Bundle Health Board - public 2 May 2019

10.00am Deganwy Room, Venue Cymru, Llanduno LL30 1BB

1 OPENING BUSINESS AND EFFECTIVE GOVERNANCE

1.1 10:00 - 19.67 Chair's Introductory Remarks - Mr Mark Polin

1.2 10:01 - 19.68 Special Measures

1.2.1 19.68.1 Task & Finish Group Chair's Assurance Report - Mr M Polin

19.68.1 SMIF Chair's Assurance Report 15.4.19 v1.0 approved by MP.docx

1.2.2 19.68.2 Draft Betsi Cadwaladr University Health Board Special Measures Improvement Framework October 2018-March 2019 - Overview Report

Recommendation:
The Board is asked to approve the overview report for submission to Welsh Government.

19.69.2a Special Measures Report Coversheet May 2019 Board.docx

19.69.2b BCU SM Oct 18 to Mar 19 Report v0.05.docx

1.3 10:16 - 19.69 Apologies for Absence

1.4 10:17 - 19.70 Declarations of Interest

1.5 10:18 - 19.71 Draft Minutes of the Health Board Meeting held on 28.3.19 for accuracy and review of Summary Action Log

19.71a Minutes Health Board Public 28.3.19 v0.03.docx

19.71b Summary Action Log Public v165 18.4.19.doc

2 ITEMS FOR CONSENT

2.1 10:28 - 19.72 Committee and Advisory Group Chair's Assurance Reports

19.72.1 Audit Committee 14.3.19 (Cllr M Hughes)
19.72.2 Quality, Safety & Experience Committee 19.3.19 (Mrs L Reid)
19.72.3 Finance & Performance Committee 26.3.19 (Mr M Polin)
19.72.4 Charitable Funds Committee 7.3.19 (Mrs J Hughes)
19.72.5 Strategy, Partnerships & Population Health Committee 2.4.19 (Mrs M W Jones)
19.72.6 Information Governance & Informatics Committee 14.2.19 (Mr J Cunliffe)
19.72.7 Healthcare Professionals Forum 15.3.19 (Mr G Evans)
19.72.8 Remuneration & Terms of Service Committee 9.4.19 (Mr M Polin)

19.72.1 Chair's Assurance Report Audit 14.3.19 v1.0 approved by MH.docx

19.72.2 Chair's Assurance Report QSE 19.3.19 V1.0.docx

19.72.3 FPC Chair's Assurance Report 26.3.19 v1.0.docx

19.72.4 Chair's Assurance Report CFC March 2019.docx

19.72.5 Chair assurance report SPPHC 2.4.19 v1.0.docx

19.72.6 Chair's Assurance Report IGIC 14.2.19 V1.0.docx

19.72.7 Chair's Report HPF 15.3.19 v1.0.doc

19.72.8 Chair's Assurance Report RTS 9.4.19 v1.0.docx

2.2 10:38 - 19.73 Mental Health Act 1983 as amended by the Mental Health Act 2007. Mental Health Act 1983 Approved Clinician (Wales) Directions 2008. Update of Register of Section 12(2) Approved Doctors for Wales and Update of Register of Approved Clinicians (All Wales) - Mr Gary Doherty

Recommendation:
The Board is asked to ratify the attached list of additions and removals to the All Wales Register of Section 12(2) Approved Doctors for Wales and the All Wales Register of Approved Clinicians

19.73 AC & s12 Report.docx

3 FOR DISCUSSION

3.1 19.74 Countess of Chester Contractual Agreement 2019/20 - Mr Gary Doherty

Recommendation:
The Board are asked to note the contents of this report. Updates will be given at each Board meeting until this issue is resolved and other Board Committees will be involved as appropriate.

19.74a COCH.docx

19.74b COCH Example of Stakeholder Letter 11 04 19.pdf

19.74c COCH Example of Stakeholder Letter 18 04 19.pdf

3.2 10:40 - 19.75 Integrated Quality & Performance Report - Mr Mark Wilkinson

Recommendation:
The Board is asked to note the report and to assist in addressing the governance issues raised.

19.75a IQPR Coversheet.docx

19.75b IQPR FINAL.pdf

3.3 11:10 - 19.76 Finance Report Month 12 - Mrs Sue Hill

Recommendation:
It is asked that the report is noted, including the draft unaudited financial position of £41.3m.

19.76 M12 Finance Report Final.docx

3.4 11:30 - 19.77 Mental Health Assurance Report : Mr Andy Roach

Recommendation:
The Board are asked to note the contents of the report

19.77a MHLDS v2.0.docx

19.77b MHLDS APPENDIX 4 Ablett Unit - January 2019.pdf

3.5 11:50 - 19.78 HASCAS and Ockenden Improvement Group Report : Mrs Deborah Carter

Recommendation:
To note the progress of the recommendations

19.78a HASCAS & Ockenden Review_progress report_coversheet.docx

19.78b HASCAS & Ockenden update report draft 0.02.docx

3.6 12:10 - 19.79 Service Strategy Update : Mr Mark Wilkinson

Recommendation:
The Board are asked to consider the paper and the requirement to develop a Clinical Services Strategy, and provide comments to facilitate the development of the process.

19.79a Service strategy coversheet.docx

19.79b Service Strategy.docx

3.7 12:30 - 19.80 Reducing smoking prevalence to improve population health : an update on progress - Miss Teresa Owen

Recommendations:

The Board is asked to:
1. Note the opportunity for continued improvement against current Tier 1 performance in relation to smoking cessation and the critical importance
of continued investment in smoking cessation services to reduce the burden of disease in North Wales.
2. Note the service developments across the Health Board
3. Endorse the approach being taken to ensure all our hospital sites become smoke free through the delivery of the Smoke Free Regulations.

19.80 Tobacco Control.docx

4 12:50 - FOR INFORMATION

4.1 19.81 Medicines Management Annual Report : Dr Evan Moore

Recommendation:
The Board is asked to note the report.

19.81 PMM Annual report.doc

4.2 19.82 Nurse Staffing Update : Mrs Deborah Carter

Recommendation:
The Board is asked to note the report.

19.82 Nurse Staffing levels Act 2016 - April 2019.docx

4.2 19.83 Summary of In Committee Board business to be reported in public

Recommendation:
The Board is asked to note the paper.

19.83 In Committee Items to be reported in public.docx

4.3 19.84 All Wales and Other Forums

4.3.1 19.84.1 Emergency Ambulance Services Committee Minutes 17.10.18

19.84.1 EASC Minutes 17 Oct 2018.docx

4.3.2 19.84.2 Emergency Ambulance Services Committee Minutes 13.11.18

19.84.2 EASC minutes 13 November 2018.docx

4.3.3 19.84.3 Emergency Ambulance Services Committee Chair's Summary 5.2.19

19.84.3 EASC Chair's Summary from 5 February 2019.docx

4.3.4 19.84.4 Welsh Health Specialised Services Committee Joint Briefing 26.3.19

19.84.4 WHSCC Joint Committee Briefing 26.3.19.pdf

5 CLOSING BUSINESS

5.1 19.85 Date of Next Meeting

Thursday 25th July 2019 @ 10.00am in Neuadd Reichel, Bangor

5.2 19.86 Committee Meetings to be held in public before the next Board Meeting

Informatics & Information Governance Committee 9.5.19
Remuneration & Terms of Service Committee 13.5.19
Quality Safety & Experience Committee 21.5.19 and 16.7.19
Finance & Performance Committee 23.5.19 and 27.6.19
Audit Committee 30.5.19
Charitable Funds Committee 20.6.19
Mental Health Act Committee 28.6.19
Strategy, Partnerships & Population Health Commitee 4.7.19

Health Board **2.5.19**	 *To improve health and provide excellent care*

Committee Chair's Report

Name of Committee:	Special Measures Improvement Framework Task & Finish Group (SMIF T&F)
Meeting date:	15.4.19
Name of Chair:	Mr Mark Polin, Chair
Responsible Director:	Mrs Grace Lewis-Parry, Board Secretary
Summary of business discussed:	• The latest iteration of the SMIF progress monitoring log was considered. The status of each Framework expectation was assessed. The discussion encompassed issues including the confirmation of robust ongoing monitoring arrangements for the 2019/20 Annual Plan, future plans for oversight of the Clinical Audit function, progress on orthopaedic services and ophthalmology, and the year-end financial and performance position. It was also agreed to hold a Board workshop focusing on leadership development. • The T&F Group received and commented upon the first draft of the Special Measures Report October 2018-March 2019, to be submitted to Welsh Government after the May Board meeting.
Key assurances provided at this meeting:	• The SMIF T&F Group was assured on progress against several expectations, some of which were agreed as 'closed', on the understanding that many of the areas covered by the Framework would require ongoing work in order to achieve sustainable improvements.
Key risks including mitigating actions and milestones	• The risk that the Health Board is not deemed to be in a position that merits the lifting of special measures is mitigated by the strengthened governance arrangements and additional rigour introduced by the Chair.
Special Measures Improvement Framework Theme/Expectation addressed	All.

Issues to be referred to another Committee	-
Matters requiring escalation to the Board:	None.
Well-being of Future Generations Act Sustainable Development Principle	Achieving the special measures expectations is approached from the perspective of sustaining service improvements in the longer term, for the well-being of patients and the wider population in the future. Much of the work underway is being carried out in partnership with colleagues from other organisations, with service users and members of the public.
Planned business for the next meeting:	Review of the updated progress monitoring log.
Date of next meeting:	18.6.19

Health Board **2.5.19**	 Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board ***To improve health and provide excellent care***

Report Title:	Draft Betsi Cadwaladr University Health Board Special Measures Improvement Framework October 2018-March 2019 - Overview Report
Report Author:	Grace Lewis-Parry, Board Secretary Liz Jones – Assistant Director, Corporate Governance
Responsible Director:	Grace Lewis-Parry, Board Secretary
Public or In Committee	Public
Purpose of Report:	As part of special measures arrangements, Welsh Government requires regular progress updates at specified time points. This report provides an overview of progress against Special Measures Improvement Framework expectations set for October 2018 to March 2019. It highlights how the Health Board's focus on quality – a key feature of special measures work since 2015 – has realised improvements in quality and safety in crucial areas such as GP out of hours services, mental health, concerns management and infection control. Significant points of note for the Board and Welsh Government as regards the latest position are: • Significant progress has been made in a number of areas. GP out of hours services have been de-escalated as a special measures concern. All Board members, including the new Chair, new Executive members and Independent Members have fully engaged in Board development activities, which have been introduced and given greater impetus to addressing the challenges faced • Executive and senior leadership capacity continues to develop and mature, supported by additional funding from Welsh Government for secondary care and turnaround • The financial plan has not been achieved for 2018/19, and the Health Board remains in a very serious financial position. Financial governance and scrutiny has been re-set, with a Finance Task Group supporting the Finance & Performance Committee and an external financial review commissioned, due to report in June 2019 • There has been sustained improvement in relation to learning from concerns, although it is recognised that more work is required to systematically share learning and evidence improvement and change

	• The Health Board has demonstrated active leadership and commitment, working with partners in the Regional Partnership Board and Public Services Boards, and will continue to do so • All recommendations from the Deloitte, HASCAS and Ockenden reviews have been progressed and monitored, increasingly as a standard component of core business, recognising that whilst many have been completed, others will require a longer timescale to become fully embedded across the organisation. Detailed reports on progress against recommendations are reported to the Board on a regular basis • Although the Health Board does not yet have an agreed clinical services strategy, there has been progress with a number of individual specialist strategies, including the transformation of vascular services in the region • The Health Board has developed an interim annual plan for 2019/20, recognising that it is a working document due to areas requiring further work. Assurance and clear actions continue to be refined in relation to the financial component of the plan, to ensure there is no further deterioration in performance. This means that the Health Board has been unable to provide a balanced and sustainable IMTP • There have been productive discussions with Welsh Government (WG) in relation to orthopaedic services. A way forward has been agreed, which the Health Board will now progress with colleagues in WG • WG has noted good progress with care pathway development and clinical engagement in relation to ophthalmology, which will support the implementation of a new framework • The Healthcare Inspectorate Wales inspections at the Ablett Unit, Hergest Unit and Nant-y-Glyn Community Mental Health Team have all positively highlighted the quality and safety of care, demonstrating that lessons are being learnt from previous inspections and reviews. Continued progress has also been made in delivering the Mental Health Strategy, with many key milestones achieved, and key posts in the Mental Health management structure have now been filled • Primary care resilience is slowly improving, although challenges remain. This is demonstrated by fewer GP practice resignations, managed GP practices moving back into GMS contracts, and all GP trainee posts in North Wales for the first time • There is ongoing dialogue with partners and stakeholders to map proposals for Health & Well-being Centres in North Wales, which will continue to evolve as part of the partnership agenda.

Approval / Scrutiny Route Prior to Presentation:	The Special Measures Task & Finish Group reviewed the draft report prior to submission to the Board.
Governance issues / risks:	As not all expectations have been fully met, without continuing focus there is a risk that some Special Measures Improvement Framework requirements will still be outstanding at the Framework's scheduled end date in September 2019. Also, without ongoing effort, there is a risk that improvements already achieved may not be sustained.
Financial Implications:	There are no financial implications relating to the submission of this overview report.
Recommendation:	The Board is asked to approve the overview report for submission to Welsh Government.

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

Special Measures Improvement Framework Theme/Expectation addressed by this paper

All.

Equality Impact Assessment

No Equality Impact Assessment is required for this overview report.

Disclosure:

DRAFT Betsi Cadwaladr University Health Board
Special Measures Improvement Framework
October 2018-March 2019 - Overview Report

1. Purpose of the Report

This report sets out an overview of the progress made by Betsi Cadwaladr University Health Board ('the Health Board') against the October 2018 – March 2019 expectations set out in the updated Special Measures Improvement Framework (SMIF) issued by Welsh Government in May 2018 and comprising the four themes of leadership & governance, strategic & service planning, mental health and primary care including out of hours services. This report is also informed by the work that has been progressed as a result of recommendations made by a number of external reviews including the WAO Structured Assessment 2018 and the Health & Social Care Advisory Service (HASCAS) and Ockenden reports.

2. Introduction/Context

2.1 Following the Health Board being placed in special measures in June 2015, a continuous organisation-wide programme of work to strengthen governance arrangements and make improvements to services has been in place. This remains a dynamic process, as the organisation works not only to address the specific expectations set out in the SMIF, but also to respond to emerging challenges.

2.2 This report is the fifth of a suite of reports setting out the progress made against the SMIF expectations. It specifically covers the period which ran from October 2018 to March 2019 and builds upon the significant number of actions previously taken. These were reported in the first report published in May 2016, the second report published in November 2016, the third report published in January 2018 and the fourth report published in November 2018.

2.3 In November 2018, following publication of the fourth progress report, the then Cabinet Secretary for Health & Social Services gave an oral statement updating on the Health Board's progress since May 2018. He noted the strong focus on Board capability, including the fact that all board level vacancies had been addressed. He also noted the introduction of more robust appraisal and assurance systems, an increased commitment to partnership working in support of '*A Healthier Wales*', the comprehensive plans put in place to address the Ockenden and HASCAS recommendations, developments in mental health services, better staff engagement, progress against some specialist service strategies and continuing improvement in GP out of hours services.

2.4 Alongside these improvements, the Cabinet Secretary also acknowledged the Health Board's challenging financial position and the need to accelerate progress on strategic and service planning, both in respect of specific areas such as orthopaedics and also from a whole-system perspective in describing more clearly the plans for service transformation. The Cabinet Secretary emphasised the need for the Health Board to spend the next 6 months focusing on finance, strategic & service planning – especially unscheduled care and referral to treatment targets (RTT) – and on delivering the Ockenden and HASCAS recommendations.

2.5 Following a meeting of the Welsh Government, Wales Audit Office (WAO) and Healthcare Inspectorate Wales (HIW) Tripartite Group in January 2019, the Minister for Health and Social Services issued a written statement in February 2019 on joint escalation and intervention arrangements across NHS Wales. The Minister noted that progress had been seen in several areas across the Health Board, most notably on GP out of hours services, which had improved to a level comparable to other organisations and was therefore removed as a special measures concern. Further improvements were also noted in mental health, quality and safety governance and board effectiveness under the new Chair. The way in which the organisation had responded to the Ockenden and HASCAS recommendations was also highlighted.

2.6 Whilst noting the positive steps forward, the Minister acknowledged that the Health Board still faced a challenging improvement agenda as it worked to improve performance and governance within the context of a sustainable 3 year plan. It was therefore decided that the Health Board would remain at its current escalation status of special measures. The Director General of NHS Wales wrote to the Health Board on 22.2.19 confirming the outcome of the tripartite meeting and setting out the concerns that remained around the lack of necessary pace for change, particularly in relation to finance, planning and performance.

2.7 On 4.3.19, the Chairman and Chief Executive, with other senior colleagues, gave evidence to the Public Accounts Committee in relation to finance and performance, progress against previous PAC recommendations, mental health services, special measures and concerns management. On 4.2.19, the North Wales Community Health Council (CHC) also provided evidence before the PAC and, whilst noting the challenges faced by the Health Board, acknowledged progress under special measures in terms of aspects of public engagement, systemic culture change and vision.

3.	**Progress**

3.1 The Special Measures Improvement Framework Task & Finish (SMIF T&F) Group, established by the Health Board at the outset of special measures, continues to meet regularly to track progress. Its membership comprises both Independent Members and Executives / Directors, with advisory input from David Jenkins (appointed as additional support by Welsh Government). It has been given a new impetus following the new Health Board Chair's decision to personally chair the T&F Group, with an enhanced focus on pace and delivery. At the Chairman's request, the Executive Team held a special measures session in January 2019, devoted to scrutinising in detail and better articulating the progress made. As a result of this additional scrutiny, evidence was provided to support the view that a number of the 'open' SMIF expectations had in fact been fully met. The SMIF T&F Group has continued to fulfil its purpose in advising and assuring the Board on the effectiveness of the arrangements in place to respond to the SMIF. An example of an assurance report submitted to the Board by the Group's Chair can be found here.

3.2 In reviewing progress made between October 2018 and March 2019, the T&F Group believes that some important progress has been made, though it is clear that

significant challenges still remain. Key achievements to highlight across the themes are as follows:

- GP out of hours services have improved and have been removed from special measures
- The Health Board has approved a Workforce Strategy, which is an important milestone contributing to the formulation of the Health Board's longer term plans
- The Health Board has approved an Estates Strategy – another important milestone that underpins overarching plans
- The Health Board has developed an interim annual plan for 2019/20, with a 3 year outlook, recognising that this is a working document that will be subject to further changes as the detail of key areas such as planned care and financial planning progresses
- There is evidence of continuing improvement in engagement, through extensive use of social media, attendance by Health Board staff at high-footfall events out in communities, and the piloting of the Live Lab approach to healthy lifestyles in conjunction with Public Health Wales and the Future Generations Commissioner
- Across the Health Board, positive patient/service user feedback dominates the listening and learning data trends, at an estimated ratio of 70/30 percent in favour of positive comments
- Ongoing Board development – including work on strengths based leadership and developing high performing teams. Procurement of external facilitation for Board development is nearing completion, with final interviews to be held in April 2019
- Additional secondary care posts have been created to support unscheduled and planned care delivery
- Progress on unscheduled care – the new service improvement approach, based on 90 day improvement cycles – has started to deliver some results in respect of demand management, speeding up flow through hospitals and improving discharge procedures
- The Health Board has made a sustained improvement reducing the number of patients delayed on our Emergency Department forecourts (ambulance handover) – in February 2019 there has been a 73 % reduction compared to the same period in 2018
- The introduction of the Single Integrated Clinical Assessment and Triage (SICAT) service, in conjunction with Welsh Ambulance Services Trust, has been a key success factor in a transformational response to the challenges of increasing unscheduled care demand
- A key milestone for the improvement of Adult and Older People's Mental Health Inpatient Services was achieved in January 2019 when the Board approved a Strategic Outline Case (SOC) including development of the care environment in the Ablett Unit at Ysbyty Glan Clwyd
- Positive feedback has been received from Healthcare Inspectorate Wales (HIW) on the quality and safety of mental health services in the Ablett Unit, Hergest Unit and Nant-Y Glyn Community Mental Health Team

- Board members have undergone dementia friend training and Ysbyty Gwynedd has been formally recognised for being 'dementia friendly'
- An Improvement Group and also Stakeholder Group are established and overseeing the implementation of the HASCAS/Ockenden recommendations
- A new post of Executive Director of Primary Care and Community Services commenced during this reporting period; this post represents a major step forward in progress towards transformation
- Positive steps forward in supporting primary care resilience have been seen through fewer GP practice resignations, managed GP practices moving back onto General Medical Services contracts, all trainee GP posts in north Wales filled for the first time, and more robust clusters
- Sustained improvement in the timeliness of responses to concerns and incidents
- Ongoing efforts to learn from incidents as shown by, for example, the significant improvements in infection rates, being the best in Wales in respect of some bacteraemia

Further information on these highlights and measures of success are included later in this report.

4. Special Measures Improvement Framework Themes:

This section of the report outlines the progress made in meeting each of the specific expectations set out under the four themes for the time period October 2018 to March 2019:

4.1 Leadership and Governance

4.1.1 Expectation: *Board development activities delivered to ensure members of the Board are fully engaged on the challenges and delivering on the strategic objectives*

4.1.2 The Board has engaged in workshops on a monthly basis, supplemented by externally facilitated Board development focused on strengths based leadership and developing high performing teams. Board workshops have covered strategy, planning, unscheduled care, finance and risk. During this period, the Board has been supported by Mr David Jenkins as an independent adviser appointed by the Minister for Health and Social Services. The full Board is spending more time than ever in less formal settings, to scrutinise strategic objectives such as referral to treatment time (RTT) targets and the financial position. In January 2019, Mr Michael Hearty became a specialist adviser to the Board, primarily focused on finance.

4.1.3 The reduced frequency of Board meetings held in public has freed up time for the Executive Team to work together on priorities, and the Executive portfolio review process has facilitated a more effective allocation of responsibilities to support delivery of the full Health Board agenda.

4.1.4 The positive impacts of this development activity are being seen in the way the Board conducts its business. Following the completion of his work with the Health Board, Mr Jenkins reported that he believed the Board now to be in a much better position in terms of its ability to identify issues requiring focus and its ability to scrutinise and challenge. He also remarked that governance was better and the Board's confidence in its ability to make improvements had grown. Also, the WAO noted in their most recent structured assessment issued in November 2018:
"We looked at how the Board organises itself to support the effective conduct of business. We found the Health Board has good arrangements to support board and committee effectiveness, and shows recent signs of strengthened scrutiny, and is working to develop a strong focus on fewer but key priorities".
The Special Measures Improvement Framework Task & Finish Group therefore deems this expectation to be achieved, though Board development will continue to be an ongoing feature of business as usual.

4.1.5 Expectation: *Action to sustain senior leadership and capacity including the structure below the executive team*

4.1.6 Action to build additional sustainable leadership and capacity is underway in a number of key areas within the structure. Utilising additional funding provided by Welsh Government, the appointment process is progressing and most appointments have been made in respect of members of the turnaround team, in mental health, and in respect of extra secondary care posts. As part of Welsh Government's £6.8m package of special measures support announced in the summer of 2018, £2.317m extra funding has been provided to close the operational management capacity gap across the 3 main hospital sites. This has freed up clinicians to focus on patient priorities, harmonising structures and strengthening leadership.

