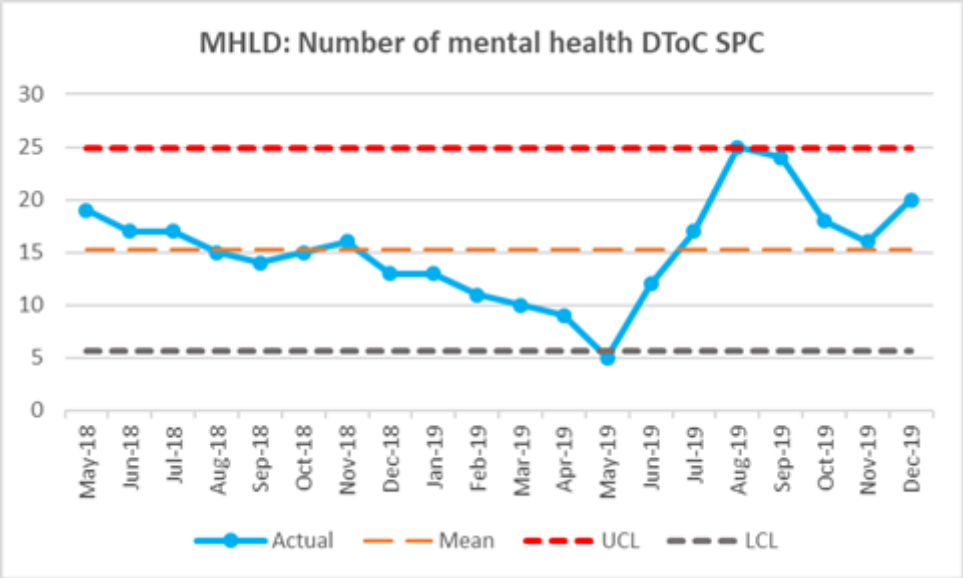


QSE Committee updated in September 2019 and November 2019 on the detailed actions to improve compliance and sustained focus applied in order to reach consistent compliance across all areas of the measure by March 2020.

People considered as having a 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.





It is positive to report the number of bed days lost are reducing for people classed as a DToC, we continue to progress reducing the numbers of people this impacts on as individuals with a significant improvement in the East MHLD area.

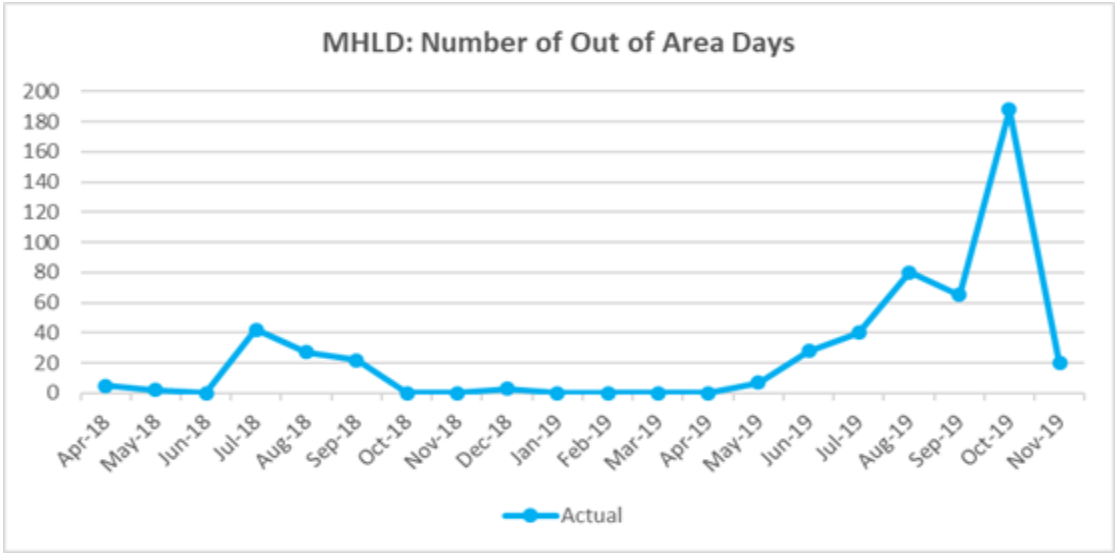
Additional actions from Area Teams are:

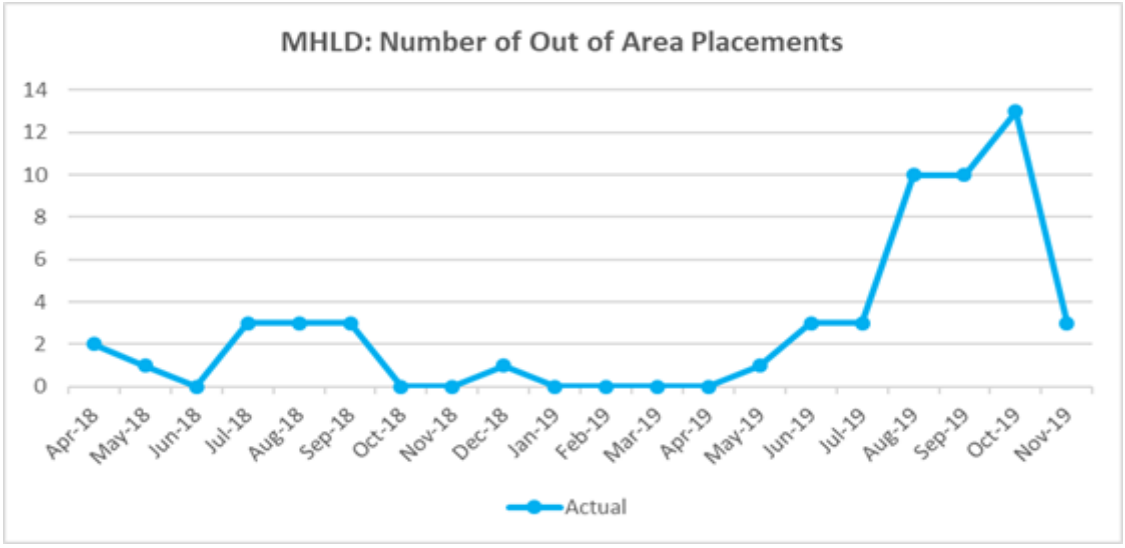
- People classified as DToC are discussed at weekly multi-disciplinary team/ward rounds
- Expected discharge dates are set on admission
- Weekly Regional Specialist Services agenda item
- Barriers to discharge is an ongoing discussion topic aligned with the Learning Disability (LD) Strategy and a standing agenda item in the daily Acute Care Meeting, daily Safety Huddles and OAM
- A work stream is being developed, aligned to the LD strategy of inpatients function and review of current intermediate care model

- Also alongside the LD transformation team and all 6 Local Authorities we are mapping out accommodation for people with LD across North Wales and developing new models of accommodation
- In additional to the Safety Huddle & Acute Care Meetings, the East have an established weekly DToC meeting, chaired by the Clinical Operational Manager and attended by CMHT, Ward staff and Continuing Health Care colleagues. In other areas, weekly DToC meetings are chaired by the Inpatient Service Manager and all band 7 Team Managers are in attendance
- Review of current Acute Care Model to take place in the new year due to the current situation of reduced Consultant cover

Out of Area Placements

Each of the area Senior Leadership Teams have worked consistently to return people as soon as possible to the home area hospital.

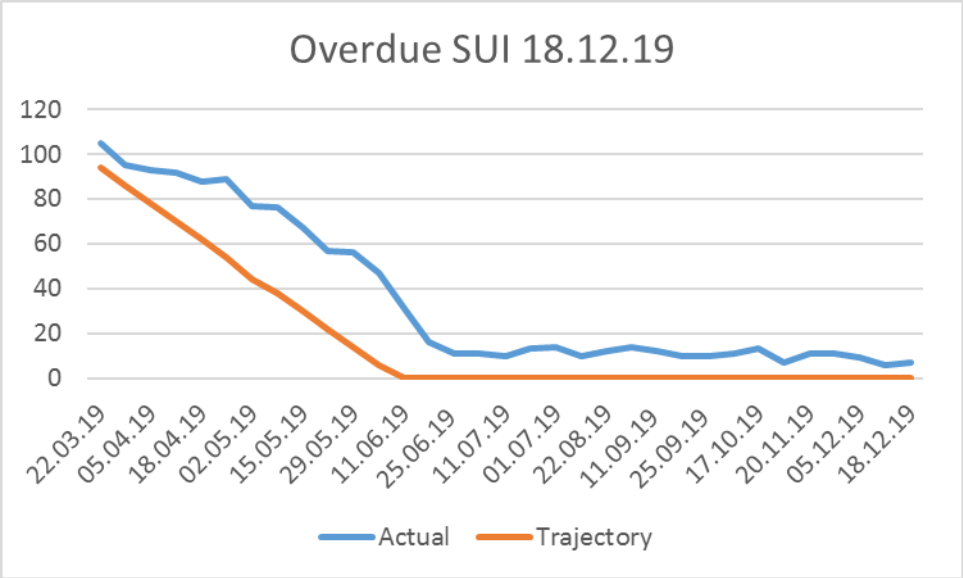




2.3 Lessons Learned from Incidents & Incident Management (SUI)

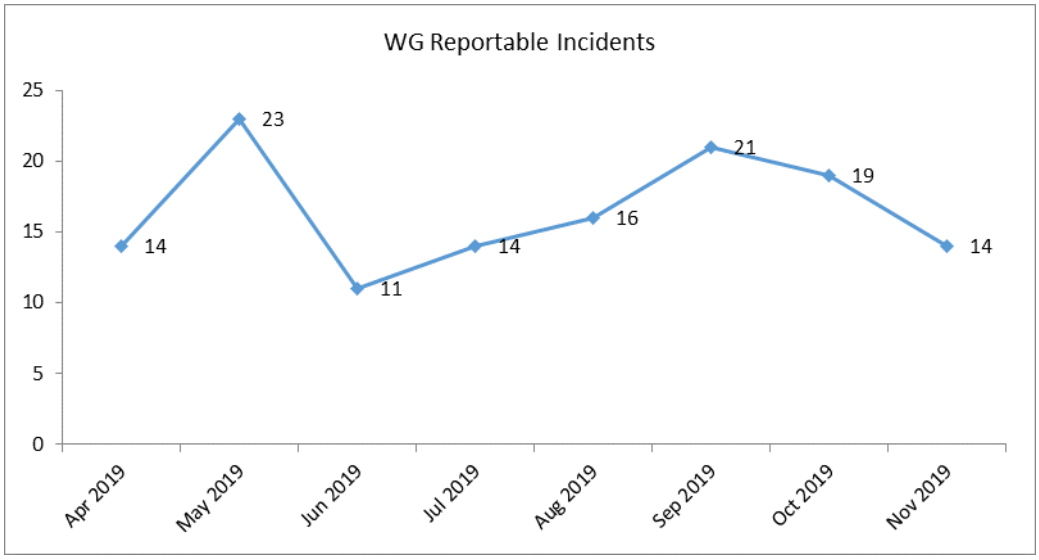
Overdue SUI is at its lowest point for the Division at 4 [17.01.2020] with 0 historical legacy cases outstanding. Two of the overdue SUI's relate to incidents investigated

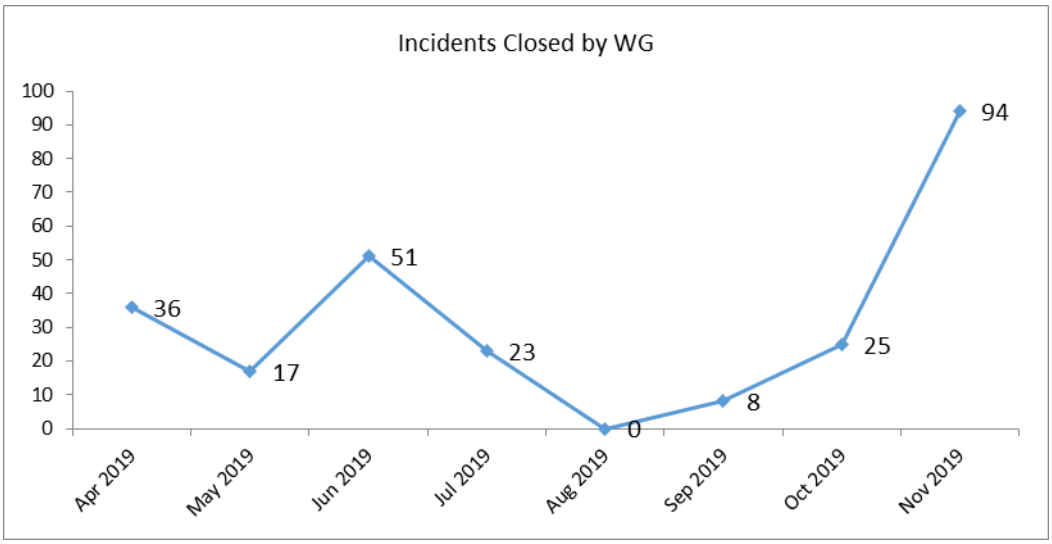
by the Police/Crown Prosecution Service, who have advised the Health Board to hold on any internal investigation until the outcome of the Court Case.



Improvements noted in all areas across the Division with a significant decrease of overdue Datix incidents reducing from 210 overdue on the 23.09.19 to 80 on the 17.01.2020. Progress monitored via the Governance Team and reported at Divisional TWC and QSEEL.

The number of reportable incidents remains consistent but what has changed is the number of incidents closed by Welsh Government. This is a positive message to bring to the attention of QSE.





The table below provides data on Welsh Government reported incidents between April and December 2019. The highest number of incidents (by category) is the unexpected death whilst under the care of MHLD services (102).

WG Reportable Incidents by Type & Reported date (month & year)	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Total
Abscondment of detained patient assessed as high risk	0	0	0	4	1	1	0	1	1	8
Any serious act of Violence or Aggression	0	1	0	0	1	0	0	0	1	3
Grade 3 or above healthcare associated pressure ulcer develops	0	0	0	0	0	0	1	0	0	1
Major Harm Caused	0	0	0	1	0	0	0	0	0	1
Mental Health - Attempted suicides as inpatients	2	0	1	0	0	1	1	0	0	5
Other type of incident	0	0	0	0	0	1	1	1	0	3
Patient fall resulting in harm/death to patient	1	5	1	1	2	3	0	1	3	17
Sensitive Issue	0	0	2	0	0	0	0	0	0	2
Suicide(or attempted) or homicide committed by an NHS MH patient	0	6	0	1	1	0	0	1	4	13
Unexpected Death whilst under the direct care of a health prof.	11	11	7	7	11	15	16	10	14	102
Total	14	23	11	14	16	21	19	14	23	155

Learning through Concerns

On 22.11.19 the Division held a Learning Event at the Optic Centre, St Asaph. We plan to make this a bi-annual event, attracting keynote speakers, just as we did this year. These included the very poignant and touching story delivered by a family bereaved by suicide and who are now working with the Division through Caniad to improve communication between clinicians and families. Dr Sharon McDonnell, Honorary Research Fellow from Dr. Louis Appleby's team (NCISH) in Manchester University presented the value of postvention and the early findings of the first national suicide survey. Mr. John Gittins, Senior Coroner central and east presented on the role of the Coroner and touched on the value of services working together, particularly MH and SMS through the co-occurring framework. In addition to the speakers, which included Caniad, there were a number of poster presentations to demonstrate our learning journey to date. The learning opportunities for our staff from this event could not be under-estimated and without exception, feedback was extremely positive.

There were over 130 attendees, which included not only divisional staff, but also Caniad representatives, Associate hospital managers, independent board members, local authority and blue light colleagues.

It is anticipated these events will be held twice a year with a draft agenda in place for our next event.

QSE Committee updated in November 2019 of the significant learning from 137 closure forms submitted to Welsh Government. 6 themes identified and a Learning Project underway will ensure that actions arising from these themes have been implemented:

- Discharge Planning
- Risk Formulation and Risk Management
- Single Point of Access (SPOA) decisions to downgrade urgent referrals
- Timely allocation of care coordinator
- Quality of documentation/record keeping
- Multiple case notes

Learning Lessons through the Coronial Process

There have been no Regulation 28 Prevention of Future Deaths issued for 2019. The Division continues to engage with HM Coroner process through the weekly coroners Board round and this ensures timely completion of statements and reports and preparation for the inquest.

Learning from Mortality, Suicide and Self-Harm

The MHLD Division have conducted a four area thematic review of all deaths by suicide of people within 2018. All unexpected deaths, including those by suicide, report via the Corporate Team to Welsh Government and are recorded and investigated within the Division. The Governance Team within MHLD monitor trends and themes relating to serious incidents, and following a query in late 2018, regarding a possible rise in the number of suicides within one area, a review undertaken to establish whether there were any connections or themes between the incidents.

The Governance Team identified all of the deaths, which had received an inquest conclusion of suicide, and devised Terms of Reference for the review. The Senior Leadership Teams in each area nominated representatives to sit on review teams, which would consider each person from their area against the Terms of Reference.

The review highlighted that we do not appear to enquire whether people have connections to other people who have died by suicide, or whether they have carried out any research into suicide methods, for instance internet searches.

Despite the limitations, several themes did emerge from the review and provided valuable learning. The main themes noted were that a high proportion of people died at home, that they died by hanging and had recently experienced a form of boundary crossing, whether this was between teams, practitioners, or geographical area. Other themes noted were co-occurring substance misuse and mental health problems and previous admission to hospital even though this may not have been recent.

The Division is working through a clear process for the staged approach to review mortality with expectation of data on numbers of cases reviewed and learning shared through Divisional Governance structures and to QSE.

The Division have carried out a comparative analysis of the results of the Divisional Thematic Review alongside the 2019 National Confidential Inquiry (NCISH) annual report. The information in the NCISH report is generated from aggregated data from 2007 to 2017, whereas the information in the Divisional review relates only to 2018, however there are several thematic commonalities.

The NCISH study showed that between 2007 – 2017, 3,593 deaths in the general population received a conclusion of suicide or undetermined and that 802 (22%) of these were people who were known to mental health services.

Methods used in suicide for all Wales showed that the most common method was hanging or strangulation, followed by self-poisoning and then by jumping or multiple injuries. This correlates directly with the results of the thematic review. The national results also showed drowning as the fourth most common method, which did not feature in the Divisional review.

The median age of people dying by suicide in Wales was 45 according to the NCISH report and in the Divisional review was 44.5. The all Wales figures showed that 69% of those dying by suicide were male, whereas in the thematic review, 48% of the people included were male.

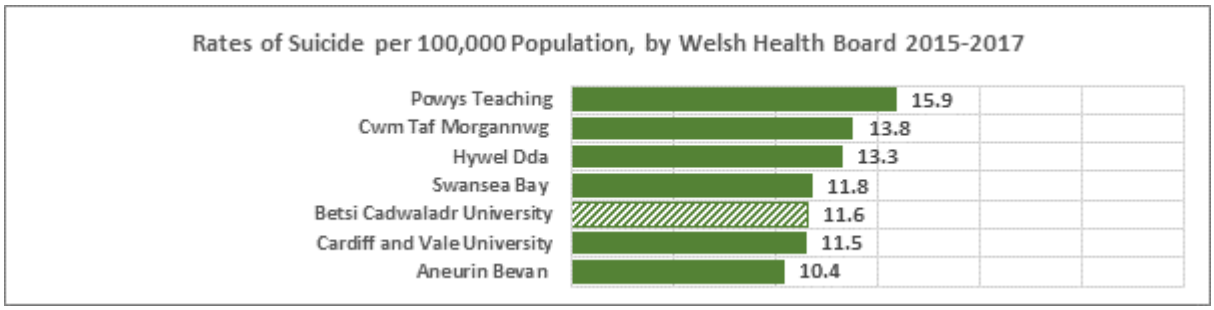
The NCISH figures for Wales showed that 49% of people had a history of alcohol misuse and 39% had a history of drug misuse. The Divisional review found that 39% of the people we reviewed had a history of drug and/or alcohol misuse, which is consistent with the figures for Wales. NCISH also showed that in Wales, 67% of people had a history of self-harm and 24% had a history of violence.

NCISH also showed that 69% of people were not currently married, 43% were living alone and 2% were homeless. 45% were unemployed and 17% were on long-term sick leave at the time of death. NCISH also monitors diagnosis of people included in their study which showed that in Wales, 40% had a diagnosis of an affective disorder such as bipolar or depression, 15% were diagnosed with schizophrenia or other delusional disorder, 9% alcohol dependence or misuse, 7% drug dependence or misuse, 9% personality disorder.

The Divisional review did not identify any inpatient suicides in 2018, the overall figures for Wales for 2007 to 2017 showed 7% of suicides of people open to mental health services were inpatients, 11% were open to crisis resolution or home treatment teams and 16% of people had been discharged from inpatient care within the 3 months prior to death. The NCISH study also showed that post-discharge suicides were more common in the 2 weeks following discharge. 1% were subject to a community treatment order (CTO) and 6% had been conveyed to a place of safety under Section 136 of the Mental Health Act in the 3 months prior to death.

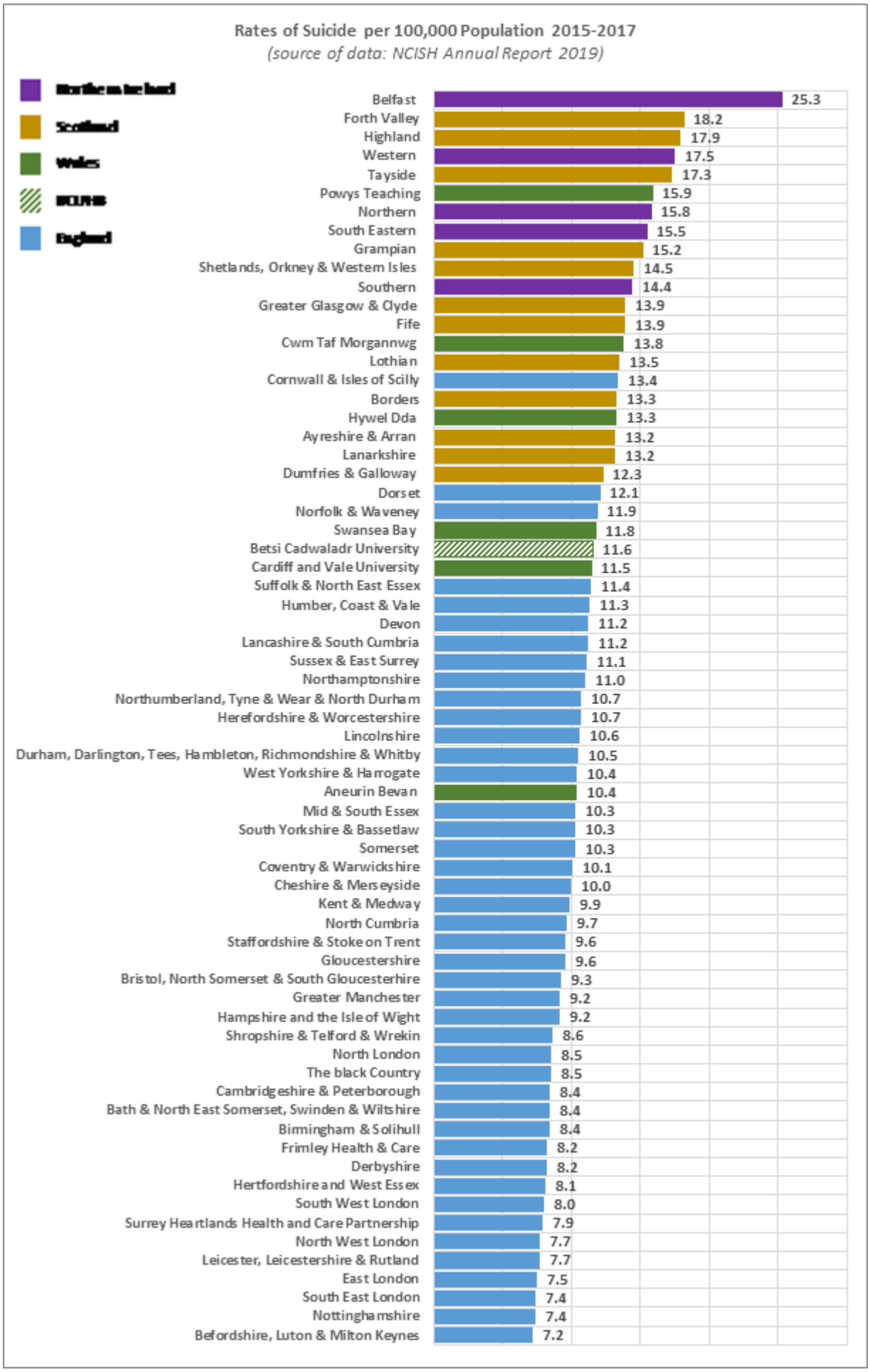
Suicide Rates in Welsh Health Boards

There was variation in suicide rates by area of residence (by Health Board) at the time of death (average rate 2015-2017). The highest rate of suicide was in Powys Teaching HB at 15.9 per 100,000 population, BCUHB had the third lowest rate in Wales at 11.6 per 100,000 37% lower than the highest and 11.5% higher than the lowest.



Suicide Rates in UK Countries

Difference in suicide rates remain between the UK countries, with the highest rate in Northern Ireland. Within the UK as a whole, BCUHB was 61.1% higher than the lowest in Bedfordshire in the South of England at 7.2 per 100,000 and 118% lower than the highest rate of 25.3 per 100,000 in Belfast.


Rates of Suicide per 100,000 Population 2015-2017
(source of data: NCISH Annual Report 2019)
Belfast 25.3
Forth Valley 18.2
Highland 17.9
Western 17.5
Tayside 17.3
Powys Teaching 15.9
Northern 15.8
South Eastern 15.5
Grampian 15.2
Shetlands, Orkney & Western Isles 14.5
Southern 14.4
Greater Glasgow & Clyde 13.9
Fife 13.9
Cwm Taf Morgannwg 13.8
Lothian 13.5
Cornwall & Isles of Scilly 13.4
Borders 13.3
Hywel Dda 13.3
Ayreshire & Arran 13.2
Lanarkshire 13.2
Dumfries & Galloway 12.3
Dorset 12.1
Norfolk & Waveney 11.9
Swansea Bay 11.8
Betsi Cadwaladr University 11.6
Cardiff and Vale University 11.5
Suffolk & North East Essex 11.4
Humber, Coast & Vale 11.3
Devon 11.2
Lancashire & South Cumbria 11.2
Sussex & East Surrey 11.1
Northamptonshire 11.0
Northumberland, Tyne & Wear & North Durham 10.7
Herefordshire & Worcestershire 10.7
Lincolnshire 10.6
Durham, Darlington, Tees, Hambleton, Richmondshire & Whitby 10.5
West Yorkshire & Harrogate 10.4
Aneurin Bevan 10.4
Mid & South Essex 10.3
South Yorkshire & Bassetlaw 10.3
Somerset 10.3
Coventry & Warwickshire 10.1
Cheshire & Merseyside 10.0
Kent & Medway 9.9
North Cumbria 9.7
Staffordshire & Stoke on Trent 9.6
Gloucestershire 9.6
Bristol, North Somerset & South Gloucesterhire 9.3
Greater Manchester 9.2
Hampshire and the Isle of Wight 9.2
Shropshire & Telford & Wrekin 8.6
North London 8.5
The black Country 8.5
Cambridgeshire & Peterborough 8.4
Bath & North East Somerset, Swinden & Wiltshire 8.4
Birmingham & Solihull 8.4
Frimley Health & Care 8.2
Derbyshire 8.2
Hertfordshire and West Essex 8.1
South West London 8.0
Surrey Heartlands Health and Care Partnership 7.9
North West London 7.7
Leicester, Leicestershire & Rutland 7.7
East London 7.5
South East London 7.4
Nottinghamshire 7.4
Befordshire, Luton & Milton Keynes 7.2

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.

Self-harm

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.

Of the 30 incidents reported in the month of November 2019, 3% (1) resulted in Death, 33% (10) resulted in Personal Injury, 37% (11) resulted in No Injury, harm or adverse outcome, 23% (7) resulted in Near Miss (With Intervention), 3% (1) Near Miss (No Intervention).

2.4 Healthcare Inspectorate Wales – Outstanding Actions

External Regulation: Healthcare Inspectorate Wales Reports and Actions

There have been no further HIW inspections as detailed in the report to QSE in November 2019. 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. The HIW inspection report for Cefni Hospital published 19th December 2019 and improvement plan in place.

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	07/11/2019 discussed in QSEEL, this has now progressed for a capital bid
Hergest	September 2018	1	S136 toilet door awaiting magnetic fixings	New doors ordered for the S136 suite in Hergest and aim to be fitted end January 2020
Central – Nant y Glyn	November 2018	2	Awaiting hand wash basin in clinic room	Both actions now closed as included in the schedule of works for NYG
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: 64 policies published on the intranet with 16 showing as out of date. 10 have progressed through the MHLD Division process and are progressing through the Health Board ratification process. There are currently 6 (9%) 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.

17 new documents are currently in process of being written. A discussion is due to be held in relation to Medicines Management documents and appropriate references and storage. It is proposed that these in future will not be included in the MHLD division's numbers, which will have a significant improvement on the divisions reporting of out of date documents, due to the responsibility for these lying with Medicines.

Developments since the last QSE report include:

Reviewed and ratified documents/policies completed HB process:
None

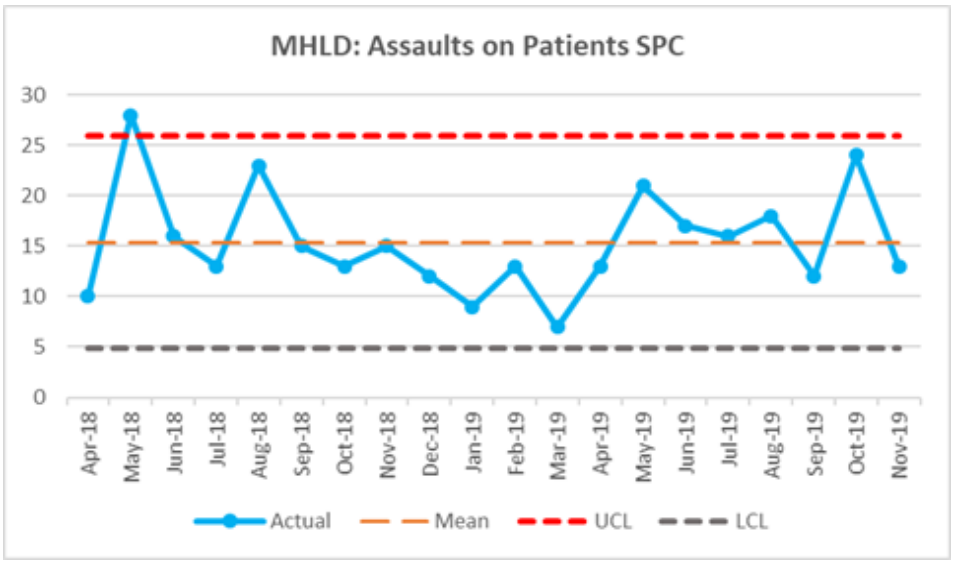
Approved by MHLD and progressing through HB process
MHLD AC001 – Liaison Psychiatry Services in acute hospitals
MH02 – Procedure for the Exceptional Admission of Children under the age of 18 years to an Acute Psychiatric Inpatient Unit
Awaiting Number – MHLD Self Administration Medication Policy
MH01 – Children Visiting Mental Health Wards Protocol
MHLD 0003 – Transfer and Discharge of Care Protocol

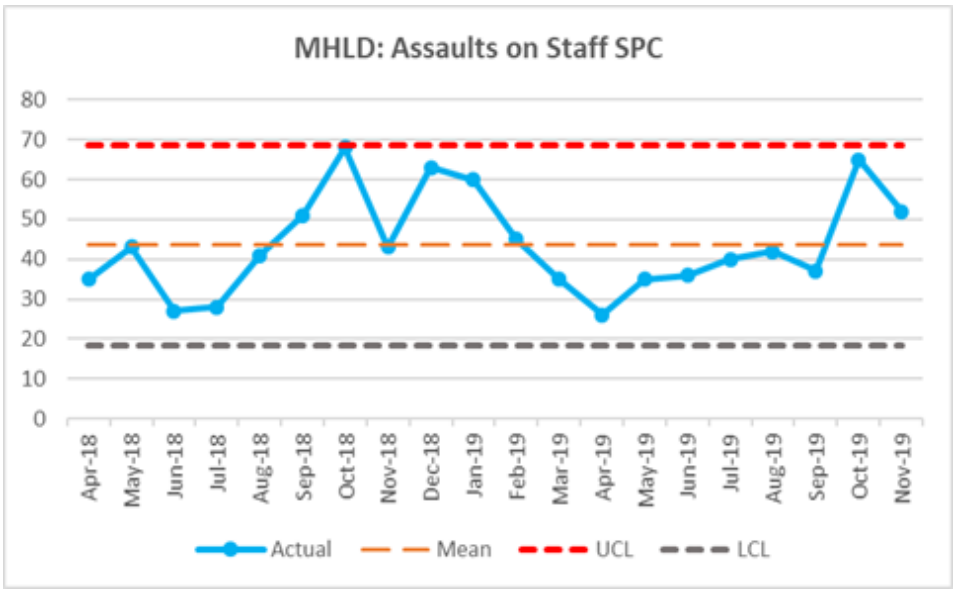
There were three policies specific to Medium Secure Services that required further work, particularly in relation to EQIA and proof reading: Handcuffs Policy, Threats to the Person in Forensic Establishments Policy and Major Incident Protocol. All three have been resubmitted for approval.

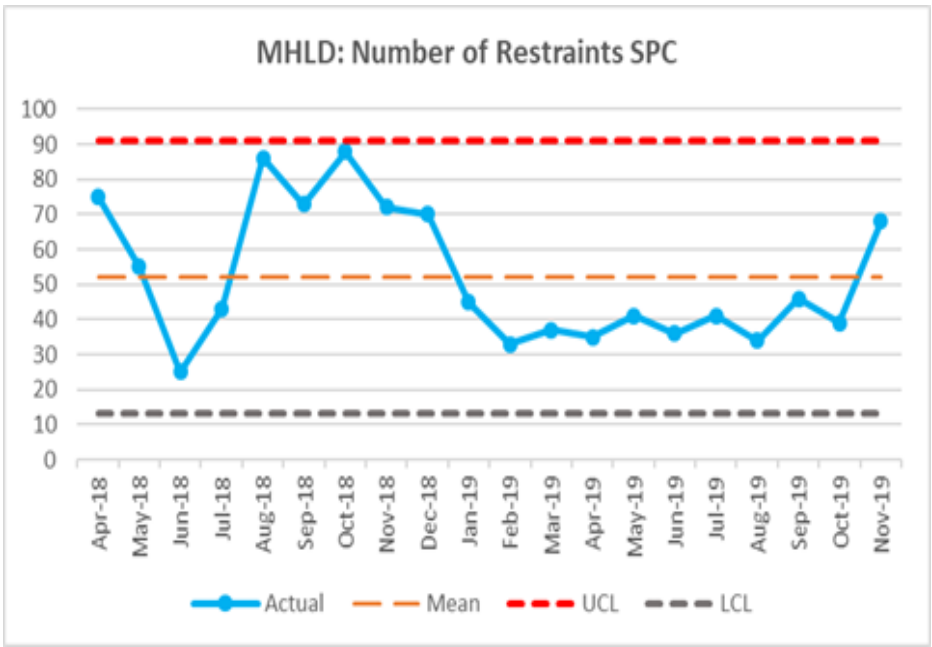
2.6 Quality & Safety Key Performance Indicators (KPI) & Monitoring Systems

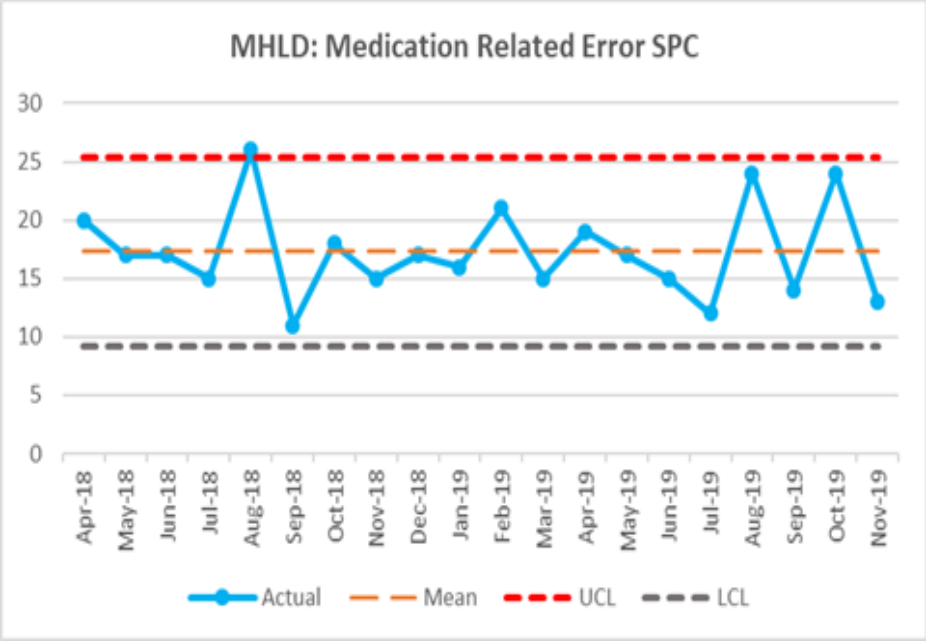
The Division shows within range variation reporting for:

- Assaults on people
- Assaults on staff
- Numbers of restraint
- Medication related errors
- Falls


MHLD: Assaults on Patients SPC
30
25
20
15
10
5
0
Apr-18
May-18
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Actual
Mean
UCL
LCL

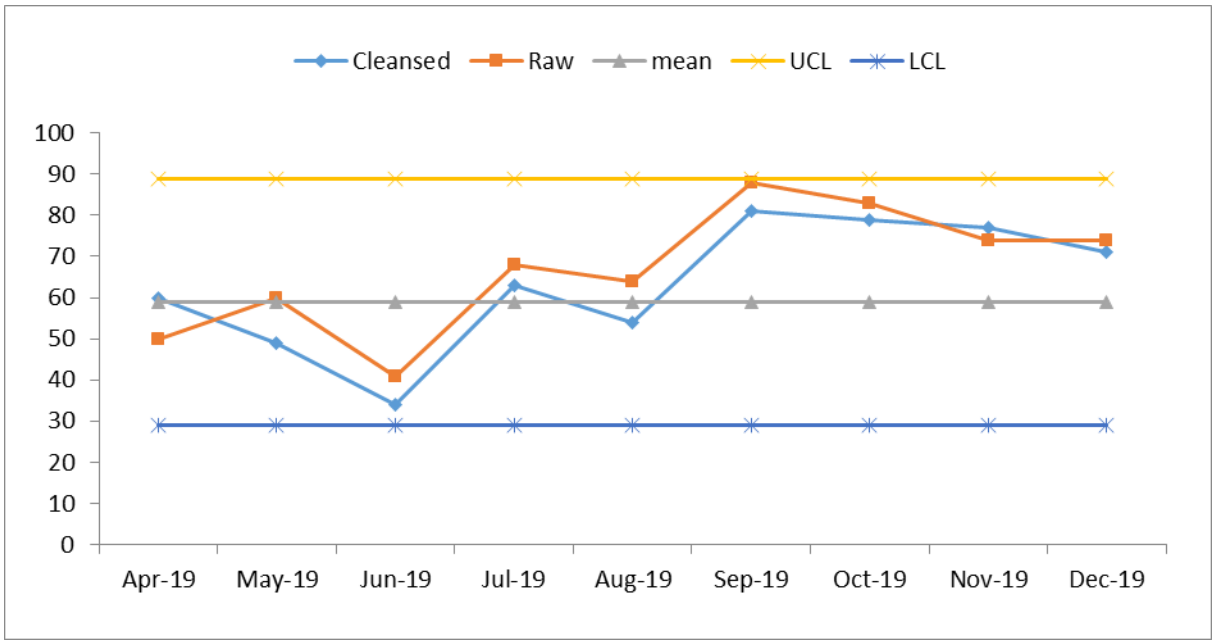

MHLD: Assaults on Staff SPC
80
70
60
50
40
30
20
10
0
Apr-18
May-18
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Actual
Mean
UCL
LCL


MHLD: Number of Restraints SPC
100
90
80
70
60
50
40
30
20
10
0
Apr-18
May-18
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Actual
Mean
UCL
LCL



Falls within the MHLD Division

April 2019 saw the completion of an intensive two year falls management programme for the Division. That programme led to a significant evidence based improvement in post falls management and a reduction in total falls of 24%. Currently, the SPC across the first three quarters 2019-20 shows no shift, no trend and no astronomical point.



There has been an increase in falls within OPMH wards during Q2 and Q3 compared to the average outcomes from the intensive management period. In part, this relates to a small number of complex acuity with falls described as high frequency but low impact for which a multidisciplinary response remains ongoing. Harm of a degree sufficient to be reportable to Welsh Government occurred on five occasions distributed across adult and older person's wards during the months of May,

November and December. Post falls management remains compliant with national quality indicators.

Memory clinic accreditation

All Memory Services are accredited with Royal College of Psychiatrists and continue to fully engage with that process of assessment against National quality standards. In advance of possible new waiting times targets for Memory Services there has been considerable work underway to identify the current position and the additional resource required to assure compliance. This work will inform the next round of accreditation.

2.7 Psychological Therapies Review

The Division commissioned a review into the provision of Psychological Therapies with the following expectations:

- Clarify the way in which its psychological therapies services currently work
- Explore the extent to which psychological mindedness is embedded in the culture and practice of its wider mental health services
- Test its readiness to increase access to, as well as quality of, Psychological Therapies
- Outline a roadmap

Recommendations from the review included:

- Focus first on engaging staff.
- Co-create a vision for psychologically-informed approaches.
- Design and equip pathways of care that are fit for purpose by:
  a. Addressing the legacy waits in East Adult Mental Health
  b. Making stepped care a reality
  c. Tackling inequality of access
  d. Looking at out of county repatriation potential.

- Devise a strategic workforce plan to build capacity and capability, and phase its implementation, with clear resource commitments at each stage.
- Undertake specific work to strengthen team-based interdisciplinary working, in line with the evidence base.
- Pay attention to the enablers of change:
  a. Take urgent action to tackle the gaping intelligence deficits in services
  b. Strengthen the governance and assurance flows from team to area to Division to Psychological Therapies Management Committee
  c. Make effective use of recognised quality improvement methodology to test ideas and engage staff. Use pilots; avoid ‘big bangs’ and initiative overload.

A Psychological Therapies Board is established to oversee implementation of the recommendations and progress reported through to QSE.

The Division continues to monitor and intervene for people waiting for psychological intervention. People at risk are seen without delay and not adding to the waiting list. A short-term waiting list initiative completed for Wrexham is now ready for a tender process, to address our largest waiting list.

100+ MDT staff have now been trained in CBT and DBT across all services. Impact will take time to show in specialist waiting times, and will require change in referral patterns and pathways.

2.8 Risk register and management

The Division currently has 32 risks on the risk register; 13 risks categorised as extreme (decrease of 2) [extract 11 December 2019]. Risk register reviewed at MHLD QSEEL, BCUHB QSG, and reported through to Divisional Directors.

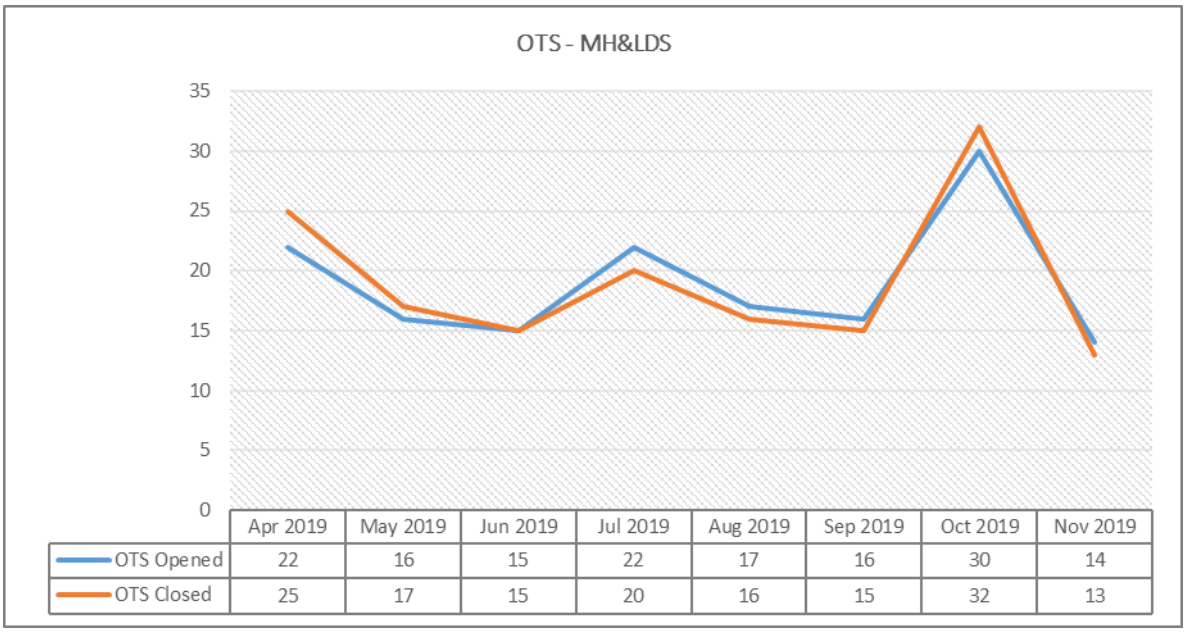
CRR13 is the only risk at Tier 1 that relates to MHLD services – "There is a risk that people receive inappropriate care within Mental Health Services due to failings in leadership and governance at all levels within the Division which could result in poor quality outcomes for people".

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 November 2019 Consent, Confidentiality or Communication remains the the most received to date for the year. As of the 30th November, there are 24 formal complaints currently open regarding the MHLD Division.

By Subject	**Apr 19**	**May 19**	**Jun 19**	**Jul 19**	**Aug 19**	**Sep 19**	**Oct 19**	**Nov 19**	**Total**
Consent, Confidentiality or Communication	4	5	5	5	3	2	3	5	**32**
Access, Appointment, Admission, Transfer, Discharge	3	3	4	2	2	3	5	3	**25**
Treatment, procedure	3	3	5	2	3	3	3	2	**24**
Abusive, violent, disruptive or self-harming behaviour	2	2	0	5	2	1	1	3	**16**
Clinical assessment (investigations, images and lab tests)	0	0	0	1	2	1	1	0	**5**

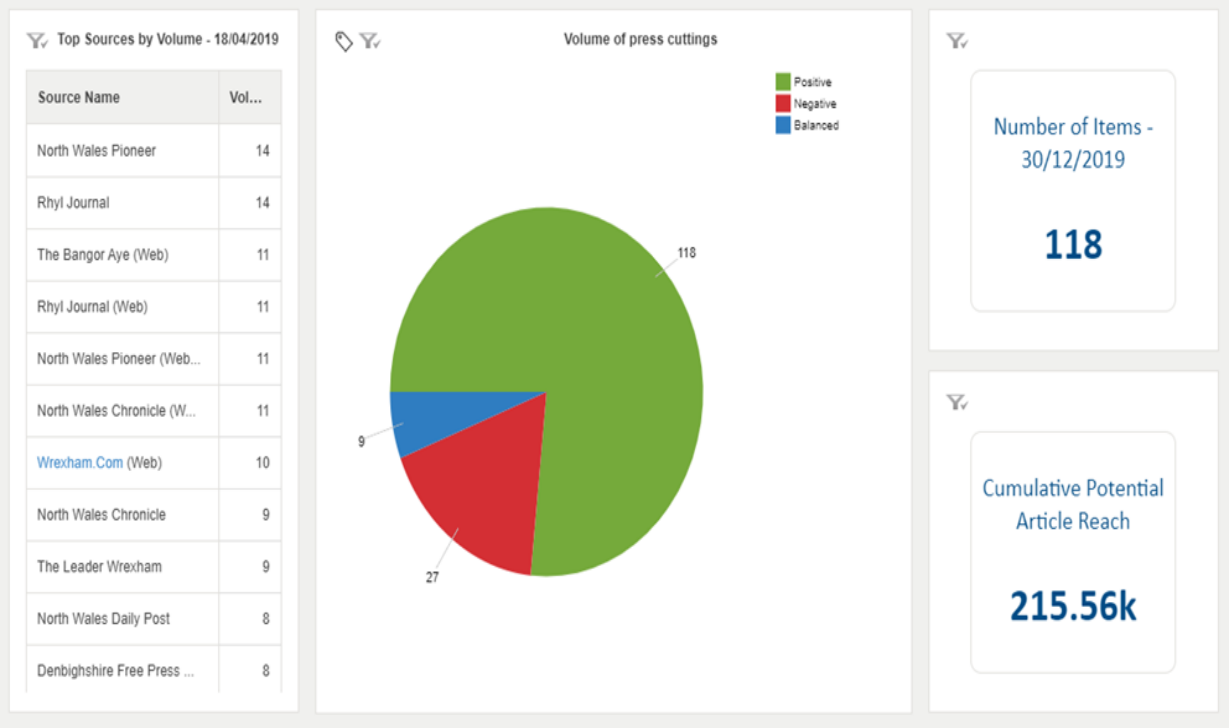
The Division's ability to respond to 'On the Spot' (OTS) concerns remains consistent over the last reporting quarter with the vast majority (86%) able to be successfully resolved.



	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019
OTS Opened	22	16	15	22	17	16	30	14
OTS Closed	25	17	15	20	16	15	32	13

2.10 Enhancing Trust and Confidence

As part of our efforts to re-earn the trust and confidence of the population we serve, we continue to work with the local, regional and national media to communicate the improvements we are making to our services. In 2019, positive media coverage of our MHLD services outnumbered negative coverage by a factor of 4:1. (118 positive articles vs 27 negative). We also received significantly fewer media enquiries relating to negative stories about MHLD services compared to 2017.



2.11 Workforce

The Division participated in the All Wales Inpatient Nursing Assessment in November 2019. The next step is to ensure results compiled by Public Health Wales from this exercise considered against the proposed MHLD inpatient model and the awaited All Wales Mental Health Principles for setting an establishment.

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

Our Strategy aims to make changes across the whole system in the way that we deliver services ranging from bed based care to services that are delivered in the community.

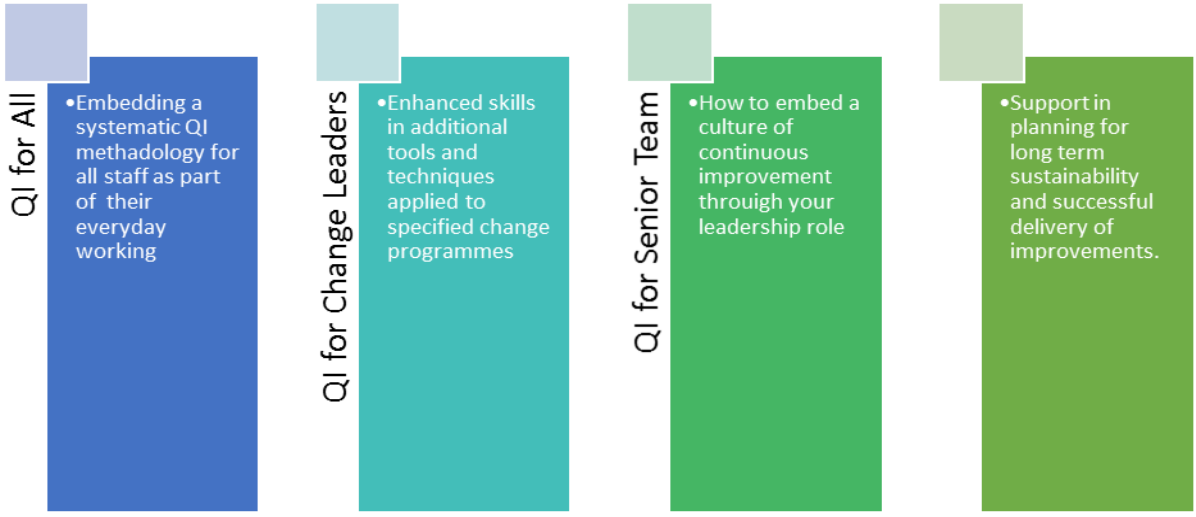
Our new approach aims to ensure that people of all ages receive the right support, in the right place, at the right time, throughout their lives. This involves moving away from a clinical, specialist model of bed-based care to one which is focused on community based prevention and early intervention.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

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

Quality Improvement Programme

Significant progress 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. The TODAYICAN movement has provided the springboard for our workforce with the 'permission' and 'trust' to embrace change and take responsibility for improvement. We now have a real opportunity to further build on the TODAYICAN ethos and embed continuous quality improvement as 'Business as Usual' across the division and across the whole system.

Our next stage is to adopt and embrace an evidence base QI methodology to drive the cultural change needed. We will strengthen the culture and behaviour for embracing shared learning, to counterbalance judgement, fear and risk aversion. This will instigate leaders to create a system where people can learn continually through a system of continuous improvement. Including the workforce, the person and the voluntary and independent sectors in an important element of our system. This project will begin January 2020. The first part is training 150 staff from across the Division.



ICAN Pathway

The three Local Implementation Teams continue to drive at pace the implementation of the ICAN Pathway, which aims to introduce new community support which will help build resilience and prevent people from falling into crisis. Once fully established, we expect that more people will receive the early support they need in the community, leading to reduced waiting times and improved outcomes for people who require the specialist support of our mental health services

The first element of the pathway has been tested over a 12 month period – these are ICAN Unscheduled Care, at North Wales' three Emergency Departments. Over the past 12 months, ICAN Unscheduled Care has supported 3,000 people in Crisis.

Taking the learning from this pilot, we are now introducing the second and third element of the pathway – which are the ICAN Community Hubs and ICAN Primary Care. 8 Community Hubs will be established over the next 3 months providing alternative early support at a community level for people with emotional need.

Over 300 individuals to date have been referred to the ICAN Work pilot, which aims to support people with mild to moderate mental health problems find and remain in paid employment in order to support their recovery.

2000 individuals and organisations have requested the ICAN Training developed. The training has been developed to encourage open conversations about mental health, to increase community resilience and to address the stigma that exists within our communities towards people living with mental illness.

Bed Based Care

We have agreed our bed based care model, which aims to expand and enhance the bed-based provision across the region. This will create opportunities to repatriate people who are currently receiving treatment out of area.

The major cultural change is that inpatient care becomes a resource of the community rather than seen and belonging as a separate service. There is significant clinical buy in and support for the model, designed through co-production

by clinicians, people with lived experience across north wales and partnership stakeholders.

We are currently in the process of establishing a project team to lead on this priority area.

Early Intervention in Psychosis

A Project Manager is now in post to lead on developing a regional Early Intervention in Psychosis Service. A Project Steering group is being established along with a detailed implementation plan.

4.0 Conclusions / Next Steps

The MHLD Division has outlined in this exception report progress made against key quality and safety metrics. Progress shown against the Mental Health Measure with plans in place to meet compliance across the Division by the end of March 2020. We have sustained improvement on DTOC, out of area placement and our management of SUI.

QSE updated on the review of Psychological Therapies and the new Implementation Board, T4MH Strategy and latest plans to embed quality improvement through 2020.

5.0. Recommendations

The Committee asked to note:

1. Progress made related to:

    - Compliance with parts of the Mental Health Measure, DTOC and out of area
    - Lessons Learned from incidents
    - HIW outstanding actions
    - Risk register: those managed through locality structures and those overseen by Divisional Directors
    - Mental Health Strategy and plans for Quality Improvement

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience Committee 28/1/20
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Development of Dementia Services
Cyfarwyddwr Cyfrifol: Responsible Director:	Gill Harris Executive Director of Nursing and Midwifery / Deputy Chief Executive
Awdur yr Adroddiad Report Author:	Trevor Hubbard Deputy Executive Director of Nursing; Sean Page Consultant Nurse; Suzie Southey Consultant Nurse
Craffu blaenorol: Prior Scrutiny:	BCUHB Dementia Strategy Group
Atodiadau Appendices:	1. Narrative report 2. Presentation

Argymhelliad / Recommendation:

The QSE Committee is asked to accept the report submitted giving an update on the future of Dementia services with a focus on ensuring consistency across the Health Board

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

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

Sefyllfa / Situation:

This assurance report is framed by the themes adopted by the Dementia clinical strategy which are taken from the Dementia Action Alliance/NHS England 'Well' agenda. This allows us to strategise and operationalise across the whole trajectory of dementia whilst remaining compliant with national quality standards, Welsh Government targets and, public expectations.

Cefndir / Background:

North Wales is home to around eleven thousand people who are living with dementia. BCUHB is the single organisation responsible for meeting the health care needs of this population and every part of the Health Board will, to a greater or lesser, extent encounter people with dementia and their carers.

There is considerable activity underway across the Health Board to maintain, develop, innovate or improve dementia care services. Much of that is as a result of strategic intention captured within the National Dementia Strategy for Wales and the BCUHB Dementia Strategy 2018-20. Further developmental activity will come from the publication during 2020 of; the Integrated Dementia Strategy for North Wales by the Regional Partnership Board, the Dementia Charter for Wales by Welsh Government and, the BCUHB Dementia Clinical Strategy.

Asesiad / Assessment & Analysis

Strategy Implications
The Dementia Clinical Strategy informs the development of the BCUHB Clinical Strategy review and provides assurance following the recommendations of the HASCAS and Ockenden reports. The strategy is cross cutting impacting on all clinical areas and teams within the Health Board and is an opportunity to ensure we are aligned to the Wales Dementia Action Plan but also to look forward to 2025 and influence the IMTP process

Financial Implications
There are no specific budgetary requirements from the paper nor recommendations on future spending

Risk Analysis
Any risks are already noted within the appropriate risk registers

Legal and Compliance
Nil identified in addition for our usual requirements to be compliant with Welsh Government Dementia Charter

Impact Assessment
No specific impacts identified

Introduction

Prevalence data suggests that North Wales is home to around eleven thousand people who are living with dementia. BCUHB is the single organisation responsible for meeting the health care needs of this population and every part of the Health Board will, to a greater or lesser, extent encounter people with dementia and their carers.

There is considerable activity underway across the Health Board to maintain, develop, innovate or improve dementia care services. Much of that is as a result of strategic intention captured within the National Dementia Strategy for Wales and the BCUHB Dementia Strategy 2018-20. Further developmental activity will come from the publication during 2020 of; the Integrated Dementia Strategy for North Wales by the Regional Partnership Board, the Dementia Charter for Wales by Welsh Government and, the BCUHB Dementia Clinical Strategy.

This assurance report is framed by the themes adopted by our clinical strategy which are taken from the Dementia Action Alliance/NHS England 'Well' agenda. This allows us to strategise and operationalise across the whole trajectory of dementia whilst remaining compliant with national quality standards, Welsh Government targets and, public expectations. The five 'well' areas come together to form a pathway which BCUHB has developed as part of its strategic partnership with the Alzheimer's Society and its vision to be 'a more dementia friendly organisation'. The BCUHB Dementia Clinical Strategy will articulate how health care services will contribute locally, regionally and nationally to recognise and acknowledge the universal rights of those affected and, to make dementia care safe, compassionate and grounded in best evidence. The strategy will fundamentally facilitate the greater inclusion of individuals, families and carers, in the shaping of health care services that are to be provided.

Preventing Well

The focus is placed on two interconnected health care actions. First, to reduce the risk of developing dementia. This is related to raising awareness of the modifiable risk factors (such as diabetes and hypertension), amongst the 'at risk' population (those over 50 years of age) and offering appropriate information or education to support behaviour change. Second, to promote a healthy lifestyle. The focus is upon the health of the general population with attention placed on behaviours such as; smoking, obesity and, excess alcohol which are monitored through the Public Health Wales Observatory. Activity underway across the Health Board include,

1. The MECC approach is embedded into clinical practice across the Health Board and is underpinned by materials published by Public Health Wales.
2. Risk reduction messages are reinforced during the mandatory skilled level of dementia training.
3. Carers Trust (under contract from BCUHB) and the Allied Health Professionals team continue to offer practical opportunities for people with dementia and carers to action the 'Six steps' program which has been accessed by 572 people during 2019.
4. Primary care clusters provide health promotion regarding the six steps within routine consultations and offer onward referral to NERS (National Exercise

Referral Scheme) for exercise programmes, and to CAIS for smoking cessation.

Diagnosing Well

This aspect of the framework is of high importance to people who are concerned that they may be developing a dementia. BCUHB attention is placed upon three actions. First, to offer the people of North Wales prudent access to specialist clinical services for the assessment, diagnosis and treatment of dementia and its sub-types. Second, to assure that the assessment and diagnostic process is concordant with national quality standards and best evidence. Third, to assure that delirium can be distinguished from dementia and treated accordingly. Activity underway across the Health Board includes,

1. Memory Assessment Services remain the primary diagnosis making mechanism for North Wales. All services remain within the National accreditation program managed by the Royal College of Psychiatrists.
2. Information management systems for Memory Assessment Services have been upgraded and standardised across services with access to WPAS. Data capture and analysis reliability is now highly assured. This allows improved reporting of diagnosis rates by sub-type to the 1000Lives memory service audit program.
3. A detailed capacity and demand analysis has been undertaken in preparation for the introduction of waiting times targets. This has allowed clear actions to emerge and a plan for achieving zero waiting lists and target compliance in advance of target introduction.
4. The BCUHB QOF Dementia registers for 2018/19 (the most recent period available) show a total number of recorded diagnoses as 5,425. This is a 6.1% increase on the 2017/18 position of 5,092. The target of a 3% increase on the previous year has been met. The expected number of people with a diagnosis is 10,727 – against this there has been an increase in recorded diagnoses from 47.5% in 2017/18 to 50.5% in 2018/19.
5. A new delirium management policy has been introduced alongside screening tools embedded in the medical clerking in documentation and supported by additional training.

Supporting Well

The responsibility of health care services is to support people with dementia, and their carers to enjoy the optimum physical health they can. To achieve this BCUHB attention is placed on six actions. First, for emergency healthcare to be more responsive to the additional needs and complications that dementia brings. Second, for access to physical healthcare for people with dementia on a mental health ward to be improved. Third, for anti-psychotic prescribing to be reduced and regulated through a new prescribing policy.

Fourth, for there to be greater access to a range of non-medical interventions to address needs arising from dementia. Fifth, for staff training in dementia care to be delivered within a robust and sustainable model. Sixth, for families and carers to be fully involved in discussions around healthcare decision making. Activity underway across the Health Board includes,

1. An AHP (Allied Health Professionals) team comprised of occupational therapist, physiotherapist, speech and language therapist and a dietician has been introduced to offer a service specifically for people with dementia.
2. Memory assessment services increasingly offering access to preventative specialist dentistry and audiology screening at the point of diagnosis of a dementia.
3. Work to reduce anti-psychotic prescribing is well underway with new prescribing guidelines and audits within primary care and the mental health division.
4. New physical health care and, end of life guidelines for dementia introduced to mental health wards.
5. All District General hospitals completed 4th round of National (Wales and England) Dementia Audit. Action plan to improve delirium screening and, discharge planning is in place and has been reported to Welsh Government.
6. BCUHB wards predominantly delivering care to people with dementia participating in the ward accreditation program. DGH's and Community hospitals engaged with the independent/external 'dementia friendly' accreditation programme. Five currently accredited, others at various stages.
7. Dementia training for staff is aligned to the National framework for Wales and is delivered in conjunction with family carers.

Living Well

In conjunction with the actions set out above in 'Supporting Well' healthcare practitioners can also impact on how well people with dementia and carers can enjoy everyday life. To achieve this BCUHB attention is placed on three actions. First, to actively sign post people with dementia and carers to support available within their local communities. Second, to support people to make decisions about the future. Third, to actively support the development of Dementia Friendly Communities across North Wales which will allow people to remain as connected, engaged and participating in those communities, and living lives of purpose and meaning, for longer. Activity underway across the Health Board includes,

1. The contract with Carers Trust to provide post diagnostic support and signposting renewed. This is a five year £1 million investment by BCUHB.
2. NEWCIS under contract from BCUHB continue to offer the carer assessment to all carers of people diagnosed with dementia.
3. A full range of advocacy services are available for people with dementia and carers across N. Wales. BCUHB remains 100% compliant with Welsh Government targets for this.
4. Transgender and dementia care guidelines developed.
5. Health Board awareness of and relationship building within the emerging Dementia Friendly Communities network across North Wales.

Dying Well

In recent years there have been general concerns that the end of life experience for a person with dementia has been one of limited choice and poor quality which has led to unnecessary distress and loss of dignity. The case for change has been strongly highlighted within the Health Board. To bring about improvement BCUHB

attention is placed on three actions. First, to support people when they feel that the time is right to plan their future care. Second, for there to be an assured quality of end of life dementia care available to each person. Third, for the person or his representatives to be included in end of life care and treatment as an equal partner in care. Activity underway across the Health Board includes,

1. The Health Board supports and part funds an Admiral Nurse post based at St. Kentigern's Hospice.
2. The partnership between the Mental Health and Learning Disability Division and MacMillan Specialist Palliative Care Services to develop high quality end of life dementia care has been highly productive in respect of guidelines, environmental improvement and staff training.
3. Consultant Nurses for dementia have provided dementia training to all hospices across North Wales.

Dementia Progress Report

Deputy Executive Director of Nursing, Consultant Nurses, Older Person Project Manager

See also,

NW Integrated DAP progress report

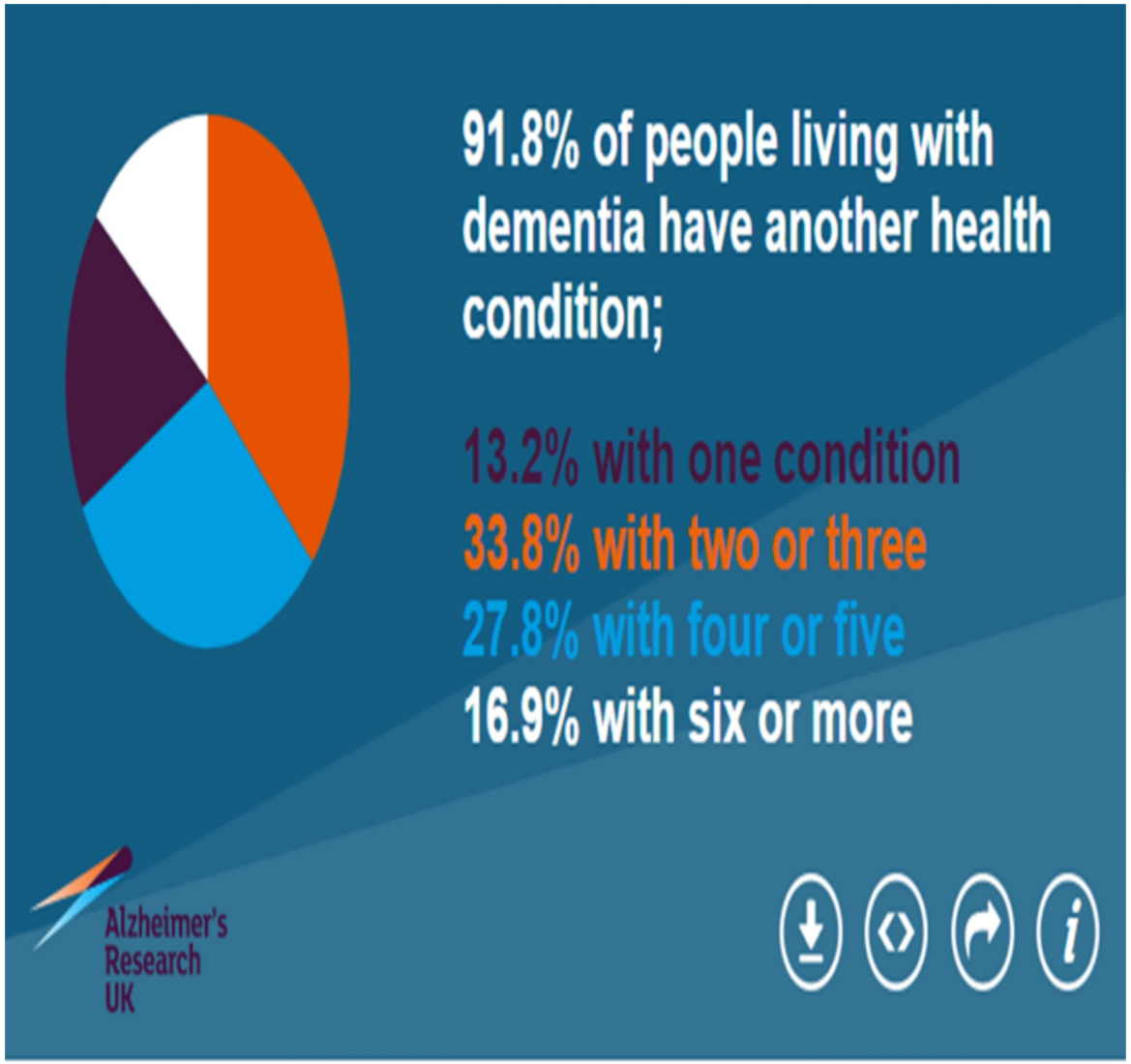
Consultant Nurses update report QS20/14

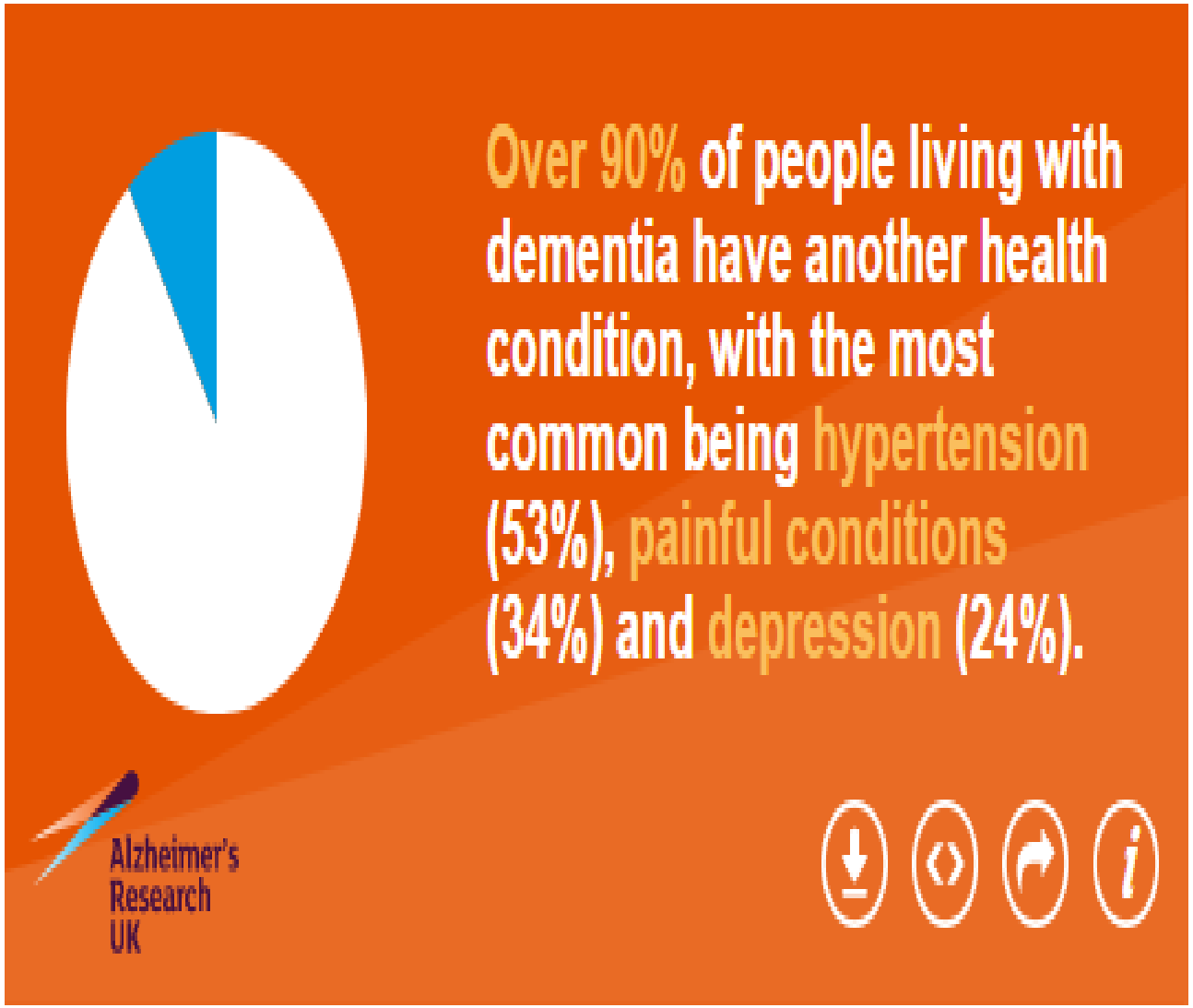
Consultant Nurses update QIS report

- Approximately 45,000 people who live in Wales have dementia. This figure will rise to over 55,000 by 2021.

- 10,727 live in North Wales. This has increased by 18% since 2014 and by 2021 the increase will be 26%.

(Alzheimer's Society 2015)


91.8% of people living with dementia have another health condition;
13.2% with one condition
33.8% with two or three
27.8% with four or five
16.9% with six or more
Alzheimer's Research UK


Over 90% of people living with dementia have another health condition, with the most common being hypertension (53%), painful conditions (34%) and depression (24%).
Alzheimer's Research UK

Developments in Dementia Care

Key Areas of work

- Dementia Clinical Strategy
- Education and Training
- Research and Audit
- Care home program
- Dementia Specific Staff
- National Programs
- Environmental Design
- Carer’s Engagement
- New Technology
- Inclusive polices, procedures and pathways


Effective and compassionate care
Engagement
Safe guarding
Carers valued
Environments
Assessment & support

The BCUHB Dementia Care Pathway

PREVENTING WELL

Risk of people developing dementia is minimised

Making Every Contact Count (MEC)

DIAGNOSING WELL

Timely accurate diagnosis, care plan, and review within first year

- Delirium
- Initial Assessment (non specialist setting)
- Diagnosis in a Specialist setting
- Further Tests

SUPPORTING WELL

Access to safe high quality health & social care for people with dementia and carers

- Emergency Health Care
- Physical Health Care in a Mental Health ward
- Medicines Management
- Hospital Admission
- Sensory health

LIVING WELL

People with dementia can live normally in safe and accepting communities

- Active Signposting
- Dementia Friends — An Alzheimer's Society initiative
- Social Care
- Support for Carers

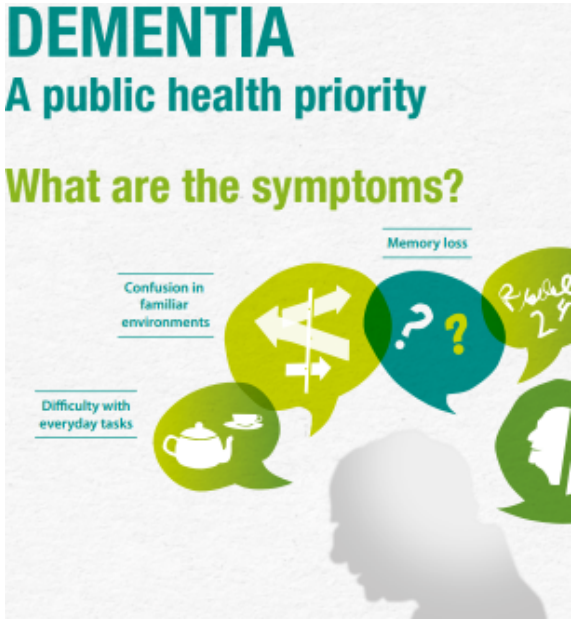
DYING WELL

People living with dementia die with dignity in the place of their choosing

- Making Future decisions now
- End of Life Care on a Mental Health Ward
- Palliative Care
- Hospice Care
- Dying at Home

Clinical Strategy

A vision that sets out BCUHB's 5-year ambition, to deliver high quality clinical care, with meaningful outcomes for people in North Wales living with Dementia. An integral contribution to the RPB Integrated Dementia Strategy.



- To enable us to support the needs of people living with or affected by dementia the clinical strategy has a focus on five key work streams/themes.
- Preventing well
- Diagnosing well
- Supporting Well
- Living well
- Dying well

Clinical Strategy

The strategy captures our current clinical activities across the spectrum of care, from public health to end of life, the intention is to give an oversight of activity, and to align, and report on cross service effort in care developments for people living with dementia and their carer's considering local, national, and international drivers and BCUHB strategic vision.

Current Position on the Dementia Clinical Strategy (DCS)

Strategy Group established under Trevor Hubbard

A draft: Strategy /TOR/Governance framework, meeting dates & membership in place

The DCS document encompasses the remaining HasCas program of works, ensuring actions and progress are continued with a focus on innovation and new vision

Base line data sets to be agreed

The next phase is an engagement with staff across BCUHB to finalize and agree the reporting metrics, and develop a framework that reflects the program of works across the health board and to bring staff into the vision of the clinical strategy.

Research & Audit

Research & Audit

The dementia and physical health research agenda is being taken forward 2020, increasing capacity and engagement, including portfolio studies, and aligning to Health and Care Research Wales.