4.1.7 In respect of the turnaround team, the additional investment has enhanced the Board's central Programme Management Office, increased programme management capacity for change programmes and will continue to further develop service improvement skills and capacity to support clinical teams to deliver change. Service improvement leads are being appointed to support the development and embedding of sustainable change plans. In mental health, the enhanced structure includes the establishment of triumvirate management teams and Local Implementation Teams (LITs) responsible for implementing the Quality Improvement and Governance Plan (QIGP) and producing local delivery plans.

4.1.8 This expectation has largely been achieved, however the position remains dynamic, with a new Executive Medical Director and Executive Director of Finance to be appointed in May. Work is also underway to consolidate interim leadership appointments for the 3 acute hospitals as part of the ongoing work to strengthen the capacity and governance arrangements across the organisational structure.

4.1.9 Expectation: *Financial plan on schedule to deliver to the finance control total agreed for 2018/19*

4.1.10 The Health Board remains in a very serious financial position and did not meet its financial control of £35m deficit, ending the year with a deficit of £40.3m,

£5.3m over the control total. As a result the Health Board has failed its three year financial duty.

4.1.11 The principal reason the control total was not met was failure to deliver the savings target of £45m, set as part of the 2018/2019 Financial Plan. The Health Board delivered £38.3m of savings, a shortfall of £6.7m

4.1.12 A Savings Programme Task Group has been established, reporting into the Finance and Performance Committee to provide additional and detailed scrutiny of the Health Board's 2019/20 savings programme, thus enhancing governance and oversight.

4.1.13 The Health Board has also commissioned an external financial review as part of focused efforts to improve the financial position. With financial support from Welsh Government, Price Waterhouse Coopers have been engaged to work alongside the Health Board in reviewing and improving it approaches to delivering sustainable improvement and change whilst at the same time saving money. The findings from the review are due to be reported to the Health Board in June 2019, with staged reporting in the interim.

4.1.14 Expectation: *Continued improvement and engagement to enable shared learning from concerns, complaints, incidents and claims*

4.1.15 Under the clinical leadership of the Executive Director of Nursing & Midwifery, the governance arrangements supporting learning from concerns, complaints, incidents and claims have been reviewed and refreshed. The Board now has an identified Champion for quality and concerns who carries the board level commitment and focus on this key area of work. The Champion has a deeper level of insight and knowledge allowing them to better support the Board in understanding the key issues.

4.1.16 The Board is sighted on the key quality and safety issues, linked to areas where concerns are commonly raised. This is done via the Quality, Safety and Experience (QSE) Committee and the Quality and Safety Group (QSG). The QSG, which is led by clinical executives, provides assurance reports to the QSE Committee. QSG also provides multi-disciplinary review and oversight, with an emphasis on promoting learning. All divisions of the Health Board provide monthly reports on their quality and safety issues, including concerns.

4.1.17 Progress on serious incident investigations and learning is tracked during weekly incident review meetings chaired by the Associate Director, Quality Assurance. The Health Board has collaborated with the Welsh Risk Pool to play a key role in driving the national claims process reform on behalf of NHS Wales. This aims to promote more effective learning from claims.

4.1.18 Corporate concerns management and support structures have been revised in order to enable the corporate team to deliver more training, support and mentorship to staff. This has facilitated the concerns management process and subsequent learning from concerns. All investigations are led by the relevant service team, which

means that lessons learnt can be acted upon earlier in the process and closer to the point of care.

4.1.19 Concerns related data is now available at ward level following roll out of the 'harms' dashboard, and implementation of a ward/unit accreditation programme has included consideration of concerns data. 'Harm summits' take place to promote harm reduction via shared learning in key areas where complaints/incidents arise. For example, the Health Board has seen significant improvements in its infection rates and continues to have the best cumulative monthly rate per 100,000 population of all health boards in Wales for *St. aureus* bacteraemia, *Klebsiella sp* bacteraemia and *Pseudomonas aeruginosa* bacteraemia. It also has the third best rate per 100,000 population for *E. coli* bacteraemia.

4.1.20 The work outlined above, coupled with investment in additional capacity in recent years, has led to improvements such as in the timeliness and quality of responses to complaints and serious incidents.

4.1.21 There has also been a sustained improvement in the management of all incidents. In particular, better management of serious incidents has resulted in a reduction in the overall number of such incidents being reported. This trend has been particularly evident over recent months.

4.1.22 Following receipt of the Public Service Ombudsman for Wales (PSOW) annual letter relating to 2017/18, the Health Board was required to reflect on the learning from the 2 public reports issued in respect of north Wales cases. The Health Board undertook a range of actions to learn lessons in response to the failures. The PSOW was satisfied with the learning that took place and closed both cases.

4.1.23 The Health Board recognises that the investigation and understanding of concerns (complaints and incidents), alongside the views of service users, is a crucial source of learning and improvement. It is acknowledged that, although improvement is evident in this area, more work is required to systematically disseminate learning and to be able to evidence implementation of lessons learnt.

4.1.24 Expectation: *Demonstrate active leadership and commitment working with partners in the Public Services Boards and Regional Partnerships to deliver on the plans and actions agreed to benefit the well-being and health of the people of North Wales including tackling inequalities*

4.1.25 The new Chair brought an added impetus to partnership working when he joined the Health Board in September 2018, by requiring increased time commitments and more active participation in the Public Services Boards (PSBs) and Regional Partnership Board (RPB). The Chief Executive now attends Public Services Board meetings. The Executive Director of Public Health has now assumed the chairmanship of the RPB and has been instrumental in encouraging joint organisational development activities between the members. The newly appointed Executive Director of Primary and Community Care has also contributed to improvements in working relationships across the 6 local authorities.

4.1.26 The Health Board has engaged with the PSBs and RPB in the development and finalisation of its 3 year outlook and 2019/20 annual plan, ensuring alignment with a whole systems approach to health and social care. It also worked with PSB and RPB partners on all four of the north Wales bids submitted to the Transformation Fund, to support service development. This joint working will continue in order to deliver on the successful bids in partnership. The Special Measures Task & Finish Group deems the requirements of this expectation to be achieved, but acknowledges that effective partnership working must continue to mature and remain a core component of day to day business to fully transform services.

4.1.27 Expectation: *All follow-up reviews recommendations progressed and plans in place for completion of actions to include the Deloitte, HASCAS and Ockenden Reviews*

4.1.28 Deloitte recommendations are being progressed and scrutinised. They are embedded within special measures monitoring arrangements, with oversight by the relevant committee, and are reviewed as an integral part of the monthly special measures meetings with Welsh Government.

4.1.29 1 The Health Board has established robust governance and reporting arrangements, incorporating terms of reference for an Improvement Group guided by a Stakeholder Group, to oversee the implementation of the recommendations from the HASCAS report and the Ockenden Governance review jointly. All recommendations from both the HASCAS and the Ockenden reports have been mapped together to ensure the necessary actions identified are embedded across the organisation and are not dealt with in isolation. Progress is reported to the Board in public session.

4.1.30 The Stakeholder Group, which is a subgroup of the Improvement Group, comprises representatives of the Community Health Council, Bangor University, St Kentigern Hospice, North Wales Police, north Wales local authorities, community voluntary councils, the North Wales Adult Safeguarding Board and Care Forum Wales as well as 6 Tawel Fan family members. Staff from the psychology service are also in attendance at these meetings to offer support to members if required.

4.1.31 In November 2018, the Board received a paper providing a progress report against the HASCAS/Ockenden recommendations. A further paper detailing improvements made was considered by both the Quality, Safety & Experience (QSE) Committee and the full Board in January 2019. This highlighted progress made in care for the older person, including dementia strategy implementation, restrictive practice guidance, recruitment to senior clinical posts, safeguarding, care pathways, partnership working, concerns management and estates issues. To date, over 60% of the HASCAS/Ockenden recommendations are either complete, or nearing completion.

4.1.32 Work is underway in relation to end of life care on older persons' mental health (OPMH) wards. This includes seeking to provide care in the patient's environment of choice, and the implementation of advanced care planning, treatment escalation plans and the all Wales arrangements for care decisions for the last days of life. Risk assessments will be undertaken with families to ensure early conversations in respect of care planning and choice. Palliative care training is to be delivered to staff within all care settings.

4.1.33 A number of ongoing initiatives aim to improve the experience for people with dementia, who are presenting for unscheduled care to the emergency departments. Specifically, the three hospital sites are involved in the Dementia Friendly Hospital Programme (and Board members have received Dementia Friend training). Good work is underway at all sites but notably, Ysbyty Gwynedd was awarded Dementia Friendly Hospital accreditation by the Alzheimer's Society at the end of last year - the first acute hospital in Wales to achieve this. As part of this programme of work the following initiatives are also underway:

- Butterfly alert cards are being rolled out, which allow a person affected by a dementia to alert emergency department staff as to their needs. The cards aims to support patients in ensuring that their dementia and any anxiety are recognised, that this leads to quicker triage, that triage is dementia friendly and the triage nurse identifies with the person and their family/carer how the person can be best supported to receive the most appropriate treatment
- The orange wallet scheme supports people with forms of disability that may not be visible and any conditions that impact upon understanding and communication when using public services
- An Emergency Department Dementia Pledge is in place which is a public facing statement that sets out what each department has committed to

4.1.34 Therefore, it can be demonstrated that plans are in place and recommendations are being progressed via an integrated governance structure with regular reporting to the Board. The Special Measures Task & Finish Group therefore deems this expectation to have been met.

4.2 Strategic and Service Planning

4.2.1 Expectation: *Demonstrable progress on the implementation on the agreed clinical services strategy including the emergence of supporting plans in specific clinical areas, and an estates strategy to underpin future models of care*

4.2.2 The Health Board does not yet have an agreed, detailed clinical services strategy in place. The Health Board has linked with other Health Boards in Wales who have already progressed with their clinical strategies and this learning is informing the development of the BCU clinical services strategy.
However, several components of an overarching clinical strategy are already in place including:

- Vascular plan - very specialist surgery will be provided at Ysbyty Glan Clwyd, where a state of the art vascular hybrid theatre and equipment has been established with significant investment from Welsh Government and the Livsey Trust. There has been a successful recruitment of senior clinical staff and the new centre will open in April 2019

- Orthopaedics plan (see 4.2.13 below)
- Ophthalmology plan (see 4.2.14 below)
- Urology and pelvic cancer – the Health Board is undertaking a strategic review of urology services and developing a business case for robotic assisted surgery to support urological and other cancer site surgery
- Stroke services plan – this focuses on the whole stroke care pathway and includes proposals for establishment of a hyperacute stroke unit; plans are progressing with exemplary stakeholder and clinical engagement.
- With the support of Welsh Government, the Health Board has completed major developments at Ysbyty Glan Clwyd, and the Emergency Department at Ysbyty Gwynedd.
- The Sub-regional Neonatal Intensive Care Centre (SuRNICC) has been open for over a year and the benefits of this specialist centre are being realised for babies across North Wales. The new service provides both special care and intensive care cots, with on-site parent accommodation.
- The Health Board has also agreed a shared approach to transforming services for children and young people, people with a learning disability, people with mental health needs and community services through the Regional Partnership Board and are working collaboratively to develop and implement these

It will be necessary to build upon these as part of a whole system approach, including primary care, and to complete the suite of plans comprising the full, integrated, clinical services strategy. The development of the clinical strategy will take place over the coming months. The technical evidence already gathered in support of strategic planning programmes will be reviewed, alongside information and feedback from our partners and stakeholders.

4.2.3 In January 2019, the Health Board considered its priorities for 2019/20, within the context of a 3 year outlook aligned to the Board's strategic direction set out in *Living Healthier, Staying Well*. The Board recognised specific challenges and the plan was further developed by service transformation groups, drawing together information on the financial implications alongside the impact on the estates, workforce and digital strategies. The plan includes a commitment to develop a clinical services strategy by the end of September 2019.

4.2.4 In March 2019, the Board received the 2019/20 annual plan and approved this as an interim working document, recognising that the financial implications were not fully aligned and further work was required in relation to planned care in particular. The development of the financial plan is being supported externally as previously described. As mentioned previously, the Health Board's Workforce Strategy and Estates Strategy were approved in March 2019. They set out the challenges and opportunities faced and provide the context / parameters which will enable improvements in service models and delivery to be made.

4.2.5 Expectation: *A Board approved three-year integrated medium-term plan submitted by March 2019, for the 2019-2022 planning cycle*

Following discussion with Welsh Government, and confirming our own understanding, it has not been possible to meet the IMTP criteria. Accordingly, an annual plan, with a 3 year outlook, has been developed. This is underpinned by and Estates Strategy and a Workforce Strategy. A Digital Strategy is also under development. From this base, the Health Board will work towards further development of the explicit requirements of an Integrated Medium Term Plan.

4.2.6 Expectation: *Delivery against agreed milestones set out in the 2018/19 operational plan on schedule, including:*

- *Sustained progress to reduce RTT and diagnostic waiting times as planned and agreed by the end of March, 2019; and*
- *Continued sustainable improvement in unscheduled care performance with a further decrease in patients waiting over 1 hour for patient handover, less than 4 and more than 12 hours in emergency care facilities that maintains progress made in the first six months of the year and which achieves targets agreed in the annual plan*

This was not fully achieved.

4.2.7 The Health Board has not delivered against the agreed milestones by the end of March 2019, although financial and Delivery Unit support was received during this period from Welsh Government for RTT, which went some way towards mitigating the seriousness of the position.

4.2.8 The Health Board has also benefitted from additional special measures funding for secondary care, announced in July 2018, which has helped build capacity and resilience in the teams.

4.2.9 There is a significant number of patients waiting longer than their planned, expected or national waiting times for their diagnostic examination. This is on all sites and across the range of referral sources (urgent, cancer, surveillance or routine).

4.2.10 The Health Board's 3 endoscopy units are unable to manage the current demand and the backlog of patients has continued to grow. The emergent operational and clinical risks have been escalated to the Board and decisive action has been taken to source additional capacity. This work has progressed alongside a detailed review of individual clinical risk to ensure potential harm to patients is minimised.

4.2.11 Some improvements have been made in relation to unscheduled care performance, driven by a series of 90 day plans. The plans have required effective partnership working and clinical leadership, to better manage demand in the pre-hospital environment as well as improving flow on the 3 acute hospital sites, and supporting complex discharges working with local authorities and third sector organisations. This has achieved a sustained improvement in ambulance handovers (1337 patients delayed in February 2018 compared to 358 delayed in February 2019) and a reduction in delayed transfers of care (reduced from 104 patients in February 2018 to 70 in February 2019).

4.2.12 The 90 day planning methodology has also been used to progress quality improvements in a number of areas including infection control and falls reduction. The information on the safety and quality of services has also significantly improved with the development of the 'harms' dashboard, which gives a real time overview of quality indicators, down to ward level, which has been the subject of positive comments within the Wales Audit Office's Structured Assessment.

4.2.13 Expectation: *Delivery of the sustainable orthopaedic services plan progressing on the agreed timeline*

The orthopaedics plan is progressing. The Health Board and Welsh Government undertook a detailed review of the key elements of the plan, considering prevention, community based services as well as secondary care internal and commissioned activity. The discussion considered both the sustainable service gap and expansion needed to meet population health needs as well as the non-recurrent and commissioned activity required to reduce and subsequently eliminate backlog over a three year period. The efficiency and productivity gains expected were identified and linked to the engagement with the national Planned Care Programme. The cost and deliverability of both recruitment and capital requirements were tested. Further work on the actions agreed is progressing, with assessment of the immediate decisions needed to realise progress in the short and medium term, including commencement of recruitment, capital development and commissioning decisions.

4.2.14 Expectation: *North Wales ophthalmology plan being implemented to agreed timescales*

The ophthalmology plan is in the process of being implemented. The Eye Care Collaborative Group (ECCG), chaired by the Area Director West, has been established to support the development of an improved, revised service model in line with the strategic plan for eye care in North Wales. The Health Board is participating in a transformative programme of work introduced by Welsh Government to ensure eye care is improved and cases prioritised through integrated clinical risk stratification of patients under the Eye Care Measures Programme. The Delivery Unit visited the Health Board in April to assess organisational readiness for implementation of the Eye Care Measures. The Health Board has received funding from the Eye Care Sustainability Fund of £429,724, to fund the testing of a more efficient cataract pathway, plus the purchase of necessary equipment.

4.3. Mental Health

4.3.1 Expectation: *LHB continuing to deliver on the plan to progress the work on the recommendations and embedding the lessons learnt/findings of HIW inspections, the HASCAS investigation and Ockenden Review as part of the delivery of the TQ&G Plan*

4.3.2 During this period, there have been 3 unannounced Healthcare Inspectorate Wales (HIW) visits to mental health premises/services – Nant y Glyn Community Health Team, Hergest Unit and the Ablett Unit. The reports have all highlighted the quality and safety of the care provided, the commitment of staff, positive feedback

from service users and improvements in access for patients. There has also been positive feedback on improvements in the quality of leadership and management and the robustness of governance arrangements. Further work is required to ensure there is consistency across all sites and aspects of the service, to achieve sustainable improvements to the environment of care and some aspects of care planning and record-keeping.

4.3.3 The work to progress the HASCAS and Ockenden recommendations has gained momentum. Stakeholders, including Tawel Fan families have been active participants in the Stakeholder Group, which is guiding the work of the Health Board, ensuring that the impact of changes on service users and carers, are being taken into account. The Group enables a more in-depth assessment to be made whilst at the same time provides a means of identifying emerging issues that need to be brought to the attention of the Health Board. Members of the Group have taken the opportunity to examine in detail individual recommnedations and the progress being made, contributing valuable insights needed to secure improvements. The embedding element is the key issue yet to be fully addressed; the Quality, Safety & Experience Committee is to lead on giving consideration to this aspect and will determine that which constitutes evidence of embedding.

4.3.4 The Mental Health and Learning Disabilities Division has developed a bespoke Quality Improvement and Governance Plan (previously the TQ&G Plan), which draws together a series of improvements themes. This is monitored by the QSE Committee. Key achievements in the period include:

- Improvements to care pathways for older people's mental health
- Staff engagement
- Improvements in the environment of care
- Strengthened clinical governance arrangements.

4.3.5 Expectation: *Continued progress demonstrated in delivering on the Mental Health Strategy*

Progress on delivering the strategy is being demonstrated. Key milestones and plans for 2019/20 have been agreed and progress has been made against the priorities below:

- Working to prevent mental health crises by focusing on early intervention and promoting emotional resilience
- Developing local alternatives to admission
- Reviewing and improving bed management and patient flow
- Working with criminal justice services to divert demand arising from the police
- Working with CMHTs and voluntary third sector agencies to review their role with people at risk of severe mental health crises

In addition, work has progressed with the launch of the 'Today I Can' programme alongside the mental health strategy, which has spread and been adopted by other sectors and organisations.

4.3.6 Expectation: *Key posts in management structure filled and resilient to any unforeseen staff absences*

Tiers 1 – 4 of the Mental Health & Learning Disabilities Division organisational structure are now all in place, creating more resilience within the system. The SMIF Task & Finish Group therefore considers this expectation to be met.

4.4 Primary Care

4.4.1 Expectation: *Progress being maintained over the winter period in implementing the national out of hours standards*

GP out of hours has now been removed from special measures.

4.4.2 Expectation: *Evidence of strengthened resilience and sustainability in primary care services*

The vision for integrated, resilient and sustainable health and social care clusters has been developed, as described below. In terms of strengthening primary care resilience, impacts have been seen through fewer GP practice resignations, managed GP practices moving back onto General Medical Services contracts, and all trainee GP posts in north Wales filled for the first time,

4.4.3 Expectation: *Vision, direction and implementation plan for primary care clusters agreed and being delivered*

The vision for integrated, resilient and sustainable health and social care clusters has been developed, with Health Board actions mapped out into the Care Closer to Home workstream. This has been co-produced with partners, and received commitment from the Public Services Boards to support and prioritise the approach once it has been formally agreed.

4.4.4 The Health Board has contributed to the successful Regional Partnership Board (RPB) bid to the Transformation Fund to support the delivery of the shared vision for clusters. A Community Transformation Board has been established, with Local Authority directors and other RPB partners, following the successful Transformation Fund application. Implementing the vision for clusters, led collaboratively with increased local autonomy will be critical to success. A cross-organisation workshop has been arranged to sense-check the detail of proposals prior to then commencing roll-out. It is anticipated that this expectation will be fully achieved following the workshop in May 2019.

4.4.5 Expectation: *Programme established in partnership to develop and implement agreed proposals for the configuration of health and well-being centres in North Wales*

4.4.6 A workstream for health and well-being centres has been mapped out with reference to the Care Closer to Home strategy. Ongoing dialogue is taking place with partners and other stakeholders to better understand the requirements within different levels of centres and at cluster level, including non-Health Board estate. The Health Board estates strategy has been widened to include primary care estates considerations.

4.4.7 It is recognised that achieving success will require the estate to be used in partnership with other services.

5. Equality Impact Assessment

As this is a retrospective report concerning progress on implementation of the Improvement Framework, an equality impact assessment is not considered necessary.

6. Conclusions/Next Steps

As described in this report, the Health Board has made progress against the October 2018 to March 2019 expectations of the Special Measures Improvement Framework. However, a number of the milestones on finance and those set out under the strategic and service planning theme have not been fully achieved. It is recognised that significant challenges remain in some areas as outlined in this report, and there is considerable further work to be done. Significant service transformation is required to ensure that future milestones can be achieved sustainably in relation to both performance and finance in the medium to long term. This will require working effectively with staff, stakeholders and communities. The Board is focused and clear on the work needed, and is committed to making progress over the next 12 months. The Board has a clear understanding of those areas requiring additional focus and the improvements required. The additional special measures support provided by Welsh Government will continue to be used to move forward on key priorities. Progress made during each of the special measures phases will continue to be monitored to ensure that improvement is achieved and sustained.

The Board approved this report for submission to Welsh Government at its meeting held on 2.5.19

Betsi Cadwaladr University Health Board (BCUHB)
Draft Minutes of the Health Board Meeting Held in Public on 28.3.19
in Catrin Finch Centre, Wrexham

Present:

Mr M Polin	Chair
Mr G Doherty	Chief Executive
Cllr C Carlisle	Independent Member
Mrs D Carter	Acting Executive Director of Nursing & Midwifery
Mr J Cunliffe	Independent Member
Mrs M Edwards	Associate Board Member, Director of Social Services
Mr G Ellis-Evans	Vice Chair, Stakeholder Reference Group
Mr G Evans	Associate Board Member, Chair of Healthcare Professionals Forum
Mr R Favager	Executive Director of Finance
Mrs S Green	Executive Director of Workforce & Organisational Development (OD)
Mrs J Hughes	Independent Member
Cllr M Hughes	Independent Member
Mrs M W Jones	Vice Chair
Mrs G Lewis-Parry	Board Secretary
Mrs L Meadows	Independent Member
Dr E Moore	Executive Medical Director
Miss T Owen	Executive Director of Public Health
Mrs L Reid	Independent Member
Mr A Roach	Associate Board Member, Director of Mental Health & Learning Disabilities
Mr C Stockport	Executive Director of Primary Care & Community Services
Mr A Thomas	Executive Director of Therapies & Health Sciences
Mrs H Wilkinson	Independent Member
Mr M Wilkinson	Executive Director of Planning & Performance

In Attendance:

Mrs K Dunn	Head of Corporate Affairs
Mr D Jenkins	Independent Adviser
Translator and Observers	

Agenda Item	Action By
19.41 Chair's Introductory Remarks The Chair welcomed Mr Gareth Evans to his first board meeting as Chair (Designate) for the Healthcare Professionals Forum. He also welcomed Mr David Jenkins to the meeting in his role as Independent Adviser. The Chair went on to record his appreciation for the contribution and support provided to the Health Board by Mrs Bethan Russell-Williams who had tendered her resignation recently. Finally he indicated that after the public session the Health Board was meeting with the Board of Health Education & Improvement Wales.	
19.42 Special Measures Improvement Framework Task & Finish Group Chair's Assurance Report 25.2.19	

The Chair presented the report and highlighted that the group had found the input from the Executive Team very valuable. He reported that a number of actions had been discharged, whilst a number remained as requiring more work. The Board Secretary added that the next end of phase report for Special Measures was being prepared for the May Board meeting. The Chair also drew attention to the letter of the 22.2.19 from the Chief Executive of NHS Wales relating to joint escalation and intervention arrangements which confirmed that GP out of hours had been de-escalated from Special Measures.	
19.43 Apologies for Absence Apologies were received for Mrs G Harris, Mr Ff Williams and Prof J Rycroft–Malone.	
19.44 Declarations of Interest None were declared.	
19.45 Draft Minutes of Trustees Board Meeting Held on 24.1.19 The minutes were approved as an accurate record pending an amendment to reflect that Mr J Cunliffe had submitted his apologies.	
19.46 Draft Minutes of the Health Board Meeting Held on 24.1.19 19.46.1 The minutes were approved as an accurate record pending the following amendments: • To reword 19.15.5 to read “Members confirmed that they felt the plan set out the strategic direction and provided a baseline on which to build” • To remove the wording “resulting in a £500K forecast deterioration in contracts” from 19.20.5 • To reword 19.25.2 to read “links with the Quality & Safety Group had been improved” • To include within 19.17.2 “The Chair of the Information Governance & Informatics Committee highlighted that there would be an impact on health records storage that would need to be taken into account as the business case progressed” 19.46.2 Updates were provided to the summary action log with members confirming closure of a range of actions and identifying others which required further work. 19.46.3 The following matters arising were raised: • That for future reference the correct terminology for staff side was now “Trade Union partners”. • That the reformatted HASCAS and Ockenden report had been well received by the Quality, Safety & Experience Committee, and that the next report to Board would include an update on the alignment of stakeholders to areas of their specific interest.	
19.47 Committee and Advisory Group Chair’s Assurance Reports **19.47.1 Mental Health Act Committee 3.1.19** The Committee Chair presented the report and highlighted the key risks arising from the deep dives into Child Adolescent Mental Health Services, noting that the report from the Delivery Unit’s visit in December 2018 was still awaited. She also suggested that there	

were differences in the data reported within a recent briefing note and the Integrated Quality Performance Report which indicated there were issues around sustainability. **19.47.2 Quality Safety & Experience (QSE) Committee 22.1.19** The Committee Chair presented the report and highlighted the continuing concern around Pressure Ulcers. The Chair also highlighted the achievement of the Health Board being the best ranked Welsh health employer within the Stonewall Top 100 Employers List for 2019. **19.47.3 Remuneration & Terms of Service Committee 14.1.19** The Chair presented the report and highlighted that work continued around reviewing Executive portfolios and the wider organisational structure, ensuring that the Committee remained fully sighted on these issues. **19.47.4 Strategy, Partnerships & Population Health Committee 5.2.19** The Committee Chair presented the report and highlighted that the Committee had reviewed the draft divisional improvement plans and had noted some gaps with concern. She added that the Regional Partnership Board had welcomed the joint working and genuine involvement in development of the Health Board's Three Year Plan. The Independent Member (Third Sector) noted that the Chief Executive had attended the Public Service Board recently to present the Three Year outlook which had been positively received. **19.47.5 Information Governance & Informatics Committee 13.11.18** The Committee Chair presented the report and highlighted the risks around the impact of delays and non-delivery of national solutions or systems. He also reported that the Committee had requested that consideration be given to splitting and clarifying corporate risks to incorporate emerging risks around the national blood inquiry. **19.47.6 Stakeholder Reference Group 5.3.19** The Vice-Chair of the group presented the report and highlighted the discussion around encouraging agency nurses to return to work in BCU on a substantive basis. The Executive Director of Workforce & Organisational Development (OD) shared the concern of the SRG and assured the Board that this principle was addressed within the Workforce Strategy. It was agreed that an appropriate representative from Workforce & OD attend the next meeting of the SRG. **19.47.7 Local Partnership Forum 8.1.19** The Executive Director of Workforce & Organisational Development presented the report and noted that there had been a useful workshop session around the development of the Workforce Strategy and that a similar approach had been suggested to address health and safety management at the next meeting of the forum. The Board's attention was also drawn to a significant improvement in job evaluation performance following the amendment of key performance indicators. **19.47.8 Finance & Performance (F&P) Committee 17.1.19 and 26.2.19**	SG

The Chair presented the report highlighting the Committee's main concerns and disappointment around the financial position and delivery against savings plan, and that performance around both planned and unscheduled care remained of concern.	
19.48 Mental Health Act 1983 as amended by the Mental Health Act 2007. Mental Health Act 1983 Approved Clinician (Wales) Directions 2008. Update of Register of Section 12(2) Approved Doctors for Wales and Update of Register of Approved Clinicians (All Wales) **19.48.1 It was resolved that** the Board ratify the list of additions and removals to the All Wales Register of Section 12(2) Approved Doctors for Wales and the All Wales Register of Approved Clinicians.	
19.49 Annual Review of Standing Orders, Scheme of Reservation and Delegation (SORD) and Board Cycle of Business **19.49.1** The Board Secretary presented the paper confirming that the Board reviewed this suite of governance papers on an annual basis, however, due to the ongoing national review of model Standing Orders, this element was being deferred to the May Audit Committee. She drew members' attention to the interim SORD that had been updated to reflect recent changes to senior portfolios, noting there would be other changes in due course. **19.49.2** The Vice Chair of the Audit Committee indicated that some Committee members had been unaware of the Managing Director roles at the three acute hospitals, until they had received the SORD. The Chair acknowledged that communication could have been improved and clarified that the Executive Team were now looking further at the organisational structure - as discussed at the Independent Members' meeting on the 25.3.19. The Chair indicated that as a principle the Independent Members would wish to be assured that the necessary capacity existed across acute sites and area teams, and that roles and accountabilities are clear. The Chief Executive added that it was clear that more senior roles needed strengthening at each of the acute sites and he was assured that the interim Managing Director arrangements were consistent with the Board's direction of travel. **19.49.3 It was resolved that** the Board:- • Noted the deferral of the Annual Review of Standing Orders pending the national review of the Model being undertaken by Welsh Government; • Approved the revisions to the SORD as endorsed by the Audit Committee; • Approved the Board cycle of business for the year ahead noting that this was an iterative document.	
19.50 Update on North Wales Vascular Service **19.50.1** The Chairman acknowledged that there had been a significant amount of public and media interest in this matter recently. The Executive Medical Director presented the paper which set out the background and context to the decision-making and he drew attention to the additional engagement and communication that had taken place. He wished to highlight the significant investment that the Health Board had made in the hybrid theatre and the dedicated ward, and reflected that despite the best efforts of many individuals there remained a level of misunderstanding around vascular services with a widely held belief that the proposals would result in all emergency vascular care moving from Ysbyty Gwynedd, and that there would also be an adverse effect on renal services	

which is not the case. The point was made that lessons needed to be learned from the communication issues experienced with this service development, and a clearer strategy for engagement and myth-busting should be maintained. **19.50.2** In response to a question regarding timely recruitment, the Executive Medical Director confirmed there had been a good level of interest with sufficient appointments having been made to safely open the ward although there were gaps that would need to be managed through the use of bank, agency and existing staff. He also confirmed that Wales Ambulance Services NHS Trust had been heavily involved in the discussions and the majority of patients would continue to be taken for assessment at the closest ED unit as dictated by their individual condition. The Chief Executive clarified that this was a continuation of what currently happens and would not be a change. He also wished to highlight that the development of the specialist centre had enabled the Health Board to achieve far more positive recruitment. The Vice Chair asked whether there was a sense as to the impact of the aneurysm screening programme on the number of emergencies. The Executive Medical Director confirmed that emergency aneurysms had fallen in general over the last 20 years which could in part be attributed to the screening programme together with aneurysms being generally a less prevalent condition as a consequence of changes in lifestyles choices. The Chair noted that the paper referred to the conclusion of job planning for consultant vascular surgeons during March and sought assurance that this would be achieved. The Executive Medical Director undertook to follow this up. **19.50.3** The Chair summarised that the organisation had the capacity and capability to establish the new facility which would go live on 10th April 2019 following investment by Welsh Government and a significant contribution by the Livesy Trust. He accepted there was a view amongst some members of the public and partners that the Board had departed from its original decision but he remained assured that this was not the case. He did accept that there had been elements of narrative within board papers that could have been clearer. It was also noted that the Executive Medical Director had personally met with a range of individuals and partners such as the Local Medical Committee and Assembly Members which had been productive meetings in terms of clarifying the Board's position and providing assurances. **19.50.4 It was resolved that** the Board note the report.	EM
10.51 Integrated Quality Performance Report **10.51.1** The Executive Director of Planning & Performance presented the report and drew members' attention to the summary dashboard which indicated that there were significant challenges across all areas although 34 of the 50 key performance indicators had improved since the last report. The Chief Executive wished to note the substantial improvement within some areas of unscheduled care. He also highlighted that dermatology was an area where there was great variability amongst cases coupled with recruitment issues. **10.51.2** In terms of endoscopy it was noted that an extraordinary meeting of the QSE Committee had been held on the 28th February 2019 to sight the Committee on the emerging position, with a further update having been provided to the March meeting. The Committee had considered how the issue had arisen and whether reporting systems currently in place were sufficient for the future. The Chief Executive set out two key actions around boosting activity via additional resources and a mobile unit, and addressing the backlog. The Executive Director of Therapies & Health Sciences stated that the mobile unit should be operational by mid-May and would screen a further 120	

patients per week. A longer term measure for Wrexham was also being developed through the capital programme. The Executive Director of Therapies & Health Sciences had also met with the Delivery Unit regarding demand models, and he confirmed that BCUHB were engaging with the national endoscopy work chaired by Mr Simon Dean. Members expressed concern at the effect on a large percentage of the organisation's diagnostic waits and that performance and quality of service in other specialties also relied on diagnostics. **10.51.3** The Chair referred to referral to treatment forecasting and modelling work ongoing with the Delivery Unit and noted that the clear expectation from Welsh Government was that the Health Board must not exceed the position as at the end of the previous year. Failure to achieve this may result in a clawback of some additional resource that had been provided. The Executive Director of Planning & Performance confirmed he was working on the terms of reference for a task and finish group with the aim to complete the first phase of work by May 2019. The Chair then sought assurance that falls were being reported appropriately and the QSE Committee Chair indicated that a report was awaited on the backlog of serious untoward incidents. The Chair noted an increase in locum expenditure. The Executive Director of Workforce & Organisational Development indicated that potential underlying factors had been identified and whilst there had been an increase she indicated that the rate was lower than the same period last year. **10.51.4** In terms of sickness rates the Executive Director of Workforce & Organisational Development confirmed that whilst the 4.5% target was not currently deliverable by the organisation, this challenge was shared by many other Boards with BCUHB currently performing the second best in Wales. She confirmed that improvement methodology would be applied to those areas where it would have the most impact. Training on the new absence management policy was currently being provided however the change from a very prescriptive to a more compassionate/ discretionary approach would take time to work through. In the meantime the focus would remain on the areas of musculoskeletal issues, absences due to accidents, stress and long term absences. **10.51.5** The QSE Committee Chair raised the matter of patient follow ups and an associated limited assurance audit report, noting that concerns had been raised at both Audit and QSE Committees in terms of prioritisation and harm. The Acting Executive Director of Nursing & Midwifery confirmed that where any harm was identified the GP and/or other healthcare professional were engaged with. It was suggested that consideration be given to how best to ensure the QSE Committee was briefed on mitigating actions in a timely manner. **10.51.6** A question was asked regarding the number of stroke consultants in post and it was confirmed that this had been looked into previously and there were no major concerns about this establishment. The Executive Director of Workforce & Organisational Development added that it was rare for an organisation to employ a full cohort of consultants who specialised in stroke only, and that generally the majority were care of the elderly consultants who had an element of stroke specialism. It was noted that the QSE Committee had received a recent paper on stroke services and it was agreed that this be refreshed and circulated to all board members as an update. **10.51.7** In response to a question regarding the Mental Health Measure, the Director of Mental Health & Learning Disabilities confirmed that the February figures had just been validated and though there was an improvement performance was still below target. The Vice Chair suggested that the demand capacity review would be key to improvement. The QSE Committee Chair noted that the paper indicated that patients were being treated	DC EM

"in turn" and she sought assurance that the priority of patients was also being taken into account. The Director of Mental Health & Learning Disabilities confirmed that patients were triaged in terms of risk. The Executive Director of Public Health added that the figures for child and adolescent mental health had been validated and there remained work to be done to improve performance and sustainability and build resilience. **10.51.8 It was resolved that** the Board note the report. *[Mrs M W Jones, Dr C Stockport and Cllr C Carlisle left the meeting]*	
19.53 Finance Reports Month 10 and Month 11 **19.53.1** The Executive Director of Finance suggested that the Month 10 paper be received for information and that the discussion focus on the Month 11 position which had been considered by the F&P Committee on the 26th March 2019. For Month 11 the actual deficit in month was £2.9m, £700k over the plan which was due to £800k planned savings not delivered and overspend on prescribing, cumulatively the Health Board is overspent by £36.5m. He highlighted that all of the expected referral to treatment resources had now been received and a potential £1m clawback had been factored into the forecast position. If this did not materialise then the Board's forecast position would be around £41m deficit. With regards to savings, £38m was forecast to be delivered against the £45m plan. The Chair acknowledged the substantial amount of savings that had been delivered but that it was not enough and the deficit would have to carry across into 2019-20 as part of the underlying deficit. The Board were aware that the position would have been considerably worse if not for the additional Welsh Government support around referral to treatment. **19.53.2 It was resolved that** the Board note the report including the forecast out-turn and recognised the significant risks to the financial position. *[Cllr C Carlisle re-joined the meeting]*	
19.54 Wales Audit Office (WAO) Annual Audit Report 2018 **19.54.1** The Board Secretary presented the report which summarised the work of WAO throughout the year, and drew attention to the unqualified opinion on the accuracy and proper preparation of the 2017-18 financial statements, and a qualified audit opinion relating to the failure to meet statutory financial duties. In addition the Auditor General had noted that whilst the Health Board was strengthening its governance and management arrangements, it continued to struggle to develop financially sustainable medium-term plans and improve priority areas of performance. The Board Secretary confirmed that the report had been discussed at the Audit Committee. The Chair welcomed the report and he was clear as to the rationale for the Auditor General making these observations. **19.54.2 It was resolved that** the report be received. *[Dr C Stockport and Mrs M W Jones re-joined the meeting]*	
19.55 Concerns Management – Update to Include Actions Requested within the Public Service Ombudsman Wales (PSOW) Annual Letter 2017-18	

19.55.1 The Acting Executive Director of Nursing & Midwifery presented the paper which described the governance framework for concerns management within the Health Board and how performance had been improved and trajectories set.

19.55.2 A comment was made that although the paper referred to a "sustained improvement for the management of all incidences" it was potentially too soon to claim this. This point was accepted although it was confirmed that the categorisation of incidents had commenced in earnest back in July 2018. A point of accuracy was also raised in that the paper had not been received at the QSE Committee as was stated on the coversheet. The QSE Committee Chair added that the improved qualitative reporting of concerns to the Committee was very much appreciated. In response to a question from the Vice Chair regarding the number of incidents, the Acting Executive Director of Nursing & Midwifery accepted that coding or grading issues could potentially skew the data, however, she was confident that there had been an actual reduction in the number of serious untoward incidents in the past year. The Chair welcomed the significant improvement which had also been noted by the PSOW in his letter.

19.55.3 It was resolved that the Board note the report.

19.56 Staff Engagement – NHS Wales Staff Survey 2018 : Delivering Improvement

19.56.1 The Executive Director of Workforce & Organisational Development presented the paper which provided an overarching Organisational Staff Survey Improvement Plan together with Divisional Improvement Plans for 2019/20. She noted that each of the plans were dynamic in nature and the Board would need to respond to feedback as it arose. Members were informed that the Organisational Improvement Plan focused on the top three areas for improvement as identified within the survey – namely work related stress, harassment, bullying or abuse and Executive Team visibility and engagement. In terms of Executive visibility, the Executive Director of Workforce & Organisational Development felt this was pivotal to setting the strategic direction and giving the workforce confidence. She then drew members' attention to the Divisional Plans and that these were focused on the areas of biggest impact. Finally she suggested that the Board would need to be able to test how staff engagement was being impacted by the annual plan.

19.56.2 A discussion ensued. It was queried whether the Staff App had been agreed through the appropriate General Data Protection Regulation and Information Governance processes, and this was confirmed. The Chair suggested that the priorities of the Organisational Improvement Plan did not appear to be fully reflected in all of the Divisional Plans. The Executive Director of Workforce & Organisational Development responded that each division reviewed their discrete report from the staff survey and calibrated them with known factors that might have affected the figures. Staff within the divisions had also been involved in determining what elements they wished to see within their respective reports. A comment was also made that in terms of bullying and harassment there would be a great level of detail behind the figures which would need to be understood in terms of developing outcomes.

19.56.3 It was resolved that the Board

- Approve the Organisational Improvement Plan.
- Note the Divisional improvement plans.
- Note and endorse the link between the national NHS Wales Staff Survey and the BCUHB ByddwchynFalch/BeProud survey work.
- Note the national changes to the approach of collecting colleague experiences.

[The Board broke for lunch]	
19.57 Enabling Strategies **19.57.1 Workforce Strategy** **19.57.1.1** The Executive Director of Workforce & Organisational Development presented the draft strategy, highlighting that the document did not purport to be a detailed workforce plan but it aimed to provide a clear direction upon which the organisation could build in terms of workforce and to provide a clear framework for the development of other strategies. She added it was important to recognise that the strategy was aligned to developing a wider workforce strategy for health and social care. **19.57.1.2** A discussion ensued. In response to a question it was confirmed that the strategy was evidence based in that it places the patient at the centre and then considers what skills would be required within the workforce to meet the needs of that patient. The section on communication of the strategy was felt to be very important and that the focus needed to be on ensuring every member of staff understood how the strategy applied to them. The issue of Welsh Language skills was raised and it was felt this should be built more strongly into the work programme, together with sequencing aspects of primary care and health inequalities. A comment was made that the development of the strategy was an important milestone for the organisation and that the importance of staff as an asset to driving transformational change must not be undervalued. In response to a point regarding alignment to other strategies it was confirmed that the document was aligned with the regional Workforce Strategy and supported opportunities for development with partners eg; integrated workforce. **19.57.1.3 It was resolved that** the Board approve the Workforce Strategy. **19.57.2 Estates Strategy** **19.57.2.1** The Executive Director of Planning & Performance presented the paper which set out the long term strategy for the BCU estate in support of Living Healthier : Staying Well. The strategy identifies the unsustainable status of the current BCU estate and provided cost comparisons of maintaining it. He accepted that the Board did not yet have a clinical strategy, however, he felt that the estates strategy appropriately set out the organisation's initial priorities. He noted that issues of outline business cases and consultation would need to be picked up as discussions progressed to a more detailed level. Members were assured that the strategy was aligned to the 2019-20 annual plan and set out a consistent direction of travel, however, there would be significant communication and engagement aspects to be worked through. **19.57.2.2 It was resolved that** the Board approve the estates strategy subject to formal annual review by the Health Board. **19.57.3 Digital Strategy** **19.57.3.1.** The Executive Medical Director provided a verbal update, highlighting that key priorities would be the implementation of the Welsh Patient Administration System; maintenance of existing services and systems; and the work to bring new technology into the organisation in order to drive transformation. He indicated that close working with Welsh Government, NHS Wales Informatics Service and others would be essential in	

terms of delivery. Members were aware of the challenges around national solutions and associated criticism by the Public Accounts Committee.	
19.58 Three Year Outlook and 2019-20 Annual Plan **19.58.1** The Executive Director of Planning & Performance presented the paper and confirmed that it reflected helpful feedback from Welsh Government. He confirmed that an equality impact assessment had been completed and apologised that this has not been provided and that a copy would be made available. He suggested that the core priorities and enablers would be familiar to Board members, and that there were a range of planned care elements that required more work. He also added there was a public-facing version of the document. **19.58.2** The Executive Director of Finance drew members' attention to Appendix 1 which set out the financial plan for 2019-20 and confirmed that this had been considered by the F&P Committee who recommended the plan to the Board. He stated that whilst the Standing Orders and Standing Financial Instructions required the Health Board to agree a budget by the 1st April, the Health Board would need to agree an interim budget for 2019-20. He reminded members that the Board had now commissioned a review of its financial plans which should culminate in a report in June 2019. The Executive Director of Finance reported that the F&P Committee had two main concerns – namely the lack of quantification of the delivery of waiting times specifically referral to treatment, and the level of savings worked up to date (ie £22.5m of £34m). It was stated that the waiting times issue continued to be worked through in terms of demand and capacity and that the financial plan being presented did not include delivery of waiting times. In terms of the savings plans it was noted that if the new Welsh Government criteria was used then only £9m would be classified as green. **19.58.3** The Executive Director of Finance referred to Table 20 which provided a summary of the financial gap assessment and reiterated the concerns around the Board's position, together with risks to be managed around growth in continuing health care and prescribing. He confirmed that the plan included £9.4m of new investments funded from core funding however some elements were yet to be financially quantified. Finally he alerted members that the Board needed to be aware that other than the £2m referral to treatment monies, there was no other funding for waiting time targets and a quick resolution was required. **19.58.4** The Vice Chair suggested that there needed to be more granularity in terms of clear targets and percentage points for improvement, with a stronger sense of ambition. She would also seek assurance that whatever targets were included were aligned with the IQPR. The Vice-Chair of the F&P Committee commented that the most significant issue was around the uncertainties in terms of savings plans. The Chair of QSE Committee noted that the paper made references to pathways and new models of care, and she reminded colleagues that there was a source of rich data available via patient and user experience. A comment was also made that the plan could be strengthened in terms of support for children with severe disabilities and their carers **19.58.5** The Chair summarised that the Board was being asked to agree an interim plan and to recognise the gaps as described relating to referral to treatment, unscheduled care and finance, with the Board being updated on these elements at the May meeting. Members felt that whilst these gaps were recognised, the plan did represent the strategic direction of travel and there was clear read-across from the enabling strategies, and that this should be the key focus of communications. In terms of savings the Chair would	MW

expect the F&P Committee to continue to build confidence around the levels and whether they met Welsh Government criteria, with other cross-cutting opportunities also being reported to the F&P Committee. The Chair added that agreement must be reached as to how the Programme Management Office capacity could best be utilised to support the transformation programme. It was noted that the plan committed the Health Board to producing a Clinical Service Strategy by the end of September 2019 and there was a discussion around the challenges to achieving this. An update would be provided to the Board in May on key milestones. **19.58.6** A conversation took place regarding how best to ensure the various elements of the plan were monitored through the Committee structure and it was agreed that this be mapped out through the Committee Business Management Group. **19.58.7 It was resolved that** the Board: • Approve the Three Year Outlook and 2019/20 Annual Plan with the exception of plans to deliver elective care in the specialties set out on page 40 of the paper i.e. services requiring recurrent investment in capacity to deliver, and services at serious risk of failing to deliver 36 week RTT target in 2019/20. • Approve the financial plan for 2019/20. • Note that a plan update will be presented to the July Board to include: o The implementation plan as a result of the financial review, and the RTT Taskforce. o The results of ongoing discussions with colleagues in Welsh Government. o Any other areas where the plan developed over time.	MW GLP
19.59 In Committee Business to be reported in Public **It was resolved that** the Board note the paper.	
19.60 All Wales Forums – Welsh Health Specialised Services Joint Committee Briefing 22.1.19 The Chief Executive confirmed that the WHSCC commissioning plan had been reflected in the BCU plan. The briefing was noted.	
19.61 All Wales Forums – Mid Wales Joint Committee for Health and Care Update January 2019 The update was noted.	
19.62 Date of Next Meeting Thursday 2nd May 2019 @ 10.00am in Venue Cymru, Llandudno.	
19.63 Committee Meetings to be held in public before the next Board Meeting It was noted that the following Committees were due to meet: Mental Health Act Committee 29.3.19 Strategy, Partnerships & Population Health Committee 2.4.19 Finance & Performance Committee 24.4.19	

19.64 Any Other Business The Chair invited Mr David Jenkins to say a few words as his role with the Health Board was coming to a close. Mr Jenkins thanked the Board for working with him over the past 15 months in terms of his independent adviser appointment by the Minister. He recorded that his experience had been wholly positive in that he was of the opinion that the Board was now in a much better position in terms of its ability to identify the issues requiring focus, to scrutinize and to exercise real challenge onto the Executives. He felt that overall governance had improved and he was more confident in the Board's ability to address the known issues and to make improvements. He recognised that when a Board had high aspirations and provided a greater level of challenge that this did increase the commitment and pressure on both Independent Members and Executives but that this was positive. He concluded by indicating he would report formally to the Minister in due course.	