Research embedded in memory services, patient involvement

NC facilitating and engaging with wider research and innovation opportunities, developing funding across community and acute settings for multidisciplinary research opportunities including care homes and primary care

National audit for dementia -

Antipsychotic Audit – Comparison to national picture

Education and Training

- Consultant Nurse's contribute as honorary lecturers the delivery of MSc programs in dementia and related care modules
- Local training specialist approach (informed level – 10,887 trained, skilled level – 1,096)
- Level 3 dementia care studies accessible (84 HCSW graduates)
- A program in development with Glyndŵr University for developing advanced practice, frailty, long term condition and emergency care Practitioners
- Collaborative program of palliative care & dementia education developed with Hospice Teams and MacMillan Specialist Palliative Care Services.
- Tide Carers work
- Risk reduction
- 1000 lives
- Delirium and dementia pathways in progress, an acute pathway for managing acute presentation of excited delirium in frail older folk on arrival to ED is in progress (family representation included)
- Developing care home emergency care response with WAST

Care home program

- West have exampled a program of dementia care in liaison with Consultant Nurse and PDN
- Utilizing the Alzheimer society program of training
- Evaluation of content and best practice
- A plan to agree and develop a sustainable and consistent core program for all areas to adopt in community dementia care
- Local appointment of dementia PDN East/ West to support community care and specialist group of practitioners to be developed
- The virtual learning and support hub (if resource approved) will engage and mobilize the dementia resource across NW with limited cost improving quality and reducing attrition of workforce
- Engaging care homes in BCUHB programs
- Integrated dementia training with local authority
- Linking standards of dementia care to commissioning of care homes – specification review

Dementia Specific staff

- Currently employ dementia support workers and soon registered nurses across NW to support PLWD in the community
- The roles are often in rural communities
- Training is minimal for this, and they care is for some of the most complex patients
- Program of induction and virtual learning and support is being developed
- Tablet/phone access to resources, training by skype, connection to others, patient family surveys, governance, retaining staff, developing expertise
- Working with WAST on sharing education and resources

National Program Engagement

- CIW
- National Wales Care engagement Program
- Dementia Friendly Hospital Charter pan Wales
- Royal College of Psychiatrist National Dementia Audit
- Health & Care research Wales
- Consultant Nurse Program
- All Wales Hip Fracture Program
- Crown Audit RCP
- All Wales Senior Nurse Advisory Group
- 1000 lives & regional partnership board

Dementia Friendly Wards, Communities & Accreditation

- Alltwen Mold and Denbigh achieved accreditation with Alzheimer Society
- Rest in progress
- Bangor Acute Hospital Achieved
- Alzheimer DF communities program
- Consider progression for BCUHB achievement/application before April 2020
- Community hospital plan
- RAG RATED MAP approach to consistency

Developments in early stages

A Well being clinic after diagnosis addressing: (Rhyl Surgery)

- Long term condition
- Physical activity
- Mental Health
- Carer's needs
- Social Prescribing
- Dental care
- MSK posture and mobility
- POA EOL advanced care plans
- Virtual learning and support network with simulation facility (presented to **Awyr Las)**
- **Intranet Page** dementia specific
- Standard induction program for dementia specific roles

Frequent ED Attenders

Pt 18	*						****		*	*			6
Pt 19						**		**	*	*			6
Pt 20		*	*			*	*		*	*			6
Pt 21	**		*					*	*	*			6
Pt 22								**			*	*	6
Total number of patients having had 6 or more ED visits in the 12 month period is 22 , with a total of 170 separate attendances of which 78 resulted in admission.	**********	**********	*********	**********	**********	*********	**********	**********	**********	**********	*********	****	170

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience Committee 28th January 2020
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Serious Incident Report – November and December 2019
Cyfarwyddwr Cyfrifol: Responsible Director:	Mrs Gill Harris, Executive Director of Nursing and Midwifery/Deputy CEO
Awdur yr Adroddiad Report Author:	Mr Matthew Joyes, Assistant Director of Patient Safety and Experience
Craffu blaenorol: Prior Scrutiny:	Review by the responsible director
Atodiadau Appendices:	Appendix 1 - Serious Incident Report – November and December 2019

Argymhelliad / Recommendation:

The QSE Committee is asked to:
1. Note the ongoing work of the quality improvement collaboratives and planned improvement work: including review of various Health Board processes and implementation of the Datix IQ Cloud.
2. Receive this report, alongside the Patient Safety Report and consider whether the Patient Safety Report submitted to the committee on a quarterly basis provides ongoing assurance around serious incidents.

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

Sefyllfa / Situation:

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

Cefndir / Background:

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

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

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Appendix 1

Serious Incident Report
November and December 2019

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

1. INTRODUCTION

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

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

1.2 Never Events are defined as Serious Incidents that are wholly preventable because guidance or safety recommendations are available at a national level and should have been implemented by all healthcare providers. The Welsh Government issues a list of serious incidents that are deemed to be Never Events. Each Never Event type has the potential to cause serious patient harm or death. However, serious harm or death does not need to have happened as a result of a specific incident for that incident to be categorised as a Never Event. Never Events require full investigation under the Serious Incident Framework.

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

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

- A data point falling outside a process limit (upper or lower) indicates something unexpected has happened as 99% of data should fall within the process limits – the process limits are indicted by dotted grey lines.
- Two out of three data points falling near a process limit (upper or lower) represents a possible change that should not result from natural variation in the system – the process limits are indicted by dotted grey lines.

- A run of seven or more values above or below the average (mean) line represents a shift that should not result from natural variation in the system – this is indicated by coloured dots.
- A run of seven or more values showing continuous increase or decrease is a trend – this is indicated by coloured dots.
- A target (if applicable) is indicated by a red dotted line.

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

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

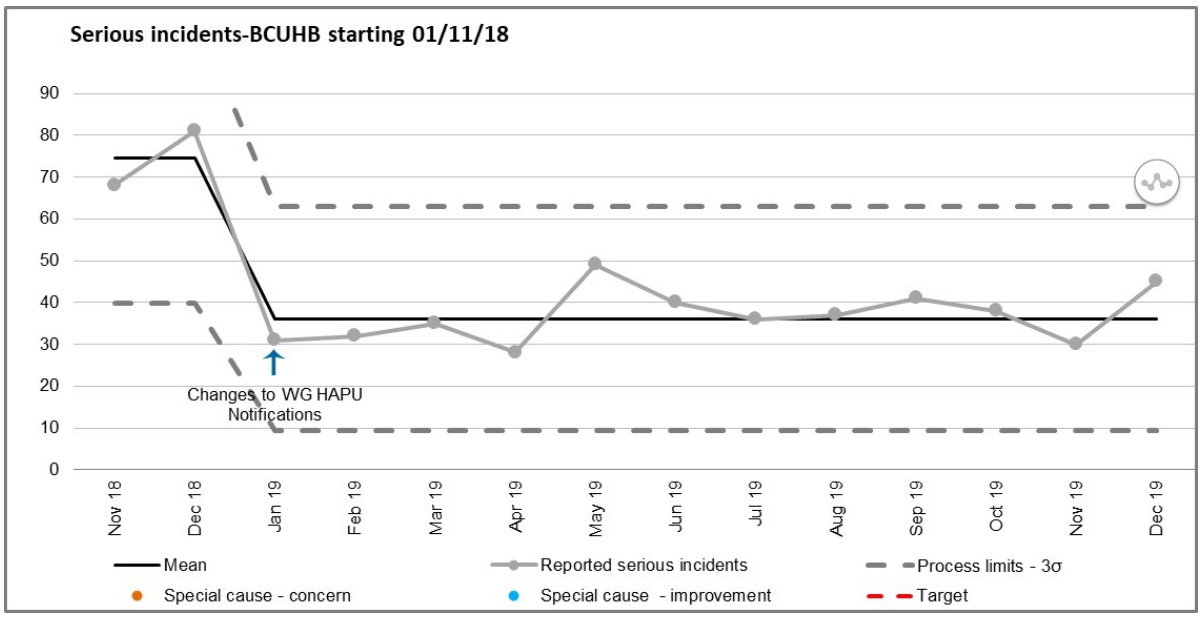
2. SERIOUS INCIDENTS

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

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

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

2.2 During November and December, 75 serious incidents were reported.



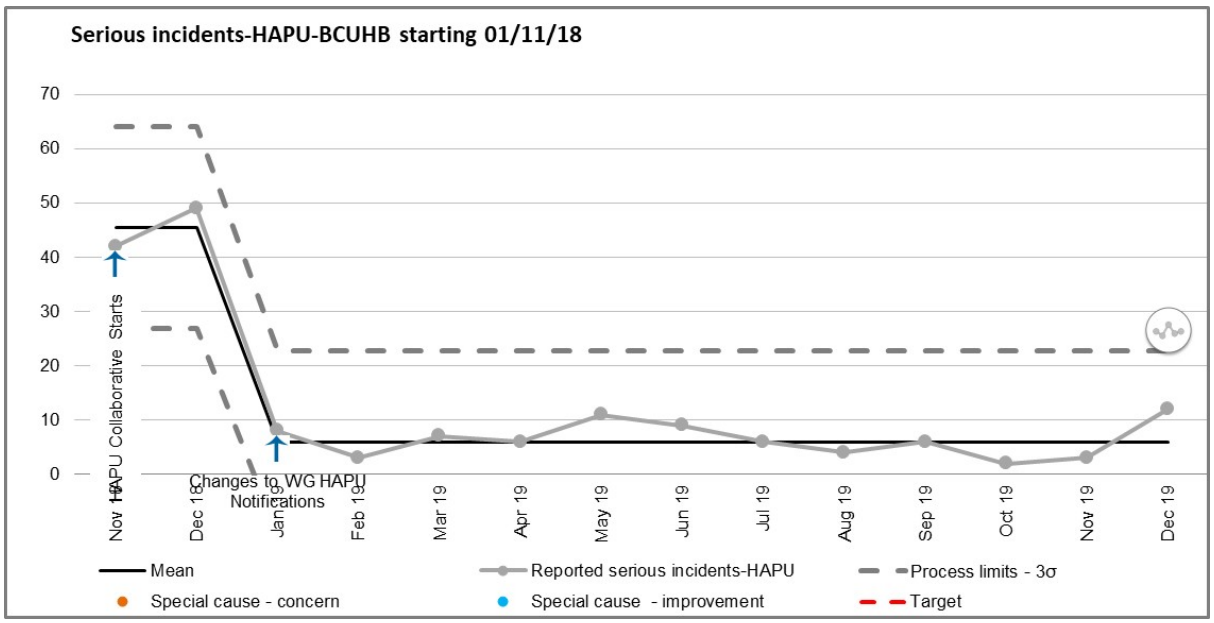
	Q4 18/19	Q1 19/20	Q2 19/20	Q3 19/20
East Acute	20	13	23	15
Central Acute	7	7	12	11
West Acute	15	22	9	5
East Area	6	12	6	9
Central Area	8	12	12	15
West Area	4	5	7	5
Women's	2	1	4	2
Radiology	0	0	2	0
MH & LD	39	47	48	55
		Changes to WG HAPU Notifications in January 2019		

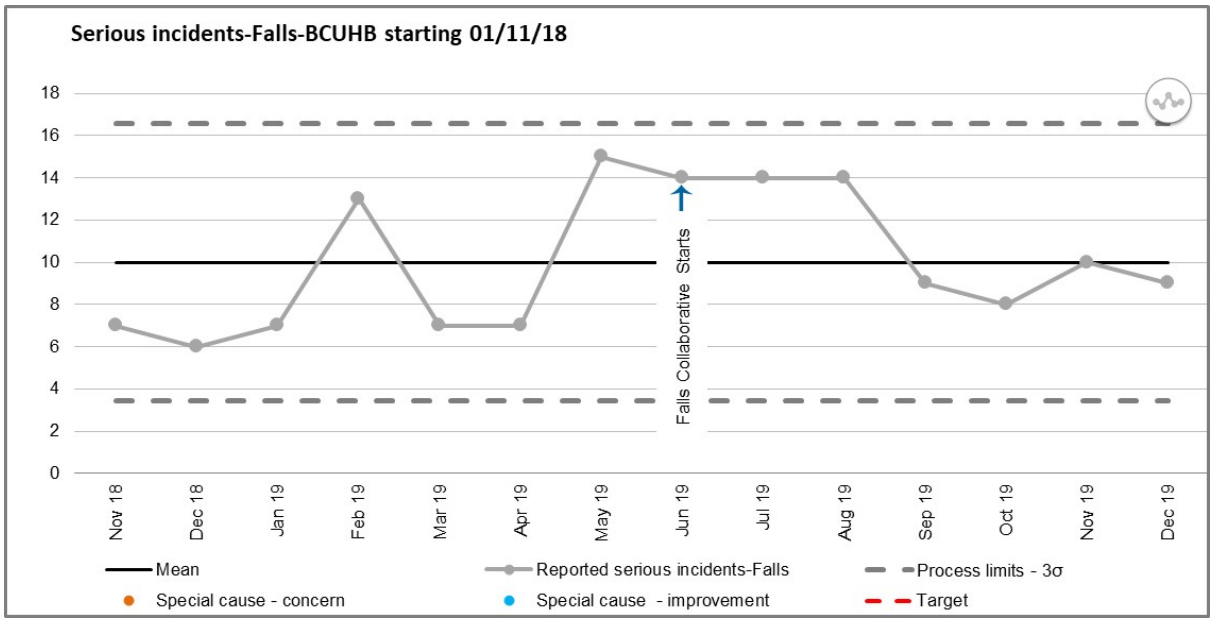
2.3 The most common categories of reported serious incidents include:

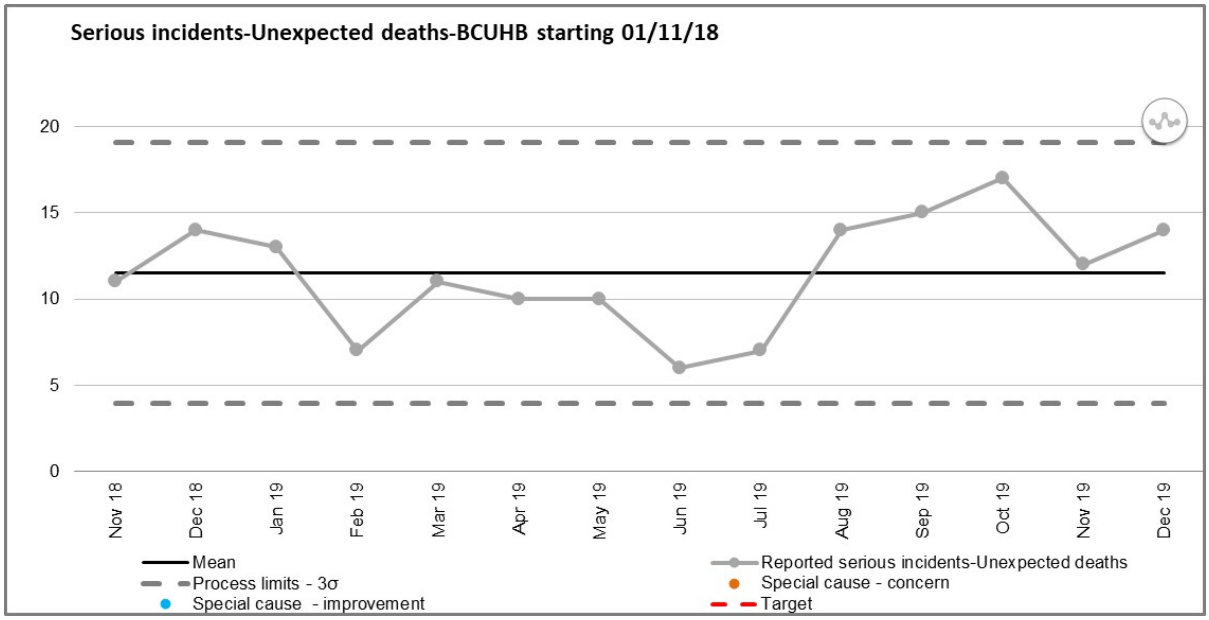
- Healthcare Acquired Pressure Ulcer (HAPU);
- Patient falls resulting in severe harm or death;
- Unexpected death whilst under the care of a health professional – the significant predominance of these incidents are deaths reported by the Mental Health and Learning Disability Division who are required to report all unexpected deaths of

patients open to services. This is regardless of whether the death was contributed to by healthcare services (as per the national Serious Incident Framework).

2.4 The following charts outline performance in relation to these areas of focus – all show common cause variation.







2.5 At the time of writing, 99 serious incidents remain open with Welsh Government of which 33 are overdue. Of these, the predominance of overdue incidents relate to Ysbyty Glan Clwyd (6), Central Area (8), Mental Health, and Learning Disability (7). All divisions have seen and continue to see a reduction in overdue incidents. A small number of incidents are overdue by twelve months (4) and these mostly relate to matters subject to police investigation. A number (8) are overdue by 6-12 months and a larger number (12) are overdue by 3-6 months. There has been significant reduction over the last 12 months and divisional governance teams are taking focused action to reduce this further.

3. NEVER EVENTS

3.1 During November and December, 2 Never Events were reported as follows:

Division	Ward/Team	Type of Event	Description	Harm
Wrexham Maelor Hospital	Fleming Ward	Retained foreign object post-operation	Retained PICC line guidewire and incorrect end connection	Minor
Ysbyty Glan Clwyd	Theatre B	Wrong site surgery	Removal of gallbladder instead of kidney	Major

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

4. LEARNING FROM SI REVIEWS

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

4.2 During November and December, 100 serious incident closure forms were submitted to Welsh Government. Following the process mentioned above, the responsible division submits a closure form summarising the investigation and action plan to the Assistant Director of Patient Safety and Experience who reviews (on behalf of the Executive Director of Nursing and Midwifery) before onward submission to Welsh Government. The following high-level themes have been identified from a review of these 100 forms:

- 22 closure forums identified no learning – these mostly related to unexpected deaths in mental health or substance misuse services where the cause of death was not connected to healthcare services;
- 8 closure forms identified issues with the completion, review and updating of pressure ulcer risk assessments, Maelor scores and care plans;
- 6 closure forms identified falls prevention information was not provided to patients;
- 5 closure forms identified issues with intentional rounding;
- 3 closure forms identified delays in referral to Tissue Viability Nursing;
- 2 closure forms identified issues with allocation of staff observations to prevent falls;
- 2 closure forms identified interface working between substance misuse services and community mental health services;
- 2 closure forms identified issues with the completion of falls risk assessments.

5. SAFETY IMPROVEMENT

5.1 The HAPU collaborative commenced in November 2018, with two cohorts of wards from across the Health Board. Through a focused approach to Pressure Area Care (with support of an expert faculty and the application of Quality Improvement methodology) the cohorts were able to determine through testing, the standards for the Health Board for Pressure Area care in the ward setting, effectively creating ‘always events’ for pressure area care. Early indication of the wards actively testing interventions are positive. HAPU Launch events were held across BCUHB in May 2019 and were attended by over 130 BCUHB staff. The Patient Safety Report contains further information on this work.

5.2 By applying similar methodology as used with the HAPU collaborative, the Inpatient Falls Collaborative commenced in June 2019 with one cohort of wards identified through analysis of falls data. The collaborative aim is to reduce falls by 15% by

November 2019 and 30% by April 2020 for our cohort wards. The collaborative aspire to achieve this aim by implementation of individual interventions for patients following an individual risk assessment. The faculty compromises of the Quality Improvement Team (Corporate Nursing) and subject experts which include Physiotherapist, Occupational Therapist, Dementia Consultant Nurse, Medical Consultant, community falls lead with technical support from a data analyst. The Patient Safety Report contains further information on this work.

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

5.4 A key focus of the Patient Safety and Experience Department in 2020 will be developing a learning framework and associated tools that support an emerging learning culture. Work is underway currently to develop initial basic tools including a new Patient Safety and Experience Newsletter and Online Learning Portal to support the sharing of learning across the Health Board. The PTR1a concerns procedure is currently under review into a single, simplified and easier to read document alongside the process reviews mentioned above.

6. CONCLUSION AND RECOMMENDATIONS

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

6.2 The QSE Committee is asked to note the ongoing work of the quality improvement collaboratives and planned improvement work: including review of various Health Board processes and implementation of the Datix IQ Cloud.

6.3 The QSE Committee is asked to receive this report, alongside the Patient Safety Report and consider whether the Patient Safety Report submitted to the committee on a quarterly basis provides ongoing assurance around serious incidents.

Cyfarfod a dyddiad: **Meeting and date:**	Quality, Safety and Experience Committee 28th January 2020
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Self-Assessment of Quality Governance Arrangements
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Mrs Gill Harris, Deputy Chief Executive / Executive Director of Nursing & Midwifery
Awdur yr Adroddiad **Report Author:**	Ms Deborah Carter, Director of Operations
Craffu blaenorol: **Prior Scrutiny:**	The self-assessment was scrutinised and approved by the Board.
Atodiadau **Appendices:**	Appendix 1 - Self-assessment document as submitted to Welsh Government

Argymhelliad / Recommendation:

The Quality, Safety and Experience Committee is asked to scrutinise the report and to consider whether any area needs further escalation to be considered by the Board.

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

Sefyllfa / Situation:

Cefndir / Background:

BACKGROUND

Following well publicised events at Cwm Taf Morgannwg University Health Board, the RCOG was commissioned by the Welsh Government to undertake an external review to investigate the care provided by the health board's maternity services. The review took place on 15-17 January 2019, and at the request of Welsh Government, the resulting report and its findings/recommendations informed a local benchmarking exercise involving health boards across Wales. Each health board was asked to consider its own maternity services in the context of the recommendations of the report and to provide assurances on the safety of those services.

The Women's Directorate in BCUHB undertook this benchmarking exercise and submitted the outcome to Welsh Government in May 2019. Some areas for ongoing improvement were identified and have been taken forward as part of the Directorate's learning culture and service development.

In November 2019 Healthcare Inspectorate Wales and the Wales Audit Office issued a report titled '*A review of quality governance arrangements at Cwm Taf Morgannwg University Health Board*'. The Minister for Health and Social Services requested that all health boards and NHS Trusts in Wales assess themselves against the recommendations of the review and provide plans for future

review of their arrangements and/or the necessary action to be undertaken. The self-assessment was required to include a narrative of current arrangements and the current level of assurance as *high, medium or low.* The Board held an extraordinary workshop session in December 2019 as part of its process for determining its self-assessment response. The approved version of the response was submitted to Welsh Government on 7.1.20.

Asesiad / Assessment

The self-assessment response sets out the Health Board's current position across 7 areas:

- Strategic focus on quality, patient safety and risk
- Leadership of quality and patient safety
- Organisational scrutiny of quality and patient safety
- Arrangements for quality and patient safety at directorate level
- Identification and management of risk
- Management of incidents, concerns and complaints
- Organisational culture and learning

Levels of assurance, based on the current position, were allocated, based on the following definitions:

'a self-assessment of 'high' indicates substantial assurance on the effectiveness of the quality governance arrangement in question, with few or no matters requiring attention. 'Medium' indicates reasonable assurance, with some matters requiring management attention. 'Low' indicates limited or no assurance, with more significant matters requiring management attention'.

Plans for future action and review were also set out in the self-assessment document, as shown in the following appendix.

All-Wales Self-Assessments of Current Quality Governance Arrangements

Following publication of the Healthcare Inspectorate Wales and the Wales Audit Office report titled '*A review of quality governance arrangements at Cwm Taf Morgannwg University Health Board*', the Minister for Health and Social Services has requested that all health boards and NHS Trusts in Wales assess themselves against the recommendations of the review and provide plans for future review of their arrangements and/or the necessary action to be undertaken. The self-assessment should include a narrative of current arrangements and the current level of assurance: ***high***, ***medium*** *or* ***low***. Whilst reference is made to specific documents in the main report and in the recommendations listed below, each organisation should demonstrate how they are discharging the requirements rather than adhering rigidly to the need to have documentation with the same titles.

Completed pro forms should be submitted to Janet Davies no later than **7 January 2020**. If you have queries do get in touch.

[For the purposes of the following table, a self-assessment of 'high' indicates substantial assurance on the effectiveness of the quality governance arrangement in question, with few or no matters requiring attention. 'Medium' indicates reasonable assurance, with some matters requiring management attention. 'Low' indicates limited or no assurance, with more significant matters requiring management attention]

Recommendations	***Self-Assessment***	***Plan for future action/review***
Strategic focus on quality, patient safety and risk		
1. *Organisational quality priorities and outcomes to support quality and patient safety are agreed and reflected within an updated version of the Health Board's Quality Strategy/Plan.*	i. The Quality Improvement Strategy (QIS) was approved by the Board in spring 2017. The Strategy provided a 3 year focus which included the organisational quality priorities and outcomes to support quality and patient safety. The QIS has been subject to ongoing review to assess its effectivity.	The QIS is currently being reviewed and is undergoing an Internal Audit Review. The findings from the Audit will be used to shape the revised QIS

	ii. Work has commenced to shape the new Clinical Strategy which will align with the QIS to ensure that we strengthen the arrangements for organisational quality and maximise our focus on improving outcomes. iii. The Annual Plan will describe the high level quality objectives and through board scrutiny will provide an opportunity for ongoing review of progress. **Supporting Staff to focus on Quality and Improving outcomes:** The Health Board has established a Quality Improvement Hub which demonstrates the organisation's commitment to improving health and delivering excellent healthcare. The Hub is a place where staff can receive help and which supports quality improvement. The Hub is supported by the website which is designed to provide staff with easy access to training support and resources, including examples of local projects that can help inspire staff to move forward with their own. The Hub also signposts to other quality improvement, innovation and research networks to support wider collaborations and help like-minded people link up with each other to support continuous improvement. To date there have been two annual conferences held to promote this initiative. Alignment of quality work across the Health Board ensures that the QI Hub is a "go to" place for supporting improvement for example with areas of improvement identified as part of the Ward Accreditation Programme and as part of the various improvement collaboratives. *Current level of assurance: Medium*	alongside the agreed priorities for the Health Board. Timeline for approval – workshop proposed for February 2020, then QSE and approval at May 2020 Board. A detailed timeline for the Clinical Strategy is being developed. Alongside the development of the three documents will be a communication plan which will ensure effective dissemination across the Health Board.

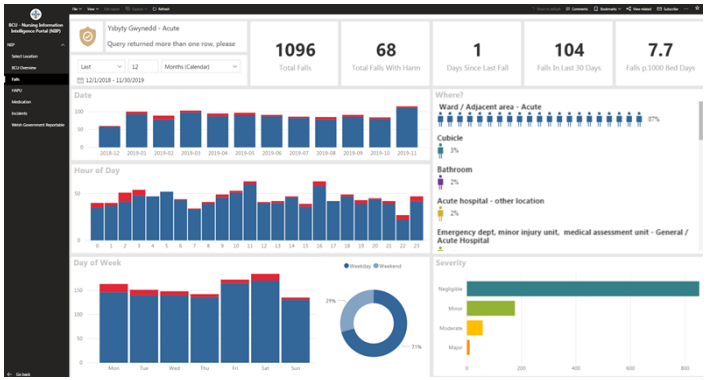
2. *The Board has a strategic and planned approach to improve risk management across the breadth of its services. This must ensure that all key strategies and frameworks are reviewed, updated and aligned to reflect the latest governance arrangements, specifically:* *i. The Board Assurance Framework (BAF) reflects the objectives set out in the current Integrated Medium Term Plan (IMTP)/annual plan and the organisation's quality priorities.* *ii. The Risk Management Strategy reflects the oversight arrangements for the BAF, the Quality and Patient Safety (Clinical) Governance Framework and any changes to the*	The Health Board's current Risk Management (RM) Strategy was approved by the Board in January 2018 and its application was further extended by the Audit Committee on the 12th September 2019 for use across BCUHB until 30th March 2020 whilst a signification overview and review of the system and process is undertaken. The Health Board's vision for risk management is underpinned by good governance and a dynamic, proactive, integrated, enterprise-wide strategic approach which emphasises the appropriate and timely management of risks in order to foster the achievement of its objectives and priority areas as articulated in its 3 Year Plan. The destination of the Health Board`s vision for risk management is an Enterprise Risk Management (ERM) Model which will be rolled out in 2021. In 2020 the Health Board will establish the ground work and foundation on which a robust risk management architecture will be built. The aim will be to fully integrate ERM with strategy and performance. The revised RM Strategy and Policy also proposes moving from a 5 Tier model to 3 to strengthen the escalation and de-escalation processes. The Health Board also have an operational level Annual Risk Management Improvement Plan which has been approved for implementation by the Risk Management Group. This is updated annually to reflect the strategy updates, audit reviews and requirements of the Health Board The RM Group has been set up with agreed terms of reference to oversee the implementation of the RM Strategy to drive through consistency and coordination of improvements in risk management practices across all areas of the Health Board. As the Group is an operational management group, it directly reports into the Executive Management Group.	a. Once ratified by the Board monitor implementation of updated Strategy and audit key performance indicators formally reporting results to the Risk Management Group. b. Provide Chairs' Assurance Report from the Risk Management Group on progress and outcomes to the Audit Committee. c. Deliver training to key individuals and groups across whole Health Board to provide consistent approach for the management of risk, the hierarchy for training will be developed alongside strong monitoring arrangements.

	management of risk within the organisation.	The Risk Management Strategy and Policy is aligned and refers to the Board Assurance Framework (BAF) as the 2 components are intrinsically linked. i. Whilst the Health Board does not have an approved IMTP, it does have an approved 3 Year Outlook, 1 Year plan. A workshop held in December identified clear objectives for the 2020/21 planning process. During this workshop, the Board Secretary was in attendance to support services to identify the principal risks to achieving their objectives.	d. Ensure the RM Group meets at least 4 times during the year. e. Ensure all risks within DATIX are realigned to the new 3 tier model. These principal risks will then be presented to the Board at a further workshop to agree and review in line with the current CRAF arrangements.
iii.	*The Quality and Patient Safety Governance Framework supports the priorities set out in the Quality Strategy/Plan and align to the Values and Behaviours Framework.*	ii There are currently three pillars to the Health Board's Quality and Patient Safety Framework, namely the QIS, Risk Management Strategy and Patient Experience Strategy. The fourth element, a Patient Safety Strategy, is currently under development. All elements will be aligned to the organisational risk and quality requirements and reflect any changes to live risks within the organisation. There are three clinical leads who are instrumental in driving the QIS.	f. The new approach to the BAF will align to the organisational priorities from a risk and quality perspective.
iv.	*Terms of reference for the relevant Board committees, including those for Audit, Quality and Safety and Risk, and at divisional /group levels, reflect the latest governance arrangements cited within the relevant strategies and frameworks.*	iii The Board has an established Clinical Effectiveness Group. The Quality, Safety and Experience Committee is supported by the Quality and Safety Group and Risk Management Group. Secondary Care, Areas, Maternity and Mental Health all have established Quality and Safety Groups. All Groups have clear terms of reference.	g. Develop Patient Safety Strategy and review all other pillars of the Quality and Patient Safety Governance Framework to ensure full alignment with the work programme to strengthen governance across the organisation.

	Current level of assurance: Low/Medium	h. Governance Review currently underway being led by the Deputy CEO. This review will seek to ensure that there is clear alignment and escalation of risks to the Board as appropriate and reflect the latest governance arrangements as cited within the relevant strategies and frameworks.
Leadership of quality and patient safety		
3. There is collective responsibility for quality and patient safety across the executive team and clearly defined roles for professional leads: ***i.*** *The role of Executive Clinical Directors and*	i. The executive team have a shared and collective responsibility for quality and patient safety. This is demonstrated through the committee structures and for example by the chairing and supporting of the 12 Improvement Groups as well as participating in Quality Impact reviews for new programmes of work and projects. ii. The role of the Executive Clinical Directors is clearly defined and articulated within the portfolios document (included within the BAF narrative document – last presented to Audit Committee in September 2019) and is regularly reviewed by the Executive Team.	a. In addition to Clinical Directors and Lead Consultants and Lead Clinicians, the Health Board will be establishing Clinical Leads for the new pathways and networks as part of

divisional/group Clinical Directors in relation to quality and patient safety is clearly defined	There are Medical and Clinical Directors with quality and patient safety within their responsibilities. There is a Chief Clinical Information Officer and three Medical Information Officers, all of whom are responsible for improving the quality of data used by the clinical teams to improve quality and safety. These arrangements reflect the large size and complexity of the Health Board.	the new digitally enabled clinical strategy.
ii. *The roles, responsibilities, accountability and governance in relation to quality and patient safety within the divisions/groups/directorates is clear*	iii. The Quality and Safety Group and Listening and Learning from Patient Experience Group (LLEG) has improved the accountability, visibility and reporting arrangements for directorate and divisional quality and safety arrangements.	b. Governance Review being led by Deputy CEO will clarify and make recommendations to strengthen any arrangements where felt appropriate, this will include the composition of the local governance teams across BCUHB.
iii. *There is sufficient capacity and support, at corporate and directorate level, dedicated to quality and patient safety.*	iv. There are dedicated Quality and Safety Leads within all Divisions, Areas and Secondary Care, this includes Mental Health and Learning Disabilities as well as Maternity, Children's and Neonatal Services. Additionally, patient safety leads and patient experience leads from the corporate department are based in each locality alongside designated teams to support the governance functions. v. Reviewing of quality and safety is built into a number of operational functions this includes matrons and lead nurse walk round and the ward accreditation process which sets standards for levels of quality across clinical environments. This includes learning from HIW inspections and reviews.	Learning from the HIW review of Maternity Services and Birth Centres will be used to strengthen internal processes. The ongoing governance review will further support work already undertaken by assessing if failings and

	Current level of assurance: Low	gaps identified within Cwm Taf exist within BCUHB and ensure that where these are identified strengthened and improved. This will include the use of data and dashboards for and how these are reported through to the Board.
Organisational scrutiny of quality and patient safety		
4. *The roles and function of the Quality and Safety Committee is fit for purpose and reflects the Quality Strategy, Quality and Patient Safety Governance Framework and key corporate risks for quality and patient safety. This should include assessment of ensuring sub-*	The Quality, Safety and Experience Committee's (QSE) role and function operates in accordance with the model terms of reference (TOR) as issued by WG. The QIS and work of the QSG and LLEG is reported to QSE. Key corporate risks for patient safety and quality are assigned to the Committee and regularly reviewed. There are no formal Sub-Committees of the Board in operation at this time, however the Governance Review underway within the Health Board is reviewing the governance arrangements. A review of all the Quality and Safety Groups across the organisation has been undertaken to ensure arrangements are in place for the assessment and	Governance Review led by Deputy CEO currently underway will provide further opportunity to ensure fitness for purpose of the overall structure, reporting and escalation. Following

groups/committees have sufficient support to function effectively; the content, analysis, clarity and transparency of information presented to the committee and the quality framework in place is used to improve oversight of quality and patient safety across the whole organisation.	escalation of risks and issues of significance. A risk escalation summary template is provided to QSG for each of the clinical services across the Health Board. The Health Board has also developed a Quality, Safety and Patient Experience Dashboard (QSPE) which builds on the Harms Dashboard it has rolled out over the last eighteen months. Dashboard screenshot:  The Executive Medical Director is also the Responsible Officer for Medical Revalidation for the Health Board, supported by a Deputy Responsible Officer and revalidation team.	the review implementation of the recommendations of the will be monitored by QSE. In addition, the function and remit of QSE Committee and cycle of business will also be reviewed to ensure that the Committee is operating effectively and sufficient focus is given to the quality, safety and experience priorities for the organisation. This will also provide an opportunity for the CBMG to reflect on the reporting arrangements across the different committees to ensure sufficient clarity and oversight at Board level. Broadening of the visibility of the QPSE

	Current level of assurance: Low/Medium	dashboard as well as other metrics within the internal viewing system IRIS will be undertaken in the coming months alongside the development of the Clinical Strategy.
5. *Independent/Non-Executive Members are appropriately supported to meet their responsibilities through the provision of an adequate induction programme and ongoing development so they can effectively scrutinise the information presented to them.*	Induction arrangements for IMs are in place at both a local level but also supported by the national programme arranged by Academi Wales. In addition the Board has been working with Kings Fund to ensure ongoing development and support and within this work is being undertaken on what represents good assurance with the IMs. Regular Board Workshops provide another mechanism to equip members with the required knowledge and thereby enable IMs to effectively scrutinise and analyse the data provided to them. Each IM has a quarterly performance review with the chair and any development needs are considered and addressed. A notable increase in governance and scrutiny has been reported upon by the Wales Audit Office over the last 12 months.	Ongoing Board Development and Workshop programme in place. Ensure that this is strengthened to include all elements within the role e.g. Consultant Interviews. And consider feedback from the work with the King's Fund which will further support the development programme for IM's

	Current level of assurance: Medium	
6. *There is sufficient focus and resources given to gathering, analysing, monitoring and learning from user/patient experience across the organisation. This must include use of real-time user/ patient feedback.*	The Health Board has an approved Patient Experience Strategy in place and has invested in real time patient feedback systems which are used comprehensively across the organisation. In addition, the Health Board is engaged in the Emergency Department Quality Framework (EDQF) programme which will enhance real-time feedback from patients using our emergency departments. This information is synthesised and fed back to local teams to enable user feedback to drive improvement and share experiences. The QSE Committee regularly receives reports on patient experience activity. Additionally, the Health Board has launched a Patient Advice and Liaison Service (PALS) (part of the patient experience department) across all three localities with new staff taking up their roles during 2019. This team regularly undertakes 'Care to Share' clinics to gather and share patient experience and stories. A dedicated case manager is in post to liaise with the Public Services Ombudsman for Wales (PSOW) to ensure the Health Board responds effectively and learns from PSOW cases.	Greater emphasis will be placed on the "learning element of listening to patients and services users" throughout 2020 as described in the Patient Experience Strategy, this will include the "You said, We did" approach. During 2020, the processes for concerns (incidents, complaints, claims, etc.) will be reviewed. The complaints process review is planned to start in January 2020 and the Community Health Council will be a key part of this work.

	Current level of assurance: Medium	The Health Board has also met with the PSOW's new Complaints Standards Authority team to understand how their work and training can be used to support improvement. A workshop is planned jointly with the CHC for February 2020 to strengthen how the complaints and patient experience teams within the Health Board, and the CHC, work more closely together.
7. *There is visibility and oversight of clinical audit and improvement activities across divisions/groups/directorates and at corporate level. This includes identification of outliers and maximising opportunities for*	The Health Board has been fully aware of the challenges it faced in terms of clinical audit. A significant amount of work has been undertaken in this area over the past twelve months and the latest 2019 Structured Assessment report from WAO has reported that… 'from a weak position, clinical audit arrangements are now developing at pace. There is clear senior management ownership, and this is helping to drive improvements to clinical policy and procedure development. This includes formality around clinical audit planning,	Embed arrangements following adoption of revised Clinical Audit Policy. The policy has incorporated feedback from various groups to

sharing good practice and learning.	reporting and the necessary assurance links into committees. The arrangements will take some time to fully put into place, but the level of progress is promising.' The revised Clinical Audit Policy is to be presented for sign off at the Quality, Safety and Experience Committee on 28.1.20. More recently the function to support Clinical Audit has transferred to the Office of the Medical Director. Regular reports have been provided to both the Audit and QSE Committee's on how the organisation's plans to develop the effectiveness of the clinical audit function are progressing. This has provided additional scrutiny and oversight at Board level. *Current level of assurance: Low*	ensure best practice is reflected and sharing of good practice and learning has sufficient focus. The clinical audit plan and reporting arrangements, including identification of outliers and learning is being reviewed to ensure that it is outcome focussed and facilitates quality improvement activities across the organisation. Progress will be monitored through the governance reporting structure going forwards.
Arrangements for quality and patient safety at directorate level		
8. *The organisation has clear lines of accountability and responsibility for quality and patient safety within divisions/groups/directorates.*	The organisation has established systems to ensure that clear lines of responsibility are in place for accountability, quality and Patient Safety. Leadership triumvirate arrangements are in place in both Acute, Primary Care, Mental Health and Learning Disabilities Services with an Executive, Clinical and Nursing Director. All have responsibility for patient safety and quality.	Complete work to formally identify a Clinical Director for each speciality.

	Work is currently being undertaken to formally identify a Clinical Director for each speciality. Objective setting through formal appraisal mechanisms are in place and expectation of participation in appropriate groups and activities are set. As an example of how the triumvirate arrangements are functioning, in Maternity services this was acknowledged as very effective as part of the HIW inspection of maternity services. *Current level of assurance: Low/Medium*	As part of the governance review we will ensure that reporting lines and structures are fully considered and recommendations to strengthen/improve made.
9. *The form and function of the divisional/group/directorate quality and safety and governance groups and Board committees have:* ***i.*** *Clear remits, appropriate membership and are held at appropriate frequently.* ***ii.*** *Sufficient focus, analysis and scrutiny of information in relation to quality and patient safety issues and actions.*	Terms of Reference are in place for all Board Committees which have clear remits, appropriate memberships, cycles of business, regular schedule of meetings and clear decision making powers. In terms of the directorate and divisional quality and safety groups as mentioned earlier a review of all the Quality and Safety Groups across the organisation was undertaken 12 months previously to ensure arrangements are in place for the assessment and escalation of risks and issues of significance. A risk escalation summary template is provided to QSG for each of the clinical services across the Health Board. Each Group has a set agenda item which focuses on quality and patient safety issues and the monitoring of actions to mitigate risk and improve patient outcomes.	Building on the work already completed, implementation of actions from the Governance review will be implemented (see section 4 above), where necessary in order to further strengthen this important governance element.

iii. *Clarity of the role and decision making powers of the committees.*	*Current level of assurance: Low / Medium*	
Identification and management of risk		
10. *The organisation has clear and comprehensive risk management systems at divisional/group/directorate and corporate level, including the review and population of risk registers. This should include clarity around the escalation of risks and responsibilities at directorate and corporate level for risk registers and the management of those risks. This must be reflected in the risk strategy.*	The Health Board's Risk Management Strategy and Policy previously incorporated the management of risk within a 5 Tier model (see section 2 above re further detail). Included within the RM Strategy and Policy there are clear guidelines noting where and how to manage a risk at each level and a flow chart describing the escalation process. This was previously described as an example of good practice following support from a subject matter expert. Section 5 of the RM Strategy and Policy explains individual's roles and responsibilities with regards to risk management, with Section 9 detailing the categorisation and management or risk at each Tier. Tier 1 – Corporate and risks scoring above 15, Tier 2 – Directorate and risks scoring 9 – 12 and Tier 3 – Area/site/service risk (which will also include transformational project and/or service improvement risks scoring 1 – 8. Section 11 describes how to articulate and manage a risk including where it is to be managed and how often it should be reviewed. All risks are reviewed regularly at divisional level and reported to QSG along with mitigating actions and escalation where additional support is required these are also reviewed by the Risk Management Group.	The recent update of the Strategy and Policy will aim to move to Enterprise Risk Management model and from a 5 Tier model to a 3 Tier version to strengthen the escalation and de-escalation processes. This is awaiting ratification by the Board in January. The revised policy will then be implemented and monitored going forwards.

	Since October 2019, a weekly review of the highest rated risks has been undertaken by the Executive Directors, which enables oversight and refinement of risks, and greater challenge to ensure review of controls and assurances. *Current level of assurance: Low/Medium*	
	Management of incidents, concerns and complaints	
11. *The oversight and governance of DATIX and other risk management systems ensures they are used as an effective management and learning tool. This should also include triangulation of information in relation to concerns, at a divisional/group/ directorate or corporate level, and formal mechanisms to identify and share learning.*	The use of the Datix incident system is well embedded within the Health Board with approximately 33,000 incidents reported annually. The system is also used as a central repository to record and manage complaints and concerns. This supports the triangulation of information and supports evidence gathering to demonstrate learning opportunities. The corporate Patient Safety and Experience Department has patient safety leads and patient experience leads, supported by local teams and a corporate hub, based in each of the three localities alongside divisional governance teams. These teams deliver training to staff and produce integrated reports for each division to bring together learning from incidents, complaints, claims, inquest and patient feedback. The corporate teams also ensure every patient safety incident is reviewed and recommendations made on further investigation and will actively be involved in the most significant incidents. The Datix system directly feeds to the dashboards mentioned above and the ward accreditation process. A weekly meeting is in place led by the Assistant Director of Patient Safety and Experience to oversee incident, inquest and complaint activity. The terms of reference are attached. A quarterly Listening	The development of a Patient Safety Strategy will aim to strengthen reporting arrangements and focus on learning from all opportunities. The Listening and Learning from Patient Experience Report and CLIC (Concerns, Litigation, Inspections, Claims) Report are both being reviewed and improved in order to provide the QSE Committee with further improved data and

	and Learning from Patient Experience Report and CLIC Report is prepared for the QSE *Committee.*  ToR Incident review meeting - plan final. Monitoring of HIW actions is managed by QSG, and regular meetings are held with the action plan leads to ensure that progress is being made and learning embedded.	analysis and a link to improvement activity underway. The Health Board is actively engaged in the new Once for Wales Concerns Management System and has a key role in a number of work streams including further development of our learning culture. As mentioned above, during 2020, the processes for concerns (incidents, complaints, claims, etc) will be reviewed. The review will also focus on HIW and CHC inspections and visits. The above work links into the risk management structures

	Current level of assurance: Medium	and BAF in order to further strengthen the triangulation of incidents, concerns and complaints information
12. *The organisation ensures staff receive appropriate training in the investigation and management of concerns (including incidents). In addition, staff are empowered to take ownership of concerns and take forward improvement actions and learning.*	The Patient Safety and Experience Department provides training to staff in the reporting, investigation and learning from concerns. This is delivered within each locality and there is a strong focus on learning from these. Additionally, the new quality dashboards mentioned above pull data from Datix and the patient feedback system allowing teams access to their data (and others) in a user-friendly format. All investigations (relating to serious incidents and complaints) require local approval before corporate review strengthening local ownership. Quality improvement work is prioritised based on data analysis such as the work within the Health Board on healthcare acquired pressure ulcers and falls. A collaborative methodology has been taken in these areas with the HAPU collaborative launching in November 2018 and the falls collaborative in June 2019. This approach encourages local ownership and improvement, the sharing of learning across the Health Board, with support from fellow clinical teams and an expert faculty. The Health Board has developed a QI Hub – the BCUQI Hub – as a resource available for staff to access quality improvement expertise and for quality Improvement projects to be shared.	During 2020 the training programme for concerns will be enhanced with the introduction of a modular series of training and a passport scheme; this will be done alongside the review of processes and a key focus will be on strengthening the use of human factors ad systems learning approaches to investigations. There will be an increased focus on the whole of the Multi-Disciplinary

	Current level of assurance: Medium	Team in order to spread and share learning.
Organisational culture and learning		
13. *The organisation has an agreed Values and Behaviours Framework that is regularly reviewed, has been developed with staff and has a clear engagement programme for its implementation.*	The Health Board has a core set of values, developed through a major staff engagement exercise. These values are embedded within a behavioural framework that underpins the performance development and review process; recruitment; all development programmes and all staff engagement activity. The Health Board has implemented comprehensive staff engagement improvement activities through a 3 year strategy and latterly through the 3 year Workforce Strategy. There are numerous examples of work undertaken to embed the values and behaviours across the organisation such as: • Roll out of the 'Proud of' campaign including local 'Proud of' groups that come together to celebrate and share positive news. • Seren Betsi Star Award – a monthly staff achievement award presented by the Chief Executive. The Seren Betsi Star Gold award was also launched at the Annual Staff Achievement Awards in 2018, where the 'Gold' winner was selected through a public vote, this is the overall winner, selected from all previous winners for that year. • 3D Listening Methodology – Discover/Debate/Deliver – is used widely to engage with staff in a variety of ways. • Staff Engagement Ambassadors – support the 3D approach and are a critical part of the process. • Listening Leads – are a vital link between staff on the ground and senior managers.	Continued focus on delivery of the organisational and Divisional Improvement plans. Deployment of one Improvement system across the organisation

	• Values Based Recruitment – Guidance on VBR has been implemented together with a suite of resources available on the intranet for managers. • The 'Proud to Lead' framework has been embedded within the PADR process to align leadership qualities and behaviours to individual's objectives. • Adopting supportive and inclusive leadership styles – a suite of senior leadership masterclasses was launched in May 2018 with the aim of bringing experienced, innovative and engaging speakers to North Wales. The programme supports senior leaders in developing their leadership capability, challenging mind-sets and provides insight into the latest research, practice and innovation in the field of leadership • Senior Leadership Development Programme – a bespoke leadership development programme is currently in development, to be launched in early 2019. The programme supports the ambition of an engaging leadership style across the organisation by enhancing the capability of leaders to deliver results through engaging with their staff at an individual and team level. In addition, in 2018 the Health Board commissioned an additional tool to enable more focussed and timely review and intervention. The ByddwchYnFalch/BeProud engagement survey tool has seen significant buy in from the pioneer teams and has provided invaluable temperature checks through the course of the last 12 months. The Health Board's staff survey feedback has improved significantly since 2013 and continues to improve against the key markers for staff satisfaction. 80% of staff agree or strongly agree that BCUHB has a clear set of values that they understand.	

	84% of staff agree or strongly agree that the values of my organisation were discussed as part of the appraisal / review process. (NHS Staff Survey 2018) *Current level of assurance: Medium*	
14. *The organisation has a strong approach to organisational learning which takes account of all opportunities presented through concerns, clinical audit, patient and staff feedback, external reviews and learning from work undertaken within the organisation and across the NHS.*	There is a strong emphasis placed on opportunities for learning across the organisation and these are being strengthened through a series of arrangements to reduce repetition of incidents and themes from concerns. The clinical audit policy has required revision to clarify the processes for undertaking the full range of clinical audits consistently across the health board. The reporting of clinical audits has been more focussed on process than outcome. There is learning from national clinical audits but greater assurance is being sought. External reviews – there is a clear audit trail of external reviews being tracked through the organisation with these being reported through the committee structure. The organisation also participates in the All Wales Network for Service User Experience and shares learning across North Wales. The organisation has a Safehaven policy in place, which encourages staff to raise concerns in an anonymous way if they need to do so. The results from the latest staff survey demonstrate an improved culture regarding openness and transparency and a culture of reporting incidents and learning.	From January 2020, clinical summits will be established with clinical leaders and the executive team (chaired by the Executive Medical Director) to review the quality of the main pathways (e.g. looking at safety, national clinical audit data, outcomes and experience measures). This is a key aspect of delivering a new digitally enabled clinical strategy. A new clinical audit policy and reporting templates that focus on

	Extract from staff survey:- 94% of staff agree or strongly agree – to the question 'If you were to experience harassment, bullying or abuse at work, would you know how to report it?' *Current level of assurance: Low/Medium*	outcomes rather than activity are being developed. National clinical audits will be explicitly embedded in the new clinical strategy and pathways – and used to benchmark the health board so that organisational learning can be improved.

Cyfarfod a dyddiad: Meeting and date:	Quality Safety & Experience (QSE) Committee 28th January 2020
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Healthcare Inspectorate Wales (HIW) – the Health Board's position statement
Cyfarwyddwr Cyfrifol: Responsible Director:	Mrs Gill Harris Executive Director of Nursing & Midwifery / Deputy Chief Executive
Awdur yr Adroddiad Report Author:	Mrs Deborah Carter Director of Operations / Associate Director of Quality Assurance
Craffu blaenorol: Prior Scrutiny:	Bi-monthly meetings submitted to the Quality Safety Group (QSG) and QSG/QSE at a local level
Atodiadau Appendices:	**Appendix A** - Corporate Nursing HIW Tracker Tool **Appendix B -** Follow-up Inspection (Unannounced), Wrexham Maelor, BCUHB, Emergency Department **Appendix C -** Hospital Inspection (Unannounced), Ysbyty Glan Clwyd, BCUHB, Maternity Services **Appendix D -** BCUHB internal Standard Operating Procedure for Healthcare Inspectorate Wales **Appendix E** - Corporate Nursing Response

Argymhelliad / Recommendation:

The Committee is asked to:
1. Note the reports and appendices;
2. Approve the proposed tracker improvement actions.

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

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

Sefyllfa / Situation:

The purpose of this paper is to provide a position statement and assurance, to the Committee, in relation to outstanding HIW actions. In addition, the Committee are asked to note the two following Healthcare Inspectorate Wales (HIW) inspection reports;

1. Follow-up Inspection (Unannounced), Wrexham Maelor, BCUHB, Emergency Department
   Inspection date: 6th and 7th August 2019
   Publication date: 7th November 2019
   Appendix B

2. Hospital Inspection (Unannounced), Ysbyty Glan Clwyd, BCUHB, Maternity Services
   Inspection date: 16th to 19th September 2019
   Publication date: 19th December 2019
   Appendix C

Prior to publication of both reports, HIW issued the Health Board with any immediate concerns and/or improvement plans for completion. These are HIW recommendations, based on the findings from the inspections and are incorporated into the Corporate Nursing Tracker Tool, **Appendix A**. These completed plans by the Health Board can be found at the end of each report.

Corporate Nursing continue to work closely with each of the operational leads assigned to the actions plans, across the Health Board, to ensure that the required improvements are captured, monitored and implemented in an appropriate and timely manner. Furthermore, Corporate Nursing leads ensure that the improvements are captured and monitored at both a local and corporate level.

The list of actions detailed in **Appendix A** represents the current reporting format. Corporate Nursing propose to review and re-design to incorporate specific themes that will further enable lessons to be learned and to ensure wider learning across the organisation.

These proposals will be taken to the newly formed Working Group for approval prior to reporting at the next QSG. It is anticipated that the terms of reference for the group will be completed at the next meeting scheduled for 30th January 2020. The main objective of the group is the joining up of learning from HIW, Patient Safety and Quality Improvement work such as the Ward Accreditation, with a "This is what we did next…" approach.

Cefndir / Background:

HIW inspect the NHS in Wales, from general practices to hospitals. HIW assess compliance based on the Health and Care Standards 2015, the Independent Health Care (Wales) Regulations 2011, and National Minimum Standards (NMS) for Independent Health Care Services in Wales. They also have a specific responsibility to ensure that vulnerable people receive good care in mental health services. As such, HIW also inspect mental health and learning disability settings and considers compliance with legislation.

As shown in **Appendix D**, there is an agreed internal Standard Operating Procedure (SOP) for HIW along with a timeline which confirms the HIW timescales for issuing the Health Board with any immediate concerns and/or improvement plans for completion, based on the findings from the inspections.

Corporate Nursing is responsible for;

1. Managing all HIW correspondence
2. Quality Assuring all HIW correspondence
3. Managing the corporate HIW Tracker Tool and expediting actions / updates from Divisions
4. Act as the conduit between the Health Board and HIW
5. Preparing monthly exception reports for Quality & Safety Group

For each of the two reports enclosed at **Appendix B** and **C**, the Corporate Nursing Tracker Tool at **Appendix A**, intends to provide the committee with an update on progress against each action and **Appendix E** provides a response from Corporate Nursing.

Asesiad / Assesent & Analysis

Strategy Implication

The provision of quality care in a safe environment is paramount to the Health Board's Quality Improvement Strategy (QIS), and Living Healthier Staying Well. These are part of our overall key objectives.

Financial Implications

Costs will be incurred in each service / area and will differ depending on HIW recommendation / Health Board action, and some costs will be part of the maintenance / refurbishment programme. Failure to provide safe care, can result in a complaint, claim and compensation of which there can be significant financial implications.

Risk Analysis

There is a risk of harm to patients and staff if the estate or facilities are not fit for purpose. If staff are unable to provide suitable care, there is a further risk of harm to the patient. There is also a reputational risk, particularly in terms of the press following any negative reports and immediate concerns.

Financial risk is associated with costs of any claims.

There is a risk of non-compliance with regulations. When standards are not met, HIW make recommendations for improvement, these feed into the NHS Wales Escalation and Intervention Arrangements.

In addition, if HIW do not receive sufficient assurance that action has been taken to address issues, they can take enforcement action.

Members are asked to note, that some of the matters raised in the HIW inspection report for Wrexham Maelor Hospital's Emergency Department are reflected on the corporate risk register under risk ID 2240, Tier 1, with a current score of 20 (Extreme) and a target score of 16 (Extreme). Mitigating actions currently in place include;

1. Multi-agency Unscheduled Care (USC) Transformation Board refreshed to USC improvement group, chaired by the Director of Operations
2. Continued cycles of improvement with 3 specific work streams: Demand, Flow and Discharge
3. Daily National Conference Calls with WG to address daily position along with safety huddles
4. Development of USC dashboard with live and daily performance information to support decision making
5. Sitrep reporting 3 times a day including SAPhTE for ED risk assessment
6. Mental Health support located within site Police Control
7. Frequent attenders WEDFANs group regularly review vulnerable patients who frequently access services to support implementation of care plans
8. Use of SHINE tool to ensure that patient safety is monitored and intentional rounding complete for all patients including those waiting for offload from ambulances
9. Active engagement in Every Day Counts programme to support key pathways of discharge

Further actions are also in place to help achieve our target score.

Legal and Compliance

There is a risk of non-compliance with regulations as per the risk analysis.

Impact Assessment

This report is purely administrative, there are no associated impacts or specific assessments required.

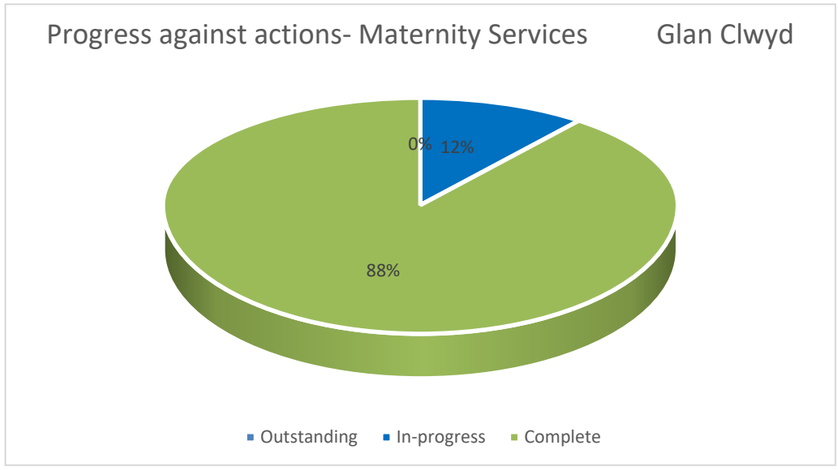
HIW reports and actions Tracker Tool

Line Ref	Year	Region	Ward / Unit	Site/Area	Date of Inspection	Report /Immediate Action letter	Date received	Lead Officer	HIW Action / recommendation	BCUHB Response (as per action plan sent to HIW)	Deadline for completion	Status	Updates	Reference to documentation	BCUHB Ref (from CEO Office)	HCS theme(s)
636	2019	BCUHB	Maternity Services	YGC- Central	Sep-19	Immediate Assurance Plan	Sep-19	Director of Midwidery & Womens Services, Maternity	The health board must provide HIW with details of the action it will take to ensure that checks of the neo-natal resuscitaires are carried out on a daily basis and in line with their policy.	1. Staff have been reminded that daily checks of neonatal resuscitaires will be the minimum expected standard. This has been communicated to all staff via safety briefings for a minimum of two weeks and will continue to be communicated at every opportunity. Shift co-ordinators will monitor compliance on a daily basis. The Matron, as an extra measure, will also monitor compliance during a daily walk about on the unit. Any concerns identified will be addressed immediately with the staff member. 2. The Matron will audit compliance of daily checks by completing a weekly audit, and will take every opportunity to remind staff of the lessons learned following the unannounced inspection. Any concerns identified will be addressed immediately with the member of staff and an action log will be completed. 3. The learning from this unannounced inspection has been communicated and will continue to be communicated at all interdepartmental meetings within the unit.	Immediate	Complete	**Update:** Commenced in September 2019 and are subject to ongoing review and audits. Daily checks of neonatal resuscitaires continues to be the minimum expected standard. Matron continues to monitor compliance thorugh daily walkabout. **Important:** Compliance has been 100% since September, until 30.12.2019 when one check was missed. This has resulted in a further immediate assurance and is captured in the immediate assurance plan received 10.01.2020 which is awaiting Executive Nursing approval - safety briefings have been circulated and staff have been updated following the inspection. Weekly quality assurance audits also take place by the Matron and any issues identified are addressed immediately with staff and the team	19041		2.1 2.9
637	2019	BCUHB	Maternity Services	YGC- Central	Sep-19	Immediate Assurane Plan	Sep-19	Director of Midwidery & Womens Services, Maternity	The health board must ensure that medication is stored safely and securely at all times.	1. staff have been reminded that full compliance with the BCUHB standards of medication storage will be expected. This has been communicated to all staff via safety briefings for a minimum of two weeks and will continue to be communicated at every opportunity 2. Shift co-ordinators will monitor compliance throughout each day. The Matron, as an extra measure, will also monitor compliance during a daily walk about on the unit. Any concerns identified will be addressed immediately with the staff member 3. The Matron will audit compliance against the standards by completing a weekly audit, and will take every opportunity to remind staff of the lessons learned following the unannounced inspection. Any concerns identified will be addressed immediately and documented in an action log 4. The BCUHB Medicines Policy MM01, highlighting the safe storage of medication has been re-circulated to all staff 5. The learning from this unannounced inspection has been, and will continue to be communicated at all interdepartmental meetings within the unit. 6. The Women's Directorate will embark upon a medicines management improvement programme utilising improvement methodologies to meet the required standards. The leads will work with local pharmacy leads and the BCUHB Medicines Management Collaborative utilising a data collection tool to monitor compliance against the standards inclusive of medicine storage 7. All wards within the health board will be part of the BCUHB audit programme, which will assess compliance with medicine management standards by the end of 2019.	Immediate	In Progress	**Update:** 1. Full compliance with the BCUHB standards of medication storage continues to be the expected standard against this action. Shift co-ordinators monitor compliance against this action throughout each shift. Any concerns identified are addressed immediately with the staff member concerned. 2. The Matron audits compliance against the standards during a weekly Quality Assurance audit. 3. A named Matron has been identified to lead on a medicine management improvement programme for the Directorate and has developed an action plan, which was presented at the October meeting of the Safer Medicines Committee, which the Matron attends on a monthly basis. 4. The Matron also attends the health Board Medicines Management Collaborative, where the monthly Directorate audits are reviewed. No further concerns have been identified to date and medication has been stored appropriately. Women's audits are reviewed at the previously detailed health board meetings and all updates with regards to medicines management are fed back to Directorate via the named Matron. Any new information and learning is disseminated to staff in all clinical areas via the Inpatient and Outpatient Matrons.	19041		2.1 2.6
638	2019	BCUHB	Maternity Services	YGC- Central	Sep-19	Immediate Assurance Plan	Sep-19	Director of Midwidery & Womens Services, Maternity	The health board must ensure that the administration of PROPESS is in line with the health board's policy and NICE guidelines	1. The Clinical Director and Labour Ward Lead at YGC fed back the learning to the clinical team with regards to the need for obstetric review of the patient before repeat prostaglandin administration and caution regarding use of repeated Propess 2. The North Wales Clinical Lead and Director of Midwifery and Women's Services shared the learning from the unannounced inspection with clinical teams across North Wales, at their monthly staff drop in sessions. 3. feedback following the unannounced inspection was also shared at Women's Quality, Safety & Experience Sub Group on 20/09/19 for wider learning. The North Wales Clinical Lead and Director of Midwifery and Women's Services, also attended all clinical areas to re iterate the learning and the required standard of practice for prostaglandin management, seeking assurances from all departments within the Directorate 4. The North Wales Clinical Lead shared a memo with all staff advising on the practice of IOL. This included a section on "What is expected if labour has not started or ARM is not possible after one cycle of Propess® treatment?"This highlighted the need for senior obstetric review and outlined the various options available to the women 5. The Women's Induction of Labour (IOL) Written Control Document (WCD) update had previously been deferred pending an update from NICE in 2020. The Directorate however decided to have an interim update of the WCD. Two identified Consultant Obstetricians (labour ward leads) will amend the current WCD to mandate obstetric review of the patient before repeat prostaglandin administration. The WCD will be revised and reviewed within the Women's Governance Framework, for agreement and ratification at QSE Sub Group and Board meetings by the end of October 2019 6. The learning from this unannounced inspection has been and will continue to be, communicated at any given opportunity and at all interdepartmental meetings within the Directorate 7. BCUHB will register as a stakeholder for the NICE Clinical Guideline, in order to review and provide early feedback on it 8. A named Obstetrician will implement an updated IOL Integrated Care Pathway (ICP). The ICP will support the learning from the inspection and include the need for obstetric review before further intervention after an initial Propess 9. To further support the counselling of women, the IOL leaflet will be updated. This will be performed by the Consultant Midwife and a named Consultant Obstetrician, and will be required to be translated into Welsh for our service users, which may delay the publication process	Immediate	In Progress	**Update:** 1, 2, 3 & 4 are complete as per "BCUHB Response". Since then, a lessons learned position statement was circulated on 26 September 2019 to all clinical areas on the required standards of practice of prostaglandin administration (evidence provided). 5. The WCD has been updated and agreed by the Women's Quality, Safety & Experience sup-group and is on the agenda for Women's Board and the health board Drugs & Therapeutics Group for January 2020. The WCD will also be added to the health board Medicines Management Group agenda in February 2020 6. Completed as per the "BCUHB Response" and is subject to ongoing review 7. Awaiting further update 8. The revised Integrated Care Pathway (ICP) was agreed at the Women's Quality, Safety & Experience sup-group in December 2019 and will be ratified at Women's Board in January 2020. 9. The Induction of Labour (IOL) patient information leaflet is on the agenda for Women's Quality, Safety & Experience sup-group and Women's Board meetings for January 2020 and once agreed will be sent for translated and printed for women and their families.	19041	CE19-2404	2.6 3.1
639	2019	BCUHB	Maternity Services	YGC- Central	Sep-19	Improvement Plan	Nov-19	Fiona Giraud	The health board must ensure that health promotion is readily available throughout the unit	1. The Directorate has worked in partnership with Public Health to secure the relevant information for display in the clinical areas for women and their families. 2. Ward managers and housekeepers will review and update the information displayed on a monthly basis. 3. White boards advising women of who is caring for them on each shift have been introduced. 4. The boards will be updated by the shift coordinator at the start of each shift and reviewed by the Matron on her daily walkabout the unit.	Immediate	Complete	**Update:** These actions were completed at the time, in September 2019 and are subject to ongoing review and audits.	19041	CE19-2404	1.1
640	2019	BCUHB	Maternity Services	YGC- Central	Sep-19	Improvement Plan	Nov-19	Fiona Giraud	The health board must ensure that the process of handover is reviewed.	1. The record of attendance logs at handover are now completed daily 2. Monthly monitoring of this introduction is performed via spot-checks led by the labour ward leads 3. Patient specific information is not retained or recorded at handover, to avoid Information Governance breaches and compliance with the Department of Health Records Management Code of Practice, Addendum 1. 4. All care planning discussions are recorded in the hospital records and in individualised hand held notes.	Immediate	Complete	**Update:** These actions were completed at the time, in September 2019 and are subject to ongoing review and audits.	19041	CE19-2404	1.1
641	2019	BCUHB	Maternity Services	YGC- Central	Sep-19	Improvement Plan	Nov-19	Fiona Giraud	The health board must ensure that patients and families are made aware of the Community Health Council (CHC) for advocacy and support.	The contact details for the Community Health Council is displayed and available in all clinical areas.	Immediate	Complete	**Update:** These actions were completed at the time, in September 2019 and are subject to ongoing review and audits.	19041	CE19-2404	1.1
642	2019	BCUHB	Maternity Services	YGC- Central	Sep-19	Improvement Plan	Nov-19	Fiona Giraud	The health board must ensure that organisation of utility rooms within the unit is maintained to high standards.	All clinical areas have been de-cluttered by the ward managers, and spot checks are undertaken as part of the Matron's daily walk about.	Immediate	Complete	**Update:** These actions were completed at the time, in September 2019 and are subject to ongoing review and audits.	19041	CE19-2404	2.1 2.4
643	2019	BCUHB	Maternity Services	YGC- Central	Sep-19	Improvement Plan	Nov-19	Fiona Giraud	The health board must ensure that doors to unauthorised access rooms are securely closed to maintain safety.	1. A memo was circulated to all staff following the unannounced inspection, to remind them of the need to keep all doors closed to avoid unauthorised access and maintain security and safety on the unit. The senior leads per shift, on a continuous basis, monitor compliance against this action. 2. Security requirements on the unit are communicated clearly at the twice-daily handovers and should any security issues arise, there are local and health board policies to support escalation of any identified concerns.	Immediate	Complete	**Update:** These actions were completed at the time, in September 2019 and are subject to ongoing review and audits.	19041	CE19-2404	2.1 2.4
644	2019	BCUHB	Maternity Services	YGC- Central	Sep-19	Improvement Plan	Nov-19	Fiona Giraud	The health board must ensure that regular checks are conducted on all resuscitation trollies throughout the unit.	1. Daily checks of neonatal resuscitaires continues be the minimum expected standard. 2. The Matron monitors compliance against this action as part of daily walk about on the unit and any issues identified are addressed immediately with the staff member concerned. Compliance has improved and continues to be 100% since the inspection in September 2019 3. The Matron completes a weekly Quality Assurance audit inclusive of daily equipment checks. Any issues identified are addressed immediately with the member of staff or relevant team. 4. The Senior Management Team also monitor compliance against this action during their regular walk about on the unit.	Immediate	Complete	**Update:** These actions were completed at the time, in September 2019. In addition, it has been confirmed in January 2019 that 100% compliance has been achieved and maintained with daily checks since inspection until recently in a further HIW Inspection of Wrexham Maternity in January 2020 where non-compliance with checks has been confirmed by HIW; one check on 30.12.2019 was missed	19041	CE19-2404	2.1 2.9

645	2019	BCUHB	Maternity Services	YGC- Central	Sep-19	Improvement Plan	Nov-19	Fiona Giraud	The health board must ensure that hand washing posters to be displayed.	Hand washing technique posters were in place above all hand washing sinks prior to the inspection in September 2019	Immediate		**Update:** These actions were completed at the time, in September 2019 and are subject to ongoing review and audits.	19041	CE19-2404	2.1 2.4
646	2019	BCUHB	Maternity Services	YGC- Central	Sep-19	Improvement Plan	Nov-19	Fiona Giraud	The health board must ensure that tap on the birthing pool is replaced.	1. The team have completed further inspections of all birthing pools and no stains could be identified, and no maintenance issues have been required for the birthing pool taps.	Immediate	Complete	**Update:** These actions were completed at the time, in September 2019 and are subject to ongoing review and audits.	19041	CE19-2404	2.1 2.4
647	2019	BCUHB	Maternity Services	YGC- Central	Sep-19	Improvement Plan	Nov-19	Fiona Giraud	The health board must ensure that all cleaning schedules are appropriately completed	1. A review of all cleaning schedules has been undertaken and those not required, removed 2. All remaining cleaning schedules are completed weekly, as per health board requirements and this is also audited as part of the ward accreditation metrics process.	Immediate	Complete	**Update:** These actions were completed at the time, in September 2019 and are subject to ongoing review and audits.	19041	CE19-2404	2.1 2.4
648	2019	BCUHB	Maternity Services	YGC- Central	Sep-19	Improvement Plan	Nov-19	Fiona Giraud	The health board must ensure that fluid balance charts are completed following commencement of intravenous fluid administration	1. The completion of fluid balance charts is managed by the Quality Improvement programme (QIP) for the maternity unit 2. Fluid balance charts are audited as part of the ward accreditation process and the Matron's weekly Quality Assurance audit. Where any omissions are identified, it is addressed directly with the member of staff to avoid a recurrence. 3. An improvement has been noted in the monthly audit results and the end date for the QIP is 31 December 2019, however, monthly audits will be continued throughout 2020. 4. The Clinical Supervisors for Midwives discuss documentation standards during their presentation on the monthly mandatory training days and these sessions are open to both midwifery and medical staff	Immediate	Complete	**Update:** These actions were completed at the time, in September 2019 and are subject to ongoing review and audits. In addition, it has been confirmed in January 2020 that the Quality Improvement Programme is ongoing and the monthly audits undertaken by the Ward Manager/Matron, are showing an improvement in compliance. Continued work is required and therefore the programme will be extended until 31st March 2020.	19041	CE19-2404	2.5 2.6
649	2019	BCUHB	Maternity Services	YGC- Central	Sep-19	Improvement Plan	Nov-19	Fiona Giraud	The health board must ensure that medication is stored appropriately and securely at all times	1. Full compliance with the BCUHB standards of medication storage continues to be the expected standard against this action. Shift co-ordinators monitor compliance against this action throughout each shift. Any concerns identified are addressed immediately with the staff member concerned 2. The Matron audits compliance against the standards during a weekly Quality Assurance audit. 3. A named Matron has been identified to lead on a medicine management improvement programme for the Directorate and has developed an action plan, which was presented at the October meeting of the Safer Medicines Committee, which the Matron attends on a monthly basis. 4. The Matron also attends the health Board Medicines Management Collaborative, where the monthly Directorate audits are reviewed.	Immediate	Complete	**Update:** These actions were completed at the time, in September 2019 and are subject to ongoing review and audits. In addition, it has been confirmed in January 2020 that no further concerns have been identified to date and medication has been stored appropriately. Women's audits are reviewed at the previously detailed health board meetings and all updates with regards to medicines management are fed back to the Directorate via the named Matron. Any new information and learning is disseminated to staff in all clinical areas via the Inpatient and Outpatient Matrons.	19041	CE19-2404	2.6
650	2019	BCUHB	Maternity Services	YGC- Central	Sep-19	Improvement Plan	Nov-19	Fiona Giraud	The health board must ensure that induction of labour medication prescribing is reviewed.	1. A lessons learned position statement was circulated on 26 September 2019 to all clinical areas on the required standards of practice of prostaglandin administration (see separate document). 2. The revision of the Integrated Care Pathway (ICP) has been completed and is out for consultation until 9 December 2019 and will be ratified at the Women's Board meeting in January 2020. 3. The Induction of Labour (IOL) patient information leaflet, aligned to the Pathway and Policy, is being updated and translated. 4. The current Written Controlled Document (WCD) states 'If, 24 hours following the insertion, labour is not established or the woman is not suitable for ARM, the middle grade doctor should be informed and the case discussed with the LW consultant'. The review of this WCD has been extended to March 2020, pending the release of the new NICE IOL guidance for its inclusion. This has been made explicit on the current WCD, on the Directorate intranet policies page. 5. The North Wales Clinical Lead has been given assurance by the Clinical Directors across North Wales that clinical practice now reflects the required standard of practice for prostaglandin administration. Continued assurance has been requested on a monthly basis following the inspection	Immediate Jan-20 Mar-20 Mar-20 Immediate	In Progress	**Update:** Actions 1 & 5 were completed at the time, in September 2019. Action 2 is complete as at January 2020 2. The revised Integrated Care Pathway (ICP) was agreed at the Women's Quality, Safety & Experience Sub-Group in December 2019 and will be ratified at Women's Board in January 2020 3. The Induction of Labour (IOL) patient information leaflet is on the agenda for Women's Quality, Safety & Experience Sub-Group and the Women's Service Board meeting in January 2020 and once agreed will be sent for translated and printed for women and their families 4. The WCD has been updated and agreed by the Women's Quality, Safety & Experience Sub-Group and is on the agenda for Women's Services Board and the Health Board Drugs & Therapeutics Group in January 2020. The WCD will also be added to the Health Board Medicines Management Group agenda in February 2020	19041	CE19-2404	2.6
651	2019	BCUHB	Maternity Services	YGC- Central	Sep-19	Improvement Plan	Nov-19	Fiona Giraud	The health board must ensure that regular medication rounds are considered.	1. Medication rounds have been reconsidered following the unannounced inspection and re-trialled. 2. The management team agreed that all ward managers should have the autonomy to introduce either a full medicine round or midwife led medicine rounds for women in their care. 3. To support continuity of care and carer (Welsh Government's Maternity Five Year Strategy), the unit has adopted the individualised medication giving approach. This approach and compliance is monitored against the health board's medicine management standards and is audited as part of ward accreditation.	Immediate	Complete	**Update:** These actions were completed at the time, in September 2019 and are subject to ongoing review and audits.	19041	CE19-2404	2.6
652	2019	BCUHB	Maternity Services	YGC- Central	Sep-19	Improvement Plan	Nov-19	Fiona Giraud	The health board must ensure that breast feeding support is reviewed and that visibility is increased throughout the unit.	1. All midwives receive annual breast feeding training and are available on an individualised basis to support women in their care. 2. The appointed Infant Feeding Co-ordinators are available to support staff across North Wales for more complex advice. 3. A business case has been developed to secure funding for extra breast feeding support across North Wales.	Immediate	Complete	**Update:** These actions were completed at the time, in September 2019 and are subject to ongoing review and audits.	19041	CE19-2404	1.1 2.5
653	2019	BCUHB	Maternity Services	YGC- Central	Sep-19	Improvement Plan	Nov-19	Fiona Giraud	The health board must ensure that patient records are secured securely at all times.	1. All case note trolleys have been fitted with digital locks and all filing cabinets now have locks and keys. 2. All staff are aware that case notes need to be returned to a locked storage facility when not in use.	Immediate	Complete	**Update:** These actions were completed at the time, in September 2019 and are subject to ongoing review and audits.	19041	CE19-2404	3.5
654	2019	BCUHB	Maternity Services	YGC- Central	Sep-19	Improvement Plan	Nov-19	Fiona Giraud	The health board must ensure that policies and procedures are reviewed and updated within appropriate timescales	1. The Written Control Document Group has an action plan available that details all policies and guidelines that have been developed within the Women's Directorate, inclusive of revision dates. All policy/guideline authors are approached when policy review is required to perform the necessary review and are prompted in a timely manner. 2. Since the unannounced inspection, all authors of outstanding policies have been asked to submit their updated versions for ratification in January 2020. This is part of wider work we are undertaking as a Health Board to update all of our policies. 3. The Director of Midwifery and Women's Services and North Wales Clinical Lead are monitoring the progress made at monthly Senior Management Team meetings. 4. A process map of Written Control Documents/Policies is also being undertaken to improve the efficiency of this process. The Maternity & Neonatal Network in Wales are leading on this improvement.	Immediate Jan-20 Immediate Mar-20	In Progress	**Update:** A memo from the Director of Midwifery & Women's Services and the North Wales Clinical Lead was circulated in December 2019 to all staff, detailing the need for WCD authors to comply with the required timeframes for updates. Agreement was reached at the Women's Quality, Safety & Experience Sub-Group, that a list of policies, authors and due dates are to be shared with the site triumvirate leadership teams, to enforce and support lines of accountability in reviewing WCD. WCD expiry dates have been extended to March 2020 to ensure staff are fully aware that the WCD on the intranet remain live for their support.	19041	CE19-2404	3.4
655	2019	BCUHB	Maternity Services	YGC- Central	Sep-19	Improvement Plan	Nov-19	Fiona Giraud	The health board must ensure that data entry is reviewed to ensure consistency.	The Directorate is working in partnership with the informatics department to triangulate data collected prior to entering it onto the maternity dashboard for accuracy purposes.	Immediate	Complete	**Update:** These actions were completed at the time, in September 2019 and are subject to ongoing review and audits.	19041	CE19-2404	3.4
656	2019	BCUHB	Maternity Services	YGC- Central	Sep-19	Improvement Plan	Nov-19	Fiona Giraud	The health board must ensure that patient records are fully reflective of the care and treatment provided to patients and in line with standards of professional record keeping.	1. Clinical Supervisors for Midwives discuss documentation standards which includes the care and treatment provided to women, during their presentations on mandatory training days. These sessions are delivered every two years alternating with enhanced communication sessions as part of an agreed Training Needs Analysis for the Directorate. These sessions are open to both midwifery and medical staff 2. The Clinical Supervisors for Midwives also provide monthly notes audit sessions for staff, where they can review sets of notes and learn directly from any good/poor practice identified during the session. The audit results are also fed back at Group Supervision sessions, which each midwife is mandated to attend annually. The results are also presented to Women's QSE sub group annually. 3. Each midwife is required to audit two sets of their own records from the previous year to discuss at a Group Supervision session annually. 4. The Clinical Supervisors for Midwives also support documentation sessions for medical staff on their induction programme and highlight the need to include the care and treatment provided to women within their medical documentation. 5. Stamps have been re-ordered for all staff to use alongside their signature when documenting an entry in a woman's notes.	Immediate	Complete	**Update:** These actions were completed at the time, in September 2019 and are subject to ongoing review and audits.	19041	CE19-2404	3.5
657	2019	BCUHB	Maternity Services	YGC- Central	Sep-19	Improvement Plan	Nov-19	Fiona Giraud	The health board must ensure that data collection methods of the birth register statistics is reviewed	1. To ensure the accuracy of the birth statistics, the monthly data collected by the Labour ward Clinical Lead Midwife is triangulated with that collected by the Governance Team and the Informatics Department. 2. Adverse Clinical Events forms are completed for each delivery and the data is collected and analysed by the Governance Team. The monthly birth statistics are then checked against the Governance Team data and also against the information collected on the Maternity Outcome e-form by Informatics.	Immediate	Complete	**Update:** These actions were completed at the time, in September 2019, and are subject to ongoing review and audits.	19041	CE19-2404	3.4