HEALTH BOARD SUMMARY ACTION LOG – ARISING FROM MEETINGS HELD IN PUBLIC

Lead Executive / Member	Minute Reference and Action Agreed	Original Timescale Set	Update	Action to be closed
Actions from Health Board 1.11.18				
~~R Favager (S Baxter G Lang)~~ ~~M Wilkinson~~	18/234.2 Work with officers in Strategy & Planning and Turnaround to develop a paper for the January Board meeting on change capacity.	~~Jan 2019~~	12.12.18 Executive Team agreed that this will be covered as part of the Three Year Plan paper going to Board on 24.1.19 24.1.19 The Executive Director of Planning & Performance confirmed that a stocktake paper had been to Executive Team exploring capacity and capability to implement change. A further paper was scheduled for Executive Team within the next two to three weeks, therefore the Board requested the action be reopened. 13.2.19 Three Year Plan on Board agenda 28.2.19 28.3.19 The Chairman requested that this item be re-opened as the Board had not yet seen what change capacity will be used for in keeping with delivery of the work plan. 18.4.19 This work is underway but is not yet complete and will be progressed as part of the realigning of executive portfolios.	
S Baxter/ Mark Wilkinson	18/243.2 Work with performance team to refine the format of the IQPR in line with discussions held This	Jan 2019	The IQPR will be continually refined in response to feedback received. The next major iteration is planned for May when the first report of performance against the new Three Year Plan will be made. This will include relevant primary care	

	includes RTT performance and improvement trajectories. .	March 2019	indicators. 24.1.19 The Executive Director of Planning & Performance asked that the action be re-opened as the RTT element was not finalised. 13.2.19 The Patient Administration Systems do not incorporate 'plan, actual, and variance' functionality of the kind that would be expected in for example a financial ledger. The Board uses a set of coordinated access and spreadsheet systems which do contain plan figures, actual performance, and therefore allow variances to be identified and investigated. These systems will be further developed for the start of 2019/20. 28.3.19 The Chairman asked that this action be re-opened as there remained work to be done on IQPR format to ensure it was in keeping with the Three Year Plan and priorities, set out performance trajectories for the coming year including referral to treatment and unscheduled care, and to strengthen the primary and community care indicators. 18.4.19. The work to refine the RTT plan and profiles will be presented to the Executive Team 24th April 2019. This will be based on the work undertaken with the operational teams to confirm which of the services are sustainable, which have a backlog only issue and which have both backlog and sustainable service gaps. Work with the teams has sought solutions for backlog and sustainability. These are presently being costed with the intention of including in the RTT paper to Executive Team. A meeting in relation to this is arranged with WG for 3.5.19. and this will inform the plan for 2019/20 which will be included in the May 2019 Finance and	

			Performance Committee papers. The revised IQPR for May 2019 is expecting to include the indicators set out in the National Delivery Framework, including the profiles for the year for each indicator and the performance for April 2019 against the indicators where these are reportable monthly.	
Actions from Health Board 24.1.19				
R Favager	19/16.4 Ensure due diligence and financial modelling is carried out in relation to the LIMS full business case.	March 2019	5.2.19 Following further discussions with the Programme Director and the wider NHS it has been agreed that the Deputy Directors of Finance for Cardiff & Value and Powys Health Board will provide the scrutiny and challenge on the business case on behalf of all Health Boards before the end of March 2019.	Closed
		April 2019	28.3.19 The Executive Director of Finance confirmed this challenge had been undertaken, and he was happy to circulate revised figures as included in the financial plan. 16.4.19 Following challenge it has been confirmed to the Health Board that the business case financial assumptions have been changed. The revised business case costs are £152,000 (Financial Plan resource set aside £171,000). The revision is based upon WG providing the capital funding. WG have confirmed that the LINC OBC is in their planning assumptions for 2019/20.	Closed
A Roach	19/18.6 Provide outside of the meeting a revised trajectory for the recovery of performance against the 28 day adult mental health measure target.	February 2019	27.2.19 Briefing Note Circulated 28.3.19 Noting the briefing that had been provided, member suggested there was still a gap in terms of determining the gap in the plan, and a description of the new model. The Vice Chair confirmed that a paper would be prepared for the Mental Health Act Committee. 16.4.19 Updated position paper and presentation regarding the actions required for sustained delivery of the Adults MH Measure performance was presented to the Mental Health Act Committee on 29th March 2019. Performance will continue to be managed on a weekly basis and monitored by the MH Senior Management Team	Closed

S Green E Moore	19/25.9 Provide a briefing note on recruitment plans and the nuances of the medical contract (as per HPF discussions).	March 2019	14.3.19 The Executive Medical Director will meet with the Chairman to respond to his queries around recruitment and the medical contract, with the possibility of a wider briefing to a board workshop at a later date. 28.3.19 It was reported that the meeting was yet to be arranged. It was agreed that the Chair (Designate) of the HPF also be invited.	
Actions from Health Board 28.3.19				
S Green	19/47.6 Following presentation of the SRG Chair's report it was agreed that the Executive Director of Workforce & Organisational Development would identify a representative to attend the next SRG to update the Group regarding the issue of encouraging previously registered nurses to return to nursing within BCU.	June 2019	Executive Director of Workforce & OD to attend SRG on 4th June	Closed
E Moore	19/50 Following consideration of the vascular servics update, the Executive Medical Director was asked to provide a briefing note to clarity and confirm the latest position with regards to job planning.	April	18.4.19 Action outstanding however will be progressed before end of May 2019.	
D Carter	19/51 Following discussion of the IQPR it was noted that there was a limited assurance audit report relating to the follow up backlog and that consideration	April	An extraordinary meeting of the QSE Committee is being arranged to sight members on this audit report.	

	should be given to how best to ensure QSE and/or Board members were sighted on this report.			
E Moore	19/51 Following discussion of the IQPR the issue of the development of a stroke action plan was raised. It was noted that the QSE Committee had received an update on the 19.3.19 and this paper would be refreshed/updated and circulated to board members.	April	18.4.19 Action outstanding however will be progressed before end of May 2019.	
M Wilkinson	19/58 An apology was made that the associated equality impact assessment of the Three Year Outlook and 2019-20 Annual Plan had not been provided with the board papers. This would be circulated and uploaded retrospectively to the website.	April	EQIA has been circulated to all board members and uploaded to the public facing website.	Closed
G Lewis-Parry	19/58 Arrange for the Committee Business Management Group to consider and map out appropriate reporting and scrutiny of the Three Year Outlook and 2019-20 Annual Plan.	April	18.4.19 Paper has been prepared and listed for consideration by the Finance & Performance Committee on 24.4.19. the final arrangements will then be shared with CBMG on 2.5.19.	Closed
G Doherty	19/58 Provide an update to the May Health Board meeting as to the	May	Paper included on Board agenda 2.5.19	Closed

	commitment within the Annual Plan to deliver a Service Strategy by the end of September.			

V165 18.4.19

Health Board **2.5.19**	GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board *To improve health and provide excellent care*

Committee Chair's Report

Name of Committee:	Audit Committee
Meeting date:	14 March 2019
Name of Chair:	Cllr Medwyn Hughes
Responsible Director:	Mrs Grace Lewis-Parry, Board Secretary
Summary of business discussed:	• WAST Handover of Care – Internal Audit Report – Update re BCU Management Response • Special measures review of expectations allocated to the Committee • Internal Audit Plan for 2019/20 and Charter • Internal Audit Progress Report • Discussion of limited assurance reports in respect of booking of medical agency staff; primary care GP leases; managing outpatients backlog; implementing the falls policy; concerns, complaints and redress; hospital catering and patient nutrition; • Clinical Audit • Wales Audit Office reports including the progress update; Audit Plan for 2019/20; Annual Audit Report; expenditure on agency staff; preparations for Brexit; and Structured Assessment together with the Health Board's management response. • Update report on actions taken since the Audit Workshop in November 2018 • Financial Conformance Report • Update on External and Internal Audit Recommendations tracker. • Post Payment Verification Progress Report • Counter Fraud Progress update
Key assurances provided at this meeting:	The Committee:- • noted that the recommendations emanating from the limited assurance reports would be monitored by the Team Central tracker. • welcomed the progress made with regard to the WAST handover of care improvements. • endorsed both the Internal and External Audit Plans for the year ahead. • endorsed the Annual Audit Report which was being presented to the March 2019 Board.

	• Endorsed the updates to the Scheme of Reservation and Delegation, recommending approval to the March 2019 Board.
Key risks including mitigating actions and milestones	• Managing the Outpatients' Backlog – Limited Assurance Internal Audit Report -Members expressed serious concerns relating to demand and capacity and failure to manage the clinical risks effectively, and the lack of evidence and traction in terms of resolving any of the issues identified in the report despite the Board having been sighted on the issues previously. Members were concerned that the matter had not been escalated on the risk register and that the audit report stated that "there have been no reports (for oversight/scrutiny) in respect of the Outpatients Follow up Backlog by the Secondary Care Senior Management Team over a number of recent months". The Committee also felt that the management response to the recommendations did not contain sufficient detail to provide assurance that the issues would be effectively resolved in a timely manner going forward. Members felt that an overarching transformational plan was needed. The Committee concluded that the matter required escalation to both Quality, Safety and Experience Committee and Board to ensure sufficient oversight and traction given the scale of the issues involved, and the need to develop both a strategic and operation plan. • Clinical Audit – Members were dissatisfied that the report did not address the specific actions identified as part of previous Structured Assessments but also recommendations arising from the Joint Audit and Quality, Safety and Experience Committee meetings in both 2017 and 2018 and the lack of traction and movement to date. Expectations were for the report to set out how clinical audit would address the strategic objectives of the organisation taking a risk based approach to support quality improvement going forward. Wales Audit Office urged that a plan setting out future arrangements, together with a clinical audit plan for the year ahead be presented to the next meeting in order to satisfy the requirements in both the Annual Governance Statement and the Annual Quality Statement.
Special Measures Improvement Framework Theme/Expectation addressed	Governance and Leadership
Issues to be referred to another Committee	• Feedback to the Special Measures Improvement Framework Task and Finish Group in respect of the Monitoring Log was agreed. Members were of the view that the narrative supporting the action log lacked sufficient detail and clarity with regard to outcomes.

	• Members welcomed the progress update in respect of the WAST handover of care report and referred this to the Quality, Safety and Experience Committee for future monitoring purposes given the quality and safety issues in respect of hospital corridor nursing during peak times.
Matters requiring escalation to the Board:	Managing the Outpatients' Backlog – Limited Assurance Internal Audit Report and Clinical Audit as detailed above.
Well-being of Future Generations Act Sustainable Development Principle	In summary, the purpose of the Audit Committee is to advise and assure the Board and the Accountable Officer on whether effective arrangements are in place – through the design and operation of the Health Board's system of assurance. As such the Committee gives consideration to the sustainable development principles in their widest sense but in particular, the focus on progress of internal and external audit reports supports the principle of putting resources into preventing problems occurring or getting worse.
Planned business for the next meeting:	Range of regular reports to also include approval of the annual report and accounts, annual quality statement and annual governance statement; review of Standing Orders, Standards of Business Conduct Policy, and Board Assurance Framework and Map.
Date of next meeting:	30 May 2019

Health Board **2.5.19**	GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board *To improve health and provide excellent care*

Committee Chair's Report

Name of Committee:	Quality, Safety and Experience Committee
Meeting date:	19th March 2019
Name of Chair:	Mrs Lucy Reid, Independent Member
Responsible Director:	Mrs Gill Harris, Executive Director of Nursing and Midwifery
Summary of business discussed:	The Committee received: • Feedback in the form of a patient story from a relative who shared their experience of the Welsh Ambulance Service and the Health Board. The Director of Quality, Safety and Patient Experience from the Welsh Ambulance Service updated the Committee on work that had been undertaken subsequently and the family's involvement in improving the patient pathway in partnership with the Health Board. A significant reduction in handover delays between ambulances and the hospital had been achieved, however there is more work to be done in this area and will continue to be a priority for both organisations. • The Listening and Learning Report for Quarter 3 2018/19 which identified the key themes reported from patients included positive comments about quality of care however lower satisfaction levels in the Emergency Departments than the acute sites as a whole. Plans have been developed to support areas and the patient experience team will be improving the real time collection of feedback and triangulation of information to facilitate this. • An update on Infection Prevention and Control and the Safe Clean Care improvement plans. A range of activities have been monitored by the programme board to address infection risks, focus on improved accountability and sustainable plans. The ward accreditation programme has used monitoring tools and assessment criteria and from March 2019, the IPC team will be joining the ward accreditation visits and the audit and assurance visits. • Report on the health and safety management system across the organisation which included a review of the divisional governance arrangements and reporting of incidents. Interim processes have been implemented for the management of RIDDOR reporting and the HSE is due to visit the Health Board following 2 chemical exposure incidents. Further improvements

	are required across the Health Board and plans are in place to address these. • Pharmacy and Medicines Management Annual Report provided a summary of the prescribing and dispensing activity for the period 2018/19. The report detailed the pharmaceutical support provided to other healthcare professionals and included managed practices, care home support and community hospitals. Key risks highlighted included pharmacy support to the Mental Health Division, cancer services in Bangor and Wrexham and recruitment challenges across the pharmacy profession. • A report on Quality and Safety in Primary Care which provided an overview of the governance arrangements in place across the Health Board. The report also identified the current challenges in the recruitment and retention and the priorities for 2019/20 including the development of multi-disciplinary workforces to ensure sustainable services. • An update on the implementation of the HASCAS and Ockenden Review recommendations. The report highlighted the progress being made against each recommendation and identified some areas currently at risk of delivering to plan. These included the delivery of safeguarding training, the management of paper healthcare records, concerns management and estates reviews. Recruitment and workforce development challenges have also been identified as areas of risk that may impact upon delivery to plan, however progress will continue to be monitored through the Implementation Group.
Key assurances provided at this meeting:	• The Committee noted the positive feedback received on the implementation of the Ward accreditation programme from a number of areas across the Health Board. • The Welsh Ambulance Service presented a report on the Amber calls clinical response model, which identified a number of recommendations to improve episodes of care. These included ensuring sufficient resources are available to meet the demand and reducing waits in the community. The Committee agreed to work in partnership with the Ambulance Service to explore improved ways of joint workforce planning for Advanced Paramedics in primary and community services.
Key risks including mitigating actions and milestones	• The Committee were unable to gain assurance from the Clinical Audit report and endorsed the feedback from the Audit Committee regarding the content, quality and scope of the paper. The Committee noted the action agreed with the Executive Team and the Audit Committee on how this was to be addressed and the urgency of the timescales. • The Committee continued to be concerned at the performance against the key mental health measures and the need to ensure that learning from incidents and Healthcare Inspectorate Wales feedback was clearly evidenced within the reporting and

	governance arrangements. The Committee supported a review of the reporting process with the division to provide assurance on action being taken to address areas for improvement. • The Committee received an update on the Hospital Acquired Pressure Ulcer collaborative and noted the increase in numbers reported. This increase was anticipated as a result of a change in reporting arrangements and the work of the collaborative improving incident reporting. The report provided details of the interventions being tested by identified cohorts and the benefits and challenges to date and supported the continued focus in this area. • The Committee received a verbal update (as part of the in-committee meeting) on the review of the Endoscopy waiting list and the actions being taken to address the risks identified. The Committee has requested regular updates on progress to address the concerns identified.
Special Measures Improvement Framework Theme/Expectation addressed	Leadership & Governance
Issues to be referred to another Committee	• Clinical Audit programme development and reporting to be monitored by the Audit Committee with updates provided to QSE Committee
Matters requiring escalation to the Board:	• Delayed progress in the development and implementation of the Clinical Audit programme • Mental Health performance and reporting arrangements
Well-being of Future Generations Act Sustainable Development Principle	The Committee gave due consideration to the sustainable development principles.
Planned business for the next meeting:	Range of standard items plus: Accessible Healthcare Standards Annual Report Annual Quality Statement Children's Services Update CLIC / Quality report Discussion with CHC on joint priorities Continuing Health Care report Committee risks from corporate risk and assurance framework Equality annual report HIW annual report Putting Things Right annual report
Date of next meeting:	21st May 2019

Health Board 2.5.19	GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board *To improve health and provide excellent care*

Committee Chair's Report

Name of Committee:	Finance & Performance Committee
Meeting date:	26.03.19
Name of Chair:	Mr Mark Polin, Chair BCUHB
Responsible Director:	Mr Russell Favager, Executive Director of Finance
Summary of business discussed:	• **Finance Report Month 11** Month 11 planned in-month deficit of £2.2m was £2.9m at month end. This was due to £800k of undelivered savings plans and £400k overspends in both prescribing in premises which had been offset by underspends on contracts, pay and income. It was noted that the Health Board was cumulatively overspent by £36.5m and that there had been a reduction in the monthly overspend in comparison to recent months. The forecast for the year end remains at £42m, with a forecast deficit of £5.5m in Month 12, which includes a £1m provision against RTT clawback and £1m relating to risks around CHC packages of care, income for English contracts and Primary Care Drugs. The main risks against the forecast outturn include £1.1m prescribing, £0.7m WHSSC, £0.4m English contracts and £1m in respect of GMS, CHC/FNC, HRG4+ and Continuing Healthcare. • **Turnaround Programme Savings Report – Month 11** The forecast for Savings delivery has reduced from £38.9m to 38.3m and this was mainly due to staffing savings schemes, and specific prescribing projects which had not delivered as expected. • **Establishment of F&P Savings Sub Group** The establishment of the Sub Group would enable improved scrutiny and challenge of the Savings programme and free up agenda time in respect of the F&P Committee. • **Capital Report Month 11** • **IQPR Month 11** • **Referral to Treatment (RTT) Update** The expected end of year figure was likely to be 6,100, mainly due to the impact of diagnostics and the Vanguard unit within endoscopy services which was expected in April and May. The

	Committee was concerned to learn of the Cardiology issues raised within the report and requested that the Executive Medical Director liaise with the Executive Director of Therapies and Health Science in order that a member's update with further clarification be provided. • **Unscheduled care 90 Day Plan Update** The report noted the achievement against the measures in the 90 day plan and how the methodology is driving improvement and change. There is a need to to improve the partnership working related to improve the Health Board's Unscheduled Care performance and there is an ongoing risk associated with continuing challenges with flow and ED to the 4 hour performance. On 26.03.19, the Committee discussed the following items in **InCommittee** session: • Assignment of leases for GP premises • GMS contract approval • Review of Dental Contracts • Ysbyty Glan Clwyd development contractual arrangements • Medical and Dental Agency Locum Report • 2019/20 Annual plan and 3 year Outlook • Mental Health & Learning Disabilities Benchmarking Report 2018
Key assurances provided at this meeting:	• The Health Board forecast remains unchanged from last month and there are provisions in place against the impact of RTT performance being less than the target. • The 90 day plan for unscheduled care is delivering some improvement against last year. • The Savings Sun Group will provide greater scrutiny over the Savings programme •
Key risks including mitigating actions and milestones	Forecast outturn has been maintained at £42m deficit but there are risks around the clawback of RTT funding, CHC, English contract income, drugs, HRG4+ and GMS. The expected delivery of savings has reduced by £0.6m against Month 10 and there is a shortfall of £6.7m against the £45m in the annual plan. The Savings Sub Group meets for the first time in April and will provide greater scrutiny and challenge around the savings programme. Both Secondary Care and MH and LD continue to forecast a significant overspend against budget and mitigating actions are being scrutinised through both CE Escalation and the Accountability Review meetings. RTT delivery remains a significant risk, against the target for 31

	March 2019 and actions to improve data quality need to be progressed. This is being closely monitored through the weekly Access meetings. The Unscheduled Care Performance remains very challenging and below target.
Special Measures Improvement Framework Theme/Expectation addressed	Governance and Leadership themes.
Issues to be referred to another Committee	None
Matters requiring escalation to the Board:	The risk to the financial outturn for the year end. Underperformance in key areas;- • Unsatisfactory progress with RTT and Unscheduled Care • Savings schemes identification and delivery for 2019/20 • Endoscopy plan development • Cardiology issues raised within the RTT report
Well-being of Future Generations Act Sustainable Development Principle	*Describe how the items of business and the development of any proposals considered by the Committee gave adequate consideration to the sustainable development principles or if not indicate the reasons for this.* *1.Balancing short term need with long term planning for the future;* *2.Working together with other partners to deliver objectives;* *3. Involving those with an interest and seeking their views;* *4.Putting resources into preventing problems occurring or getting worse; and* *5.Considering impact on all well-being goals together and on other bodies)*
Planned business for the next meeting:	• Finance report month 12 • Turnaround Report month 12 • Savings Sub Group update • Ysbyty Penrhos Stanley paper • Detoxification service proposal • Unscheduled care update and Building Better Care report • Annual work programme • RTT update • IQPR • Special Measures Improvement Framework Update • Capital report Month 12 • Discretionary Capital Programme 2019/20 • Draft Annual Report 2019/20
Date of next meeting:	24.4.19

Health Board **2.5.19**	GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board *To improve health and provide excellent care*

Committee Chair's Report

Name of Committee:	Charitable Funds Committee
Meeting date:	7th March 2019
Name of Chair:	Mrs Jackie Hughes
Responsible Director:	Mr Russ Favager, Executive Director of Finance
Summary of business discussed:	• The Charitable Funds Finance Report for Quarter 3 of 2018/19 explained that income from donations and fundraising was down 7% on the same period last year whilst legacy income was broadly similar. The grant funded charitable expenditure for Quarter 3 totalled £1,530,000, showing a decrease of 4% compared to last year. There was a significant unrealised loss made on the investments of £400,000. This has been somewhat offset by gains made in the first half of the year, to bring the year to date loss to £97,000. However it was noted that the latest investment portfolio valuation, taken at the end of February, showed that the portfolio has regained all of the losses made and is £312,000 higher than at the start of the financial year. The Committee approved the report and actions being taken. • The Charitable Funds Fundraising Report for Quarter 3 of 2018/19 outlined the activities of the Fundraising team over the period. Progress has been made with getting Joint Working Agreements signed, with 70% now completed. The outstanding agreements are being reviewed by Attend, the National Charity which oversees the Leagues of Friends, on behalf of the organisations involved and will be completed by the June meeting. The Committee discussed and approved by the report. • The Committee noted and expressed their thanks for the contribution of £500,000 from the Livsey Trust towards equipment in the new Hybrid Theatre at YGC. • An update of the current position regarding the Legacy Strategy was presented and discussed. • The draft minutes from the Charitable Funds Advisory Group for the 31st January were received and noted. All applications which had been approved by the Advisory Group were ratified. • The Charity Risk Register was brought to the Committee for approval. All risks were reviewed and approved.

	• The Rothschild Portfolio Investments Report as at 31st December was received and noted. It was reported that following a significant downturn in the markets at the end of 2018, the calendar year reported a loss of 3.39%, which is the first yearly negative return since Rothschild were appointed. Despite these losses, the portfolio is still ahead of the return objective (inflation +3%) and reporting a better position than if a cautious investment approach had been maintained. Markets have picked up again in January and February, overturning the losses seen at the end of the year. • The Committee approved a bid for funding for the ChemoCare roll-out project (£92,000) and approved in principle an application for Motiv8 (£47,150), pending receipt of further information. • The Committee approved the charity's budget for 2019/20 which totals £477,000. This covers the running costs of the charity, including administration, governance and fundraising. It was noted that these costs are charged to General Funds and funded by income from and any gains on the investments. • A proposal for a charity staff lottery was considered. The Committee asked for the paper to be formally taken to Local Partnership Forum for their views. • The revised Reserves Policy for the charity, which maintained the target level of reserves at £3,060,000, was approved by the Committee. • The Committee Work Plan for 2019/20 was approved. • An update report on the staff engagement strategy was noted. The Committee requested that authors be invited to the next meeting to discuss progress.
Key assurances provided at this meeting:	• The charity has operated within its Reserves Policy for 2018/19 and remains liquid. • The investment portfolio has performed in line with the investment strategy.
Key risks including mitigating actions and milestones	• Income from donations and legacies is showing as deterioration from previous years and is subject to monitoring. • Joint Working arrangements must all be formalised by the next Committee meeting in June.
Special Measures Improvement Framework Theme/Expectation addressed	• Leadership and Governance
Issues to be referred to another Committee	• None
Matters requiring escalation to the Board:	• None

Well-being of Future Generations Act Sustainable Development Principle	• Developing a strategy for legacies and donations in line with the Health Board's identified priorities supports the WBFGA long term planning priority. • Working together with partners lies at the very heart of fundraising, particularly with volunteers, fundraisers and other charities through Joint Working Agreements • The Advisory Group is a good working example of involving those with an interest as part of decision making when allocating grant funding. • Charitable Funds are a driver in supporting the prevention agenda through funding opportunities and by alignment with Health Board LHSW priorities.
Planned business for the next meeting:	Standing agenda items, plus: • Attendance of the investment managers, Rothschild, at the meeting. • Update on the staff engagement strategy, with Workforce in attendance. • Joint Working Arrangements must all be finalised. • In-committee session to discuss the charity strategy.
Date of next meeting:	20th June 2019

Health Board 2.5.19	 *To improve health and provide excellent care*

Committee Chair's Report

Name of Committee:	Strategy, Partnerships and Population Health Committee
Meeting date:	2.4.19
Name of Chair:	Marian Wyn Jones, BCUHB Vice Chair
Responsible Director:	Mark Wilkinson, Executive Director Planning and Performance
Summary of business discussed:	The Committee received an update on the development of an Integrated Research and Innovation strategy, which will come back to Committee for approval. The aim is to bring together research, innovation and improvement to meet the needs of the population of North Wales. The Committee received an update on progress against the Mental Health Transformation project, part of Welsh Government's Transformation Programme to deliver A Healthier Wales. It aims to provide seamless integrated urgent care for those experiencing mental health crisis or requiring immediate support. The Committee noted the progress on the Learning Disability Transformation project and the actions to be completed in the next phase to share best practice consistently across the region. The Committee endorsed the Civil Contingencies and Business Continuity Draft Work Programme for 2019/20, building upon established organisational resilience arrangements expected within the Health Board. The Committee provided feedback on work undertaken to date to review current partnership and commissioning arrangements for third sector services and to develop a third sector strategy for the Health Board. The Committee endorsed the approach being taken to ensure all hospital sites become smoke free through the delivery of the Smoke Free Regulations, and noted the opportunity for continued improvement against Tier 1 performance in relation to smoking cessation to reduce the burden of disease. The Committee received a briefing on the Community Services

	Transformation project to be delivered in partnership with the six Local Authorities to establish integrated community based services, building upon existing partnerships, contributing to the overall transformation required within clusters. The Committee received a presentation on the Gwynedd & Anglesey Public Service Boards wellbeing plans, and their implications for the Health Board.
Key assurances provided at this meeting:	The following key assurances were gained in the meeting: The Committee noted a governance structure for the strategic co-ordination and planning of Adverse Childhood Experiences within BCUHB, and received a good level of assurance around the development of a plan for wider strategic co-ordination and ACE planning work.
Key risks including mitigating actions and milestones	The effects of Adverse Childhood Experiences are well documented. But the lifelong prevention approach is not currently fully reflected within BCUHB service plans and ownership of this agenda is required across all divisions. The new plan should help mitigate against the risk. Failure to work effectively in partnership with the third sector could have a detrimental impact on the quality of care and failure to engage appropriately would breach current legislative expectations. The BCUHB Corporate Risk Register highlights the risk if population health issues such as smoking are not fully addressed. Service developments within the MHLD Transformation projects could not be sustainable at project end. A project evaluation has been commissioned in mitigation so that lessons are learnt alongside.
Special Measures Improvement Framework Theme/Expectation addressed	• Mental Health / Strategic & Service Planning • Engagement
Issues to be referred to another Committee	None
Matters requiring escalation to the Board:	None

Well-being of Future Generations Act Sustainable Development Principle	The Committee gave consideration to the following sustainable development principles: *1.Balancing short term need with long term planning for the future;* Recognition of the imperative to develop lifelong prevention work in ACE's across divisions. *2.Working together with other partners to deliver objectives;* The Role of Local Authorities and partners in delivering the Transformation projects. *3. Involving those with an interest and seeking their views;* Community Health Council in attendance at Committee Meetings. *5.Considering impact on all well-being goals together and on other bodies* The Committee supports close working with Local Authorities and third sector partners.
Planned business for the next meeting:	Range of regular reports plus Volunteering Strategy Strategic Equalities Plan Welsh Language Annual report Engagement update Organisational Plan Substance Misuse
Date of next meeting:	4.7.19

Health Board 2.5.19	GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board *To improve health and provide excellent care*

Committee Chair's Report

Name of Committee:	Information Governance and Informatics Committee
Meeting date:	14.2.19
Name of Chair:	Mr John Cunliffe, Independent Member
Responsible Director:	Dr Evan Moore, Executive Medical Director
Summary of business discussed:	• The Committee reviewed its assigned corporate risks. • The Informatics Operational Plan 2018-19 Performance Update for Q3 was noted. • An update against the development of a BCU Digital Strategy was noted. • The Committee approved the Informatics Operational Plan for 2019-20 subject to any significant changes once the budget and capital details were known. • An assurance report from the Chair of the Digital Transformation Group was received. • A summary key performance indicator report on Information Governance for Q3 of 2018-19 was received. The Committee requested that the format evolve from Q1 of 2019-10 onwards to better meet members' requirements and to allow a full KPI report to be received in public.
Key assurances provided at this meeting:	• The Committee welcomed the update paper on the development of a Digital Strategy which it found clear and easy to follow. • The Committee were pleased to note improved performance in dealing with Health Records requests and that mandatory training compliance levels had been maintained.
Key risks including mitigating actions and milestones	• The Committee requested further work to clarify the assigned corporate risks and to strengthen the sources of assurance. • Of particular concern are the delays, functionality and prioritisation of National systems and programmes. • The Committee raised a general point regarding the accurate completion of coversheets and that where risks or concerns were included within the accompanying narrative paper, these should also be highlighted on the coversheet. This had been brought to the attention of the Board Secretary. • The Committee were concerned that models for integrating services would be at risk if national developments were not

	delivered. • The progress with the CHAI (a mobile nursing application within paediatrics) remained of concern.
Special Measures Improvement Framework Theme/Expectation addressed	• Governance
Issues to be referred to another Committee	None
Matters requiring escalation to the Board:	
Well-being of Future Generations Act Sustainable Development Principle	*Describe how the items of business and the development of any proposals considered by the Committee gave adequate consideration to the sustainable development principles or if not indicate the reasons for this.* *1.Balancing short term need with long term planning for the future;* *2.Working together with other partners to deliver objectives;* *3. Involving those with an interest and seeking their views;* *4.Putting resources into preventing problems occurring or getting worse; and* *5.Considering impact on all well-being goals together and on other bodies)* The Committee is content that these principles are taken into account as part of its core business and in the consideration of papers.
Planned business for the next meeting:	Range of regular reports plus: • Change management policy • Discussion with NHS Wales Informatics Service • Committee annual report 2018-19
Date of next meeting:	9.5.19

Health Board **02/05/19**	GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board *To improve health and provide excellent care*

Advisory Group Chair's Report

Name of Advisory Group:	Healthcare Professionals Forum (HPF)
Meeting date:	15.3.19
Name of Chair:	Mr Gareth Evans, Clinical Director Therapy Services
Responsible Director:	Mr Adrian Thomas, Executive Director of Therapies & Health Science
Summary of key items discussed:	• H19/03 Chief Executive Officer – Annual Discussion • H19/06 Corporate Planning Update – BCUHB Draft Three Year Plan 2019/22 • H19.08 Chair's and Members' written updates received • H19/16.1 Membership • H19/16.2 Vice Chair Role
Key advice / feedback for the Board:	**H19/03 Chief Executive Officer – Annual Discussion -** The Forum welcomed Mr Gary Doherty, Chief Executive Officer to the forum. GD welcomed GE to his new role and thanked Professor Rees for his contributions and work as the previous Chair. GD acknowledged the significance of health professionals working together in the Forum and the importance of this. He then outlined the BCUHB and NHS environment and challenges, including Special Measures, Workforce, Finance, RTT and Unscheduled care. Following this, he and then took Questions from the forum members. Questions were asked regarding provision of the Contact Lens Service, and a question regarding Theatre Staffing in the East for Cataract Surgery. Due to time constraints, GD encouraged members to email him directly with any further issues that they wished him to note. **H19/06 Corporate Planning Update – BCUHB Draft Three Year Plan 2019/22 -** The Forum received the presentation from the Head of Health Strategy and Planning, in relation to the BCUHB Draft Three Year Plan 2019/22. Following the presentation the Forum had been asked for advice, regarding improving clinical engagement and staff roles regarding prioritisation, facilitation and encouragement. It was noted that planning should be an ongoing process to support ongoing engagement. Members also thought that capacity to undertaking planning was also required in clinical teams as well as with managers. In relation to how staff can be

	encouraged to engage with new ways of working there was a view that an organisational approach to quality improvement would have a lot of support. **H19.08** Chair's and Members' written and oral updates were received from all members, issues to note where: **H19.08.1** Nursing - MJ provided a written update for nursing which included: • Ward Accreditation **H19.08.2** Pharmacy - JS reported that: • The first wave of community pharmacist independent prescribers would qualify in Summer 2019, with additional training intakes to continue. An enhanced service is under development to allow these pharmacists to prescribe medications from their pharmacy for some acute conditions that would normally be managed by a GP. • Concerns raised regarding supply issues and the potential that the situation will worsen due to Brexit. It was noted that Community pharmacists are being encouraged to be proactive and assist GPs with suggesting alternative drugs to prescribe. **H19.08.3** Health Sciences - JW reported that: • The Primary Care Audiology have been shortlisted in the UK Advancing Healthcare Awards for Innovation in Healthcare Science. The annual Awards event celebrates the contributions of Allied Health Professionals and Healthcare Scientists and will take place on April 12th 2019 • A North Wales Collaborative Care Group for Hearing Loss has been convened. **H19.08.4** Therapies - GE reported that: • The Head of Dietetics in the West had been shortlisted in the "Realising potential through creativity" category of the UK Advancing Healthcare Awards (as above) • The first ever post for a Consultant AHP for Dementia in Wales would be advertised this Spring; BCUHB have declared interest in hosting the post. • The launch of the Allied Health professions framework for Wales, will be held later this Spring. **H19.08.5** Dental - SS reported that: • The target set by Welsh Government for 20% of general dental practices to become involved in the dental contract reform initiative had been achieved. • Access to Pre-Operative Assessment Clinic approved for adult community dental services dental patients requiring general anaesthetic for treatment had been reported as good progression going forwards. • It was noted that funding for paediatric dentistry within North Wales would be sought as part time funding, in conjunction

	with Liverpool Hospital. **H19.08.6** Optometry and Ophthalmology – AM: • There was discussion regarding the Service Risks of Contact Lens Provision and equipment. **H19.10 Work Shop time (proposal) – Adrian Thomas** AT proposed the Forum should have some dedicated workshop time to consider, discuss and inform strategies under development. The forum agreed collectively to take this forward. **H19/16.2 Vice Chair role** – The role of vice chair is now vacant and expressions of interest are to be sought.
Planned business for the next meeting:	Range of standing items plus: • Workforce and OD update • Planning & Performance update • Public Health update
Date of next meeting:	14th June 2019

Health Board 2.5.19	GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board *To improve health and provide excellent care*

Committee Chair's Report

Name of Committee:	Remuneration & Terms of Service Committee
Meeting date:	9.4.19
Name of Chair:	Mr Mark Polin, Chair
Responsible Director:	Mrs Sue Green, Executive Director of Workforce & OD
Summary of business discussed:	• The Committee approved a revised approval process for Workforce & Organisational Development Policies. • The Committee's annual report for 2018-19 was approved for submission to the Audit Committee. • The following issues were discussed In Committee meeting : Current Upholding Professional Standards in Wales cases; pay protection progress report; executive portfolios and acting/interim arrangements; national pay rates for Single Integrated Clinical Assessment and Triage Service.
Key assurances provided at this meeting:	• Management of HR processes as part of HASCAS investigation, noting that Trade Union partners had commented positively on the process (this matter was discussed in-committee).
Key risks including mitigating actions and milestones	• None raised
Special Measures Improvement Framework Theme/Expectation addressed	• Leadership and Governance.
Issues to be referred to another Committee	Onward submission of Committee Annual Report to Audit Committee
Matters requiring escalation to the Board:	None.
Well-being of Future Generations Act Sustainable Development Principle	*1.Balancing short term need with long term planning for the future* – considered as part of Executive portfolio issues *2.Working together with other partners to deliver objectives* – policies approval process

	3. Involving those with an interest and seeking their views – consultation on policies *4. Putting resources into preventing problems occurring or getting worse* – consideration of Executive portfolios; consideration of pay protection issues. *5. Considering impact on all well-being goals together and on other bodies* –
Planned business for the next meeting:	• Range of standing items plus - • Options paper for specific Executive and Director posts as a result of the portfolio realignment and other planned changes.
Date of next meeting:	13.5.19.

Health Board 2.5.19	GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board ***To improve health and provide excellent care***

Report Title:	Mental Health Act 1983 as amended by the Mental Health Act 2007. Mental Health Act 1983 Approved Clinician (Wales) Directions 2018. Update of register of Section 12(2) Approved Doctors for Wales and Update of Register of Approved Clinicians (All Wales)
Report Author:	Mrs Heulwen Hughes, All Wales Approval Manager for Approved Clinicians and section 12(2) Doctors
Responsible Director:	Dr Evan Moore, Executive Medical Director
Public or In Committee	Public
Purpose of Report:	Betsi Cadwaladr University Health Board is the Approving Board for Approved Clinicians and section 12(2) Doctors in Wales and as such, receives regular register updates.
Approval / Scrutiny Route Prior to Presentation:	The information is collated by the All Wales Project Support Team and register updates are submitted directly to the Board.
Governance issues / risks:	Patient safety Risk of legal challenge
Financial Implications:	Not Applicable
Recommendation:	The Board is asked to ratify the attached list of additions and removals to the All Wales Register of Section 12(2) Approved Doctors for Wales and the All Wales Register of Approved Clinicians.

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

4.To work in partnership to support people – individuals, families, carers, communities - to achieve their own well-being		4.Putting resources into preventing problems occurring or getting worse	
5.To improve the safety and quality of all services	√	5.Considering impact on all well-being goals together and on other bodies	
6.To respect people and their dignity			
7.To listen to people and learn from their experiences			

Special Measures Improvement Framework Theme/Expectation addressed by this paper

Leadership and Governance

Equality Impact Assessment

No equality impact assessment is considered necessary for this update paper. Approval Process is part of Legislative process.

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

Update of Register of Approved Clinicians and Section 12 (2) Approved Doctors for Wales 2nd February 2019 – 5th April 2019		
	AC	**S12 (2)**
Approvals and Re-approvals	10	5
Removed – Expired	1	0
Approvals suspended	0	N/A
Approvals re-instated – returned to work in Wales	1	N/A
Approval Ended	0	0
Retired	1	1
Removed – AC approved	N/A	1
No longer registered	1	1
Transferred from AC register	N/A	0
Approval Ended as no longer working in Wales	1	0
Registered without a licence to practice	0	0

Mental Health Act 1983 as amended by the Mental Health Act 2007.
Mental Health Act 1983 Approved Clinician (Wales) Directions
Update of Register of Approved Clinicians for Wales

2nd February 2019 – 5th April 2019

Approvals and re-approvals – 10

Surname	First Name	Workplace	Expiry Date
Slack	Philip Matthew	Older Persons' Team, Mental Health Unit, Royal Glamorgan Hospital, Ynysmaerdy, Pontyclun, CF72 8XR	12 February 2024
Nwogwugwu	Nnamdi	Ty Catrin, Dyfrig Road, Cardiff CF5 5AD	12 March 2024
Potter	Robert	Child & Family Clinic, Princess of Wales Hospital, Bridgend	06 March 2024
Gaur	Sandhya	Ablett Unit, Glan Clwyd Hospital, Bodelwyddan, Rhyl LL18 5UJ	24 April 2022
Owino	Walter Edward Jason	Community LD Team, St David's Park, Ewloe, Flintshire	30 April 2023
Roberts	Anthony Peter	Delfryn House, Argoed Hall Lane, Mold, CH7 6FQ	26 April 2020
Moldavsky	Daniel	Bryngofal Ward, Caebryn, Prince Phillip Hospital, Bryngwyn Mawr, Llanelli, SA14 8QF	02 September 2020
Colter	Robert	St Cadocs Hospital, Lodge Road, Caerleon, NP18 3XQ	01 April 2024
Thiagarajan	Senthil Kumar	St Teilo House Goshen Street Rhymney Tredegar Gwent NP22 5NF	02 November 2021
Udegbe	Chinwendu Benedict	From 08.04.19 - Ablett Unit, Ysbyty Glan Clwyd, Sarn Lane, Bodelwyddan, Nr Rhyl, Denbighshire LL18 5UJ	16 August 2023

Approvals re-instated – 1

Surname	First Name	Workplace	Expiry Date
Roberts	Anthony Peter	Delfryn House, Argoed Hall Lane, Mold, CH7 6FQ	26 April 2020

Approvals expired – 1

Surname	First Name	Workplace	Expiry Date
Al-Amin	Miriam		05 February 2019

Approvals Suspended – 0

Surname	First Name	Workplace	Expiry Date

Retired – 1

Surname	First Name	Workplace	Expiry Date
Hourahane	Barbara	Ty Draw, The Avenue, The Common, Pontypridd, CF37 4DF	11 February 2019

No longer Registered - 0

Surname	First Name	Expr1004	Expiry Date

No longer working in Wales – 1

Surname	First Name	Expr1004	Expiry Date
Rashid	Haroon	Hergest Unit, Ysbyty Gwynedd, Penrhosgarnedd, Bangor, LL57 2PW	25 March 2019

Approvals Ended – 0

Surname	First Name	Workplace	Expiry Date

Mental Health Act 1983
Update of Register of Section 12(2) Approved Doctors for Wales

2nd February 2019 – 5th April 2019

Approvals and Re-approvals – 5

Surname	First Name	Workplace	Date Approval Expires
Vikram	Udaya	Liaison Psychiatry, Ablett Unit, Glan Clwyd Hospital, Bodelwyddan	11 February 2024
Wiltshire	Edwin J Mark	59 Church Road, Whitchurch, Cardiff, CF14 2DY	12 February 2024
Channareddy	Anjana Garakupati	University Hospital of Wales, Heath Park, Cardiff CF14 4XW	19 February 2024
Raja	Jawad Sultan	Heddfan Unit, Croesnewydd Road, Wrexham LL13 7TD	19 February 2024
Foell	Jens	Plas Menai Health Centre, Penmaenmawr Road, Llanfairfechan, Conwy, LL33 0PE	01 April 2024

Removed – Expired – 0

Surname	First Name	Workplace	Date Approval Expires

Removed – AC approved – 1

Surname	First Name		Workplace
Afzal	Maryam		St Cadocs Hospital, Lodge Road, Caerle

No longer registered – 1

Surname	First Name	Workplace	Date Approval Expires
Winston	Christopher Mark	Private Address	18 September 2019

Transferred from AC Register – 0

Surname	First Name	Date Approval Expires	Workplace

No longer working in Wales – 0

Surname	First Name	Workplace	Date Approval Expires

Registered without a licence to practice – 0

Surname	First Name	Workplace	Date Approval Expires

Removed – Retired – 1

Surname	First Name	Workplace	Date Approval Expires
Banerjee	Dulal	Private Address	2021

Health Board

2.5.19

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

To improve health and provide excellent care

Report Title:	Countess of Chester Contractual Agreement 2019/20
Report Author:	Mr Gary Doherty, Chief Executive
Responsible Director:	Mr Gary Doherty, Chief Executive
Public or In Committee	Public
Purpose of Report:	To update the Board on the situation regarding the flow of North Wales patients to the Countess of Chester Hospital
Approval / Scrutiny Route Prior to Presentation:	This matter has not been scrutinised by a Board Committee
Governance issues / risks:	There are a number of key issues which arise from the current situation. A proportion of North Wales patients have traditionally accessed the Countess of Chester Hospital both for planned and for emergency care. If the access for elective referrals is to be withdrawn over a protracted period of time/indefinitely then provision will need to be made for an increased level of treatment within BCUs provider services for these patients.
Financial Implications:	A sustained reduction in activity for North Wales patients at the Countess of Chester Hospital will reduce our costs with them, however, some level of additional cost will be incurred in expanding services within BCU to provide the lost capacity. As described in the attached paper the paper the impact of the change in referral pathways will take some time to model in detail.
Recommendation:	The Board are asked to note the contents of this report. Updates will be given at each Board meeting until this issue is resolved and other Board Committees will be involved as appropriate.

Health Board's Well-being Objectives *(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)*	√	**WFGA Sustainable Development Principle** *(Indicate how the paper/proposal has embedded and prioritised the sustainable development principle in its development. Describe how within the main body of the report or if not indicate the reasons for this.)*	√

1.To improve physical, emotional and mental health and well-being for all	√	1.Balancing short term need with long term planning for the future	√
2.To target our resources to those with the greatest needs and reduce inequalities		2.Working together with other partners to deliver objectives	√
3.To support children to have the best start in life		3. Involving those with an interest and seeking their views	
4.To work in partnership to support people – individuals, families, carers, communities - to achieve their own well-being		4.Putting resources into preventing problems occurring or getting worse	
5.To improve the safety and quality of all services		5.Considering impact on all well-being goals together and on other bodies	
6.To respect people and their dignity			
7.To listen to people and learn from their experiences			

Special Measures Improvement Framework Theme/Expectation addressed by this paper

Strategic and Service Planning
Engagement
Leadership and Governance

Equality Impact Assessment

As described in the attached paper the impact of the change in referral pathways will take some time to model in detail. Once firm data is available on the impact of the decision and options modelled a full Equality Impact Analysis will be undertaken.