658	2019	BCUHB	Maternity Services	YGC- Central	Sep-19	Improvement Plan	Nov-19	Fiona Giraud	The health board must ensure that follow on work from audits is reviewed to ensure learning and service improvements take place.	It has been agreed that all audit findings are discussed at the Women's QSE sub-group. Results of the audit and required improvement plans are referred to the relevant forums for development and monitoring. The Forums will then be required to provide updates on their improvement plans on a quarterly basis to Women's QSE sub-group to ensure improvements are implemented and embedded into service and care provision.	Immediate	Complete	**Update:** These actions were completed at the time, in September 2019, and are subject to ongoing review and audits.	19041	CE19-2404	3.3
659	2019	BCUHB	Maternity Services	YGC- Central	Sep-19	Improvement Plan	Nov-19	Fiona Giraud	The health board must ensure that management empowerment and leadership support is reviewed to enable career progression.	1. The Directorate offers professional development for all staff. 2. Staff are encouraged to liaise with their line managers to identify areas in which they feel they need to professionally develop during their annual appraisal. 3. Shadowing opportunities are available to staff at all levels of leadership within the Directorate and nationally. 4. Secondment opportunities within the health board, local authorities and nationally, are also encouraged and supported by the Directorate. 5. Staff are actively encouraged to join policy development groups and to support audit by linking with the relevant audit leads. 6. Clinical midwives are also given some designated responsibility for linking with other services i.e. bereavement and maternity voices. 7. Newly appointed staff in leadership positions are supported in their role and in the skill of appropriate delegation. 8. Staff also support strategic development within the health board and lead at a national level.	Immediate	Complete	**Update:** These actions were completed at the time, in September 2019 and are subject to ongoing review and audits.	19041	CE19-2404	3.3
660	2019	BCUHB	Maternity Services	YGC- Central	Sep-19	Improvement Plan	Nov-19	Fiona Giraud	The health board must ensure that the medical rota is reviewed.	1. An independent review of medical rotas has been completed, as part of the health board's medical workforce strategy. Immediate solutions have been supported by the health board. 2. Medium to long-term options will be discussed with executive colleagues on 2 December 2019.	Immediate	Complete	**Update:** These actions were completed at the time, in September 2019 and are subject to ongoing review and audits.	19041	CE19-2404	7.1

Progress against actions- Maternity Services Glan Clwyd	
Outstanding	0
In-progress	3
Complete	22
Total	25

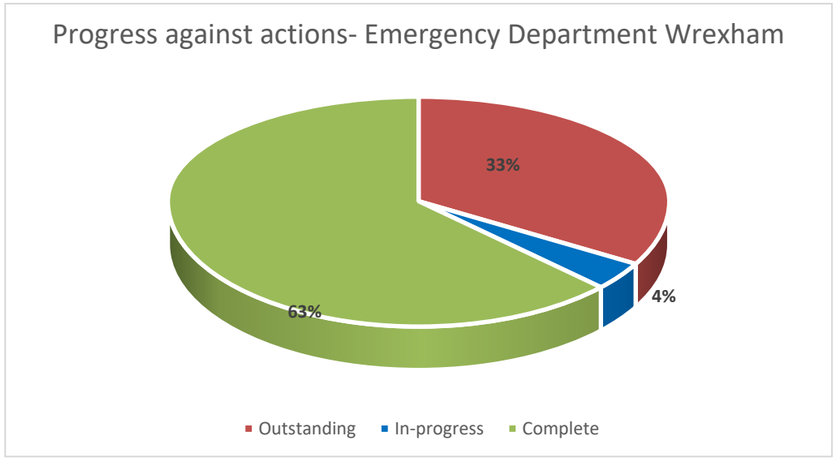


HIW reports and actions (excluding MH / LD - please see seperate Tracker Tool)

Line Ref	Year	Region	Ward / Unit	Site/Area	Date of inspection	Report /Immediate Action letter	Date received	Lead Officer	HIW Action / recommendation	BCUHB Response (as per action plan sent to HIW)	Deadline for completion	Status	Updates	Reference to documentation	BCUHB Ref (from CEO Office)	HCS theme(s)
633	2019	BCUHB	ED	WMX-East	Aug-19	Immediate Assurance Plan	Aug-19		The health board must provide HIW with details of the action it will take, to ensure that patients who are waiting on trolleys in the corridor receive appropriate and timely care.	1. Formal risk assessment to be completed with clear mitigation and controls for the use of corridor for all patients. The formal risk assessment will be a part of the BCUHB escalation framework (likely risk score above 16 and will be part corporate risk register) 2. Immediate corrective action of clinical teams to incorporate patient's nursed in the corridor as a part of ED safety huddle and document all the actions taken. Matron and Heads of Nursing to perform daily random audit to gain assurance with compliance. 3. The practice has been reinforced with all nursing staff about the use of the SHINE document at time of initial assessment 4. All agency workers will receive an effective induction for the Emergency Department and clinical supervision will be provided to ensure compliance with policies. 5. The clinical staff will complete the National Emergency Warning (NEWS) Score according to the policy and will escalate to the Shift Leaders and doctor in-charge as required. 6. If the patient's clinical condition deteriorated, the staff have been instructed to re-triage the patients and inform the senior clinician as suggested by the triage category. 7. Patients to receive an apology letter whilst waiting in the ED corridor from the Managing Director during overcrowding within the ED. 8. The use of the multipurpose room is reinforced to all the staff to provide appropriate and dignified care at all times to the corridor patients 9. Develop and implement the Standard Operating Procedure (SOP) to ensure there is a clear escalation process for all the staff to ensure appropriate and timely care provision for the corridor patients. This would be further supported by internal ED escalation policy. 10. Reinforce the Health Board's Escalation Policy to escalate corridor patients to the Hospital Management Team (HMT) lead through daily bed meetings to gain specialty support to maintain patient safety 11. The departmental Matron (in hours) and Shift Leader (out of hours) to ensure the opportunity of completing the patient experience survey is offered to all the patients within the ED corridor 12. This action plan will be monitored at the weekly Unscheduled care meeting and the department will establish a task and finish group to monitor this action plan locally. 13. A weekly audit is performed to gain assurance of compliance for the above actions and to drive further improvement	Immediate	Outstanding	**Update:** 1. The risk assessment is complete and approved 2. The audit has been performed to ensure appropriate use of the corridor. The ED safety huddle has been updated to review the appropriateness 3. The use of SHINE at time of initial assessment was reinforced and it has been communicated to all the staff during daily brief. This is also subject to ongoing audit 4. The induction for agency workers has been updated to ensure fit for its purpose 5. The communication about importance of completing the NEWS score has been communicated to all staff and the NEWS audit is in place 6. Staff have been informed to re-triage patients when clinical condition changes and act accordingly through daily safety briefs (Verbal). Able to pull this data through Symphony 7. An apology letter has been approved and patients to receive it from 9th Sept 2019 8. The multipurpose room is in use at all times and its use gets re-in forced with staff on daily basis by Shift leader (verbal) 9. the SOP has been developed to ensure clear escalation process for all the staff to follow and for approval by Secondary care Quality & Safety Committee on 17th September 2019 10. BCUHB's Escalation Policy has been reinforced with Shift Leaders to ensure support for the Hospital Management Team is gained as required (verbal & bed meetings) 11. The patient survey is devised for corridor patients and the daily feedback commenced 12. The action plan to be sent to Unscheduled Care meeting in Sept 19 13. The audits are ongoing on daily and weekly basis as required	19043	CE19-1384	2.1 3.1 3.5 5.1
634	2019	BCUHB	ED	WMX-East	Aug-19	Immediate Assurance Plan	Aug-19	Secondary Care Medical Director	The health board must provide HIW with details of the action it will take to ensure that suitable pressure relieving mattresses are readily available for use on trolleys within the ED.	1. The importance of appropriate skin checks (at admission and as required)has been reinforced to the staff. Staff have also been informed about the importance of pressure ulcer prevention &care as per policy for the patients nursed on ED trolley mattresses. This includes the patients being nursed in the corridor 2. All staff to ensure that the Maelor score is completed as per policy and actions taken accordingly. In case of patient's further clinical and physical deterioration, staff have been reminded about the importance of re-checking the Maelor score and acting accordingly 3. All patients within the department are placed on the profile bed with appropriate air mattress as indicated by the Maelor Score 4. The current trolley mattress within ED to be reviewed and the Huntleigh (trolley provider within ED) to be contacted to ensure we are using the trolley mattresses for our patients as per their recommendations. 5. The ED trolley mattress audit performance is sustained as per policy. 6. Harm reviews are currently undertaken to review the hospital acquired harms for long trolley waits.The ED Matron is to present the findings of any harm reviews in local Hospital Acquired Pressure Ulcer (HAPU). 7. This action plan will be monitored at the weekly unscheduled care meeting, and the department will establish task and finish group to monitor this action plan locally. 8. A weekly audit is performed to gain assurance of compliance for the above actions and to drive learning and further improvement.	Immediate	Outstanding	**Update:** 1. The importance of appropriate skin checks has been reinforced to the staff and the compliance is checked as a part of ongoing documentation audit 2. The importance of the effectiveness of Maelor score has been re-in forced to all the staff and the checked via documentation audit. A different tool would be used moving forward 3. The air mattress is used as indicated by the Maelor score 4. The representative for the HuntLeigh trolley has been requested to attend and guidance from Selfmed followed 5. The ED trolley mattress audit performance is sustained as per policy- see above 6. The HAPU meeting will commence in October 2019 and the harm review to be presented then. Meanwhile rapid review is completed on Hospital acquired pressure ulcers as required. The audit is embedded 7. The HIW action plan will be monitored at the weekly unscheduled care meeting, and the department will establish task and finish group to monitor this action plan locally The action plan was sent to Unscheduled Care meeting in Sept 19.	19043	CE19-1384	2.2
635	2019	BCUHB	ED	WMX-East	Aug-19	Immediate Assurance Plan	Aug-19	Secondary Care Medical Director	The health board must provide HIW with details of the action it will take to ensure that patients are issued with ID wrist bands at an early stage in their care pathway within the ED.	1. The Triage, Majors and Resuscitation areas now have the electronic printers installed. This is now being used to issue printed ID wrist bands across all areas 2. Ensure weekly audit is performed to gain assurance with compliance of ID wrist bands 3. This action plan will be monitored at the weekly unscheduled care meeting the department will establish task and finish group to monitor this action plan locally. 4. A weekly audit is performed to gain assurance of compliance for the above actions and to drive further improvement	Immediate	Outstanding	**Update:** 1. The electronic printers are installed in Triage, Majors and Resuscitation areas 2. Weekly and daily audit are in place to ensure compliance 3. The action plan was sent to Unscheduled Care meeting in Sept 19 4. The weekly audits are performed and non-compliance is acted upon as required	19043		2.1 3.1
636	2019	BCUHB	ED	WXM-East	Aug-19	Improvement Plan	Oct-19	Naomi Holder Director of Nursing, East	The health board must ensure that the Butterfly scheme is implemented consistently within the department	1. Training and education to be provided to all staff by Emergency Department (ED) dementia link nurse	Feb-19	In Progress	**Update:** In addition to the update below for, we are awaiting an update in relation to training and education by the ED dementia nurse	19043		1.1
637	2019	BCUHB	ED	WXM-East	Aug-19	Improvement Plan	Oct-19	Naomi Holder Director of Nursing, East	The health board must ensure that the Butterfly scheme is implemented consistently within the department	2. Ensure implementation of the Butterfly scheme through the departmental safety huddles 3. Monitor adherence and raise awareness through daily departmental safety huddle	Nov-19 Nov-19	Complete	**Update:** staff have been reminded to ensure the Butterfly scheme is used at all times (document in updated action plan to provide evidence of this) The departmental safety huddle has been updated to ensure the shift leaders monitor compliance (see embedded document in updated action plan). Point 3 is complete	19043		1.1
706	2019	BCUHB	ED	WXM-East	Aug-19	Improvement Plan	Oct-19	Naomi Holder Director of Nursing, East	The health board must ensure that waiting times are accurately communicated	1. Waiting times be updated hourly in the waiting area on the allocated white board. 2. Internal voice system to be used to announce the waiting times on an hourly basis 3. The above action to be monitored through frequent spot checks 4. Identify the means of displaying the waiting times electronically	Nov-19 Nov-19 Nov-19 Dec-19	Outstanding	**Update:** The team are embedding the process of hourly updates, there are some inconsistencies. An email has been circulated to reception and nursing teams to reiterate the importance of communicating waiting times with patients. Team to continue spot checks (see embedded documents in updated action plan)	19043		4.2
707	2019	BCUHB	ED	WXM-East	Aug-19	Improvement Plan	Oct-19	Naomi Holder Director of Nursing, East	The health board must ensure that patient information is made available through the medium of Welsh	1. Patient information boards to be displayed in Welsh, support for this gained from the Welsh Language Officer 2. Gap analysis of welsh language speakers to be undertaken within the ED 3. Opportunity is offered and promoted to the staff to learn the Welsh language	Nov-19 Dec-19 Dec-19	Complete	**Update:** Some of the boards have been displayed in Welsh and there is a clear plan to ensure the rest are completed by December 19. A poster has been displayed for staff to give consideration to learn Welsh Language within the department.	19043		4.2
708	2019	BCUHB	ED	WXM-East	Aug-19	Improvement Plan	Oct-19	Naomi Holder Director of Nursing, East	The health board must discourage staff from using abbreviations when speaking with patients and visitors	1. All staff reminded and encouraged through daily safety briefs to ensure the abbreviations are not used when communicating with patients and visitors The above action will be monitored through daily matron spot checks and challenged as required	Nov-19 Dec-19	Complete	**Update:** Reminder circulated to staff to ensure abbreviations are not used to communicate with patients and a letter informing staff of the same has been distributed to the nursing staff (evidence provided in action plan). This action will be monitored through daily matron spot checks and challenged as required	19043		3.2
709	2019	BCUHB	ED	WXM-East	Aug-19	Improvement Plan	Oct-19	Naomi Holder Director of Nursing, East	The health board must continue to monitor waiting times and implement further strategies to improve patient flow through the department	As a part of our Building Better Care improvement programme the following actions have been taken: 1. The current medical workforce job plans are under review to align better skill mix with demand 2. A business case for additional medical workforce is waiting executive approval 3. An external review conducted for ED workforce in October, the feedback provided to be included in the revised business case 4. The Emergency Nurse Practitioner workforce are on illnesses training module to manage more patients through ENP streaming 5. The direct to speciality referrals from triage and Paediatrics area 6. The General Practitioner (GP) at triage trial was completed, which demonstrated an improvement in waiting times for minors and there is plan to provide more consistent GP cover at the triage 7. The improvement of the patient flow will be through the emergency floor, which incorporates the Ambulatory Emergency Care Unit, Frailty Assessment and Short Stay Unit	Nov-19	Outstanding	**Update:** 1, 2 & 3. Naomi and the team are continuing to work with the deputy medical directorate. 4. the team have provided a copy of the draft Executive Summary for their business case which is awaiting executive approval. This is following an external review of the departments workforce conducted in October 2019. 5. ED are continuing to work with the Paediactric team to develop a new pathway. Evidence of this has been provided. Mon to Fri daytime primary Care practitioner presence. Trial ongoing 7. This action was completed on the 4th November 2019 and is governed by the Standard Operating Procedure (see embedded document in updated action plan) Points 4 & 7 are complete	19043		5.1
710	2019	BCUHB	ED	WXM-East	Aug-19	Improvement Plan	Oct-19	Naomi Holder Director of Nursing, East	The health board must ensure that care plans are person centred	1. Monthly documentation audit to include the review of care plan documentation to ensure individualised approach 2. Action and compliance will be monitored as a part of the ED matron's audit	Nov-19	Complete	**Update:** Evidence has been provided; the use of the Shine document has been incorporated into the ED matron's audit. This will be reviewed and monitored.	19043		6.1
711	2019	BCUHB	ED	WXM-East	Aug-19	Improvement Plan	Oct-19	Naomi Holder Director of Nursing, East	The health board must ensure that DoLS assessments are routinely conducted on patients presenting with conditions such as dementia, head injury or general confusion	1. The Emergency Care Matrons to be on the signatory list to perform the DoLS assessments 2. The safeguarding team to hold roadshows within ED focusing on DoLS during the safeguarding awareness week 3. The senior nursing staff (Band 7 and band 6- 19 WTE) to be trained and educated to assess the mental capacity on the admission as required	Nov-19 Nov-19 Dec-19	Outstanding	**Update:** The Emergency Care Matrons are booked onto the DOLS signatory training (1 Matron booked for 2nd Dec 19 and 1 Matron booked for Jan 20). Safeguarding team plan to provide further education on DOLS for Emergency Care staff by December 19- awaiting further update that this is fully complete and around monitoring moving forward	19043		6.2

712	2019	BCUHB	ED	WXM-East	Aug-19	Improvement Plan	Oct-19	Naomi Holder Director of Nursing, East	The health board must ensure that the shower room on MAU is refurbished	1. Secure estates quotation refurbish the shower on Medical Assessment Unit 2. Request refurbishment works to be undertaken	Nov-19 Dec-19	Complete	**Update:** The request has been made to Estates to gain the quote to refurbish the shower room (evidence provided of referral to Estates dated 06.11.19 highlighting risk and urgency). More recent update is that the work on AMU Short Stay Ward has started on 13.01.2020	19043		2.1
713	2019	BCUHB	ED	WXM-East	Aug-19	Improvement Plan	Oct-19	Naomi Holder Director of Nursing, East	The health board must ensure that food items are not stored with clinical equipment on both MAU and CDU	1. Immediate corrective action of food items were stored as per policy and the housekeepers have been reminded not to store food items with clinical equipment 2. The above action is being monitored through housekeeper weekly audit	Nov-19	Complete	**Update:** The audit is completed by Housekeepers on a weekly basis (evidence provided). This action is now complete and is subject to further monthly auditing	19043		2.1
714	2019	BCUHB	ED	WXM-East	Aug-19	Improvement Plan	Oct-19	Naomi Holder Director of Nursing, East	The health board must ensure that pressure area risk assessments are routinely undertaken and that suitable pressure relieving mattresses are available for use on trolleys	1. The importance of appropriate skin checks (at admission and as required) has been reinforced to the staff. Staff have also been informed about the importance of pressure ulcer prevention &care as per policy for the patients nursed on ED trolley mattresses 2. All staff to ensure that the Maelor score is completed as per policy and actions taken accordingly. In case of patient's further clinical and physical deterioration, staff have been reminded about the importance of re-checking the Maelor score and acting accordingly 3. All patients within the department are placed on the profile bed with appropriate air mattress as indicated by the Maelor Score 4. The ED trolley mattress audit performance is sustained as per policy The above actions will be monitored as a part of the ED matron's audit	Immediate	Complete	**Update:** The actions noted were commenced with immediate effect in August 2019 and are subject to review and audit by the ED Matron and Nursing Director	19043		2.2
715	2019	BCUHB	ED	WXM-East	Aug-19	Improvement Plan	Oct-19	Naomi Holder Director of Nursing, East	The health board must ensure that pressure area risk assessments are routinely undertaken and that suitable pressure relieving mattresses are available for use on trolleys	5. The quote for the hybrid mattresses for trollies is to be obtained to gain the financial support from Health Board	Dec-19	Outstanding	**Update:** The hybrid mattress for trollies has been trialled but not suitable. The team are now exploring further options- further update awaited	19043		2.2
716	2019	BCUHB	ED	WXM-East	Aug-19	Improvement Plan	Oct-19	Naomi Holder Director of Nursing, East	The health board must ensure that falls risk assessments are undertaken in a timely fashion	1. Staff have been reminded to ensure the falls risk assessments are completed as per policy 2. Embed SHINE document to ensure the staff have a set time frame to complete The above action will be monitored as a part of the ED matron's audit	Nov-19	Outstanding	**Update:** 1. Staff have been reminded to ensure the falls risk assessment completed as per policy (evidence provided)- this needs strengthening rather than just issuing a newsletter to staff. Will continue to work with leads 2. SHINE document is in the embedding process and evidence has been provided as assurance that the team are monitoring compliance of all aspects of SHINE to ensure it is fully embedded. The ED Matron will continue to review and audit.	19043		2.3
717	2019	BCUHB	ED	WXM-East	Aug-19	Improvement Plan	Oct-19	Naomi Holder Director of Nursing, East	The health board must ensure that patients' eating and drinking needs are consistently assessed and nutrition and hydration monitoring charts are completed as required	1. All staff reminded to ensure the nutritional status of the patient is assessed and is monitored as required 2. Support and train red cross staff to maintain the intake/output and/or food chart The above action will be monitored as a part of the ED matron's audit	Nov-19	Complete	**Update:** 1. Staff have been reminded to ensure the nutritional status of the patient is assessed and monitored (evidence provided). 2. The team met with the Manager of Red cross on 22.11.2019 and it was deemed that the above action was not in scope of their practice, hence action no longer valid. However, this will be carried out by nursing staff and will be monitored as a part of the ED Matron's audit	19043		2.5
718	2019	BCUHB	ED	WXM-East	Aug-19	Improvement Plan	Oct-19	Naomi Holder Director of Nursing, East	The health board must ensure that controlled drugs are checked on a daily basis	1. Reiterate senior nurse's responsibility in ensuring adherence medicines standards to include the controlled drugs are checked as per policy 2. Ensure designated staff are allocated to check Controlled Drugs on a daily basis to ensure there is a clear responsible and accountable person The above action will be monitored through matron's weekly audit to ensure 100% compliance	Immediate	Complete	**Update:** Completed in August 2019 and evidence provided. This is subject to ongoing review and audit	19043		2.6
719	2019	BCUHB	ED	WXM-East	Aug-19	Improvement Plan	Oct-19	Naomi Holder Director of Nursing, East	The health board must ensure that staff sign controlled drug registers at point of checking and/or administration	1. All staff have been reminded to ensure the controlled drug registers are signed as per policy 2. The above action will be monitored through matron's weekly audit and the departmental Pharmacist will be provide an independent audit	Nov- 19 Dec-19	Complete	**Update:** the staff have been reminded of the above action (evidence provided). The action will be monitored through matron's weekly audit and the departmental Pharmacist will be provide an independent audit	19043		2.6
720	2019	BCUHB	ED	WXM-East	Aug-19	Improvement Plan	Oct-19	Naomi Holder Director of Nursing, East	The health board must ensure that Oxygen is only administered when formally prescribed	1. All staff (medical and nursing) have been formally written to ensure the oxygen is prescribed prior to administration with exception of emergencies 2. Oxygen to be prescribed at the first opportunity if administered in case of an emergency The above action will be monitored through an oxygen audit on a monthly basis	Nov-19	Complete	**Update:** 1. A reminder has been circulated to staff in October regarding the prescribing of Oxygen. Staff have also been reminded of the action (evidence provided). The actions will be monitored through an oxygen audit on a monthly basis	19043		2.6
721	2019	BCUHB	ED	WXM-East	Aug-19	Improvement Plan	Oct-19	Naomi Holder Director of Nursing, East	The health board must ensure that the door to the paediatric are is locked when staff are not in attendance	1. All staff to be reminded to lock the doors of paediatric area are locked whilst not in attendance 2. Shift Leaders to ensure that staff are in attendance whilst patients are in the paediatric area. This will be monitored through matron spot checks and 2 hourly departmental safety huddle	Nov-19	Complete	**Update:** Staff have been reminded of the action (evidence provided). Safety Huddle Log sheet also now in use (evidence provided). The action will be monitored through matron spot checks and 2 hourly departmental safety huddle	19043		2.7
722	2019	BCUHB	ED	WXM-East	Aug-19	Improvement Plan	Oct-19	Naomi Holder Director of Nursing, East	The health board must ensure that the resuscitation trolleys are checked on a regular basis as per policy	1. Communication to all senior nurses to reiterate the standard that all resuscitation trollies are checked as per policy 2. Ensure designated staff are allocated to check on a daily basis to ensure there is a clear responsible and accountable person 3. The above action will be monitored through matron's weekly audit to ensure 100% compliance	Nov-19 Dec-19	Complete	**Update:** The HIW action plan has been shared with all Senior nurses to ensure compliance. A staff allocation board has been introduced and there is a named person for checking the resuscitation trollies. The action will be monitored through matron's weekly audit to ensure 100% compliance	19043		2.9
723	2019	BCUHB	ED	WXM-East	Aug-19	Improvement Plan	Oct-19	Naomi Holder Director of Nursing, East	The health board must ensure that patients are assessed for pain relief and that the effectiveness of the effectiveness of the pain relief in reviewed and documented	1. Department triage nurses to be reminded of the standard that all patients are assessed for the pain at the time of triage 2. Welfare Health Care Support worker allocated to patient waiting area to ensure the effectiveness of pain relief is assessed and documented and escalate concerns to the registered nurse The above actions will be monitored through ED Matron's weekly audit	Nov-19	Complete	**Update:** Staff have been reminded of this action (evidence provided). Health Care Support Workers have been reminded to ensure the effect analgesics monitored and escalated as required. The actions will be monitored through ED Matron's weekly audit.	19043		3.1
724	2019	BCUHB	ED	WXM-East	Aug-19	Improvement Plan	Oct-19	Naomi Holder Director of Nursing, East	The health board must ensure that trolleys containing patients' care notes are locked when not in use The health board must ensure that computer screens are locked when staff are not in attendance	1. Communication to all staff reiterating information governance standards The above action will be monitored through the senior management spot checks 2. The HON to explore the alternatives to store the case notes out of the patients and public areas	Nov-19 Dec-19	Outstanding	**Update:** Email sent to staff (evidence provided). The action will be monitored through the senior management spot checks. However, no update in terms of any alernative which the HON were going to explore and evidence required of liaision with Informatio Governance. Corporate Nursing will continue to work with leads	19043		3.4
725	2019	BCUHB	ED	WXM-East	Aug-19	Improvement Plan	Oct-19	Naomi Holder Director of Nursing, East	The health board must continue to monitor staff levels and skill mix within the department	1. Review the role of the Assistant Practitioner introduced and recruited 2. Ensure the e-roster for the Emergency Department is completed according to the policy and the temporary workforce is requested as required 3. Daily staffing and skill mix to be reviewed by the senior nursing team 4. Sustain ongoing recruitment activity to recruit registered nurses to ensure reduced reliance on temporary workforce	Nov-19	Complete	**Update:** The 3 trained AP and 2 trainee Aps commenced in Nov 19. E-roster is approved and produced in line of the Health Board E-roster policy and evidenced via the e-roster reporting system. staff allocation board has been introduced to ensure the daily staffing and skill mix is reviewed regularly and effectively. there is an ongoing recruitment drive for ED and have 3 WTE vacancies currently, which will be advertised following band 5 interviews on 2nd December.	19043		7.1
726	2019	BCUHB	ED	WXM-East	Aug-19	Improvement Plan	Oct-19	Naomi Holder Director of Nursing, East	The health board must ensure that all staff have access to training in order to ensure that they have the right skills and competencies	1. Communication to all staff to reiterate the necessity for mandatory training compliance 2. Monitor above action is monitored through Electronic Staff Records on a weekly basis 3. Monitor compliance through Matron and Head on Nursing's 1:1s for the nursing workforce training 4. Directorate General Manager (DGM) to monitor compliance for medical and administrative staff	Nov-19	Complete	**Update:** Improved mandatory compliance for nursing staff within ED since the time of inspection. General email sent to staff to improve compliance. (evidence provided). This is subject to ongoing auditing and monitroing by Monitor compliance through Matron and Head on Nursing's 1:1s for the nursing workforce training and also Directorate General Manager (DGM) to monitor compliance for medical and administrative staff	19043		7.1
727	2019	BCUHB	ED	WXM-East	Aug-19	Improvement Plan	Oct-19	Naomi Holder Director of Nursing, East	The health board must reflect on the less favourable staff responses to some of the questions in the HIW questionnaire, as noted in the Quality of Management and Leadership section of this report, and take action to address the issues highlighted	1. 15 drip stands have been purchased for ED, the monthly meetings with equipment library to ensure there is sufficient amount of intravenous pumps and infusers are available in the department. The clinical supplies have ordered regularly and topped up on a daily basis 2. The Datix board is regularly updated around the themes. The Emergency Care safety summit to be launched to ensure staff are informed about the near misses and the preventative measures	Complete Nov-19	Complete	**Update:** The datix board has been maintained around the themes and the themes are shared via daily safety brief (see embedded document). Point 1 is already complete (at the time of action plan)	19043		7.1

Progress against actions- Emergency Department Wrexham	
Outstanding	9
In-progress	1
Complete	17
Total	27



Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Follow-up Inspection (Unannounced)

Wrexham Maelor Hospital, Betsi Cadwaladr University Health Board, Emergency Department

Inspection date: 06 and 07August 2019

Publication date: 7 November 2019

This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

Copies of all reports, when published, will be available on our website or by contacting us:

In writing:

Communications Manager

Healthcare Inspectorate Wales
Welsh Government

Rhydycar Business Park

Merthyr Tydfil

CF48 1UZ

Or via

Phone: **0300 062 8163**

Email: **hiw@gov.wales**

Fax: **0300 062 8387**
Website: **www.hiw.org.uk**

Digital ISBN 978-1-83933-483-2

Contents

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that people in Wales receive good quality healthcare

Our values

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

- **Independent**
- **Objective**
- **Caring**
- **Collaborative**
- **Authoritative**

Our priorities

Through our work we aim to:

Provide assurance:	**Provide an independent view on the quality of care**
Promote improvement:	**Encourage improvement through reporting and sharing of good practice**
Influence policy and standards:	**Use what we find to influence policy, standards and practice**

1. What we did

Healthcare Inspectorate Wales (HIW) completed an unannounced, follow-up inspection of the Emergency Department (ED) at Wrexham Maelor Hospital, within Betsi Cadwaladr University Health Board, on the 06 and 07 August 2019.

Our team, for the inspection comprised of three HIW Inspectors, two clinical peer reviewers and one lay reviewer. The inspection was led by a HIW senior healthcare inspector.

Further details about how we conduct follow-up inspections can be found in Section 5.

2. Summary of our inspection

Overall, we found evidence that the service strived to provide safe and effective care. However, we found some evidence that the health board was not fully compliant with all Health and Care Standards in all areas.

We found that the health board had implemented and sustained some of the improvements listed in the action plan drawn up, following the last inspection of the department. However, some areas remained in need of improvement, and these are referred to in more detail within the relevant sections of this report.

This is what we found the service did well:

- Staff engagement
- Information for patients
- Designated paediatric section
- Governance and visibility of departmental managers

This is what we recommend the service could improve:

- Waiting times and patient flow
- Overview of patients in corridor
- Medication management
- Storage in Medical Assessment Unit (MAU) and Clinical Decisions Unit (CDU)
- Upgrade shower in MAU
- Care documentation and assessments
- Pressure relieving mattresses on trolleys
- Some aspects of staff training
- Staffing recruitment.

3. What we found

Background of the service

Wrexham Maelor Hospital is the district general hospital for the central area of North Wales. It originally opened in the 19th century, but was re-built in 1986. The hospital serves a population of approximately 195,000 and it has around 603 beds (17-18, Stats Wales), with a full range of specialties.

Wrexham Maelor Hospital is run by the Betsi Cadwaladr University Health Board. The health board provides a full range of primary, community, mental health and acute hospital services, for a population of around 678,000 people across the six counties of north Wales, as well as some parts of mid Wales, Cheshire and Shropshire. There is an allocated budget of £1.3 billion, and a workforce of approximately 16,500 throughout the health board.

HIW last inspected the Emergency Department at Wrexham Maelor Hospital on 05 December 2017. The immediate assurances issued immediately following the previous inspection, and the areas for improvement highlighted, together with the health board's responses, are detailed within the relevant sections of this report.

Quality of patient experience

We spoke with patients, their relatives, representatives and/or advocates (where appropriate) to ensure that the patients' perspective is at the centre of our approach to inspection.

Patients spoken with during the course of the inspection expressed satisfaction with the care and treatment received.

We observed good interactions between staff and patients, with staff supporting patients in a dignified and respectful manner.

Staff within the department worked well together, and with other members of the multidisciplinary healthcare team, to provide patients with individualised care according to their assessed needs. However, patients expressed concerns about waiting times.

We found good management and leadership within the department, with staff commenting positively on the support that they received from the department managers.

Dignified care

We found that patients were treated with dignity and respect by the staff team.

We saw good interactions between staff and patients, with staff attending to patients' needs in a discreet and professional manner. Patients we spoke with commented positively on the way staff carried out their duties.

We observed staff being kind and respectful to patients. We saw staff making efforts to protect patients' privacy and dignity when providing assistance with personal care needs. For example, curtains were used around individual bed/treatment areas when care was being delivered. However, we saw that up to six patients were being cared for on trolleys within the main ED corridor area. Although staff were making every effort to maintain patients' privacy and dignity, this area was very busy and was not conducive to the maintenance of dignity and privacy.

Patients told us that staff were kind and that they had received the care they needed. Comments included:

"Treated with respect by everyone."

The environment within the department was clean and tidy, adding to the sense of patients' well-being.

Staying healthy

We found that patients were involved in the planning and provision of care, as far as was possible. Where patients were unable to make decisions for themselves, due to their presenting physical/mental conditions or memory problems, we found that relatives were consulted and encouraged to help make decisions around treatment planning and care provision in accordance with the Health and Care Standards.

We saw good interactions between staff and patients, with staff attending to patients' needs in a calm, discreet and professional manner.

The Butterfly[1] scheme was in operation within the department, whereby butterfly symbols were used to identify patients with a diagnosis of dementia or cognitive impairment, and who required additional support or a different approach to the provision of care. However, we found that the scheme was not being applied consistently.

Improvement needed

The health board must ensure that the Butterfly scheme is implemented consistently within the department.

Patient information

During the last inspection, the following areas for improvement were highlighted:

[1] The Butterfly Scheme aims to improve patient safety and wellbeing by teaching staff to offer a positive and appropriate response to people with memory impairment and allows patients with dementia, confusion or forgetfulness to request that response via a discreet butterfly symbol on their notes.

- Evaluate and improve effective methods of communicating waiting times for patients
- Improve information resources for patients in the waiting area
- Evaluate leaflets in utilisation within the health board, to ensure Welsh NHS / Public Health Wales resources are utilised as a primary source whenever available
- The health board must improve and develop Welsh language resources available, and ensures it receives the same level of attention as that of the English language.

The health board committed to take the following actions in their improvement plan dated 02 February 2018:

- Head of Nursing for Medicine met with ED Matron on 20th December 2018
- Evaluation of existing patient information has taken place
- Meeting with Matron for ED on 17 January 2018, and arrangements to be made for all Information posters to be translated into Welsh
- Visitor Waiting Time Information Screens have now been placed on order
- Deputy Department General Manager for Medicine in conjunction with Band 6 ED staff member, to undertake patient survey to elicit what information patients would like to see on the system.

During this inspection we found that patients were informed of waiting times by means of a hand written board in the main reception waiting area. The information on this board was not updated regularly and did not accurately reflect waiting times.

We found that the general provision of information to patients within the department had improved, with notice boards placed in prominent areas within the department, to display audit results. However, further work was needed to improve the provision of information within the waiting area and the provision of information through the medium of Welsh.

Improvement needed

The health board must ensure that:

- Waiting times are accurately communicated
- Patient information is made available through the medium of Welsh.

Communicating effectively

Throughout our inspection visit, we viewed staff communicating with patients in a calm and dignified manner.

All patients who completed a questionnaire said they had been able to use their preferred language and agreed that staff were always polite, both to them and to their friends and family.

Patients told us that staff had talked to them about their medical conditions and helped them to understand them. However, some patients told us that they found the use of abbreviations, by staff, to describe the various areas within the department confusing. We therefore recommended that staff be discouraged from using abbreviations when speaking with patients and visitors.

Some patients told us that they had arrived at the department by ambulance. All of those arriving by ambulance said the crew had been reassuring and treated them with respect. All said the crew had explained what was happening and helped them understand.

Nearly all patients told us that staff referred to them by their preferred name.

A hearing loop system was available for people with hearing difficulties.

Improvement needed

The health board must discourage staff from using abbreviations when speaking with patients and visitors.

Timely care

Staff worked well with other members of the multidisciplinary healthcare team, to provide patients with individualised care according to their assessed needs.

However, patients expressed concerns about the waiting times. Around half of patients who completed questionnaires said they had been waiting for less than four hours. A fifth said they had been waiting for four to eight hours, and few said they had been waiting more than eight hours. Some comments included:

> *"Waiting seems long three hours."*
>
> *"Waiting times too busy. Poor communication."*
>
> *"Last Saturday left coughing blood in waiting room seven hours."*

The department was very busy on both days of the inspection, with patients having to wait some considerable time to be admitted to the necessary wards within the hospital. However, we observed all patients who were waiting to be admitted, being cared for and treated in a professional manner. There were no delays observed during the day of our visit in offloading patients from ambulances into the department.

Improvement needed

The health board must continue to monitor waiting times and implement further strategies to improve patient flow through the department.

Individual care

Planning care to promote independence

We found that there were generally good care planning processes in place, which took account of patients' views on how they wished to be cared for. Care plans were generic in format and more needs to be done to make them person centred.

Through our conversations with staff and our observations, we confirmed that patients and/or their nominated representatives were involved in decisions about their care needs.

Overall, patients' records were completed to a satisfactory standard and were generally clear and concise. Care files were tidy and easy to navigate.

There was relevant, up to date information available throughout the department on the importance of the early recognition of sepsis[2].

Improvement needed

The health board must ensure that care plans are person centred.

People's rights

We saw that staff provided care in a way to promote and protect patients' rights.

We found that Mental Capacity assessment and Deprivation of Liberty Safeguards (DoLS)[3] assessments were being conducted on patients with diagnosed mental health needs. However, such assessments were not being conducted for patients presenting with other conditions such as dementia, head injury or general confusion.

Improvement needed

The health board must ensure that DoLS assessments are routinely conducted on patients presenting with conditions such as dementia, head injury or general confusion.

Listening and learning from feedback

During the last inspection, the following area for improvement was highlighted:

[2] Sepsis is a life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs.

[3] DOLS are a part of the Mental Capacity Act 2005 that provide a means of lawfully depriving someone of their liberty in either a hospital or care home, if it is in their best interests and is the least restrictive way of keeping the person safe from harm.

- The health board must ensure that information is freely available to all patients on the NHS Wales process for raising a concern / complaint Putting Things Right[4].

The health board committed to take the following actions in their improvement plan dated 02 February 2018:

- Patient feedback kiosk available in ED entrance/exit
- Five Putting Things Right information posters have been placed around the department
- Putting Things Right information leaflets have been provided to ED in both Welsh and English, and information on making a complaint to the health board has been compiled and is currently being translated into Welsh.

During this inspection we found that Putting Things Right information was available within the department. In addition, patients and their representatives had opportunities to provide feedback on their experience of services provided, through face to face discussions with staff. There were good systems in place for managing complaints and we were told by staff that the number of complaints received about the service were low.

There was a formal complaints procedure in place which was compliant with Putting Things Right.

[4] Putting Things Right is a process for dealing with Complaints, Claims and Incidents which are collectively termed “Concerns”. This represents a significant culture change for the NHS in Wales in the way in which it deals with things that go wrong, introducing a single and consistent method for grading and investigating concerns, as well as more openness and involvement of the person raising the concern.

Delivery of safe and effective care

We considered the extent to which services provide high quality, safe and reliable care centred on individual patients.

We found that the staff team were committed to providing patients with safe and effective care.

There were formal medication management processes in place. However, we found that some elements of medication management required improvement.

We identified potential risks to patient safety, in relation to the care of patients who were waiting on trolleys in the corridor area.

Safe care

During the last inspection, the following area for improvement was highlighted:

- The health board to provide HIW with an action plan detailing how it intends to address the current practice, whereby patients have to wait on chairs outside the Clinical Decisions' Unit (CDU) for care and treatment, when beds are not available
- The health board to implement standardised protocols across all appropriate sites, in regards to the standardised consistent assessment and care of patients unable to be offloaded from ambulances, due to the unavailability of beds within the hospitals
- The health board to evaluate the current systems for referring patients to the Out of Hours (OOH) GP service, and take action as necessary to promote the timely assessment of other patients at the triage phase.

The health board committed to take the following actions in their improvement plan dated 02 February 2018:

- Business case in draft in respect of accommodating GP admissions in Medical Assessment Unit
- Local Escalation Action Process (LEAP) document used across BCUHB to provide ability to surge patients to place in holding areas during times of extreme pressure

- Meeting planned system and process to be redesigned with the view that OOH staff will collect and transfer patients to appropriate area
- Monthly meeting to be put in place between ED matron and OOH matron

During this inspection we found that every effort was being made to reduce the numbers of patients waiting on chairs outside CDU. However, this will need to be monitored to ensure further improvement. This should be done as part of the overall monitoring of patient flow through the department.

We were not alerted to any on-going issues with regards referrals to the OOH GP service.

There was good communication with ambulance crews. Emphasis was on moving patients off ambulances into the department as soon as possible to free up the vehicles.

There was an Escalation Policy in place to manage patient flow through the department and to manage patients treated on trolleys in corridor areas. However, it was identified that patients who were waiting on trolleys in the corridor were not receiving appropriate and timely care. Members of the inspection team had to intervene on three separate occasions, with the care of patients waiting on trolleys in the main corridor within ED:

- We had to alert the nurse responsible for the patients in the ED corridor, to a patient who was experiencing increased chest pain
- We had to alert the nurse responsible for the patients in the ED corridor, to a patient who had been incontinent of urine. In addition, the patient concerned had been discussed at the 1.00pm patient flow meeting, and was due to be discharged. However, on further examination by doctors within the ED, the patient was found to have an urinary tract infection and was dehydrated. The patient was subsequently moved to the Medical Assessment Unit for treatment and not discharged
- We observed the nurse responsible for patients in the ED corridor, undertaking observations on a patient. The nurse was not using a timer when counting the patient's respirations. We checked the patient's records, and found that the nurse had documented a respiratory rate for the patient, that may therefore have been inaccurate

- During the inspection, we found that there were no pressure relieving mattresses available for any patients, who were waiting on trolleys within the ED

- We found the use of patient identification (ID) wrist bands to be inconsistent. On the first day of the inspection, we saw patients undergoing diagnostic investigations and treatment who were not wearing ID wrist bands. This was escalated to the shift manager who reminded staff of the need to ensure that all such patients must be issued with and wearing a wrist band. However, during the second day of the inspection, we saw a patient on an intravenous infusion who was not wearing an ID wrist band.

We considered the above practices to be unsafe and increased the risk of harm to patients. As a consequence, an immediate assurance was issued to the health board. This meant that we wrote to the health board immediately following the inspection requiring that urgent remedial actions were taken. Details of the immediate improvement plan can be found in Appendix B.

Managing risk and promoting health and safety

During the last inspection, the following areas for improvement were highlighted:

- Leaking cistern requires fixing.

The service committed to take the following actions in their improvement plan dated 02 February 2018:

- Emergency Department Matron has reported fault to estates in December / January 2018 (remedial repairs). Cistern is working but on time has a repeated fault and estates reviewing with regarding to full replacement.

- Review of Portering Wheelchair Cleaning Procedure Undertaken. Amendment of Procedure to be made by 31January 2018 to include:

    - Checking for damage

    - Removing from use immediately

    - Labelling ‘do not use’ and stating the damage

    - Where to store

    - Who to report damage to

During this inspection, we found that general environmental audits and risk assessments were being undertaken on a regular basis, in order to reduce the risk of harm to patients and staff. These were being formally reported to senior managers and displayed within the department for patients and visitors to see. However, we found that there was a lack of storage within the MAU. Wheelchairs and commodes were stored in front of the fire escape. This was brought to the attention of the nurse in charge of the ward, who took immediate action to have the items removed.

We found issues with the flooring within the shower room on MAU which presented a trip hazard to patients and staff. We were informed that this matter had been passed to the maintenance department for action. We also found that there were holes in the wall coverings within the shower room and broken shower fittings which allowed water to pool thus increasing the risk of cross infection.

We also found that some food items, for use by patients, were being stored with clinical equipment on both MAU and CDU.

Improvement needed

The health board must ensure that:

- The shower room on MAU is refurbished
- Food items are not stored with clinical equipment on both MAU and CDU.

Preventing pressure and tissue damage

We saw that staff on MAU consistently assessed patients regarding their risk of developing pressure damage to their skin, and that suitable pressure relieving mattresses were available on beds. However, some patients within the majors[5] area of the main ED, did not have formal pressure area risk assessments completed. In addition, as previously mentioned, suitable pressure relieving mattresses were not readily available for use on trolleys, for those patients waiting more than four hours for a bed.

[5] The area of the ED where patients with more serious injuries or medical needs are cared for.

Improvement needed

The health board must ensure that pressure area risk assessments are routinely undertaken and that suitable pressure relieving mattresses are available for use on trolleys.

Falls prevention

From reviewing a sample of individual care files, we found little evidence to show that risk assessments were undertaken in a timely fashion, to reduce the risk of falls.

Improvement needed

The health board must ensure that falls risk assessments are undertaken in a timely fashion.

Infection prevention and control

During the last inspection, the following areas for improvement were highlighted:

- All commodes to clearly identify that they have been decontaminated following use
- Linen bins to be emptied in timely manner
- All wheelchairs in use to be fit for purpose.

The service committed to take the following actions in their improvement plan dated 02 February 2018:

- Cleaning schedule for monitoring the sluice by house keeper to be put in place on a daily basis
- New Cleaning Standards policy launched January 2018 being embedded into practice
- Head of nursing met with ED matron on 20 December 2017 clearly outlining expectations and standards.

During this inspection we found that there was a comprehensive infection control policy in place, and we found that regular audits were being undertaken to ensure that staff were adhering to the policy and good practice principles. As previously

mentioned, notice boards had recently been provided to display infection control audit outcomes in prominent positions within the department.

Staff had access to, and were using, personal protective equipment, such as disposable gloves and aprons to reduce cross infection. Hand washing and drying facilities were available. We also saw hand sanitising stations strategically placed near entrances/exits for staff and visitors to use, to reduce the risk of cross infection.

During the first day of the inspection, we found some areas of the department that required cleaning. However, on the second day of the inspection we found the situation to have improved.

Nutrition and hydration

We looked at a sample of care records and found that patients' eating and drinking needs were not consistently assessed, and nutrition and hydration monitoring charts were not always being used where required. In addition, there was little documented evidence of the use of the All Wales Nutritional Care Pathway[6].

We saw staff providing encouragement and support to patients to eat independently. Red Cross staff were also seen assisting patients to eat and drink. This was done in a dignified and unhurried manner.

The meals served to patients appeared well presented and appetising. Patients told us that the food was good.

Improvement needed

The health board must ensure that patients' eating and drinking needs are consistently assessed and nutrition and hydration monitoring charts are completed as required.

[6] The All Wales Nutrition Care Pathway for hospitals was introduced in 2009, and details the pathway for the nutrition screening of patients on admission and the nutritional care throughout their hospital stay.

Medicines management

During the last inspection the following Immediate Assurance issues were highlighted:

- The health board is required to provide HIW with details of the action taken to ensure that medicines are safely stored in the ED, and on other wards and departments across the health board
- Consideration must be given to following Patient Safety Notices (PSN):

  PSN 015 / July 2015 The storage of medicines: Refrigerators

  PSN 030 / April 2016 The safe storage of medicines: Cupboards

The health board confirmed the following in response:

- All three emergency departments have appropriate facilities for the secure storage of hospital medicines
- Staff immediately reminded that patient's own medicines must be placed in a locked cupboard
- Weekly spot check audit on compliance for a further month in Wrexham Maelor ED
- All ward /departments reminded through daily safety huddles and ward safety briefs for the next week, of the requirements for the correct procedure for the management of patients own medication.
- Matron's spot check each ward / department within 48 hours to ensure that staff are aware of the correct procedure and that the procedural requirements of PSN 15 and PSN 030 are met.
- Project plan to address structural requirements (for example, lighting and temperature) identified following comprehensive medicines storage walkabouts in October and November across all sites to be completed.

During the last inspection, the following areas for improvement were highlighted:

- The health board must ensure that all fridges containing medication throughout the health board sites are locked when not in direct usage by staff

- Health board must ensure that oxygen be prescribed appropriately within patients records, and inputted on the patients medication administration records

The service committed to take the following actions in their improvement plan dated 02 February 2018:

- Fridges with integral locks on order for minors and majors area
- In the interim re-location to resuscitation area
- Prescribing is appropriate in clinical areas – Oxygen prescribing on cas. card (which is an appropriate mechanism) where there is a decision to admit the patient, the inpatient treatment sheet will be utilised for patients – agenda item for the ED Governance meeting in Feb 2018
- Audit of compliance with PSN 015 and PSN 030 in progress across secondary care inpatient areas
- Weekly review of medication stored within the department utilising approved BCU medicines management safe storage audit tool
- Hospital Board wide review of medication storage facilities including fridges undertaken and new standards introduced.

During this inspection we confirmed that the majority of the areas for improvement highlighted during the previous inspection had been addressed.

We observed medication being administered to patients, and saw staff approaching the administration of medication activity in an unhurried way, taking time to ensure that patients were able to take their medication, without becoming anxious or distressed. However, as previously mentioned, we saw some patients without identification wrist bands. As a consequence, an immediate assurance was issued to the health board. This meant that we wrote to the health board immediately following the inspection requiring that urgent remedial actions were taken. Details of the immediate improvement plan can be found in Appendix B.

We reviewed a sample of medication administration records and we found that these were, on the whole, completed to a satisfactory standard. However, there were some missed signatures within the controlled drug registers and evidence that the controlled drugs were not being checked routinely every day.

As was the case during the previous inspection, we found that some patients were administered oxygen without it being formally prescribed.

A pharmacist was available within the ED from 9.00am until 3.00pm, Monday to Friday, to audit medication and offer staff guidance and advice.

Improvement needed

The health board must ensure that:

- Controlled drugs are checked on a daily basis
- Staff sign controlled drug registers at point of checking and/or administration
- Oxygen is only administered when formally prescribed with the exception of emergencies.

Safeguarding children and adults at risk

There were written safeguarding policies and procedures in place, and the majority of staff had undertaken appropriate training on this subject.

There was a separate waiting and treatment area for children with a key pad operated door at the entrance. However, we found the door to be propped open with no staff in attendance.

Improvement needed

The health board must ensure that the door to the paediatric area is locked when staff are not in attendance.

Blood management

We found that there were robust systems in place for the management of blood transfusions and was supported by formal written policies and protocols.

Staff involved in the administration of blood transfusions had received training in the process. Once training has been completed then staff are permitted unique scan access to the blood storage fridge. The fridge is stocked by pathology department staff.

Medical devices, equipment and diagnostic systems

During the last inspection, the following areas for improvement were highlighted:

- The health board to ensure that emergency resuscitation trolleys are checked daily and staff document this accordingly.

The service committed to take the following actions in their improvement plan dated 02 February 2018:

- Audit in place to monitor compliance and accurate checking of trolleys
- Weekly audit of crash trolley checking in ED has demonstrated improvement – however, inconsistencies on occasion with daily checks. Maintenance of checking compliance weekly.
- BCUHB CPR policy states frequency of checks and responsibilities of staff. The Resuscitation Team complete audits across BCUHB to ensure compliance of trolley checks, if area non-compliant, audits frequency is increased.

During this inspection we checked the resuscitation trolleys in use within the department. We found that the trolleys was well stocked and had sufficient equipment to deal with an emergency. However, we found that the trolleys were not being checked on a regular basis.

Medical electronics department responsible for checking and maintaining all the equipment within ED. We found all safety checks to be in date.

Improvement needed

The health board must ensure that the resuscitation trolleys are checked on a regular basis as per policy.

Effective care

Safe and clinically effective care

Areas for improvement identified at last inspection included the following:

- We recommend the health board remind all staff of the importance of undertaking pain assessments and repeating these assessments following intervention or analgesia.

The service committed to take the following actions in their improvement plan dated 02 February 2018:

- Revised vital signs observation charts to be implemented following awareness training – pain monitoring form part of the overall patient assessment

During this inspection we found evidence of good multidisciplinary working between the nursing and medical staff.

There were comprehensive policies and procedures in place to support staff in their work.

We found that pain relief was being administered as required. However, this was not always reflected in formal assessment documentation, and there was little evidence of review of the effectiveness of the pain relief.

Improvement needed

The health board must ensure that patients are assessed for pain relief and that the effectiveness of the pain relief is reviewed and documented.

Information governance and communications technology

There was an information governance framework in place, and staff we spoke with were aware of their responsibilities in respect of record keeping and maintenance of confidentiality. However, on the first day of the inspection, we found a trolley containing patients' care notes left open with no staff in attendance within the main ED. In addition, we found a computer screen left unlocked with no staff in attendance within the paediatric area of the department.

Improvement needed

The health board must ensure that:

- Trolleys containing patients' care notes are locked when staff are not in attendance
- Computer screens are locked when not in use.

Record keeping

During the last inspection, the following areas for improvement were highlighted:

- The health board to remind staff to include times of inputs in patients' records and introduce appropriate strategies to monitor this area of record keeping ensuring robust and comprehensive practice.

The service committed to take the following actions in their improvement plan dated 02 February 2018:

- Documentation audit to be completed (Monthly) to establish baseline with communication and improvement - to continue until standard improved, then move to 6 monthly

During this inspection we viewed a sample of patients' care notes and found them to be generally well maintained and relatively easy to navigate. However, as previously mentioned, we found evidence of inconsistencies in the completion of some care documentation, such as fluid and nutrition charts, pain assessments, falls and pressure area risk assessments.

Quality of management and leadership

We considered how services are managed and led and whether the workplace and organisational culture supports the provision of safe and effective care. We also considered how services review and monitor their own performance against the Health and Care Standards.

Overall, we found good management and leadership within the department, with staff commenting positively on the support that they received from the department managers.

Staff told us that they were treated fairly at work and that an open and supportive culture existed. Staff also told us that they were aware of the senior management structure within the organisation, and that the communication between senior management and staff was generally effective

Senior nurses and other managers were working diligently in order to promote the safe and effective care and treatment of patients attending the department.

Governance, leadership and accountability

We found that there were well defined systems and processes in place to ensure that the health board focussed on continuously improving its services. This was, in part, achieved through a rolling programme of audit and established governance structures which enabled nominated members of staff to meet regularly, to discuss clinical outcomes associated with the delivery of patient care.

Key staff from the department and senior hospital managers met regularly during the day to discuss the prevailing situation within the department, with a view to preventing any emerging issues before they escalated. Staff reported that this process was effective in managing the pressures on the department and patient flow.

During discussions with staff, we were told that there was good communication within the department and good informal, day to day staff supervision and support processes in place.

Staff and resources

Workforce

Areas for improvement identified at last inspection included the following:

- The health board must provide HIW with an action plan clearly evaluating how it intends to address staffing shortfalls within the ED of Wrexham Maelor hospital.
- The health board must ensure all staff receive timely annual appraisals.

The service committed to take the following actions in their improvement plan dated 02 February 2018:

- This is 7.2 whole time equivalent registered nurse vacancies and others are on maternity leave
- Bespoke Wrexham Maelor recruitment and retention advertising campaign acute site. Retention strategy includes:
    - Preceptorship programme
    - Intra venous and pump agency training for agency registered nurse (to include Aseptic Non Touch Technique)
    - Undergraduate interviews undertaken twice yearly to appoint specific requests for ED appointments
    - Task and finish group held on fortnightly basis
    - Reconfiguring and completing establishment review to appoint specific roles with prepared advert for Emergency Nurse Practitioner in Emergency Department
- Compliance with Performance and Development Review (PADR) currently 67% within the Emergency Department.
- Programme in place for completion of PADR

During this inspection we found that there was sufficient staff on duty across the department. However, there was some reliance on agency staff to cover vacancies and sickness.

There was generally a good skill mix of staff. However, we were informed that there were not enough qualified children's nurses to cover every shift.

Figures presented showed that 83% of staff working in ED and 98% of staff working in MAU had received a performance and development review/annual appraisals within the past 12 months.

We distributed HIW questionnaires to staff to find out what the working conditions are like and to obtain their views on the standard of care.

We received 11 completed questionnaires from a range of staff.

Most staff indicated in the questionnaires that they had undertaken learning and development, in areas such as health and safety, fire safety and infection control while at the hospital, in the last 12 months.

A majority of staff had undertaken training for advanced life / paediatric life support and Deprivation of Liberty in the last twelve months. However, only a minority said they had undertaken training on dementia and de-escalation and privacy and respect in the last 12 months.

The majority of staff who completed a questionnaire said that the training or learning and development they complete helps them to do their job more effectively, and most said it helps them to stay up to date with professional requirements and ensures that they deliver a better experience for patients.

Nearly all staff members who completed a questionnaire told us that they had an appraisal, annual review or development review of their work in the last 12 months.

The majority of respondents said that they were able to make suggestions to improve patient care although a minority said they felt involved in decisions that were made that affected them.

Around half of the respondents said that they are usually able to meet all the conflicting demands on their time at work, and that they often do not have adequate materials, supplies and equipment to do their work. Comments included:

> *"Not nearly enough equipment, which leads to poor care"*

> *"Limited facilities, require further equipment."*

Some staff who completed a questionnaire felt there were not enough staff within the organisation to enable them to do their job properly. Comments included:

> *"The ED is under-staffed and under-resourced from a nursing, medical and pharmacy perspective. I sympathise with my ED*

colleagues who cannot deliver the standard of care they wish to patients or to the standard the patient needs. However, they do the best with the resources available. Delays are common from clerking, to patient care to medicines administration."

"The current environment in the ED borders on unsafe. Whilst individually each patient is kept as safe as possible, collectively the crowding leads to high risk environment."

The majority of the staff who completed a questionnaire, however felt that they were satisfied with the quality of care they are able to give to patients. Although only half agreed that the privacy and dignity of patients is maintained and that patient independence is promoted.

The majority of staff who completed a questionnaire thought that the organisation encourages teamwork. However, only a minority felt that the organisation was supportive, and that front line professionals who deal with patients are empowered to speak up and take action when issues arise.

Around half of the staff said there was a culture of openness and learning within the health board that supports staff to identify and solve problems. The majority of respondents thought that the health board has access to the right information to monitor the quality of care across all clinical interventions.

The majority of staff who completed a questionnaire agreed that the care of patients is the organisation's top priority, and nearly all agreed that the organisation acts on concerns raised by patients. Around half of the staff agreed they would recommend the organisation as a place to work, and most said that they would be happy with the standard of care provided by the organisation, if a friend or relative needed treatment. Comments included:

"When I have raised concerns … senior management are very receptive and we have improved … as a result. However, it remains very much a work in progress."

"…people who provide frontline service are fantastic and dedicated, but are at breakpoint and burn out."

All of the staff members who completed a questionnaire told us that patient experience feedback, such as patient surveys, was collected. Around half told us that they received regular updates on the patient experience feedback, and most felt that patient experience feedback is used to make informed decisions within their directorate or department.

Staff were asked in the questionnaire about their immediate manager, and the feedback received was positive. Comments included:

> *"Our management team are very helpful and very approachable. They listen and understand if there is anything which needs addressing."*

The majority of staff agreed that their manager encourages them to work as a team, can be counted on to help them with a difficult task at work, gives feedback, and is supportive in a personal crisis. Comments included:

> *"Any concerns I have raised have been addressed in a timely manner."*

> *"My line manager is fantastic - very enthusiastic, supportive and understanding of the pressures in ED. In my role, I could be in ED 24/7 to ensure everybody gets the same standard of pharmaceutical care however, she's taught me to do my best in the time…."*

A majority of staff who replied felt that their managers ask for their opinion before decisions were made that affect their work, and can be counted on to help them with a difficult task at work.

A majority of staff who completed a questionnaire reported that they knew who the senior managers were in the organisation. Around half said there is effective communication between senior management and staff, and the majority said that senior managers regularly involve staff in important decisions, with half saying that management act on staff feedback. Comments included:

> *"I feel we have a fantastic senior team of managers who are always very supportive and very helpful."*

A majority of staff said that senior managers are committed to patient care and that they have sight of new guidance, patient safety alerts and medical device alerts, and that they are supported to ensure implementation of those.

Around half of respondents agreed that their immediate manager takes a positive interest in their health and well-being. However, a third disagreed that their organisation takes positive action on health and well-being, and that they were offered full support in challenging situations. Most said they were aware of the Occupational Health support available to them, and that their working pattern allows for a good work life balance.

Around half of the staff told us in the questionnaires that they had seen errors, near misses or incidents in the last month that could have hurt staff, and around two thirds said they had seen errors, near misses or incidents that could have hurt patients. All staff who had seen an error, near miss or incident had reported it. Comments included:

> *"Medication safety is the mainstay of my role. I Datix all serious and life threatening errors and document all medication related admissions for review … and improve patient care - especially at the care interface such as the ED. I am confident approaching nursing and medical staff if I observe them making a medicines related error and educating them."*

All staff said they were aware of the incident reporting system and a majority said they had adequate training on this system.

A third of staff told us that the organisation treats staff who are involved in an error, near miss or incident fairly, and most agreed that their organisation encourages them to report errors, near misses or incidents.

A majority of staff indicated that they felt the organisation would treat any error, near miss or incident that is reported confidentially, and few felt that the organisation would blame or punish the people who are involved in such incidents. A majority of responses agreed action would be taken on incidents identified.

Around half of the staff agreed that they are informed about errors, near misses and incidents that happen in the organisation, and around half said they were given feedback about changes made in response to reported errors, near misses and incidents. Comments included:

> *"…the situation in ED is less transparent and I'm not aware of staff being told of recent errors/near misses etc and how to prevent them."*

Staff told us that they knew how to report unsafe clinical practice and that they would feel secure about raising such concerns.

Most staff members who completed a questionnaire felt that their organisation acted fairly with regard to career progression or promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age.

Improvement needed

The health board must:

- Continue to monitor staff levels and skill mix within the department
- Ensure that all staff have access to training in order to ensure that they have the right skills and competencies
- Reflect on the less favourable staff responses to some of the questions in the HIW questionnaire, as noted in the Quality of Management and Leadership section of this report, and take action to address the issues highlighted.

4. What next?

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking
- Appendix C: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas

The improvement plans should:

- Clearly state when and how the findings identified will be addressed, including timescales
- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed.

As a result of the findings from this inspection the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.

5. How we conduct follow-up inspections

Follow-up inspections can be announced or unannounced. We will always seek to conduct unannounced inspections because this allows us to see services in the way they usually operate. The service does not receive any advance warning of an unannounced inspection. In some circumstances, we will decide to undertake an announced inspection, meaning that the service will be given up to 12 weeks' notice of the inspection.

The purpose of our follow-up inspections is to see what improvements the service has made since our last inspection.

Our follow-up inspections will focus on the specific areas for improvement we identified at the last inspection. This means we will only focus on the Health and Care Standards 2015 relevant to these areas.

During our follow-up inspections we will consider relevant aspects of:

- Quality of patient experience
- Delivery of safe and effective care
- Management and leadership

Feedback is made available to service representatives at the end of the inspection, in a way which supports learning, development and improvement at both operational and strategic levels. We will also highlight any outstanding areas of improvement that need to be made.

Further detail about how HIW inspects the NHS can be found on our website.

Appendix A – Summary of concerns resolved during the inspection

The table below summaries the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
No immediate concerns were identified during this inspection.			

Appendix B – Immediate improvement plan

Service: Wrexham Maelor Hospital, Emergency Department

Date of inspection: 06 and 07 August 2019

The table below includes any immediate concerns about patient safety identified during the inspection where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking.

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must provide HIW with details of the action it will take, to ensure that patients who are waiting on trolleys in the corridor receive appropriate and timely care.	2.1, 3.1, 3.5 and 5.1	Formal risk assessment to be completed with clear mitigation and controls for the use of corridor for all patients. The formal risk assessment will be a part of the BCUHB escalation framework (likely risk score above 16 and will be part corporate risk register). Immediate corrective action of clinical teams to incorporate patient's nursed in the corridor as a part of ED safety huddle and document all the actions taken. Matron and Heads of Nursing to	Head of Nursing (HON) – Emergency Care (EC) Shift Leader and Lead Consultant – Emergency Department (ED)	30th August 2019 (Immediate) 12th August 2019 (Immediate)

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		perform daily random audit to gain assurance with compliance. The practice has been reinforced with all nursing staff about the use of the SHINE document at time of initial assessment. All agency workers will receive an effective induction for the Emergency Department and clinical supervision will be provided to ensure compliance with policies. The clinical staff will complete the National Emergency Warning (NEWS) Score according to the policy and will escalate to the Shift Leaders and doctor in-charge as required. If the patient's clinical condition deteriorated, the staff have been instructed to re-triage the patients and inform the senior clinician as suggested by the triage category.	HON- EC Shift Leader – ED. Shift Leader – ED. Shift Leader – ED	12th August 2019 (Immediate) 12th August 2019 (Immediate) 12th August 2019 (Immediate) 12th August 2019 (Immediate)

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		Patients to receive an apology letter whilst waiting in the ED corridor from the Managing Director during overcrowding within the ED. The use of the multipurpose room is reinforced to all the staff to provide appropriate and dignified care at all times to the corridor patients. Develop and implement the Standard Operating Procedure (SOP) to ensure there is a clear escalation process for all the staff to ensure appropriate and timely care provision for the corridor patients. This would be further supported by internal ED escalation policy. Reinforce the Health Board's Escalation Policy to escalate corridor patients to the Hospital Management Team (HMT) lead through daily bed meetings to gain specialty support to maintain patient safety.	Directorate General Manager- EC Shift Leader- Emergency Care. HON- EC HON- EC Matron- ED	30th August 2019 (Immediate) 12th August 2019 (Immediate) 30th August 2019 12th August 2019 (Immediate)

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		The departmental Matron (in hours) and Shift Leader (out of hours) to ensure the opportunity of completing the patient experience survey is offered to all the patients within the ED corridor. This action plan will be monitored at the weekly Unscheduled care meeting and the department will establish a task and finish group to monitor this action plan locally. A weekly audit is performed to gain assurance of compliance for the above actions and to drive further improvement.	Matron- ED Shift Leader- ED Triumvirate – EC Matron- ED HON- EC	19th August 2019 (immediate) September 2019 19th August 2019 (Immediate)
The health board must provide HIW with details of the action it will take to ensure that suitable pressure relieving mattresses are readily available for use on trolleys within the ED.	2.2	The importance of appropriate skin checks (at admission and as required) has been reinforced to the staff. Staff have also been informed about the importance of pressure ulcer prevention & care as per policy for the patients nursed on ED trolley	Matron- ED	

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		mattresses. This includes the patients being nursed in the corridor. All staff to ensure that the Maelor score is completed as per policy and actions taken accordingly. In case of patient's further clinical and physical deterioration, staff have been reminded about the importance of re-checking the Maelor score and acting accordingly. All patients within the department are placed on the profile bed with appropriate air mattress as indicated by the Maelor Score. The current trolley mattress within ED to be reviewed and the Huntleigh (trolley provider within ED) to be contacted to ensure we are using the trolley mattresses for	Matron- ED Shift Leader- ED Matron- ED	

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		our patients as per their recommendations. The ED trolley mattress audit performance is sustained as per policy. Harm reviews are currently undertaken to review the hospital acquired harms for long trolley waits. The ED Matron is to present the findings of any harm reviews in local Hospital Acquired Pressure Ulcer (HAPU). This action plan will be monitored at the weekly unscheduled care meeting, and the department will establish task and finish group to monitor this action plan locally.	Shift Leader- ED Matron- ED Triumvirate- EC	

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		A weekly audit is performed to gain assurance of compliance for the above actions and to drive learning and further improvement.	Matron- ED	
The health board must provide HIW with details of the action it will take to ensure that patients are issued with ID wrist bands at an early stage in their care pathway within the ED.	2.1 and 3.1	The Triage, Majors and Resuscitation areas now have the electronic printers installed. This is now being used to issue printed ID wrist bands across all areas. Ensure weekly audit is performed to gain assurance with compliance of ID wrist bands. This action plan will be monitored at the weekly unscheduled care meeting the department will establish task and finish group to monitor this action plan locally. A weekly audit is performed to gain assurance of compliance for the	Matron- ED Matron- ED Triumvirate- EC Matron- EC	9th August 2019 (Immediate) 12th August 2019 (Immediate) September 2019 12th August 2019 (Immediate)

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
		above actions and to drive further improvement.		

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative:

Name (print): Kate Clarke

Job role: Secondary Care Medical Director

Date: 13 August 2019

Appendix C – Improvement plan

Service: Wrexham Maelor Hospital, Emergency Department

Date of inspection: 06 and 07 August 2019

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Improvement needed	Standard	Service action	Responsible officer	Timescale
Quality of the patient experience				
The health board must ensure that the Butterfly scheme is implemented consistently within the department.	1.1 Health promotion, protection and improvement	Training and education to be provided to all staff by Emergency Department (ED) dementia link nurse.	Matron- ED	28th February 2020
		Ensure implementation of the Butterfly scheme through the departmental safety huddles.	Matron- ED	30th November 2019
		Monitor adherence and raise awareness through daily departmental safety huddle.	Shift Leader -ED	30th November 2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that waiting times are accurately communicated.	4.2 Patient Information	Waiting times be updated hourly in the waiting area on the allocated white board.	Directorate General Manager-ED	30th November 2019
		Internal voice system to be used to announce the waiting times on an hourly basis.	DGM-ED	30th November 2019
		The above action to be monitored through frequent spot checks.	DGM- ED	30th November 2019
		Identify the means of displaying the waiting times electronically.	DGM- ED	31st December 2019
The health board must ensure that patient information is made available through the medium of Welsh.		Patient information boards to be displayed in Welsh, support for this gained from the Welsh Language Officer.	Matron- ED	30th November 2019
		Gap analysis of welsh language speakers to be undertaken within the ED	Matron - ED	31st December 2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Opportunity is offered and promoted to the staff to learn the Welsh language.	Matron- ED	31st December 2019
The health board must discourage staff from using abbreviations when speaking with patients and visitors.	3.2 Communicating effectively	All staff would be reminded and encouraged through daily safety briefs to ensure the abbreviations are not used when communicating with patients and visitors. The above action would be monitored through daily matron spot checks and challenged as required.	Matron and DGM- ED	30th November 2019 31st December 2019
The health board must continue to monitor waiting times and implement further strategies to improve patient flow through the department.	5.1 Timely access	As a part of our Building Better Care improvement programme the following actions have been taken- • The current medical workforce job plans are under review to align better skill mix with demand. • A business case for additional medical workforce is waiting executive approval.	DGM- ED Managing Director (MD)- Wrexham Maelor Hospital (WMH).	30th November 2019 30th November 2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
		• An external review conducted for ED workforce in October, the feedback provided to be included in the revised business case.	DGM- ED	30th November 2019
		• The Emergency Nurse Practitioner workforce are on illnesses training module to manage more patients through ENP streaming.	HON- Emergency Care	Completed
		• The direct to speciality referrals from triage and Paediatrics area.	DGM- ED	30thNovember 2019
		• The General Practitioner (GP) at triage trial was completed, which demonstrated an improvement in waiting times for minors and there is plan to provide more consistent GP cover at the triage.	MD- WMH	30thNovember 2019
		• The improvement of the patient flow will be through the emergency floor, which incorporates the Ambulatory	DGM- Medicine Specialities	4th November 2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Emergency Care Unit, Frailty Assessment and Short Stay Unit.		
The health board must ensure that care plans are person centred.	6.1 Planning Care to promote independence	Monthly documentation audit to include the review of care plan documentation to ensure individualised approach. Action and compliance will be monitored as a part of the ED matron's audit. Supporting documentation provided.	Matron –ED Matron- ED	4th November 2019 4th November 2019
The health board must ensure that DoLS assessments are routinely conducted on patients presenting with conditions such as dementia, head injury or general confusion.	6.2 Peoples rights	The Emergency Care Matrons to be on the signatory list to perform the DoLS assessments. The safeguarding team to hold roadshows within ED focusing on DoLS during the safeguarding awareness week. The senior nursing staff (Band 7 and band 6- 19 WTE) to be trained and	Matron- Emergency Care Safeguarding Team Matron- ED	30th November 2019 30th November 2019 31st December 2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
		educated to assess the mental capacity on the admission as required.		
Delivery of safe and effective care				
The health board must ensure that the shower room on MAU is refurbished.	2.1 Managing risk and promoting health and safety	Secure estates quotation refurbish the shower on Medical Assessment Unit Request refurbishment works to be undertaken	HON- EC HON EC	30th November 2019 31st December 2019
The health board must ensure that food items are not stored with clinical equipment on both MAU and CDU.		Immediate corrective action of food items were stored as per policy and the housekeepers have been reminded not to store food items with clinical equipment. The above action is being monitored through housekeeper weekly audit.	Matron- ED	Completed 30th November 2019
The health board must ensure that pressure area risk assessments are routinely undertaken and that suitable pressure relieving mattresses are available for use on trolleys.	2.2 Preventing pressure and tissue damage	The importance of appropriate skin checks (at admission and as required) has been reinforced to the staff. Staff have also been informed about the importance of pressure ulcer prevention	Matron- ED	Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
		&care as per policy for the patients nursed on ED trolley mattresses.	Matron –ED	Completed
		All staff to ensure that the Maelor score is completed as per policy and actions taken accordingly. In case of patient's further clinical and physical deterioration, staff have been reminded about the importance of re-checking the Maelor score and acting accordingly. Supporting documentation provided.		
		All patients within the department are placed on the profile bed with appropriate air mattress as indicated by the Maelor Score.	Shift Leader –ED	Completed
				Completed
		The ED trolley mattress audit performance is sustained as per policy Supporting documentation provided.	Matron –ED	
				Ongoing
		The above actions will be monitored as a part of the ED matron's audit.	Matron- ED	

Improvement needed	Standard	Service action	Responsible officer	Timescale
		The quote for the hybrid mattresses for trollies is to be obtained to gain the financial support from Health Board.	HON- EC	31st December 2019
The health board must ensure that falls risk assessments are undertaken in a timely fashion.	2.3 Falls Prevention	The staff have been reminded to ensure the falls risk assessments are completed as per policy. Embed SHINE document to ensure the staff have a set time frame to complete it. Supporting documentation provided. The above action will be monitored as a part of the ED matron's audit.	Matron- ED Matron- ED Matron-ED	30thNovember 2019 Complete Ongoing
The health board must ensure that patients' eating and drinking needs are consistently assessed and nutrition and hydration monitoring charts are completed as required.	2.5 Nutrition and Hydration	All staff reminded to ensure the nutritional status of the patient is assessed and is monitored as required. Support and train red cross staff to maintain the intake/output and/or food chart.	Matron- ED Matron- ED	30th November 2019 30th November 2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
		The above action will be monitored as a part of the ED matron's audit.	Matron-ED	31st December 2019
The health board must ensure that controlled drugs are checked on a daily basis.	2.6 Medicines Management	Reiterate senior nurse's responsibility in Ensuring adherence medicines standards to include the controlled drugs are checked as per policy. Supporting documentation provided. (Ensure designated staff are allocated to check Controlled Drugs on a daily basis to ensure there is a clear responsible and accountable person. The above action will be monitored through matron's weekly audit to ensure 100% compliance.	Matron-ED Shift Leader-ED Matron-ED	Completed Completed 30th November 2019
The health board must ensure that staff sign controlled drug registers at point of checking and/or administration.		All staff have been reminded to ensure the controlled drug registers are signed as per policy. The above action will be monitored through matron's weekly audit and the	Matron-ED	30thNovember 2019 31st December 2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
		departmental Pharmacist will be provide an independent audit.	Matron and Pharmacist -ED	
The health board must ensure that Oxygen is only administered when formally prescribed.		All staff (medical and nursing) have been formally written to ensure the oxygen is prescribed prior to administration with exception of emergencies. Oxygen to be prescribed at the first opportunity if administered in case of an emergency. The above action will be monitored through an oxygen audit on a monthly basis.	Triumvirate –ED Triumvirate –ED Matron-ED	30th November 2019 30th November 2019 31st December 2019
The health board must ensure that the door to the paediatric are is locked when staff are not in attendance.	2.7 Safeguarding children and adults at risk	All staff to be reminded to lock the doors of paediatric area are locked whilst not in attendance.	Matron-ED Shift Leader-ED	30thNovember 2019 30th November 2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Shift Leaders to ensure that staff are in attendance whilst patients are in the paediatric area. The above action will be monitored through matron spot checks and 2 hourly departmental safety huddle. Supporting documentation provided.	Matron and Shift Leader- ED	30th November 2019
The health board must ensure that the resuscitation trolleys are checked on a regular basis as per policy.	2.9 Medical devices, equipment and diagnostic systems	Communication to all senior nurses to reiterate the standard that all resuscitation trollies are checked as per policy. Ensure designated staff are allocated to check on a daily basis to ensure there is a clear responsible and accountable person. The above action will be monitored through matron's weekly audit to ensure 100% compliance.	Matron-ED Shift Leader-ED Matron-ED	30th November 2019 30th November 2019 31st December 2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that patients are assessed for pain relief and that the effectiveness of the effectiveness of the pain relief in reviewed and documented.	3.1 Safe and Clinically Effective care	Department triage nurses to be reminded of the standard that all patients are assessed for the pain at the time of triage. Welfare Health Care Support worker allocated to patient waiting area to ensure the effectiveness of pain relief is assessed and documented and escalate concerns to the registered nurse. The above actions will be monitored through ED Matron's weekly audit.	Matron-ED Shift Leaders-ED	30th November 2019 30th November 2019 31st December 2019
The health board must ensure that trolleys containing patients' care notes are locked when not in use. The health board must ensure that computer screens are locked when staff are not in attendance.	3.4 Information Governance and Communications Technology	Communication to all staff reiterating information governance standards. The above action will be monitored through the senior management spot checks.	Matron and DGM-ED Matron and DGM	30th November 2019 31st December 2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
		The HON to explore the alternatives to store the case notes out of the patients and public areas.	HON-EC	31st December 2019
Quality of management and leadership				
The health board must continue to monitor staff levels and skill mix within the department.	7.1 Workforce	Review the role of the Assistant Practitioner introduced and recruited. Ensure the e-roster for the Emergency Department is completed according to the policy and the temporary workforce is requested as required. Daily staffing and skill mix to be reviewed by the senior nursing team. Sustain ongoing recruitment activity to recruit registered nurses to ensure reduced reliance on temporary workforce.	HON-EC	29th November 2019
The health board must ensure that all staff have access to training in order to ensure that they have the right skills and competencies.		Communication to all staff to reiterate the necessity for mandatory training compliance.	Matron-ED Matron - ED	29th November 2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Monitor above action is monitored through Electronic Staff Records on a weekly basis. Monitor compliance through Matron and Head on Nursing's 1:1s for the nursing workforce training. Directorate General Manager (DGM) to monitor compliance for medical and administrative staff.	HON - EC DGM-ED	
The health board must reflect on the less favourable staff responses to some of the questions in the HIW questionnaire, as noted in the Quality of Management and Leadership section of this report, and take action to address the issues highlighted.		The staff felt that they often do not have adequate material, supplies and equipment to do their work. • 15 drip stands have been purchased for ED, the monthly meetings with equipment library to ensure there is sufficient amount of intravenous pumps and infusers are available in the department. The clinical supplies have ordered regularly and topped up on a daily basis.	Matron ED	Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
		The staff felt they were not always communicated about recent errors and near misses and how to prevent them. • The Datix board is regularly updated around the themes. The Emergency Care safety summit to be launched to ensure staff are informed about the near misses and the preventative measures.	HON- ED	29th November 2019

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative

Name (print): Jasleen Kaur

Job role: Head of Nursing, EQ, Wrexham

Date: 5th November 2019

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection (Unannounced)

Ysbyty Glan Clwyd – Maternity Services, Betsi Cadwaladr University Health Board

Inspection date: 16 – 19 September 2019

Publication date: 19 December 2019

This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

Copies of all reports, when published, will be available on our website or by contacting us:

In writing:

Communications Manager

Healthcare Inspectorate Wales
Welsh Government

Rhydycar Business Park

Merthyr Tydfil

CF48 1UZ

Or via

Phone: 0300 062 8163

Email: hiw@gov.wales

Website: www.hiw.org.uk

Digital ISBN 978-1-83933-697-3

Contents

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that people in Wales are receiving good care.

Our values

- **Patient-centred: we place patients, service users and public experience at the heart of what we do**
- **Integrity: we are open and honest in the way we operate**
- **Independent: we act and make objective judgements based on what we see**
- **Collaborative: we build effective partnerships internally and externally**
- **Professional: we act efficiently, effectively and proportionately in our approach.**

Our priorities

Through our work we aim to:

Provide assurance:	**Provide an independent view on the quality of care.**
Promote improvement:	**Encourage improvement through reporting and sharing of good practice.**
Influence policy and standards:	**Use what we find to influence policy, standards and practice.**

1. What we did

Healthcare Inspectorate Wales (HIW) completed an unannounced inspection of Ysbyty Glan Clwyd within Betsi Cadwaladr University Health Board on 16, 17 and 18 September 2019. This inspection is part of HIW's national review of maternity services across Wales[1].

The following hospital wards were visited during this inspection:

- Celyn ward - antenatal ward (before delivery) with a capacity of 13 beds and postnatal ward (following delivery) with a capacity of 18 beds
- Midwifery led unit - with a capacity of two delivery rooms, one birthing pool and two postnatal beds
- Labour ward - (during labour) with a capacity of six delivery rooms and one birthing pool
- Triage assessment area with a capacity of four trolley bays and a waiting room
- Two operating theatres.

Our team, for the inspection comprised of two HIW inspectors, three clinical peer reviewers (one consultant obstetrician and two midwives) and one lay reviewer. The inspection was led by a HIW inspection manager.

HIW explored how the service met the Health and Care Standards (2015).

Further details about how we conduct hospital inspections can be found in Section 5 and on our website.

[1] https://hiw.org.uk/national-review-maternity-services

2. Summary of our inspection

Overall, we found that the service provided care in a respectful and dignified way to patients.

However, we identified a number of improvements were required to ensure that the service was providing safe and effective care at all times. This included ensuring that there was sufficient oversight of the day to day activities on the wards.

This is what we found the service did well:

- Women and their families were positive about the care and treatment provided during their time in the unit
- We observed professional, kind and dignified interactions between staff and patients
- There were good arrangements in place to provide women and families with bereavement and perinatal mental health support
- Strong midwifery leadership and good support offered to staff.

This is what we recommend the service could improve:

- Regular checking of resuscitation equipment for new born babies
- Review of induction of labour medication administration
- Review of the reliance upon locum medical staffing
- Review of policies and procedures
- Some areas of patient record keeping
- Availability of health promotion information throughout the unit.

3. What we found

Background of the service

Betsi Cadwaladr University Health Board is the largest health organisation in Wales, providing a full range of primary, community, mental health and acute hospital services for a population of around 678,000 people across the six counties of North Wales (Anglesey, Gwynedd, Conwy, Denbighshire, Flintshire, and Wrexham). The health board has a workforce of approximately 16,500.

There are three main hospitals (Ysbyty Gwynedd in Bangor, Ysbyty Glan Clwyd in Bodelwyddan and Wrexham Maelor Hospital), along with a network of community hospitals, health centres, clinics, mental health units and community based teams.

Ysbyty Glan Clwyd (Glan Clwyd Hospital) is the district general hospital for the central area of North Wales, situated in Bodelwyddan near Rhyl. The hospital serves a population of approximately 195,000. The acute hospital service has a total of 684 beds, with a full range of specialties.

Maternity services are offered to all women and their families living within the geographical boundary of the health board. Maternity services also provides care to women who chose to birth in the health board facilities who reside outside the geographical boundary.

The health board averages around 6,000 births per year, with around 1,785 of these at Ysbyty Glan Clwyd.

Women who birth within the health board have the choice of four birth settings. These include homebirths, a free-standing midwife unit, midwife led care at an alongside midwife unit and an obstetric unit. Ysbyty Glan Clwyd comprises of an obstetric led unit together with a midwifery led unit (birthing centre).

Quality of patient experience

We spoke with patients, their relatives, representatives and/or advocates (where appropriate) to ensure that the patients' perspective is at the centre of our approach to inspection.

Patients were positive about their overall experience of the service and felt they had been treated with dignity and respect. We observed polite, friendly and supportive interactions between staff and patients and their families.

Health promotion information required improvement throughout the unit to maintain active sharing and learning regarding staying safe, healthy and well informed care.

Improvements were suggested in the handover process to strengthen communication between multidisciplinary teams.

Delays were seen in waiting for medical reviews following ultrasounds scans or bloods being taken in the triage assessment unit, delaying discharge.

During the inspection, we distributed HIW questionnaires to patients, families and carers to obtain their views on the standard of care provided. A total of nine questionnaires were completed. We also spoke with 14 patients during the inspection.

Patients who completed questionnaires rated the care and treatment provided during their stay in the maternity unit as excellent (scores were detailed as nine out of ten and above). Patients and their families who we spoke with also said they had a good experience in the whole of the unit. Patient comments included:

> *"Myself and my family were treated with a great amount of respect. Staff were amazing and I am grateful for them".*
>
> *"Outstanding midwives".*
>
> *"Fantastic staff, University students were so attentive and concerned with patients".*

"Fantastic, Delivery suite is fantastic".

However, some patients that we spoke with told us that the delays seen within the triage assessment unit when waiting for ultrasound or blood test results often delayed timely discharge home.

The majority of the patients confirmed their postnatal stay had been more than 24 hours.

Staying healthy

Although the hospital was a designated no smoking zone, which extended to the use of vapour/e-cigarettes, we saw little information in relation to smoking cessation throughout the unit.

Dignified care

During the course of our inspection, we witnessed many examples of staff being compassionate, kind and friendly to patients and their families. We saw staff treating patients with respect, courtesy and politeness at all times. The majority of patients who completed our questionnaires were very positive about their experience of care.

We also saw staff promoting privacy and dignity when helping patients with their personal care. We reviewed care documentation and did not find any areas of concern regarding dignified care.

There were en-suite facilities within some of the birthing and postnatal rooms to help support dignity during the patient's stay. Where en-suites facilities were not available, shared toilet facilities were available nearby.

All but two of the patients who completed our questionnaire, said they saw the same midwife in the birthing unit as they did at their antenatal appointments. Half of the patients were six to twelve weeks pregnant when they had their booking appointment. Patients confirmed that they had been offered a choice about where to have their baby. All patients said they were asked by the midwife about how they were feeling and coping emotionally in the antenatal period.

The majority of the staff we spoke with said they had received bereavement training and would feel confident in accessing the correct policies and support, to enable them to appropriately care for any recently bereaved parents. There was a dedicated bereavement room within the unit, known as the 'Dolwen Suite'. We saw this provided a suitable environment for patients and families to use. If this room was in use, we were told that an unoccupied postnatal room would be made

suitably available. We were told that a bereavement lead who worked across the three sites within the health board was available through core working hours to offer support and advice. Staff also told us that the on-call matron for the maternity service would be the first point of contact if guidance was required outside of core hours.

Patient information

We found that directions to the maternity unit were clearly displayed throughout the hospital. This made it easily accessible for people to locate the appropriate place to attend for care. Visiting times were clearly displayed within the unit and staff told us that there would be flexibility around this if requested.

We found there was little health promotion information displayed in relation to breastfeeding, skin to skin advice, post-natal mental health and general advice on keeping healthy before, during and after pregnancy.

Daily staffing details were not displayed within in the unit to inform patients of who would be caring for them.

Information was predominately available in English, with limited information in Welsh. We were told there was a rolling programme in place to ensure that all information was bi-lingual and current information was in the process of being translated.

Staff we spoke with were aware of the translation services within the health board and how to access these. Welsh speaking midwives were also identifiable by the Welsh speaker logo[2] on uniform.

Improvement needed

The health board must ensure that:

- A range of health promotion is readily available throughout the unit to support patients to make healthy and informed choices

2 The Iaith Gwaith brand is an easy way of promoting Welsh services by identifying the Welsh speakers on your team. If someone is wearing a badge, or lanyard, this shows that they can have a conversation in Welsh.

- Information about staff is displayed for patients, including within the labour ward, to inform patients of who is caring for them.

Communicating effectively

Overall, patients seemed to be positive about their interactions with staff during their time in the unit. Most patients who completed a questionnaire said they felt confident to ask for help or advice when required. The majority of patients also said they had been listened to by midwifery and medical staff during their stay. Most patients also said staff had always spoken with them about their birth choices.

We saw that staff maintained patient privacy when communicating information. We noticed that it was usual practice for staff to close doors of consultation rooms when providing care to protect patients' privacy and dignity.

We saw that staff within the unit met twice daily, at shift change-over time. Midwifery and medical handovers were held separately due to midwifery and medical shifts not following the same working pattern. However, this means that there are no formal daily systems to facilitate communication between teams which could affect patient care. The handover meetings we were able to attend, displayed effective communication in discussing patient needs and plans with the intention of maintaining continuity of care. However, there was no formal log of who was in attendance at the multidisciplinary handover, neither was the information captured or logged of the discussions that took place.

Each ward had a patient safety at a glance board[3] which was used on a daily basis by multidisciplinary teams. These boards clearly communicated patient safety issues and daily care requirements or plans, as well as individual support required and discharge arrangements. The inspection team highlighted the live

[3] The Patient Status at a Glance Board (PSAG) is used in hospital wards for displaying important patient information such as; the infection risk levels, mobility, admission and discharge flow, occupied number of beds, nursing and medical teams, amongst others.

camera link from the ward patient safety at a glance board displaying information in the handover room was of noteworthy practice, in ensuring the most up to date information was available for discussion at handover. It was however felt by the inspection team, that it would also be beneficial for central patient monitoring data currently displayed at the midwives station to also be displayed in the handover room to aid discussions.

We were also told by staff that a vibrant maternity voices group, which is chaired by a service user, had been created for mums-to-be and new mums to meet and discuss services, care, etc. There was also a Facebook page seen for anyone wishing to learn more regarding maternity services within North Wales.

Improvement needed

The health board must ensure that the process of handover is reviewed to ensure patient care planning is communicated effectively.

Timely care

The in-patients we spoke with told us that staff were very helpful and would attend to their needs in a timely manner. We were also told by staff that they would do their utmost to ensure patients were regularly checked for personal, nutritional and comfort needs. This was also seen within the patient's records we reviewed. We also saw that call bells were seen to be easily accessible and answered in a timely manner.

We saw that patient observations were recorded on a recognised national chart to identify patients who may becoming unwell or developing sepsis. Staff were aware of the screening tool and reporting system for sepsis, which enabled appropriate and timely action to be taken.

Individual care

Planning care to promote independence

We found that facilities were easily accessible for all throughout the unit.

We looked at a sample of patient records within the unit and found evidence that patient's personal beliefs and religious choices were captured during antenatal appointments. This was to help ensure they were upheld throughout their pregnancy, labour and postnatal care. We saw that care plans also promoted people's independence based on their assessed abilities.

We found that senior medical and midwifery staff promoted individual care and choices for patients. Birthing partner support was also promoted. All of the birthing rooms were well equipped. One of the birthing rooms also had a plumbed in birthing pool which patients could use during labour.

People's rights

We found that family/carers were able to provide patients with assistance and be involved in their care in accordance with patients' wishes and preferences. These arrangements were recorded in patients' notes to ensure that all members of the team were informed of patient preferences.

Both staff and patients told us that open visiting was available, allowing the partner, or a designated other, to visit between 9.00am and 8.00pm, however, just over a third of the patients who completed the questionnaire confirmed that a partner or someone close to them had not been able to stay with them for as long as they wanted to. Staff also told us that birthing partners could stay with the patient during labour.

The hospital provided a chaplaincy service and there was a hospital chapel. We were also told about arrangements to enable patients from different faiths to access the prayer rooms to meet their spiritual needs.

Listening and learning from feedback

Information was available on the health board's website relating to the process for patients to follow should they have concerns they wish to raise, there was also information available on the unit. We were told by the senior management team that ward managers within the unit were fully aware of the NHS Wales Putting Things Right[4] process and how to deal with complaints. Staff confirmed that they were aware of how to deal with complaints. However, staff did not routinely provide patients with details of the Community Health Council (CHC)[5] who could provide advocacy and support to raise a concern about their care.

[4] http://www.wales.nhs.uk/sites3/home.cfm?orgid=932

[5] http://www.wales.nhs.uk/sitesplus/899/home

We were told that following an informal complaint, lead matrons would contact a patient offering to discuss their issues, as well as promoting the formal complaint procedure should they wish to follow this route. Staff explained that this was used as a way of addressing concerns, but also with a view to highlight any practice issues that may need resolving. Staff told us that communication was maintained with patients and families throughout any concern received and they were also given the opportunity to meet with senior members of staff to discuss their concerns further.

Staff told us that they regularly seek patient feedback through feedback forms or questionnaires, one of which is the birth afterthoughts information card which was given to all women following birth. We were told that these are acted upon by the senior management team and shared with staff during lessons learnt meetings and appraisals.

Improvement needed

The health board must ensure that patients and families are made aware of the Community Health Council (CHC) for advocacy and support.

Delivery of safe and effective care

We considered the extent to which services provide high quality, safe and reliable care centred on individual patients.

We could not always be assured that patient care was provided in a safe and effective way. This is because we identified potential risks to patient safety regarding the checks of resuscitation equipment for new born babies, security of medication and concerns regarding induction of labour medication administration. We also identified areas for improvement regarding infection prevention and control and the security of patient information.

We did however, identify some good processes in place within the unit, such as clinical incidents management and ensuring learning is shared across the service.

We found patient safety was promoted in daily care planning and this was reinforced within the patient records we reviewed.

The service adhered to appropriate arrangements for safeguarding procedures, including the provision of training.

We found that breastfeeding support and provision within the unit needed to be reviewed.

Safe care

Managing risk and promoting health and safety

The unit appeared to be generally clean, appropriately lit and well ventilated, however we found a number of areas which were cluttered such as the utility rooms and sluice on the Labour Ward and Celyn Ward.

We observed utility, kitchen and sluice doors which were wedged open throughout the unit which could pose a potential risk to patients and visitors due to unauthorised access to equipment.

We considered the unit environment, and found sufficient security measures in place to ensure that babies were safe and secure within the unit. We noted that access to the birthing unit was restricted by locked doors, which were only accessible with a staff pass or by a member of staff approving entrance. We were also assured that abduction drills and fire drills regularly take place to ensure safety is maintained in an emergency.

We looked at the arrangements within the unit for accessing assistance in the event of a patient emergency. We found that all rooms had access to an emergency buzzer and call bells. We found the emergency trolley, for use in a patient emergency, was well organised and contained all of the appropriate equipment, including a defibrillator. The emergency drugs were also stored on the resuscitation emergency trolley, however we could not be assured that regular stock, date and maintenance checks were taking place on this equipment.

Emergency evacuation equipment was seen within the birth pool rooms, which could be used in the event of complications during a water birth. We were also assured that all staff had received appropriate training in their appropriate use in the case of emergency.

Improvement needed

The health board must ensure that:

- Organisation of utility rooms within the unit is maintained to high standards
- Doors to unauthorised access rooms are securely closed at all times to maintain safety
- Regular checks are conducted on all resuscitation trollies throughout the unit to ensure equipment is safe for use.

Falls prevention

We saw there was a risk assessment in place for patients admitted onto the unit and those using birthing pools. We were informed that any patient falls would be reported via the health board's electronic incident recording system. Staff explained that the incident reporting system would be followed to ensure lessons were learnt and acted on appropriately.

Infection prevention and control

We found that the clinical areas of the unit were clean and we saw that personal protective equipment was available in all areas and was being used by all healthcare professionals.

During the inspection, we observed all staff adhering to the standards of being Bare Below the Elbow[6] and saw good hand hygiene techniques. We found hand washing and drying facilities were available. Alcohol sanitiser gels were available throughout the unit. However, we did not see information displayed to promote the correct hand washing procedure for staff to follow.

We were told that an infection control audit had been carried out by the health board recently and we were shown the results of this. We found that cleaning schedules for the unit were in place and up-to-date and we saw designated labels on equipment to signify that it was clean and ready for use.

We saw high compliance with infection prevention and control training. Staff explained that any concerns raised regarding infection prevention and control would be escalated to senior members of staff.

Some side rooms within the unit were available for patients use should there be a requirement to reduce the risk of infection and help prevent infections being transferred to other patients.

We were told that the birthing pool was cleaned daily, however, we found the birthing pool within the labour ward was stained and the taps were wrapped in material to stop the tap from leaking. This was escalated to the senior management team during the inspection due to the infection prevention and control risk. We were advised that this would be addressed by the estates team following our inspection.

[6] Best practice is for staff involved in direct patient care to be bare below the elbow, this includes wearing short sleeved clothing, not wearing jewellery (with the exception of a plain wedding band), wrist watches, nail polish or false nails.

Whilst we found the general cleaning of the unit was adequate, we noted in some areas within the unit where the cleaning schedule had not been completed by the domestic cleaners.

Improvement needed

The health board must ensure that:

- Information on hand washing procedures are displayed to support effective hand hygiene practices
- Appropriate infection control can be maintained in the birthing pool
- All cleaning schedules are appropriately completed.

Nutrition and hydration

During our inspection, we looked at how patients' nutritional needs were being met throughout the day and night.

Within the unit there were facilities available to purchase drinks if required. We saw patients being offered hot and cold drinks and water jugs were within easy reach. Staff on the unit had access to facilities to make toast and drinks for patients outside of core hours. Patients also told us that the food and drinks available were to a good standard.

In the patient care records we reviewed, we found that patient nutritional requirements were well documented. However, there were inconsistencies seen when women returned to the postnatal ward following a caesarean section procedure and administration of intravenous fluids. The majority of the patient care records reviewed did not have appropriate fluid balance charts commenced or instigated through the care giving process.

Improvement needed

The health board must ensure that the appropriate fluid balance charts are completed following commencement of intravenous fluid administration.

Medicines management

We looked at the arrangements for the storage and administration of medicines within the unit. We found that medication cupboards were left unlocked during the first day of the inspection. This could pose a potential risk to the safety of

patients and visitors due to the risk of unauthorised access to medicines. This was raised at the time of the inspection and the medication cabinets were rectified immediately, with all doors being closed and cupboards locked.

There were daily checks of the temperature at which medication was stored. We found there were suitable arrangements for the safe and secure storage and administration of controlled drugs.

We also noted from discussions with staff and a review of a sample of patient records that the prescribing and administration of medication during induction of labour was not in line with the health board policy. Upon checking the medication licence details, it was also established as being administered outside of licence guidance. Our concerns regarding this were dealt with under our immediate assurance process. Details of the immediate improvements we identified are provided in Appendix B.

We looked at a sample of medication records and saw these had been completed appropriately. However, we found there to be gaps in administration of regularly prescribed drugs which was considered to be the result of medications rounds not being conducted within the unit.

Pharmacy support was available to the unit and an out-of-hours computerised process was available for staff to check stock and availability of drugs across the hospital during these times, to ensure there were no delays in patients receiving medication. The unit also had access to a stock of take home medication, allowing patients to be discharged in a timely manner.

Improvement needed

The health board must ensure that:

- Medication is stored appropriately and securely at all times
- Induction of labour medication prescribing is reviewed to ensure safe administration in care
- Regular medication rounds are introduced to ensure patient's needs are met when required.

Safeguarding children and adults at risk

The health board had policies and procedures in place to promote and protect the welfare of children and adults who may be at risk. Safeguarding training was

mandatory and all staff we spoke to confirmed they had received training within the past 12 months.

There was an appointed lead safeguarding midwife for the health board who would provide support and training to staff. We were told that safeguarding training included guidance regarding female genital mutilation, domestic abuse, sexual exploitation and bruises on babies, as well as the procedures to follow in the event of a safeguarding concern.

We were told that formal safeguarding supervision sessions are held regularly and staff are encouraged to discuss issues in a group supervision session. Formal safeguarding supervision had been recently introduced and was mandatory for staff to attend two sessions per year. The health board recently started to roll-out the process to community based midwives, with the intention of expanding this across the rest of the service over the year.

There were appropriate procedures in place to alert staff to safeguarding concerns with regards to patients being admitted onto the unit, to ensure care and treatment was provided in an appropriate way.

Medical devices, equipment and diagnostic systems

As previously mentioned, we considered the arrangements for the checking of resuscitation equipment within the unit. We found the checks on the neo-natal resuscitaire[7] to be inconsistently recorded and did not demonstrate that they had been carried out on a daily basis. Our concerns regarding this were dealt with under our immediate assurance process. Details of the immediate improvements we identified are provided in Appendix B. An additional recommendation is made within the 'Quality of management and leadership' section of this report with regards to the oversight of the day to day checking of equipment.

We found that regular checks of other pieces of equipment, such as blood pressure machines, had been carried out in a consistent and regular manner.

[7] Device to have during labour and delivery procedures, combining an effective warming therapy platform along with the components needed for clinical emergency and resuscitation.

Effective care

Safe and clinically effective care

During our inspection, based on our immediate concerns identified, we were not always assured that patient care was provided in a safe and effective way. This was because of inadequate checks on emergency equipment and issues around induction of labour medication prescribing. We also found there was insufficient management oversight of ward activities to ensure essential processes and procedures were being followed to support the delivery of safe and effective care. This included regular audits on infection prevention and control, and emergency equipment checks. It was however, positive to find that staff reacted quickly and promptly to address the issues we raised.

Staff who we spoke with told us that they were happy with the quality of care they were able to give to their patients. We were told by staff and patients that those in the birthing unit would always be kept comfortable and well cared for. In addition, that pain relief would be available to patients during labour. We also saw good evidence of medical assessment and treatment plans throughout the patient records reviewed. We observed staff effectively prioritising clinical need and patient care within the unit, and from the patient records reviewed, it was evident that clinical need prioritisation was forefront in care planning.

We were also told that the unit had dedicated theatre staff coverage from the general theatres in the hospital, for caesarean sections or other surgical procedures. There were two operating theatres seen (main and back-up), and midwives we spoke with confirmed that unless they were trained to do so, they were never expected to practice as a scrub nurse[8] and perform scrub duties.

Although we saw that a breastfeeding coordinator was appointed, staff told us that the substantial workload covered meant that visibility on the unit to promote breastfeeding was greatly reduced. Although the majority of patients who completed the questionnaire felt supported with the feeding of their babies, one

[8] Scrub nurses are registered nurses who assist in surgical procedures by setting up the room before the operation, working with the surgeon during surgery and preparing the patient for the move to the recovery room.

patient who completed a questionnaire felt that more support in breastfeeding was needed within the unit.

Improvement needed

The health board must ensure that breasting feeding support is reviewed and that visibility is increased throughout the unit.

Quality improvement, research and innovation

A lead clinical research and improvement midwife was in place, who covered maternity services across the health board. We were told that projects to support education in GAP and GROW[9], epilepsy in patients, and the full review of documentation and the creation of care pathways across the unit had been recent projects completed. We were told that further work was planned to implement the use of innovation champion midwives across the service, who would be encouraged to become involved in innovation and research projects to support the team.

The health board maternity practice development midwife was also seen to carry out the inspirational work of Practical Obstetric and Multi-Professional Training. (PROMPT)[10], which was being rolled out across the whole of Wales due to its successful implementation.

The unit was also an early adopter of the Obstetric Cymru (Obstetric Bleeding Strategy for Wales) in maternity services, for the management of postpartum haemorrhage, with evidence in the health records reviewed by the inspection team of continued implementation of strategy recommendations.

[9] GAP – Growth assessment protocol - GROW – Gestation related optimal weight (A procedure designed to monitor potential problems during gestation, specifically for women who have previously delivered small babies)

[10] PROMPT - Practical Obstetric and Multi-Professional Training. The course teaches attendees how deal with obstetric emergencies.

Information governance and communications technology

We found there were a number of areas where patient information was not being securely managed or stored, to uphold patient confidentiality and to prevent unauthorised access.

Patient information was being stored within unlocked filing cabinets on Celyn Ward. However, when this was escalated to the senior management team an immediate risk assessment was carried out by the information governance lead for the health board. Although the health board felt the risk was low as the nurses' station was manned, we found that there were times when this area was not manned and we noted patient's visitors wondering around the corridors.

The internal intranet was informative for staff, with a wide range of accessible midwifery and medical clinical policies and procedures. However, we found a number were out-of-date and requiring review.

We found that a monthly maternity dashboard was produced which included information in relation to each hospital and across the health board. This provided information with regards to the clinical activity, induction of labour, clinical indicators and incidents. The dashboard was rated red, amber and green depending upon the level of associated risk. However, we could not be assured that the data was up-to-date, as we found upon reviewing the dashboard, some areas were missing completed data entries.

Data was also seen to be collated from birth registers manually by two members of labour ward midwives, however, Welsh Government receive all maternity data via electronic information systems as well as national bodies, such as the National Maternity and Perinatal Association when benchmarking outcomes of birth. Maternity data is captured electronically following birth, therefore we suggested that the department used this method as opposed to manual data collection, as a more efficient resource.

Record keeping

Overall, we found the standard of record keeping to be adequate with care plans well documented between multidisciplinary teams. However, some patient records we reviewed were disorganised and difficult to navigate. We saw appropriate observations charts, care pathways and bundles being used. However, whilst we saw that preventative measures had been put in place to

prevent venous thromboembolism[11] for patients on the unit, risk assessments had not been documented to support the reason why.

We also saw inconsistencies across the medical health records reviewed with gaps in areas such as medical signatures and General Medical Council registration number completion.

Improvement needed

The health board must ensure that:

- Patient records are held securely at all times
- Policies and procedures are reviewed and updated within appropriate timescales
- Dashboard data entry is reviewed to ensure consistency
- Patient records are fully reflective of the care and treatment provided to patients and in line with standards of professional record keeping
- Data collection methods are reviewed to reduce manual entry.

[11] https://www.nice.org.uk/guidance/ng89/chapter/Recommendations#risk-assessment

Quality of management and leadership

We considered how services are managed and led and whether the workplace and organisational culture supports the provision of safe and effective care. We also considered how the service review and monitor their own performance against the Health and Care Standards.

Specialist midwives were appointed across the health board and we found them to be useful and knowledgeable resources for the unit teams.

Staff reported that there was good multidisciplinary team working, and we saw evidence to support this.

We also found evidence of good leadership and management amongst midwifery and medical teams within the unit. Unit staff who completed questionnaires and those we spoke with, were positive regarding the support they received from senior staff.

Governance, leadership and accountability

We saw a number of regular meetings were held to improve services and strengthen governance arrangements. Such meetings included a monthly maternity quality and safety group, monthly audit review meetings and obstetric clinical review of incident meetings. Additionally, there were monthly ultrasound screening, labour ward, postnatal and neonatal forums and weekly multidisciplinary meetings. We found there was good overall monitoring and governance of the staffing levels of the service.

We also found there was internal audit activity taking place, which was being monitored and presented in appropriate quality, safety and risk meetings and forums. However, staff told us that follow-up actions identified from audits were not always carried out to provide assurance that active learning and service improvements were taking place.

The senior management team confirmed that actions and recommendations from national maternity audits, such as Mothers and Babies: Reducing Risk through

Audits and Confidential Enquiries (MBBRACE)[12] and Each Baby Counts[13] were taken forward in the unit. This is to improve patient care, experience and future reporting of risk reduction and patient safety. Annual external validation is received from the respective national audit bodies such as MBBRACE and ongoing work takes place to ensure the unit is in line with the recommendations made.

The health board demonstrated a clear and robust process to managing clinical incidents. A lead governance midwife was in place, who held responsibility for reviewing, investigating and managing clinical incidents across the health board. All staff we spoke with told us that the organisation encourages them to report errors, near misses or incidents and that these were never dealt with in a punitive manner.

Monthly risk meetings are held at Ysbyty Glan Clwyd where reported incidents, investigations and their findings were discussed in a multidisciplinary format. We saw that minutes were produced and information/learning shared across maternity services across the health board to support changes to practice and learning. We were assured that the internal risk register was monitored and acted upon when required.

A monthly clinical governance meeting was held, which also had oversight of the reported incidents. The lead governance midwife presented themes and trends to this meeting, with the view of highlighting any areas of practice improvements required across the heath board. Lessons learnt were previously shared and circulated to all staff within a monthly feedback newsletter, summarising the month's issues. The senior management acknowledged that this was a vital source of sharing and plan to re-instate this in due course. We also promoted that a newsletter is a good means to provide positive feedback to staff and to highlight where good practice has been evident.

---

[12] MBRRACE - Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK with the aim of providing robust information to support the delivery of safe, equitable, high quality, patient-centred maternal, new-born and infant health services.

[13] Each Baby Counts - the Royal College of Obstetricians and Gynaecologists (RCOG)'s national quality improvement programme to reduce the number of babies who die or are left severely disabled as a result of incidents occurring during term labour.

Staff felt the daily leadership within the unit to be excellent, however, we did see that the senior ward matrons were carrying out tasks, such as rota management which would be ideally managed by ward managers. Staff also said they would like to see further empowerment in daily management tasks and they felt this would be possible with appropriate leadership support.

We also saw good work carried out by the consultant midwife to achieve expert practice. This included the development of the new Vaginal Birth After Caesarean Section (VBAC)[14] protocol, user engagement in service development, and creation of many training initiatives to increase learning and development.

Improvement needed

The health board must ensure that:

- Follow on work from audits to be reviewed to ensure learning and service improvements take place
- Management empowerment and leadership support is reviewed to enable career progression.

Staff and resources

Workforce

All staff we spoke with felt they received good leadership and support, personally and professionally. Strong team working was seen to be encouraged by all senior managers. This was confirmed by staff we spoke with and those who completed our questionnaires. A number of staff said they considered their working environment to be like a family, and they were happy to work within Ysbyty Glan Clwyd. Some of the comments from staff included the following:

[14] VBAC - Vaginal Birth After Caesarean Section – Where many women who have had one previous caesarean section can safely have a vaginal birth in a subsequent pregnancy, or they can choose to have a caesarean section.

"Great friendly place to work. I am proud to work here".

"Excellent line manager - fosters a culture of openness and team work. Supportive and encouraging".

Senior staff we interviewed shared with us the success of support given to the maternity services from Deloitte Risk Advisory UK[15]. This support mechanism was introduced into the health board four years ago when the health board was placed into special measures[16]. Effective outcomes have been seen in relation to working practices, working relationships and operational risk management.

We were told by all staff that midwifery rotas were well managed within the unit. If there were any shortages of staff cover, community midwives would be called in. Senior managers would also step in to cover. All the staff we spoke with told us there were rarely issues with staffing coverage. They advised that this is managed well by the senior team. However, we were told that there was a large amount of long term sickness within the medical team, and this appeared to be managed well.

We saw there were departmental escalation processes in place, and all staff we spoke with were aware of where to locate the policy and how to escalate issues such as staffing shortages. However, one staff member noted that managers may not always be immediately available due to their workload.

Medical staff we spoke with said that there is a heavy reliance on the good will of doctors to cover shortages in the medical staffing rota. We also saw evidence that during twilight shifts (between the hours of 2100 hours and 0200 hours), consultants would often undertake the role of a registrar to cover the deficit with the registrar on-call duties. We were also told by some medical staff that the service needs to implement the role of a fetal medical consultant within the maternity outpatients, to deliver care to women requiring support in the antenatal period. This was discussed with the senior management team and they

[15] Delloite Risk Advisory UK – an organisation who supported the HB to enable business to understand and manage their risks more effectively, allowing them to create and protect their values for all of their stakeholders.

[16] Special measures refer to a range of actions which can be taken to improve health boards, trusts or specific NHS services in exceptional circumstances.

confirmed funding had been secured for this role and it would be advertised imminently.

We saw evidence of robust induction programmes for both midwifery and medical staff, and staff felt these were of benefit when commencing their role. We also saw that the training and mentorship for medical staff was very positive. Medical staff we spoke with and those who completed the questionnaire confirmed that the training, support and guidance is of a high standard. The staff we also spoke with told us that the organisation will do its utmost to encourage and support good teamwork.

We found that there was a process in place for monitoring staff attendance and compliance with mandatory training. Health board mandatory training, such as health and safety, fire safety, infection prevention and control, and safeguarding, is predominately completed on-line and is monitored centrally through an electronic staff record. Staff receive prompts to inform them when their training is due to expire to ensure they remain within timescales.

The service holds three mandatory maternity related study days across the year. One of the days is PROMPT training, which is a multidisciplinary training event used to encourage multidisciplinary working in emergency situations. All staff we spoke with said they attend this training when they can and find it very useful. We were shown compliance figures for PROMPT training and were assured that regular training was taking place. This was also confirmed in the staff questionnaires received.

The health board had a lead midwife for practice education/practice facilitation, and part of their role is to monitor compliance with training across the year. Staff are required to book themselves onto the relevant training days and attendance is reported to the senior teams.

Clinical supervisors for midwives were in place across the health board. Their roles were to provide support and professional supervision to midwifery staff. There is a national target[17] to make sure that supervisors meet with midwives for

[17] https://gov.wales/sites/default/files/publications/2019-03/clinical-supervision-for-midwives-in-wales.pdf

four hours each year. The health board monitor compliance with this target during the previous financial year, and are continuing this on an ongoing basis.

The clinical supervisor for midwives was also responsible for carrying out appraisals. We confirmed that within Ysbyty Glan Clwyd, all appraisals were up-to-date. Staff we spoke with told us that they have regular appraisals and they see them as positive meetings to increase continuous professional development.

We found that there was a good level of support in place from the specialist lead midwives, who were knowledgeable about their specialist roles. These leads provide support and guidance through study days, supervision sessions and meetings with staff, as and when required. We also saw a good range of skill mix throughout the unit.

Although we were told there were no nursery nurses employed within the services, we saw that maternity support workers were encouraged to develop their skills to the next level in qualification. This would mean more support could be given to the midwives and new mothers in areas, such as breastfeeding, bathing and general care needs.

Improvement needed

The health board must ensure that the medical rota is reviewed to ensure adequate medical cover is in place at all times.

4. What next?

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking
- Appendix C: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

The improvement plans should:

- Clearly state when and how the findings identified will be addressed, including timescales
- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed.

As a result of the findings from this inspection the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.

5. How we inspect hospitals

We have a variety of approaches available to us when we inspect NHS hospitals, including:

- In-depth single ward inspection: we undertake a thorough and detailed review of one ward
- Multi ward inspection: we visit a number of wards and departments within one hospital site to identify issues or themes which may apply to the whole hospital
- Multi hospital inspection: we visit a number of hospitals within the same health board to assess the governance and delivery of whole services.

Hospital inspections are usually unannounced. We will always seek to conduct unannounced inspections because this allows us to see services in the way they usually operate. The service does not receive any advance warning of an unannounced inspection.

Feedback is made available to service representatives at the end of the inspection, in a way which supports learning, development and improvement at both operational and strategic levels.

We check how hospitals are meeting the Health and Care Standards 2015. We consider other professional standards and guidance as applicable.

These inspections capture a snapshot of the standards of care within hospitals.

Further detail about how HIW inspects the NHS can be found on our website.

Appendix A – Summary of concerns resolved during the inspection

Service: Ysbyty Glan Clwyd

Area: Maternity Services

Date of Inspection: 16 – 18 September 2019

The table below summaries the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
N/A			

Appendix B – Immediate improvement plan

Hospital Inspection: Immediate improvement plan

Service: Ysbyty Glan Clwyd

Area: Maternity Services

Date of Inspection: 16 – 18 September 2019

Delivery of safe and effective care				
Improvement needed	**Regulation / Standard**	**Service action**	**Responsible officer**	**Timescale**
Finding The inspection team considered the arrangements for the checking of emergency equipment throughout the unit.	2.1 Managing Risk and Promoting Health and Safety	Following the unannounced inspection, staff have been reminded that daily checks of neonatal resuscitaires will be the minimum expected standard. This has been communicated to all staff via safety	Delivery Suite/ Midwifery Led Unit co-ordinators (sisters)	Completed and on-going

We found that checks of equipment used in a patient emergency were insufficient. This is because checks were inconsistent and not recorded as being carried out on a daily basis. We found this in relation to the following equipment: • Neo-natal resuscitaires **<u>Improvement needed</u>** **The health board must provide HIW with details of the action it will take to ensure that checks of the neo-natal resuscitaires are carried out on a daily basis and in line with their policy.**	2.9 Medical Devices, Equipment and Diagnostic Systems	briefings for a minimum of two weeks and will continue to be communicated at every opportunity. Shift co-ordinators will monitor compliance on a daily basis. The Matron, as an extra measure, will also monitor compliance during a daily walk about on the unit. Any concerns identified will be addressed immediately with the staff member. The Matron will audit compliance of daily checks by completing a weekly audit, and will take every opportunity to remind staff of the lessons learned following the unannounced inspection. Any concerns identified will be addressed immediately with the member of staff and an action log will be completed. The learning from this unannounced inspection has been communicated and will continue to be communicated at all	Matron Matron Senior management team	 Completed and on-going Completed 19/09/19 and on-going

		interdepartmental meetings within the unit.		
<u>Finding</u> The inspection team considered the arrangements for the safe storage of medications throughout the unit. We found there were a number of areas where medication was not being securely stored, to prevent unauthorised access and to uphold patient safety. We found that medication cupboards were left unlocked and doors left open to medication rooms. **<u>Improvement needed</u>** **The health board must ensure that medication is stored safely and securely at all times.**	2.1 Managing Risk and Promoting Health and Safety 2.6 Medicines Management	Following the unannounced inspection, staff have been reminded that full compliance with the BCUHB standards of medication storage will be expected. This has been communicated to all staff via safety briefings for a minimum of two weeks and will continue to be communicated at every opportunity. Shift co-ordinators will monitor compliance throughout each day. The Matron, as an extra measure, will also monitor compliance during a daily walk about on the unit. Any concerns identified will be addressed immediately with the staff member.	Shift co-ordinators /Matron	Completed 19/09/19, and on-going

		The Matron will audit compliance against the standards by completing a weekly audit, and will take every opportunity to remind staff of the lessons learned following the unannounced inspection. Any concerns identified will be addressed immediately and documented in an action log	Matron	Completed 20/09/19, and on-going
		The BCUHB Medicines Policy MM01, highlighting the safe storage of medication has been re-circulated to all staff.	Governance secretary	Completed 26/09/19, and on-going
		The learning from this unannounced inspection has been, and will continue to be communicated at all interdepartmental meetings within the unit.	Senior management team	Completed, and on-going
		The Women's Directorate will embark upon a medicines management improvement programme utilising improvement methodologies to meet the required	Matron	

		standards. The leads will work with local pharmacy leads and the BCUHB Medicines Management Collaborative utilising a data collection tool to monitor compliance against the standards inclusive of medicine storage. All wards within the health board will be part of the BCUHB audit programme, which will assess compliance with medicine management standards by the end of 2019.	Medicines Management Collaborative	17/10/19, and on-going End 2019
Finding We found in speaking to staff that it was common practice to administer two PROPESS (Induction of Labour Suppository) suppositories to women to induce labour. However, this was not in line with the health board's current policy and NICE guidelines. In	2.6 Medicines Management 3.1 Safe and Clinically Effective Care	Following the unannounced inspection, the Clinical Director and Labour Ward Lead at YGC fed back the learning to the clinical team with regards to the need for obstetric review of the patient ***before*** repeat prostaglandin administration and	Clinical Director Labour ward Lead	Completed 18/09/19

discussion with staff, we understand this issue had been previously been raised with medical and midwifery staff, however this was not consistently communicated. **<u>Improvement needed</u>** **The health board must ensure that the administration of PROPESS is in line with the health board's policy and NICE guidelines.**		caution regarding use of repeated Propess. The North Wales Clinical Lead and Director of Midwifery and Women's Services shared the learning from the unannounced inspection with clinical teams across North Wales, at their monthly staff drop in sessions. The feedback following the unannounced inspection was also shared at Women's Quality, Safety & Experience Sub Group on 20/09/19 for wider learning. The North Wales Clinical Lead and Director of Midwifery and Women's Services, also attended all clinical areas to re iterate the learning and the required standard of practice for prostaglandin management, seeking assurances from all departments within the Directorate	North Wales Clinical Lead Director of Midwifery and Women's Services North Wales Clinical Lead	Completed 19/09/19 Completed 20/09/19 Completed 26/09/19

		The North Wales Clinical Lead shared a memo with all staff advising on the practice of IOL. This included a section on "What is expected if labour has not started or ARM is not possible after one cycle of Propess® treatment?" This highlighted the need for senior obstetric review and outlined the various options available to the women. The Women's Induction of Labour (IOL) Written Control Document (WCD) update had previously been deferred pending an update from NICE in 2020. The Directorate however decided to have an interim update of the WCD. Two identified Consultant Obstetricians (labour ward leads) will amend the current WCD to mandate obstetric review of the patient ***before*** repeat prostaglandin administration. The WCD will be revised and reviewed within the Women's Governance	Director of Midwifery and Women's Services North Wales Clinical Lead Consultant O&G, Labour Ward Lead YG Consultant O&G, Labour Ward Lead YGC Senior Management Team	31/10/19 Completed 19/09/19, and on-going 31/10/19

		Framework, for agreement and ratification at QSE Sub Group and Board meetings by the end of October 2019 The learning from this unannounced inspection has been and will continue to be, communicated at any given opportunity and at all interdepartmental meetings within the Directorate BCUHB will register as a stakeholder for the NICE Clinical Guideline, in order to review and provide early feedback on it. A named Obstetrician will implement an updated IOL Integrated Care Pathway (ICP). The ICP will support the learning from the inspection and include the need for obstetric review ***before*** further intervention after an initial Propess.	North Wales Clinical Lead Consultant O&G, Labour Ward Lead YG	30/10/19 30/11/19

		To further support the counselling of women, the IOL leaflet will be updated. This will be performed by the Consultant Midwife and a named Consultant Obstetrician, and will be required to be translated into Welsh for our service users, which may delay the publication process.	Consultant Midwife Consultant O&G, Labour Ward Lead YG	

Health Board Representative:

Name (print): **Fiona Giraud**

Role: **Director of Midwifery & Women's Services, Maternity**

Date: **26th September 2019**

Appendix C – Improvement plan

Service: Ysbyty Glan Clwyd

Area: Maternity Services

Date of Inspection: 16 – 18 September 2019

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Improvement needed	Standard	Service action	Responsible officer	Timescale
Quality of the patient experience				
The health board must ensure that health promotion is readily available throughout the unit	Standard 1.1 Health promotion, Protection and Improvement			

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that Information about staff is displayed for patients, including within the labour ward.	Standard 1.1 Health promotion, Protection and Improvement			
The health board must ensure that the process of handover is reviewed.	Standard 1.1 Health promotion, Protection and Improvement			
The health board must ensure that patients and families are made aware of the Community Health Council (CHC) for advocacy and support.	Standard 1.1 Health promotion, Protection and Improvement			
Delivery of safe and effective care				
The health board must ensure that organisation of utility rooms within the unit is maintained to high standards.	Standard 2.1 Managing risk and promoting health and safety and 2.4			

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that doors to unauthorised access rooms are securely closed to maintain safety.	Standard 2.1 Managing risk and promoting health and safety and 2.4			
The health board must ensure that regular checks are conducted on all resuscitation trollies throughout the unit.	Standard 2.1 Managing risk and promoting health and safety 2.9 Medical devices, equipment			
The health board must ensure that hand washing posters to be displayed.	Standard 2.1 Managing risk and promoting health and safety 2.4 IPC			
The health board must ensure that tap on the birthing pool is replaced.	Standard 2.1 Managing risk and promoting health and safety			

Improvement needed	Standard	Service action	Responsible officer	Timescale
	2.4 IPC			
The health board must ensure that all cleaning schedules are appropriately completed.	Standard 2.1 Managing risk and promoting health and safety 2.4 IPC			
The health board must ensure that fluid balance charts are completed following commencement of intravenous fluid administration.	Standard 2.5 Nutrition and Hydration 2.6 Medicines management			
The health board must ensure that medication is stored appropriately and securely at all times.	2.6 Medicines management			
The health board must ensure that induction of labour medication prescribing is reviewed.	2.6 Medicines management			

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that regular medication rounds are considered.	2.6 Medicines management			
The health board must ensure that breast feeding support is reviewed and that visibility is increased throughout the unit.	Standard 1.1 Health promotion, Protection and Improvement Standard 2.5 Nutrition and Hydration			
The health board must ensure that patient records are secured securely at all times.	Standard 3.5 Record keeping			
The health board must ensure that policies and procedures are reviewed and updated within appropriate timescales	Standard 3.4 Information governance and communications technology			

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that data entry is reviewed to ensure consistency.	Standard 3.4 Information governance and communications technology			
The health board must ensure that patient records are fully reflective of the care and treatment provided to patients and in line with standards of professional record keeping.	Standard 3.5 Record keeping			
The health board must ensure that data collection methods of the birth register is reviewed.	Standard 3.4 Information governance and communications technology			
Quality of management and leadership				
The health board must ensure that follow on work from audits is reviewed to ensure learning and service improvements take place.	Standard 3.3 Quality improvement,			

Improvement needed	Standard	Service action	Responsible officer	Timescale
	research and innovation			
The health board must ensure that management empowerment and leadership support is reviewed to enable career progression.	Standard 7.1 Workforce			
The health board must ensure that the medical rota is reviewed.	Standard 7.1 Workforce			

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative

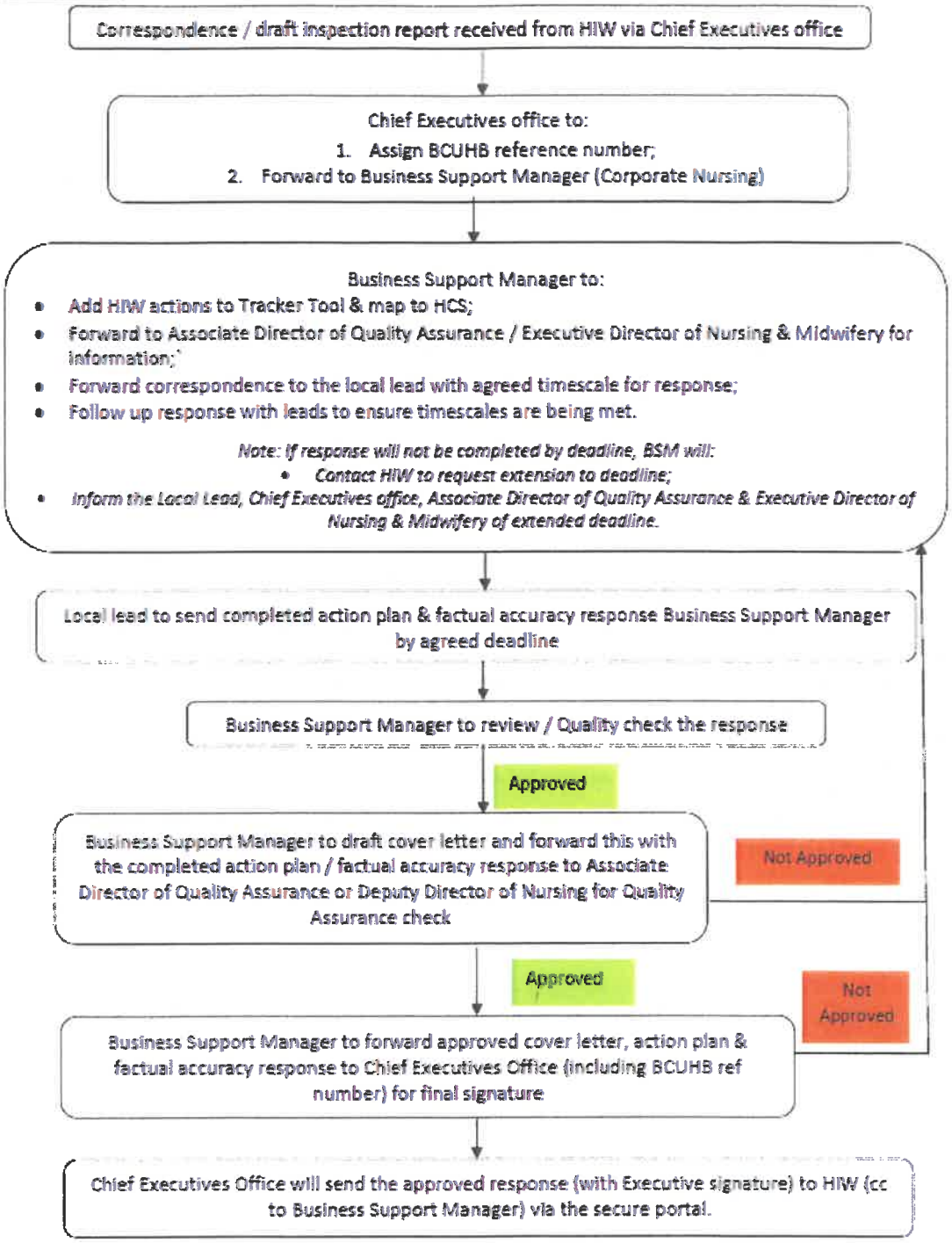
Name (print):

Job role:

Date:

Appendix C

BCUHB – Internal Process for HIW inspection reports (May 2018)



BCUHB – HIW Internal Process (May 2018 – V0.2)

4.1 POST INSPECTION

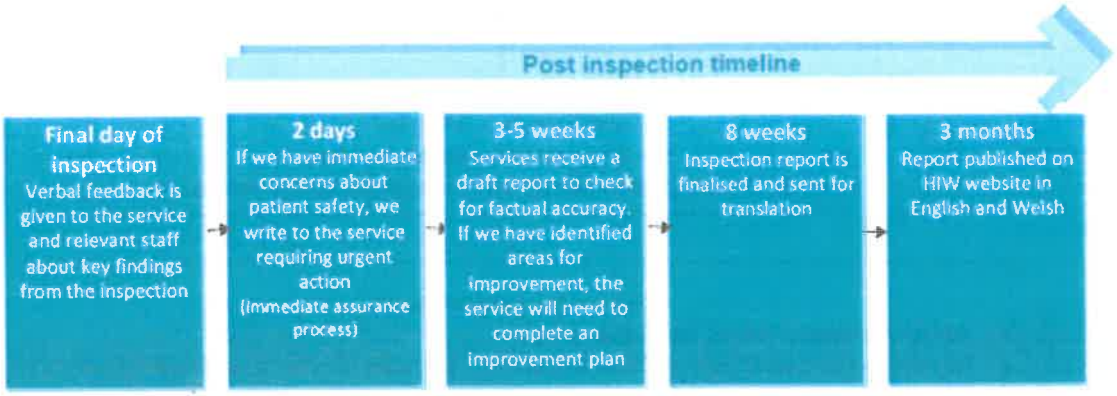


Figure 1 - HIW "How we inspect"

Corporate Nursing Response

We recognise that the patient safety issues highlighted in both reports are unacceptable, and we have already made a number of immediate changes to provide reassurance about the quality and safety of care provided in Wrexham Maelor's Emergency Department and Glan Clwyd's Maternity Unit. These changes are detailed in full in the published inspection reports, along with details of our action plans for improvement.

In addition to improvements to be made, it is important that we also praise the compassionate care provided and the progress we are making to ensure the quality of care and the sharing of good practice.

We welcome feedback from HIW inspections as this enables us as an organisation to strengthen and improve the services which we provide.

Cyfarfod a dyddiad: **Meeting and date:**	Quality, Safety & Experience Committee 28th January 2020
Cyhoeddus neu Breifat: ***Public or Private:***	Public
Teitl yr Adroddiad **Report Title:**	Corporate Risk Register and Assurance Framework Report
Cyfarwyddwr Cyfrifol: **Responsible Director:**	CRR02 Executive Director of Nursing and Midwifery CRR03 Director of Primary and Community Care CRR05 Executive Director of Nursing and Midwifery CRR13 Director of Mental Health and Learning Disabilities CRR16 Executive Director of Nursing and Midwifery CRR20 Executive Director of Workforce and Organisational Development CRR21 Executive Director of Workforce and Organisational Development **Risk for Escalation** • ID2956 - Potential to comprise patient safety due to large backlog and lack of follow-up capacity - Executive Director of Nursing and Midwifery. The following Health and Safety risks are being proposed for escalation by the - Executive Director of Workforce and Organisational Development. • ID3019 - Asbestos Management and Control • ID3020 - Contractor Management and Control • ID3021 - Vibration Control • ID3022 – Electrocution at Work • ID3023 – Legionella Management and Control • ID3024 – Non-compliance of Fire Safety Systems **Risk for De-escalation** • ID2950 – Potential inability of Care Homes to provide safe quality care – Executive Director of Nursing and Midwifery (split from CRR03).
Awdur yr Adroddiad **Report Author:**	Mrs Justine Parry, Assistant Director of Information Governance and Risk Mr David Tita, Head of Risk Management
Craffu blaenorol: **Prior Scrutiny:**	The full Corporate Risk 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. This report has been approved for submission to the Committee by the Deputy Chief Executive / Executive Director of Nursing and Midwifery.
Atodiadau	1

Appendices:	

Argymhelliad / Recommendation:

The Quality, Safety and Experience 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) Consider and approve the reduction in the current risk score for CRRR13 from 16 to 12;
4) Approve the split of the Continuing Health Care and Potential inability of Care Homes to provide safe quality care risks, with the latter risk being newly formed and proposal for de-escalation and management at Tier 2 by the Executive Director of Nursing and Midwifery;
5) Review and approve the new risks for escalation onto the Corporate Risk Register.

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

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

Sefyllfa / Situation:

The attached report has been produced from the web-based Datix system and details the risk entries allocated to the Quality, Safety and Experience Committee (QSE).

On the 12th December 2019, the Audit Committee requested a further review of the risks assigned to each committee. The Corporate Risks assigned to the QSE Committee will be presented to the next meeting on the 5th May 2020.

Cefndir / Background:

The Health Board has undertaken a complete review of its risk management strategy which is underpinned by a risk management vision statement clearly setting the Board's vision and direction of travel regarding risk management. The new strategy underlines the powerful intention and firm commitment of the Health Board to embark on the implementation and embedding of an Enterprise Risk Management (ERM) Model across the entire organisation from `Ward to Board` in 2020/21 and will be presented to the Board on the today for ratification and implementation from 1st April 2020.

The renewed energy for the management of risk across the Health Board has created a positive culture of risk awareness and momentum across the Health Board that is providing focus for ongoing debates and conversations around how best to capture, strengthen and monitor the effective management of the Health Board's 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 framework 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, fostering a better understanding of the Health Board's strategic and extreme operational risks.

Defining the principal risks 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 Risk Management Team continue to support all Divisions to review their risks, advising on escalation/de-escalation or closure of the risk where sufficient mitigating controls are now firmly embedded. A newly established Executive Risk Scrutiny panel meets every week to review all Tier 2 risks and those currently rating Extreme. Feedback is also provided to each Division to support the future management of the risk.

The results of the recent Risk Management Gap and Training Needs Analysis undertaken by the risk management team across the Health Board also indicate a commitment by colleagues to regularly review and update their risks. In response, whilst the Risk Management Strategy clarifies the governance and escalation process for risks from `Ward to Board`, a training pack has been developed as well as targeted support being provided to ensure that staff are sufficiently empowered and confident in raising, capturing and discussing risks at their local Governance and Quality and Safety meetings.

Asesiad / Assessment & Analysis

Following a review of the full Corporate Risk and Assurance Framework on the 12th December 2019, by the Audit Committee, a further review of the risks assigned to the QSE was requested.

In summary, following review and scrutiny, the following changes have been made to the below risks since the last report was received by the QSE Committee:-

- **CRR02 Infection Prevention and Control.**

Key progress: Following a review of this risk during the previous meeting, it was noted the mitigating controls and further actions remain on track. A further review by the Risk Handler has been undertaken with the mitigating controls updated to reflect the change of the monthly Executive-led scrutiny meetings to 6 weekly. Further actions have also been identified to support the achievement of the target risk score and these include implementation of the key actions arising from further reports by Jan Stevens, continue work on the influenza preparedness and review of the Pandemic Policy, further development of the Infection Prevention Team in 2020 and closure working alongside Tissue Viability, Pharmacy and Continence service in relation to HCAIs. 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, therefore the risk description has been slightly revised taking this into account. The mitigating controls have been strengthened to include area and divisional CHC Teams in place, implementation of the revised CHC Improvement Group and CHC Operational Groups with clear reporting and governance arrangements in place and the establishment of the partnership arrangements with the National Commissioning Unit to oversee strategy development. Further actions have also been revised and include implementation of a programme of CHC support with the NCCU to focus on training, development, performance management and stakeholder engagement, development of KPIs within the new IT system, development of the CHC commissioning strategy and implementation of a joint contracting process for providers in formal escalation. There has been no change to the current risk scoring.

The Care Home element of this risk has been split and is being presented for de-escalation and management at Tier 2.

- **CRR05 Learning from Patient Experience.**

Key progress: The risk description has been reviewed and updated with more detail included to describe the risk and the impact of the risk should it materialise. Mitigating controls have been refreshed to include revised meetings and scrutiny routes to manage processes and strengthen lessons learnt across the whole Health Board, nan Health Board quality improvement collaborative programmes commenced, new Patient Advice and Liaison Service (PALS) in place and fully resourced, training programme in place, Patient Safety Alerts process in place, Quality and Safety Group in place to oversee patient safety and to cascade learning from patient safety issues, Joint protocol in place between Health Boards and Welsh Ambulance Service Trust to undertake joint investigations when appropriate, Mortality review process in place to support learning from deaths. Further actions have also been revised and include a full concerns processes review and redesign, Patent Safety Alert process to be moved to the Patient Safety and Experience Department allowing for greater integration of data/insight and activity, development of a Patient Safety and Experience Learning Library and Bulletin to further promote learning, implementation of new "Once for Wales" RLDatix concerns management system to aid learning across the Health Board and Wales. There has been no change to the current risk scoring, however the target risk score is being recommended for adjustment so that the impact remains the same but the likelihood will decrease with the implementation of the mitigating controls. This also then aligns with the Health Board's risk appetite statements.

- **CRR13 Mental Health Services.**

Key progress: As part of the corporate risk review at the Audit Committee on the 12th December 2019, a request to update the controls and further actions with completion dates was requested. Key controls have been strengthened to include the Board assurance provided at all levels of MHLD governance framework, MHLD presenting weekly at Corporate complaints and concerns meeting, monthly at QSG, bi monthly to QSE, Board as required/requested and F&P, more focused monitoring on progress at Board level agreed and implemented, implementation of renewed focus and escalation arrangements for dealing with operational issues: weekly operations meeting in each area, daily safety huddles, weekly leadership review, MHLD QSG and MHLD F&P, Governance Framework developed and fully embedded, recommendations from Internal Audit Review (2019) implemented, Mental Health Strategy approved by the Board and now in implementation phase, external reviews and visits including positive HIW inspections detailed to QSE and Board, MHLD provides Quality and Performance assurance to Executive accountability meetings, monitoring continues via SMIF and implementation of HASCAS investigation and wider governance review including completion of HASCAS recommendation specific to MHLD has been successfully achieved. This is monitored through corporate governance processes and QSE Committee. Further actions have also been identified to support the achievement of the target risk score and these include a review of Tier 7 & 8 in leadership structure underway and to be finalised and implemented, improving the use of patient experience and real time feedback intelligence to inform service improvements, further embed learning culture across the division, systematic implementation of Quality Improvement Methodology across the division at all levels.

Given the strengthened controls and improved assurance arrangements, the Committee is requested to consider and approve the reduction in the current risk score from 16 to 12.

- **CRR16 Safeguarding.**

Key progress: As part of the corporate risk review at the Audit Committee on the 12th December 2019, the title of the risk has been updated. Risk controls have been strengthened to include implementation of key controls relating to the review and effectiveness of the Safeguarding structure and action plans, this relates to increasing DoLS signatories, development of a Signatories Governance Framework and Specialist training. Bespoke DoLS Training and reporting of compliance and activity at Safeguarding

Forums in accordance with the Safeguarding Reporting Framework has also been put in place, bespoke training continues to be delivered to key high priority areas with responsibilities for 16/17 year olds who may be / or experience a deprivation of their liberty as a result of a Supreme Court Judgement. Further actions have also been updated to reflect the required changes to be implemented. There has been no change to the current risk scoring.

- **CRR20 Security Risk.**

Key progress: As part of the corporate risk review at the Audit Committee on the 12th December 2019, concerns were raised regarding the appropriate scoring for the target risk. This was an error and has been addressed so that the Impact remains a 5 but the likelihood is reduced. There has been no change to the current risk scoring.

- **CRR21 Health & Safety Risk.**

Key progress: As part of the corporate risk review at the Audit Committee on the 12th December 2019, key controls have been updated to include Health and Safety risk assessment system is in place in some service areas. There has been no change to the current risk scoring.

Proposed Risk for Escalation

Seven risks are being presented for approval onto the Corporate Risk Register. These are:

- **Reference ID2956 - Potential to comprise patient safety due to large backlog and lack of follow-up capacity.**
- **Reference ID3019 - Asbestos Management and Control.** There is a significant risk that BCUHB is none compliant with the Asbestos at Work Regulations 2012.
- **Reference ID3020 - Contractor Management and Control.** There is a risk that BCUHB fails to achieve compliance with Health and Safety Legislation due to lack of control of contractors on sites.
- **Reference ID3021 - Vibration Control.** There is a risk the Health Board personnel are exposed to Vibration harm.
- **Reference ID3022 – Electrocution at Work.** There is a risk that BCUHB is non-complaint with the Electricity at Work regulations 1989.
- **Reference ID3023 – Legionella Management and Control.** There is a significant risk that the BCUHB is non-compliant with COSHH Legislation (L8 Legionella Management Guidelines).
- **Reference ID3024 – Non-compliance of Fire Safety Systems.** There is a risk that the Health Board's is non-compliant with Fire Safety Procedures (in line with Regulatory Reform (Fire Safety Order 2005).

Once the Committee has reviewed these risks to be incorporated onto the Corporate Risk Register, the appropriate corporate reference number will be allocated.

Proposed Risk for De-escalation

Reference ID2950 – Potential inability of care homes to provide safe quality care.

Key Progress: This risk has been split from CRR03 to focus on the provision of safe quality care within Care Homes. Based on the mitigating controls and intervention by the Health Board, it is proposed that this element of the original CRR03 risk is de-escalated and managed at the Tier 2 by the Executive Director of Nursing and Midwifery.

Previously Deescalated Risk
CRR04 – Maternity Services risk was deescalated in July 2018 following agreement at the Board meeting on the 12th July 2018.

Current Risk Level		Impact				
		Very Low - 1	Low - 2	Moderate - 3	High - 4	Very high - 5
Likelihood	Very Likely - 5			CRR03		
	Likely - 4			CRR05	CRR13 CRR16	CRR20 CRR21
	Possible - 3					CRR02
	Unlikely - 2					
	Rare – 1					

Strategy Implications
In line with the Health Board's Risk Management Strategy, all corporate risks are reviewed by a dedicated Committee of the Board which provides a structure and framework to consistently manage both strategic and operational risks as drivers for better decision making. These risks will identify the risks associated with the delivery of the Health Board's objectives as defined in the 3 year plan and annual plans.

Financial Implications
The effective and efficient mitigation and management of risks has the potential to leverage a positive financial dividend for the Health Board through better integration of risk management into business planning, decision-making and in shaping how care is delivered to our patients thus leading to enhanced quality, less waste and no claims.

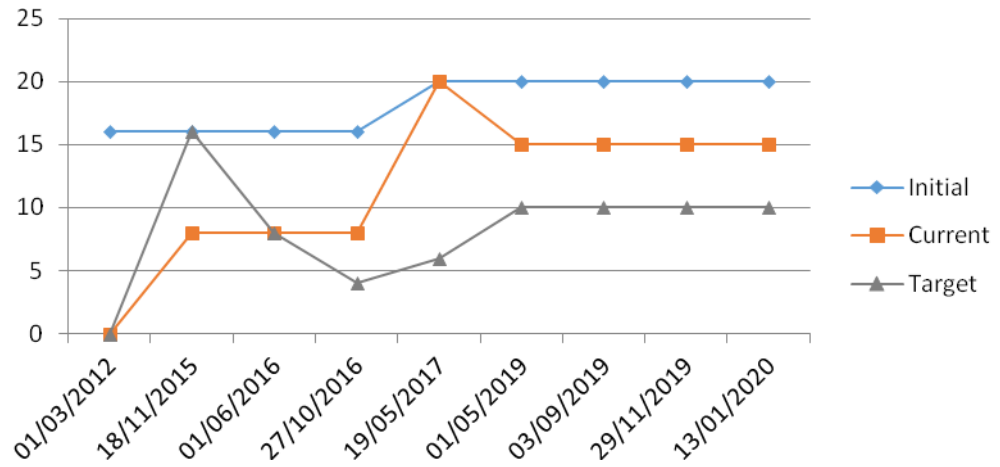
Risk Analysis
No risks have been identified from crafting this report as the risk of inaction is far greater than that of positive engagement with its content.

Legal and Compliance
Due to the nature of this report, legal and compliance issues are addressed as part of the risk assessment for each risk entry.

Impact Assessment
Due to the nature of this report, Impact Assessments are not required.

Appendix 1

CRR02	**Director Lead:** Executive Director of Nursing and Midwifery	**Date Opened:** 1 March 2012
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 13 January 2020
	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.		



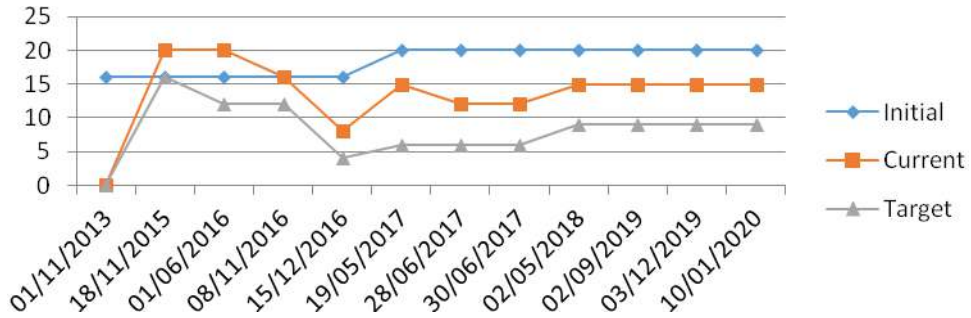
	Impact	Likelihood	Score
Initial Risk Rating	5	4	20
Current Risk Rating	5	3	15
Target Risk Score	5	2	10
Movement in Current Risk Rating since last presented to Board in November 2019	**No Change** ⇔		

Controls in place	**Further action to achieve target risk score**
1. Infection Prevention Sub-Group scrutinise trajactories 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 are in place. 4. 6 weekly Executive-led scrutiny meetings to review infections and learning from each site in place.	1. Continue the implementation of SCC and IP via annual work programmes. 2. Consider aligning SCC with IP Annual Work Prgramme. 3. Implement the other actions identified in the 2019-20 annual infection prevention programme. 4. 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 and rollout. 5. Continue to progress key actions from Duerden and Jan Stevens

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. 6. External review performed August 2017; report on further actions presented to Board. Second review report received in August 2019 shows improvement, as does the internal audit on Safe Clean Care (SCC) assurance in June 2019. 7. SCC Programme launched 29-01-18. 8. CAUTI snapshot carried out in September 2019. 9. Deep dive considers every 6 organisms under WG scrutiny.	reports 2016, 2017, 2019 in relation to Variation, Consultant Microbiologist staffing and capacity, Antimicrobial Stewardship, Estates and Facilities, policies and procedures and Safe Clean Care. 6. Scrutinise every avoidable infection and lessons learnt from these are shared formally from Post Infection Reviews and Deep Dives. 7. Continue work on influenza preparedness and response for Winter 19-20 and review Pandemic policy and procedures. 8. 12 Key action points carried out HB wide in November 2019 which showed a decrease in 5 of the 6 trajactories. 9. Educational event and Link practitioners in place December 2019. 10. Canula devices and documents approved for distribution. 11. Collaberative work with Continence, Tissue Viability and pharmacy to address unwarrented variation. 12. Improved visability across the HB from IP service. 13. Review of all IP policies and SOPs. 14. Development of IP team 2020. 15. Working alongside Tissue Viability, Pharmacy and Continence service in relation to HCAIs.

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:** 10 January 2020
	Risk: Continuing Health Care	**Target Risk Date:** 31 March 2021
There is a risk that the CHC National Framework is not complied with. This is due to limited understanding of the framework and inconsistent application. This could lead to poor patient experience, outcomes and value for money.		



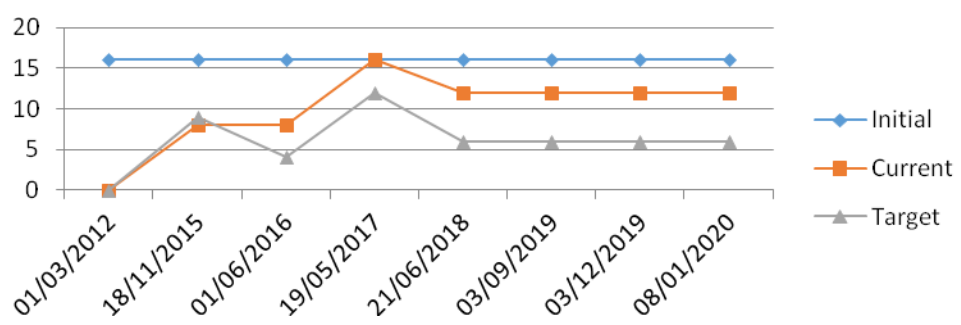
	Impact	Likelihood	Score
Initial Risk Rating	4	5	20
Current Risk Rating	3	5	15
Target Risk Score	3	3	9
Movement in Current Risk Rating since last presented to Board in November 2019	**No Change** ⟺		

Controls in place	**Further action to achieve target risk score**
1. National CHC Framework. (2014). 2. Area and divisional CHC team with local accountability. 3. Revised BCUHB CHC Improvement Group and CHC operational Group Reporting and Governance Framework agreed. 4. Annual WG self assessment. 5. Contracts and contract monitoring team in place. 6. CHC Contracts in place for all placements. 7. Partnership established with the National Commisioning Collaborative Unit to oversee overarching strategy development improving quality, experience and value.	1. Progress programme of CHC support with NCCU, to include focus on training and development, data and performance management, standard operating proceedures, stakeholder engagement and realignment of CHC within the Health Board. 2. Development of dashboard KPI's for CHC with Broadcare. 3. Monthly exception reporting. 4. Develop CHC commissioning strategy. 5. Develop and finalise the joint contracting process for providers in formal escalation.

Assurances	**Links to**		
	Strategic Goals	**Principal Risks**	**Special Measures Theme**
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.	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:** 08 January 2020
	Risk: Potential inability to learn from patient safety and experience concerns	**Target Risk Date:** 31 December 2020
There is a risk that the Health Board does not listen and learn from patient safety and experience due to the untimely management, investigation and subsequent improvement actions from concerns (incidents, complaints, claims, inquests). This could lead to repeated failures in quality and safety of care, poor patient experience, loss of organisational memory and reputational damage to the Health Board.		



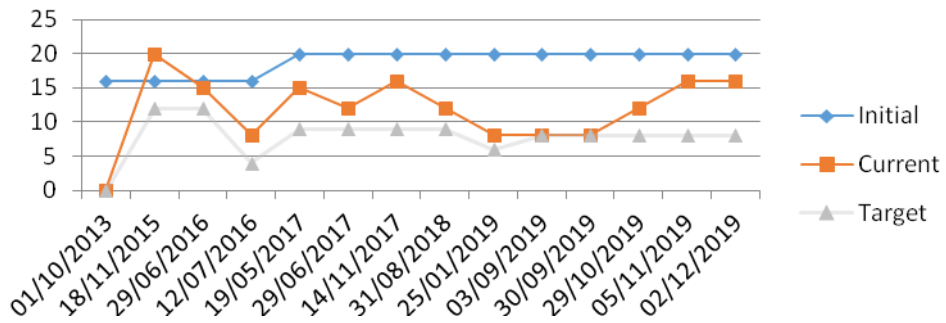
	Impact	Likelihood	Score
Initial Risk Rating	4	4	16
Current Risk Rating	3	4	12
Target Risk Score	2	3	6
Movement in Current Risk Rating since last presented to Board in November 2019	**No Change** ⟺		

Controls in place	**Further action to achieve target risk score**
1. Processes in place to manage concerns (incidents, complaints, claims, inquests) in accordance with PTR Regulations. 2. Corporate and divisional meetings to manage processes and cascade learning including daily reviews within divisions, weekly reviews within divisions and a weekly pan Health Board Incident and Complaint Review Meeting. 3. Reporting to share learning and monitor performance at divisional and pan Health Board levels; including divisional quality and safety reports, divisional patient experience reports and a Health Board monthly and quarterly Patient Safety Report and quarterly Patient Experience Report. 4. Harm Dashboards available for local clinical leaders to identify opportunities for learning and improvement. 5. Pan Health Board quality improvement collaborative programmes	1. Concerns processes (incidents, complaints, claims, inquests) being fully reviewed following appointment of the new Assistant Director of Patient Safety and Experience – full process re-design will take place throughout 2020 in co-production with stakeholders, building on national best practice. 2. Patent Safety Alert process to be moved to the Patient Safety and Experience Department allowing for greater integration of data/insight and activity. 3. Development of a Patient Safety and Experience Learning Library on the intranet to further promote learning. 4. Development of a Patient Safety and Experience Bulletin to further promote learning. 5. Review and update of training and development with a particular emphasis on developing and embedding human factors and systems

commenced based on identified risks including a Falls Collaborative, Sepsis Collaborative and a Healthcare Acquired Pressure Ulcer (HAPU) Collaborative. 5. Patient Safety and Experience Department in place to develop and manage processes and systems and offer advice and assurance – supported by divisional governance teams and linked to the BCU Quality Improvement Hub. 6. New Patient Advice and Liaison Service (PALS) fully resourced and launched in 2019. 7. Learning from Event (LfE) Reports prepared for all claims and redress cases. 8. The Head of Patient Safety is part of, and chairs, the All-Wales Redress Case Review Group enabling learning from across the country to be identified. The Patient Safety and Experience Department is represented at, and fully engaged in, each All-Wales concerns related network. 9. Training programme in place to support continued learning, delivered by the Patient Safety and Experience Department. 10. Patient Safety Alerts process in place to cascade learning across the Health Board. 11. Quality and Safety Group in place to oversee patient safety and to cascade learning from patient safety issues, and a Patient Experience Group in place to undertake the same for patient experience (divisions provide reports to both groups). 12 Joint protocol in place between Health Boards and Welsh Ambulance Service Trust to undertake joint investigations when appropriate. 13. Mortality review process in place to support learning from deaths. 14. Site audits by the Community Health Council (CHC) received through a single point of contact within the Health Board. 15. Inspections by Health Inspectorate Wales (HIW) received and coordinated through a single point of contact within the Health Board along with regular meetings with the HIW relationship manager.	thinking. 6. Implementation of new "Once for Wales" RLDatix concerns management system to aid learning across the Health Board and Wales. 7. Review of the weekly incident and complaint review meeting and development into a weekly Patient Safety Summit. 8. Structure review within the Patient Safety and Experience Department to improve the focus and profile of patient safety and to integrate complaints with patient experience/PALS. 9. Enhancement of the mortality review process to implement the new national Medical Examiner programme. 10. Workshop to be held with the Community Health Council to develop partnership working.

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	PR9 PR7 PR1	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:** 17 January 2020
	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.		



Between August 2018 and October 2019 a reduction in score was unauthorised, this has been reverted to correct score

	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 November 2019	**No Change** ⟺

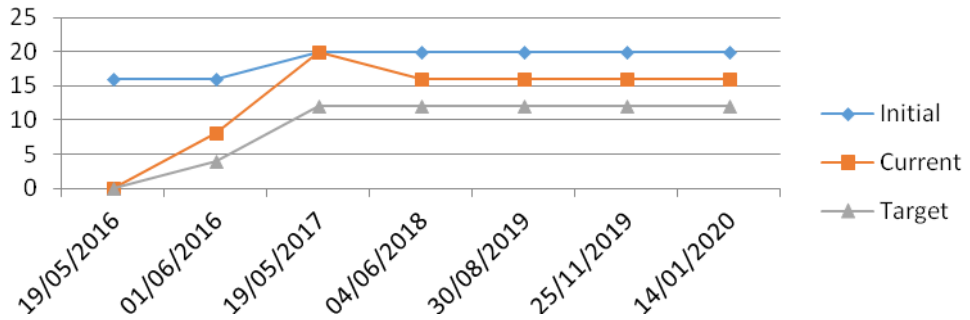
Controls in place	**Further action to achieve target risk score**
1. Board assurance provided at all levels of MHLD governance framework – local, divisional and directors, MHLD presents weekly at Corporate complaints and concerns meeting, monthly at QSG, bi monthly to QSE, Board as required/requested and F&P. 2. More focussed monitoring on progress at Board level agreed and implemented. 3. Achieved and implemented renewed focus and escalation arrangements for dealing with operational issues: weekly operations meeting in each area, daily safety huddles, weekly leadership review, MHLD QSG and MHLD F&P. 4. Governance Framework developed and fully embedded – review of committee names being undertaken to ensure consistency with	1. Review of Tier 7 & 8 in leadership structure underway. 2. Improve the use of patient experience and real time feedback intelligence to inform service improvements. 3. Further embed learning culture across the division. 4. Systematic implementation of Quality Improvement Methodology across the division at all levels. 5. Implementation of actions following skill mix review on inpatients wards to inform our future staffing levels linked to the All Wales Staffing Principles. 6. Delivery Unit have undertaken demand and capacity review with the Community Mental Health Teams, which will inform BCUHB and Local Authority future plans for staffing.