Countess of Chester Contractual Agreement 2019/20

Purpose of Report

To update the Board on the situation regarding the flow of North Wales patients to the Countess of Chester Hospital.

Background

The Health Board, as with many other Health Boards in Wales, has arrangements in place for patients who receive their care in England, be that emergency or planned, general care or very specialist care. All these agreements, whether that be with specialist Trusts like Alder Hey or with general hospitals like Chester, are funded under a Wales wide approach to cross border arrangements. English NHS agencies have made changes to the structure of the tariff system for 2019/20 for determining the amounts payable to provider trusts for the treatment of patients. Due to the changes a process of direct engagement has been agreed between Welsh Government, the UK Government Department of Health and Social Care and representatives from the English NHS to agree a way forward for Wales.

Each year we discuss and sign off agreements with numerous English providers, and whilst some of these discussions are complex (and occasionally go beyond the start of the new financial year) agreement is reached and a contract is signed. For 2019/20 we have, as yet, been unable to reach an agreement with the Countess of Chester and on the 19th March received a letter from the Countess of Chester informing us that they were unable to undertake to deliver any Welsh elective work from 1 April 2019, whilst there was no signed contract in place. A range of discussions and meetings took place both before and after the letter from Chester, but these meetings, though productive and held within a context of very good working relationships, could not resolve the key issue. It should be noted should any agreement be reached with Chester it would need to be replicated across all English providers who treat patients from Wales. Local discussions with the Countess need to be held alongside discussions between the Welsh and English NHS (the Welsh Government have raised the matter with the UK Government Department of Health and Social Services on an official and Ministerial level).

Communications

The Health Board wrote to GPs on the 4th April regarding the Chester decision. Letters were also sent to key stakeholders on the 11th and 18th of April (copies attached). As can be seen, over the period from late March into April discussions between BCU and Chester have clarified the range of referrals which Chester will and will not accept, with a jointly agreed protocol being sent to GPs on the 17th of April.

Impact

The referral protocol agreed with Chester will see a range of North Wales patients continue to be treated by them, but not all – in simple terms new, routine referrals will not be accepted (except for maternity where all new referrals will be accepted). As such, modelling the exact impact is difficult as it will depend on the number of urgent

referrals and cannot simply be calculated by looking at activity levels from last year extrapolated forward. We will assess the situation in more detail once we have a full month of referral data, which will be available in early May.

Next Steps

We will continue to work with our colleagues in Chester to resolve the contractual position and discussions between the Welsh and English NHS will continue to address this matter. In the mean time we will of course work with the Countess to ensure there is a smooth process in place for North Wales patients to access care and maintain patient safety, including a weekly call between the two organisations to address any issues and a weekly tracking report for any referral returned from Chester to BCU. We will also assess the impact of the change in referral flows, which will be used to undertake a capacity analysis to develop plans to either meet the increase required through other English providers or through an expansion of provision within BCU.

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Bloc 5, Llys Carlton, Parc Busnes Llanelwy, Llanelwy, LL17 0JG

Block 5, Carlton Court, St Asaph Business Park, St Asaph, LL17 0JG

Example of Stakeholder Letter

Ein cyf / Our ref: GD/KS/2014
Eich cyf / Your ref:
☎: 01745 448788 ext 6364
Gofynnwch am / Ask for: Di Platt
E-bost / Email: di.platt@wales.nhs.uk
Dyddiad / Date: 11th April 2019

Annwyl Gyfaill,

Rwyf yn ysgrifennu i'ch diweddaru ar y sefyllfa ynglŷn â phenderfyniad Ymddiriedolaeth y GIG Countess of Chester i beidio â derbyn cyfeiriadau newydd i gleifion o Gymru am driniaethau dewisol o 1 Ebrill. Nid yw hyn yn cael effaith ar gleifion mamolaeth, y rhai sy'n mynd i'r Adran Achosion Brys a chleifion o Ogledd Cymru sydd eisoes yn aros am driniaeth yn y Countess of Chester. Mae'n ddrwg gen i fod y diweddariad hwn yn hwyrach na'r hyn fyddech chi wedi ei ddymuno, ond roeddwn yn gobeithio y byddai cytundeb wedi bod, fel yn y blynyddoedd a fu pan gafwyd anawsterau.

Fel pob Bwrdd Iechyd yng Nghymru, mae ein hagwedd at drefniadau talu am ofal iechyd a ddarperir i drigolion Cymru yn Lloegr yn unol â'r hyn y cytunwyd arno gyda'r GIG yng Nghymru i sicrhau cysondeb trefniadau ariannu i ddarparwyr o Loegr.

Mae asiantaethau'r GIG yn Lloegr wedi gwneud newidiadau i strwythur y system tariff at 2019/20 ar gyfer penderfynu faint sy'n ddyledus i ymddiriedolaethau sy'n darparu am driniaethau cleifion. Oherwydd y newidiadau, cytunwyd ar broses o ymgysylltu uniongyrchol rhwng Llywodraeth Cymru, Adran Iechyd a Gofal Cymdeithasol Llywodraeth y DU a chynrychiolwyr o GIG Lloegr i gytuno ar ffordd ymlaen i Gymru. Yn lleol, mae trafodaethau'n parhau rhyngom ni ac Ymddiriedolaeth y GIG Countess of Chester. Rydym yn disgwyl canlyniad positif i'r ymgysylltu hwn cyn bo hir ac rydym yn siomedig bod Ysbyty Countess of Chester, y mae gennym berthynas hir dymor dda â nhw, wedi cymryd y penderfyniad hwn sy'n effeithio ar ein poblogaeth wrth i drafodaethau barhau.

Yn y cyfamser, nid yw meddygon teulu o ddwyrain Sir y Fflint yn gallu cyfeirio cleifion am driniaethau dewisol dros y ffin yn y Countess of Chester. Rydym wedi ysgrifennu at bob meddyg teulu i roi gwybod iddynt am y newidiadau hyn a byddwn yn parhau i ymgysylltu â nhw ynglŷn â datblygiadau. Tra bydd y trafodaethau lleol a chenedlaethol yn parhau, bydd cleifion newydd yn cael eu cyfeirio at BIPBC ac rydym yn gweithio i wneud lle i gleifion sy'n cael eu cyfeirio o'r newydd o fewn ein gwasanaethau presennol yng Ngogledd Cymru.

Mae'r daflen Cwestiynau Cyffredin isod yn rhoi mwy o wybodaeth

Rydym wedi cynhyrchu dogfen Cwestiynau Cyffredin i gleifion, sydd ar gael ar ein gwefan.

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

Dear Colleague

I am writing to update you on the situation regarding the decision by the Countess of Chester NHS Foundation Trust not to accept new referrals of patients from Wales for elective treatment from the 1 April. This does not impact maternity patients, those attending the Accident and Emergency Department and patients from North Wales who are already waiting for treatment at the Countess of Chester. I am sorry that this update is later than you may have wished, but I was hoping that, as in previous years where there have been difficulties, an agreement would have been reached.

Like all Health Boards in Wales, our approach to payment arrangements for healthcare provided to Welsh residents in England is in line with what has been agreed with the NHS in Wales to ensure consistency of funding arrangements for English providers.

English NHS agencies have made changes to the structure of the tariff system for 2019/20 for determining the amounts payable to provider trusts for treatment of patients. Due to the changes a process of direct engagement has been agreed between Welsh Government, the UK Government Department of Health and Social Care and representatives from the English NHS to agree a way forward for Wales. Locally negotiations are also continuing between ourselves and the Countess of Chester NHS Foundation Trust. We expect this engagement will conclude positively in the near future and are disappointed that the Countess of Chester, whom we have a long term relationship with, has taken this decision that impacts on our population whilst discussions are on-going.

In the meantime, GPs in the East Flintshire area are no longer able to refer patients for elective treatment over the border at the Countess of Chester. We have written to all GPs to inform them of these changes and will continually engage with them on developments. Whilst the local and national discussions continue new patients will be referred to BCUHB and we are working to accommodate newly referred patients within our existing services in North Wales.

We have produce a Frequently Asked Questions document for patients which is available on our website.

Yours sincerely

Gary Doherty
Prif Weithredwr
Chief Executive

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

Bloc 5, Llys Carlton, Parc Busnes Llanelwy, Llanelwy, LL17 0JG

Block 5, Carlton Court, St Asaph Business Park, St Asaph, LL17 0JG

Example of Stakeholder Letter

Ein cyf / Our ref: GD/RE/2028
Eich cyf / Your ref:
☎: 01745 448788 ext 6364
Gofynnwch am / Ask for: Di Platt
E-bost / Email: di.platt@wales.nhs.uk
Dyddiad / Date: 18th April 2019

Annwyl Gyfaill,

Yn dilyn fy llythyr dyddiedig 11 Ebrill, cynhaliwyd trafodaethau pellach gyda Countess Chester NHS Foundation Trust, bydd rhai cyfeiriadau dewisol nawr yn cael eu derbyn e.e. rhai cyfeiriadau canser, felly rydym wedi diwygio'r canllawiau ac wedi ysgrifennu at yr holl feddygon teulu i'w hysbysu. Rydym wedi diweddaru'r ddogfen Cwestiynau a Ofynnir yn Aml i Gleifion, sydd ar gael ar ein gwefan.

Dymunaf bwysleisio ein bod yn parhau i weithio gyda'n cydweithwyr yng Nghaer i ddatrys y sefyllfa gytundebol a bod ymgysylltiad yn parhau ar lefel genedlaethol rhwng yr asiantaethau GIG yng Nghymru a Lloegr, gyda chefnogaeth swyddogion Llywodraeth Cymru a Llywodraeth y DU, i ddatrys ar lefel system a dod i gytundeb teg ar y cyd ar gyfer taliadau traws ffiniau.

Yn y cyfamser, wrth gwrs byddwn yn gweithio gyda'r Countess i sicrhau bod proses lyfn yn ei lle i gleifion gogledd Cymru i gael mynediad at ofal a chynnal diogelwch cleifion, gan gynnwys galwad wythnosol rhwng y ddau sefydliad i fynd i'r afael ag unrhyw broblemau a darparu adroddiad olrhain wythnosol ar gyfer unrhyw gyfeiriadau a ddychwelwyd o Gaer i PBC.

Yr eiddoch yn gywir

Gary Doherty
Prif Weithredwr
Chief Executive

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

Dear Colleague

Further to my letter dated 11th April, please note that following further discussions with the Countess of Chester NHS Foundation Trust, certain elective referrals will now be accepted e.g. some cancer referrals and so we have refined the guidance and written out to all GPs to inform them. We have updated the Frequently Asked Questions document for patients which is available on our website.

I would emphasise that we continue to work with our colleagues in Chester to resolve the contractual position and that engagement continues on a national level between NHS Wales and English NHS agencies, supported by Welsh Government and UK Government officials, to resolve at a system level a collective fair agreement for cross border payments.

In the mean time we will of course work with the Countess to ensure there is a smooth process in place for North Wales patients to access care and maintain patient safety, including a weekly call between the two organisations to address any issues and a weekly tracking report for any referral returned from Chester to BCU.

Yours sincerely

Gary Doherty
Prif Weithredwr
Chief Executive

Health Board **02.05.19**	GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board ***To improve health and provide excellent care***

Report Title:	Integrated Quality & Performance Report
Report Author:	Mr Ed Williams, Head of Performance Assurance
Responsible Director:	Mr Mark Wilkinson, Executive Director of Planning & Performance
Public or In Committee	Public
Purpose of Report:	This report provides the Board with a summary of key quality, performance, financial and workforce indicators.
Approval / Scrutiny Route Prior to Presentation:	This paper has been scrutinised and approved by the Executive Director of Planning & Performance
Governance issues / risks:	**Governance** Our report outlines the key performance and quality issues that have been determined to align to our core priorities in 2018/19. The performance is scrutinised using the national delivery framework indicators via the Finance and Committee and Quality, Safety and Experience Committees of the Board. The Summary of the end of year position 2019 compared to March 2018, as well as comparative performance for March 2019 compared to February 2019 is included as an Executive Summary within the report itself. The quality of the reporting is affected by the timeliness and accuracy of the data available aligned to the timing of the Board and Committee meetings. The report aims to provide the most up to date validated performance information to the committee. The report will change with effect from May 2019, to include the revised national delivery framework indicators aligned to our interim operational plan, showing the indicators scrutinised by each committee, profiles for these indicators for 2019-20 and for the monthly reportable indicators the performance for April 2019.The Primary Care indicators for 2019/20 will also be included from May 2019.
Financial Implications:	*N/A*

Recommendation:	The Board is asked to note the report and to assist in addressing the governance issues raised.

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

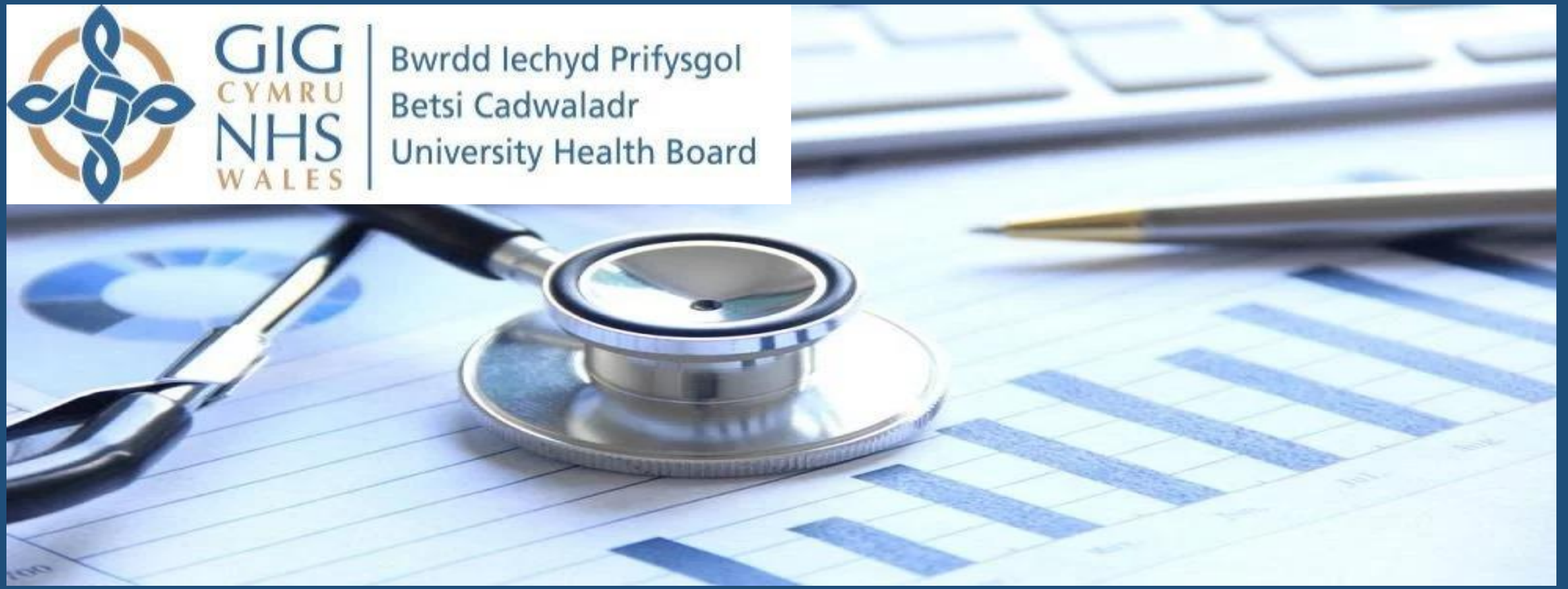
Special Measures Improvement Framework Theme/Expectation addressed by this paper
This paper supports the revised governance arrangements at the Health Board and supports the Board Assurance Framework by presenting clear information on the quality and performance of the care the Health Board provides.

Equality Impact Assessment
The BCU annual plan has been Equality Impact Assessed. The measures reported to the Board are aligned to the core priorities of the Board and from May 2019 will be aligned to the annual operating plan.

Integrated Quality and Performance Report – Health Board

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board



March 2019

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Integrated Quality and Performance Report

Health Board Version

March 2019

About this Report

This **Integrated Quality & Performance Report** 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 and as such the resulting Actions should be recorded and disseminated accordingly using the '**Outcomes & Actions**' sheet provided.

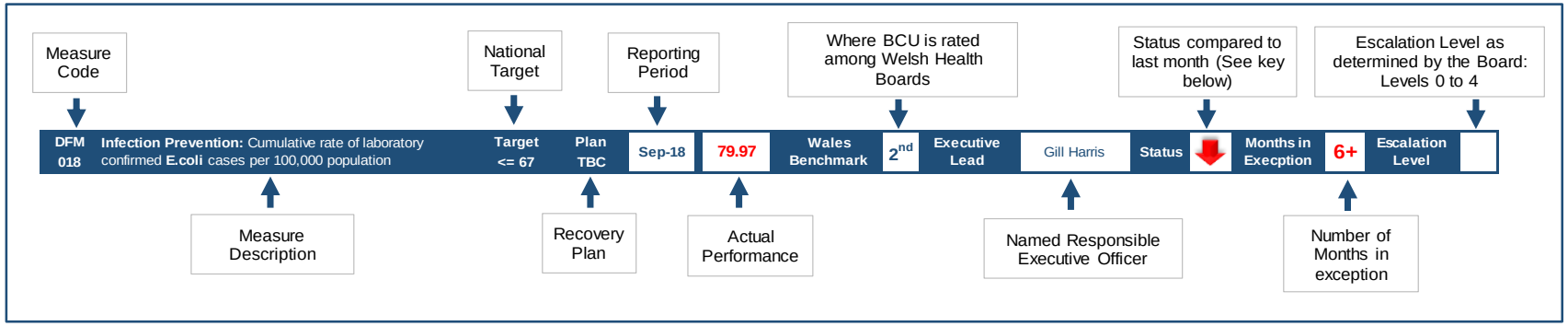
Escalated Exception Reports

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 a) that they have a plan and set of actions in place to improve performance, b) that there are measurable outcomes aligned to those actions and c) that they have a defined timeline/ deadline for when performance will be 'back on track'. Although these are normally scrutinised by Quality & Safety or Finance & Performance Committees, there may be instances where they need to be 'escalated' to the Board. These will be included within the relevant Chapter on an 'as-required' basis.

Statistical Process Control Charts (SPC)

Where possible 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.

Description of the KPI bar Components:



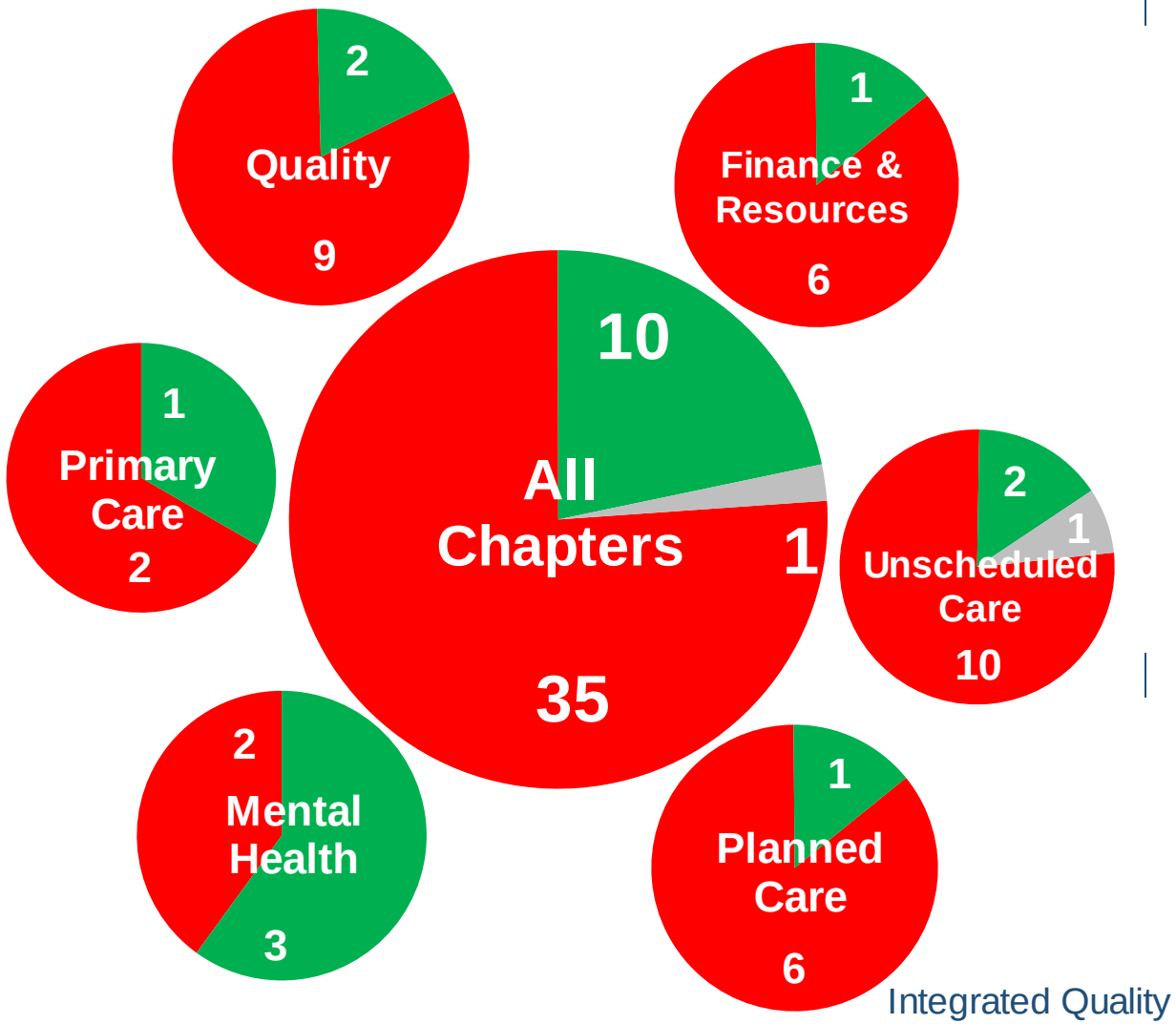
Status Key:

Achieved & Improved	↑	Achieved but Worse	↓	Achieved Static	→
Not Achieved Static	←	Not Achived but Improved	↑	Not Achieved Worse	↓

Integrated Quality and Performance Report
Health Board Version

March 2019

Summary Dashboard



Headlines

Most Improved

Measure	Status		(Target)
Total Number of Measures Improved	22		46
Total Number of Measures Static	5		N/A
Finance: Agency & Locum Spend	£2.5m	↓	<= £2.8m
Referral to Treatment: Over 36 Weeks	6,004	↑	0
Ambulance Handovers over 1 Hour	438	↓	0
Infection Prevention: C.Difficile	24.6	↑	<= 26.00
PADR Rate (%)	67.1%	↑	>= 85%

Of Most Concern

Measure	Status		(Target)
Total Number of Measures Worse	19		0
Emergency Department 4 Hour Waits (inc MIU)	71.90%	↓	>= 95%
Diagnostic Waits over 8 Weeks	2,278	↓	0
Follow Up Waiting List Backlog	87,712	↓	<= 75,000
Finance: Financial Balance	2.80%	↓	<= 2.0%

Integrated Quality and Performance Report
Health Board Version

March 2019

Executive Summary

Of the 46 measures within this report, the Health Board has improved performance against 22, remained static for 5 and has got worse for 19, an overall worse position compared to the last report in January 2019.
The Health Board is the best performing in Wales with regards reducing S.Aureus infections, and 2nd best for reducing E.Coli infections. Work is required to further improve the level of these infections. At 4th in Wales in terms of C.Difficile, there is still room for improvement. The number of Healthcare Acquired Pressure Ulcers (HAPU) reported as Serious Incidents remains a concern. Betsi Cadwaladr is the best performing Health Board in Wales in terms of Flu Vaccinations for Over 65's, Under 65's at risk groups and for pregnant women.