BCUHB framework. 5. Recommendations from Internal Audit Review (2019) implemented. 6. Mental Health Strategy approved by the Board and now in implementation phase with areas sustaining strategy change and new developments evidenced with new initiatives that are being modelled across MH services as good practice. 7. Senior Management and Clinical Leadership is no longer a holding structure but implemented with a permanent structure of leadership established, including to Tier 5 & 6. 8. External reviews and visits including positive HIW inspections detailed to QSE and Board. 9. MHLD provides Quality and Performance assurance to Executive accountability meetings in two forms of scrutiny i) Divisional presentation and ii) with each area health economy and is not in escalation as a result of current progress. 10. Monitoring continues via SMIF. 11. Implementation of HASCAS investigation and wider governance review including completion of HASCAS recommendation specific to MHLD has been successfully achieved. This is monitored through corporate governance processes and QSE Committee. 12. Ward accreditation embedded. 13. Improved scrutiny at local and divisional level in relation to PTR has resulted in improved KPIs across all of PTR. MHLD is the only division to have 0 complaints overdue. This is monitored via QSEEL. 14. Implementation of Listening Leads and BE PROUD OD Programme across the division with full engagement at Director level.	7. Additional actions to address Sickness across MHLD includes the development of Wellness strategy developed for MHLD – wellness, work and you!

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

5. External Accreditation. 6. Delivery Unit oversight of CTP. 7. Caniad coproduction and objective day to day review of services. 8. Enhanced WG support has now concluded following intense scrutiny and input due to assurances provided by MHLD, including PAC report as submitted evidence.			

CRR16	**Director Lead:** Executive Director of Nursing and Midwifery	**Date Opened:** 19 May 2016
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 14 January 2020
	Risk: A Failure To Discharge Statutory and Legislative Safeguarding Responsibilties	**Target Risk Date:** 31 March 2020
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 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 November 2019	**No Change** ⟺		

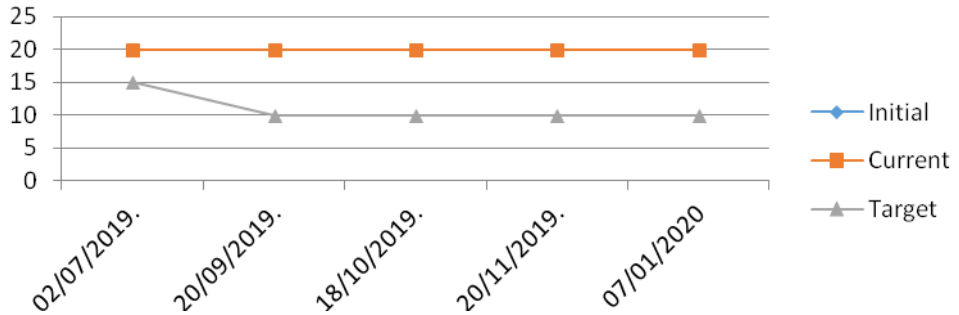
Controls in place	**Further action to achieve target risk score**
1. A cycle of Business Planning meetings have been implemented within the Nursing and Midwifery Directorate which scrutinises and reviews Level 1 and 2 Risks and is attended by the Associate Director of Safeguarding. 2. A refreshed Safeguarding Reporting Framework has been implemented which sets out clear lines of accountability and is underpinned by a Cycle of Business. 3. A standardised data report on key areas including Adult at Risk, Child at Risk and DoLS is submitted to Safeguarding Forums in order that data is scrutinised and risks identified. 4.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 Safeguarding Forum[s] Agendas. Issues of Significance reports require risks to be	1. The third and final phase of the review of all Safeguarding JDs will be submitted to A4C January 2020. 2. Vacant posts continue to be progressed through the establishment control approval process to maintain a fully funded Safeguarding Team. 3. 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 was incorporated into the Structure Report at QSG 10th January 2020. 4. In line with the HASCAS Recommendation / DO Recommendation 8, 6, 11 and 9. A Business Case is to be presented to the Finance and performance Group. 5. The legal framework and organisational accountability for Deprivation of Liberty Safeguards [DoLS] continues to place increased

identified and reported on in terms of mitigating action. 5. The new Senior Management tier has been appointed to within the Safeguarding Structure. This will strengthen strategic oversight in key areas. 6. A paper has been presented to QSG on the 10.1.20, in line with HASCAS / DO recommendation Numbers 8 and 6 and 11 and 9. This is relating to the review and effectiveness of the Safeguarding structure and progress report relating to the DoLS 2017-2018 action plan. Key controls have been implemented by increasing the number of DoLS Signatories, development of a Signatories Governance Framework and Specialist training. Bespoke DoLS Training and reporting of compliance and activity at Safeguarding Forums in accordance with the Safeguarding Reporting Framework has been put in place. See Risk 2548. 7. Bespoke training continues to be delivered to key high priority areas with responsibilities for 16/17 yr olds who may be / or experience a deprivation of their liberty as a result of a Supreme Court Judgement 26.9.19.	demands upon the organisation. In addition DoLS will be replaced by the Liberty Protection Safeguards [LPS] in 2020/2021 and will have a greater impact upon activity. The recent Supreme Court Judgement relating to 16/17 yr olds, came into force on the 26.9.19. A National Task and Finish Group and a BCU implementation group is to be convened to support the review and identify the impact the new legislation will have on organisations. 6. The programme of work to support the implementation of the Supreme Court Judgement and the increased activity is to be driven by a Task & Finish Group as agreed by QSG and completed by 31.3.20 (see Risk 2548. 7. 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 January 2020. See Risk 2548. 8. The appointment of a Named Doctor, Adult at Risk remains outstanding however positive discussions have taken place with the Office of the Executive Medical Director. The business case to be presented at Finance and Performance Group is to include the financial requirements to support the appointment of a Named Doctor Adult at Risk and additional clinical support. 9. Fully engage with the Corporate Safeguarding Governance Audit and Deprivation of Liberty Safeguarding [DoLS] Audit, conducted by the NHS Wales Shared Services Partnership Audit and Assurance Service. Engage with any actions identified.

Assurances	**Links to**		
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.	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	3 7	PR9	Governance

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:** 07 January 2020
	Risk: Security Risk	**Target Risk Date:** 1 November 2020

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.



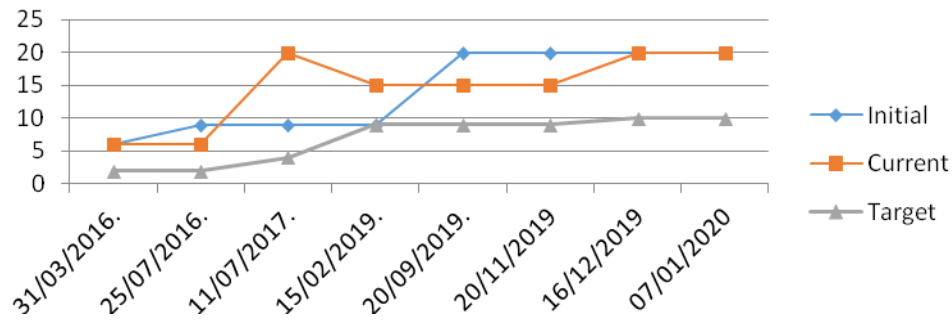
	Impact	Likelihood	Score
Initial Risk Rating	5	4	20
Current Risk Rating	5	4	20
Target Risk Score	5	2	10
New Risk Approved by QSE in November 2019	**No Change** ⇔		

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) An external contractor is supporting the Head of H&S to review all aspects of Security across the Board. 4) 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. Finalise and implement the CCTV Policy. 3. Clear lines of communication with the contractor, review of the contract in relation to key holding responsibilities and reporting on activities to be implemented. 4. Responsibilities of Security roles within BCUHB to be clearly defined. 5. Lone worker procedures and risk assessments further established. 6. Reducing numbers of violence incidents to staff through clear markers and systems for monitoring violent patients. 7. 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**		
1. Strategic Occupational Health and Safety Group	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	3		SM4 SM1

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:** 07 January 2020
	Risk: Health & Safety Leadership and Management	**Target Risk Date:** 1 November 2020
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	5	4	20
Current Risk Rating	5	4	20
Target Risk Score	5	2	10
Movement in Current Risk Rating since last presented to Board in November 2019	**Increased** ⇧		

Controls in place	**Further action to achieve target risk score**
1. Health and Safety risk assessment systems are in place in some service areas to protect staff, patients and others from hazards. 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 in place. 5. Mandatory Training in place. 6. Clinical and Corporate Health and Safety Teams established. 7. Corporate Health and Safety Team established. 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**		
Not Applicable	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	8		Not Applicable

2956	**Director Lead:** Executive Director of Nursing and Midwifery	**Date Opened:** 11 November 2019
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 06 December 2019
	Risk: Potential to comprise patient safety due to large backlog and lack of follow-up capacity.	**Target Risk Date:** 31 December 2020
The is a risk that patient safety and experience may be comprised due to the Health Board's lack of follow-up capacity especially in outpatients specialities within Secondary across all three sites. This could lead to claims, poor patient experience, harm, reputational damage and deterioration in patient conditions who might have missed their 100% follow-up target.		

	Impact	Likelihood	Score
Initial Risk Rating	4	5	20
Current Risk Rating	4	5	20
Target Risk Score	4	2	8
New risk presented for escalation			

Controls in place	**Further action to achieve target risk score**
1. Ophthalmology and Cancer services have been validated and patients who might have come to harm due to missing their follow-up have been prioritised and seen in clinics. 2. Monitoring of follow-up numbers at weekly meetings. 3. Tendering completed for an external company to validate all follow-ups in OPD. 4. Close links with all services to ensure appropriate care planning for patients are in place. 5. Strong clinical engagement and project management support established. 6. Prioritisation of patients at clinical risk and harm reviews being undertaken for all patients who have missed their 100% follow-up.	The current reported number of backlog patients who have exceeded their follow up time by a 100% stands at 57,187 as of the end of December, of which 6,332 are booked and 50,855 are un-booked. 1. Continue the work to date outlined in the previous action plan following the best practice methodology but support with the best practice methodology outlined above. 2. Focus on the highest risk specialities for the immediate implementation of harm reviews with agreed trajectories for reduction by: - Urology - Cardiology - General surgery

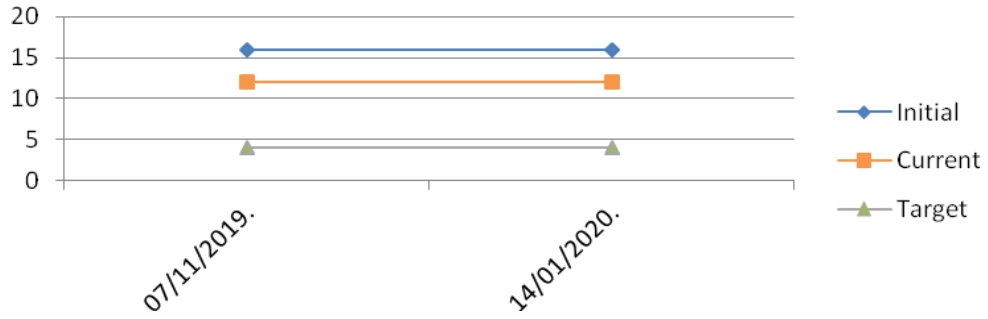
	- Ophthalmology 3. Work on the trajectory of 15% reduction of the backlog by March 2020 and monitor these on a weekly basis through the local PTL meeting. 4. Establish a process that will allow the Health Board to contact all patients who are over 52 weeks and currently un-booked to establish if they still require an appointment in the larger specialties. 5. Review any new patient breaching 52 weeks or over 100% beyond their follow-up appointment will have a harm review to prevent growth of the backlog. 6. Agree monitoring and governance arrangements.

Assurances	**Links to**		
• Monitoring and governance arrangements for this risk in place. • Review of Ophthalmology and Cancer patients now completed. • Risk is now regularly reviewed at QSE with potential of adding onto the CRR.	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	2 3 4 5 7	NA	Strategic and Service Planning

2950	**Director Lead:** Executive Director of Nursing and Midwifery	**Date Opened:** 7 November 2019
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 14 January 2020
	Risk: Potential inability of care homes to provide safe quality care	**Target Risk Date:** 30 November 2021

There is a risk that within Areas, there are a number of care homes (residential and nursing) who are in escalation and vulnerable. This relates to their ability to safely support patients over a 24-hour period.

This has an impact on the availability of suitable nursing and residential placements, which will impact acute hospital discharges and the timely transfer of patients into the community. This may also affect patient safety, the ability to meet identified and commissioned care needs, staff safety and the reputation of the Health Board and Areas.



	Impact	Likelihood	Score
Initial Risk Rating	4	4	16
Current Risk Rating	4	3	12
Target Risk Score	4	1	4

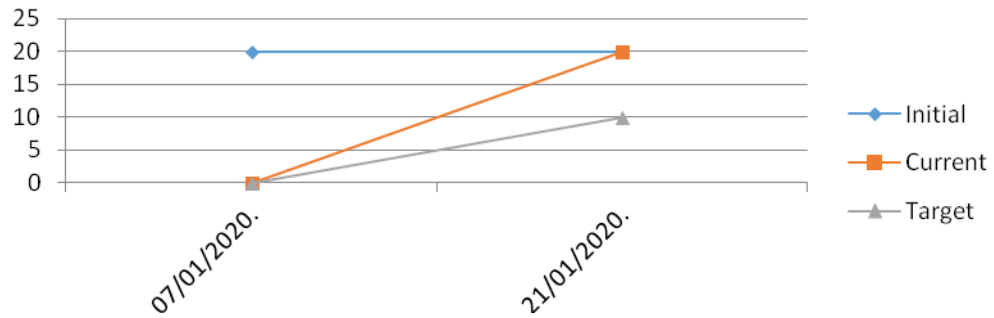
Newly formed split risk from CRR03

Controls in place	Further action to achieve target risk score
1. BCUHB Continuing Health Care Teams are based in Area teams and have a programme of contract monitoring in place working jointly with LAs and Practice Development Teams to assess the quality of care against care standards and provide individual care home action plans for specific care homes requiring additional support. 2. A programme of CHC patient reviews is in place and provides opportunity to assess quality of care within care homes with nursing. This includes out of hours periods where concerns are raised for continuity of support. 3. Monitoring and education plans are initiated and supported by Area Practice development teams reporting to their respective Area/	1. Exception reporting to be developed from each Area / Divisional Nurse Director including their local assurance of actions and improvement to the Executive Nurse Director. 2. Area Nurse Directors have reviewed their local risk registers and assessed risks associated with Care Homes within their locality. They are continuing to work with their Practice Development Team members to understand common issues being experienced in relation to their local care home sector and working to identify deficits, gaps in provision and any duplication / overlap with reporting through their local QSG. They are continuing to mitigate the risk by ensuring systems are in place to coordinate healthcare provision to care home

Divisional Nurse Directors. 4. Supportive plans are agreed jointly with other key partners, and regularly reviewed in line with the escalation process across BCUHB and relevant Local Authorities and other partners. 5. Area Management teams are updated on a regular basis. 6. Continued close Area monitoring and review of local actions to support care homes in escalation. 7. Maintaining joint processes with Local Authorities and other partners to ensure that interventions are put in place at the earliest opportunity to prevent further escalation. 8. Ensuring risk assessment and escalation of individual patients and clinical issues are in place. 9. Care Homes in escalation are closely monitored locally and supported by Health Board staff within Areas under the oversight and leadership of Area Nurse Directors working in partnership with Local Authorities. 10. Prevention and intervention is supported by assessment of care and maximising on training and education.	residents, including from the community services, Directed Enhanced Service for Care Homes (DES). 3. Improve sustainability of Care Homes through staff resource allocation and assurance that patient care is safely managed. Area Nurse Directors are continuing to maximise the benefits and outcomes from the existing resources and to make recommendations for additional investment where required.

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 6 7		Strategic and Service Planning

3019	**Director Lead:** Executive Director of Workforce and Organisational Development	**Date Opened:** 07 January 2020
	Assuring Committee:	**Date Last Reviewed:** 07 January 2020
	Risk: Asbestos Management and Control	**Target Risk Date: 0**2 November 2020
There is a significant risk that BCUHB is none compliant with the Asbestos at Work Regulations 2012. This is due to the evidence that not all surveys have been completed and re-surveys are a copy of previous years surveys. There are actions outstanding in some areas from surveys. This may lead to the risk of contractors, staff and others being exposed to asbestos, resulting in death from mesothelioma or long term ill health conditions, claims, HSE enforcement action including fines, prosecution and reputation damage to BCUHB.		



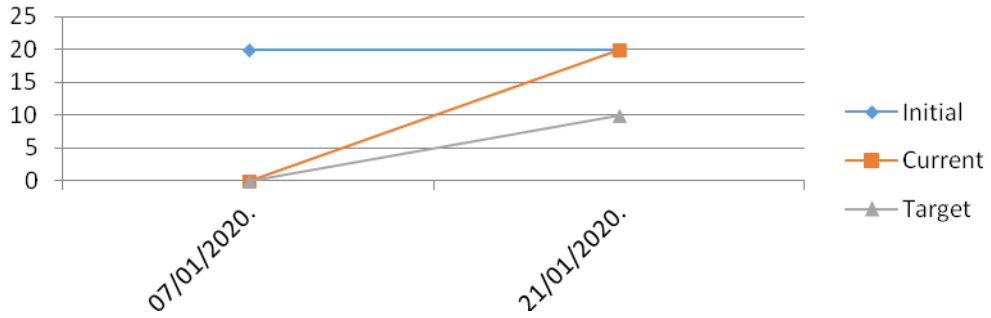
	Impact	Likelihood	Score
Initial Risk Rating	5	4	20
Current Risk Rating	5	4	20
Target Risk Score	5	2	10
New risk presented to Committee			

Controls in place	Further action to achieve target risk score
1. Asbestos Policy in place. 2. A number of surveys undertaken, quality not determined. 3. Asbestos management plan in place. 4. Asbestos register available on some sites, generally held centrally. 5. Targeted surveys were capital work is planned or decommissioning work undertaken. 6. Training for operatives in Estates. 7. Air monitoring undertaken in some premises where there is limited clarity on asbestos condition.	1. Undertaking a re-survey of 10-15 premises to determine if the original surveys are valid. This is problematic as finances are not available for this work, increasing the risk of exposure to staff and contractors. 2. Update and review the Asbestos Policy and Management Plan. 3. Review schematic drawings and process to be implemented to update plans from Safety Files etc. This will require investment in MiCad or other planning data system. 4. Ensure priority assessments are undertaken and highest risk escalated. 5. Evaluate how contractors are provided with information and instruction on asbestos within their work environment. Ensure work is monitored.

	6. Ensure all asbestos surveys are available at all sites and there is a lead allocated for premises. 7. Annual asbestos surveys to be tracked and monitor for actions providing positive assurance of actions taken to mitigate risks. 8. Update intranet pages and raise awareness with staff who may be affected by asbestos. 9. QR Code identification to be provided on all areas of work with identified asbestos signage in non public areas.

Assurances	**Links to**		
	Strategic Goals	**Principal Risks**	**Special Measures Theme**
	8		SM4 SM1

3020	**Director Lead:** Executive Director of Workforce and Organisational Development	**Date Opened:** 07 January 2020
	Assuring Committee:	**Date Last Reviewed:** 07 January 2020
	Risk: Contractor Management and Control	**Target Risk Date:** 01 December 2020
There is a risk that BCUHB fails to achieve compliance with Health and Safety Legislation due to lack of control of contractors on sites. This may lead to exposure to substances hazardous to health, non compliance with permit to work systems and result in injury, death, loss including prosecution, fines and reputation damage.		



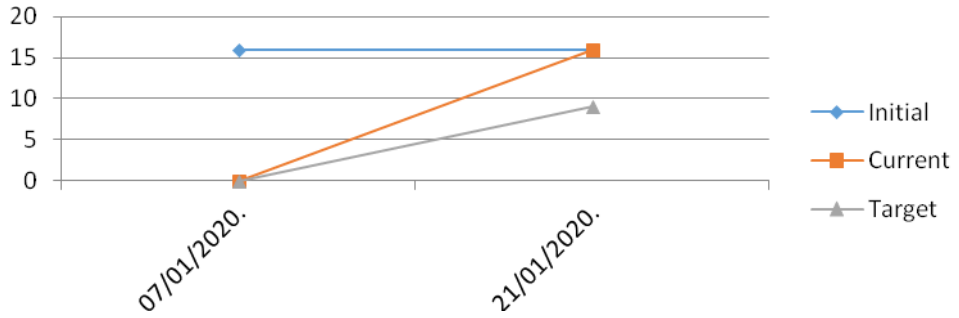
	Impact	Likelihood	Score
Initial Risk Rating	5	4	20
Current Risk Rating	5	4	20
Target Risk Score	5	2	10
New risk presented to committee			

Controls in place	**Further action to achieve target risk score**
1. Control of contractors procedure in place for operational estates. 2. Evaluation of standing orders and assessment under Construction Design and Management Regulations. 3. Induction provided to some contractors but not all. Not all come through operational Estates such as IT. 4. There are a number of permit to work paper systems in place.	1. Identify current guidance documents and ensure they are fit for purpose. 2. Identify service Lead on each site to take responsibility for Contractors and H&S Management within H&S Policy). 3. Draft and implement a Control of Contractors Policy that all adhere to including IT and other services who work on BCUHB premises. 4. Identify current tender process & evaluation of contractors, particularly for smaller contracts consider Contractor Health and Safety Scheme on all contractors. This will ensure minimum H&S are implemented and externally checked prior to coming top site. 5. Evaluate the current assessment of contractor requirements in respect of H&S, Insurance, competencies etc. Is the current system fit for purpose and robust? 6. Identify the current system for signing in / out and/or monitoring of

	contractors whilst on site. Currently there is no robust system in place. Electronic system to be implemented such as SHE data base. 7. Identify level of Local Induction and who carry it out and to what standard. 8. Identify responsible person to review RA's and signs off Method Statements (RAMS), skills, knowledge and understanding to be competent to assess documents (Pathology, Radiology, IT etc.). 9. Identify the current Permit To Work processes to determine whether is it fit for purpose and implemented on a pan BCUHB basis.

Assurances	**Links to**		
	Strategic Goals	**Principal Risks**	**Special Measures Theme**
	8		SM4 SM1

3021	**Director Lead:** Executive Director of Workforce and Organisational Development	**Date Opened:** 07 January 2020
	Assuring Committee:	**Date Last Reviewed:** 07 January 2020
	Risk: Vibration Control	**Target Risk Date:** 01 May 2020
There is a risk the Health Board personnel are exposed to Vibration harm. This is caused by specific equipment which is employed within specific areas of the Health Board. This may lead to Hand / Arm Vibration injury and result in potential disability such as White Finger.Ultimately, such injuries could result in financial claims against the Health Board / Ill Health Retirement and breaches in Health & safety Legislation.		



	Impact	Likelihood	Score
Initial Risk Rating	4	4	16
Current Risk Rating	4	4	16
Target Risk Score	3	3	9
New risk presented to committee			

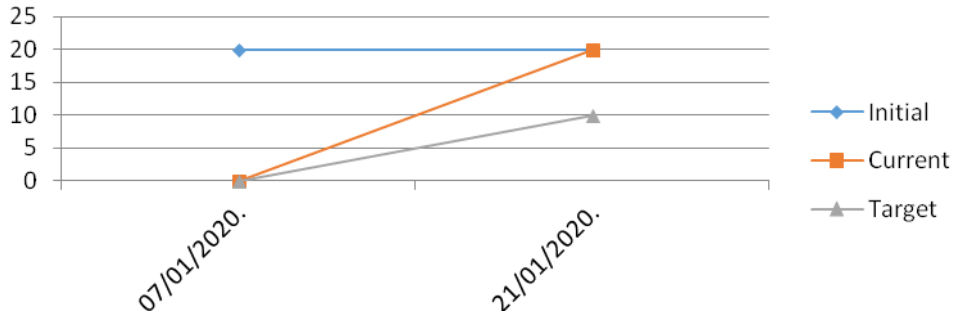
Controls in place	Further action to achieve target risk score
1. The current system is limited to specific service areas. 2. There has been a number of visits by and external consultant to monitor the level of exposure in mortuary and grounds maintenance. 3. Draft Policy in place.	1. Identification of all staff who are using vibrating or percussive equipment. This may include mortuary, grounds maintenance staff, fracture clinic, Theatres and Dental. 2. Staff awareness programme to be implemented in service areas identified. 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. Failure to do so may result in fines and prosecution. 10. Tracking of equipment and maintenance procedure EBME and others to review.

Assurances	**Links to**		
	Strategic Goals	**Principal Risks**	**Special Measures Theme**
	8		SM4 SM1

3022	**Director Lead:** Executive Director of Workforce and Organisational Development	**Date Opened:** 07 January 2020
	Assuring Committee:	**Date Last Reviewed:** 07 January 2020
	Risk: Electrocution at Work	**Target Risk Date:** 31 December 2020

There is a risk that BCUHB is non-complaint with the Electricity at Work regulations 1989. This is caused by in-completion of installation testing and portable appliance testing. This may result in electrocution of Staff and Visitors to BCUHB Sites and potential fire throughout BCUHB premises. Electrical 5 year inspection testing is incomplete in a number of service areas.



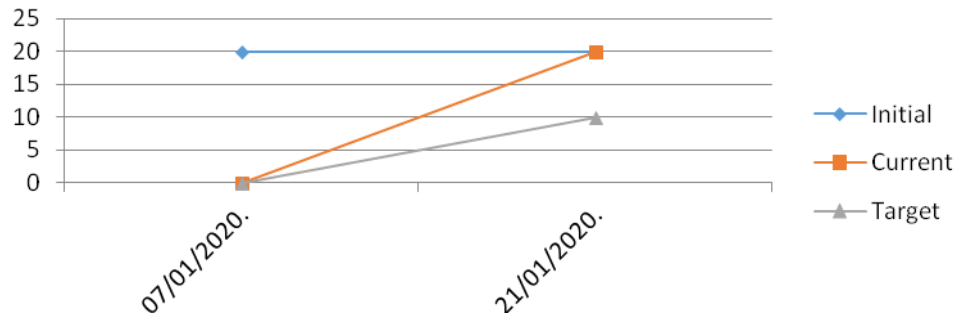
	Impact	Likelihood	Score
Initial Risk Rating	5	4	20
Current Risk Rating	5	4	20
Target Risk Score	5	2	10
New risk presented to committee			

Controls in place	**Further action to achieve target risk score**
1. There is PAT testing in place but not all equipment is captured. 2. There are a number of trained staff who work with electricity. There are Competent persons available for High Voltage and Low Voltage work. 3. BCUHB has an authorised officer for overseeing high voltage work through shared services. 4. A Electrical Safety Group is being established. 5. High Voltage work is outsourced. 6. Reasonable systems for isolation work identified in gap analysis.	1. BCUHB Policy and Procedure is required to be in place to include scope for non-estates agents/contractors, and staff responsibilities (IT Radiology etc). 2. Risk Assessment/Evidence Based procedure and schedule for electrical testing, including individually owned items. 3. Centralised PAT testing asset register with last and next testing date, capable of producing reports on all, overdue and upcoming (e.g. 3 months) test dates a risk based approach to testing required. 4. Procedure for installation, commissioning, inspection, maintenance and decommissioning of electrical equipment, including roles and responsibilities, equipment types, competency requirements, key-holder/lock-off/isolation procedure and SOP for Permit To Work System.Live/Dead Work. 5. Surveys/schematic records needed on MiCad system.

	6. Testing/witnessing/maintenance checking through services. 7. Ensure all electrical installations have regular inspection regime in place (5 yearly).

Assurances	**Links to**		
	Strategic Goals	**Principal Risks**	**Special Measures Theme**
	8		SM4 SM1

3023	**Director Lead:** Executive Director of Workforce and Organisational Development	**Date Opened:** 07 January 2020
	Assuring Committee:	**Date Last Reviewed:** 07 January 2020
	Risk: Legionella Management and Control.	**Target Risk Date:** 30 November 2020
There is a significant risk that the BCUHB is non-compliant with COSHH Legislation (L8 Legionella Management Guidelines). This is caused by a lack of formal processes and systems to minimise the risk to staff, patients, visitors and General Public, from water-borne pathogens (such as Pseudomonas). This may ultimately lead death, ill health conditions in those who are particularly susceptible to such risks, and a breach of relevant Health & Safety Legislation.		



	Impact	Likelihood	Score
Initial Risk Rating	4	5	20
Current Risk Rating	5	4	20
Target Risk Score	5	2	10
New risk presented to committee			

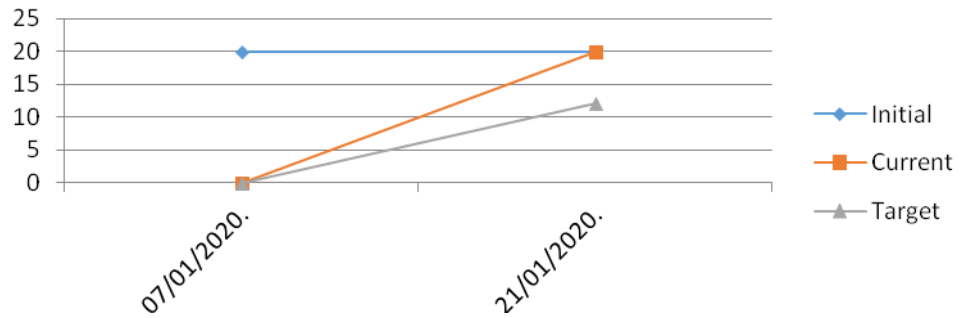
Controls in place	Further action to achieve target risk score
1. Legionella and Water Safety Policy in place. 2. Risk assessment undertaken by clear water. 3. High risk engineering work completed in line with clearwater risk assessment. 4. Bi-Annual risk assessment undertaken by clear water. 5. Water samples taken and evaluated for legionella and pseudomonis. 6. Authorising Engineer water safety in place who provides annual report.	1. Update Corporate H&S Review template and H&S Self Assessment Template to ensure that actions are completed by all wards and Departments to ensure systems are in place. 2. Ensure that engineering schematics are in place for all departments and kept up to date under Estates control. Implement MiCAD/database system to ensure all schematics are up to date and deadlegs easily identified. 3. Departments to have information on all outlets and deadlegs, identification of high risk areas within their services to ensure they can be effectively managed. 4. Departments to have a flushing and testing regime in place, defined in a Standard Operating Procedure, with designated responsibilities and recording mechanism Ward Manager or site responsible person.

	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 (Public Health Wales). 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, this requires appropriate clinical and microbiology support to be effective.

Assurances	**Links to**		
	Strategic Goals	**Principal Risks**	**Special Measures Theme**
	8		SM4 SM1

3024	**Director Lead:** Executive Director of Workforce and Organisational Development	**Date Opened:** 07 January 2020
	Assuring Committee:	**Date Last Reviewed:** 07 January 2020
	Risk: Non-Compliance of Fire Safety Systems	**Target Risk Date:**

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



	Impact	Likelihood	Score
Initial Risk Rating	4	5	20
Current Risk Rating	4	5	20
Target Risk Score	3	4	12
New risk presented to committee			

Controls in place	Further action to achieve target risk score
1. Fire risk assessments in place in a number of service areas. 2. A number of areas have evacuations. 3. There is a fire safety group established. 4. There is a fire Policy in place. 5. The Fire Authority regularly inspect BCUHB premises and provide reports on their findings which have action plans in place. 6. Appointed fire engineer in place who oversees fire safety system in place. 7. Commission independent shared services audits. 8. Information from unwanted fire alarms and actual fires is collated and reviewed as part of the fire risk assessment process.	1. BCUHB required to comply with all elements of the Fire Safety Order 2005. 2. Review Internal Audit Fire findings and ensure all actions are taken. 3. Identify how actions identified in the site FRA are escalated to senior staff and effectively implemented. 4. Identify how site specific fire information and training is conducted and recorded. 5. Consider how bariatric evacuation training - is undertaken define current plans for evacuation and how this is achieved? 6. How is evacuation training delivered / monitored? 7. How is fire safety advice provided to contractors, define when this happens? 8. AlbaMat training - is required in all service areas a specific training

	package is required with Fire and Manual Handling Team involved. 9. Ensure actions from the fire authority findings are escalated and actions completed reporting back to the Strategic OHS Group.

Assurances	**Links to**		
	Strategic Goals	**Principal Risks**	**Special Measures Theme**
	8		SM4 SM1

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience (QSE) Committee 28TH January 2020
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	General Medical Council Enhanced Monitoring of Education and Training in Medicine at Wrexham Maelor Hospital (WMH)
Cyfarwyddwr Cyfrifol: Responsible Director:	Dr David Fearnley, Executive Medical Director
Awdur yr Adroddiad Report Author:	Miss Emma Woolley, Director for Medical and Dental Education, BCUHB
Craffu blaenorol: Prior Scrutiny:	First presentation of issue to QSE
Atodiadau Appendices:	None

Argymhelliad / Recommendation:

The Committee is asked to note the report and seek any further assurance.

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

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

Sefyllfa / Situation:

The medical education and training environment in medicine at Wrexham is failing to meet the required General Medical Council's (GMC) standard and was placed under Enhanced Monitoring by the GMC on the recommendation of Health Education and Improvement Wales (HEIW) in July 2019. Without the necessary improvement, this risks withdrawal of trainee doctors from the site and thus the Health Board's ability to provide a service. This includes those doctors working for Area-based specialties and whose rotas include on-call for acute medicine.

Cefndir / Background

BCUHB is commissioned by HEIW to provide medical education and training for junior doctors in an environment that must meet the General Medical Council's standards set out in https://www.gmc-uk.org/education/standards-guidance-and-curricula/standards-and-outcomes/promoting-excellence . These standards outline the expectations as regard the safety of the healthcare being delivered as well as the standards of education.

The majority of teaching and learning occurs in the practice of delivering healthcare to our patients and thus these training grade posts provide a considerable service element. Posts are funded by HEIW, a budget that is currently worth £8,701,693. Thus, any threat to decommission training posts has both a service and financial implication for the Health Board.

Standards are monitored by a number of means:

- the annual GMC survey,
- data from assessment meetings with trainees,
- local intelligence gathered by HEIW Faculty teams,
- junior doctor forums
- roster monitoring
- other more informal means.

HEIW have been monitoring standards for the past two years and despite recognising the attempts and progress made to improve standards, HEIW felt the failure to show sustained improvement needed escalating to the GMC.

Reasons for Enhanced Monitoring:

- **Workload**: this is multifactorial but impacts on doctors' ability to practice safely and to allow for education and training in the workplace.

- **Access to training curriculum requirements**: in particular the access to clinics for learning due to workload elsewhere and the lack of physical space and equipment

- **Working environment:** access to digital technology to support more efficient working eg. Tracking of patients and results. Medical model which meant working across multiple ward areas with 'safari' ward rounds

Despite unanimous praise for individual consultants, of the 11 doctors interviewed by HEIW none of them would recommend WMH as a place to work

Action:
The local Hospital Management Team are meeting monthly to agree, enact and monitor action plans to address the issues raised by HEIW. As can be expected in the current context there are limitations to that which can be achieved in certain areas given the difficulty in recruitment, workload/capacity issues and the financial constraints within the Health Board.

Achievements to date to address the issues include:

Workload:	A programme of education and training of non-medical staff for tasks such as venepuncture, ECGs and cannulation enabling doctors to undertake more medical-based tasks eg diagnosis and treatment planning to increase patient flow and ease their workload. (see figure 1.) However it must be noted that nursing colleagues have their own issues with staffing and workload and thus a reduced capacity for these tasks. Audit of bleeps received by junior staff to be undertaken to gather quantitative data on volume, reason and type of task (completion end of February 2020)

Access to training curriculum requirements:	Review of clinic schedules and templates to ensure trainees can be accommodated. Timetables shared with juniors to support attendance
Working environment:	Investment in and opening of the new acute medical unit and agreement for expansion of the acute medicine consultant body (New unit open but recruitment to consultant positions remains difficult. There is ongoing work with Hunter Clinical recruitment agency)
	External recruitment of Clinical Director for medicine (interview 5th February)
	Further development of patient pathways for the new tertiary vascular service

Conclusion:
A further visit by HEIW is planned for early 2020 (date yet to be confirmed). A failure to address the issues could result in the recommendation of the withdrawal of training posts.

The training of the non-medical workforce has not resulted in a perceptible change in workload. This is possibly a result of the immense winter pressures but is also likely to reflect the UK-wide increase in workload due to increasing age and acuity of patients presenting to secondary care. The junior workforce in Wrexham medicine is fully recruited to suggesting that the workload is such that the traditional number of staff (medical and non-medical) is no longer sufficient to manage it.

Whilst the local teams continue to work on what they have the power to change, improvement in the necessary time frame is unlikely without the support from the Health Board and other bodies for:

- investment in digital solutions for enabling the management of healthcare (for example, digital means of communication between healthcare professionals. This is under consideration by the Digital Improvement Group and key to the implementation of a digitally enabled clinical strategy for the Health Board).

- funding to be agreed urgently for experienced Physician Associates working in the medical team to support and manage the current workload. This will also allow doctors in training to access the necessary education requirements that BCUHB is commissioned to provide e.g. out-patient clinics for the doctors in training. Investment in the immediate term has the ability to save on medical workforce requirements as their competence develops helping solve future medical recruitment issues. The outcome of a workforce review for medicine at WMH the Health Board's commissioned external agency is awaited.

Strategy Implications
The risks and recommendations have implications for the Health Board's ability to manage both planned and unscheduled care. The reputational importance of training status is an important factor in further development of medical education and careers in North Wales.

Financial Implications
Withdrawal of central funding from HEIW for training post salaries and study leave budgets and an increased cost burden for the HB in providing healthcare for its population via locum spend

Risk Analysis
Safe, effective and positive experience care requires a supported workforce. The GMC analysis has prompted an urgent and comprehensive review of the training experience and this is reflected in the risk register as a wider risk of recruitment and retention of capable staff.

Legal and Compliance
This report summarises the actions that are being taken to ensure compliance with national training standards.

Impact Assessment
The report refers to nationally agreed training standards and the actions being taken to achieve these standards.

.

Cyfarfod a dyddiad: **Meeting and date:**	Quality, Safety and Experience Committee 28th January 2020
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Review of Open Visiting Policy
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Mrs Gill Harris, Executive Director of Nursing and Midwifery
Awdur yr Adroddiad **Report Author:**	Ms Anne-Marie Rowlands, Associate Director Professional Regulation and Education
Craffu blaenorol: **Prior Scrutiny:**	Quality and Safety Group has previously considered the matter and recommended the policy be submitted for approval.
Atodiadau **Appendices:**	Appendix 1 – Open Visiting Policy Appendix 2 – EqIA screening

Argymhelliad / Recommendation:

The Committee is asked to approve the updated Open Visiting Policy

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

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

Sefyllfa / Situation:

The policy has been updated in line with the requirements to do so.

Cefndir / Background:

Open visiting hours were introduced in 2017. Following consultation, the policy has been updated in line with the policy review timetable.

Asesiad / Assessment & Analysis

Strategy Implications

Health Board Well-being Objectives

- To improve physical, emotional and mental health and well-being for all
- To work in partnership to support people – individuals, families, carers, communities - to achieve their own well-being
- To respect people and their dignity
- To listen to people and learn from their experiences

Wellbeing of Future Generations Act sustainable development principles

- Healthier Wales
- Cohesive communities.

Financial Implications

There are no anticipated financial implications.

Risk Analysis

There are no risks anticipated.

Legal and Compliance

There are no legal implications anticipated.

Impact Assessment

An EqIA has been completed and there are no identified negative impacts.

Appendix 1

Version & Reference Number NU13/V2

OPEN VISITING POLICY

Author & Title	Anne-Marie Rowlands, Associate Director Professional Regulation & Education				
Responsible dept. / director:	Corporate Nursing/Executive Director of Nursing and Midwifery				
Approved by:	Quality and Safety Group				
Date approved:	8th November 2019				
Date activated (live):	June 2017				
Documents to be read alongside this document:	Living Heathier, Staying Well. BCUHB Approach to Dementia Care.				
Date of next review:	November 2022				
Date EqIA completed:	June 2017/reviewed November 2019				
First operational:	June 2017				
Previously reviewed:	No				
Changes made yes/no:	Yes				

N.B. Staff should be discouraged from printing this document. This is to avoid the risk of out of date printed versions of the document. The Intranet should be referred to for the current version of the document

Contents:

1. Introduction/Policy Statement

The Health Board is fully committed to implementing a person-centred approach to the delivery of health care for patients and their families/carers who access our services. The Health Board believes that responding to the needs of our patients/ visitors will further enhance the development of a person-centred health care service.

Our staff are committed to responding to the needs and expectations of patients and they understand the invaluable role that the patient's family, carer, friends and relatives make in the patient's recovery. These are the people who know the patient best and those who, simply by their presence, can help to reassure patients in times of uncertainty, anxiety or vulnerability.

The open visiting policy enables a more flexible approach to visiting in acute and community hospitals for all relatives and carers.

The Health Board supports John's Campaign, which is the right of a carer to stay with an individual with dementia in hospital. For someone with dementia, having a loved one by their side during their stay in hospital can be reassuring and comforting and involving a family carer, from admission to discharge, is proven to give better quality of care and improved outcomes. Wards across acute and community hospitals are adopting this campaign and an open visiting hours policy supports the implementation of the campaign.

2. Scope

This policy applies to all of our acute and community inpatient areas within the Health Board.

Adopting a more flexible approach enables patients' family and friends to feel more involved and participate in the patient's care, thus helping the patient to obtain the most benefit from inpatient care, supporting a seamless discharge and ensuring continuing care needs are addressed.

In specialist areas such as critical care, high dependency units, coronary care units, maternity units, paediatrics units, special care baby units and mental health units some restrictions may apply. Restrictions may also apply if there are any Infection Prevention and Control issues. Any restrictions will be displayed on the entrance to the ward or unit to inform patients and their families.

3. Aims and Objectives

This policy promotes an open and flexible approach to visiting times. Communication between the ward or department manager, staff and visitors is essential to the successful implementation of this policy, with clinical staff using their professional judgment to apply discretion and flexibility to balance patient and visitor needs.

4. Roles and responsibilities

It is the responsibility of all staff to support and promote person-centred patient care and open visiting times.

The ward or department manager will ensure that open visiting times is in place within their area of responsibility and that relatives and patients are informed of the open visiting arrangements, and any restrictions that may be in place. Wherever possible this discussion with the patient and their relatives should occur during the admission process.

The overall responsibility for ensuring patients and client needs are met during visiting times remains with the ward/department manager.

5. Visiting Times

Flexible visiting promotes an environment in which the patient establishes visiting parameters that best suit individual circumstances. The ultimate goal is to meet the psychological and emotional needs of the patient and those who comprise the patient's support system, through flexible visiting. A visitor is deemed anyone who the patient determines is significant to his or her well-being and whose presence would enhance his or her time in hospital.

5.1 Communication and Information

Signs will be displayed at the entrance to the unit or ward. Leaflets will be made available for visitors and patients.

The Open Visiting Poster (Appendix 1) will be displayed on the information board, which is located at the entrance to the ward/unit. The Visitors Charter (Appendix 2) will be explained to patients and relatives on admission, with a copy made available.

An open visiting schedule offers flexibility for relatives and patients. However it is important that families and carers are aware that whilst open visiting time is in place, there must be sufficient rest, recuperation and treatment time for the patient, and other patients within the bay or unit.

Person-centred health care recognises the important role caregivers, families and friends play in the lives of patients. Staff will discuss with patients What Matters to them, which will include the role of family / friends and caregivers whilst they are in hospital.

It is important also that the privacy and dignity of patients is maintained during visiting times, therefore staff will discuss when visiting is not convenient due to personal care, treatment or examinations, which will require visitors to leave the room or ward /department. In order to maintain patient confidentiality, visitors will be required to leave during medical or other ward rounds. There may also be times where patients are required to leave the ward to go for tests or scans. Staff will advise visitors in advance if possible, however, there may be occasions when visitors attend and patients are not on the ward.

If patients or visitors use electronic devices, then these should not be used to take photographs without consent. If watching TV or listening to music then headphones should be used to ensure that the sound is not disruptive to others.

Information about canteens/cafeterias will be available for visitors to minimise any inconvenience if they have to wait a while before being able to return to the ward. The BCU Health Board Internet website and Social Media will provide details of visiting times.

5.2 Protected Mealtimes

Protected or supported mealtimes are in place within the Health Board so that the care environment supports patients to obtain the most benefit from mealtimes. Certain hospital activities and interventions are limited at this time to allow patients to eat their meals without disruption and enable staff to assist those patients that require help at mealtimes.

Relatives and carers are welcomed at mealtimes and encouraged to be involved in the mealtime experience of the patient. This is particularly the case where the patient requires assistance at mealtimes. If visitors are on the ward during mealtimes, then they should recognise that this is protected time and that, as much as possible, patients should be able to eat their meals with minimal disruption.

5.3 Number of Visitors

There will be a limit to the number of visitors per bed at any one time, which must be two. If there are too many visitors at any one time, staff will remind visitors of the policy and provide details of restaurant facilities and other waiting areas.

5.4 Special Considerations

There may be occasions when the number of visitors may exceed two per bed and when visitors may need to stay overnight. Examples of this would be when the patient is at the end of life, or patients with cognition problems who are agitated overnight.

Families should discuss all such requests with the nurse in charge who has responsibility for ensuring all patients and client needs are met.

5.5 Staff Availability during Visiting

Staff will be available to speak with relatives during visiting. If shift handover occurs during visiting times, a member of staff will be identified to speak with relatives.

5.6 Infants, Children and Young People visiting

Children considered as family members, or equivalent, will be allowed to visit. Visiting of infants, children and young people is at the discretion of the nurse in charge. All children must remain under direct supervision from family members at all times.

Children and young people might be a carer for a relative and in these circumstances they may visit unsupervised and stay for the length of normal visiting.

5.7 Infection Prevention

Infection Prevention and Control in hospitals and other health care facilities is very important. To help stop the spread of infection, it is recommended that visitors entering or leaving the ward clean their hands, either by washing at a sink at the entrance to the ward, or by using the hand gel provided.

Visitors will be advised that they should contact the nurse in charge before visiting if they are unsure of the infectious status of the person they are visiting within a hospital setting. They must also be informed of any appropriate infection prevention precautions required when visiting, including any personal protective equipment which may be needed.

Information on good Infection Prevention and Control (IPC) is available from staff and the IPC team will be available to discuss any specific guidance to visitors and carers where needed.

Staff must advise all visitors that they must not visit if they have signs of a cough, cold or diarrhoea / vomiting or have been in contact with an infectious disease, e.g. chicken pox. They should be advised to contact NHS Direct or their GP for advice.

6. Equality, Well-being and the Environment

An EqIA has been completed, with no anticipated adverse impact. Posters in public areas will be bilingual. Language and communication has been referenced within the Visitors Charter.

7. Resources and Training

There are no anticipated resource or training implications with respect to the implementation of the policy

8. Monitoring, Audit and Implementation

The implementation of this policy is the responsibility of the Divisions, with audit and feedback through local line management structures. The policy will be reviewed in three years.

9. Appendices

Appendix 1: Open Visiting Poster

Open Visiting

Open visiting is in place within all of our hospitals which means that you can visit most wards at a time to suit you, your family and of course, the patient.

There are some specialist units such as critical care, high dependency unit, coronary care unit, maternity units, paediatric units, special care baby units and mental health units where there may be further restrictions, which will be clearly communicated.

There may also be times during an infection outbreak where restrictions may be in place in the ward or unit you are visiting. Any restrictions will be clearly displayed outside the ward, unit or side room.

There will still be a limit to the number of visitors per bed at any one time, which should be two.

There will also be occasions when visiting is not convenient due to patient care, treatment, examinations or ward rounds. Staff will ask you to come back later or move to another area of the ward for a short period of time.

A visitor's charter is available from staff on the wards which sets out guidelines which we hope you will adhere to during your visit.

If you have any questions please speak to the nurse in charge of the ward or department.

Appendix 2: Visitors Charter: An information guide

Our priority is to provide high quality care for our patients. Visiting times are open for all our inpatient areas to enable relatives and carers to feel more involved in the care that we provide in hospital and planning for discharge home. <u>Staff will</u> • Be polite and courteous at all times and support relatives who wish to participate in a patient's care; • Do our best to create a calm and useful environment to help our patients recover; • Use our skills to prioritise the planning of care to our patients and communicate our decisions; • Keep family members and next of kin informed; • Arrange for you to speak to a member of the medical team if required; • Do all we can to protect patients from infection; on occasions this may result in restricting visiting or moving patients to an allocated side room; • Provide a safe clean hospital; • Give your relatives all the care they need, but we do have to make sure all our patients needs are met; • Discuss with patients their language of choice, and communicate wherever possible with patients, and their families, in this language (or have access to an interpreter).	<u>Relatives and Carers we would invite you to please be:</u> • Polite and courteous to staff, other patients and visitors; • Do not visit if you are unwell and not for at least 48 hours after your last episode of diarrhoea and vomiting; • Use the alcohol gel provided and adhere to infection prevention restrictions that may be in place; • Use the chairs provided rather than sitting on patients beds; • Allow housekeeping staff to undertake daily cleaning; where patients are in isolation you may be asked to leave the room so a full clean can be completed, which may take up to half an hour; • Do not use the patient toilets or bathrooms. Please ask a member of staff for directions to the public facilities; • Provide your relative with their toiletries, dentures, glasses, suitable clothing and footwear; • Understand and respect that information cannot be given out unless the patient has given their permission. If you feel you do not have sufficient information please let us know; • Understand that you may be asked to leave the ward during personal care, treatment, examinations, ward rounds or if a medical emergency occurs. This is to ensure confidentiality and privacy and dignity for all patients is maintained; • Discuss babies, children and young people visiting and any restrictions on visitor numbers with the ward manager; • Be respectful, please keep noise levels to a minimum and put your electronic devices on silent or vibrate; • Do not take photos without consent and please use headphones if listening to music or watching TV on electronic devices;

	• Remember that rest is important and allow your relative, the opportunity to rest for periods throughout the day; • Be respectful of other patients rest, recuperation and bedtime; • Do not bring in food for your own, or your relatives, consumption. Staff will be happy to direct you to the nearest restaurant facility; • Do not disturb the nursing staff when they are administering medications; • Do not smoke or use e-cigarettes within the hospital or hospital grounds.
For general enquiries please contact the nurse in charge of the ward or department you are visiting.	

Engagement has taken place with:

Name	**Title**	**Date Consulted**
Members	Professional Advisory Group	February 2017
Members	Professional Advisory Group	May 2017
Members	Local Partnership Forum	June 2017
Geoff Ryall-Harvey	Community Health Council	June 2017
Policy Review 2019		
Members	Professional Advisory Group	June 2019
Sean Page/ Suzie Southey	Consultant Nurse for Dementia	July 2019
Amanda Miskell	Assistant Director of Nursing – Infection Prevention	July 2019
Members	Community Health Council	August 2019

Appendix 2

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

For:	Open Visiting Policy
Date form completed:	2.6.17 and updated 25.10.19 to new format

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

IT FORMS

PARTS A: SCREENING and B: KEY FINDINGS AND ACTIONS

Introduction:

These forms have been designed to enable you to record, and provide evidence of how you have considered the needs of all people (including service users, their carers and our staff) who may be affected by what you are writing or proposing, whether this is:

- a policy, protocol, guideline or other written control document;
- a strategy or other planning document e.g. your annual operating plan;
- any change to the way we deliver services e.g. a service review;
- a decision that is related to any of the above e.g. commissioning a new service or decommissioning an existing service.

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

Assessing Impact

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

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

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

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

Part A Form 1: Preparation

1.	What are you assessing i.e. what is the title of the document you are writing or the service review you are undertaking?	Open Visiting Policy
2.	Provide a brief description, including the aims and objectives of what you are assessing.	The policy, which was introduced in 2017 has been reviewed and updated in line with two yearly cycle.
3.	Who is responsible for whatever you are assessing – i.e. who has the authority to agree or approve any changes you identify are necessary?	Executive Director of Nursing and Midwifery
4.	Is the Policy related to, or influenced by, other Policies or areas of work?	John's Campaign Dementia Strategy BCUHB Our Values, Purpose, Vision and Strategic Goals BCUHB Working in Partnership to Improve Health and Deliver Excellent Care across North Wales HASCAS & Ockenden Recommendations BCUHB Ward Accreditation Standards
5.	Who are the key Stakeholders i.e. who will be affected by your document or proposals? Has a plan for engagement been agreed?	Employees, patients and service users
6.	What might help or hinder the success of whatever you are doing, for example communication, training etc.?	Communication internally and BCUHB webpage Staff and visitor adherence to policy

Part A Form 1: Preparation

7.	Think about and capture the positive aspects of your policy that help to promote and advance equality by reducing inequality or disadvantage.	The Health Board is fully committed to implementing a person-centred approach to the delivery of health care for patients and their families/carers who access our services. The Board believes that responding to the needs of our patients/visitors will further enhance the development of a person-centred healthcare service. Our staff are committed to responding to the needs and expectations of patients and they understand the invaluable role that the patient's family, carer, friends and relatives make in the patients' recovery. These are the people who know the patient best and those who, simply by their presence, can help to reassure patients in times of uncertainty, anxiety or vulnerability. The open visiting policy enables a more flexible approach to visiting in acute and community hospitals for all relatives and carers. The Health Board supports John's Campaign, which is the right of a carer to stay with an individual with dementia in hospital. For someone with dementia, having a loved one by their side during their stay in hospital can be reassuring and comforting. Involving a family carer from admission to discharge is proven to give better quality of care and improved outcomes. Wards across acute and community hospitals are adopting this campaign and an open visiting hours policy supports its implementation.

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

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

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

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

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

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

Part A

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

Protected characteristic or group	Will people in each of these protected characteristic groups be impacted by what is being proposed? If so is it positive or negative? (tick appropriate below)				Reasons for your decision (including evidence that has led you to decide this) A good starting point is the EHRC publication: "Is Wales Fairer (2018)?" You can also visit their website here	How will you reduce or remove any negative Impacts that you have identified?
	Yes	No	(+ve)	(-ve)		
Age (e.g. think about different age groups)	√		√		Aimed at promoting equality and dignity for all patients and provides guidance for staff, and visitors. Positive impact anticipated as increased scope for patients to be supported by their families, and greater flexibility for older visitors who may have to travel some distance to hospital sites, especially in winter months. The policy will make provision for family members or carers to enter wards during 'protected mealtimes' in the event that an older or younger patient requires assistance or support with eating/drinking. The policy will acknowledge that in some cases, a child or young person may be a carer for the patient and therefore may visit unsupervised and stay for the length of normal visiting. The policy acknowledges that special arrangements, flexibility or adaptations maybe required in certain areas such as neonatal and paediatric or where the presence of a parent or carer is essential to wellbeing or care provision. The policy requires young children visiting service users/patients to be accompanied by an adult.	

Part A

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

Disability (think about different types of impairment and health conditions:- i.e. physical, mental health, sensory loss, Cancer, HIV)	√		√		For those with mental or physical disability, reasonable adjustment can be made and additional time given to communicate what the policy involves. By providing flexible visiting hours, visitors with a disability that inhibits or restricts mobility will not need to rush to meet specific visiting times. The extended visiting times will have a positive impact on all disability groups and carers of disabled dependents allowing greater flexibility, convenience and choice of visiting times. The policy specifically states that reasonable adjustments will be made those people that have disability and have difficulty complying with the visiting times. The extended visiting times should also have a positive impact on the availability of accessible car parking at the hospital sites.	
Gender Reassignment (sometimes referred to as 'Gender Identity' or transgender)		√			No anticipated impact	
Pregnancy and maternity	√		√		Greater flexibility for pregnant women or those on maternity leave to visit loved ones. Alternatively, for family to visit those on the maternity unit.	
Race (include different ethnic	√			√	Consideration will need to be given to racial and ethnic differences in extended family, friendship and support	

minorities, Gypsies and Travellers) Consider how refugees and asylum-seekers may be affected.					networks as there will be a limit to the number of visitors per patient. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4116141/	The policy will direct staff to provide details of restaurant facilities and other waiting areas.
Religion, belief and non-belief	√		√		Consideration will need to be given to families / friends whose cultural or religious observances include large family gatherings as there will be a limit to the number of visitors per patient. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4116141/ The extended visiting times will have a positive impact on all people of different religions or beliefs allowing greater flexibility, convenience and choice to accommodate prayer times etc. The policy specifically states that reasonable adjustments will be made those people that have difficulty complying with the visiting times because of their religion or belief which may be particularly relevant where religious fasting is being observed such as Ramadan and family/friends wish to assist the service user/patient with feeding. Visitors of any faith or none may access the hospital Chapel for worship, reflection or quiet time.	

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

Sex (men and women)	√		√		More women undertake a caring role than men. Caring roles can make it difficult for people to visit their relatives or friends in hospital. Without flexibility for visiting hours, it can be difficult and confusing for visitors who are trying to balance caring and/or work responsibilities due to variances in visiting times and duration across the Health Board. https://www.wenwales.org.uk/wp-content/uploads/6033-WEN-Unpaid-Care-FINAL1.pdf	
Sexual orientation (Lesbian, Gay and Bisexual)		√			No anticipated impact	
Marriage and civil Partnership (Marital status)		√			No anticipated impact	
Low-income households	√		√		This policy provides for greater flexibility for patients and visitors. There may be low-income households that do not have access to mobile phones / landlines and their only form of contact may be through visiting. By offering flexible visiting hours, visitors will also be able to utilise public transport more efficiently, i.e. during off peak / reduced fare times or in areas where public transport is limited. Flexible	

					visiting times support visitors to visit outside of their normal working hours and reduce the need to take unpaid leave.	

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

Human Rights:

Do you think that this policy will have a positive or negative impact on people's human rights? For more information on Human Rights, see our intranet pages at: http://howis.wales.nhs.uk/sitesplus/861/page/42166

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

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

Will people's Human Rights be impacted by what is being proposed? If so is it positive or negative? (tick as appropriate below)				**Which Human Rights do you think are potentially affected?**	**Reasons for your decision (including evidence that has led you to decide this)**	**How will you reduce or remove any negative Impacts that you have identified?**
Yes	**No**	**(+ve)**	**(-ve)**			
√		√		Article 8	The policy would support Article 8, Right to respect for private and family life	

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

Welsh Language:

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

Welsh Language	Will people be impacted by what is being proposed? If so is it positive or negative? (tick appropriate below)				Reasons for your decision (including evidence that has led you to decide this)	How will you reduce or remove any negative Impacts that you have identified?
	Yes	No	(+ve)	(-ve)		
Opportunities for persons to use the Welsh language		√			Visiting hours poster would be available bilingually in clinical areas	
Treating the Welsh language no less favourably than the English language		√			Information leaflets would be bilingual	

Part A Form 4: Record of Engagement and Consultation

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

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

What steps have you taken to engage and consult with people who share protected characteristics and how have you done this? Consider engagement and participatory methods.	Circulated draft policy widely within BCUHB Circulated policy to Community health Council Members for their views
Have any themes emerged? Describe them here.	No themes emerged
If yes to above, how have their views influenced your work/guided your policy/proposal, or changed your recommendations?	

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

Part B Form 5: Summary of Key Findings and Actions

1. What has been assessed? (Copy from Form 1)	Open Visiting Policy

2. Brief Aims and Objectives: (Copy from Form 1)	The policy which was introduced in 2017, has been reviewed and updated in line with two yearly cycle.

From your assessment findings (Forms 2 and 3):

3a. Could any of the protected groups be negatively affected by your policy or proposal?	Yes	No √
3b. Could the impact of your policy or proposal be discriminatory under equality legislation?	Yes	No √
3c. Is your policy or proposal of high significance? For example, does it mean changes across the whole population or Health Board, or only small numbers in one particular area?	Yes √	No

4. Did your	Yes	No √

Part B Form 5: Summary of Key Findings and Actions

assessment findings on Forms 2 & 3, coupled with your answers to the 3 questions above indicate that you need to proceed to a Full Impact Assessment?	Record here the reason(s) for your decision i.e. what did Forms 2 & 3 indicate in terms of positive and negative impact for each characteristic, Human Rights and Welsh Language? The EQIA has not identified any significant adverse impact. The policy will have a positive impact for patients and their families, as offers enables a more flexible approach to visiting in acute and community hospitals for all relatives and carers. An open visiting policy supports the implementation of John's campaign. The policy is intended to apply equally to those affected by its provisions, however acknowledges that everyone is different	
5. If you answered 'no' above, are there any issues to be addressed e.g. reducing any identified minor negative impact?	Yes	√
	Record Details: No significant anticipated negative impact, the policy has been in place for two years and favourably received.	
6. Are monitoring arrangements in place so that you can measure what actually happens after you implement your policy or proposal?	Yes √	No
	How is it being monitored?	Through patient experience, satisfaction, compliments, complaints, ward accreditation
	Who is responsible?	Site and Area Directors of Nursing
	What information is being used?	Patients experience, compliments, complaints, ward accreditation, user groups
	When will the EqIA be reviewed? (Usually the	2 years

Part B Form 5: Summary of Key Findings and Actions

	same date the policy is reviewed)	

7. Where will your policy or proposal be forwarded for approval?	Quality Safety Group

8. Names of all parties involved in undertaking this Equality Impact Assessment – **please note EqIA should be undertaken as a group activity**	Name	Title/Role
	Anne-Marie Rowlands	Associate Director Professional Regulation
	Ade Evans	Head of Education and Development
Senior sign off prior to committee approval:	Advise Sought from	Mike Townson, Senior Equalities Manager
Please Note: The Action Plan below forms an integral part of this Outcome Report		

Action Plan

This template details any actions that are planned following the completion of EqIA including those aimed at reducing or eliminating the effects of potential or actual negative impact identified.

Part B Form 5: Summary of Key Findings and Actions

	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	N/A	N/A
2. What changes are you proposing to make to your policy or proposal as a result of the EqIA?	N/A	N/A	N/A
3a. Where negative impacts on certain groups have been identified, what actions are you taking or are proposed to reduce these impacts? Are these already in place?	The policy will direct staff to provide details of restaurant facilities and other waiting areas	Operational staff	As the need arises
3b. Where negative impacts on certain groups have been identified, and you are proceeding without reducing them, describe here why you believe this is justified.	The screening indicates a generally positive impact	N/A	N/A
4. Provide details of any actions taken or planned to advance equality of opportunity as a result of this assessment.	N/A	N/A	N/A

Part B Form 5: Summary of Key Findings and Actions

	Proposed Actions	Who is responsible for this action?	When will this be done by?

Cyfarfod a dyddiad: **Meeting and date:**	Quality, Safety and Experience Committee 28th January 2020
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Nurse Staffing Levels Policy
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Mrs Gill Harris, Executive Director of Nursing and Midwifery
Awdur yr Adroddiad **Report Author:**	Ms Anne-Marie Rowlands, Associate Director Professional Regulation and Education
Craffu blaenorol: **Prior Scrutiny:**	Quality and Safety Group has previously considered the matter and recommended the policy be submitted for approval.
Atodiadau **Appendices:**	1. Nurse Staffing Levels Policy 2. All Wales Nurse Staffing Levels Workforce Planning Tool 3. Triangulation of Patient Harm Incidents Report *4.* EqIA

Argymhelliad / Recommendation:

The Committee is asked to approve the Nurse Staffing Levels Policy.

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

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

Sefyllfa / Situation:

The Health Board is required to have an operational framework, that supports the calculation and maintenance of nursing staffing levels; outlines the roles and responsibilities of key professionals; and identifies the actions that are to be taken to review, record, report and escalate where nurse staffing levels are not maintained.

Cefndir / Background:

The Nurse Staffing Levels (Wales) Act 2016 became law in Wales in March 2016, with a phased commencement. The Act requires health service bodies to have regard for the provision of appropriate nurse staffing levels, and to ensure that they are providing sufficient nurses to allow nurses time to care for patients sensitively. Under the Act, this duty extends to anywhere NHS Wales provides or, commissions a third party to provide nurses. The Act begins with adult acute medical and surgical inpatient wards. The designated person is formally presents the nurse staffing level for each ward to the Board on an annual basis and ensures a written update is provided following the bi-annual recalculation and at any other time recalculation is deemed necessary.

The policy was approved at Professional Advisory Group on the 7th October 2019 and at Quality and Safety Group (QSG) on 8th November 2019. The EqIA has been strengthened in line with comments from QSG to consider Article 3, Article 8 and the positive Welsh Language impact.

Asesiad / Assessment & Analysis

Strategy Implications

Health Board Well Being Objectives

- To improve physical, emotional and mental health and well-being for all;
- To target our resources to those with the greatest needs and reduce inequalities;
- To improve the safety and quality of all services;
- To respect people and their dignity;
- To listen to people and learn from their experiences.

Wellbeing of Future Generations Act

- Balancing short term need with long term planning for the future;
- Involving those with an interest and seeking their views;
- Working together with other partners to deliver objectives;
- Putting resources into preventing problems occurring or getting worse;
- Considering impact on all well-being goals together and on other bodies

Financial Implications

There are no funding implications associated with the implementation of the policy. Staffing establishments to meet the requirements of the Nurse Staffing Levels (Wales) Act 2016 are funded. The funded establishments however do not support additional escalated beds. The 2019 Annual Nurse Staffing Levels (Wales) Act 2016 report went to the Health Board on 2nd May 2019.

Risk Analysis

There are no risks anticipated with the policy. The policy has been developed in order to mitigate the risks associated with non-compliance of the legislation

Legal and Compliance

The policy has been developed to ensure compliance with the legislation

Impact Assessment

An EqIA has been completed and not identified adverse impact. The policy will have a positive impact as the provision of appropriate staffing will help ensure quality of care across settings, meeting each person's needs. It will also promote a safe working environment for staff and ensure staffing decisions take account of contextual factors. The policy is intended to apply equally to those affected by its provisions, however acknowledges that everyone is different.

Appendix 1

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Version & Reference Number 1.0

Nurse Staffing Levels Policy

Author & Title	Gaynor Hales, Project Lead – Nurse Staffing Act (original policy 2018) Anne-Marie Rowlands, Associate Director Professional Regulation and Education (policy review 2019)				
Responsible dept. / director:	Gill Harris, Executive Director of Nursing and Midwifery				
Approved by:					
Date approved:	Gill Harris, Executive Director of Nursing and Midwifery				
Date activated (live):					
Documents to be read alongside this document:	Nurse Staffing Levels Wales Act (2016) Statutory guidance Welsh Government; Nurse Staffing Levels (Wales) Act 2016; Welsh Levels of Care (Edition 1); Health Care Monitoring System (HCMS) How to Guide; NICE publication 'Safe staffing for nursing in adult inpatient wards in acute hospitals' (2014); OP01 BCUHB Protocol for the Management of Emergency Pressures and Escalation (2015); GC04 BCUHB Operational Scheme of Delegation; Health System Escalation and De-Escalation Policy for Glan Clwyd Hospital; West Procedure for Bed Escalation Capacity (Ysbyty Gwynedd & Community Hospitals); Wrexham Maelor Hospital Escalation Policy.				
Date of next review:	May 2021				
Date EQIA completed:	25.10.19				
First operational:					
Previously reviewed:	No				
Changes made yes/no:					

N.B. Staff should be discouraged from printing this document. This is to avoid the risk of out of date printed versions of the document. The Intranet should be referred to for the current version of the document.

Contents

1. INTRODUCTION

Nursing and healthcare staff play a critical role in delivering safe, high quality care to patients and service users. Betsi Cadwaladr University Health Board (HB) puts patients at the heart of all that we do. There is strong evidence that having the right number of staff delivering care in the right place impacts positively on both clinical outcomes and patient experience (Francis 2013, Keogh 2013, and Berwick 2013). Addressing these issues ensures we prioritise the safety and experience of our patients and staff. Clearly safe staffing is not just about staffing ratios, but ensuring that we have the right staff, with the right skills, in the right place at the right time.

The Nurse Staffing Level (Wales) Act 2016 became law in Wales in March 2016, requiring organisations to calculate and monitor the number of nurses required to sensitively care for patients. The Act enables a phased implementation and came into effect for Adult Acute Medical and Surgical Wards in April 2018.

The Nurse Staffing levels (Wales) 2016 Operational Guidance has been developed to provide Health Boards with advice on using the Welsh Levels of Care, participating in the biannual audits, analysing results and undertaking triangulation to calculate and report nurse staffing levels. The guidance can be located on the following link: http://www.1000livesplus.wales.nhs.uk/document/347547

The National (UK) understanding of Professional Nurse Staffing Standards is also made explicit within the NICE publication 'Safe staffing for nursing in adult inpatient wards in acute hospitals' (2014), which can be accessed on the following link: https://www.nice.org.uk/guidance/sg1

2. POLICY STATEMENT

The purpose of this policy is to provide information and standards, which will underpin:

- The Health Board's overarching responsibility to provide sufficient nurses to allow time to care for patients sensitively;
- The calculation of the nurse staffing levels;
- The "reasonable steps" to be taken to maintain nurse staffing levels;
- The escalation and reporting process;
- The requirements to undertake the biannual review of nurse staffing levels.

It is intended that this policy works in conjunction with existing polices and other written control documents issued by the Health Board.

3. SCOPE

The policy is Health Board wide and relevant to those involved in the calculating and maintaining of nurse staffing levels including nursing, workforce, finance and corporate teams.

The policy currently covers all adult acute inpatient medical and surgical wards within Secondary Care as defined by the Act (see definition appendix 1).

Section 25B (3) gives Welsh Ministers the power to make regulations to extend the duty to calculate nurse staffing levels to other settings. The policy would therefore be reviewed when this duty is extended.

4. AIMS AND OBJECTIVES

The aims of this policy are:

- To support the calculation and maintenance of the nurse staffing level;
- To outline the reasonable steps to be undertaken to maintain planned nurse staffing levels;
- To support patients care needs with processes which ensure maximum value from available nurse staffing;
- To provide guidance to nursing staff and managers to safely manage risk to patient safety and staff well-being when not able to maintain the planned nurse staffing level and ensure that this is reported, monitored and appropriate actions are taken to mitigate the risks by taking reasonable steps;
- To provide the mechanism through which open and transparent information on the nurse staffing level on each adult acute medical and surgical ward within the Health Board can be shared.

The objectives of this policy are to:

- Provide clear and agreed principles for the calculation of the nurse staffing levels;
- Support the maintenance of the nurse staffing level for all adult acute inpatient wards;
- Clarify the roles and responsibilities of all parties involved in the process;
- Provide a clear escalation and reporting process for when the planned nurse staffing level is not maintained.

5. ROLES AND RESPONSIBILITIES

The responsibility for meeting the requirements of the Act applies to staff at all levels, from the ward to the Board, with the Board and Chief Executive being ultimately responsible for ensuring the Health Boards' compliance with the Act.

Board

When exercising their responsibilities the Board must consider, and have due regard to, the duty on them under section 25A of the Act to have sufficient nurses to allow the nurses time to care for patients sensitively wherever nursing services are provided.

In addition, the Executive Directors of Nursing, Workforce, Organisational Development and Finance are required under sections 25B and 25C of the Act to provide evidence and professional opinion to the Board to assist with its decision making in relation to calculating and maintaining the nurse staffing level in adult acute medical and surgical in-patient wards.

Roles and responsibilities are detailed below:

Executive Director of Nursing and Midwifery	The designated person, who is authorised within the governance framework to calculate the nurse staffing level for the adult acute inpatient wards on behalf of the Chief Executive; Establishes the timetable for the annual cycle, supported by appropriate professional nursing, finance, operational and workforce personnel to facilitate the biannual calculation of the nurse staffing level; Calculates the number of registered nurses and those undertaking nursing duties (under the supervision of, or delegated to) by a registered nurse appropriate to provide person centred care that meets all reasonable requirements; Undertakes and records the rationale for the calculation every 6 months as a minimum, or more frequently if there is a change in use/service which is likely to alter nurse staffing level, or if they deem necessary; Formally, presents the nurse staffing level for each ward to their Board on an annual basis, provides a written update following the bi-annual recalculation and at any other time recalculation is deemed necessary.
Director of Workforce and Organisational Development	Ensures an effective system of workforce planning, based on the Welsh Planning System, is in place in order to deliver a continuous supply of the required numbers of staff; There are systems in place to ensure active and timely staff recruitment (at both a local, regional, national and international level); There are effective staff well-being and retention strategies in place that take account of the NHS Wales Staff Survey; There are operational processes in place that enable the use of appropriately skilled, temporary (bank or agency) nursing.
Director of Finance	Ensures that the nurse staffing level is funded from the Health Board's revenue allocation and that it takes into account the actual salary points of staff employed on the wards where section 25B applies.
Deputy Executive Director of Nursing	Corporate support and consistency in the development of workload and workforce assessments;

	Provide support and training in the use of recognised methodologies in the development of annual workload and workforce assessments; Support the processing of vacancies that are in line with the annual workload and workforce assessments and are part of the agreed vacancy management plan for the area; Develop corporate reporting systems regarding staffing risks and concerns.

Nursing Management Structure
The Nursing Management Structure refers to all those nursing posts within the structure that sit between the ward sister/charge nurse and the Executive Director of Nursing.

7) Directors of Nursing	Roles and responsibilities as outlined in 1) 2) 3) 4) 5) 6) - in addition: Responsible for the calculation of the nursing staff levels every six months at minimum, and when there is a change in service or use which is likely to change the nurse staffing levels and on an annual basis for all other areas, ensuring confirmation and challenge as part of the triangulation; Responsible for monitoring the professional standards in relation to the nurse staffing level at operational level and agreeing the nurse staffing levels for area of responsibility; Develop and implement a recruitment and retention plan for nursing in conjunction with workforce and organisational development; Ensure the Executive Director of Nursing and Midwifery as the 'designated person' is kept appraised; Present the six monthly staffing calculations to the Executive Director of Nursing and Midwifery, with the rationale for the calculation, and any variation or change to proposed staffing templates; Ensures any professional concerns regarding staffing including vacancies, sickness absence and acuity are escalated accordingly and included on the divisional Risk Register.
6) Head of Nursing	Roles and responsibilities as outlined in 1) 2) 3) 4) 5) - in addition:

	Provide professional leadership and guidance in the calculation of the nurse staffing levels and ensure all reasonable steps are taken in mitigating risk related to staffing levels; Review the patient acuity and quality indicator data and provide information that enables the Site Director of Nursing to exercise professional judgement when calculating the nurse staffing levels; Ensure any staffing risks or concerns are managed appropriately and timely to ensure that patient care and safety, and that nurses, are not compromised; Review monthly reports on nurse staffing levels, complaints and harm, and ensure reasonable steps are taken to manage risks in line with the reporting requirements of the Act.
5) Matrons	Roles and responsibilities as outlined in 1) 2) 3) - in addition: Ensure effective and efficient use of nurse staffing resources to support safe, effective and fair advance planning by signing off the planner roster; Proactively manage daily workforce planning across areas of responsibility to ensure staff are distributed according to clinical need and patient acuity; Ensure daily acuity is completed within the SafeCare system, and that staff understand their responsibilities on a daily basis in completing this; Ensure that on occasions where staffing is below agreed template an assessment is made as to whether the staffing negatively impacts on the patient experience/care provision using triangulation of acuity, professional judgement and quality indicators; Review all Datix reports and undertake final grading of all investigations and identify any trends or issues that arise and ensure that these are actioned.
4) Clinical Site Manager	Roles and responsibilities as outlined in 1) - in addition: Maintain an overview of staffing and patient acuity across the site; At Safety Huddle/operational site meetings review staffing and agree reasonable steps to mitigate;

	Escalate staffing issues to the Head of Nursing or Bronze on call out of hours; Ensure that all “reasonable steps” are taken to maintain nurse staffing levels, including adjusting the nurse staffing levels to match the patient workload or changing the workload to match the nurse staffing level and step down of any surged beds; Ensure in the event of staffing being moved from other areas within the organisation that this is risk assessed and recorded within the SafeCare system.
3) Ward Manager	<u>Roles and responsibilities as outlined in 1) 2) - in addition:</u> Undertake the bi-annual acuity audits for their ward and validate accuracy and completeness of the acuity data; Involved in the six monthly calculations and provide their professional opinion about the nurse staffing levels for their ward; Maintain the system for informing patients of the nurse staffing levels, ensuring the staffing board is kept updated; Ensures effective roster management in line with the rostering policy; Continuously assess the clinical environment and keep the Matron/Head of Nursing formally appraised of the situation; Ensure that all “reasonable steps” are undertaken to maintain the nurse staffing level and escalate any concerns; Review, record and report every occasion when the number of nurses deployed varies from the planned roster; Ensure mitigating actions are sufficient to maintain a safe service to both service users and staff.
2) Nurse in Charge	<u>Roles and responsibilities as outlined in 1) - In addition:</u> Ensure that staff, bank and agency workers are moved in line with agreed principles;

1) Registered Nurses	Ensure own knowledge of this policy, the Act and the statutory guidance; Raise concerns with manager and on Datix when the nurse staffing levels have not been maintained; Awareness that all staff may be moved to another area to work, in line with their skills and competencies; Assess patient acuity on a daily basis using the Welsh Levels of Care for inclusion in the SafeCare system; Ensure risk assessment completed for patients requiring enhanced levels of care, in line with the policy.

Operational Management Structures
The operational management structure relates to operational posts within the divisions and their responsibilities in line with the Act.

Divisional Management Team	Ensure own knowledge of this policy, the Act and the statutory guidance and that these are applied to decision making for area of responsibility; Ensure budget setting takes account of the biannual staffing calculation requirements of the Act; Ensure that systems are in place to enable any required multi-disciplinary team learning from individual as well as collated nurse-staffing related Datix reports within the service, ensuring trends identified and acted upon; Ensure that Datix findings are an integral part of the governance assurance framework; Ensure that service planning (e.g. those within IMTP) takes account of the requirements set out in the Nurse Staffing Levels (Wales) Act; Ensure efficient and effective vacancy approval processes are in place within the Division/service to minimise delays within recruitment processes and escalate any delays that are outside the control of the operational team; Consideration of the temporary closure of beds and changes to the patient pathway as means through which to maintain nurse staffing levels where required.

On Call Manager	Ensure own knowledge of this policy, the Act and the statutory guidance and applied to decision making out of hours; Ensure all reasonable steps are taken to maintain nurse staffing levels which would include: ➢ supporting the Clinical Site Manager in adjusting the nurse staffing levels to match the patient workload; ➢ redeployment of staff; ➢ changing the workload to match the nurse staffing levels and step down of any surged beds; ➢ utilisation of bank/overtime, additional hours; ➢ approval for additional hours or agency in line with agreed control process Ensure all staffing decisions documented within on call log; Report staffing position risks and mitigation at conference calls and escalate concerns accordingly.

6. CALCULATING THE NURSE STAFFING LEVEL

6.1 Triangulation

A triangulated approach is used for the calculation, utilising qualitative and quantitative information to determine the required nurse staffing level.

The triangulated approach takes account of the following:

Professional judgement

- The qualifications, competencies, skills and experience of the nurses providing care to patients;
- The effect of temporary staff on the nurse staffing level;
- The effect of a nurse's considerations of a patient's cultural needs;
- Conditions of a multi-professional team dynamic;
- The potential impact on nursing care of a ward's physical condition and layout;
- The turnover of patients receiving care and the overall bed occupancy;

- Care provided to patients by other staff or health professionals, such as health care support workers;
- Any requirements set by a regulator to support students and learners;
- The extent to which nurses providing care are required to undertake administrative functions;
- The complexity of the patient's needs in addition to their medical or surgical nursing needs, such as patients with learning disabilities;
- Specific consideration to the provision of care through the medium of Welsh;
- Professional judgement including: ward acuity, specialism and the care hours per patient day, location geography and layout of the ward.

Patient acuity
The social, psychological, spiritual and physical care needs of patients are assessed using the Welsh Levels of Care which can be accessed on the following link: http://www.1000livesplus.wales.nhs.uk/document/320549.

Quality indicators
Consider the quality indicators that are particularly sensitive to care provided by a nurse including:
- Patient falls – any fall that a patient has experienced whilst on the ward;
- Pressure ulcers – total number of hospital acquired pressure ulcers judged to have developed while a patient on the ward;
- Medication errors – any error in the preparation, administration or omission of medication by nursing staff (including medication related never events);
- Complaints – wholly or partially about care provided to patients, by nurses, made in accordance with the complaints regulators.

In addition, other quality indicators that may be deemed appropriate include:
- Patient feedback;
- Unmet care needs;
- Failure to respond to patient deterioration;
- Staff well-being and ability to take annual leave;
- Staff compliance with mandatory training and performance appraisal development reviews.

Other factors which can be considered during the calculation process are outlined within Appendix 5 of the All Wales Operational Guidance. The guidance can be located on the following link:
http://www.1000livesplus.wales.nhs.uk/document/347547

6.2 Frequency of Calculation
The routine bi-annual calculation of the nurse staffing levels should take place around March/April and August/September of each year. The timetable takes account of the All Wales bi-annual capture of acuity data, which occurs in January and June each year.

There may be occasions that require recalculation of the staffing levels outside of the bi-annual timetable. These factors are varied, with examples including:
- Exception reporting by the ward manager;
- High or consistent use of bank and agency workers;

- Prolonged inability to maintain the roster or consistent use of ward manager in the roster;
- Change of patient profile or skill mix/experience of staff;
- Concerns arising from negative patient feedback, complaints, incidents, harm dashboard and safeguarding.

The calculation of the nurse staffing level will be undertaken in partnership by the ward manager, matron, head of nursing/site nursing director and finance lead, with the available information triangulated to agree the proposed nurse staffing level for each ward.

The evidence and rationale used to determine the nurse staffing level must be recorded for each ward, outlining the rationale and the sources of information used to inform the triangulation approach. The All Wales Nurse Staffing Level Workforce Planning template must be used (appendix 2).

Once the Board have approved the bi-annual staffing calculations, the templates within E-Rostering will be updated in line with agreed Workforce and Organisational Development processes. Finance will align the budgets to the agreed staffing levels.

7. MAINTAINING THE NURSE STAFFING LEVEL

The Health Board will ensure all reasonable steps are taken to maintain the planned nurse staffing level on a shift by shift and long term basis.

Divisional teams will ensure effective roster management in line with agreed Roster Policy and robust systems which are in place for scrutiny and performance management of agreed Roster KPIs.

Corporate steps include:

- Workforce planning for a continued supply of required staff assessed using the Welsh Planning System;
- Active recruitment in a timely manner at local, regional, national, and international level;
- Retention strategies that include consideration of the NHS Wales Staff Survey results;
- Well-being at work strategies that support nurses in delivering their roles;
- Ensure strategic requirements of the Act are embedded into the organisation's IMTP/annual planning process;
- Robust workforce planning at ward/service level which are reviewed at least annually through IMTP/education commissioning processes;
- Workforce policies and procedures which support effective staff management (e.g.: flexible working for staff);
- Robust organisational risk management framework.

Operational steps include:

- Changing shifts within existing establishment and cancelling study days, annual leave, administration days;
- Ward manager working the shift as part of planned numbers;

- Creating additional hours in line with agreed Workforce and Organisational Development approval process;
- Looking at the wider multidisciplinary team to provide support;
- Re-allocation of staff across wards/departments/sites;
- In line with agreed approval and booking processes:
    - Use of bank workers;
    - Offering overtime;
    - Use of agency workers.
- Consideration of changes to the patient pathway (which should be clinically appropriate);
- The temporary closure of beds (in line with agreed escalation processes to close beds).

Additional hours created above agreed roster template must have a clear rationale, evidenced by a risk assessment in line with the requirements of the Enhanced Care Policy (October 2019).

8. MONITORING AND RECORDING NURSE STAFFING LEVELS

8.1 SafeCare system

The SafeCare Health Roster module provides an electronic view of staffing and patient acuity, enabling real time staff deployment to ensure safer and more efficient staffing levels. Information about the planned staff on duty is uploaded into the SafeCare module directly from the main Health Roster system. The ward manager, deputy or nurse in charge will identify appropriate levels of care for each patient based on the Welsh Levels of Care.

Commented [BW(-OotBS1]: Change in font

The ward manager, deputy or nurse in charge is responsible for accurately recording the staff on duty and patient acuity in the SafeCare Health Roster system. The data must be submitted at the agreed census period times in order to manage nurse-staffing levels on a shift by shift basis taking into account patient acuity.

When entering details of the staff on duty and the patient acuity, the ward manager, deputy or nurse in charge must review the information within SafeCare to ensure its accuracy.

Professional Judgement Level

When the levels of care have been entered onto the system the ward manager, deputy or nurse in charge must review the shift rating in the system and if applicable enter a professional judgement level against this. Professional judgement levels within the system can be used to identify those shifts where the ward manager, deputy or nurse in charge has assessed and considers that, based on their professional judgement; the rating in the system requires amendment. The ward manager, deputy or nurse in charge is able to add professional judgement reasons to the system to both increase and decrease a shifts rating. The original rating will also be recorded within the system.

Red Flag Events
Red flag events are those occurrences stipulated by NICE (July 2014) which may be an indicator that the quality of care has declined and patients are vulnerable.

Red flag events recommended for recording and reporting through SafeCare are

a) Unplanned omission in providing patient medications;
b) Delay of more than 30 minutes in providing pain relief;
c) Patient vital signs not assessed or recorded as outlined in the care plan;
d) Missed "intentional rounding" - fundamentals of care needs are not met as outlined in the care plan;
e) Less than 2 Registered Nurses (RNs) on a ward during any given shift;
f) Shortfall in Registered Nurses time on any given shift (e.g. 8 hours or 25%, whichever is reached first).

Red flags can be raised and recorded on SafeCare by the nurse in charge. This must include the reason for raising the flag.

The Matron or Clinical Site Manager must also record on SafeCare the action taken to resolve a red flag event, as this is evidence of reasonable steps undertaken to manage staffing where template may be below requirements.

A red flag event requires escalation to Matron or Head of Nursing (in hours) and Clinical Site Manager or Bronze on call (out of hours) for an immediate review of patient safety and the mitigation of risk.

Health Board guidance relating to SafeCare can be accessed on the following link: http://howis.wales.nhs.uk/sitesplus/861/searchresultssql/?q=safecare

8.2 Managing Staffing below Planned Staffing levels
The clinical environment is complex and managing staffing is a dynamic process; the planned roster therefore may be appropriately varied to respond to patients' dependency and acuity across the system. There will be occasions when the professional judgement indicates that it is appropriate to deviate from the planned roster and the rationale for this should be documented within the SafeCare system.

The escalation and documentation process outlined below details triggers, responsibilities and reasonable steps in the event staffing is below the planned roster, however staff should continue to use their professional judgment to interpret and apply the triggers as circumstances determine.

Green: No reported concern or compromise to patient care or safety as staffing hours available are in excess of the shift requirement.

Triggers: Red flags reviewed and mitigated, able to maintain the agreed staffing levels.

Action: Update SafeCare with staffing and acuity details. Add professional judgement and red flags. Ensure SafeCare updated if staff moved to support another area. Continue to monitor to ensure all areas staffed within agreed template and operational guidance.

Grey: staffing hours available are reflective of the shift requirement, with no staffing excess or short of hours according to patient acuity at the time of recording.

Triggers: Increased activity/dependency, unplanned absence, one shift in 24 hours not covered, staffing template maintained however skill mix, competency, qualifications or experience not suitable for care needs.

Action:

- Ensure **Green** action plan and risks identified are completed;
- Document within SafeCare;
- Review and cancel management time, planned TOIL, study leave;
- Redeploy internal staffing resources based on SafeCare;
- Use additional or unused hours, send shifts to bank;
- Escalate to Matron/Clinical Site Manager.

Amber: staffing hours available are 1 – 6 hours below the shift requirement based on the staffing hours and patient acuity recorded. Risk of patient care being compromised, impacting on the patients' required care interventions (medication, observation, input or output), progress, outcomes, or dignity.

Triggers: Multiple shifts not staffed to agreed level but to a level that meets the current patient/acuity or service demand, Shortfall of 25% RN time available for requirement of shift and skill mix is not met.

Action:

- Ensure **Grey** action plan and risks identified completed;
- Escalate to Head of Nursing (Bronze out of hours) and review staffing across service area;
- Ask other care groups to review rotas and workload;
- Review ability to redeploy across wards/departments based on SafeCare including Matrons, specialists nurses and educators;
- Short notice leave cancelled including TOIL and, potentially, annual leave;
- Offer overtime and request Agency authorisation;
- Report shortage and contingency plan at Safety Huddle/operational site meetings;
- Update SafeCare ensuring reasonable steps undertaken to mitigate risks recorded.

Red: Reported concern over the nurse staffing level - staffing hours available are more than 7 hours below the shift requirement, based on the staffing hours and patient acuity recorded.

Triggers: Significant or ongoing shifts not staffed to agreed level; compromised ability to safely meet current acuity, dependencies or complexity; less than 50% RN time; skill mix not met; Inability to de-escalate from high risk (amber) after 24 hrs.

Actions:

- Ensure **Amber** action plan and risks identified completed;
- Escalate to Director of Nursing (Silver on call out of hours);
- Director of Nursing (Silver on call) considers (in line with operational escalation plans);

- Temporary partial bed closure;
- Cancellation of non-urgent electives;
- Cancellation of outpatient activity;
- Cross-organisation response and support;
- Divert options;
- Update SafeCare and report on Datix and feedback outcome to Head of Nursing/Bronze on call;
- Urgent implementation of plan to de-escalate staffing concerns;
- Agree and document plan and timescales for recovery/de-escalation and document;
- Escalate to Deputy Director Nursing/Executive Directors of Nursing and Midwifery (Gold on call out of Hours).

9. TRAINING

The E-Rostering team will provide initial, and any update, training on the use of the SafeCare system. This will include Train the Trainer so that identified ward/department staff can continue training. Training on staffing and acuity is also included within the ward manager/matrons development training programmes and twice yearly by the All Wales Nurse staffing lead

10. MONITORING AND REPORTING

All incidents related to safe staffing, or harms where safe staffing levels was a potential factor, must be escalated through the line management arrangements and reported on Datix, which includes mandatory questions on staffing levels.

Monthly divisional staffing reports include triangulation of nurse sensitive indicators, and quality indicators where staffing has fallen below planned levels, to identify the impact on care of not maintaining the nurse staffing levels (Appendix 3). Staffing reports are presented to Division and Corporate Quality and Safety groups in line with the agreed reporting cycle.

The complaints system includes a series of questions to enable triangulation of staffing information and actions taken, where complaints are wholly or partially attributable to nursing care. On closure of the complaint professional judgement would be used to ascertain if inability to mitigate/maintain staffing levels had an impact on the care provided and the resulting impact and actions taken as a result.

The all Wales Staffing group will be issuing guidance for Health Boards on their reporting requirements under the Act. Non-compliance with the Act are considered under the Joint Escalation and Intervention Arrangements (2014) undertaken twice yearly by the Welsh Government, the Wales Audit Office and the Healthcare Inspectorate Wales.

11. IMPLEMENTATION
Following its approval the policy will be distributed electronically via the Professional Advisory Group, divisional operational teams, bulletin, relevant Health Board policies page and will be listed as an agenda item on all operational/ nursing/ department meetings so that all staff are aware of its existence, content and their personal role responsibilities required to adhere to it. Any training needs identified should be fed back via the service structure and arrangements should be made to meet these needs as quickly as possible to ensure comprehensive and consistent implementation of the policy.

12. INFORMING PATIENTS AND THE PUBLIC
The Health Board will inform patients and the public about planned staffing levels by displaying this information, with the date it was approved, on Staffing Boards which are located at the entrance to each ward/department. Bilingual leaflets and posters for patients and relatives about the Nurse Staffing Levels (Wales) Act are also available.

13. **EQUALITY, WELL-BEING AND THE ENVIRONMENT**
An EqIA has been completed and is included with no anticipated adverse impact.

14. REVIEW
This policy will be reviewed within 2 years, or sooner, following updated All Wales guidance or the extension of the settings covered by the Act by Welsh Ministers.

15. FURTHER INFORMATION
Berwick (2013) *A promise to learn a commitment to act. Improving the Safety of Patients in England*. National Advisory Group on the Safety of Patients in England.

Francis (2013) *Report of the Mid-Staffordshire NHS Foundation Trust Public Enquiry* London. The Stationary Office.

Keogh Review (2013) *into the quality of care and treatment provided by 14 hospital Trusts in England*. NHS England.

National Escalation Process and Action Plans 2014, Welsh Government.

NICE (2014) Safe Staffing for Nursing in Adult Inpatient Wards in Acute Hospitals. NICE.

NMC (2015) The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives.

Welsh Government (2016) Nurse Staffing Levels (Wales) Act.

16. APPENDICES

Appendix 1: **Definition Adult Acute Medical and Surgical Wards**

Adult acute medical inpatient ward	An area where patients aged 18 or over receive active treatment for an acute injury or illness requiring either planned or urgent medical intervention, provided by, or under, the supervision of a consultant physician. Patients are deemed to be receiving **active treatment** if they are undergoing interventions prescribed by the consultant and/or their team, and/or advanced practitioners for their acute injury or illness.
Adult acute surgical inpatient ward	An area where patients aged 18 or over receive active treatment for an acute injury or illness requiring either planned or urgent surgical intervention, provided by, or under, the supervision of a consultant surgeon. Patients are deemed to be receiving **active treatment** if they are undergoing interventions prescribed by the consultant and/or their team, and/or advanced practitioners for their acute injury or illness.

NB: a full glossary is available in the All Wales Nurse Staffing Operational Guide (2016) http://www.1000livesplus.wales.nhs.uk/document/347547

Appendix 2: Nurse Staffing Levels Workforce Planning template

Attached separately

Appendix 3: Triangulation of Patient Harm Incidents Report

Attached separately

Consultation 2019

Name	Title	Date
Jan Garnett	Head Of Nursing, Secondary Care, YGC	May 2019
Eleri Evans	Head Of Nursing, Secondary Care, YG	May 2019
Heather Piggott	Head Of Nursing, Secondary Care, WMH	May 2019
Jo Brown	E-Roster Manager	May /Sept 2019
Debra Hickman	Secondary Care Nurse Director	May/Aug/ Sept 2019
Trevor Hubbard	Executive Deputy Director of Nursing	May/Aug/ Sept 2019
Deborah Carter	Interim Executive Director of Nursing and Midwifery	Sept 2019
Alison Griffiths Mandy Jones Naomi Holder	Nurse Directors, Glan Clwyd Nurse Directors, Ysbyty Gwynedd Nurse Directors, Wrexham	Sept 2019
Chris Lynes Keith Jones Andrea Hughes	Nurse Director, Area West Interim Nurse Director, Area Central Nurse Director, Area East	Sept 2019
Fiona Giraud	Director Midwifery and Women's Services	Sept 2019
Reena Cartmell Amanda Miskell Michelle Denwood Julie Smith	Associate Director of Nursing Assistant Director, Infection Prevention Associate Director Safeguarding Associate Director Quality	Sept 2019
Kath Clarke	Head of Patient Safety Incidents, Corporate Nursing	Sept 2019
Jayne Thomas Martin McSpadden Angie Martin Jo Douglas	Paediatric Service Manager, Central Paediatric and Neonatal Service Manager, East Head of Nursing, Childrens Services, Central Clinical Service Manager Paediatrics And Neonatal, West	Sept 2019
Tracy Regan Davies	Head of HR - Corporate Services And Specialist Advice	Sept 2019
Lawrence Osgood	Associate Director Workforce Performance & Improvement	Sept 2019
Ann McEvoy	Interim Head Of Resourcing	Sept 2019
Professional Advisory Group	Members – various	Oct 2019

Health board / trust		Site		Ward Name		Period Reviewe	from ##################	to ################

Staff Nyrsio Nurse Staffing

Current Roster

24.87 WTE

Headcount per shift			Mon	Tue	Wed	Thu	Fri	Sat	Sun
		Beds							
	Early (LD) Shift Duration	RN							
		HCSW							
	Late Shift Duration	RN							
		HCSW							
	Night (LN) Shift Duration	RN							
		HCSW							

Band 7	1.00	Band 6	2.00	Band 5	13.25	Band 4		Band 3		Band 2	8.62

Ward Shift Types	WTE Planned Roster	+	Uplift	+	Sister / Charge Nurse	Total No. Staff WTE
					Supernumerary	
12 hour shifts	17.18	+	26.9%	+		WTE = 24.87

Proposed Roster (after review)

24.87 WTE

Headcount per shift			Mon	Tue	Wed	Thu	Fri	Sat	Sun
		Beds							
	Early (LD) Shift Duration	RN							
		HCSW							
	Late Shift Duration	RN							
		HCSW							
	Night (LN) Shift Duration	RN							
		HCSW							

Band 7	1.00	Band 6	2.00	Band 5	13.25	Band 4		Band 3		Band 2	8.62

Required Establishment
(Variance from current)

	WTE Planned Roster	+	Uplift	+	Sister / Charge Nurse	Total No. Staff WTE
					Supernumerary	
RN 0.00 WTE	17.18	+	26.9%	+	1WTE	= 24.87
0.00 WTE HCSW 0.00 WTE						

RED values show the calculated increase in the WTE establishment required to comply with the **Nurse Staffing Levels (Wales) Act 2016**, based on the Act defined triangulated approach.

Acuity & Dependancy (e.g. Welsh Levels of Care)

Professional Judgement

Quality Indicators

Outcome Summary

Person(s) informing the calculation	Ward Sister / Charge Nurse		Senior Nurse / Matron		Divisional Nurse / Head of Nursing	
Authorising person	Designated Person (e.g. Exceutive Director of Nursing)		Date Calculation made by person(s) informing the calculation	Friday, February 1, 2019	Date Presented to Board	Friday, February 1, 2019
					Date to be reviewed (latest date)	Thursday, August 1, 2019

Nurse Staffing Levels (Wales) Operational Guideance. Refer to Appendix 5: Factors which must be considered during the calculation process

This template states the minimum dataset / information that is required and has been agreed nationally

Acuity Visualiser

Site reporting template

Site	
Directorate	
Reporting period	

Number of adult acute medical inpatient wards where section 25B applies	
Number of adult acute surgical inpatient wards where section 25B applies	
Number of occasions where nurse staffing level was recalculated within the reporting month	
Confirmation that ward boards are displaying the correct planned staffing information	

Section 25E (2a) Extent to which the nurse staffing levels are maintained

	Medicine	Surgery
Number of occasions the planned nurse staffing level has not been maintained and the risk has not been safely mitigated		
Did this shortfall directly relate to any patient incident?		
If yes, has a datix been completed?		

Section 25E (2b) Impact on care of not maintaining the

Patient harm incidents (i.e. nurse - sensitive Serious Incidents / Complaints)	Total number of closed serious incidents / complaints during last reporting period	Total number of closed serious incidents / complaints during current reporting period
Hospital acquired pressure damage (grade 3, 4 and unstageable)		
Falls resultng in serious harm or death (i.e. level 4 and 5 incidents)		

Medication related never events		
Complaints about nursing care resulting in patient harm		

Action taken	
Next Steps	

ED	Women's	Total

nurse staffing levels

Increase (decrease) in number of closed serious incidents / complaints between reporting periods	Number of serious incidents / complaints where failure to maintain the nurse staffing level was considered to have been a factor

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

IT FORMS

PARTS A (Screening – Forms 1-4) and

B (Key Findings and Actions – Form 5)

For:	Nurse Staffing Levels Policy
Date form completed:	25.10.19

PARTS A: SCREENING and B:

KEY FINDINGS AND ACTIONS

Introduction:

These forms have been designed to enable you to record, and provide evidence of how you have considered the needs of all people (including service users, their carers and our staff) who may be affected by what you are writing or proposing, whether this is:

- a policy, protocol, guideline or other written control document;
- a strategy or other planning document e.g. your annual operating plan;
- any change to the way we deliver services e.g. a service review;
- a decision that is related to any of the above e.g. commissioning a new service or decommissioning an existing service.

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

Assessing Impact

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

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

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

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

Part A Form 1: Preparation

1.	What are you assessing i.e. what is the title of the document you are writing or the service review you are undertaking?	Nurse Staffing Levels Policy
2.	Provide a brief description, including the aims and objectives of what you are assessing.	The Nurse Staffing Levels Policy approved in 2018 by Professional Advisory Group has been updated to take account of the following • Nurse Staffing levels (Wales) 2016 Operational Guidance updated in April 2019 • Recommendations following the BCUHB Internal Audit of Corporate Legislative Compliance - Nurse Staffing Levels (Wales) Act 2016 in April 2019
3.	Who is responsible for whatever you are assessing – i.e. who has the authority to agree or approve any changes you identify are necessary?	Executive Director of Nursing and Midwifery as the 'designated person' under the Nurse Staffing levels (Wales) Act
4.	Is the Policy related to, or influenced by, other Policies or areas of work?	Nurse Staffing Levels Wales Act (2016) Statutory Guidance Welsh Government; Nurse Staffing Levels (Wales) Act 2016; Welsh Levels of care (Edition 1); Health Care Monitoring System (HCMS) How to Guide; NICE publication 'Safe staffing for nursing in adult inpatient wards in acute hospitals' (2014); OP01 BCUHB protocol for the Management of Emergency pressures and escalation (2015); GC04 BCUHB Operational Scheme of Delegation; Health System Escalation and De-Escalation Policy for Glan Clwyd Hospital West Procedure for Bed Escalation Capacity (Ysbyty Gwynedd & Community Hospitals); Wrexham Maelor Hospital Escalation Policy;
5.	Who are the key Stakeholders i.e. who will be affected by your document or proposals? Has a plan for engagement been agreed?	Employees, the Board, patients and service users.

Part A Form 1: Preparation

6.	What might help or hinder the success of whatever you are doing, for example communication, training etc.?	Communication and training will help in the implementation of the policy. Communication would be via existing management structures and the internal bulletin. Training would be via divisions and corporate teams.
7.	Think about and capture the positive aspects of your policy that help to promote and advance equality by reducing inequality or disadvantage.	The policy will help ensure improved outcomes for service users by putting in place a framework to support appropriate staffing for high quality care. Provision of high quality care requires the right people, in the right place, with the right skills at the right time to ensure the best health and care outcomes for service users. The policy will also support and empower staff decision making in relating to staffing decisions in line with the requirements of the Nurse Staffing Levels (Wales) Act.

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

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

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

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

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

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

Part A

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

Protected characteristic or group	Will people in each of these protected characteristic groups be impacted by what is being proposed? If so is it positive or negative? (tick appropriate below)				Reasons for your decision (including evidence that has led you to decide this) A good starting point is the EHRC publication: "Is Wales Fairer (2018)?" You can also visit their website here	How will you reduce or remove any negative Impacts that you have identified?
	Yes	No	(+ve)	(-ve)		
Age (e.g. think about different age groups)	√		√		Promote a safe working environment for staff. For patients staffing decisions take account of acuity and dependency of patients which may or may not be age related, staffing policy will support quality of care and meeting each person's needs.	
Disability (think about different types of impairment and health conditions:- i.e. physical, mental health, sensory loss, Cancer, HIV)	√		√		People with a disability will be affected positively if staffing levels increase. For staff, reasonable adjustment in the workplace would apply in line with Guidance (WP27 and Managing Attendance at Work Policy). The complexity of patient needs, including disability would be identified as part of the triangulation approach of acuity assessment, professional judgment and local context	
Gender Reassignment (sometimes		√			Staffing policy applicable regardless of gender of staff or patients.	

referred to as 'Gender Identity' or transgender)						
Pregnancy and maternity	√		√		Pregnant women or those with caring responsibilities would be eligible to submit requests for flexible working if the policy impacted on personal circumstances. The complexity of the caring needs of pregnant women would be identified as part of the triangulation approach of acuity assessment, professional judgment and local context.	
Race (include different ethnic minorities, Gypsies and Travellers) Consider how refugees and asylum-seekers may be affected.	√		√		Cultural needs would be identified as part of the holistic assessment of care, triangulated with acuity and professional judgement.	
Religion, belief and non-belief	√		√		Religions, belief or non-belief would be assessed as part of the triangulation approach to calculating staffing requirements.	
Sex (men and women)	√		√		Higher proportion of the nursing and midwifery workforce are female, the policy would promote a safe working	

					environment for staff, positive impact if staffing levels increase.	
Sexual orientation (Lesbian, Gay and Bisexual)		√			Not anticipated would impact on sexual orientation.	
Marriage and civil Partnership (Marital status)		√			Not anticipated would impact on marriage or civil partnership.	
Low-income households		√			Not anticipated would influence low-income households. Staffing requests would be submitted in line with health board roster and flexible working policy.	

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

Human Rights:

Do you think that this policy will have a positive or negative impact on people's human rights? For more information on Human Rights, see our intranet pages at: http://howis.wales.nhs.uk/sitesplus/861/page/42166

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

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

Will people's Human Rights be impacted by what is being proposed? If so is it positive or negative? (tick as appropriate below)				**Which Human Rights do you think are potentially affected**	**Reasons for your decision (including evidence that has led you to decide this)**	**How will you reduce or remove any negative Impacts that you have identified?**
Yes	**No**	**(+ve)**	**(-ve)**			
√		√		Article 3 - Prohibition of inhuman or degrading treatment Article 8 - Right to respect for family & private life	The policy would support improved outcomes for service users by putting in place a framework to support appropriate staffing for high quality care.	

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

Welsh Language:

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

Welsh Language	Will people be impacted by what is being proposed? If so is it positive or negative? (tick appropriate below)				Reasons for your decision (including evidence that has led you to decide this)	How will you reduce or remove any negative Impacts that you have identified?
	Yes	No	(+ve)	(-ve)		
Opportunities for persons to use the Welsh language	√		√		Uniforms display Welsh Language Speaker logo for those that are able to converse with patients and colleagues in Welsh.	
Treating the Welsh language no less favourably than the English language	√		√		Information for patients relating to the Nurse Staffing Act will be bilingual in line with Health Board policy.	

Part A Form 4: Record of Engagement and Consultation

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

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

What steps have you taken to engage and consult with people who share protected characteristics and how have you done this? Consider engagement and participatory methods.	Circulated draft policy widely within BCUHB. Met with Secondary Care Heads of Nursing to ascertain how policy used in practice. Agenda item on Professional Advisory Group and Nurse Staffing and Efficiency Group.
Have any themes emerged? Describe them here.	Not in relation to proposed updated policy. 2018 draft policy following themes emerged - Too lengthy & repetitive; - Roles or systems not applicable to BCUHB; - Too many appendices, not applicable to or used in practice; - Some terminology within not a requirement of the Act.
If yes to above, how have their views influenced your work/guided your policy/proposal, or changed your recommendations?	Themes have been amended within updated version (2019).

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

Part B Form 5: Summary of Key Findings and Actions

1. What has been assessed? (Copy from Form 1)	Nurse Staffing Levels Policy

2. Brief Aims and Objectives: (Copy from Form 1)	The Nurse Staffing Levels Policy developed in 2018 has been updated to take account of the following: • Nurse Staffing levels (Wales) 2016 Operational Guidance updated in April 2019; • Recommendations following the BCUHB Internal Audit of Corporate Legislative Compliance - Nurse Staffing Levels (Wales) Act 2016 in April 2019.

From your assessment findings (Forms 2 and 3):

3a. Could any of the protected groups be negatively affected by your policy or proposal?	Yes	No √
3b. Could the impact of your policy or proposal be discriminatory under equality legislation?	Yes	No √
3c. Is your policy or proposal of high significance? For example, does it mean changes across the whole population or Health Board, or only small numbers in one particular area?	Yes √	No

Part B Form 5: Summary of Key Findings and Actions

4. Did your assessment findings on Forms 2 & 3, coupled with your answers to the 3 questions above indicate that you need to proceed to a Full Impact Assessment?	Yes	No √
	Record here the reason(s) for your decision i.e. what did Forms 2 & 3 indicate in terms of positive and negative impact for each characteristic, Human Rights and Welsh Language? The EqIA has not identified an adverse impact. The policy will have a positive impact as the provision of appropriate staffing will help ensure quality of care across settings, meeting each person's needs. It will also promote a safe working environment for staff and ensure staffing decisions take account of contextual factors. The policy is intended to apply equally to those affected by its provisions, however acknowledges that everyone is different	
5. If you answered 'no' above, are there any issues to be addressed e.g. reducing any identified minor negative impact?	Yes	√
	Record Details: No anticipated negative impact, the policy provides definition of responsibilities, escalation, monitoring and reporting requirements.	
6. Are monitoring arrangements in place so that you can measure what actually happens after you implement your policy or proposal?	Yes √	No
	How is it being monitored?	SafeCare system, E Rostering, Harms Dashboard, Staffing reports, secondary care submit monthly report and quarterly report re staffing levels Act to the Board
	Who is responsible?	Site and Area Directors of Nursing with escalation accordingly as outlined within the Policy
	What information is being used?	Staffing information, Datix, Complaints, Incidents

Part B Form 5: Summary of Key Findings and Actions

	When will the EqIA be reviewed? (Usually the same date the policy is reviewed)	2 years

7. Where will your policy or proposal be forwarded for approval?	Quality, Safety and Experience Committee

8. Names of all parties involved in undertaking this Equality Impact Assessment – **please note EqIA should be undertaken as a group activity**	Name	Title/Role
	Anne-Marie Rowlands	Associate Director Professional Regulation & Education
	Comments sought from	Debra Hickman, Secondary Care Nurse Director; Julie Smith, Associate Director Quality; Alison Griffiths, Nurse Director; Mandy Jones, Nurse Director; Naomi Holder, Nurse Director; Fiona Giraud, Director of Midwifery and Womens Services
Senior sign off prior to committee approval:	Advise Sought from	Mike Townson, Senior Equalities Manager
Please Note: The Action Plan below forms an integral part of this Outcome Report		

Part B Form 5: Summary of Key Findings and Actions

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	N/A	N/A
2. What changes are you proposing to make to your policy or proposal as a result of the EqIA?	N/A	N/A	N/A
3a. Where negative impacts on certain groups have been identified, what actions are you taking or are proposed to reduce these impacts? Are these already in place?	N/A	N/A	N/A
3b. Where negative impacts on certain groups have been identified, and you are proceeding without reducing them, describe here why you believe this is justified.	N/A	N/A	N/A

Part B Form 5: Summary of Key Findings and Actions

	Proposed Actions	Who is responsible for this action?	When will this be done by?
4. Provide details of any actions taken or planned to advance equality of opportunity as a result of this assessment.	N/A	N/A	N/A

Cyfarfod a dyddiad: **Meeting and date:**	Quality, Safety & Experience (QSE) Committee 28th January 2020
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Draft Clinical Audit Policy & Procedure v1.15
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Dr David Fearnley Executive Medical Director
Awdur yr Adroddiad **Report Author:**	Dr Melanie Maxwell Senior Associate Medical Director/Improvement Cymru Clinical Lead
Craffu blaenorol: **Prior Scrutiny:**	Previous drafts have been shared with the participants in a BCU wide development workshop, Divisional Quality & Safety Groups; Corporate Quality and Safety Group, the Audit Committee and Workshop, the Joint Audit and QSE Committees, and discussion with the Executive Lead for Primary and Community Care.
Atodiadau **Appendices:**	Appendix 1 – the draft policy Appendix 2 - draft EQIA

Argymhelliad / Recommendation:

The Committee is asked to approve the draft policy and procedure document.

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

Sefyllfa / Situation:

There has not been a specific audit policy & procedure in place that describes the expectations of the Board with regards to delivering audit that supports planning for improvement in service quality and provides robust assurance that the implemented changes are delivering better outcomes.

This draft policy once implemented will start move audit in a way that supports the clinical strategy and work on improving clinical pathways; it will need reviewing and further amendment as these strategic plans mature and the new governance structures are agreed and implemented.

Appendix (i) within the policy document portrays the current governance arrangements and will be updated as soon as the new governance structure is agreed.

Cefndir / Background:

This policy aims to support a culture of best practice in the management and delivery of clinical audit. The purpose of this policy is to set out the rationale for clinical audit and provide a framework for such activity, including standards, guidance and procedures.

This policy has been developed from a workshop with representation from services across BCUHB, enhanced by discussion from the groups listed above.

Asesiad / Assessment

Strategy Implications
The policy describes the prioritization of audits encompassing the Welsh Government mandated audits (Tier 1), local priority audits based on BCUHB priorities and risks (Tier 2). It supports the delivery of best practice and high quality services – prudent healthcare.

Financial Implications
There is shortfall in the corporate Clinical Audit department - a business case will be developed. There needs to be adequate time within job plans to undertake audit and improvement work – this is inconsistent at present for all professional groups and has not yet been quantified. There is a paucity of electronic support - data capture or action plan monitoring. Options will need to be explored and a business case made.

Risk Analysis
The policy will require an implementation plan to ensure ownership and leadership at all levels

Legal and Compliance
The expectation is to develop a quarterly monitoring report that builds to an annual report on activity providing evidence of a robust process and changes in practice to improve patients care. Implementation will deliver the mandatory requirements as set out by the Welsh Government annually.

Impact Assessment
The Equality Impact Assessment has been amended following discussion with the Head of Equality and Human Rights and is attached at Appendix 2.

Version & Reference Number

Clinical Audit Policy & Procedure (DRAFT)

Author & Title	Clinical Audit Policy. Trevor Smith (Head of Clinical Audit and Effectiveness). Dr Melanie Maxwell Senior Associate Medical Director
Responsible dept / director:	Office of the Medical Director. Dr David Fearnley Executive Medical Director
Approved by:	Quality, Safety and Patient Experience Committee
Date approved:	
Date activated (live):	
Documents to be read alongside this document:	BCUHB Quality Improvement Strategy (2017-2020).
Date of next review:	
Date EqIA completed:	

First operational:					
Previously reviewed:					
Changes made yes/no:					

N.B. Staff should be discouraged from printing this document. This is to avoid the risk of out of date printed versions of the document. The Intranet should be referred to for the current version of the document`

1.0 Introduction / Overview:

1.1 Clinical Audit:

Clinical audit is a multi-professional, multidisciplinary activity.

"Audit is not concerned primarily with fault or discrepancy finding, but with the examination of working practice to improve effectiveness". Dickens (1994)

Figure 1 The Clinical Audit Cycle

"*Clinical audit is a quality improvement cycle that involves measurement of the effectiveness of healthcare against agreed and proven standards for high quality, and taking action to bring practice in line with these standards so as to improve the quality of care and health outcomes.*"

New Principles of Best Practice in Clinical Audit (HQIP, January 2011).

Within the Health Board clinical audit is embedded within the future direction of improvement activity. Audit is a tool within the quality framework, identifying and prioritising improvement activities (Quality Planning) and providing assurance about service quality (Quality Control):

Figure 2: Quality Cycle: based on Juran and Godfrey (1999).

2.0 Policy Statement

This policy is applicable across all services participating in clinical audit within the Health Board. It sets out the expectations of the Health Board with respect to audit planning, multidisciplinary participation, and acting on the audit findings to maximize its effectiveness.

Clinical audit planning prioritises externally mandated requirements (as documented in the annual *National Clinical Audit and Outcome Review Plan* from Welsh Government), as well as local priorities in line with the Health Board's strategic objectives and risks.
Services should consider audits that provide information and/or assurance relating to key risks and strategies, such as the quality improvement strategy, and other service improvement activity relevant to the Health Board's priorities using the agreed tier structure (see section 8.1).

3.0 Aims / Purpose

This policy aims to support a culture of best practice in the management and delivery of clinical audit.
The purpose of this policy is to set out the rationale for clinical audit and provide a framework for such activity, including standards, guidance and procedures.

4.0 Objectives

This policy outlines processes in relation to clinical audit activity within BCUHB. It will reinforce its role within the quality framework in delivering quality improvement and quality control.

This includes:

- Topic selection based upon priorities (national and local).
- Local governance arrangements
- Clinical audit and effectiveness training
- Patient and carer involvement
- Roles and responsibilities
- Assurance about the effectiveness of services in relation to best practice

5.0 Scope.

This policy relates to all BCUHB staff (including students and volunteers) and partner organisations participating in clinical audit activity within BCUHB; either by professional requirement, individual interest or relevance to a specific pathway / care group. This policy is also applicable when BCUHB is working in partnership with other health and social care partners. Where BCUHB commissions activity externally, quality assurance including participation in audit, is included within the contractual arrangements.

6.0 Roles and Responsibilities

6.1 Chief Executive Officer (CEO).

The Chief Executive Officer has overall responsibility in relation to the statutory duty for quality within the organisation and for participation in the mandatory requirements for clinical audit participation, as set out within the Welsh Government's *National Clinical Audit and Outcome Review Plan (NCAORP).*

6.2 Executive Medical Director.

The Executive Medical Director is the Executive lead for clinical audit and effectiveness activity; ensuring that the BCUHB audit plan aligns with mandatory requirements, organisational priorities and is supported across all clinical services including primary, community and secondary care. The Clinical Audit and Effectiveness Department is located within the Office of the Medical Director.

6.3 Professional Leadership Roles.

This group includes other clinical executives, medical directors, nursing directors and other clinical leaders, including clinical audit leads where they exist. Staff in these roles will support the implementation of this policy for services that fall within their remit and sphere of influence.

6.4 Lead Auditors.

Lead auditors are responsible for individual audits. They will ensure the clinical audit cycle is completed in line with their service's clinical audit annual plan. This will include data collection, discussion of the findings and development and delivery of the action plan to improve care. It is their responsibility to escalate any delays or concerns through the service's governance framework.

6.6 Other Staff.

All staff have a duty to ensure they are providing effective care to deliver best outcomes for patients. Participation in relevant clinical audit to enable benchmarking against key standards, supporting the development of subsequent action plans and undertaking quality improvement activity is expected.

6.7 Clinical Audit and Effectiveness Department.

The department's role is managing the audit process. This includes working with services to develop the annual clinical audit plan, maintaining a central repository of audit activity, monitoring the timely implementation of the plan and delivering assurance reports to relevant governance groups culminating in an annual clinical audit report.

The department will provide proportionate support to BCUHB staff for all stages of the clinical audit cycle; priority is given to the mandatory audits (national or local).

The department delivers ad hoc audit and effectiveness training (see section 11).

7.0 Groups / Committees

The following Groups / Committees have a role in ensuring that clinical audit activity within their remit is optimised in terms of improvement potential and assurance. This will include approval, reporting and monitoring as relevant to each group's terms of reference. (See Appendix (i) – governance structure)

7.1 Audit Committee

The Audit Committee is the approving committee for the annual plan (national and locally prioritised audits). It will seek assurance on the overall plan, its fitness for purpose and its delivery. The role of the Audit Committee includes seeking assurance on:

- Does the organisation have a plan - and is it fit for purpose?
- Is it completed on time?
- Does it cover all relevant issues?
- Is it making a difference and leading to demonstrable change?
- Is change supported by recognised improvement methodologies?
- Does the organisation support clinical audit effectively?

7.2 Quality, Safety and Experience Committee (QSE)

The Quality, Safety and Experience Committee requires more detailed assurance that clinical audit is supporting the delivery of effective health care. It requires assurance that clinical audit is used to identify areas for improvement and subsequent actions deliver better outcomes for patients.

QSE will receive the clinical audit annual plan and recommend its adoption to the Audit Committee. It will be the approving committee for the Clinical Audit Policy and Procedure.

7.3 Joint Audit & Quality Committee

This committee meets annually. It includes all members of the Quality, Safety and Experience Committee and Audit Committee. Its purpose is to jointly review the effectiveness of clinical audit and receive the annual audit report.

7.4 Quality and Safety Groups

At each level of service e.g. Corporate/Divisional/ Site there are quality and safety groups. These groups ensure there is an effective audit function, supporting quality planning and assurance. Risks identified through the clinical audit process and outcome will be considered, mitigated and/or escalated from sites and divisions to the corporate group as appropriate.

7.5 Clinical Effectiveness and Audit sub Group (CEAsG).

CEAsG provides a forum where clinical audit and service evaluation is discussed as a standard agenda item. In relation to clinical audit, CEAsG receives exception reporting from a number of effectiveness-related groups including the Clinical Improvement and Audit Groups or equivalent Quality and Safety Groups. This group will reports to the corporate Quality & Safety Group.

8.0 Registration of audits:

All clinical audit activity within the Health Board should be prioritised to ensure it aligns with strategic or operational priorities as outlined in the service or corporate annual clinical audit plan.

All local clinical audit projects conducted within the Health Board must be approved prior to registration, either by the relevant Quality & Safety Group or Clinical Lead, in advance of registration with the CA&E department.

There is a clearly defined application procedure for registration, which involves the following steps:

8.1 Registration Tiers within BCUHB.

Tier 1: National "must do" audits. These clinical audits are mandated by Welsh Government or other regulatory bodies such as *Medicines & Healthcare products Regulatory Agency* (MHRA). Local available resources are prioritized to support these audits. Nationally mandated audits require the completion of the assurance proforma to be returned to Welsh Government within 4 weeks. This documents the actions being taken to address the audit report findings.
NB: All National Clinical Audit and Outcome Review Plan (NCAORP) projects must be incorporated within relevant Divisional/Directorate annual clinical audit plans.

Tier 2: Local priority audits: These 'local must do' audits support delivery of the Quality Improvement Strategy goals and priorities, including accreditation requirements specific to the service, NICE guidance compliance, safety audits, audit related to high risk activity and corporately agreed service improvement priorities. These audits will take priority over completing tier 3 audits.
NB: All Corporate projects agreed at BCUHB Quality & Safety Group as priorities must be incorporated within relevant Division/Directorate annual clinical audit plans.

Tier 3: Local audits. This activity relates to those audits that have been agreed by the Division/Directorate to be included within their local, annual forward plan for clinical audit activity (see section 8.3 below). These should be risk based. All Tier 3 projects must:

- be approved by their Divisional/Directorate or Primary Care Lead.
  NB: These should not be approved unless there is local capacity and completion will not detract from completing Tier 1& 2 audits, including the associated improvement work.
- be registered with the Clinical Audit & Effectiveness Department (registration form accessed through intranet site via link:
  http://howis.wales.nhs.uk/sitesplus/861/page/45363
- provide a blank copy of the data collection pro-forma / spreadsheet.
- have a registration form signed by the clinical lead or their clinical supervisor and the Divisional/Directorate Clinical Audit Lead or Primary Care Lead.

NB: It is recognised that tier 3 audits may be undertaken as part of education and/or training, to learn the methodology. However, they should still be subject to completion of the audit cycle.

Quality improvement projects may use audit as a tool for measurement; however, they fall outside the scope of this policy. Quality improvement projects should be registered on the quality improvement hub (https://www.bcuqi.cymru)

8.2 Clinical Audit and Effectiveness Department Registration Database

All approved projects are allocated a unique ID number. A database is held within the Clinical Audit and Effectiveness Department, storing all Health Board registered clinical audits/ service evaluations. This facilitates audit activity reporting, identifies potential re-audits and provides evidence to support reviews and Health Board-wide comparison of findings. It enables quality planning and identification of quality improvement projects to support reliable care.

8.3 Annual Divisional / Directorate Clinical Audit Plan

An annual clinical audit plan will be agreed within each Division/Directorate including Primary Care and Community Services by the end of January. Early allocation of suitable lead auditors and the resources including clinicians' time required to complete the audit will optimise completion of the plan.

A systematic approach which enables the multidisciplinary team to prioritise and agree upon topics for inclusion is recommended with domains including:

- ***Frequency*** ('how often' or 'how many'?)
- ***Degree of risk*** (likelihood of something going wrong or not being done).
- ***Level of concern*** (how important is the question?)
- ***Outcome*** (what is the impact in relation to potential for improvement/harm?)

(Welsh Assembly Government, 2003)

8.4 Corporate Clinical Audit Annual Plan

The corporate clinical audit annual plan will be agreed by the end of February each year.
This will include all identified tier 1 and tier 2 audits.
Tier 1 audits will capture in-year data collection and/ or review of report and action planning. Some audit reports will be an analysis of historic data, usually from the previous year.
Tier 2 audits will be based on audits identified by the Clinical Executive Leads as well as Divisional Management teams in line with section 8.1 above.

8.5 Clinical Audit and Effectiveness Department Support

The Clinical Audit and Effectiveness Department is resourced to support Tier 1 and Tier 2 activity. Tier 1 activity will be prioritised.
Clinical Audit and Effectiveness (CA&E) staff will meet with lead auditor(s) to assess the level of support they require and to:

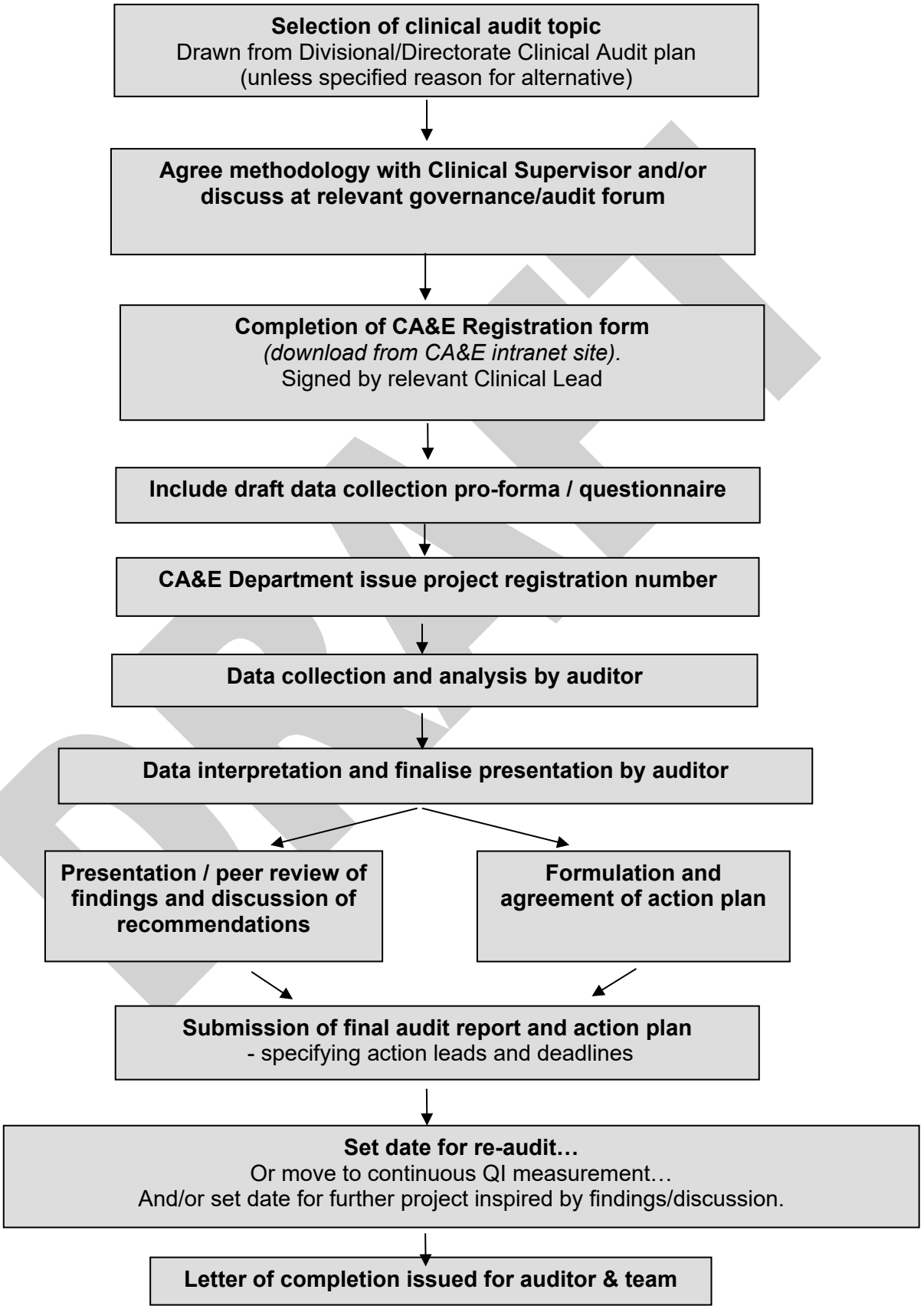
- Identify potential for patient participation/involvement.
- Identify potential for multidisciplinary participation/involvement.
- Agree the proposed methodology.
- Assist/advise with identification of evidence-base/critical appraisal.
- Assist with construction of clear and measurable audit standards.
- Agree data collection pro-forma/questionnaire format.
- Confirm local management support.
- Confirm the appropriate Divisional/Directorate clinical lead is aware of the project.
- Agree project timescales (including planned presentation date).
- Ensure Welsh Government assurance proformas are completed in a timely manner.

8.6 Assurance Reporting

The Clinical Audit and Effectiveness department will produce quarterly annual plan monitoring reports to the Quality, Safety & Experience Committee. These reports will be cumulative, building to an annual report that will be received by the Joint Audit & Quality Committee in November each year. The report will document progress against the plan and highlight key service improvements related to clinical audit activity.

PROCEDURE

Figure 1: **Algorithm displaying clinical audit registration and progression.**



9.0 Developing a Clinical Audit Project

The process for clinical audit project development, registration and progression are displayed in algorithm format above.

9.1 Selection of topic

The Divisional / Directorate Annual Clinical Audit plan identifies the topics for Supervisors advising their trainees, juniors and other colleagues. Staff contacting Clinical Audit and Effectiveness department for advice will also be directed to these plans and the relevant Clinical Lead for their clinical area.

9.2 Multidisciplinary audit

Clinical Leads and lead auditors will assess all audits in relation to their potential for multidisciplinary and multi-professional involvement. Consultation with all relevant staff groups will occur. Where applicable, the lead auditor will be advised to invite participation from colleagues representing other professionals appropriate to the topic and also consider Managed Clinical Services colleagues such as Radiology and Pathology.

Multidisciplinary audit refers to a clinical audit team composed of representatives from at least two different disciplines (ideally those associated with the episode of care being audited).

9.3 Patient and Public Involvement

In planning each audit the potential for service user, carer and/or public involvement should be assessed and promoted. This may involve communication with appropriate forums relevant to the topic and/or the service to achieve this. This would range from gaining feedback regarding the proposed audit pro-forma/questionnaire to direct involvement where possible with other stages of the audit, guided by the relevant Information Governance considerations.

9.4 Presentation / dissemination / feedback

All lead auditors will feedback their findings to the relevant service forum, where peer review will confirm that the findings are clinically robust. In addition, findings will be shared as widely amongst the Health Board as appropriate to the topic.
Auditors will agree, in discussion with their Clinical Lead, the appropriate venue for PowerPoint style presentation (see Appendix ii - template) and efficacy of utilising other media options (poster, circulation of brief written report, intranet, etc.).

9.5 Action planning

Where recommendations are made as a result of the audit, an action plan must be developed following consultation with the relevant staff (ideally at a service forum). Peer review will ensure that findings are disseminated and ascertain whether the recommendations are robust. The action plan must be specific, objective, set within measurable timescales and accountable in relation to who is responsible for each action. (See appendix iii - action plan template). Tier 1 audits require the completion of the assurance proforma (Part A&B) within 4 weeks of the report release; this documents the actions being taken in response to the audit findings nationally and locally.

9.6 Submission of Clinical Audit Report

On completion of the audit, the lead auditor is required to provide the Clinical Audit and Effectiveness department with a copy of the final report and action plan (see Appendix iv – report template).

9.7 Re-audit

Re-audit is not always necessary. For example, if no improvement needs have been identified or there is an alternative methodology to ensure improvement. In the latter case, it is important that all recommendations are tracked and monitored through the appropriate committee. Where assurance is required through audit, this needs to be included within a future clinical audit annual plan.

9.8 Letter of Completion for Project Lead

On receipt of the final report, the lead auditor/team (who demonstrate direct contribution) will be issued with a letter confirming their participation by the Clinical Audit and Effectiveness department. This letter will include additional bullet points as evidence is provided, such as:

- Presentation/dissemination/Peer Review of findings.
- Agreement of recommendations/action plan.
- Implementation of intervention.
- Re-audit (or clearly scheduled date and allocation of new lead).
- Clear link to another related project topic (audit, service evaluation, research).

9.9 Assurance

The Clinical Audit and Effectiveness department will be responsible for:

- Collating the annual corporate clinical audit plan each new financial year,
- Providing the Quality, Safety and Experience Committee with cumulative quarterly reports leading to an annual report that monitors progress against the plan.
- Providing JAQS with an annual report against plan.

10.0 Equality, including Welsh Language

Betsi Cadwaladr University Health Board is committed to advancing equality and protecting and promoting the rights of everybody to achieve better outcomes for all. The legislative framework requires us to promote equality in everything that we do.

Clinical audit activity should be undertaken with regard to equality and inclusion and opportunities to advance equality optimised. The process for determining choice of clinical audit projects, and identifying service user samples, must be inclusive and representative of the total population and where relevant consider protected characteristics of: age, disability, gender reassignment, race, religion/belief, gender, sexual orientation, marriage/civil partnership, pregnancy/maternity.

An Equality Impact Assessment (EqIA) for this polcy has been completed.

11.0 Training

All staff participating in clinical audit activity should have a good understanding of this methodology.
There is an 'e' learning '*Introduction to Clinical Audit'* training session which is accessible through the BCUHB intranet site:
http://howis.wales.nhs.uk/sitesplus/861/page/59825

In addition, the Clinical Audit & Effectiveness department will respond to requests to provide face to face sessions for teams where this can be delivered within capacity.

12.0 Review

The Clinical Audit Policy, as a new policy will be reviewed in one year's time and then on a three year cycle.

13.0 References

DICKENS, P. (1994). In: Welsh Assembly Government. (2003). *An introduction to clinical audit.* Wales

Healthcare Quality Improvement Partnership (HQIP). (2011). *New Principles of Best Practice in Clinical Audit.*

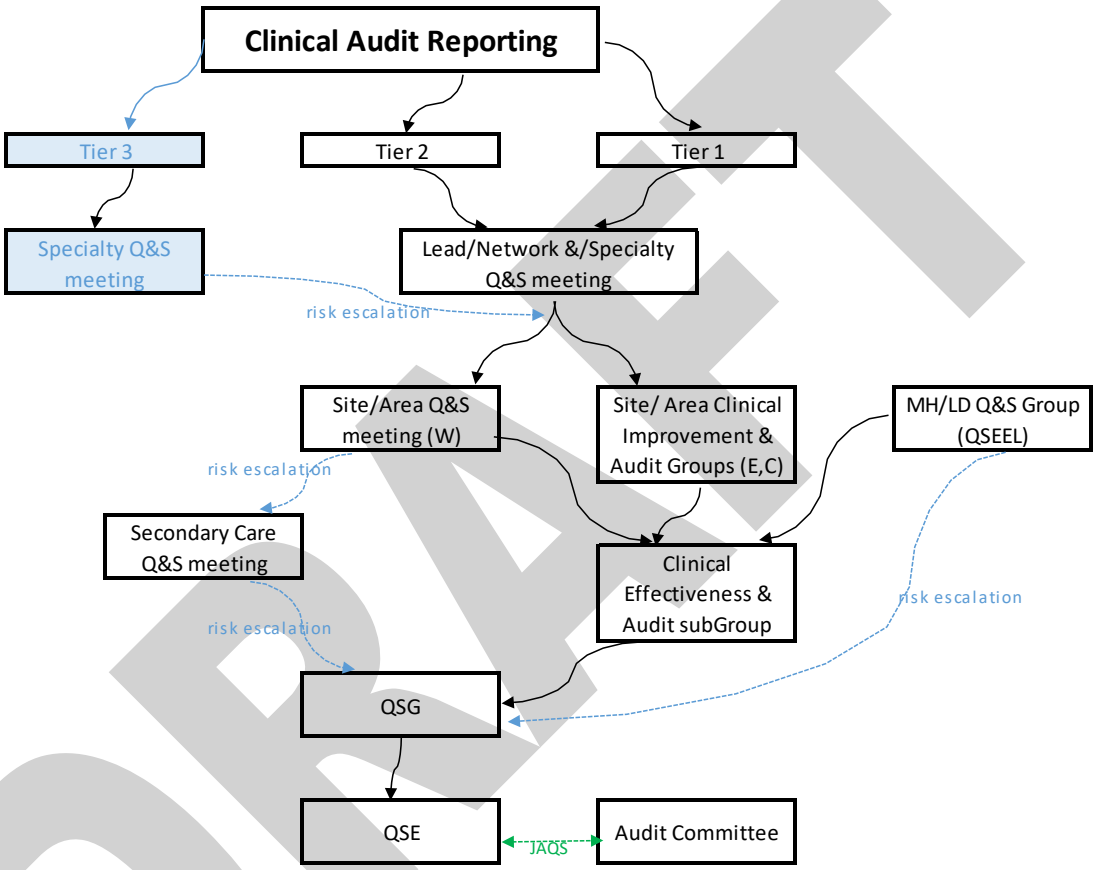
JURAN, J.M., GODFREY, A.B. (eds). (1999). *Juran's Quality Handbook.* 5th Edition. New York: McGraw Hill.

Welsh Assembly Government. (2003). *An Introduction to Clinical Audit*. Wales.

14.0 Appendices

Appendix i: Governance

NB: Quality governance structures are currently under review and this will be amended once agreed.



Appendix ii: Template for PowerPoint presentation slides.
Here you will see suggested slide headings which contain guidance notes to advise on what to include within each section.

Using PowerPoint to present your findings

Title of Audit……

Project lead / team

Service / Specialty

Date of presentation

Name of forum

Introduction / Background

Set the scene…..

- Outline why you conducted it and provide enough background information regarding the setting and history of the unit/team.
- State which guidelines/standards/research you selected to measure practice against?
- Explain treatment/care pathway (include relevant structures and processes).
- Refer to previous audits, associated findings or recommendations.

Aim / Goals

Specify your Aim:

- This will be an overarching statement, which highlights what you want to achieve.

Specify the Objectives:

- This breaks down the aim into manageable, measurable and objective actions.

Methodology

What was audited and how?

Include sample criteria:

- Inclusion/exclusion criteria?
- Random, stratified, etc.
- How many did you audit?
- Where applicable, demographics may be added.
- Specify the dates within which your sample falls.

Include data collection:

- Retrospective or prospective?
- Who collected the data?
- Provide details of your pilot study (numbers, changes made).

Standards

- What were the standards that you measured against?
- What was the evidence-base?

Results

What were your results against the standards you measured against.

- Draw out the meaningful data
  - Choose and appropriate graphical format. What is your n value and total? Don't forget your chart title.
  - Consider presenting percentages against each standard, alongside comparable data where applicable (e.g. previous findings or other dept).

Remember…….

- A consistent approach to use of numbers or percentages will minimise confusion.
- Maintain anonymity of clinicians and patients.

Conclusions

- Please highlight problem areas, improvement needs and any areas of good practice.
- Draw together your findings, highlighting main points for discussion and action.

01/08/2019 7

Recommendations / Action Plan

What now?

Include

Recommendations and relate back to your audit standards.

- Where were these discussed (forum).

Describe your action plan.

- Specify who is responsible for each action – ensure that they agree to this!
- Set timescales and review dates (if applicable) for each action.
- Make actions realistic and achievable.

Date for re-audit (if appropriate).

01/08/2019 8

Next steps

After presenting your findings:

Communication is key.

- Agree:
  - action plan following peer review discussion.
  - review date to monitor actions.
  - Re-audit date.
  - Consider: continuous measurement, research or other QI methodology (as appropriate).
- Ensure handover of actions to willing colleague if leaving.
- Agree on appropriate further dissemination of results to MDT colleagues.

01/08/2019 9

Appendix iii: Action planning template

Title			
Lead Auditor		**Author:**	
Contributors			
Approving Committee		**Date:**	
Is this on the risk register		**If yes, Score:**	

Action Plan:
(Please complete the action plan to specify how improvements will be made - i.e. what will be done, when and by whom?)

Issue Identified	**Improvement Action**	**By Who**	**By When**
Re-audit:	Date:	By Whom:	

Appendix iv (overleaf): Template for final Clinical Audit report

Use attached guidance sheet: "Using Template Format for Clinical Audit Report".

Auditor (person conducting audit):	**Audit No:**	**Date:**
Audit Team members:	**Speciality / Service:**	

Full title of clinical audit project:
Include enough information to make the topic and location clear.

Introduction / background:
Set the scene for your audit. Outline why you conducted it and provide the reader with enough background information to understand the setting and history of the unit/team.

- What are the reasons for selecting this topic?
- Which guidelines/standards did you select to measure practice against?
- Refer to and summarise any relevant research or other forms of evidence.
- Outline topic-specific information and explain abbreviations or specialised terminology.
- Explain treatment/care pathway (including relevant structures and processes).
- Refer to previous audits and associated findings or recommendations.

Specify Aim:
This will be an overarching statement, which highlights what you want to achieve.
Specify Objectives:
This breaks down the aim into manageable, measurable and objective actions.

Standards:
What were the standards that you measured against – what was the evidence-base?

Methodology:
Explain the audit methodology you used, including sample criteria, time period and data sources used (i.e. what was audited and how?)

This section is important as it needs to make explicit the *'who, how, when and where'* elements of your project procedure. As in a scientific report, it is important that anyone wanting to replicate your project can do so by following your methodology.

The sample:

- Were there any inclusion/exclusion criteria?
- How was your sample selected? - random, stratified, etc.
- How did you identify participants? - Information Dept, admission book, etc.
- How many did you audit?
- If cases were missing - specify why (e.g. notes missing).
- Where applicable, demographics may be added (either here or in your results section)
- Specify the dates within which your sample falls.

The data collection:

- Was your data collection retrospective or prospective?
- Who collected the data?
- When were pro-forma/questionnaires completed/returned?

The pilot:

- Provide details of your pilot study (numbers, changes made).

Did you include your pilot data in your final analysis? If not, outline reason (e.g. data items changed significantly following pilot).

Results:
Provide the results of audit against the standards that you were measuring against and also any supporting or additional information. *Table format provided below*.

- Present only results that relate to the audit criteria.
- Don't be tempted to flood the reader with unnecessary data. The clarity of the point you are trying to communicate may be lost.
- Follow a logical order and grouping of results (such as the care pathway).
- Draw out the meaningful data and present in an accessible and graphical format (where applicable).
- Ensure all charts and tables are titled and state the 'n value' (total number 'out of').
- State how the data was stored and analysed (such as Excel or SPSS).
- It may be useful to use a table to present percentages against each standard, alongside comparable data where applicable (e.g. previous findings or other dept).
- A consistent approach to use of numbers or percentages will minimise confusion.
- Maintain anonymity of clinicians and patients.
- Use objective statements and avoid subjectivity.

No.	Standard	% Achieved	% Not Achieved
1.			
2.			
3.etc.			

Conclusions:
Please highlight problem areas, improvement needs and any areas of good practice.
Draw together your findings, highlighting main points for discussion and action.

Recommendations:
Clearly state your recommendations and relate back to your audit standards.

Action Plan:
Please complete the action plan to specify how improvements will be made - i.e. what will be done, when and by whom?
Complete the action plan to specify how improvements will be made (i.e. what will be done, when and by whom).
Following discussion of the recommendations at the appropriate forum, construct an action plan.

- Specify who is responsible for each action – ensure that they agree to this!
- Set timescales and review dates (if applicable) for each action.
- Make actions realistic and achievable.
- Set a date for re-audit (if appropriate).

Problem identified	Action	By Whom	By When
Re-audit:	Date:	By Whom:	

How has / will the clinical audit improve patient care? Please summarise the way in which your findings and implementation of recommendations will improve care.
References:
All full list of references should be provided using a recognised referencing system (such as Harvard).
Appendices:
Always include the clinical audit pro-forma within your appendices.
Ensure that a copy of the report is sent to the Clinical Audit and Effectiveness Department and the Specialty / Service clinical audit lead.

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

EQUALITY IMPACT ASSESSMENT FORMS
PARTS A and B: SCREENING AND OUTCOME REPORT

Introduction:
These forms have been designed to enable you to record, and provide evidence of how you have considered the needs of all people (including service users, their carers and our staff) who may be affected by what you are writing or proposing, whether this is:

- a policy, protocol, guideline or other written control document;
- a strategy or other planning document e.g. your annual operating plan;
- any change to the way we deliver services e.g. a service review;
- a decision that is related to any of the above e.g. commissioning a new service or decommissioning an existing service.

This is not optional: Equality Impact Assessment is a specific legal requirement on public sector organisations under equalities legislation and failure to comply could result in a legal challenge to a decision or strategy. More importantly, equality impact assessment helps to inform better decision-making and policy development leading to improved services for patients. **This form should not be completed by an individual alone, but should form part of a working group approach.**

The Forms:
You must complete:

- **Part A** – this is the Initial Screening that is always undertaken and consists of Forms 1 to 3; these forms are designed to enable you to make an initial assessment of the potential impact of what you are doing, and decide whether or not you will need to proceed to a Full Impact Assessment (Part C);

AND

- **Part B** – this is the Outcome Report and Action Plan (Form 4) you will need to complete whether or not you proceed to a Full Impact Assessment;

Together, these forms will help to provide evidence of your Impact Assessment and how you have shown “due regard” to the duties.
You may also need to complete **Part C** (see separate Form) – if parts A and B indicate you need to undertake a Full Impact Assessment. This enables you to fully consider all the evidence that is available (including engagement with the people affected by your document or proposals) to tell you whether your document or proposal will affect people differently. It also gives you the opportunity to consider what changes you may need to make to eliminate or mitigate any adverse or negative impact you have identified.
Remember that these forms may be subject to external scrutiny e.g. under a Freedom of Information request.

Once completed, the EqIA Forms should accompany your document or proposal when it is submitted to the appropriate body for approval.

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

Part A

Form 1: Preparation

1.	What are you assessing i.e. what is the title of the document you are writing or the service review you are undertaking?	Clinical Audit Policy and Procedure
2.	Provide a brief description, including the aims and objectives of what you are assessing.	The aim of this document is to develop and sustain a culture of best practice in clinical audit. The objective is to outline the roles and responsibilities in relation to clinical audit activity, including the Trust's procedures and expectations for registering and approving clinical audit project proposals.
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?	Executive Medical Director is the nominated Executive Lead The Quality, Safety and Patient Experience Committee approves changes to the policy & procedure document
4.	Is the Policy related to, or influenced by, other Policies/areas of work?	BCUHB Quality Improvement Strategy (2017).
5.	Who are the key Stakeholders i.e. who will be affected by your document or proposals?	Key stakeholders are: All clinical staff expected to contribute to clinical audit as a means of reviewing and improving patient care and their own practice and to any non-clinical staff involved in the audit process including volunteers and students. Patients' involvement is promoted (see section 9.3). For the Tier 1 (nationally mandated) audits patients and/or carer views are sought.
6.	What might help/hinder the success of whatever you are doing, for example communication, training etc?	There needs to be: • Good communication and dissemination regarding the policy. This will be through: ➢ BCUHB Intranet. ➢ Relevant BCUHB groups and forums. ➢ Cascade through Clinical Audit / Governance / Quality leads. ➢ BCUHB Communication Department circulations. • Resources to support engagement in participation including time to complete clinical

		audits. • Clear understanding of processes related to the policy • Skills training for clinical audit and quality improvement availability – online audit training is available. Quality Improvement training is available to book through the online BCU QI Hub.

Form 2: Considering the potential impact of your document, proposals etc in relation to equality and human rights

Characteristic or other factor to be considered	Potential Impact by Group. Is it:- Positive (+) Negative (-) Neutral (**N**) No Impact/Not applicable (**N/a**)	High Medium or Low	Please detail here, <u>for each characteristic listed on the left</u>:- (1) any Reports, Statistics, Websites, links etc. that are relevant to your document/proposal and have been used to inform your assessment; and/or (2) any information gained during engagement with service users or staff; and/or any other information that has informed your assessment of Potential Impact.
Age	**N**		This policy and procedure applies to all individuals regardless of their characteristics. Actions are based on the outcomes in relation to the measured standards.
Disability	**N**		*As above.*
Gender Reassignment	**N**		*As above.*
Marriage & Civil Partnership	**N**		*As above.*
Pregnancy & Maternity	**N**		*As above.*
Race / Ethnicity	**N**		*As above.*
Religion or Belief	**N**		*As above.*
Sex	**N**		*As above.*
Sexual Orientation	**N**		*As above.*
Welsh Language	**N**		*As above.*
Human Rights	**N**		*As above.*

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 premise of clinical audit is to establish the extent to which evidence-based standards are evidenced in practice in a manner that reduces variance and optimises standardisation of excellent care and treatment for all. Clinical Audit & Effectiveness (CA&E) Department support is provided equally to all BCUHB staff and with respect for diversity. All CA&E Department team members have completed the Equality & Human Rights online training. This is a mandatory training requirement for staff within BCUHB.
2. Describe here how your policy or proposal could better advance equality of opportunity (if relevant)	The premise of clinical audit is to establish the extent to which evidence-based standards are evidenced in practice in a manner that reduces variance and optimises standardisation of excellent care and treatment for all. There is opportunity to explore characteristics within audits (where that information is collected) to advance equality of opportunity. Clinical audit can be used to explore equality of opportunity, delivering improvement based on the results obtained.
3. Describe here how your policy or proposal might be used to foster good relations between different	The policy would: • Promote good practice as outlined above and encourages adherence to National

groups (if relevant)	guidance and standards. • Promote standardisation and equality of access to good practice. • Encourage patient and public involvement in clinical audit activity.

Part B:

Form 4 (i): Outcome Report

Organisation:	BETSI CADWALADR UNIVERSITY HEALTH BOARD

1. What is being assessed? (Copy from Form 1)	Clinical Audit Policy and Procedure

2. Brief Aims and Objectives: (Copy from Form 1)	The aim of this document is to develop and sustain a culture of best practice in clinical audit. The objective is to outline the roles and responsibilities in relation to clinical audit activity, including the Trust's procedures and expectations for registering and approving clinical audit project proposals.

3a. Could the impact of your decision/policy be discriminatory under equality legislation?	Yes	No √
3b. Could any of the protected groups be negatively affected?	Yes	No √
3c. Is your decision or policy of high significance?	Yes √	No

4. Did the decision scoring on Form 3, coupled with your answers to the 3 questions above indicate that you need to proceed to a Full Impact Assessment?	Yes	No √
	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 assessment above and within Part A demonstrate the positive impact that this policy will have upon the promotion and quantification of good practice. This will optimise equality of access to standardised care and treatment that is evidence-based and reduce unnecessary variation.	
5. If you answered 'no'	Yes	No √

above, are there any issues to be addressed e.g. mitigating any identified minor negative impact?	Record Details:	
6. Are monitoring arrangements in place so that you can measure what actually happens after you implement your document or proposal?	Yes √	No
	How is it being monitored?	Review date will be set. There will be quarterly reports monitoring progress against the annual audit plan (see section 8.6). An annual audit report will be produced.
	Who is responsible?	Head of Clinical Audit and Effectiveness, Office of the Medical Director.
	What information is being used?	E.g. will you be using existing reports/data or do you need to gather your own information? This will be based on nationally produced and benchmarked reports, locally produced reports and action plans and local monitoring within the Clinical Audit and Effectiveness Department.
	When will the EqIA be reviewed? (Usually the same date the policy is reviewed)	This will be reviewed alongside the scheduled review of the policy.

7. Where will your decision or policy be forwarded for approval?	BCUHB Quality, Safety and Patient Experience Committee

8. Describe here what engagement you have undertaken with stakeholders including staff and service users to help inform the assessment	A bespoke workshop was held for clinical audit leads and audit staff across BCU. The resultant draft policy was then circulated to the Divisional Quality and Safety meetings for further input. Draft documentation was shared with the corporate Quality and Safety Group, Audit Committee and Joint Audit and Quality SubCommittee.

9. Names of all parties	Name	Title/Role

involved in undertaking this Equality Impact Assessment:		
	Trevor Smith	Head of Clinical Audit & Effectiveness
	Dr Melanie Maxwell	Senior Associate Medical Director
Please Note: The Action Plan below forms an integral part of this Outcome Report		

Form 4 (ii): Action Plan
This template details any actions that are planned following the completion of EqIA including those aimed at reducing or eliminating the effects of potential or actual negative impact identified.

	Proposed Actions	Who is responsible for this action?	When will this be done by?
1. If the assessment indicates significant potential negative impact such that you cannot proceed, please give reasons and any alternative action(s) agreed:	No potential negative impact identified	N/A	N/A
2. What changes are you proposing to make to your document or proposal as a result of the EqIA?	None	N/A	N/A
3a. Where negative impacts on certain groups have been identified, what actions are you taking or are proposed to mitigate these impacts? Are these already in place?	No potential negative impact identified	N/A	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.	No potential negative impact identified	N/A	N/A
4. Provide details of any actions taken or planned to advance equality of opportunity as a result of this assessment.	Consider how to promote patient and carer engagement in clinical audit	Head of Clinical Audit & Effectiveness	Next review

Cyfarfod a dyddiad: Meeting and date:	Quality Safety & Experience Committee 28th January 2020
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Mental Health and Learning Disabilities Division - Resubmission of Written Control Documents
Cyfarwyddwr Cyfrifol: Responsible Director:	Mr Andy Roach
Awdur yr Adroddiad Report Author:	Mrs Wendy Lappin
Craffu blaenorol: Prior Scrutiny:	In accordance with the Policy for the Management of Health Board Wide Policies, Procedures and other Written Control Documents (WCD), authors are responsible for ensuring that appropriate consultation has taken place with the relevant individuals and groups. Each WCD was considered by the Quality Safety Group (QSG) at the meeting held on 11th September 2019 with detail of prior scrutiny being set out on the respective title pages. The QSG was supportive of recommending each of the written control documents to the QSE Committee for approval. QSE Committee considered the WCDs on 24th September 2019 and requested further work be undertaken ahead of resubmission.
Atodiadau Appendices:	Appendix 1 Written control document relating to Threats to Persons in Forensic Establishments Appendix 2 EQIA relating to Threats to Persons in Forensic Establishments Appendix 3 Written control document relating to Major Incidents (Ty Llewelyn) Appendix 4 EQIA relating to Major Incidents (Ty Llewelyn) Appendix 5 Written control document relating to Handcuffs Appendix 6 EQIA relating to use of Handcuffs

Argymhelliad / Recommendation:

The Committee is asked to:
1. Approve the amended written control documents for implementation.

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

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

Sefyllfa / Situation:

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. The Committee, within the remit of its terms of reference, may consider and approve policies concerning Quality, Safety and Patient Experience matters.

Cefndir / Background:

Following generic feedback from the QSE Committee, the attached WCDs have been reviewed within the Mental Health & Learning Disabilities Division and formatting and typographical errors duly amended. Specific comments on each WCD have been incorporated as follows:

Handcuffs Policy

- The terminology used within the document is required to be in accordance with that used by allied agencies and training providers.

- In respect of clarification of scenarios and options the policy identifies when and why the use of handcuffs would be implemented.

- The use of handcuffs to facilitate escorted leave is on all occasions a pre planned action which involves the patient and staff members who have been identified to facilitate the leave. Identified staff will have undertaken approved handcuff training and the leave will be care planned and risk assessed accordingly to ensure the most appropriate escorts are identified taking into account any staff concerns.

Threats to the Person in Forensic Establishments Policy

- EQIA amended in regards to consistent reference to firearms act.

- The policy is not felt to require further review by the Occupational Health and Safety group as liaison and review have taken place and been have agreed with allied agency: North Wales Police. This is an existing policy which takes into account the potential risks associated with mentally disordered offenders.

Major Incident Protocol – Ty Llywelyn Medium Secure Unit

- With regards to referencing medium secure units, the policy refers to Ty Llywelyn in its title and within its body. The only other medium secure facility to be mentioned is that of the Spinney Unit which is the identified placement contained within the associated mutual Aid plan.

- In relation to contacting the matron ahead of contacting the police there is no mention of this within the document, however, implementation and escalation processes are clearly defined.

- With regards to security Ty Llywelyn is a registered Hospital run by Health Care professionals operating within a medium secure care environment, Security is the responsibility of all staff working within its parameters and this is reflected in unit policies and procedures. Whilst we liaise closely BCUHB security leads, North Wales police and the Ministry of Justice it is not felt that links with alternative security providers are indicated in line with national medium secure standards.

- The policy is not felt to require further review by Health and Safety group as liaison and review have taken place and been have agreed with allied agency: North Wales Police. This is an existing policy which takes into account the potential risks associated with mentally disordered offenders.

Asesiad / Assessment & Analysis

Strategy Implications
WCDs support good governance.

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.

Risk Analysis
Up to date and easy to follow policies and written control documents minimise risk to patients, visitors, employees and the Health Board

Legal and Compliance
WCDs help to ensure that statutory requirements, standards and regulations are understood, and provide a framework to monitor compliance.

Impact Assessment
Each of the WCDs have been subject to EQIA screening – copies of which are appended.

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Version 4

MHLD 0008

Threats to the person in Forensic Establishments (Ty Llywelyn Medium Secure Unit)

Author & Title	Ian Jones, Practice Development Nurse/Security Lead Simon Allen, Clinical Operational Manager – Forensic and Rehab Services				
Responsible Dept / director:	Mental Health/Learning Disability Division				
Approved by:	MHLD Policy Implementation Group 07.05.19 MHLD Q-SEEL – 16.05.19 PAG – 12.08.19 Chairs Approval				
Date approved:					
Date activated (live):	April 2019				
Documents to be read alongside this document:	Ty Llywelyn Security Policy Ty Llywelyn Major Incident Protocol Fire Safety Policy Postal Packets Policy				
Date of next review:	January 2023				
Date EqIA completed:	April 2019				
First operational:	June 2016				
Previously reviewed:	Jan 2019				
Changes made yes/no:	No				

N.B. Staff should be discouraged from printing this document. This is to avoid the risk of out of date printed versions of the document. The Intranet should be referred to for the current version of the document.

CONTENTS

1. Introduction/Overview

Ty Llywelyn is a medium secure unit which accommodating male patients between the ages of 18-65, usually detained under the Mental Health Act (1983). Patients in Ty Llywelyn are deemed to require secure conditions in order to manage the risk that they pose to themselves and the wider public and to manage the potential for absconding.

The nature and function of the service requires the Health Board to have a policy in place to ensure that staff are aware of the processes in place to enable them to deal effectively and safely with a number of high risk, threat situations.

2. Policy Statement

The policy exists to provide a framework for the management of specific high risk scenarios which would trigger the implementation of the Ty Llywelyn Major Incident Protocol (MIP). Although these are not the only circumstances in which the MIP would be activated they are the high risk scenarios which would give concern for immediate threat to life and limb within the unit.

3. Aims/Purpose

The policy will provide a framework to enable staff to deal effectively and safely with these scenarios.