The Health Board's financial position remains a serious concern and details will be provided in the Financial Report.

The validated RTT 36 Week positon at end of March 2019 is 6,004 (290 higher than March 2018) waiting over 36 weeks for treatment. Most significant concerns are in Endoscopy with 2,064 patients waiting over 8 weeks for diagnostic endoscopies. The delays in endoscopy have contributed to more patients waiting beyond the 62 day threshold for cancer treatment. Focus on delivering access for clinically prioritised patients is demonstrating improvements with two of the three units now compliant with cancer milestones for endoscopy and the third site showing improved compliance.

Improved performance in our Emergency Departments did not continue into March 2019 compared to February 2019, but is still an improved position compared to March 2018. There has been a significant reduction in delays to ambulance handovers and to patients waiting over 12 hours to be treated in our emergency departments. Performance against 3 of the 4 measures concerning Stroke Care have improved this month. There have also been improvements in performance against our Out of Hours measures which are, as of February 2019 are no longer in Special Measures. Furthermore, the sustained reduction in number of Non-Mental Health Delayed Transfers of Care (DToC) continues with 70 patients reported as DToCs in March 2019 compared to 133 in March 2018. Although still well below the target rates, performance against the Assessment and Treatment within 28 Days Measures in both Adult Mental Health and Child & Adolescent Mental Health Services has improved in February 2019. The service has continued its sustained reduction in the number of patients experiencing Delayed Transfers of Care (DToC) and at 192 has exceeded the 194 target figure.

On pages 6 and 7 are summaries comparing performance between March 2018 and March 2019 positions. Of the 49 measures compared, performance has improved against 31, is static for 1 and is worse for 17, showing an overall improvement in performance between the end of 2017/18 and the end of 2018/19 financial years.

Executive Summary

March 2018 to March 2019 Comparison

Quality

Measure	(Target)	2018	Status	2019
Infection Prevention: C.Difficile	<= 26.00	39.38	↑	24.6
Infection Prevention: S.Aureus	<= 20.00	28.6	↑	25
Infection Prevention: MRSA*	0	40	↑	19
Healthcare Acquired Pressure Ulcers (HAPU)	<= 21	57	↑	42
New Never Events*	0	5	↓	8
Mortality: Crude Under 75 yoa	<= 0.70%	0.84%	↑	0.74%
Mortality: Universal Mortality Reviews	>= 95%	91.10%	↑	94.50%
Falls Prevention (Reported as Serious Incidents)**	<= 122	76	↑	67
Flu Vaccination: Over 65's	>= 72%	70.60%	↑	71.00%
Flu Vaccination: Under 65's at Risk	>= 53%	51.64%	↓	47.90%
Flu Vaccination: Workforce	>= 65%	54.70%	↓	51.20%

** Total within 12 Months*
*** Of figures available*

Finance & Resources

Measure	(Target)	2018	Status	2019
Finance: Financial Balance	<= 2.0%	0.00%	↓	2.82%
Finance: Agency & Locum Spend	<= £2.8m	£1.1m	↓	£2.3m
Sikness absence rates (% Rolling 12 months)	<= 4.50%	4.93%	↓	4.98%
Mandatory Training (Level 1) Rate (%)	>= 85%	82%	↑	84%
PADR Rate (%)	>= 85%	62%	↑	67%
% Staff agreed PADR was useful	>= 51%	51%	↑	54%
Information Governance Training	>= 85%	78.00%	↑	81.00%
Overall Staff Engagement Score (2018)	>= 3.51	3.51	↑	3.74
% Staff happy for BCU to treat family & friends	>= 61%	61%	↑	67%

Planned Care

Measure	(Target)	2018	Status	2019
Referral to Treatment (RTT): < 26 Weeks	>= 95%	84.60%	↑	84.80%
Referral to Treatment (RTT): > 36 Weeks All	0	5,714	↓	6,004
Referral to Treatment (RTT): > 36 Weeks Welsh	0	5,663	↓	5,918
Diagnostic Waits: > 8 Weeks	0	476	↓	2,278
Follow-up Waiting List Backlog*	75,000	81,021	↓	87,712
Cancer: 31 Days (non USC Route)**	>= 98%	98.50%	↑	98.90%
Cancer: 62 Days (USC Route)**	>= 95%	86.70%	↓	80.88%
Outpatient DNA: New	<= 5%	5.98%	↑	5.28%
Outpatient DNA: Follow up	<= 7%	6.48%	↑	5.63%
Postponed Procedures	<= 2,565	N/A	↑	2,570

* Note increase due in part to implementation of WPAS
** February 2019 Data
N/A New Measure 2018/19

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Executive Summary

March 2018 to March 2019 Comparison

Unscheduled Care

Measure	(Target)	2018	Status	2019
Emergency Department 4 Hour Waits (inc MIU)	>= 95%	67.83%	↑	71.90%
Emergency Department 12 Hour Waits	0	2,062	↑	1,608
Ambulance Handovers within 1 Hour	0	1,172	↑	438
Ambulance Response within 8 minutes	>= 65%	73.89%	↓	70.40%
Out of Hours: Within 20 Minutes	>= 98%	64.00%	↑	80.00%
Out of Hours within 60 Minutes*	>= 98%	N/A	N/A	None
Stroke Care: Admission within 4 Hours	>= 59.7%	31.00%	↑	50.00%
Stroke Care: CT Scan within 1 Hour	>= 54.4%	43.00%	↓	40.70%
Stroke Care: Review by consultant 24 Hours	>= 84.5%	73.00%	↑	81.30%
Stroke Care: Thrombolysed DTN < 45 mins	Improve	10.00%	↓	7.70%
Delayed Transfers of Care (DToC): Patients Non MH	<= 113	113	↑	70
Delayed Transfers of Care (DToC): Patients MH	<= 15	15	↑	10

** No Calls to Out of Hours were Triaged as Very Urgent in March 2019*

Mental Health

Measure	(Target)	2018	Status	2019
MHM1a - Assessments within 28 Days	>= 80%	76.17%	↑	77.40%
MHM1b - Therapy within 28 Days	>= 80%	78.99%	↓	67.06%
MHM2 - Care Treatment Plans (CTP)	>= 90%	85.40%	↑	90.70%
MHM3 - Copy of Agreed plan within 10 Days	100%	100%	→	100%
Delayed Transfers of Care (DToC) Days	<= 194	243	↑	192

Primary Care

Measure	(Target)	2018	Status	2019
% GP practices open during daily core hours	>= 91%	92.45%	↑	92.50%
% GP practices open between 17:00 and 18:30	>= 99%	66.04%	↓	66.00%
% Population accessing NHS Dentists	>= 50%	49.50%	↓	49.30%

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Escalations from Committees

As part of the normal cycle of business going forward this template will be used to record any areas escalated from committee meetings of the Board to be considered by the Board. As this is the first month in which this format has been used the Committees have not met to populate this template.

QSE Committee
No additional indicators were escalated following scrutiny this month.

Measure Escalated

Reason Escalated

F&P Committee
USC and RTT are already in escalation status and form part of the key indicators to the Board. No additional indicators were identified for escalation this month

Measure Escalated

Reason Escalated

Chapter 1: Summary

Quality

Measure	Status	(Target)
Infection Prevention: C.Difficile	24.6	<= 26.00
Infection Prevention: S.Aureus	25	<= 20.00
Infection Prevention: MRSA	5	0
Healthcare Acquired Pressure Ulcers (HAPU)	42	<= 21
New Never Events	0	0
Mortality: Crude Under 75 yoa	0.74%	<= 0.70%
Mortality: Universal Mortality Reviews	94.50%	>= 95%
Falls Prevention (Reported as Serious Incidents)	11	0
Flu Vaccination: Over 65's	71.00%	>= 72%
Flu Vaccination: Under 65's at Risk	47.90%	>= 53%
Flu Vaccination: Workforce	51.20%	>= 65%

Of the 1 1measures in this chapter, performance has improved for 8, remained static for 2 and is worse for 1

DFM 018	**Infection Prevention:** Cumulative rate of laboratory confirmed **E.coli** cases per 100,000 population	Target <= 67	Plan TBC	Mar-19	84.70	Wales Benchmark	2nd	Executive Lead	Deborah Carter	Status	↑	Months in Exception	6+
DFM 019	**Infection Prevention:** Cumulative rate of laboratory confirmed **S. Aureus** cases per 100,000 population	Target <=20	Plan 20	Mar-19	25.00	Wales Benchmark	1st	Executive Lead	Deborah Carter	Status	↑	Months in Exception	6+
DFM 020	**Infection Prevention:** Cumulative rate of laboratory confirmed **C.difficile** cases per 100,000 population	Target <=26	Plan 26	Mar-19	24.60	Wales Benchmark	3rd	Executive Lead	Deborah Carter	Status	↓	Months in Exception	6+

Actions:

- Infection Prevention & Control (IPC)Team continue to monitor all admissions with potential Infection risks on a daily (M-F) basis.
- Geno typing takes place for any Clostridium difficile infections.
- Post infection reviews are carried out for all C. difficile infections (CDI) and these are followed up for 4/52 following completion of treatment or discharge.
- Monitor population sizes and demographics in relation to infection rates and trajectories.
- New work programme for 2019/2020 drafted for approval at next Strategic Infection Prevention (IP) Group.
- Develop a prevalence study for Catheter Associated Urinary Tract Infections.

Outcomes:

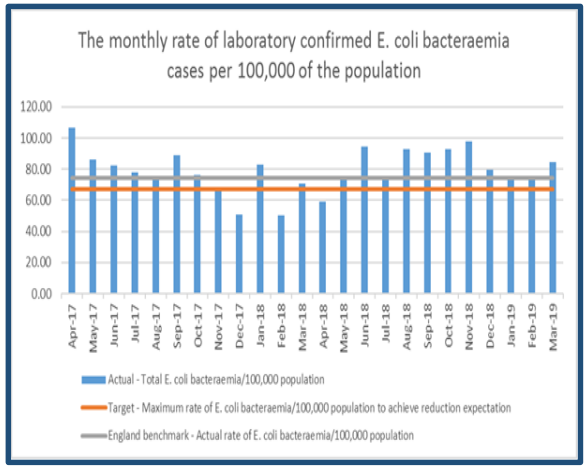
- Concentrated effort on delivering a specialist and expert resource by giving back ownership on everyday IP business.
- Recognising our isolated cases and potential cross infection risks before they occur.
- Supporting patients to remain at home, manage their treatment and prevent unnecessary admission
- Performance framework populated for the 6 organisms with associated trajectories.
- Reduction in unnecessary antibiotic prescribing and related resistance.
- Implement an evidenced based assessment tool to remove urinary catheters.
- Scrutiny and learning from focused HCAI executive review.

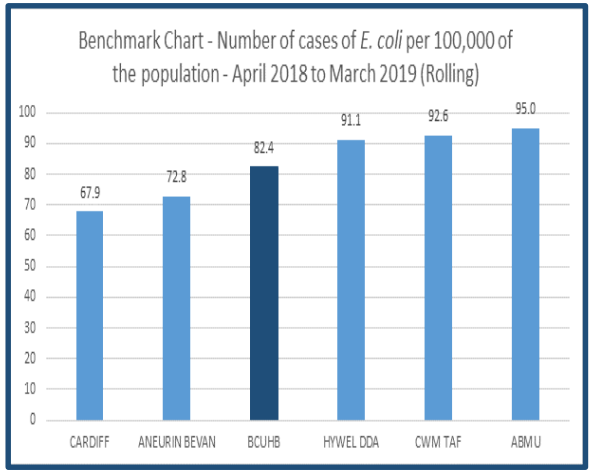
Timelines:

Continually monitor rates and innovative practice in reducing avoidable infection/harm and remain within the trajectories set for the health board.

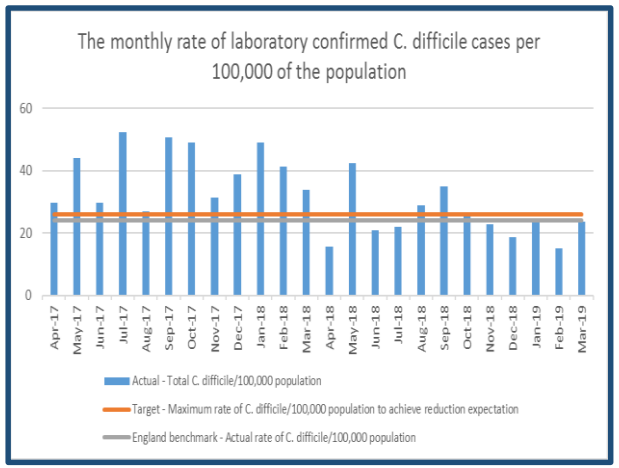
Infection Prevention Graphs

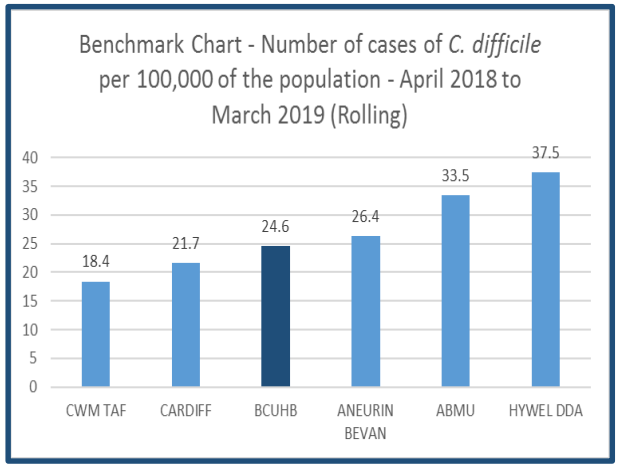
E.Coli



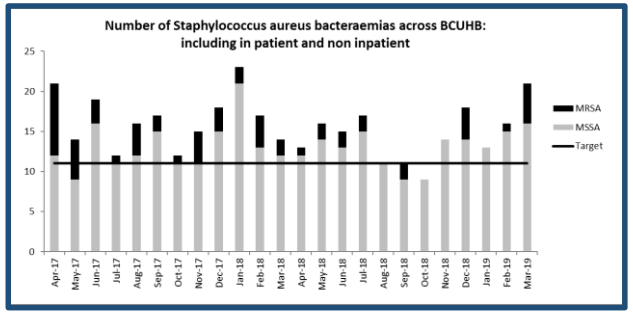


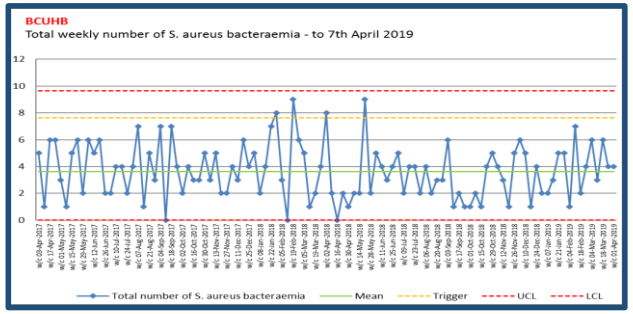
Clostridium Difficile

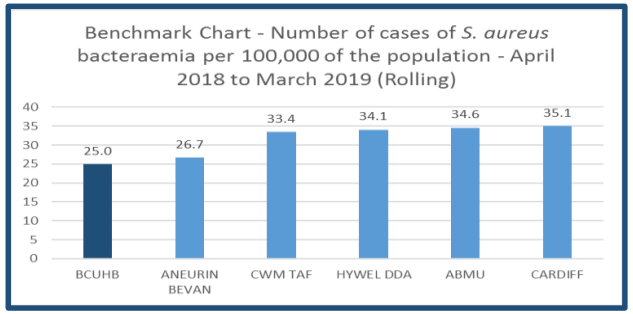




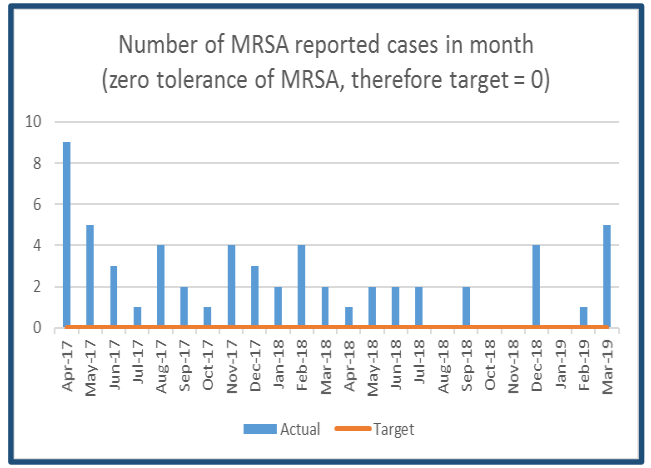
Staphylococcus Aureus (S. Aureus)

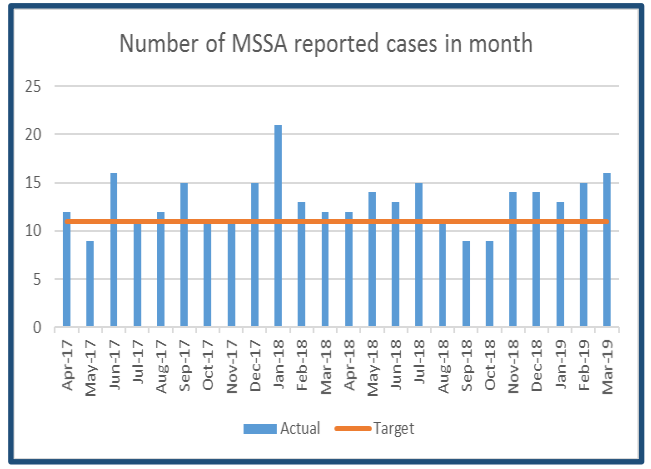






S. Aureus split: MRSA and MSSA





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Pressure Ulcers (HAPU)

DFM		Target	Plan			Wales Benchmark		Executive Lead		Status		Months in Exception	
026	Number of Healthcare Acquired **Pressure Ulcers** (HAPU) Grade 3,4 or unstageable reported as Serious Incidents	<= 21		Feb-19	42		7th		Deborah Carter		↑		6+

Actions

HAPU collaborative commenced November 2018 with the aim to reduce the incidence of HAPU for inpatients only. 14 wards identified and currently testing interventions with the aim being to provide a Health Board Standard for identification of patients at risk, prevention and management of pressure ulcers and a standard for reporting and measuring for informing of further improvements across the Health Board.

Tissue Viability team review, and advise grade 3 upwards classification pressure ulcers with inpatients

Outcomes

Early indications are that there is requirement for an increase of staff knowledge and awareness by enhancing the Tissue Viability resources;

Amendments to the datix incident reporting system;

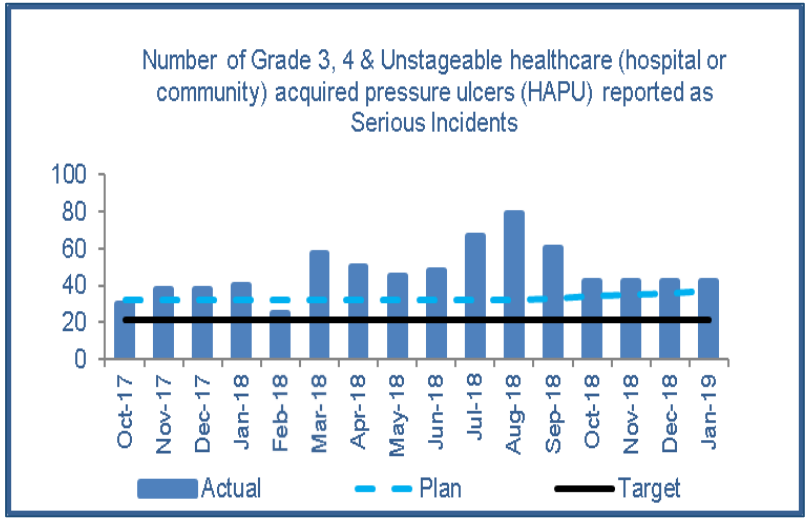
Standardisation of reporting mechanism may lead to an initial increase as a Health Board;

Introduction of simplified documentation to support evidenced care for prevention and management of pressure ulcers.

Timelines

The HAPU collaborative is due to complete initial testing by the end of March 2019 with a Health Board launch of the standard in May 2019 following detailed analysis of the wards data.

The review of the standard will include its transferability to the community (patients in care homes and own homes) setting.



Falls Reported as Serious Incidents

DFM 028	Number of patient **falls** reported as Serious Incidents	Target 0	Plan	Feb-19	11	Wales Benchmark	7th	Executive Lead	Deborah Carter	Status	↓	Months in Exception	6+

Actions

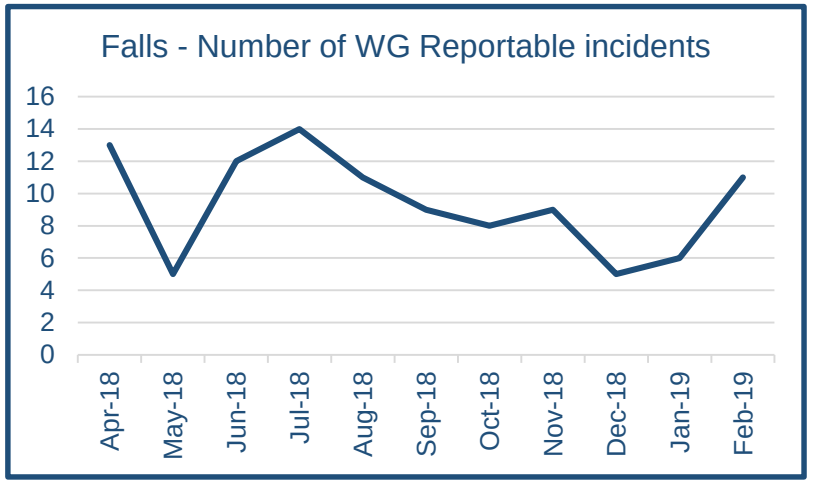
- Compliance with Mandatory training for the prevention and management of falls for ward based staff
- Incidents of falls to be reported effectively, divisional falls groups to consider root cause analysis and lessons learnt.
- By exception, monthly reporting of serious incidents of falls to QSG via Divisonal leads
- Development of a falls collaborative, using the methodology applied for the recent HAPU collaborative, to provide a standardised approach to care with the aim of reducing falls with harm for patients when inpatients.
- Evidence of compliance with the Inpatient Falls policy as part of the ward accreditation scheme.
- Dissemination of lessons learnt via the strategic inpatient fall groups
- Supporting wider initiatives to prevent patient deconditioning within the ward environment, such as such as #endpjparalysis

Outcomes Expected

- 100% compliance of falls assessment and care planning requirements
- 85% compliance with mandatory training
- 100% utilisation of the falls bundle/ pathway
- Reduction in the number of falls with harm reported from an inpatient environment.
- Monthly reports via Datix and Serious Incident reports

Timeline

The organisation is currently meeting the Welsh Government target and expects to maintain this.