4. Objectives

The policy will enable staff to recognise and respond to incidents which would trigger the implementation of the Ty Llywelyn Major Incident Protocol.

5. Scope

- All staff employed within Ty Llywelyn Medium Secure Unit.
- Forensic Psychiatric Service Management.
- BCUHB Senior Management

6. Roles and Responsibilities

The enactment and escalation of the policy remains the responsibility of staff employed within Ty Llywelyn Medium Secure Unit, Forensic Service Management and BCUHB Management group.

7. Main Body

a) VIOLENT DISORDER/RIOT SITUATION

Violent Disorder/riots are exceedingly rare occurrences. They can be spontaneous or pre-planned outbreaks of determined disruption to the service by persons(s) using violence and/or acts of destruction and can be dangerous to public, patients, staff, visitors and others. There may also be a financial implication when damage occurs to buildings and internal fixtures and fittings

Violent Disorder/riot is defined as 'A violent disturbance of the peace 'and 'The breakdown of peaceful and law abiding behaviour' (Oxford English Dictionary).Riot- Where twelve or more persons who are present together use or threaten unlawful violence for the purpose and conduct of them (taken together) is such that it would cause a person of reasonable firmness present at the scene to fear for his personal safety each of the persons using unlawful violence for the common purpose of riot.(Public Order Act 1986) Within Ty Llywelyn Medium Secure Unit this would manifest as a group of people acting collaboratively to cause harm to staff or fellow patients, to destroy / damage property and or attempt escape from the secure hospital.

Violent Disorder/riots can be unpredictable and so it can be difficult to plan specific responses in advance. This protocol is concerned with the prevention and management of riot / serious disturbance and returning the unit to normal operation as soon and safely as possible should the situation occur.

Prevention

All threats and/ or intelligence in relation to patient disorder must be taken seriously and reported immediately to the most senior member of staff on duty. Such a situation requires full assessment and patients may need to be isolated and moved around the unit as required to minimise the potential of riot or serious disturbance.

Occasionally, individual patients may resist planned interventions, or may become disturbed in their behaviour and be thought to be at increased risk of violence due to mental state. This policy is not intended to provide guidance for managing inpatient violence or aggression that would normally be considered in the patients risk management plan.

Please refer to 'Proactive Reduction and Therapeutic Management of behaviours which challenge' Policy (MHLD 0049) for this guidance.

Management of Incident

Violent Disorder/riot is deemed to have occurred if:

- Individuals make a determined attempt to disrupt operation of the service, using violence and/or damage to property, to a level that puts the safety and well being of the public, themselves and/or others within the unit in jeopardy, or;
- Individuals threaten to breach security within or beyond the perimeter of the unit, and
- If It is beyond the resources of staff to restore safety and therapeutic mileu

Priority is to preserve the safety of as many people as possible by withdrawing from the immediate vicinity and directing non participating patients, staff and others to a safe area.

Staff must not engage if perpetrators are brandishing / purporting to or are suspected of possessing weapons.

The most senior member of staff within Ty Llywelyn (Incident Officer) must determine whether the incident requires the instigation of the Ty Llywelyn Major Incident Protocol and activate the Protocol accordingly.

Local intervention may be implemented to restore order when:

i. The incident is contained.
ii. There is no further risk of serious injuries.
iii. Non-participants are not trapped within the vicinity.
iv. Damage to the environment is not extensive and poses no public safety risk.

If the situation does not meet any of these criteria, and there is little prospect of local resolution the Ty Llywelyn Major Incident Protocol must be activated.

Post Incident Management

Account for all patients and staff and determine their wellbeing and whether medical or other assistance is required, provide clean area for patients to reside whilst staff carry out post incident procedures and are able to resume normal patient supervision, which may involve transfer to other areas.

Assess riot participants and determine care, treatment and placement needs (this may include police custody).

If the Ty Llywelyn Major Incident Protocol has not been initiated, staff may need to preserve evidence and photograph any damage. The area of the incident should only be cleared when given clearance from senior staff and following liaison with police and fire service.

Contact Estates to secure, remove or repair any unsafe items after damage has been recorded.

Arrange for senior staff to provide debrief sessions for staff and patients.

Ensure that all relevant documentation is completed with statements These will be collated by Modern Matron and provided to police as required.

b) HOSTAGE SITUATION

Definitions

This document will adopt the following definition for hostage situations :'A person seized or held as security for the fulfillment of a condition'(Oxford English Dictionary): 'an incident in which a person is unlawfully held against his/her will, usually through the use of threats or when actual physical force is used'(Cambridge English Dictionary).Hostage Taking. A person ,whatever his nationality who in the United Kingdom or elsewhere a) Detains any other person ("The Hostage") and b) in order to compel a State international or governmental organisation or person to do or abstain from doing any act, threaten to kill, injure, or continue to detain the hostage.(Taking of Hostages Act 1982). The perpetrator of the act will be referred to as the 'hostage-taker' and the victim as the 'hostage'. It is also worth remembering that there could, in situations of this nature, be more than one hostage-taker or hostage.

General Principles

Should a hostage situation develop anywhere within Ty Llywelyn, it must be regarded as serious by all staff members and lead to initiation of the Ty Llywelyn Major Incident Plan.

First-on-Scene

This term refers to the person discovering a hostage situation and is a crucial stage in determining a successful outcome.

Resist the temptation to intervene verbally or physically as this may inflame the situation and endanger any hostages.

Upon being made aware of a hostage situation staff must notify the Senior Nurse on the unit immediately, await instructions, and not return to the incident unless instructed to do so.

The most senior member of staff must initiate the Ty Llywelyn Major Incident Protocol and identify an Incident Manager

Incident Management
Evacuate the immediate area quickly and quietly and ensure that all staff, service users and visitors are safe and accounted for.

The incident area and immediate surroundings should be designated a secure area.

For the course of the hostage situation, only key personnel should be allowed access into this area i.e. those who have a specific role or involvement in managing the incident. Staff must maintain safe distance from the hostage situation.

Non-essential staff, service users and visitors are not allowed in secure areas.

Once notified, the parameters of the secure area will be reviewed by the Incident Manager.

Observation
It is important to gather as much information as possible regarding the incident as this may help the police and Incident Manager in their overall strategies. Make a note of the following:

- What has happened?
- Who is involved; how many hostages or hostage takers are there involved. (Gender of all involved).
- Where they are.
- Any weapons or barricades involved.
- Any injuries, including the hostage-taker.
- The mental state and mood of the hostage-taker and hostage.
- Any evidence that drugs or alcohol are involved.
- Any relevant environmental factors such as damage to the building, wet floors etc.
- Any relevant physical medical conditions history (angina, pregnancy etc)
- Have the hostage takers issued any demands /reasons.

Other Staff
The following are important points for other staff to note:

- Do not attend the scene unless specifically told to do so.
- Respond to all delegated tasks quickly and calmly.
- Keep phone-lines clear – make only essential calls and keep them brief.

Post-Incident Process
Post incident process should be followed as per Ty Llywelyn Major Incident Plan.

c) DETECTION OF A FIREARM

Ty Llywelyn maintains a restricted items list (Ty Llywelyn Security Policy) in order to prevent contraband items from entering the premises. Firearms, naturally, are contained within the list of contraband items and it remains incumbent upon all staff to apply procedures rigorously to deter attempts to introduce a firearm via any route. This procedure and the secure structures at the perimeter of the unit constitute one aspect of the clinic's preventative measures.

For other preventative measures please view Ty Llywelyn Security Policy.

However unlikely a firearm incident may appear, staff must remain conversant with this policy and retain a working knowledge of the following procedures.

(i) **Action to be taken upon discovering a firearm within the unit.**

If it is safe to leave the firearm undisturbed, whilst preventing access to it by others, then the area should be preserved as a scene-of-crime for police investigation. During regular office hours The Service Manager / Modern Matron On-Call Consultant should be contacted by the most senior staff member (Incident Officer) at the scene for advice. Do not touch the firearm. In the event of the incident taking place outside of regular office hours the Incident Officer will contact the Bronze on-call as per organisational on-call guidelines.

If it is not safe to leave the firearm in situ, preserve the scene as best you can, remove the firearm to the Incident Officer who should ensure that the firearm is removed to a non-clinical area. Make no attempt to unload or "make safe" the weapon. Treat the firearm as if it is loaded and ready to fire. Do not carry it by the trigger or with fingers inside the trigger guard. If you can avoid touching the firearm you should, to preserve forensic evidence, e.g. by carrying it inside a plastic bag. Staff should be aware that 'home-made' firearms do not always present as conventional weapons and caution should be adopted around the discovery of suspicious devices.

If you cannot avoid touching the firearm, carry it by the barrel with the barrel pointed at the floor. Wherever possible, obscure the firearm from view e.g. wrapped in paper/material. Never insert objects i.e. pens, into the barrel/trigger guard to carry the firearm.

The Incident Officer or delegated other will contact the police, advise them a firearm is being held and their attendance at scene is required.

Discovery of ammunition should be managed in the same cautious manner.

(ii) **Action to be taken should a person be known/suspected of being in possession of a Firearm within the Unit.**

Contact the police by ringing 999 and advise them that we have activated the Major Incident Protocol as a firearm has been detected or an individual is known or suspected of being in possession of a firearm.

Whenever the Major Incident Protocol is activated in the suspicion of firearm possession, Reception staff must be informed in order that they can facilitate Police access and limit unnecessary access to the unit.

Under no circumstances should the person be challenged nor any attempt made to encourage surrender of the firearm, nor to disarm them forcibly.

All other patients, visitors and staff should be removed from the vicinity of the individual suspected of being in possession of a firearm. Once the area has been evacuated, staff should leave the area, locking access doors behind them, creating a contained zone. The area should be vacated as calmly and covertly as possible.

Upon Police attendance at the Unit, the Incident Officer will appraise them as to events in the designated Incident Management Room.

Police should be advised of pertinent patient health issues that may have a bearing on their deployment and operation.

Unit staff will co-operate fully both during the incident, whilst re-establishing order and in related post incident investigations/criminal proceedings.

(ii) **Roles and Responsibilities**

For an outline of roles and responsibilities refer to core roles and responsibilities in Section 10 of the Major Incident Protocol.

d) EXPLOSIVE DEVICE THREAT/SUSPICIOUS PACKAGES

Explosive device threats whether genuine or ‘false alarms’ are regrettable hazards of modern living. The nature of Ty Llywelyn as a Medium Secure Unit renders it more likely to be the subject of an explosive device threat. It is Ty Llywelyn policy that all notifications of an explosive device are treated as genuine until such time they are demonstrated to be hoax/malicious.

Hoax/malicious phone calls reporting explosive devices are a criminal offence and as such must be reported to the police.

Calls reporting explosive devices fall in to two categories:

- Threats where no device has actually been planted:

Such hoaxes may not be merely malicious and consideration must be given to them being an attempt to test security, disrupt or create diversion.

- Threats warning of a genuine device:

These may be attempts to avoid casualties but they also enable individuals to blame others in the event of injury.

Genuine threats are frequently inaccurate with regard to where and when a device may explode and staff receiving a telephone threat may not be trained in respect of such calls. While staff may be unable to assess a threat, accuracy or origin their recall and impressions of the caller could be important.

It is acknowledged that receiving such a threat may have an adverse affect on staff members who may require counseling /additional support following the incident.

Explosive device threats must be taken seriously taking in to account the service provided and security/safety implications for patients, visitors and staff.

(i) **Primary Aims and Objectives**

- To ensure the safety of patients, visitors, staff and general public
- Inform Emergency Services
- To maintain Unit security
- To identify/discount the threat at the earliest opportunity
- To return the Unit to normal operation as soon as is safely practical

(ii) **On receipt of a Telephoned Threat**

During regular office hours The Service Manager/Modern Matron, On Call Consultant should be contacted by the most senior staff member (Incident Officer) in Reception/on the Ward. In the event of the incident taking place outside of regular office hours the Incident Officer will contact the Bronze on-call as per organisational guidelines.

It is important to gain as much information from the caller as possible. Do not interrupt the caller; try to keep him/her talking. Note down: (See Appendix 1)

a) Sex and approximate age of the caller
b) The tone of voice (deep, soft, slurred, intoxicated, angry, happy, nervous, confident)
c) Any specific characteristics (accent, speech impediment, unusual pronunciation)
d) Background noises (traffic, machinery, music)
e) Nature of call / coin box whether caller number displayed (phone 1471 for caller ID)
f) Did the voice sound familiar?

(iii) **Try to engage the caller in conversation by asking the following questions:**

a) Where has the device been placed?
b) When will it explode?
c) What does it look like?
d) What type of explosive is it?
e) Why has the device been placed here?
f) Attempt to get the caller/ organisation name

(iv) **Follow on actions**

a) Note the time of the call
b) Telephone Police using 999 giving details of the call/ Activate Ty Llywelyn Major Incident Protocol
c) Ring 1471 (If the telephone has that facility) or contact switchboard to attempt to trace caller number
d) During regular office hours The Service Manager/Modern Matron, On Call Consultant should be contacted by the most senior staff member (Incident Officer) in Reception/on the Ward .In the event of the incident taking place

outside of regular office hours the Incident Officer will contact the Bronze on-call as per organisational guidelines.

e) Evacuate the area by activating fire alarm system and carry out the evacuation procedures as for fire

(v) **Letter Bombs / Parcels**

Such devices could be delivered through normal postal services (Royal Mail, Courier) or by hand.

(vi) **Staff suspicions may be aroused by:**

a) Weight - If excessive for size and apparent contents
b) Grease marks on the wrapping exterior i.e. Seeping from inside the package

(vii) **If suspicions cannot be alleviated:**

a) Do not attempt to open or tamper with the package/letter.
b) Inform the police immediately/Activate Ty Llywelyn Major Incident Protocol
c) Evacuate the area using fire alarm procedure.
d) Do not use Unit Radios/Pagers/Mobile phones within 30 metres as this could lead to device detonation.

8. Training

The importance of training cannot be over emphasised in terms of amelioration of the risk of threats to individuals within Forensic settings. It is recognised that the nature of risk can be fluid and therefore training and update of all staff is essential. This will be achieved through initial induction training and annual unit staff update as a facet of the in house Ty Llywelyn training plan.

9. Audit

Annual audit will be undertaken through review of unit training records and DATIX incidents relating to threats towards the person in Forensic Establishments ie. Ty Llywelyn.

10. Review

Every three years.

11 Appendices

APPENDIX 1

EXPLOSIVE DEVICE THREAT TELEPHONE CALL INFORMATION SHEET

(Please retain in Reception/Ward Offices)

Date……..

Time Call Received…….hrs

Time caller hung up…….hrs

Exact words used by caller:
……
……
……
……
……
…….....

Questions to ask:

Where has the device been placed?

……

…….....
.

When will it detonate?.....(date/time)

What does it look like?

.....
.

What kind of explosive is it?

.....
..

Why did you place the device here?

.....
..

Name of caller/ Organisation involved

.....
..

DESCRIPTION OF CALLERS VOICE

Male/Female (Please circle)

Approximate age:

Young……. Middle Aged……
Elderly……

Tone of voice (deep, soft, slurred, intoxicated, angry, laughing, nervous, confident)

.....
..

.....
..

.....
..

Any special characteristics (accent, speech impediment or unusual pronunciation)

.....
..

.....
..

Background Noises (traffic, machinery, music)

.....
..

.....
..

.....
..

Call from a call/coin box and telephone number if shown on your telephone display screen:

.....
..

.....
..

.....
..

Did the voice sound familiar?

.....
..

.....
..

If so who did it sound like?

.....
..

.....
..

.....
..

Give a summary of anything peculiar that you may have sensed or thought of during the call. Although it may not seem significant it could be of great value when associated with past or future calls of this nature.

Remarks:
.....
..

.....
..

.....
..

.....
..

.....
..

.....
..

Senior Staff Informed (Service Manager, Modern Matron, Consultant on Call, Bronze on call)

Details:

.....
..

.....
..

.....
..

Time Informed……..hrs

Person receiving threat phone call:

.....
..

(If necessary please use other side for additional info)

- **References**

The Mental Health Act 1983 as amended by the Mental Health Act 2007
The Code of Practice 2008
The Mental Health Act Reference Guide 2008

This table should be completed and added at the end of the document:

Members of the Working Group:

Name	**Title**
Simon Allen	Clinical Operational Manager – Forensic and Rehab Services
Lisa Jones	Modern Matron
Ian Jones	Practice Development Nurse/Security Lead
Greg Yates	Ward Manager

Engagement has taken place with:

Name	**Title**	**Date Consulted**
North Wales Police		January 2019
Ty Llywelyn Staff		January 2019
BCUHB Fire Officer		January 2019

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

EQUALITY IMPACT ASSESSMENT FORMS
PARTS A and B: SCREENING AND OUTCOME REPORT

Introduction:
These forms have been designed to enable you to record, and provide evidence of how you have considered the needs of all people (including service users, their carers and our staff) who may be affected by what you are writing or proposing, whether this is:

- a policy, protocol, guideline or other written control document;
- a strategy or other planning document e.g. your annual operating plan;
- any change to the way we deliver services e.g. a service review;
- a decision that is related to any of the above e.g. commissioning a new service or decommissioning an existing service.

This is not optional: Equality Impact Assessment is a specific legal requirement on public sector organisations under equalities legislation and failure to comply could result in a legal challenge to a decision or strategy. More importantly, equality impact assessment helps to inform better decision-making and policy development leading to improved services for patients. **This form should not be completed by an individual alone, but should form part of a working group approach.**

The Forms:
You must complete:

- **Part A** – this is the Initial Screening that is always undertaken and consists of Forms 1 to 3; these forms are designed to enable you to make an initial assessment of the potential impact of what you are doing, and decide whether or not you will need to proceed to a Full Impact Assessment (Part C);

AND

- **Part B** – this is the Outcome Report and Action Plan (Form 4) you will need to complete whether or not you proceed to a Full Impact Assessment;

Together, these forms will help to provide evidence of your Impact Assessment and how you have shown “due regard” to the duties.

You may also need to complete **Part C** (see separate Form) – if parts A and B indicate you need to undertake a Full Impact Assessment. This enables you to fully consider all the evidence that is available (including engagement with the people affected by your document or proposals) to tell you whether your document or proposal will affect people differently. It also gives you the opportunity to consider what changes you may need to make to eliminate or mitigate any adverse or negative impact you have identified.

Remember that these forms may be subject to external scrutiny e.g. under a Freedom of Information request.

To enter text, click on the grey box in the part of the form you are completing. Help text will appear in the status bar at the foot of the page. Some boxes have drop-down lists from which you can select options. Others may simply be a box to answer a question. Once completed, the EqIA Forms should accompany your document or proposal when it is submitted to the appropriate body for approval.

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

Part A

Form 1: Preparation

1.	What are you equality impact assessing? What is the title of the document you are writing or the service review you are undertaking?	Threats to the Person Procedures in Forensic Establishments	
2.	Provide a brief description, including the aims and objectives of what you are assessing.	A policy which ensures that incidents related to Violent Disorder/Riot Situations, Hostage Situations, Detection of Firearms, Explosive Device Threats/ Suspicious Packages within Ty Llywelyn Medium Secure Unit are safely and efficiently addressed.	
3.	Who is responsible for the document/work you are assessing – i.e. who has the authority to agree/approve any changes you identify are necessary?	Forensic Mental Health Service Management Team	
4.	Who is Involved in undertaking this EqIA? Include the names of all the people in your sub-group.	Name	Title/Role
		Simon Allen	Clinical Operations Manager - Forensic and Rehab
		Ian Jones	Practice Development Nurse
		Lisa Jones	Modern Matron
5.	Is the Policy related to, or influenced by, other Policies/areas of work?	'Revised Adult Mental Health Services National Service Framework' (2005) Guidance for Commissioners of Forensic Mental Health Services (Joint Commissioning Panel for Mental Health, May 2013) National Policing Improvement Agency Guidance on Command and Control Minimum Standards for Medium Secure Units (RPsych 2010) Firearms Act 1968(The Firearms Actmakes it an offence for any individual to have unlawful posession of a firearm).	

6.	Who are the key Stakeholders i.e who will be affected by your document or proposals?	BCUHB North Wales Police North Wales Fire and Rescue Welsh Ambulance Trust Welsh Health Specialised Services Committee Secure Services Contract Team Ministry of Justice
7.	What might help/hinder the success of whatever you are doing, for example communication, training etc?	Circulation and communication of the document Staff training and awareness Inter-agency development of process Key stakeholders communicating the plan effectively within their own organisations. Preparatory walk through of plans Ongoing robust maintenance of the plan

Form 2: Considering the potential impact of your document, proposals etc in relation to equality and human rights

Characteristic or other factor to be considered	Potential Impact by Group. Is it:-		Please detail here, <u>for each characteristic listed on the left</u>:- (1) any Reports, Statistics, Websites, links etc. that are relevant to your document/proposal and have been used to inform your assessment; and/or (2) any information gained during engagement with service users or staff; and/or (3) any other information that has informed your assessment of Potential Impact.
	Positive (**+**) Negative (**-**) Neutral (**N**) No Impact/Not applicable (**N/a**)	Scale (see Table A on next page)	
Age	(N)	Neutral (N)	Clinical assessments and treatment planning allow due consideration for any age related factors. These factors would be taken into account during the implementation of any part of the policy.
Disability	(N)	Neutral (N)	Disability will be taken account of for patients, staff and others by way of regular risk assessment if an indivudal in the environment to which the policy applies has a disability which requires adjustments to be made.
Gender Reassignment	(N/a)	Neutral (N)	N/A
Pregnancy & Maternity	(N/a)	No impact/Not applicable (N/a)	Any pregnant women working in the environment to which the policy applies will have an up to date risk assessment in place.
Race / Ethnicity	(N)	Neutral (N)	An individual's race / ethnicity will be fully taken into account during care and treatment planning and by proxy this policy. Any change in the environment in which an individual might be cared for will be planned taking their race and ethnicity into account as far as is safe and practical to do so.

Religion or Belief	(N)	Neutral (N)	There is a risk that implementation of this policy might result in triggering of the Ty Llywelyn Major Incident Plan. This might in turn might result in an individual being temporarily cared for in an environment which might not be the conducive to their immediate needs. There may be situations whereby the environment in which the individual is temporarily cared for might not have access to facilities required for an individual to practice their faith. The nature of the major incidents which this policy caters to means that a pragmatic approach to immediate care and management might need to be adopted in order to ensure the safety of all affected by the incident. Any disruption to the environment which has an impact upon any individals ability to adhere to the customs of their faith will be managed accordingly to allow for worship as soon as is safe. The ability to adhere to principles of faith during an incident where security is acutely compromised cannot be guaranteed.
Sex	(N)	Neutral (N)	The in patient unit currently has single sex facilities only but during implementation of this policy we cannot guarantee that any change in the environment in which the individual is temporarily cared for will be single sex.
Sexual Orientation	(N/a)	No impact/Not applicable (N/a)	Clinical assessments and treatment planning allow due consideration for any issues related to sexual orientation. These factors would be taken into account during the implementation of any part of the policy.
Welsh Language	(-)	Low positive (+)	The organisational commitment to supporting the Welsh Language Act and service user language preferences is identified through assessment and care and treatment planning. However during implementation of this policy we cannot guarantee that a change in the environment in which the individual is temporarily cared for may not comply with the Welsh Language Act.
Human Rights	(N)	Neutral (N)	Application of this policy would take into account the Mental health Act 1983 – Code of Practice, Human Rights Act 1998, Mental Capacity Act 2005 – Code of Practice, Deprivation of Liberty Safeguards – Code of Practice.

Guidance on completing Form 2: For each of the characteristics listed, and considering the aims and objectives you detailed in Q2 on Form 1, you need to consider whether your document or proposal likely to affect people differently, and if so, will this be in a positive or negative way? For example, you need to decide:

- will it affect men and women differently?
- will it affect disabled and non-disabled people differently?
- will it affect people in different age groups differently? - and so on covering all the protected characteristics.

Use the table below to indicate the scale of any impact identified. The factors used to determine an overall assessment for each characteristic should include consideration of scale and proportionality as well as potential impact.

Table A

High negative	Note: It is important to understand that we will be required to demonstrate what we have considered and/or done in order to mitigate or eliminate any negative impact on protected groups identified within the assessment. Details should be recorded in sections 3a/3b in the Action Plan in Form 4.
Medium negative	
Low negative	
Neutral	
Low positive	
Medium positive	
High positive	
No impact/Not applicable	

Form 3: Assessing Impact Against the General Equality Duty

As a public sector organisation, we are bound by the three elements of the "General Duty". This means that we need to consider whether (if relevant) the policy or proposal will affect our ability to:- • Eliminate unlawful discrimination, harassment and victimisation; • Advance equality of opportunity; and • Foster good relations between different groups	
1. Describe here (if relevant) how you are ensuring your policy or proposal does not unlawfully discriminate, harass or victimise	The policy is designed to protect vulnerable individuals from incidents which present immediate risk of harm to life and limb. The Firearms Act 1968 makes it an offence for any indivdual to have unlawful possession of a firearm. Regardless of age, gender, religon, disability, sexual orentation, race and ethinicty no individual is exempt under UK Law.
2. Describe here how your policy or proposal could better advance equality of opportunity (if relevant)	N/A

3. Describe here how your policy or proposal might be used to foster good relations between different groups (if relevant)	It provides an approach that strengthens the concept of co-working and collaboration between different partner organisations to ensure achieving a common aim of patient and public safety and security.

Part B:

Form 4 (i): Outcome Report

Organisation:	BETSI CADWALADR UNIVERSITY HEALTH BOARD

1. What is being assessed?	Threats to the Person Procedures in Forensic Establishments

2. Brief Aims and Objectives:	A policy which ensures that incidents related to Violent Disorder/Riot Situations, Hostage Situations, Detection of Firearms, Explosive Device Threats/ Suspicious Packages within Ty Llywelyn Medium Secure Unit are safely and efficiently addressed.

3a. Could the impact of your decision/policy be discriminatory under equality legislation?	Yes ☒	No ☐
3b. Could any of the protected groups be negatively affected?	Yes ☒	No ☐
3c. Is your decision or policy of high significance – consider the scale and potential impact across BCUHB including costs/savings, the numbers of people affected and any other factors?	Yes ☐	No ☒

4. Did the assessment of potential impact on Form 2, coupled with your answers to the 3 questions above indicate that you need to proceed to a Full Impact Assessment?	Yes ☐	No ☒
	Record Reasons for Decision i.e. what did the assessment of scale on Form 2 indicate in terms of positive and negative impact for each characteristic? There may be an impact upon the ability to care for people through the Welsh language as the Mutual Aid acute dispersal plan which could be activated if the Major Incident Plan is triggered indicates that patients will be moved to a hospital in England whilst Ty Llywelyn in out of use. BCUHB will endeavour to send Welsh speaking staff with these patients wherever it is possible to do so and will prioritise this issue.	

5. If you answered 'no' above, are there any issues to be addressed e.g. mitigating any identified minor negative impact?	Yes ☐	No ☒	Not applicable ☐
	Record Details:		

6. Are monitoring arrangements in place so that you can measure what actually happens after you implement your document or proposal?	Yes ☒	No ☐
	How is it being monitored?	Robust multi agency debriefing process post incident
	Who is responsible?	
	What information is being used?	E.g. will you be using existing reports/data or do you need to gather your own information?
	When will the EqIA be reviewed? (Usually the same date the policy is reviewed)	December 2021

7. Where will your decision or policy be forwarded for approval?	BCUHB Board Level

8. Describe here what engagement you have undertaken with stakeholders including staff and service users to help inform the assessment	Distribution of policy for comment to MH/LD Division BCUHB / North Wales Police / BCUHB Fire Officer

	Name	Title/Role

9. Name/role of person responsible for this Impact Assessment	Simon Allen Ian Jones	IService Manager Practice Development Nurse
10. Name/role of person approving this Impact Assessment	Statutory compliance committee	
Please Note: The Action Plan below forms an integral part of this Outcome Report		

Form 4 (ii): Action Plan
This template details any actions that are planned following the completion of EqIA including those aimed at reducing or eliminating the effects of potential or actual negative impact identified.

	Proposed Actions	Who is responsible for this action?	When will this be done by?
1. If the assessment indicates significant potential negative impact such that you cannot proceed, please give reasons and any alternative action(s) agreed:			
2. What changes are you proposing to make (or have already made) to your document or proposal as a result of the EqIA?			
3a. Where negative impact(s) on certain groups have been identified, what actions are you taking or are proposed to mitigate these impacts? Are these already in place?			
3b. Where negative impact(s) on certain groups have been identified, and you are proceeding without mitigating them, describe here why you believe this is justified.			

	Proposed Actions	Who is responsible for this action?	When will this be done by?
4. Provide details of any actions taken or planned to advance equality of opportunity as a result of this assessment.			

NOTE: If your decision recorded above is that you will need to proceed to a Full Equality Impact Assessment, then you should refer to the Full Impact Assessment Forms (Part C)

This page is intentionally blank

Note: For detailed guidance on the completion of these forms, please refer to Chapter 3 of the Toolkit that is available on the Equality pages of the BCUHB Intranet site.

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Version 5

MHLD 0009

MAJOR INCIDENT PROTOCOL
TY LLYWELYN MEDIUM SECURE UNIT

Author & Title	Ian Jones, Forensic Practice Development Nurse/Security Lead Simon Allen, Clinical Operational Manager – Forensic and Rehab Services
Responsible dept / director:	Director of Mental Health & Learning Disability Division
Approved by:	MHLD Policy Implementation Group – 7th May 2019 MHLD Q-SEEL 16th May 2019 PAG August 2019 Chairs Approval QSG September 2019 QSE
Date approved:	16th May 2019 as draft whilst progressing through Health Board processes
Date activated (live):	May 2019
Documents to be read alongside this document:	• Ty Llywelyn Mutual Aid Agreement • Forensic Service Business Continuity Plan • Ty Llywelyn Operational Policy • Ty Llywelyn Security Policy • Fire Procedure • Threats to the Person in Forensic Establishments Policy
Date of next review:	May 2020
Date EqIA completed:	January 2019

First operational:	2014				
Previously reviewed:					
Changes made yes/no:					

N.B. Staff should be discouraged from printing this document. This is to avoid the risk of out of date printed versions of the document. The Intranet should be referred to for the current version of the document.

CONTENTS

1. Introduction/Overview

Clinical services for mentally disordered offenders in North Wales are provided by The Forensic Mental Health Services.

Ty Llywelyn is a 25 bedded purpose-built Medium Secure Unit on the Bryn y Neuadd Hospital site, Llanfairfechan.

The Unit provides assessment, treatment and rehabilitation for patients who, with the appropriate balance of care, are considered likely to recover and ultimately return to their own communities.

Referrals are taken from a variety of sources including the generic Mental Health Services, Criminal Justice System, GPs, Prison Services, Special Hospitals and Social Services.

The care and treatment of every patient is planned and regularly reviewed by a team which includes Consultant Psychiatrists, Nurses, Social Workers, Therapists and Psychologists.

The standards for MSU's specify that all Units should have contingency / major incident protocol, and that this must be agreed with the Police and other Emergency Services covering as a minimum Hostage Taking, Serious Disorder, Riot and Escape (NICE 25,Ty Llywelyn Threats to the Person in Forensic Establishments Policy). The purpose of such a protocol is to ensure the safety of patients, visitors, staff and others in addition to:

- Maintaining security
- Discovering or discounting the threat at the earliest opportunity
- Returning the unit to normal routine as soon as safely possible
- Assisting the Police in establishing the origin of the threat

2. Protocol Statement

The Major Incident Protocol provides BCUHB with the framework for the most effective response to significant incidents and adverse circumstances which have the potential to occur within the secure in-patient environment of Ty Llywelyn Medium Secure Unit. It also guides the organisation through the crisis response phase of a major incident and towards the implementation of a Business Continuity and Service Recovery Plan.

3. Aims/Purpose

The Major Incident Protocol (MIP) is aligned to a series of procedures specific to the various serious and high risk scenarios with the specific patient population managed at Ty Llywelyn that have the potential to occur. These scenarios could include, amongst others:

1. Fire
2. Hostage
3. Bomb threat
4. Firearms
5. Violent Disorder / Riot
6. High risk absconsion

These scenarios have their own specific procedures to confirm and direct action appropriate / specific to the nature of the scenario. These all dovetail the Major Incident Protocol (MIP), which acts as the overarching protocol for the co-ordination and management of any Major Incident Scenario. The MIP provides a framework for the most effective response to the above scenarios plus any additional scenarios that would render the entire MSU or part thereof uninhabitable to inpatients and unsuitable for staff occupation. The management of any scenario or type of major incident with the MIP will be in accordance with available resources and aim to ensure the most prompt return to normal operational status and practice. In order to ensure a response appropriate to the nature of the Major Incident and in acknowledgement of the variance between the above scenarios, the various agencies and departments with a role and function sign up to 'Memorandums of Intent' and in doing so they commit to the details within the Protocol ensuring the safety of both MSU patients and members of the public, thereby maintaining an effective and fast response to the major Incident situation.

The MIP advises partner agencies and organisations of the MHLD Divisions responsibilities, protocols and specific procedures for co-coordinating a response to a Major Incident. These partner agencies include Welsh Government, HIW, WHSSC, neighboring general hospitals and mental health units, Local Authorities and Emergency Services.

4. Objectives

The document provides the framework for a safe, effective coordinated response to a major incident occurring within Ty Llywelyn Medium Secure Unit and where the transfer of patients to appropriate alternative accommodation indicated

5. Scope

The document relates to all staff employed within Ty Llywelyn Medium Secure Unit.
Forensic Service Management team
BCUHB senior management

6. Roles and Responsibilities

The enactment and escalation of the protocol remains the responsibility of staff employed within Ty Llywelyn Medium Secure Unit, Forensic Service Management and the wider BCUHB Management group.

7. Main Body

7.1 Prevention

The above events are extremely rare occurrences within MSU's. Ty Llywelyn operates as a secure environment in line with Royal College of Psychiatry Minimum Standards for Medium Secure Units which include:

- A physical environment incorporating security features such as perimeter fencing, locked areas and external/internal CCTV.
- A high level of security awareness and relational security training amongst staff.
- Detailed pre-admission assessments highlighting prior risk of offending behaviour.
- Comprehensive multi-disciplinary individual patients risk assessments.
- Appropriate levels of observation whilst patients are both within the MSU and the community.
- Provision of high quality patient care in line with the Mental Health Measure (Wales).
- Fostering a positive culture between staff and patients in which patients can feel influential over their care and the environment.
- Adequate staffing levels.
- Adherence to local and organisational policies and procedures.

7.2 Categorisation of Incident

An incident within the secure perimeter of the MSU resulting in the entire loss of the clinical environment and requiring the immediate safe transfer of all patients is categorised as a **CLASS A INCIDENT.**

An incident within the secure perimeter of the MSU, that results in only a partial loss of the clinical environment requiring the safe transfer of only some of the patients to alternative temporary accommodation is categorised as a **CLASS B INCIDENT**.

7.3 Categorisation of Patient

MSU patients present various levels of risk, which, in association with the legal requirements for safe custody of all patients will necessitate the need for a clear classification system to denote the risk profile for each patient. This specific risk profile will exist only for the purposes of the MIP and will not be used to assist day to day clinical management of the patient population.

It is the responsibility of the Responsible Clinician / Multi-Disciplinary Team to establish each patient's risk profile which will be recorded in the patient's notes, the MIP Incident Bag. Categorisation will take place prior to admission to Ty Llywelyn and be reviewed and recorded in clinical notes fortnightly at the Clinical Team Meeting.

Category 1 Patients

This group of patients would be those most likely to abscond, be detained under a restriction order, have no leave outside the unit or whose mental state would be seen as currently having deteriorated to such a degree as to pose a high risk. Included in this category would be patients on trial leave from high secure hospital and prisoners transferred to hospital for assessment also patients where there has been a high level of media attention or issues of sensitivity relating to their offence. This group will require a highest level of security in transfer to any temporary placement alternative appropriate custody.

Category 2 Patients

This group of patients would be those who would require close monitoring, may be subject to restriction orders and have some degree of escorted leave outside the unit. Some of these patients could be accommodated temporarily in alternative appropriate accommodation. This may include a Psychiatric Intensive Care (PICU) placement or alternative medium or low secure placement.

Category 3 Patients

This patient group would be at a stage where they already have unescorted grounds / community leaves and, as such, are deemed a lower risk. These patients would be able to be grouped together to enable their movement to temporary accommodation with a much reduced escorting resource and might typically be placed within an open acute ward within the Division or a psychiatric rehabilitation unit. Some of these patients may have commenced their graduated discharge plans to areas of lesser security and, with MOJ permission; these patients could be temporarily advanced to the appropriate placement.

7.4 Transfer and Conveyance

The MOJ must be contacted and provided with details of detained patients under Court Section, together with the location where these patients are to be temporarily detained. The MOJ will then give verbal authorisation and if necessary confirmation via email to the effect that a Warrant has been issued for the transfer of such patients to the alternative appropriate environment. The MOJ has a 24 hour telephone number (0300 303 2079).

- Patients should be grouped according to their categorisation status with the first consideration being to move Category 1 patients securely and safely off the premises to their temporary accommodation.

- These patients will be given priority by MSU Staff, Police and additional Emergency Services in attendance and, wherever practicable, will be placed in health vehicles for safe transfer.

- Category 2 and 3 Patients can then follow supported by remaining MSU staff and Emergency Services until all Patients have been safely evacuated from the Unit.

- Should a decision be made to transfer a patient by emergency service vehicles, MSU staff will remain in attendance as a health escort unless otherwise indicated by emergency services risk assessment.

- Patients being transferred out of Ty Llywelyn MSU to temporary alternative appropriate environments will be supervised by Ty Llywelyn staff wherever necessary. Observation levels need to be maintained in line with individual Patient's Care and Treatment Plans / MHM documentation.

- The care of transferred detained Patients from the MSU remains the responsibility of the MHLD Division / BCU, even if in temporary Police custody or an alternative public sector or private secure environment. (See Mutual Aid Agreement)

Staff will ensure that appropriate vehicles will be used dependent on level of risk; the division has agreed all available vehicles will be handed over. Ty Llywelyn Community Team pool car keys are held in the upstairs team office in Ty Llywelyn.

7.5 Activating Major Incident Protocol

The MIP will be activated by telephoning the Emergency Services via 3333 whereby Reception will then contact the emergency services stating that the 'Major Incident Protocol' needs to be activated for the Ty Llywelyn MSU because of:

- Fire
- Hostage
- Bomb threat
- Firearms
- Violent Disorder / Riot
- High Risk Absconsion

The caller should request that the Force Incident Manager (FIM) initiate a response in line with the agreed MIP. This will enable the emergency services to recognise the call as:

- Genuine
- Of Serious Nature
- Requiring a pre-agreed response
- Necessary to ensure public protection

The emergency services will set into motion appropriate responses according to the incident type which may result in the deployment of police officers and other emergency services as necessary, to the MSU in response to the incident.
The strategies required of the Police / emergency services and Ty Llywelyn staff will be different for each specific type of Incident and are described under the separate procedures for each incident. These should be read and followed in conjunction with the MIP once the Major Incident Protocol has been activated. MSU staff should cross reference between documents as applicable.

Awareness of the content of the MIP is not sufficient in preparation to deal with each of the six types of incident listed above. All MSU staff needs to maintain a high level of awareness of the content of each of these separate procedures in addition to the Major Incident Protocol.

7.6 Stakeholder Responses

In the event that Police intervention is required, the authority to act will be determined by the North Wales Police Command and Control Structure.

In all cases of a major incident, the relevant emergency service (in accordance with incident type) may deploy to Ty Llywelyn MSU, but will not automatically take charge of the incident or Unit. There are many areas where the emergency services can assist in restoring control of an incident without taking direct action or being the lead responsible agency.

If it is decided that an emergency service needs to be the lead agency and take direct action, they must first be granted permission to intervene by the MHLD Division / BCU. If required control of the unit can be signed over to emergency services by the most senior member of staff on duty. This document is to be retained by the relevant emergency service which ‘signs over’ the unit to them allowing emergency services to enter and take the required action (Appendix 2). Prior to signing over the unit, the MHLD Division retains responsibility for events within the unit. A similar process and document needs to be signed upon conclusion of a major incident to confirm that control and responsibility has reverted back to the MHLD Division.

7.7 Major Incident Room

A Major Incident room should be established as soon as the MIP is activated. The location of the room will depend upon the extent of any damage to the MSU, risk to staff or need to locate the room elsewhere, e.g. on the Bryn Y Neuadd Site or another location The location of the room will be determined by the Incident Manager.

In the event of a Category A Major Incident affecting the whole of the MSU, the switchboard function, which operates from the Unit for the Bryn Y Neuadd site, would be transferred to another District General Hospital. The telephone number for the unit would be 01248 682101.Once the Major Incident Room is established, the main phone contact number must be communicated to all agencies. If mobile phones are required the ward mobiles can be collected from reception and used.

7.8 Roles and Responsibilities

Core roles and responsibilities have been identified to support successful activation of MIP (Appendix 1).

First on Scene

The role and responsibility of the first on scene is:

Preservation of life, safety and security.
Activation of internal alarm systems.
To advise the person in charge of the unit and take instruction.

The roles and responsibilities of specific individuals within the MIP are contained within Role Cards (Appendix 2).

These main roles are:

Major Incident Officer

Take charge of the incident and establish a structured management plan in relation to the incident.

Staffing Coordinator

Support and deploy staff as directed by the Major Incident Officer.

Communications Officer

Ensure effective communication links across all agencies; carry out briefings as directed by the Major Incident Officer.

7.9 Post Incident

Once the major incident has been brought under control arrangements will be made to ensure the MSU can return to its normal operational function at the earliest opportunity. Staff will be briefed as to timescales, any interim arrangements and adjustments specific to MSU patients temporarily located elsewhere and the impact on their roles, shifts and base.

Staff may be required, on a temporary basis, to work at another location within or outside BCUHB and will be supported by line managers to facilitate this. Staff will be expected to engage with any associated investigation indicated in the aftermath of a Major Incident. Staff will be supported by line managers and appropriate BCUHB Workforce and Organisational Development Department (WODD) who will give advice, guidance and support as necessary.

Anyone involved in a major incident may suffer the impact of trauma and stress, including professionals and patients. De-briefing allows for an assessment of the potential impact to be considered and following this Initial Impact Assessment the MHLD Division in association with Partner Divisions, WOD and the BCUHB Health at Work Department will develop and provide a programme of counseling and support in response to identified need.

7.10 Staff Awareness

It is the responsibility of all staff working within the North Wales Forensic Service to evidence appropriate knowledge and awareness of the MIP and associated specific procedures for various incidents

7.11 Mutual Aid Plan

Any activation of the MIP might require the instigation of the Mutual Aid Plan. The North Wales Forensic Service Manager / Modern Matron or senior clinician will confirm activation of the Mutual Aid Plan.

8. Equality including Welsh Language

An EQIA has been completed.

There is a risk that the implementation of the plan might result in an individual being temporarily cared for in an environment which might not address their immediate religious/faith needs. The nature of major incidents to which the plan refers means a pragmatic approach to immediate care and management might need to be adopted in order to ensure the safety of all affected by the incident.

The organisational commitment to supporting the Welsh Language Act and service user language preferences are identified through assessment and care and treatment planning. However during implementation of the Major Incident Protocol it

cannot be guaranteed that a change in the environment in which the individual is temporarily cared for may comply with the Welsh Language Act.

Application of this pathway will take in to account:

- Mental Health Measure(Wales 2010)
- Revised Adult Mental Health Services National Frame work
- Guidance for the Commissioners of Forensic Mental Health Services (2013)
- National Policing Improvement Agency Guidance on Command and Control
- Minimum Standards for Medium Secure Units (RPsych 2010)
- Mental Health Act 1983
- Code of Practice
- Human Rights Act 1998
- Mental Capacity Act 2005-Code of Practice
- Deprivation of Liberty Safeguards-Code of Practice

9. Resources

- Mutual aid agreement between BCUHB and The Spinney
- Ongoing in house staff security training.
- Ongoing liaison with Emergency services/partner agencies

10. Training

Ongoing in house staff security training takes place during staff induction and annually as part of security update training.

Training coordinated by Modern Matron/practice development.

Audit will take place annually as a facet of the training review

11. Implementation

The Major Incident Protocol (MIP) is aligned to a series of in house procedures/protocols specific to the various serious and high risk scenarios with the specific patient population managed at Ty Llywelyn.

The document will be implemented when a high risk scenario occurs within Ty Llywelyn Medium Secure Unit, namely:

- Fire
- Hostage situation
- Explosive Device/Suspicious package
- Detection of a firearm
- Violent Disorder / Riot
- High Risk Absconsion.

12. Further Information - Clinical Documents

- Ty Llywelyn Operational Policy
- Ty Llywelyn Security Policy
- Fire Procedure
- Threats to the Person in Forensic Establishments Policy -
  (Hostage situation)
  (Explosive Device /Suspicious package Detection of firearms)
  (Violent Disorder / Riot)
  (High Risk Absconsion)

13. Audit

Audit will take place annually as a facet of the training review

Ward Managers and Modern Matron retain the responsibility to ensure staff receive training and update in respect of the situations and processes pertaining to the implementation of the Major Incident Protocol within Ty Llywelyn.

It is envisaged that in the implementation of the Major Incident Protocol formal review of the processes would take place.

14. Review

Review will take place on a 3 year basis.

15. References

The Mental Health Act 1983 as amended by the Mental Health Act 2007
The Code of Practice 2008
The Mental Health Act Reference Guide 2008

16. Appendices

Appendix 1 Role Cards
Appendix 2 Operational Handover Document
Appendix 3 Ty Llywelyn Major Incident Communications Log
Appendix 4 Major Incident Plan Evacuation and Movement Matrix
Appendix 5 Contingency/Mutual Aid Plan
Appendix 6 AWOL Form

MAJOR INCIDENT OFFICER	MAJOR INCIDENT ACTION CARD 1
Normal Role	Will always be the most senior member of staff at the location when an incident occurs. The role of Major Incident Officer may be handed over to a more senior member of staff at any time during the incident.
Major Incident Role	Establish the Incident control room
	To lead the major incident control team
	Coordinate strategic response to an incident until such time that the On-call Command and Control procedures are in place at the scene
The Major Incident Officer will take charge of the incident and establish a structured manner in which to manage the incident	

Essential Actions

- Establish a major incident room as soon as the MIP is activated.
- Collect major incident bag which will contain essential equipment for incident coordination.
- Clarify with first on scene that contact with police has been made with Police by telephoning the Emergency Services via 3333 / 999 emergency number and that the Force Incident Manager has been instructed that the 'major incident protocol' needs to be activated.
- Appoint staff to the required roles of Staffing Co-ordinator and Communications Officer.
- Implement and adhere to the procedures specific to the nature of the major incident as each requires a variable response.
- Brief Police and other emergency services on their arrival and ensure that the Staffing Co-ordinator facilitates the establishment of respective emergency services 'Mobile Control Posts' and any casualty clearing stations and ambulance loading areas if necessary.
- If required, adhere to Division agreements for the authorisation of immediate expenditure as required.
- Following the conclusion of a major incident the Major Incident Officer should seize and secure any documentation generated by Health Board staff during the course of the incident.
- The Major Incident Officer should complete a Datix report outlining the course of the events and indicating where all evidential / seized documentation are located to assist with further investigations.
- Brief emergency services on issues relating to the layout of the building, patient / staff locations and assist in the creation of a dynamic operation risk assessment.
- Collate all relevant clinical documentation which will inform stakeholders in relation to clinical presentation, risk and legal status of the patient population.
- Ensure that Communications Officer has established links with the Ministry of Justice.

STAFFING CO-ORDINATOR	MAJOR INCIDENT ACTION CARD 2
Normal Role	Always allocated by the Major Incident Officer
Reports To	Major Incident Officer / BCU Command & Control
Major Incident Role	To deploy staff to appropriate areas as directed by Major Incident Officer / Incident Control Room
	To ensure that the whereabouts of all responding BCUHB staff are known at all times
The Staffing Co-ordinator will ensure that the responding staff carry out all directions with unified approach, and act in accordance with guidance given by emergency services.	

Essential Actions

- Support and deploy staff in association with Major Incident Officer to ensure appropriate levels of clinical supervision are provided for patients being transferred or re-located.
- Assess staff in relation to skill mix, their location during initial incident response and the co-ordination of staff both entering and leaving the incident area.
- Assess the need for additional staff including relief staff, staff re-deployment or central nursing agency staff.
- Consider issues relating to staff welfare including; breaks, meals and if required transportation and accommodation.
- Arrange any necessary patient transfers in association with the Major Incident Officer.
- Ensure staffing deployment is in-line with the procedures specific to the nature of the major incident as each requires a variable response.

These are critical roles in the event of a major incident and require knowledge and understanding of the Major Incident Protocol, the different areas of Ty Llywelyn the Health Board and of individual staff responsibilities. The roles must be established early in the event of a Major Incident being declared and handed over to an appropriate senior staff member when available.

COMMUNICATIONS OFFICER CARD 3	MAJOR INCIDENT ACTION
Normal Role	Always allocated by the Major Incident Officer
Reports To	Major Incident Officer / BCU Command & Control
Major Incident Role	Ensure good communications across a wide range of agencies
	Maintain a comprehensive, contemporaneous chronology of events,
Communication in the event of a major incident should be expected to be extremely difficult. It is important that the communications officer is able to identify, prioritize and maintain essential lines of communication	

Essential Actions

- Contact the Ministry of Justice at the earliest opportunity and inform them of the potential need to re-locate patients due to a major incident.
- Brief senior staff as required; including BCUHB Command and Control staff (Bronze, Silver and Gold On-Call)
- Assist Major Incident Officer to brief emergency services.
- Prepare responses to internal queries from partner agencies.
- Liaise with commissioners as applicable.
- Arrange for immediate supply needs to be met.
- Divert Press & Media enquiries to Senior Management Team or Bronze on-call.
- Maintain a comprehensive, contemporaneous chronology of events to include:

    - All telephone communications, incoming and out-going.
    - Verbal and non-Verbal communications.

Appendix 2 – Operational Handover Document

HANDOVER PROCEDURE TO BE USED IN THE EVENT THAT FULL OPERATIONAL CONTROL OF THE UNIT NEEDS TO BE HANDED OVER THE A REPRESENTATIVE FROM THE EMERGENCY SERVICES	
BCUHB ROLE :	
NAME :	
TITLE :	
DATE :	
TIME :	
SIGNATURE :	
HANDED OVER TO :	(e.g. North Wales Police)
NAME :	
TITLE :	
DATE :	
TIME :	
SIGNATURE :	
REASON FOR HANDOVER :	
UNIT SIGNED BACK TO BCUHB VIA: **(STATE PERSONS NAME / TITLE)**	
SIGNATURE:	
DATE:	
TIME:	

Appendix 3 –Ty Llywelyn Major Incident Communications Log

DATE	TIME	COMMUNICATION TYPE (email etc)	MADE BY	MADE TO	DESCRIPTION
12/4/2019	**18:00**	**Telephone**	**J. Smith (Incident Officer)**	**North Wales Police**	**Report Major Incident**

THIS DOCUMENT MUST BE PRESERVED AS EVIDENCE FOLLOWING THE CONCLUSION OF THE INCIDENT AND HANDED TO THE MAJOR INCIDENT OFFICER

Appendix 4 – Conveyance Matrix

MAJOR INCIDENT PROTOCOL – EVACUATION & MOVEMENT MATRIX

EVACUATION LOCATION CODE →	RED	AMBER	GREEN
DETAILS OF PREFERRED / COMPULSORY EVACUATION DETAILS AND ESSENTIALS ACTIONS	WHENEVER POSSIBLE THE PATIENT SHOULD REMAIN IN TY LLYWELYN MEDIUM SECURE UNIT THE PATIENT MUST ONLY BE MOVED IN SECURE TRANSPORT. THE PATIENT MUST NOT BE TRANSPORTED IN THE COMPANY OF OTHER PATIENTS. THE PATIENT WILL BE MOVED NON-STOP TO AN ALTERNATIVE SECURE ENVIRONMENT WHICH MAY INCLUDE:- ALTERNATIVE MEDIUM SECURE UNIT. IF APPROPRIATE RETURN TO HIGH SECURITY. POLICE CUSTODY IF APPROPRIATE RETURN TO PRISON NO PATIENT ASSESSED BELOW CATERGORY 1 WILL BE EVACUATED TO A RED LOCATION OTHER THAN A MEDIUM SECURE UNIT	CONSIDERATION TO BE GIVEN TO THE PATIENT REMAINING IN TY LLYWELYN MEDIUM SECURE UNIT. THE PATIENT CAN BE MOVED IN BOTH SECURE AND NON-SECURE TRANSPORT (WITH CONSIDERATION GIVEN TO ESCORTS). WHEN APPROPRIATE THE PATIENT CAN SHARE TRANSPORT, DEPENDENT ON CLINICAL RISK ETC. THE PATIENT CAN BE MOVED TO THE FOLLOWING:- A LOCALITY ACUTE MENTAL HEALTH PICU. LOCAL LOCKED / LOCKABLE REHABILITATION UNIT. ALTERNATIVE MEDIUM SECURE UNIT / PROVIDER. (ASSESS NEED FOR HEIGHTENED OBSERVATION ON ARRIVAL)	TO BE RE-LOCATED WHENEVER THE NEED ARISES. THE PATIENT CAN BE MOVED IN A STANDARD VEHICLE, AND CAN BE MOVED AS PART OF A GROUP. THE PATIENT CAN BE MOVED TO THE FOLLOWING LOCATIONS: A LOCALITY ACUTE MENTAL HEALTH PICU. LOCALITY ACUTE MENTAL HEALTH WARD (WITH ESCORTS) LOCAL LOCKED / LOCKABLE REHABILITATION UNIT. ALTERNATIVE MEDIUM / LOW SECURE UNIT PROVIDER.
PATIENT CAT. CHECK →	CATEGORY 1	CATEGORY 2	CATEGORY 3

Appendix 5 – Mutual Aid Plan

Contingency Plan
Emergency bed contingency

Introduction
As part of the provision for secure in-patient facilities there is the need to ensure that probity around this is maintained when major incidents occur, which render part, or all, of the facilities as unusable.

The contingency plan allows for the transfer of patients to temporary accommodation for between 12–72 hours following a major incident requiring full evacuation of the unit.

The following procedure has been established to maintain communication between services and to enable senior staff to make appropriate arrangements for the service users and accompanying staff.
The following document represents the agreements in place with these providers, in situations of this nature and considers the major aspects of these operations in terms of:

- Communication
- Decision making
- Clinical risk
- Transportation
- In-house/local operational provision
- Future planning
- Staffing
- Funding

The purpose of the document is to consider these factors in a systematic way to provide clear guidance and support in dealing with these emergency situations.

The scenarios will be subject to desktop exercises with the providers included, and the procedures agreed within, will be developed following these.

These plans will also be reviewed and ratified on an annual basis which will capture any changes in functions, or, to buildings that may impact on this agreement.

The agreement has been reached with providers to satisfy the contingency needs of these individual units involved, as well as supporting the wider contingency plans of the specialised commissioning team. Crucially, the commissioners contingent needs can only be met by provider units agreeing to support each other in these circumstances, so this agreement also has their support in place.

Key components of the shared agreement are:

- The plans for each unit in their decision making around the movement of the service users, were agreed around them being non-prescriptive at this stage, it was felt that decisions would be best made on the day and that functioning in the capacity of each

unit in providing support was the most appropriate way forward.

- It is understood, that the agreement is only for the first 72 hours of any such situation and that any agreed plans would be appropriate to these circumstances/timescales.

- Buy-in around transport arrangements was crucial, in that any services that are affected by these types of situations, should expect that partners involved in the agreement will prioritise this need and respond accordingly with its support. This was agreed by partners.

- Each unit would need to carry out a risk assessment on their patient group prior to any decant and establish where it would be most appropriate to move which patient to. They could then be clear about which area would be the most appropriate to provide the support depending on the risks identified. Included in this risk assessment would also be consideration of how long the service will remain out of commission.

Plans for decant:
The unit would need to carry out a risk assessment on their patient group prior to any decant and establish where it would be most appropriate to move which patient to. They could then be clear about which area would be the most appropriate to provide the support depending on the risks identified. Included in this risk assessment would also be consideration of how long the service will remain out of commission.

The Spinney
Related policies include:
- Serious Untoward Incident
- Business continuity.

Introduction

The contingency plan allows an option for the transfer of male patients to The Spinney for temporary accommodation for between 12–72 hours following a major incident requiring full evacuation of the unit.

There may also be some service users whose risk profile can be catered for in conditions of lesser security, i.e. LSU, so we would use the document Appendix A to quantify the individual need and utlise the provision there if appropriate, and other LSU beds where appropriate.

The following procedure has been established to maintain communication between services involved and to enable senior staff to make appropriate arrangements for the service users and accompanying staff.

The Procedure

The Spinney providing assistance

In the event that the building or part thereof of one of the partner Hospital is declared unfit and full or partial evacuation is required to The Spinney; there will be contact with the Site Co-ordinator/Senior Nurse On Call via 01942 885300. ROCG on call will then be contacted to oversee the contingency.

Senior Nurse On Call/ROCG on call (The Spinney) will note the request and require the following information: (see Appendix A):

- Briefing about the incident and status of the building.
- Briefing about the number of service users involved and their current location (e.g. temporary shelter).
- Risk Status of the patient group to be transferred, paying attention to any individuals who are disturbed/disruptive/traumatised and may require to be accommodated in a suitable ward environment, rather than the temporary accommodation in the conference suite.
- The number of staff who will accompany the patients and any needs in terms of staffing resources.
- Any other resource requirements which The Spinney may be able to assist with e.g. catering / pharmacy requirements.
- Transport arrangements and desired time of arrival at The Spinney.

The Spinney Senior Nurse on Call will contact the Site Co-ordinator to notify and appraise them of the situation and give them the details obtained from Emergency Coordinator.

The Senior Nurse on Call will activate the response contingency plans i.e. transportation of mattresses to the social room/main gym (as appropriate), make catering/pharmacy arrangements for the visiting service users and staff; arrange for on call personnel (in hours) to assist with making ready the temporary accommodation.

The Spinney Maintenance will arrange for available staff to assist with preparations i.e. receive mattresses/catering supplies, clear the main gym area and social room area and make ready for receiving service users and staff.

The Spinney will arrange for the receipt of any high risk service users expected and make arrangements for their clinical care for the duration. The visiting hospital will identify the individual needs of each high risk service user, including their staffing requirements. They will be responsible for providing care/medical staff for these service users. Any high risk service user, who cannot be safely accommodated in the main gym and social room area, should be transferred to a ward/s if beds can be found for them. Beds on available wards will be made available for as many of the transferred service users as possible. Use of temporary sleeping accommodation in the main gym/social room area will be a “last resort”.

Senior Nurse on Call at The Spinney will then liaise to confirm and discuss the arrangements made and agree transfer arrangements. Senior Nurse on call will maintain communication to ensure all information is up to date with a changing situation.

Once the visiting service users have been transferred to The Spinney, the visiting hospitals Senior Manager will be able to make further arrangements for their transfer to other NHS Trust facilities or other external facilities, as a more permanent arrangement; this will be expected to occur within 12–72 hours from the incident.

Specific Considerations for The Spinney
The outline plan is for wards to be used as temporary, emergency accommodation. If there are no beds available, mattresses will be used in the gym/social room as appropriate.

Mattresses and some bedding are stored in the housekeeping department and arrangements will need to be made to bring these to the designated place at The Spinney

The gymnasium/social room if to be used will need to be prepared; some tables and chairs can remain (enough to accommodate the people coming), the remainder will be removed and secured by the maintenance department.

Check any vacancies/spare beds on the wards to accommodate the high risk patients.

Arrange for a quick key and security induction for the staff shortly after arrival at the unit, to facilitate movement around The Spinney

Ensure that appropriate staff is informed as soon as possible so that all meetings/functions booked for the social room/main gym is cancelled with immediate effect and until further notice.

The visiting hospital Manager to ensure they make contact with the nurse in charge of the patients and further ensure that this contact is maintained through shift changes throughout their stay.

As soon as possible after arrival, the site coordinator should engage the nurse in charge of the service users to ascertain any special pharmacy requirements; special needs requirements (e.g. diet) and assist in meeting their needs. (Partnerships in Care will recharge any NHS Trust for any out of pocket expenses incurred during the emergency).

- The gymnasium/social room will provide the following accommodation: Floor space which can accommodate approximately up to 12 mattresses
- Floor space can also accommodate some chairs and tables; there is a television aerial and electrical socket.
- There is access to gent's toilet – there are no bathroom/shower facilities. These are to be shared with The Spinney service users and staff.
- The dining room has refreshment facilities.

Within the first 8 hours of the transfer, it is imperative that the visiting hospitals Directorate Senior Managers and Elysium corporate senior managers/Incident Management Team meet together to review the transfer and look to further planning and resource implications etc.

It is imperative that high quality communications are maintained between senior managers and duty managers to ensure the smooth running of, what will be a difficult and ever changing situation.

Ty Llywelyn

It should be noted that Ty Llywelyn is a male only facility.

Ty Llywelyn has 25 beds and will only be able to accommodate utilizing the gymnasium environment. It would be unsuitable for Ty Llywelyn to accept high risk transfers from the affected hospital during the period of mutual aid.

Ty Llywelyn providing assistance

In the event that the building or part thereof of The Spinney is declared unfit and full or partial evacuation is required to Ty Llywelyn; there will be contact with the Modern Matron / Senior Nurse On Duty or Unit Coordinator via 01248 682682. The senior member of staff on duty will then oversee the contingency. Ty Llywelyn is able to offer assistance with the temporary transfer of up to 10 service users between 12 and 72 hours.

The senior member of staff will note the request and require the following information: (see Appendix A):

- Briefing about the incident and status of the building.
- Briefing about the number of service users involved and their current location (e.g. temporary shelter).
- Risk Status of the patient group to be transferred, paying attention to any individuals who are disturbed/disruptive/traumatised and may require to be accommodated in a suitable ward environment, rather than the temporary accommodation in the conference suite.
- The number of staff who will accompany the patients and any needs in terms of staffing resources.
- Any other resource requirements which Ty Llywelyn may be able to assist with e.g. catering / pharmacy requirements.
- Transport arrangements and desired time of arrival at Ty Llywelyn.

The senior nurse at Ty Llywelyn will notify and apprise the Forensic Service Senior Management Team of the situation and give them the details obtained from Emergency Coordinator.

The senior nurse will activate the response contingency plans i.e. transportation of mattresses to the gym, make catering/pharmacy arrangements for the visiting service users and staff; arrange for on call personnel (in hours) to assist with making ready the temporary accommodation.

The senior nurse will arrange for available staff to assist with preparations i.e. receive mattresses/catering supplies, clear the main gym area and social room area and make ready for receiving service users and staff.

Beds on available wards will be made available for as many of the transferred service users as possible. Use of temporary sleeping accommodation in the main gym/social room area will be a “last resort”.

The senior nurse at Ty Llywelyn will then liaise to confirm and discuss the arrangements made and agree transfer arrangements. The senior nurse will maintain communication to ensure all information is up to date with a changing situation.

Once the visiting service users have been transferred to Ty Llywelyn, the visiting hospitals Senior Manager will be able to make further arrangements for their transfer to other NHS Trust facilities or other external facilities, as a more permanent arrangement; this will be expected to occur within 12–72 hours from the incident.

Out Of Hours
If the Mutual Aid agreement should be required to be activated outside of normal working hours the following process should be used:

Ty LLywelyn offering assistance:

- Spinney Hospital to contact the Unit Coordinator at Ty Llywelyn.
- Unit Coordinator to inform Bronze On Call Manager for Mental Health/Learning Disabilities Division that the Mutual Aid Agreement is being activated.
- The Bronze On Call Manager will then assist the Unit Coordinator in following the actions as outlined above (Ty Llywelyn Providing Assistance) and report to the Forensic Service Senior Management Team when appropriate.
- The Bronze On Call Manager will make the decision to call in extra staff if required to assist with carrying out the Mutual Aid Agreement safely.

Contact details The Spinney

The Spinney Hospital
Everest Rd,
Atherton,
M469NT

Tel-01942 885300
Fax-01942 885301

Interim Hospital Director	Sandy Adams-Thompson	07393 460802
Regional Operations Director	Mike Bennett	07771 767404

Contact details Ty Llywelyn

Ty Llywelyn MSU
Bryn Y Neuadd Hospital
Llanfairfechan
LL33 0HH

Tel: 01248 682682
Fax: 682146
Service Manager: 07798924964
Modern Matron: 01248 682682

<table>
<tr><td colspan="4">The Procedure for Each Transfer</td></tr>
<tr><td>Date</td><td>Number of Staff Required</td><td>Description of Incident/status of building</td><td>How many Service Users at current location</td></tr>
<tr><td></td><td></td><td rowspan="4"></td><td rowspan="3"></td></tr>
<tr><td>Time</td><td>Call received from</td></tr>
<tr><td></td><td></td></tr>
<tr><td colspan="2"></td></tr>
<tr><td colspan="2">Description of Patient being transferred</td><td>Any other Requirements (catering/pharmacy)</td><td>Transport and Time of Arrival</td></tr>
<tr><td colspan="2"></td><td></td><td></td></tr>
<tr><td>Signed</td><td colspan="2"></td><td>Date:</td></tr>
</table>

Appendix 6 – AWOL Form

Date of Admission		Section			
Date Form Completed					
Details Updated		Current Named Nurse			
Updated By					
Patient's Title		Date Of Birth			
Surname					
Previous Surname		Sex			
First Name					
Other Names		Marital Status		Ethnicity	
Aliases					
Index Offence		Date Of Offence			
Categorisation under Major Incident Procedure (1,2,3)					
Home Address		Telephone Numbers			
Description/Distinguishing Features		Height		Weight (if known)	
		Hair Colour		Eyes Colour	
Front View Full		Head Picture			
Side View Left		Side View Right			
Date Pictures Taken					
Next Of Kin		Next Of Kin Address			
Relationship to Patient					

Family Address if different to Next Of Kin	Telephone Numbers including Mobile Phone
Significant Other/Person/s at Risk	Address
Relationship To Patient	

Psychiatric Condition/ History/ Physical Issues

Current Psychiatric Medication	Current Other Medication
	Haloperidol, Lorazepam, Procyclidine

Allergies

Specific Risk Factors

Previous Absconding	Date	
	Outcome	

Any Other Information

DETAILS OF INCIDENT

Date Of Incident	
Time Reported Missing	
Place Last Seen	
Time Last Seen	

Current Mental State

Current Description (including Clothing if known)				
Any Other Relevant Information				
Specific Information; i.e. Passport Number, Bank Book Number etc				
Name Of Incident Officer/N.I.C.				Grade
Time Unit Coordinator Informed				
Time Senior Nurse Informed				
Details Faxed/E-mailed to Police				Time Sent
Faxed		E-Mailed		
North Wales Police Fax Number				
North Wales E-Mail Address				

Members of the Working Group:

Name	Title
Simon Allen	Service Manager
Ian Jones	Practice Development Nurse
Lisa Jones	Modern Matron
Dr Caroline Mulligan	Consultant Forensic Psychiatrist
Dr Faoud Bassa	Consultant Forensic Psychiatrist
Louise Llewelyn	OT Service Manager
Dr Julia Wane	Consultant Clinical Psychologist
Dr Katie Elliott	Consultant Clinical Psychologist
Paul Grimshaw	Reception Supervisor
Anne Hills Jones	Administration Manager
Greg Yates	Ward Manager
Harri Roberts	Ward Manager
Nicky Jones	Ward Manager
Gareth Griffiths	BCUHB Fire Officer

Engagement has taken place with:

Name	Title	Date Consulted
North Wales Fire Service		January 2019
Welsh Ambulance Service		January 2019
North Wales Police		January 2019
MH & LDS Division		

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

EQUALITY IMPACT ASSESSMENT FORMS
PARTS A and B: SCREENING AND OUTCOME REPORT

Introduction:
These forms have been designed to enable you to record, and provide evidence of how you have considered the needs of all people (including service users, their carers and our staff) who may be affected by what you are writing or proposing, whether this is:

- a policy, protocol, guideline or other written control document;
- a strategy or other planning document e.g. your annual operating plan;
- any change to the way we deliver services e.g. a service review;
- a decision that is related to any of the above e.g. commissioning a new service or decommissioning an existing service.

This is not optional: Equality Impact Assessment is a specific legal requirement on public sector organisations under equalities legislation and failure to comply could result in a legal challenge to a decision or strategy. More importantly, equality impact assessment helps to inform better decision-making and policy development leading to improved services for patients. **This form should not be completed by an individual alone, but should form part of a working group approach.**

The Forms:
You must complete:

- **Part A** – this is the Initial Screening that is always undertaken and consists of Forms 1 to 3; these forms are designed to enable you to make an initial assessment of the potential impact of what you are doing, and decide whether or not you will need to proceed to a Full Impact Assessment (Part C);

AND

- **Part B** – this is the Outcome Report and Action Plan (Form 4) you will need to complete whether or not you proceed to a Full Impact Assessment;

Together, these forms will help to provide evidence of your Impact Assessment and how you have shown “due regard” to the duties.

You may also need to complete **Part C** (see separate Form) – if parts A and B indicate you need to undertake a Full Impact Assessment. This enables you to fully consider all the evidence that is available (including engagement with the people affected by your document or proposals) to tell you whether your document or proposal will affect people differently. It also gives you the opportunity to consider what changes you may need to make to eliminate or mitigate any adverse or negative impact you have identified.

Remember that these forms may be subject to external scrutiny e.g. under a Freedom of Information request.

To enter text, click on the grey box in the part of the form you are completing. Help text will appear in the status bar at the foot of the page. Some boxes have drop-down lists from which you can select options. Others may simply be a box to answer a question. Once completed, the EqIA Forms should accompany your document or proposal when it is submitted to the appropriate body for approval.

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

Part A

Form 1: Preparation

1.	What are you equality impact assessing? What is the title of the document you are writing or the service review you are undertaking?	Forensic Service Major Incident Plan	
2.	Provide a brief description, including the aims and objectives of what you are assessing.	The is an assessment of the impact of the implementation of an major incident plan for forensic mental health services within the Mental Health and Learning Disability Division, BCUHB. The major incident plan is designed to outline process and procedures to be followed in the event of a major incident within services as defined by the plan. A major incident is categorised as: Fire, Bomb, Hostage, Firearm, Large Scale Disorder, Multiple Escape.	
3.	Who is responsible for the document/work you are assessing – i.e. who has the authority to agree/approve any changes you identify are necessary?	Forensic Mental Health Service Management Team	
4.	Who is Involved in undertaking this EqIA? Include the names of all the people in your sub-group.	Name	Title/Role
		Ian Jones	Forensic Practice Development Nurse/Security Lead
		Simon Allen	Service Manager
5.	Is the Policy related to, or influenced by, other Policies/areas of work?	Mental Health Measure (Wales 2010) 'Revised Adult Mental Health Services National Service Framework' (2005) Guidance for Commissioners of Forensic Mental Health Services (Joint Commissioning Panel for Mental Health, May 2013) National Policing Improvement Agency Guidance on Command and Control Minimum Standards for Medium Secure Units (RPsych 2010)	
6.	Who are the key Stakeholders i.e who will be affected by your document or proposals?	BCUHB North Wales Police North Wales Fire and Rescue Welsh Ambulance Trust	

		Welsh Health Specialised Services Committee Secure Services Contract Team Ministry of Justice
7.	What might help/hinder the success of whatever you are doing, for example communication, training etc?	Circulation and communication of the document Staff training and awareness Inter-agency development of process Key stakeholders communicating the plan effectively within their own organisations. Preparatory walk through of plans Ongoing robust maintenance of the plan

Form 2: Considering the potential impact of your document, proposals etc in relation to equality and human rights

Characteristic or other factor to be considered	Potential Impact by Group. Is it:-		Please detail here, <u>for each characteristic listed on the left</u>:- (1) any Reports, Statistics, Websites, links etc. that are relevant to your document/proposal and have been used to inform your assessment; and/or (2) any information gained during engagement with service users or staff; and/or (3) any other information that has informed your assessment of Potential Impact.
	Positive (+) Negative (**-**) Neutral (**N**) No Impact/Not applicable (**N/a**)	Scale (see Table A on next page)	
Age	Neutral		Clinical assessments and treatment planning allow due consideration for any age related factors. These factors would be taken into account during the implementation of any part of the plan.
Disability	Negative		There is a risk that implementation of the plan might result in an individual being temporarily cared for in an environment which might not be the conducive to their immediate needs. The nature of the major incidents which the plan caters to means that a pragmatic approach to immediate care and management might need to be adopted in order to ensure the safety of all affected by the incident.
Gender Reassignment	Neutral		
Pregnancy & Maternity	N/A		
Race / Ethnicity	Neutral		An individual's race / ethnicity will be fully taken into account during care and treatment planning and by proxy the major incident plan. Any change in the environment in which an individual might be cared for will be planned taking their race and ethnicity into account.
Religion or Belief	Negative		There is a risk that implementation of the plan might result in an individual being temporarily cared for in an environment which might not be the conducive to their immediate needs. There may be situations whereby the environment in which the individual is temporarily cared for might not have access to facilities required for an individual to practice their faith. The nature of the major incidents which the plan caters to means that a pragmatic approach to immediate care and management might need to be adopted in order to ensure the safety of all affected by the incident.
Sex	Neutral		The in patient unit currently has single sex facilities only but during implementation of the Major Incident Plan we cannot guarantee that a change in the environment in which the individual is temporarily cared for will be single sex.
Sexual Orientation	Neutral		Clinical assessments and treatment planning allow due consideration for any issues related to sexual orientation. These factors would be taken into account during the implementation of any part of the plan.
Welsh Language	Negative		The organisational commitment to supporting the Welsh Language Act and service user language preferences is identified through assessment and care and treatment planning. However during implementation of the Major Incident Plan we cannot guarantee that a change in the environment in which the individual is temporarily cared for will comply with the Welsh Language Act.
Human Rights	Neutral		Application of this pathway would take into account the Mental health Act 1983 – Code of Practice, Human Rights Act 1998, Mental Capacity Act 2005 – Code of Practice, Deprivation of Liberty Safeguards – Code of Practice

Guidance on completing Form 2: For each of the characteristics listed, and considering the aims and objectives you detailed in Q2 on Form 1, you need to consider whether your document or proposal likely to affect people differently, and if so, will this be in a positive or negative way? For example, you need to decide:

- will it affect men and women differently?
- will it affect disabled and non-disabled people differently?
- will it affect people in different age groups differently? - and so on covering all the protected characteristics.

Use the table below to indicate the scale of any impact identified. The factors used to determine an overall assessment for each characteristic should include consideration of scale and proportionality as well as potential impact.

Table A

High negative	Note: It is important to understand that we will be required to demonstrate what we have considered and/or done in order to mitigate or eliminate any negative impact on protected groups identified within the assessment. Details should be recorded in sections 3a/3b in the Action Plan in Form 4.
Medium negative	
Low negative	
Neutral	
Low positive	
Medium positive	
High positive	
No impact/Not applicable	

Form 3: Assessing Impact Against the General Equality Duty

As a public sector organisation, we are bound by the three elements of the "General Duty". This means that we need to consider whether (if relevant) the policy or proposal will affect our ability to:- • Eliminate unlawful discrimination, harassment and victimisation; • Advance equality of opportunity; and • Foster good relations between different groups	
1. Describe here (if relevant) how you are ensuring your policy or proposal does not unlawfully discriminate, harass or victimise	We are ensuring that this document does not unlawfully discriminate, harass or victimise through a robust system of review and maintenance of the plan in accordance with the patient population profile.
2. Describe here how your policy or proposal could better advance equality of opportunity (if relevant)	By ensuring that continual access to forensic services is ensured to both service users and other professionals and is available as a clinical option for service users in line with assessment and eligibility despite disruptions in core service continuity.

3. Describe here how your policy or proposal might be used to foster good relations between different groups (if relevant)	It provides an approach that strengthens the concept of co-working and collaboration between different partner organisations to ensure achieving a common aim of patient and public safety and security.

Part B:

Form 4 (i): Outcome Report

Organisation:	BETSI CADWALADR UNIVERSITY HEALTH BOARD

1. What is being assessed?	Forensic Service Major Incident Plan

2. Brief Aims and Objectives:	To assess the impact of the implementation of major incident plan for forensic mental health services within the Mental Health and Learning Disability Division, BCUHB.

3a. Could the impact of your decision/policy be discriminatory under equality legislation?	Yes	No x
3b. Could any of the protected groups be negatively affected?	Yes x	No
3c. Is your decision or policy of high significance – consider the scale and potential impact across BCUHB including costs/savings, the numbers of people affected and any other factors?	Yes x	No

4. Did the assessment of potential impact on Form 2, coupled with your answers to the 3 questions above indicate that you need to proceed to a Full Impact Assessment?	Yes ☐	No x
	Record Reasons for Decision i.e. what did the assessment of scale on Form 2 indicate in terms of positive and negative impact for each characteristic? Low negative identified with regards to religion and belief, disability and Welsh language characteristics which would be covered within assessment and care and treatment planning and appropriate liaison with other services relevant to the service user's care. Implementation of the Major Incident Plan might result in the temporary inability to cater for the needs of the characteristics above but these would be considered as a matter of urgency for each individual affected by the incident. The needs of the patient population will be reviewed on a regular basis and the detail of the management of a major incident adapted to meet their needs whenever possible within the caveat that there may potentially be an overriding responsibility to safety and security for a limited period of time.	

5. If you answered 'no' above, are there any issues to be addressed e.g. mitigating any identified minor negative impact?	Yes ☒	No ☐	Not applicable ☐
	As indicated above .		

6. Are monitoring arrangements in place so that you can measure what actually happens after you implement your document or proposal?	Yes ☒	No ☐
	How is it being monitored?	Robust multi agency debriefing process post incident.
	Who is responsible?	Forensic Mental Health Services Management Group
	What information is being used?	Factual information post incident. Key stakeholder feedback on the implementation of methodologies contained within the plan.
	When will the EqIA be reviewed? (Usually the same date the policy is reviewed)	January 2022

7. Where will your decision or policy be forwarded for approval?	MH & LDS Division

8. Describe here what engagement you have undertaken with stakeholders including staff and service users to help inform the assessment	In developing the document due consideration has been given to the various protective characteristics and their protection within clinical practice. Key stakeholder agencies have been involved in the construction of the plan and retain their own responsibilities for implementing strategies to manage major incidents aligned with the plan. The EQUI will be circulated alongside the Procedure document for broader consultation

	Name	Title/Role
9. Name/role of person responsible for this Impact Assessment	Ian Jones Simon Allen	Forensic Practice Development Nurse/Security Lead Service Manager
10. Name/role of person approving this Impact Assessment	Statutory compliance committee	
Please Note: The Action Plan below forms an integral part of this Outcome Report		

Form 4 (ii): Action Plan
This template details any actions that are planned following the completion of EqIA including those aimed at reducing or eliminating the effects of potential or actual negative impact identified.

	Proposed Actions	Who is responsible for this action?	When will this be done by?
1. If the assessment indicates significant potential negative impact such that you cannot proceed, please give reasons and any alternative action(s) agreed:			
2. What changes are you proposing to make (or have already made) to your document or proposal as a result of the EqIA?	Ensure inclusion in individual patient profiles any needs under the protective factors of: disability, religion/belief, Welsh language.		
3a. Where negative impact(s) on certain groups have been identified, what actions are you taking or are proposed to mitigate these impacts? Are these already in place?	As above.		

	Proposed Actions	Who is responsible for this action?	When will this be done by?
3b. Where negative impact(s) on certain groups have been identified, and you are proceeding without mitigating them, describe here why you believe this is justified.			
4. Provide details of any actions taken or planned to advance equality of opportunity as a result of this assessment.	Implementation of document	Ian Jones Simon Allen	March 2019

NOTE: If your decision recorded above is that you will need to proceed to a Full Equality Impact Assessment, then you should refer to the Full Impact Assessment Forms (Part C)

This page is intentionally blank

Note: For detailed guidance on the completion of these forms, please refer to Chapter 3 of the Toolkit that is available on the Equality pages of the BCUHB Intranet site.

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Version 3

MHLD 0041

Mental Health & Learning Disabilities Division
POLICY FOR THE USE OF HANDCUFFS
(Specific to Ty Llywelyn Medium Secure Unit)

Author & Title	Paul Hanna, Head of Nursing, Regional Specialist Services, Mental Health and Learning Disability Division Simon Allen, Clinical Operational Manager for Forensic and Rehab Services				
Responsible Dept / Director:	Director of Mental Health and Learning Disabilities Division				
Type of Document	Policy				
Approved by:	MHLD Policy Implementation Group 07.05.19 MHLD Q-SEEL – 16.05.19 PAG – 12.08.19 Chairs Approval QSG 11.09.19				
Date approved:	QSE				
Date activated (live):	June 2019				
Documents to be read alongside this document:	• Health Offender Partnerships 2007 Best Practice Guidance: Specification for Adult Medium Secure Services • Crown Prosecution Service: Handcuffing of Defendants 2008 • Association Chief Police Officers England, Wales and Northern Ireland 2006: Guidance on the Use of Handcuffs • Mentally Disordered Offenders: the restricted patient system • Handcuffing Course Guidance Booklet – Jan 2019				
Date of next review:	May 2022				
Date EqIA completed / reviewed:	April 2018				
First operational:	September 2018				
Previously reviewed:					
Changes made yes/no:					
Details of changes since last review					

N.B. Staff should be discouraged from printing this document. This is to avoid the risk of out of date printed versions of the document. The Intranet should be referred to for the current version of the document

CONTENTS

1. INTRODUCTION

1.1 The aims of this policy are to provide information and guidance for staff concerning:

- The reasons for the use of handcuffs;
- The requirement for appropriate assessment and justification before their use; and
- Their roles and responsibilities in relation to the use of handcuffs.

1.2 Handcuffs will be required for the maintenance of security and / or safety in certain circumstances, as directed by the Ministry of Justice, when patients are being escorted outside a secure perimeter or transferred to another unit or establishment. The most common example is when there is a significant risk that a patient may attempt to abscond whilst escorted to an external appointment. Another is when there is a significant risk that a patient will attempt to cause harm while being escorted outside or being transferred.

1.3 At the pre-admission meeting before a service user is admitted the issue of emergency leave and whether the use of handcuffs needs to be considered will be agreed and documented by the Multi-Disciplinary Team and a lead from the Positive Interventions Clinical Support Service (PICSS).

1.4 Despite the above points, it is important to note, the guiding principle is that patients will not have handcuffs applied routinely while being escorted or transferred. In order to adhere to this principle and to comply with relevant guidance and legislation, an individual risk assessment should take place before any use of handcuffs. These assessments should take into account the following points.

- The patient's circumstances and background;
- Their current and recent presentations;
- The circumstances and environment of the proposed trip outside a secure perimeter;
- risks to the safety of the patient;
- risks to the safety of the escorting staff;
- risks to the safety of other professionals;
- risks to the safety of the public

1.5 Ordinarily, those who undertake this assessment will be members of the patient's multi-disciplinary team (MDT), including where possible, the person who will be the Lead Nurse for the secure escort and the person who will apply the handcuffs. The assessing members of staff should be satisfied that, acting in good faith,

they have considered matters objectively and come to a decision that they believe to be defensible should it be questioned or challenged.

1.6 For planned occasions when a patient will be escorted to a non-secure environment and there will be (or may be) a requirement to remove the handcuffs, there should be a management plan that addresses this in detail.

1.7 Mental Health Act Code of Practice for Wales (revised 2016) states that in some exceptional circumstances where the patient's behaviour leads to the identification of the need for some form of mechanical restraint, such restraint may, in certain circumstances, be agreed by the hospital managers.

1.8 As outlined above, the use of handcuffs is not the first line method of managing disturbed or violent behaviour within Betsi Cadwaladr University Health Board. As the use of handcuffs undoubtedly constitutes a form of mechanical restraint, this policy is intended to satisfy the *Code of Practice* requirement for a policy to be in place governing handcuff use.

1.9 The application of handcuffs will be considered a use of force. This means that each application of handcuffs to a patient must be reasonable, necessary and proportionate intervention for each individual occasion. Intentional application of force to a person will constitute an assault if it is not justifiable.

1.10 The principal legal authority that is relevant to such instances stems from Section 3(1) Criminal Law Act 1967 and from Common Law (re: self defence and preventing a breach of the peace). The members of staff who escort a patient may use force in order to prevent crime and to stop a patient from becoming unlawfully at large. When secure transfers are undertaken, section 137 MHA 1983, `Provisions as to custody, conveyance and detention`, is also relevant. The members of staff who undertake a secure transfer may use reasonable force in order to stop a patient from escaping from legal custody.

1.11 Written confirmation of use of handcuffs must be completed on the relevant form, `Record of Use of Handcuffs'. This confirmation will be undertaken jointly by the Lead Nurse for the escort and the member of staff who applies the handcuffs. However, it is important that both understand their contributions to this.

1.12 As the application of handcuffs will be considered a use of force, the following points apply to the person who applies the handcuffs:

- She or he must be aware of all relevant facts, including the risk assessment,
- She or he must believe the use of handcuffs to be appropriate and reasonable on that occasion.

These matters are essential because she or he is responsible for her/his actions.

1.13 The Lead Nurse for the escort / transfer has overall responsibility and accountability for the escort so:

- She or he must be a registered practitioner, Band 5 or above who has been involved in the leave planning, risk assessment and will also have awareness of the patients individualised care plan.

1.14 The person whom the patient will be handcuffed to should be appropriately trained and assessed as a suitable escort and amenable to undertake this role,

- She or he will be involved in the planning and have an awareness of any identified risk factors.

.

2. SCOPE

This policy applies to all staff working clinically with patients, or involved in authorisation for/ application of handcuffs in the Ty Llywelyn Forensic Service.

3. DUTIES

3.1 Chief Executive

The Chief Executive is responsible for ensuring the Health Board has appropriate policies in place and complies with its legal and regulatory obligations.

3.2 Accountable Director

The Executive Director for Mental Health Services is the responsible Director for this policy and has overall responsibility for ensuring that the security policy and practice within the Ty Llywelyn Forensic Service to legislative requirements and the Clinical Security Framework.

3.3 Multi Disciplinary Teams

As far as practicable, multi-disciplinary teams are responsible for discussing and planning leave (including secure escorts/transfers), and completing a risk assessment prior to the leave commencing. In relevant cases, the risk assessment will include consideration of whether or not use of handcuffs is appropriate.

3.4 The Positive Interventions Clinical Support Service

The Positive Interventions Clinical Support Service will be a standing member of the MDT when the use of handcuffs is being considered. They will support the Handcuff Monitoring group that will meet on a quarterly basis to review the use of handcuffs in the period.

3.5. The escorting team of staff

3.5.1 When handcuffs are used to escort or transfer a patient, the escorting team of staff will have at least 3 members. On almost all occasions, a vehicle will be used, and when this is the case, the team of 3 will not include the driver in its number.

3.5.2 All members of staff who make up the secure escort team must attend a briefing prior to escorting a patient in handcuffs. As far as practicable, the briefing should involve the Clinical team managing the service user's care. This can be done by contacting the relevant Security Department in advance and it is to ensure consistency in the undertaking of secure escorts and transfers. Where it is not practicable to have someone from the Clinical team involved, a briefing should still take place and include all members of staff who will form the escorting team. Even in the event of an unplanned/ emergency escort, the members of staff involved in escorting the patient should be made aware of the plan for the occasion and their roles and responsibilities. They must also know about basic safety procedures, in the event that the service user becomes difficult to manage while attached to a member of staff.

3.5.3 As mentioned in point 1.5 above, if there will be or may be a requirement to remove the handcuffs during the episode of leave, there should be a management plan that addresses that in detail. When handcuffs are used (or might be used) for a prolonged period – such as an inpatient stay in a general hospital – the management plan must include regular reviews of the use of the handcuffs. The reviews will include reviewing use of escort chains if these have been used (e.g. for a patient admitted to a general hospital. The Lead Nurse for the escort will be responsible and accountable for ensuring reviews are undertaken and recorded clearly. As a guide, reviews should be undertaken at least every day and when circumstances alter.

3.6 Staff at the secure reception

Staff at the secure reception will be responsible for issuing and receiving returned handcuffs, escort chains and keys. They will also be responsible for maintaining inventories of these.

4. JUSTIFICATION OF THE USE OF HANDCUFFS

4.1 As mentioned in Section 1 above, patients who are being escorted outside secure buildings will not have handcuffs applied routinely. An individual risk assessment should be undertaken in each case and this should lead to a professional, defensible decision being made. Any use of handcuffs must be justifiable.

4.2 As a guide for staff, the situations listed below may lead to decisions to use handcuffs.

4.2.1 Where it is assessed that the application of handcuffs is necessary to prevent the patient from trying to escape from our custody whilst outside a secure perimeter.

4.2.2 Where it is assessed that the application of handcuffs is necessary to prevent the patient from causing harm to others (e.g. escorting staff, members of the public) while being escorted or transferred.

4.2.3 Where it is assessed that the application of handcuffs is necessary to prevent the patient from causing harm to herself / himself while being escorted or transferred.

5. USE OF HANDCUFFS FOR PLANNED LEAVE

5.1 Relatively few episodes of leave within Ty Llywelyn require *secure* escort / transfer arrangements and the use of handcuffs, but of those that do, a distinction can be made between “planned” and “unplanned / emergency” occasions.

5.2 Episodes of planned leave that require secure escorting arrangements will be subject to thorough and documented risk assessment before they go ahead. This includes attending medical treatment that is not considered to be “urgent” or an “emergency”.

5.3 Generally, transfers that require secure arrangements will always be planned and not be emergencies so they too will be subject to thorough and documented risk assessment before they go ahead.

5.4 Both the decision to use handcuffs and the rationale for this should be documented clearly in the patient’s electronic record (Paragon).

5.5 All relevant authorisation must be complete and available to the escorting team of staff before the planned secure leave or secure transfer occurs. E.g. Section 17 form when applicable.

5.6 Patients who are subject to restriction orders also require suitable authorisation from the Ministry of Justice (MoJ) for leave.

5.6.1 If such leave has been granted in the past it must be checked whether or not the leave granted covers this particular episode. If it does not, or if the leave has since been revoked, further permission will be required.

5.6.2 For episodes of leave for medical treatment for restricted patients, MoJ document Annex B – *Medical leave application for restricted patients* – should be completed and submitted in advance.

5.6.3 If there is any doubt concerning MoJ authorisation, the MoJ should be contacted before the leave takes place in order to clarify matters.

5.7 In cases of transfer of patients subject to restriction orders, a warrant for transfer will be required from the MoJ.

5.8 The escorting team of staff should address and check all relevant paperwork as part of their briefing and prior to taking the patient out of the secure perimeter. They should not escort a handcuffed patient outside the secure perimeter unless they are satisfied that all is in order and all arrangements are clear to them.

5.9 The use of handcuffs should be explained to the patient prior to the leave or transfer. Wherever possible, s/he should be involved in the plan.

5.10 If there are any concerns that discussing the plan with the patient will increase the risk of her / him attempting to abscond or cause harm during the leave, or that it might cause her / him distress, staff should agree to limit the information that they provide. Matters discussed with the patient should be recorded in electronic records (Paragon) and the escorting team of staff must be made aware of what has and what has not been discussed with the patient.

5.11 The member of staff to whom the patient will be handcuffed will on all occasions be of the same gender. The lead nurse for the escort must satisfy themselves that the use of handcuffs will not impede the patient's or staff's (i.e. the person whom the patient will be handcuffed to) safety or wellbeing. The lead nurse will check the patient's wrists for any visible injuries and determine whether the application of handcuffs is appropriate. Any changes to skin integrity in this area prior to the application of handcuffs should be noted and recorded on a body map. Similarly, a check should be carried out on the person whom the patient will be handcuffed to, and any marks noted and recorded in the relevant paperwork.

5.12 During a planned secure escort in which handcuffs have been applied, they should only be removed if:

- their removal is stipulated for these circumstances on the management plan, or,
- in extreme circumstances, if there are clear grounds to justify this (e.g. if handcuffs are impeding essential examination or treatment).

The Lead Nurse for the escort will be responsible and accountable for the decisions and actions undertaken.

5.13 If neither of the above apply, but there appears to be a reason to remove the handcuffs, authorisation for their removal should be sought via telephone contact with a senior nurse (Modern Matron, Service manager or Bronze Manager on-Call) or someone in a more senior position than this.

5.14 Generally, handcuffs will not be removed during secure transfers. On arrival at the destination they should be removed only when in a secure part of the receiving unit / facility and following agreement with the receiving staff. In the event of extreme circumstances en route, if there were clear grounds to justify removal (e.g. if handcuffs were impeding essential examination or treatment) they could be removed. The Lead Nurse for the escort would be responsible and accountable for the decisions and actions undertaken.

5.15 If handcuffs have been removed during a secure escort or transfer, whether because this formed part of the management plan, following authorisation via the telephone or because of extreme circumstances, they should remain off only for as long as is necessary. The Lead Nurse for the escort will be responsible and accountable for the decisions and actions undertaken.

6. USE OF HANDCUFFS FOR UNPLANNED / EMERGENCY LEAVE

6.1 Unplanned secure *transfers* of patients to other units / facilities should not take place.

6.2 As a guide, unplanned *leave* that requires secure escorting arrangements and the use of handcuffs should not take place. However, in emergencies, such as when a patient who has no leave appears to require urgent or emergency medical treatment and this cannot be provided inside the relevant unit, secure escort should be facilitated.

6.3 As far as is practicable, an immediate risk assessment will be required prior to this unplanned / emergency leave so that suitable risk management arrangements can be put in place. E.g. use of handcuffs if indicated by the risk assessment, a suitable number of escorts, a secure vehicle if available.

6.4 As far as is practicable, the immediate risk assessment will be undertaken by the Nurse in Charge, the members of staff who will form the escort team and the Unit Co-ordinator. Wherever possible it should also be discussed with the Service Manager or the Bronze Manager on Call. The outcome of this assessment, including the rationale, plus details of those involved must then be documented by the Unit Co-ordinator in her / his report and by the Nurse in Charge (or a delegated Registered Nurse) in the patient's electronic record (Paragon). The Duty Senior Nurse of the unit and the Bronze on Call should also make a record of his/her involvement.

6.5 The risk assessment must balance the apparent risk to the patient with the heightened risk posed by such unplanned leave e.g. risk of absconding, risk to the public, risk to the escorting member of staff.

6.6 In extreme cases, such as when a patient is unconscious or immobile, in may be inappropriate to use handcuffs but appropriate to take them. This is in case the circumstances alter and the patient regains full consciousness or mobility.

6.7 Staff should be aware that a minority of patients might feign ill health or harm themselves intentionally in order to be taken out of a secure environment.

6.8 The Lead Nurse for the escort must satisfy themselves that the use of handcuffs will not impede the patient's or staff's (i.e. the person whom the patient will be handcuffed to) safety or wellbeing. The Lead Nurse will check the patient's wrists for any visible injuries and determine whether the application of handcuffs is appropriate. Any changes to skin integrity in this area prior to the application of handcuffs should be noted and recorded on a body map. Similarly, a check should be carried out on the person whom the patient will be handcuffed to, and any marks noted and recorded in the relevant paperwork.

6.9 During an unplanned secure escort/ in which handcuffs have been applied, they should only be removed if there are clear grounds to justify this (e.g. if they are impending essential medical examination or treatment). They should remain off only for as long as is necessary.

6.10 Relevant members of staff should be precise in recording the times and details of Contact and events: i.e. contents of discussions and subsequent decisions, times of handcuff removal and handcuff re-application etc.

6.11 If unplanned / emergency leave is required for a patient who is subject to a restriction order, MoJ authority should be obtained beforehand wherever possible. Where this is not practicable, the MoJ should be informed as soon as it is practicable. The MoJ should also be informed as soon as it is practicable. The MoJ should also be updated on the risk management arrangements and, when it takes place, the return of the patient within the secure perimeter.

7. RECORDS OF THE USE OF HANDCUFFS

7.1 It is important that the exact times of events are recorded clearly and sequentially:

The exact time at which the handcuffs were applied;

The exact time the patient (with escorting staff) left the secure building;

The exact time and place at which they were removed; and

Any other applications and removals that take place during the episode of secure level or transfer.

7.2 The names of staff involved and the patient must be documented clearly as per requirements on the relevant paperwork.

7.3 When the secure escort/transfer has been completed the Lead Nurse for the escort is responsible and accountable for overseeing the completion and then the distribution of copies of the forms.

8. ISSUE AND RETURN OF HANDCUFFS

8.1 Staff at the relevant secure reception will issue the handcuffs and keys to a member of the escorting team, and maintain a record of this. They will also record the return of the items when the escorting team return them.

9. TRAINING

9.1 Training in the use of handcuffs will be provided by Ty Llywelyn in house trainers who have undertaken Ashworth Hospital accredited 'Train the Trainers' course. This will be funded by Regional services and will be through BCUHB procurement processes.

9.2 All staff whose role may involve the use of handcuffs will be required to attend and complete approved in house training. Updates / refreshers should be completed (by meeting the set training criteria) every 2 years.

9.3 If more than 2 years has lapsed for a member of staff, she/he will not be 'live' in relation to handcuff training. As far as practicable, members of staff who are no longer on the 'live' register should not apply handcuffs to a patient nor be handcuffed to a patient.

9.4 Ty Llywelyn Handcuff trainers are required to maintain their skills via attendance and completion of trainers' training updates via:

Security Training Department
Merseyside NHS Foundation Trust
Indigo Building
Ashworth Hospital
Maghull
Merseyside
L31 1HW

10. MONITORING AND REVIEW

10.1 Ty Llywelyn will produce a *Use of Handcuffs* report quarterly which provides details of when handcuffs have been used in the service. Reports are distributed to Service Directors and Senior Managers and to the County Wide Services Senior Management meeting at its monthly meeting. The report will be reviewed by the leadership team with the support of the Centre Positive Interventions Clinical Support Service team.

10.2 In the instances of emergency handcuff use consideration will be given to completion of DATIX.

10.3 This policy will be reviewed every 3 years, or sooner where a need is identified. The Service Manager is responsible for ensuring the reviews are carried out

11. SUPPORTING DOCUMENTS/BIBLIOGRAPHY

Criminal Law Act 1967

Department of Health (2008) *Code of Practice, Mental Health Act 1983*: TSO

Department of Health (2008) *Reference Guide to the Mental Health Act 1983* London: TSO

Human Rights Act 1998

Mental Health Act 1983 (amended 2007)

Mental Health Act Code of Practice for Wales (2016)

MOJ form (Annex B), *Medical Leave application for restricted patients R (on the application of Graham) v Secretary of State for Justice [2007]*

[This provides interesting insight into a ruling on whether or not the handcuffs of a prisoner who was escorted for hospital treatment could constitute and infringement of his rights under Article 3 of the European Convention on Human Rights. Article 3 forbids torture and inhuman or degrading treatment.]

Appendix 1

Use of Handcuffs – Application for Authorisation Record Sheet

Patients name:	**Date of Birth:**
Sex: **Male / Female**	**Hospital Number:**
Ward:	**Legal Status:**
Consultant (RC):	

Reason for request for use:

Risk Assessment:	
Current Leave Status:	**Destination:**
Nature of Escort:	**Need for Escort:** **Low** **Medium** **High**
Index Offence:	

Past/recent history of absconding:	**Risk to public, staff or self:**
Current Mental State:	
Patients current physical state, (particularly conditions relevant to handcuff use, e.g. muscular-skeletal injuries):	
Risk assessment of destination/ Things to consider:	
Circumstances in which handcuffs may be removed & reapplied while outside of secure services:	
Staff escort number:	**Ratio and gender of staff to patient:**
Risk assessment related to risk of escape from the secure perimeter:	
Date:	**Completed by Print & sign:**

Authorisation 09:00 – 17:00 hours		
Authorised by: (Name)	**Signature:**	**Date:**
Authorised by: (Name)	**Signature:**	**Date:**

Declined by: (Name)	**Signature:**	**Date:**
Reason for refusal:		
Declined by: (Name)	**Signature:**	**Date:**
Reason for refusal:		

Authorisation Out of Hours		
Authorised by: (Name)	**Signature:**	**Date:**
Authorised by: (Name)	**Signature:**	**Date:**
Declined by: (Name)	**Signature:**	**Date:**
Reason for refusal:		
Declined by: (Name)	**Signature:**	**Date:**
Reason for refusal:		

Appendix 2

Use of handcuffs – Use form

Patients name:	**Date of Birth:**
Sex: **Male / Female**	**Hospital Number:**
Ward:	**Legal Status:**
Consultant (RC):	

Handcuffs applied by (Name):	**Signature**	**Date:**
Secure Transport used: **YES** ☐ **NO** ☐ **Handcuff use directs the use of secure transportation.**		
DETAILS OF EVENT / INCIDENT & GENERAL SAFETY PROCEDURES CARRIED OUT:		
Handcuffs removed by (Name):	**Signature:**	**Date:**

ANY INJURIES SUSTAINED:	**YES** ☐ **NO** ☐
IF YES, PLEASE GIVE DETAILS INCLUDING CAUSE OF INJURY:	
SEEN BY DOCTOR:	**YES** ☐ **NO** ☐
DATIX COMPLETED:	**YES** ☐ **NO** ☐

COPY AND SEND TO:	
Locality Manager Forensics	☐
Modern Matron Forensics	☐
Ward Manager	☐

Appendix 3

Handcuff use -Handcuff Condition Log Daily Check

Date:	Time:	Checked by: (print name)	Condition of Handcuffs/ Action Taken:	Signature:

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

EQUALITY IMPACT ASSESSMENT FORMS
PARTS A and B: SCREENING AND OUTCOME REPORT

Introduction:
These forms have been designed to enable you to record, and provide evidence of how you have considered the needs of all people (including service users, their carers and our staff) who may be affected by what you are writing or proposing, whether this is:

- a policy, protocol, guideline or other written control document;
- a strategy or other planning document e.g. your annual operating plan;
- any change to the way we deliver services e.g. a service review;
- a decision that is related to any of the above e.g. commissioning a new service or decommissioning an existing service.

This is not optional: Equality Impact Assessment is a specific legal requirement on public sector organisations under equalities legislation and failure to comply could result in a legal challenge to a decision or strategy. More importantly, equality impact assessment helps to inform better decision-making and policy development leading to improved services for patients. **This form should not be completed by an individual alone, but should form part of a working group approach.**

The Forms:
You must complete:

- **Part A** – this is the Initial Screening that is always undertaken and consists of Forms 1 to 3; these forms are designed to enable you to make an initial assessment of the potential impact of what you are doing, and decide whether or not you will need to proceed to a Full Impact Assessment (Part C);

AND

- **Part B** – this is the Outcome Report and Action Plan (Form 4) you will need to complete whether or not you proceed to a Full Impact Assessment;

Together, these forms will help to provide evidence of your Impact Assessment and how you have shown "due regard" to the duties.

You may also need to complete **Part C** (see separate Form) – if parts A and B indicate you need to undertake a Full Impact Assessment. This enables you to fully consider all the evidence that is available (including engagement with the people affected by your document or proposals) to tell you whether your document or proposal will affect people differently. It also gives you the opportunity to consider what changes you may need to make to eliminate or mitigate any adverse or negative impact you have identified.

Remember that these forms may be subject to external scrutiny e.g. under a Freedom of Information request.

Once completed, the EqIA Forms should accompany your document or proposal when it is submitted to the appropriate body for approval.

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

Part A

Form 1: Preparation

1.	What are you assessing i.e. what is the title of the document you are writing or the service review you are undertaking?	Use of Handcuffs in Ty Llywelyn Medium Secure Unit
2.	Provide a brief description, including the aims and objectives of what you are assessing.	This is an assessment of the impact of the implementation the Use of Handcuffs in Ty Llywelyn Medium Secure Unit Policy for Forensic Mental Health services, within the Mental Health and Learning Disability Division, BCUHB. The Policy is designed to outline process and procedures to be followed when utilising high risk escorted leave that require planned use of Handcuffs.
3.	Who is responsible for the document/work you are assessing – i.e. who has the authority to agree/approve any changes you identify are necessary?	Forensic Service Management team
4.	Is the Policy related to, or influenced by, other Policies/areas of work?	Therapeutic Engagement and Observation Policy Ty Llywelyn Security Policy Ty Llywelyn Escort Policy Ty Llywelyn Section 17 Therapeutic Leave Policy Code of Practice for Wales 2016
5.	Who are the key Stakeholders i.e. who will be affected by your document or proposals?	BCUHB MSU Patient Group Families and Carers Ministry of Justice
6.	What might help/hinder the success of whatever you are doing, for example communication, training etc?	Circulation and communication of the document Staff training and awareness Patient awareness sessions

Form 2: Considering the potential impact of your document, proposals etc in relation to equality and human rights

Characteristic or other factor to be considered	Potential Impact by Group. Is it:-		Please detail here, <u>for each characteristic listed on the left</u>:- (1) any Reports, Statistics, Websites, links etc. that are relevant to your document/proposal and have been used to inform your assessment; and/or (2) any information gained during engagement with service users or staff; and/or any other information that has informed your assessment of Potential Impact.
	Positive (+) Negative (**-**) Neutral (**N**) No Impact/Not applicable (**N/a**)	High Medium or Low	
Age	N/A		Clinical assessments and treatment planning allow due consideration for any age related factors. These factors would be taken into account during the implementation of any part of the policy for both staff and patients.
Disability	Neutral		Disability will be taken account for patients, staff and others by way of regular risk assessment of any individuals residing or working in Ty Llywelyn who has a recognised disability which requires adjustments to be made.
Gender Reassignment	N/A		Gender reassignment would be taken into account for the patient on admission and for staff following pre leave planning stage, risk assessment.
Pregnancy & Maternity	Neutral		No impact to patient group – All male. Escorting staff will require risk assessment to ensure high risk escort and application of handcuffs is appropriate in line with BCUHB policy.
Race / Ethnicity	N/A		An individual's race / ethnicity will be fully taken into account during care and treatment planning and leave risk assessment.
Religion or Belief	N/A		Religion and belief would be taken into account on admission and included in the care and treatment plan. Consideration given to escorting staff beliefs and religious ideation when planning leaves, although no impact when using handcuffs.
Sex	N/A		The gender of any escorting staff will be taken into account and included in any risk assessment carried out prior to leave out of the unit being authorised however the use of handcuffs should not have an impact on gender.
Sexual Orientation	N/A		Clinical assessments and treatment planning allow due consideration for any issues related to sexual orientation although this will not impact on any individual staff member or patient.
Welsh Language	Neutral		The organisational commitment to supporting the Welsh Language Act and service user language preferences is identified through assessment and care and treatment planning Welsh language will be taken into account when planning all leaves and explanations of policy use can be provided in the medium of welsh if required.

Human Rights	Neutral		Application of this policy would take into account the Mental health Act 1983 – Code of Practice, Human Rights Act 1998, Mental Capacity Act 2005 – Code of Practice, Deprivation of Liberty Safeguards – Code of Practice.

Guidance on completing Form 2: For each of the characteristics listed, and considering the aims and objectives you detailed in Q2 on Form 1, you need to consider whether your document or proposal likely to affect people differently, and if so, will this be in a positive or negative way? For example, you need to decide:

- will it affect men and women differently?
- will it affect disabled and non-disabled people differently?
- will it affect people in different age groups differently? - and so on covering all the protected characteristics.

Use your judgement to indicate the scale of any impact identified. The factors used to determine an overall assessment for each characteristic should include consideration of scale and proportionality as well as potential impact.

Form 3: Assessing Impact Against the General Equality Duty

As a public sector organisation, we are bound by the three elements of the "General Duty". This means that we need to consider whether (if relevant) the policy or proposal will affect our ability to:- • Eliminate unlawful discrimination, harassment and victimisation; • Advance equality of opportunity; and • Foster good relations between different groups	
1. Describe here (if relevant) how you are ensuring your policy or proposal does not unlawfully discriminate, harass or victimise	The policy operates within the mental health act code of Practice legislation and use of handcuffs will be pre planned and care planned following documented risk assessment from the clinical team.
2. Describe here how your policy or proposal could better advance equality of opportunity (if relevant)	Enables staff to reduce the risks presented to the patient and others when utilising high risk leave outside of the secure perimeter of the medium secure unit when accessing additional treatment, supporting court attendance and hospital transfer.
3. Describe here how your policy or proposal might be used to foster good relations between different groups (if relevant)	It provides an approach that strengthens the concept of collaboration and support between Forensic services, Wider BCUHB services, Police, Probation the Courts and Prison service.

Part B:

Form 4 (i): Outcome Report

Organisation:	BETSI CADWALADR UNIVERSITY HEALTH BOARD

1. What is being assessed? (Copy from Form 1)	Use of Handcuff in Ty Llywelyn Medium Secure Unit

2. Brief Aims and Objectives: (Copy from Form 1)	This is an assessment of the impact of the implementation of Use of Handcuff in Ty Llywelyn Medium Secure Unit Policy for forensic mental health services, within the Mental Health and Learning Disability Division, BCUHB. The Policy is designed to outline process and procedures to be followed when planning, applying for and implementing safe use of Handcuffs within Ty Llywelyn, Medium Secure Unit.

3a. Could the impact of your decision/policy be discriminatory under equality legislation?	Yes	No X
3b. Could any of the protected groups be negatively affected?	Yes	No X
3c. Is your decision or policy of high significance?	Yes X	No

4. Did the decision scoring on Form 3, coupled with your answers to the 3 questions above indicate that you need to proceed to a Full Impact Assessment?	Yes	No X
	Record here the reason(s) for your decision i.e. what did Forms 2 & 3 indicate in terms of positive and negative impact for each characteristic?	

5. If you answered 'no' above, are there any issues to be addressed e.g. mitigating any identified minor negative impact?	Yes	X
	Record Details:	

6. Are monitoring arrangements in place so that you can measure what actually happens after you implement your document or proposal?	Yes X	No
	How is it being monitored?	All incidents of Handcuff use will be reviewed by Ty Llywelyn clinical team and datix completed for review by Mental Health division governance / Putting things right team.
	Who is responsible?	Ty Llywelyn Clinical team
	What information is being used?	Existing record keeping process within the medium secure unit including risk assessments, use of handcuff documentation to be reviewed by modern matron.
	When will the EqIA be reviewed? (Usually the same date the policy is reviewed)	During next policy review

7. Where will your decision or policy be forwarded for approval?	MH/LD divisional policy meeting

8. Describe here what engagement you have undertaken with stakeholders including staff and service users to help inform the assessment	Policy approved by BCUHB, Forensic senior management team, Health inspectorate Wales and WHSSC also involved. Policy also went for Consultation with Ty Llywelyn staff group.

9. Names of all parties	Name	Title/Role

involved in undertaking this Equality Impact Assessment:		
	Simon Allen	Service manager
	Paul Hanna	Modern Matron
Please Note: The Action Plan below forms an integral part of this Outcome Report		

Form 4 (ii): Action Plan
This template details any actions that are planned following the completion of EqIA including those aimed at reducing or eliminating the effects of potential or actual negative impact identified.

	Proposed Actions	Who is responsible for this action?	When will this be done by?
1. If the assessment indicates significant potential negative impact such that you cannot proceed, please give reasons and any alternative action(s) agreed:			
2. What changes are you proposing to make to your document or proposal as a result of the EqIA?			
3a. Where negative impacts on certain groups have been identified, what actions are you taking or are proposed to mitigate these impacts? Are these already in place?			
3b. Where negative impacts on certain groups have been identified, and you are proceeding without mitigating them, describe here why you believe this is justified.			
4. Provide details of any actions taken or planned to advance equality of opportunity as a result of this assessment.	Circulation and communication of the Policy document Staff training and awareness Patient awareness sessions	Modern Matron / Ward Managers	Following approval of policy

Quality, Safety & Experience Committee **28th January 2020**	GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board *To improve health and provide excellent care*

Advisory Group Chair's Report

Name of Advisory Group:	Quality and Safety Group

Meeting date:	8th November 2019

Name of Chair:	Deborah Carter, Director of Operations, Associate Director of Quality Assurance

Responsible Director:	Deborah Carter, Director of Operations, Associate Director of Quality Assurance

Summary of key items discussed:	**Mental Health & Learning Disabilities** Year to date since the 'Today I can' idea was raised, as a divisional response to the HASCAS recommendations. Tryweryn ward team won the 'Nursing times' Team of the year award for the work done in reducing the number of patient restraints episodes. **Point of care testing update– David Fletcher** DF informed that group disappointingly they have not been able to progress actions as planned, successful recruitment has taken place to increase the team which should progress the work. Plan is to review the teams available, and look at restructuring, the gap analysis will feed into the business case for a sustainable service in the future. Report talked through, agreed that a bigger piece of work is needed and will feedback into **February meeting**. **Clinical audit plan – Q2** MM informed the group that the report for today's meeting was not circulated due to the Audit committee not being happy with the contents. Although there are staffing shortages within the corporate team, the plan is progressing well. MM asked for Secondary care focus on the national audits and a

	plan on how to deliver next year. **DoLS – Michelle Denwood** Paper covered the changes in legislation requirement, MD highlight that the DoLs team are currently only trained for adults and is working on the requirements to enhance the team**.** Task & finish group has been set up to work through the actions, determine the risks and develop plans**.**
Key advice / feedback for the QSE:	**Risks to highlight:** <u>Central</u> • Failure to recruit/ retain primary care GPs and clinical staff – score 15 • Risk of shortage of registered domiciliary health workers due to implementation of inspection of social care act 2016 – score 15 <u>East</u> • Methadone incident at HMP Berwyn talked through, distraction was the main cause and discussions are taking place to resolve this. <u>MH&LD – Steve Forsyth</u> • Heddfan doors - further damage to some doors due to patient behaviours, alternative fixes being looked at. Still a number of beds out of commission as a result, but patients are being repatriated back to north Wales from out of area – **score 15** <u>Childrens</u> • Flu vaccination in Schools – on advice from PHW the flu immunisation sessions planned for children aged 4-10 years in schools in November have had to be reprogrammed. With at least a 2 week delay. Further advice on sessions beyond these two weeks will be issued as soon as possible taking into account the latest information on vaccine availability. This affects all the UK and is due to quality control manufacturing issues. To ensure that the delay in vaccine supply does not impact on those who are most vulnerable, we are prioritising LAIV vaccination in primary care of children: o aged 2 and 3 years o aged 2 to 17 years in a clinical risk group who would normally receive LAIV (including those who would normally receive a vaccine in school). <u>Pharmacy and Meds management</u> • An external audit of the four Sterile Production Units was undertaken in September and October 2019 by the National Quality Assurance Lead for Wales. Although internal audit takes

	place against Medicines and Healthcare Regulation Authority (MHRA) standards, this independent assessment is particularly important, as the licensed sites (YGC & YMW) are due inspections by the MHRA. As NHS licensed manufacturing units are treated the same as commercial organisations, any deviations from the Good Manufacturing Standards need to be addressed urgently. Each audit report is accompanied by an action plan and each site is required to provide a response to the recommendations within 28 days of receipt. • Medicine shortages – A risk assessment is undertaken on impact of each shortage taking into consideration where they are used, the potential impact of the shortage, early communication with clinicians to consider therapeutic alternatives & the centralisation of BCUHB stock - **score 20** <u>West – Chris Lynes</u> • Insufficient domiciliary care workers following introduction of RISCA (2016) – score 16 • Rheumatology from 15th November 2019 the service will be down to one consultant, with 2 vacancies. There is insufficient capacity to meet demand therefore patients will not be seen in a timely manner and will result in 52 week breaches –**score 20** <u>Secondary care</u> • Discussions are taking place regarding the fragility of the cancer service - **score 20** • Breast Radiology - NWMCS have not been able to recruit which is impacting on the service being delivered at YGC. The risk has risen back to a **score of 25** and mitigations are being explored. Secondary Care are working with NWMCS and Adrian Thomas, Executive Director of Therapies and Health Sciences. A paper is being prepared for EMG. <u>Estates & Facilities</u> • Wrexham Maelor - Business continuity programme case has been submitted to WG, excepting response in January 2020 - **score 16** • VAP/WAP – currently have 28 posts awaiting approval, additional delays to the existing lengthy TRAC process, currently underspend on budget for pay– **score 18** Group also highlighted that Domestics have an impact on clinical services, Infection Prevention rates, and there is also an increase in overtime payments

Special Measures Improvement Framework Theme/Expectation addressed	
Planned business for the next meeting:	To be determined from cycle of business
Date of next meeting:	12th December 2019

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

Quality, Safety & Experience Committee

28th January 2020

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

To improve health and provide excellent care

Advisory Group Chair's Report

Name of Advisory Group:	Quality and Safety Group
Meeting date:	12th December 2019
Name of Chair:	David Fearnley, Executive Medical Director
Responsible Director:	Mrs Gill Harris - Executive Director of Nursing and Midwifery
Summary of key items discussed:	<u>East - Andrea Hughes</u> • There was a hostage situation at HMP Berwyn which involved a prisoner refused parole taking a member of staff hostage. The review/ investigation has taken place and appropriately reported (No harm incident). <u>Pharmacy & Medicine Management – Louise Howard-Baker</u> • Interventions – a cost avoidance exercise took place on one day in November which highlighted savings of £58k and had common themes identified. <u>Mental Health – Adrian Jones</u> • Dementia care mapping on Gwynwyn ward showed a remarkable improvement since last undertaken (acknowledged leadership changes) • Heddfan doors - to date 5 of the doors have been repaired/ replaced and the sixth door will be reconfigured to enable this to be opened outwards, if successful then will look at rolling this design out - (risk score 15) <u>Dashboard demonstration – Martin Williams</u> MW provided a demonstration of the new version of the nursing portal (previously known as the harms dashboard)

	Ward Accreditation/ HAPU/ Falls collaboration update – Di Read DR informed the group that the detailed figures have been increased since the report was written to: • 27 wards silver • 32bronze • 9 white There is no backlog of wards awaiting validation, with 80 wards done so far, for which there are a number of themes that are are similar. Neonatal death review report – Siobhan Adams The review is retrospective and many service improvements have been made since 2016, which have been referred to within the report. Local reviews are also being conducted and action plans are in place for further service improvements, which provides assurance of governance arrangements. Q2 Health & Safety report – Peter Bohan There are 27 RIDDORS outstanding with the issue being that the RCAs are not being returned. The quality is also questionable for which PB will be working with MJ on the policy. Integrated single care homes action plan East – Jayne Sankey • Linked in with IPOP and the team. The action plan is owned by the senior nurses in the area, with plans to extend the membership and roll out as it matures. West – Chris Lynes • Compliant with most of the actions • NEWS training for care home staff training will be starting in January and also involve Local Authority staff • Dementia training completed and have purchased an Alzheimer's package, funding obtained for a dementia nurse who will be starting on the 1st April to support care homes Central – Sharon Comrie

	• Develop support for the care home team link, Conwy MDT currently support over 50 homes which in itself has a significant resource issue. Have to access services on a case by case basis, otherwise would struggle to cope with the demand. A strategic group will be started soon and will have MD and directors support. • Have put dementia support workers resource into care homes <u>Roll out of the Wrexham medication related admission – Louise Howard-Baker</u> They have identified three areas for focus: • Acute Kidney Injury (AKI) • Bleeds • Falls Facilitated by the Primary Care Support Unit, a proposal was made to the Cluster Leads to focus on a single BCUHB project, on the basis that it would be easier to support with available tools and resources. Approximately 7,000 patients are admitted each year to our acute hospitals with acute kidney injury (AKI) and many are avoidable. To date all 14 clusters have indicated that they will focus on interventions that will reduce avoidable admissions for AKI. <u>Policies approved</u> • IV Fluid guideline • Amendment to MM01 • MM17 – Management of Delirium • Guideline acute management of Parkinson's Disease in patients with compromised swallow or nil by mouth
Key advice / feedback for the QSE:	**Risks to highlight:** <u>VAP/WAP</u> Delays with TRAC process, putting non pay items forward for equipment because of delay in normal ordering process and orders rejected a number of items. ACTION – Deborah Carter/David Fearnley to highlight at exec meeting. <u>Secondary Care</u> Melanie Maxwell highlighted that there is limited progress with the

	mortality review and the patients needing a review are not getting a stage 2, there is also poor attendance at meetings. DH confirmed that there are gaps in the clinical leadership with discussions taking place. ACTION – further discussion needed outside the meeting MM and Deborah Hickman <u>Anaphylaxis boxes update – Debra Hickman</u> A scoping exercise has been completed across BCU which shows significant variation regarding the boxes being used and where they are located. A task & finish group has been set up for which Louise Howard-Baker will be chairing with colleague support and a notice issued to staff to check location, as interim urgent action need standardisation. ACTION – LHB to feedback into future meeting <u>Medical gases – Patrick Hill</u> Severe risk at WMH regarding pipeline system – strategy and plan of medical measures needs to be clarified and shared and design for VE needs to be expedited (£3k design costs required). Rod Taylor informed that the business case was approved and Neil Bradshaw appointed as the project director, funding will be drawn from April and will cover this week. ACTION - Discuss outside the meeting
Special Measures Improvement Framework Theme/Expectation addressed	Mental Health - reported that compliance with measure will be by March 2020.
Planned business for the next meeting:	To be determined from cycle of business and action log.
Date of next meeting:	10th January 2020

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety & Experience Committee 28th January 2020
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Improvement Group (HASCAS & Ockenden) Chair's Assurance Report
Cyfarwyddwr Cyfrifol: Responsible Director:	Mrs Deborah Carter, Director of Operations / Associate Director of Quality Assurance
Awdur yr Adroddiad Report Author:	Claire Brennan, Head of Office, Director of Nursing
Craffu blaenorol: Prior Scrutiny:	HASCAS & Ockenden Improvement Group
Atodiadau Appendices:	Appendix 1: Progress update of recommendations

Argymhelliad / Recommendation:

The Committee is asked to note the progress of the recommendations to date

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

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

Sefyllfa / Situation:

The paper provides the progress update against the recommendations arising from both the HASCAS independent investigation and the Ockenden governance review.

Cefndir / Background:

The Quality, Safety & Experience Committee meeting held 19th November received a report on the progress against the HASCAS & Ockenden recommendations. The attached report is an updated and refreshed version to reflect current progress to date.

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 requirements of the recommendation with assurance that ongoing monitoring is undertaken by a relevant working group.

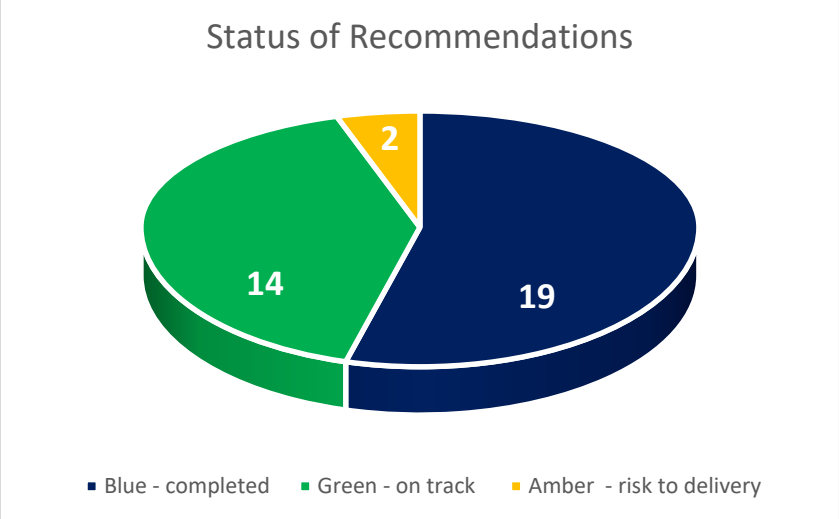
The status of the total 35 recommendations for both HASCAS & Ockenden is detailed below;

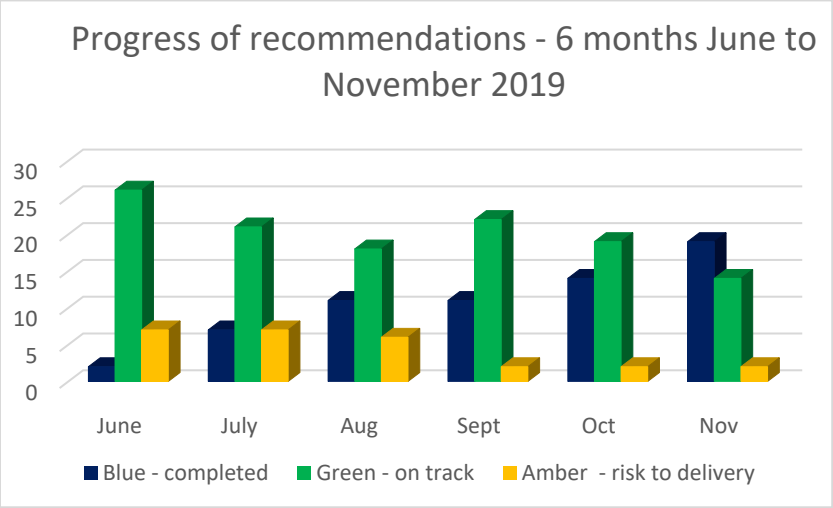
- 14 are reporting green, as on track to achieve delivery, some of these recommendations are almost due to complete and any that are proposed for closure will be formally reviewed at the Improvement Group meeting on 18th November and shared with Stakeholder Group members;

- 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;

- 19 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.
  - Ockenden recommendation 2a – Quality Impact Assessment
  - Ockenden recommendation 2b – Integrated Reporting
  - Ockenden recommendation 3 – Policy Review
  - HASCAS recommendation 11 – Evidence Based Practice
  - Ockenden recommendation 2c – Workforce Development
  - Ockenden recommendation 4a – Staff Engagement
  - Ockenden recommendations 4d – Clinical Engagement
  - Ockenden recommendation 13 – Culture Change

The following graphs show the overall status of the recommendations to date as well as the progression of recommendations towards completion over the past 6 months.





Improvement Group

The Improvement Group continues to meet on a bi-monthly basis to monitor progress and scrutinise any risks to delivery and mitigating actions. The last meeting was held on Monday 18th November. The meeting received the monthly highlight reports and discussions took place with the operational leads present, the following recommendations were proposed as being fully implemented which the group approved;

For recommendations that have been signed off as fully implemented, operational leads have confirmed that for sustainability purposes 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.

The next meeting of the Improvement Group will be held on 4th February 2020.

In addition to the bi-monthly Improvement Group meetings, additional one to one meetings have been established with each operational lead. These meetings enable a more in-depth review of progress and any issues for 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 and the next meeting date has been identified for 18th February 2020.

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 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 were invited to engage with the revision of the DoLS structure, consultation and review.
- Stakeholder members have participated as interview panel members
- 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 that it 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 OPMH including anti-ligature and the 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.

Asesiad / Assessment & Analysis

Strategy Implications
The report is for administrative purposes in response to the findings of both the HASCAS Independent Investigation and the Ockenden Governance Review. In terms of impact the recommendations align to the overall improvement work that the Health Board is driving.

Financial Implications
The Executive Team have agreed the funding for the required additional posts to support progress of the relevant recommendations where this need was identified.

Risk Analysis
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

Legal and Compliance
There are no legal implications

Impact Assessment
Operational leads will undertake any necessary equality / quality impact assessments where applicable within the remit of the work for their respective recommendations

HASCAS & Ockenden Recommendations progress update to Quality, Safety & Experience Committee 28th January 2020

Recommendation	operational lead	Timescale															Progress update
		Dec-19	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	
HASCAS 1 Integrated Care Pathways 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 & dementia** 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 strategy** Develop a clear plan for the clinical services of older people to improve training across the workforce, set clinical standards and uniformity with a solid foundation of evidenced based policies and procedures	Associate Director of Nursing																	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 1, Ockenden 1 and Ockenden 12 recommendations. Former implementation plans have been translated into the logic models, and are now used as our baseline for delivery. There are eight specific actions identified to be achieved in this combined programme of work for the older person, 6 of which are completed. Work continues to progress the 2 remaining actions which are in relation to an integrated service gap analysis which is acknowledged as a longer term action and care pathways for older persons and dementia that are under development.

HASCAS & Ockenden Recommendations progress update to Quality, Safety & Experience Committee 28th January 2020

Recommendation	operational lead	Timescale															Progress update
		Dec-19	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	
HASCAS 2 & Ockenden 8 Dementia Strategy 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 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.	Area Nurse Director (West)																	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, 6 of which have been completed. This programme of work is expected to be completed by the end of January 2020.
HASCAS 3 Care Homes & Service Integration 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.	Associate Director of Nursing																	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. The three main outputs to be achieved within the programme of work have been completed.
Ockenden 2d Consultant Nurse in Dementia 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.	Area Nurse Director (West)																	Second Consultant Nurse for Dementia has been in post since July 2019
HASCAS 4 Safeguarding Training BCUHB will revise its safeguarding training programme to ensure it is up to date and fit for purpose. The updated training programme will incorporate all relevant legislation and national guidance BCUHB will engage with all prior safeguarding course attendees to ensure that they are in receipt of 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	Associate Director of Safeguarding																	All existing safeguarding training packages have been refreshed and updated to ensure that packages are in line with current legislation. A learning environment has been created, led and embedded by Corporate Safeguarding. This is promoted online and through the Safeguarding Bulletin, which targets education, learning and updates relating to legislation, policy and procedures. Robust analysis of training compliance occurs through the refreshed Safeguarding Reporting Framework and into Area/Secondary Care /Divisional governance 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. And actions taken to remediate.

HASCAS & Ockenden Recommendations progress update to Quality, Safety & Experience Committee 28th January 2020

Recommendation	operational lead	Timescale															Progress update
		Dec-19	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	
safeguarding training sessions in the numbers required. There are multiple factors involved which will require a detailed and timed action plan with external oversight.																		Activity continues to embed safeguarding practice and is monitored via the Safeguarding reporting framework.
HASCAS 5 Safeguarding Informatics and Documentation BCUHB has conducted an audit on the compliance of filing safeguarding information in patients' case notes. 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.	Associate Director of Safeguarding																	The Health Records department and the Associate Director of Safeguarding have worked collaboratively 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 a digitalisation system from paper records by the Health Records Department.Good Record Keeping Training now explicitly includes a section on filing safeguarding information.Communications cascaded on Things You Need To Know (TYNTK) to remind staff of the importance of appropriately filing 'safeguarding' informationSupplier of the safeguarding divider (for the case note folders) include updated Safeguarding terminology and also 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. Level 3 Record Management training is included within the Safeguarding Training portfolio. This package incorporates the safe storage of safeguarding information.

HASCAS & Ockenden Recommendations progress update to Quality, Safety & Experience Committee 28th January 2020

Recommendation	operational lead	Timescale																Progress update
		Dec-19	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	
HASCAS 6 Safeguarding Policies & Procedures 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	Associate Director of Safeguarding																	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. The Safeguarding team are linking in with the Board Secretary and the Policy on Policies (PoP) and the work to develop a central repository as part of this process. A priority list of policies was identified with a full review of Phase 1 completed of which the priority procedures and guidance were approved at QSG. In addition, other key processes have been signed off. The work for this recommendation continues to be monitored is via the Safeguarding Governance & Performance Group.
HASCAS 7 Tracking of Adults at Risk across NW 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.	Associate Director of Safeguarding																	BCUHB worked in collaboration with North Wales Safeguarding Adult Board to coordinate a Task and Finish Group for shared learning with regard to documentation and communication. The Lead Practitioner programme has been developed in collaboration with the North Wales Safeguarding Adults Board (NWSAB). Over 70 key BCUHB staff were identified to participate in the pilot and undertake the Lead Practitioner training, which was 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 2020-21 and progress is monitored via the NW Adult Safeguarding Board.

HASCAS & Ockenden Recommendations progress update to Quality, Safety & Experience Committee 28th January 2020

Recommendation	operational lead	Timescale															Progress update
		Dec-19	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	
HASCAS 8 Evaluation of Revised Safeguarding Structures / Ockenden 6 Safeguarding Structures BCUHB will evaluate the effectiveness of its new safeguarding structure in the fourth quarter of 2018/2019. This will be overseen by Welsh Government	Associate Director of Safeguarding																	An evaluation of the existing 2017 Organisational Change Policy safeguarding structure was presented to Quality & Safety Group on 10th January 2020. 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. Implementation will take place once financial approval has been gained. A number of vacancies have been successfully recruited to including posts for the Business Support Team and Senior Team Manager in the West with identified start dates over the next few months. Employment and recruitment process is underway for the Regional Adult at Risk/Dementia post. The job description for the currently vacant Business Manager post is being reviewed and is awaiting banding prior to recruitment processes. As part of the organisational update the third and final phase of the current Safeguarding JDs are in the process of being reviewed to ensure that they are fit for purpose. The Named Doctor Adults at Risk Job Description, implementation and engagement requires further action to progress. The Executive Medical Director is progressing this which will need reorganisation of the senior medical roles in 20/21 to enable the development of this new part, the delay for this has been included on the risk register.
HASCAS 9 Clinical Records BCUHB needs to undertake a detailed check of clinical records in the investigation cohort to evaluate and reorder all co-mingled case notes. BCUHB needs to ensure that none of the commingling involving living patients could have led to any inappropriate acts or omissions on the part of clinical treatment teams during any episode of care (past and present) BCUHB needs to restructure and redesign its hard copy clinical records archiving and retrieval systems. This redesign needs to provide assurance in relation to the tracking of individual case notes across North Wales together with a set of service level agreements pinpointing the timeframes required for clinical record retrieval and access.	Chief Information Officer																	Actions progressed to ensure correction of the co-mingling of the cohort records. Good Record Keeping Training includes a section on filing safeguarding information. Communications cascade on the Health Boards internal corporate bulletin to remind staff of the importance of appropriately filing safeguarding information. Safeguarding divider for the case note folders are updated to include full list of documents provided by Safeguarding lead. Health records policy (HR1) redesigned to take account of transition to digital records. Clinical Audit lead has also included 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. Action to strengthen the checks made by the Access To Health Records (ATHR) teams prior to release - 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 co-mingling checks being carried out. Additional resources will be required to complete the roll out and take on the next steps to be fully compliant with the ICO recommendations Recruitment process is underway for Band 7 Project Manager required to undertake baseline work of the storage, processes, management arrangements & standards compliance, for all types of patient records and present the business case for pan-BCUHB compliance with legislation and standards for in patient records management.

HASCAS & Ockenden Recommendations progress update to Quality, Safety & Experience Committee 28th January 2020

Recommendation	operational lead	Timescale															Progress update
		Dec-19	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	
HASCAS 10 Prescribing & monitoring of anti psychotic medication 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.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.	Chief Pharmacist																	Anti-psychotic prescribing audits have been completed within primary care and secondary care. Results are being collated and will be presented to OPMH and other clinicians initially, prior to wider presentation to other divisions / specialities and primary care. Anti-psychotics also features within the single care home action plan developed for Recommendation 3.CAIR (checklist for antipsychotic initiation and review form) has been developed and distributed to all OPMH and Community Mental Health Teams (CMHT) across MH&LD division which has reported limited uptake to date. Actions identified to issue posters and reminders to wards to raise staff awareness with further audits undertaken to monitor completion of the forms. CAIR forms will also be sent out to care homes and discussions around education and training are in progress.Training plan to be developed for staff following a recognised need for training and awareness of the purpose and side effects of anti-psychotics and the need for a benchmark assessment before starting anti-psychotics.
HASCAS 11 Evidence Based Practice 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.	Acting Board Secretary																	The new external BCUHB website is now live and work continues to upload revised policies. This work is now considered business as usual. A policy working group has been established to review policies and subsequently reduce the significant focus within QSE committee meetings to sign off the significant number of revised policies.
HASCAS 12 Deprivation of Liberties 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 and report to the BCUHB Board a review of the 2017-18 DoLS work plan as set out in the 2017-18 Annual Report. Any remaining actions are required to be SMART.	Associate Director of Safeguarding																	Internal Audit has been provided with evidence to support the scope of the internal Safeguarding DoLS audit, publication of the findings and outcome is awaited. DoLS activity during the period of 2017-18 has been reviewed. Based upon the outcome of this activity and the evaluation of 2018-19 Safeguarding annual report action log. A paper to commence discussions relating to the revised structure of the DoLS team, to enable full implementation of the actions, reduce risk and increase activity was presented to QSG 10th January 2020 . The timing for this activity has been amended due to the recent Supreme Court Judgement relating to 16-17yr olds. A paper detailing this judgement was presented to QSG in November 2019. The role and responsibility of the DoLs signatory 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 and an evaluation of the activity is taking place. The one remaining vacant BIA post was due to follow the recruitment process. These posts are critical due to the high activity, which is both challenging and complex. Unfortunately

HASCAS & Ockenden Recommendations progress update to Quality, Safety & Experience Committee 28th January 2020

Recommendation	operational lead	Timescale																Progress update
		Dec-19	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	
																		as the current posts have been banded higher than the intended budget the outstanding (6th) BIA post has not proceeded to recruitment due to budget restraints. Financial approval is awaited. An evaluation of new working practices has taken place including the Mental Capacity Documentation Pilot and the Signatories training package and will be reported to Safeguarding Governance & Performance Group on 22nd January 2020.
HASCAS 13 Restrictive Practice Guidance 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	Director of Nursing (Mental Health)																	The 2 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. A full schedule of training dates in proactive approaches was established for all clinical areas where a training need was identified. In addition to this, the corporate training team are receiving ongoing support from the Positive Interventions Clinical Support Service (PICSS) team to deliver this training across the organisation. Training in the use of Datix to report incidents of restrictive physical intervention is included. Within the MHLD division, BCUHB Psychiatric Intensive Care Unit staff (Tryweryn) together with Caniad recently showcased to the Leaders Collaborative conference a number of initiatives being introduced to the wards which 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.
HASCAS 14 Care Advance Directives 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	Senior Associate Medical Director																	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, which showed that in general, patients were receiving the 5 priorities of care, although not in as timely a manner as required and that end of life conversations needed to take place earlier. Results have been analysed and an audit report finalised. Out of date guidance was found in critical care and national updated guidance is awaited. Plans in place to repeat the audit in 6 months and align to national mandated audit. All information will feed into the strategic EOL group.

HASCAS & Ockenden Recommendations progress update to Quality, Safety & Experience Committee 28th January 2020

Recommendation	operational lead	Timescale															Progress update
		Dec-19	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	
HASCAS 15 End of Life Care Environments Improve end of life environment on OPMH wards and associated guidance training	Senior Associate Medical Director																	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. A meeting was held with stakeholders recently to provide assurance of progress. Positive feedback had also been received regarding the improvements to the bereavement rooms. BCUHB has taken part in the National Audit for Care at End of Life - Carer survey and had the highest number of returns. Strategic Group for Palliative and End of Life Care chaired by Dr Chris Stockport established. Operational group will be formed to move the work forward; the spread and sustainability of actions on these recommendations will move to this once fully functional.
Ockenden 2a Quality Impact Assessment 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	Acting Board Secretary																	An internal audit brief has been prepared to review whether the Health Board has an adequate system for developing, monitoring and managing quality impact assessments, this has now been authorised by the Executive Director of Workforce. This review will identify any issues arising which will be progressed as recommendations on the audit tracker and monitored accordingly through this process. The work of this group is now considered business as usual with robust monitoring process in place via the review and audit tracker.
Ockenden 2b Integrated reporting 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.	Acting Board Secretary																	Two cycles of Health Economy reviews have been completed following the Interim Accountability framework the second cycle was informed by learning from the first review and outcomes fed back. Effectiveness of the interim accountability framework will be required post the Q3 reviews which are set for February 2020 with an intent to formalise the Performance Framework from 2020-2023 planning cycle. The work of this group is now considered business as usual with a robust process for reporting in place and monitoring any future changes through integration arrangements and structured assessments will be monitored through clear process going forward.
Ockenden 14 Board Development 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.	Acting Board Secretary																	This action was completed through the Health Board participating in a dementia friendly awareness session delivered on 10th January 2019 and this training will form part of any future board members induction. A further dementia friendly awareness session was held for senior managers as members of the Executive Management Group on 3rd July.

HASCAS & Ockenden Recommendations progress update to Quality, Safety & Experience Committee 28th January 2020

Recommendation	operational lead	Timescale															Progress update
		Dec-19	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	
Ockenden 2c Workforce 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	Executive Director of Workforce																	An organisational improvement plan for retention is in place and the Workforce & Organisational Development (WOD) teams are working together to improve retention in hotspot areas. WOD teams are also working with the Assistant Directors of Nursing to improve retention on identified wards and examine exit interview data. The WOD senior workforce group has now been superseded by the Workforce Improvement Group and monitoring progress on Mental Health workforce objectives. 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
Ockenden 3 Policy Review 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.	Acting Board Secretary																	Ockenden recommendation 3 is linked to HASCAS recommendation 11 in terms of the policy work, which continues to upload revised policies onto the BCUHB new website. Consultant Nurse for Dementia is linked in with this work to ensure consideration of dementia as a quality impact within policies. A policy working group has been established to review policies and subsequently reduce the significant focus within QSE committee meetings to sign off revised policies. The work for this recommendation is agreed as business as usual with work ongoing to continue to upload the revised policies and agreed monitoring arrangements established.

HASCAS & Ockenden Recommendations progress update to Quality, Safety & Experience Committee 28th January 2020

Recommendation	operational lead	Timescale															Progress update
		Dec-19	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	
Ockenden 4a Staff engagement 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	Executive Director of Workforce																	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. '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. Regular cohorts of Pioneers will continue and this is now part of the mainstream Organisational Development portfolio. Cohort 3 has now commenced with 7 out of the 9 teams being from MH&LD. The work for this recommendation is considered as business as usual with work ongoing to review and monitor the ongoing work through the Workforce Improvement Group.
Ockenden 4b & 4c Staff surveys 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.	Executive Director of Workforce																	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 next national NHS Staff Survey will take place in 2020. The Organisational Survey has been redesigned and tailored to the Health Boards 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. BCUHB's internal staff engagement survey has been launched and will run on a quarterly basis with an improvement planning process integral to its monitoring. The actions undertaken for this recommendation are now considered business as usual with the work ongoing for the staff surveys being monitored through the Workforce Improvement Group.

HASCAS & Ockenden Recommendations progress update to Quality, Safety & Experience Committee 28th January 2020

Recommendation	operational lead	Timescale															Progress update
		Dec-19	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	
Ockenden 4d clinical engagement BCUHB must take urgent and sustained steps to ensure the continued involvement of all clinical colleagues in the leadership and management of BCUHB	Executive Director of Workforce																	Three Medical and Dental conferences have now been held the third one reviewed points raised at the previous two conferences and provided an update on actions taken to address topics that were raised. 3D staff listening methodology has been developed and used widely throughout the Health Board by staff engagement ambassadors. An interactive toolkit together with a range of materials are also available online for staff to access and use. 3D is also an integral part of the Be Proud Pioneer team toolkit. Clinical Leadership meetings are established on a quarterly basis A Ward Managers Development programme has commenced to develop management and leadership skills and competencies to enable individuals to build effective capability within their roles as clinical leaders. A Matrons development programme has also been established which commenced at the end of 2019. A bespoke engaging leadership development programme has been developed in partnership with our external provider Carter Corson. The programme is called 'Leading for Transformation' and has held 5 cohorts with 75 senior leaders engaged. Clinical engagement work is now considered business as usual and encompassed within the workforce objectives with all development programmes mainstreamed into the Organisational Development team's work on an ongoing basis.
Ockenden 5 Partnership working 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	Assistant Director Health Strategy																	Proposal to devolve the centrally held Voluntary Organisation budget and establish a commissioning forum approved by the Executive Team and a paper on the refresh of third sector working was finalised in September 2019 and has also been shared with the Stakeholder Reference Group and Community Voluntary Councils. Third sector budgets have now been devolved to divisions for local management. 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. The paper will sit alongside the 2020/21 annual plan as restatement of commitment to working with third sector colleagues. Work is ongoing to refresh principles following discussions with third sector colleagues and to confirm priorities for 2020/21 to support implementation of the refresh.It is anticipated that the work of this recommendation will be complete by end March 2020.

HASCAS & Ockenden Recommendations progress update to Quality, Safety & Experience Committee 28th January 2020

Recommendation	operational lead	Timescale															Progress update
		Dec-19	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	
Ockenden 7 Concerns Management 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	Associate Director of Quality Assurance																	Work continues to progress to respond to the actions identified to better manage concerns in a timely and effective manner. This includes establishing 4 co-production workshops for the complaints process re-design which will take place in February 2020 across each locality in NW. 2. A joint workshop has also been arranged in February with the Community Health Council to develop improved joint working and collaboration. Trajectories identified to deliver real time management of complaints and incidents continue to be monitored via weekly incident review meetings. The Health Board continues to be fully engaged in the new Once for Wales Concerns Management System development and implementation. New Assistant Director of Patient Safety and Experience has met with the CHC Chief Officer and Deputy as well as the local improvement officer for the Public Services Ombudsman for Wales (PSOW) with the Ombudsman also meeting the CEO for their annual meeting where no issues of concern were raised at either meetings. A meeting has also been held with the PSOW Complaint Standards Authority Team are supporting the improvements in complaints handling across Wales. New Nursing Information and Intelligence Portal launched to replace the Harms Dashboard with improved local access to quality and safety information. Continued focus and scrutiny within divisions, with support from corporate teams, to investigate and respond to concerns within PTR timeframes.
Ockenden 10 Reviewing external reviews 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.	Acting Board Secretary																	Following the review undertaken by the Corporate Nursing Team to strengthen assurances the BCU/HIW management plan 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. The work of this recommendation is now considered business as usual with agreed monitoring arrangements in place.
Ockenden 11 Estates OPMH 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	Director of Estates & Facilities																	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 confirmed and recruitment underway for a Project Management post to support the project and actions required in

HASCAS & Ockenden Recommendations progress update to Quality, Safety & Experience Committee 28th January 2020

Recommendation	operational lead	Timescale															Progress update
		Dec-19	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	
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.																		Work stream 2 tasked with developing the Enhancing the Healing Environment (EHE) assessment across all wards within MH&LD OPMH facilities. 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 to support work stream 2.
Ockenden 13 Culture change There will need to be sustained, visible (in clinical areas), stable leadership within MH&LD division over a longer period of time to ensure that the culture within mental health and specifically OPMH continues to develop in a positive way. The cultural change that is necessary towards dementia needs to happen across BCUHB and to happen from Board to Ward. This cultural change needs to happen not just within MH&LD but everywhere within BCUHB where care and treatment may be provided to persons with dementia, their families and friends.	Executive Director of Workforce																	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 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 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. Organisational Improvement Plan has been developed following a number of staff engagement events as well as drawing on data from the qualitative element of the staff survey and has been approved by Board. 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. 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 work for this recommendation is now considered business as usual and will continue to monitor progress via the Workforce Improvement Group.

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience Committee 28th January 2020
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Health and Social Care (Quality and Engagement) (Wales) Bill
Cyfarwyddwr Cyfrifol: Responsible Director:	Mrs Gill Harris, Executive Director of Nursing and Midwifery/Deputy CEO
Awdur yr Adroddiad Report Author:	Mr Matthew Joyes, Assistant Director of Patient Safety and Experience
Craffu blaenorol: Prior Scrutiny:	Review by the responsible directors
Atodiadau Appendices:	None

Argymhelliad / Recommendation:

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

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

Sefyllfa / Situation:

The Health and Social Care (Quality and Engagement) (Wales) Bill was introduced on 17 June 2019 by the Minister for Health and Social Services. The Bill proposes to introduce changes aiming to:

- Place quality considerations at the heart of the NHS in Wales;
- Strengthen the voice of citizens across health and social services, with a new Citizen Voice Body for health and social care (replacing Community Health Councils);
- Place a duty of candour on NHS organisations at an organisational level, requiring them to be open and honest when things go wrong; and
- Strengthen the governance arrangements for NHS Trusts, by introducing a formal Vice-Chair role for each Trust.

The Health, Social Care and Sport Committee of the Senedd considered the general principles of the Bill, took evidence between July – October 2019, and published its report on 15 November 2019. The Finance Committee and Constitutional and Legislative Affairs Committee also considered the Bill, reporting on 15 November 2019. The Welsh Government is now considering these reports.

Cefndir / Background:

The Welsh Government first consulted on proposals in 2015 in the Green Paper, *'Our Health, Our Health Service'*, which sought views on matters relating to the quality of health services and its governance and functions. The Welsh Government published a summary of the responses to the Green Paper in February 2016. In July 2017, the Welsh Government published a White Paper consultation: *'Services fit for the future, quality and governance in health and care in Wales'*.

In July 2018, the then First Minister made a statement on the legislative programme, committing to bringing forward an NHS Quality Bill focused on the four areas set out in the Bill (as below), which was then introduced in July 2019.

The Bill contains 5 Parts, including an Overview of the Act in Part 1. Part 2 reframes the existing duty of quality to require NHS bodies and Welsh Ministers (in relation to health) to exercise their functions with a view to securing improvements in the quality of services they provide. Part 3 introduces a duty of candour on all NHS bodies at an organisational level. Part 4 establishes a new independent Citizen Voice Body for health and social care (replacing Community Health Councils). Part 5 gives Welsh Ministers powers to appoint a Vice-Chair on NHS Trust Boards and contains other general provisions, including consequential amendments to other legislation and provision about when and how the Bill comes into force.

Asesiad / Assessment & Analysis

Duty of quality

The Bill introduces a broad duty to require the Welsh Ministers and NHS bodies to exercise their functions (in relation to health) 'with a view to securing improvement in the quality of health services' (replacing the existing quality duty). The Welsh Ministers and NHS bodies must all publish separate annual reports detailing the steps they have taken to comply with the duty, and include an assessment of the extent of any improvement in outcomes achieved. The Welsh Ministers must lay a copy of the Welsh Government's report before the National Assembly for Wales. The Bill states that "quality" includes, but is not limited to:

- The effectiveness of health services;
- The safety of health services; and
- The experience of individuals to whom health services are provided.

Duty of candour

The Bill places a new duty of candour on NHS bodies at an organisational level. The duty of candour is triggered if it appears to the NHS body that both of the following conditions are met:

- A service user has suffered an adverse outcome ('unexpected or unintended harm that is more than minimal'); and
- The provision of the health care was or may have been a factor in the outcome suffered by the service user.

The Bill then sets out details of "the candour procedure" which must be followed. The Explanatory Memorandum (EM) clarifies that "the provisions will place a duty on NHS bodies at an organisational level, and not onto individual health care staff". The Bill places duties on primary care providers to prepare an annual report for Local Health Boards (LHBs). NHS bodies must also

prepare annual reports on whether the duty of candour has come into effect, and if it has, provide details and any steps taken to prevent the situation from happening again.

Citizen Voice Body for Health and Social Care

The Bill proposes a Citizen Voice Body for Health and Social Care in Wales. This new national body will represent the interests of the public in relation to health services and social services. It will abolish existing Community Health Councils (CHCs) which currently carry out these functions in relation to health services. The functions of the new body will include:

- Seeking the views of the public on health services and social services;
- Providing assistance and advocacy services to individuals who wish to make a complaint; and
- Making representations to local authorities and NHS bodies on anything it considers relevant to the provision of health or social services (which the local authority or NHS body must then give regard to).

The new body, unlike CHCs, will cover both health and social services. However, it will not have the power of entry and inspection currently held by CHCs, nor duties to scrutinise service change.

Vice-Chair roles in NHS Trusts

The Bill contains provisions for the appointment of Vice-Chairs of Boards of Directors of NHS Trusts.

The constitutional and membership arrangements for Trusts and LHBs are not currently consistent. Under existing legislation, Vice-Chairs can be appointed to the Board of LHBs where the Welsh Ministers consider it appropriate. However, there is no equivalent power for the Welsh Ministers to appoint a Vice-Chair to the Board of NHS Trusts, and the Bill rectifies this.

Financial Impact

The Regulatory Impact Assessment (RIA), published as part of the EM, reports that the overall net cost of the Bill falls within the range of £11 - £11.5 million. The majority of estimated costs are associated with the establishment of the new Citizen Advice Body (£6.1 million). An additional £3.7 million is identified for the introduction of a duty of candour. The costs will fall on the Welsh Government (£6.3 million) and NHS bodies (ranging from £4.8 million to £5.2 million). Apart from the cost of the Vice Chair posts for NHS Trusts (ranging from £164k to £630k) and the additional legal costs arising from the duty of candour (£21k), the rest of the costs on NHS bodies are described in the EM as ‘opportunity costs’, suggesting that the cost will be absorbed by them. The RIA suggests that the Bill is expected to lead to a range of benefits, such as improving the quality of services, having a stronger voice and, potentially, reducing the number of complaints about services. However, it reports such benefits “cannot be quantified due to a high degree of variability or a lack of available data”.

Reviews by Senedd Committees

As mentioned above, various committees of the Senedd have consulted upon and reviewed the bill.

The majority of responses to the consultation were broadly supportive of the aims of the Bill, particularly of the moves to improve quality and candour, to allow Vice Chairs to be appointed by

NHS Trusts and for the new Citizen Voice Body to cover both health and social care. However the majority of stakeholders also felt that the duties of quality and candour in the Bill should be strengthened (and suggested a number of ways to do so, including sanctions). They also expressed concerns about aspects of the new Citizen Voice Body. Many stakeholders strongly felt that action should be taken to ensure that the new body will have local representation across Wales, and sufficient powers and 'teeth' (including powers of entry for unannounced visits and a right to a response from public bodies). Key themes in evidence received include the view that:

- There is a lack of clarity in duty of quality provisions, with many questioning what will be measured, and how compliance will be monitored given the lack of sanctions in the Bill;
- Quality of staff training and the definitions developed for the duty of candour will be crucial to the success of the duty (with many noting that legislation alone will not change the culture of the NHS). Many also feel sanctions are required for breaches/non-compliance;
- It is unclear how the duties will align with social care. Some also questioned the logic of the duties of quality and candour only applying to the health service given the increasing integration of health and social care systems; and
- The new Citizen Voice Body must be sufficiently resourced; clearly independent from the Welsh Government; have a local/regional presence across Wales; a power of entry and ability to make unannounced visits; and a right to a response to representations made.

The HSCS Committee recommended that the Senedd agrees the general principles of the Bill. The Committee made 19 recommendations to the Welsh Government, mainly calling for amendments to the Bill to strengthen the provisions including recommendations to amend the provisions of the Bill relating to the Citizen Voice Body. For example, it recommends that members of the Citizen Voice Body should be appointed by the National Assembly for Wales (rather than the Welsh Government). It also proposes that the body should have a qualified right of access to health and social care settings for the purpose of speaking to service users, and carrying out reasonable and proportionate checks on the care being provided. The Committee reasons that specific conditions or restrictions on the use of this power could be set out in detail in accompanying regulations or statutory guidance. It also recommends that a formal response be required from the appropriate organisation to any representation made by the Citizen Voice Body. The Finance Committee made nine recommendations, including for the Welsh Government to undertake further work analysing and estimating the benefits of the Bill, which are identified as key drivers for implementing the legislation, and to produce a revised RIA. The Committee also recommends that the Welsh Government reconsiders the levels of costs for awareness and training for the duties of quality and candour, and undertakes further work and provides further detail on the costs in a number of areas, including legal costs. The Constitutional and Legislative Affairs (CLA) Committee made three recommendations including for the Minister to explain during the Stage 1 debate why a definition of the duty of candour does not appear on the face of the Bill and where the public can find information about its meaning. It also recommends that the Minister sets out clearly and in detail how he intends to use the powers contained in section 26 of the Bill (on the' power to make transitional etc. provision'). The CLA Committee is concerned at the breadth of powers being taken by the Welsh Ministers under this section, and recommends an amendment to change the wording of section 26.

Impact on the Health Board

At this stage, until the Welsh Government have reviewed and responded to the above recommendations, it is difficult to fully assess the impact to the Health Board. A number of the consultation responses to the Bill notes that there are elements of detail absent and this may come forward in the final Bill. However, in brief:

- Duty of quality – this duty creates a definition of quality (patient safety, clinical effectiveness and patient experience), which has been elsewhere adopted in the UK (the “Darzi definition” of quality). There is a requirement to act in the interests of improving quality and produce an annual report on this. These duties may be covered in part by the existing quality impact assessment process and the annual quality statement although some refinement are to be expected. The Health Board may find it useful to use these three strands of quality to organise its quality activities or reporting.
- Duty of candour – this duty creates a requirement to be open following patient safety incidents and to prepare an annual report on this. It will be similar to the statutory duty in other parts of the UK (implemented following the Francis Review) although it appears the threshold for triggering the duty will be lower but the process more straightforward. There will be a requirement for the Health Board to review its incident processes and provide training for staff (both of which will increase the cost of incident governance). A review of the incident process is already planned for 2020 and this will allow the duty to be considered and implemented as part of this work.
- Citizens Voice – as it stands, the proposed bill will reduce some scope of the existing CHC such as their right to enter and inspect services and their right to scrutinise service changes. However their role in seeking the views of the community and their role in advocacy (particularly with complaints) would remain. The changes will have some impact on how the Health Board interfaces with the new body.
- Appointment of a Vice Chair of a Trust – this requirement will not apply to the Health Board.

This report has been prepared from a publication provided by the Senedd Research Unit, the Welsh Government Draft Bill and Ministerial Statement and the NHS Confederation consultation response.

Cyfarfod a dyddiad: **Meeting and date:**	Quality, Safety & Experience Committee 28th January 2020
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Summary of business considered in private session to be reported in public
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Mrs Gill Harris, Executive Director of Nursing and Midwifery
Awdur yr Adroddiad **Report Author:**	Mrs Kate Dunn, Head of Corporate Affairs
Craffu blaenorol: **Prior Scrutiny:**	None
Atodiadau **Appendices:**	None

Argymhelliad / Recommendation:

The Committee is asked to note the report

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

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

Sefyllfa / Situation:

To report in public session on matters previously considered in private session

Cefndir / Background:

Standing Order 6.5.3 requires the Board to formally report any decisions taken in private session to the next meeting of the Board in public session. This principle is also applied to Committee meetings.

Asesiad / Assessment

The Committee considered the following matters in private session on 19.11.19:

- Approval of previous minutes
- Update on follow up backlog
- Endoscopy update
- Inquest update
- Urology update
- Serious incidents report