Chapter 1 – Quality Concerns

DFM 046	The percentage of concerns that have received a final reply (under Regulation 24) or an interim reply (under Regulation 26) up to and including 30 working days from the date the concern was first received by the organisation	Target	Plan			Wales Benchmark	7th	Executive Lead	Deborah Carter	Status	↓	Months in Exception	6+
		>= 75%	>= 75%	Feb-19	27.00%								

Actions:

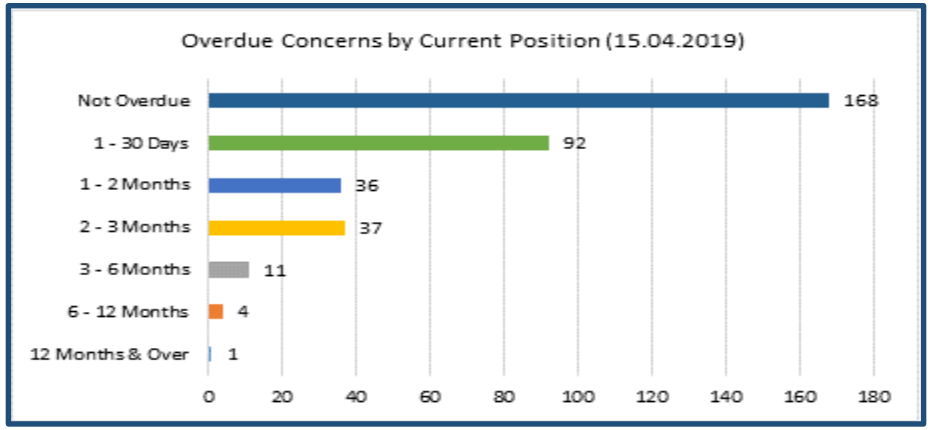
- All complaint responses over overdue complaints discussed weekly with the Director of Quality Assurance
- Daily, weekly and monthly monitor of performance in place
- Review of model for corporate and governance teams to allow greater support to the wider complaints management.

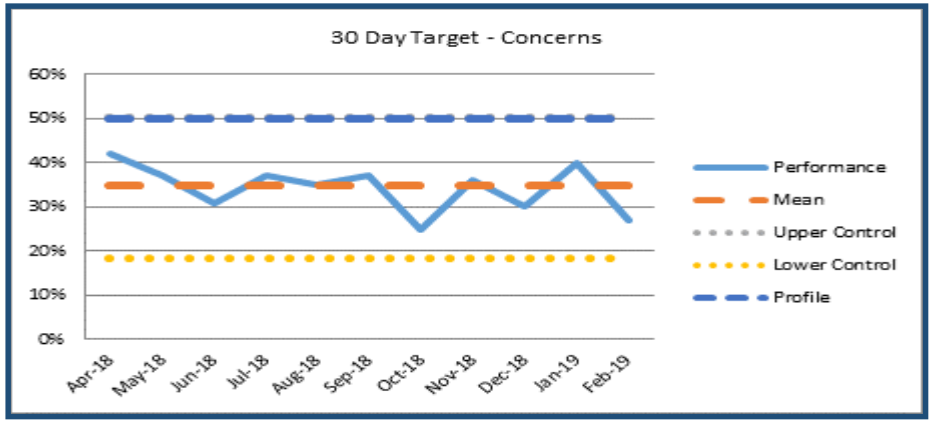
Outcomes:

- Reduction in the number of longer overdue complaints
- No complaints over 12 months time frame
- Divisions on trajectory for management of the number of complaints over 6 months of age
- Performance for complaints overdue by 2-3 months is stable
- Single senior lead for complaints management across BCUHB

Timeline:

- New trajectories have been issued to each of the Divisions with expectation that they will be in line with these by June 2019





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DFM 032	**Mortality**:% Universal Mortality Reviews (UMR) carried out within 28 days of death	Target >= 95%	Plan >=95%	Mar-19	94.50%	Wales Benchmark	2nd	Executive Lead	Evan Moore	Status	↓	Months in Exception	6+
DFM 033	**Mortality**: % Crude under 75 years of age	Target <=0.70%	Plan	Mar-19	0.74%	Wales Benchmark	4th	Executive Lead	Evan Moore	Status	←	Months in Exception	6+

Actions

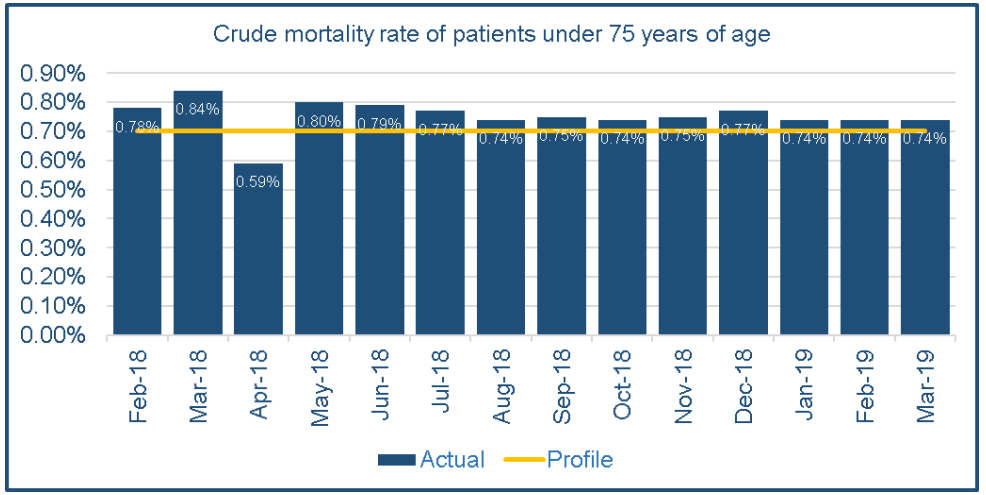
- DATIX mortality module being developed and will be rolled out in phases during 2019
- There will be training package developed for the DATIX module to enable consistent approach then pan BCU into its usage
- Developing plans to commence collaborative for Acute kidney injury to launch late 2019
- RAMG to look at focussed work also on hospital acquired pneumonia- work is on-going looking in to this and what needs to be improved

Outcomes

- Compliance in stage 1 remains variable but it is expected to become more stable or show improvements once DATIX is rolled out
- Crude in <75 years of age has improved but continues to be monitored

Timelines

- This is on-going work and due to the complexity timelines at this stage are difficult to predict. Once we have access to the DATIX module we can develop plans to train and roll out system but would expect this to take 4-6 months to complete everything.



DFM005a	% uptake of influenza vaccine in Under 65's at risk	Target >= 55%	Plan >= 53%	Mar-19	47.90%	Wales Benchmark	1st	Executive Lead	Teresa Owen	Status	↑	Months in Exception	6+
DFM005b	% Uptake of influenza vaccine in Over 65's	Target >= 75%	Plan >= 72%	Mar-19	71.00%	Wales Benchmark	1st	Executive Lead	Teresa Owen	Status	↑	Months in Exception	6+

Actions

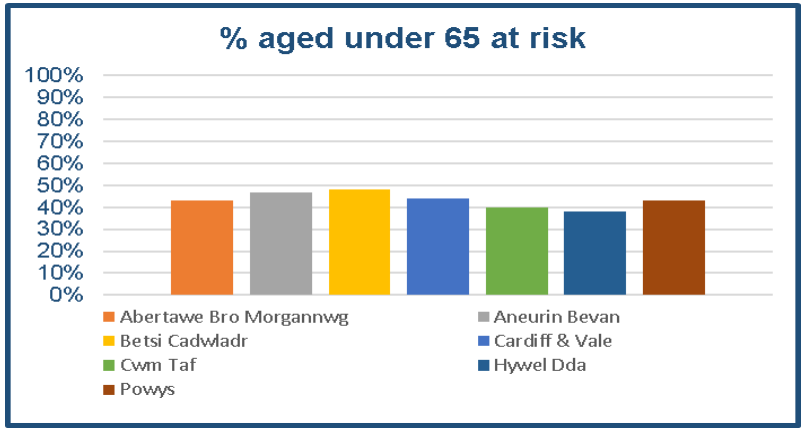
- In terms of data collection the Flu vaccination campaign has now concluded for the 2018-19 campaign
- Uptake on pregnant women will be available in April 2019 following a Point of Delivery Audit conducted in January 2019.
- Vaccination uptake data is being circulated to the Areas and Clusters for discussion locally
- Immunisation training in 2019 includes discussion of the uptake data and the NICE guidance to maximise uptake
- Planning for the 2019-20 campaign is well underway

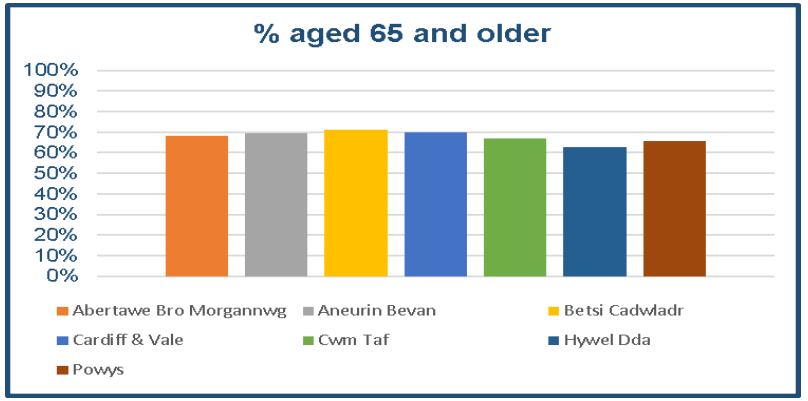
Outcomes

- 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 by focusing on a smaller number of targeted improvement areas which will include a plan for securing more effective clinical engagement.
- Identify improvement opportunities in 4 specific areas.
  ◄ 65 years+ ◄ at risk patients under 65 years ◄ 2&3 year olds ◄ NHS staff

Timelines

- We are now in between Flu campaigns.
- The final Seasonal Influenza Flu annual report 2018-19 is due to be published in June 2019
- The Flu WHC for the 2019-20 campaign is due for publication imminently and will aid local early planning.





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Flu Vaccination Staff

DFM0 05d	Uptake of influenza vaccination among: Health care workers	Target >= 60%	Plan >= 60%	Mar-19	51.24%	Wales Benchmark	5th	Executive Lead	Teresa Owen	Status	↑	Months in Exception	6+

Actions

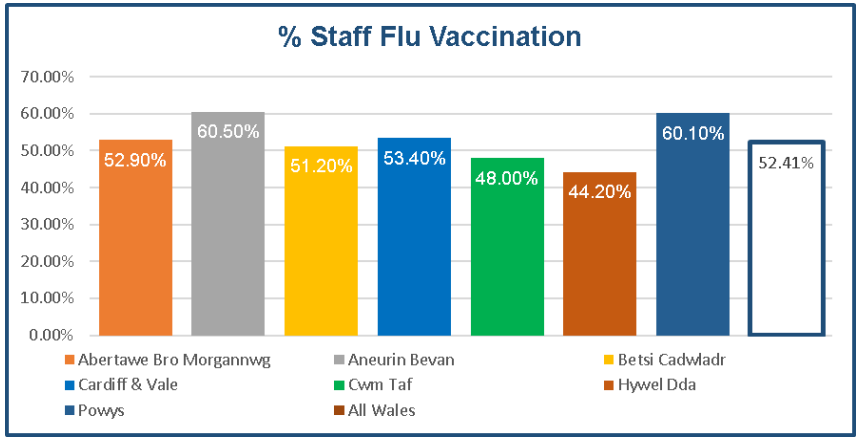
Increase staff uptake to achieve 60% (n10,667) flu vaccination uptake for BCUHB staff.
Increase staff flu vaccination up-take in our 67 high risk areas to 75% compliance.
Evaluate the effectiveness of the flu campaign with local flu leads.
Complete flu de-brief for staff flu campaign with flu monitoring group / staff leads.
Evaluate effectiveness of flu campaign model for 2018 / 19.

Outcomes

After 184 days of the flu campaign starting we are at a 51.24% uptake (n9110). We would need to provide a further 1577 flu vaccinations to reach target of 60% (10,667).
We are 319 doses lower (2.60%) when compared to this time in the previous year.
20 out of 67 (29.9%) high risk areas have attained a 75% plus vaccination rate.
We have 229 Local vaccinators (21 short of target) trained to deliver flu vaccinations. Local flu vaccinators have provided 62% of all local flu vaccinations to BCU staff.
Weekly flu reports sent to all management teams to highlight uptake, gaps and priority areas for action to include areas of high risk.
Flu de-brief completed and key messages, recommendations and learning being evaluated.

Timelines

We have not achieved target of 60% by 31st March 2019.
Flu is still circulating and there is a risk of staff catching and spreading flu if they haven't had their flu jab.
Increased pressures on service delivery, staffing / resource, sickness absence and cost.
Begin to design and draft the flu campaign model for 2019 / 20 based on recommendations.



	2017	21.03.19	Variance	% to target
Area East	59.98%	55.22%	4.76%	4.78%
Area Central	55.63%	53.61%	2.02%	6.39%
Area West	54.55%	53.63%	0.92%	6.37%
Secondary Care East	57.57%	55.39%	2.18%	4.61%
Secondary Care Central	51.42%	48.64%	2.78%	11.36%
Secondary Care West	57.32%	53.02%	4.30%	6.98%
Women's	58.45%	61.85%	-3.40%	-1.85%
MH&LD	44.19%	44.25%	-0.06%	15.70%
Estate and Facilities	47.02%	42.24%	4.78%	17.69%

Chapter 2: Summary

Finance & Resources

Measure	Status	(Target)
Ward nurse staffing fill rate (%)	85%	>= 95%
Ward nurse staffing skill mix ratio (% Reg)	55%	>= 60%
Finance: Agency & Locum Spend	£2.5m	<= £2.8m
Sikness absence rates (% Rolling 12 months)	4.98%	<= 4.94%
Mandatory Training (Level 1) Rate (%)	84%	>= 85%
PADR Rate (%)	67%	>= 85%
Finance: Financial Balance (%)	2.80%	<= 2%

Compared to the previous report, of the 7 Measures in this chapter, performance has improved for 3 and worse for 4.

WGM 201	Ward nurse staffing fill rate (%)	Target >= 95%	Plan	Mar-19	85.00%	Wales Benchmark	N/A	Executive Lead	Deborah Carter	Status	←	Months in Exception	6+
WGM 202	Ward nurse staffing skill mix ratio (% Registered)	Target 60%	Plan	Mar-19	55.00%	Wales Benchmark	N/A	Executive Lead	Deborah Carter	Status	↑	Months in Exception	6+

Actions

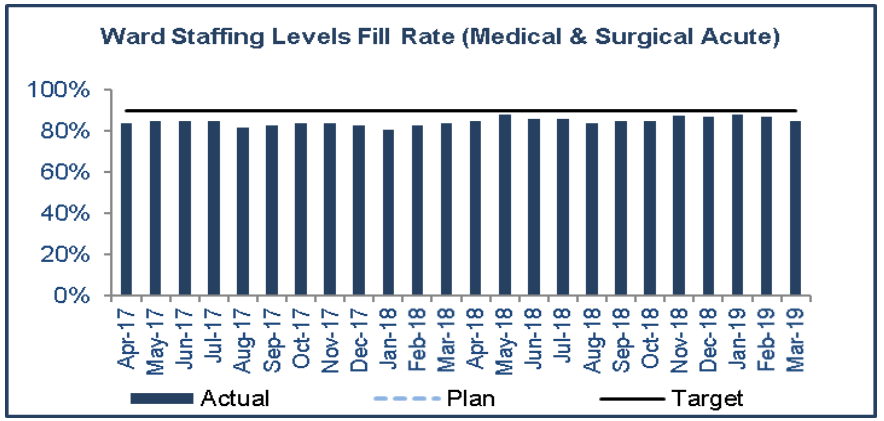
- BCUHB attendance at RCNi Manchester in February. Advert closed 10/03/2019
- Priority Wards Campaign commenced in Wrexham Maelor and Ysbyty Glan Clwyd sites
- Focussed support from recruitment team to support Ward Managers
- New Graduate weekend recruitment event scheduled for March 16th & 17th. To be held centrally at Ysbyty Glan Clwyd.
- Budget review meetings to agree staffing templates underway across the 3 acute sites (in line with Nurse Staffing Act 2016).

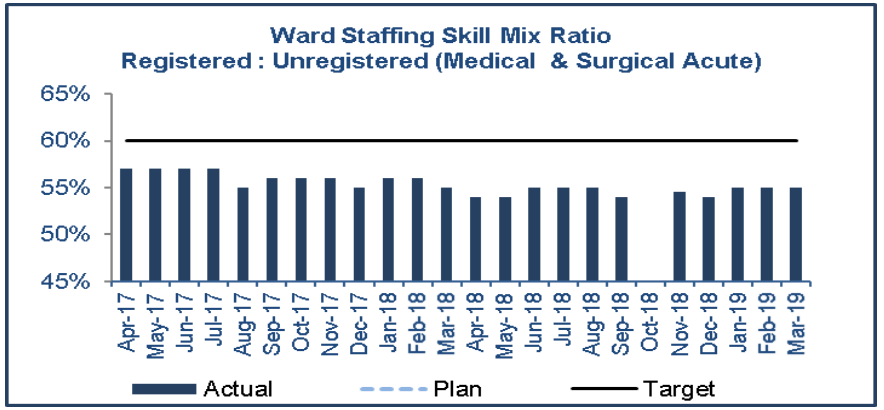
Outcomes

- Improvement seen with BCUHB Fill Rate this month.
- 18 applicants to RCNi Manchester advert (9 external).
- Anecdotal evidence to support reduced time to hire as a result of focussed Priority Wards Campaign.
- Improvement in vacancies position in last quarter.
- 129 confirmed attendees for weekend recruitment event.
- 101 Adult graduates amongst these.

Timelines

- Improved position expected in the Autumn with 101 new adult graduates expected September 2019. Likely NMC registration November 2019.





Chapter 2 – Finance & Resources

Agency & Locum Spend

LM 501F	Finance: Agency & Locum Spend	Target Reduce	Plan <= £2.8m	Mar-19	£2.5m	Wales Benchmark	N/A	Executive Lead	Russ Favager	Status	↓	Months in Exception	6+

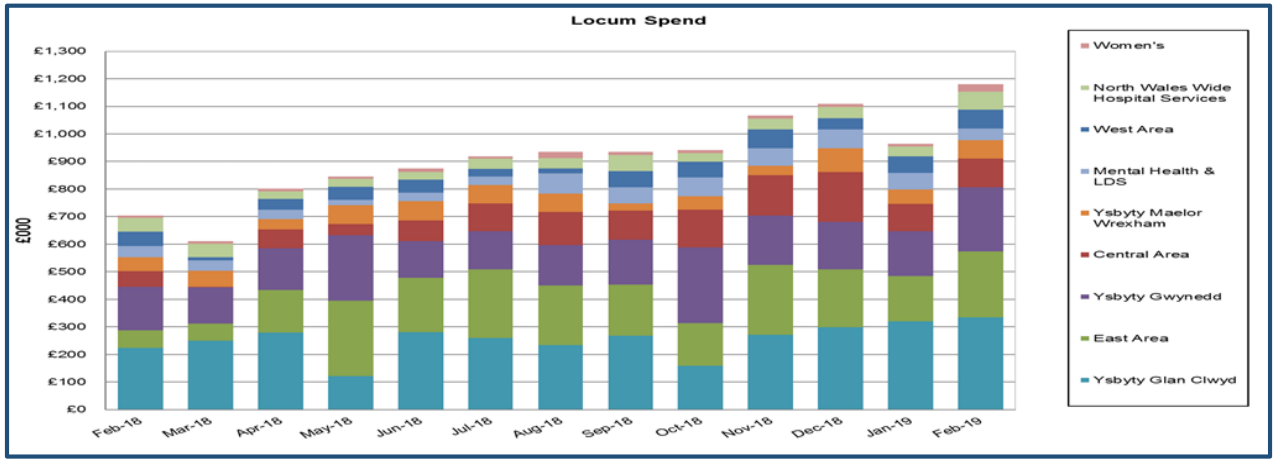
The total spend for agency for 2018/19 is £31.6 m for agency and £11.9 for locums. Compared to performance in 2017/18 Agency spend has reduced from £34,162,355 (£2,567,344) whilst internal locum spend has increased from £8,052,749 (£3,820,326).
Spend increased for both in month 12 by a total of £735k.

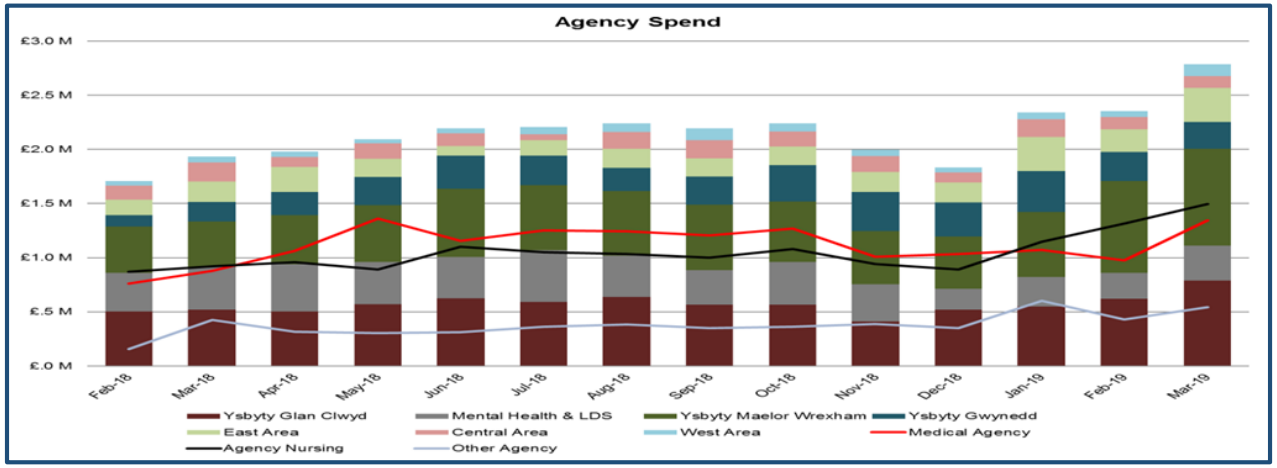
Actions and outcomes:

- Enhanced Control measures are in place for most staff groups across the organisation prior to approval of agency expenditure
- Temporary staffing improvement and roster improvement projects are in place and are being recalibrated to ensure they are focussing on the areas of highest impact.
- Recruitment hotpots have been mapped and plans developed to increase substantive appointments and temporary staffing capacity in areas with the highest agency reliance/spend.
- A review of the internal locum process is underway to establish a more robust mechanism for prospective consideration and timely payment.

Timescale

Each division will have improvement trajectories in place by the 2nd week of May 2019.





Integrated Quality and Performance Report
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LM 502F	Finance: Financial Balance	Target	Plan	Mar-19	2.82%	Wales Benchmark		Executive Lead	Russ Favager	Status	↓	Months in Exception	6+

The Health Board's 2018/19 Financial Plan is a forecast deficit of £35m. The deficit for the month of March 2019 is £3.811m and this is £1.731m over plan. The cumulative deficit for the financial year is £40.315m and this is £5.315m over plan. There may be further year-end funding adjustments from Welsh Government, so the financial position may change.

Outcomes

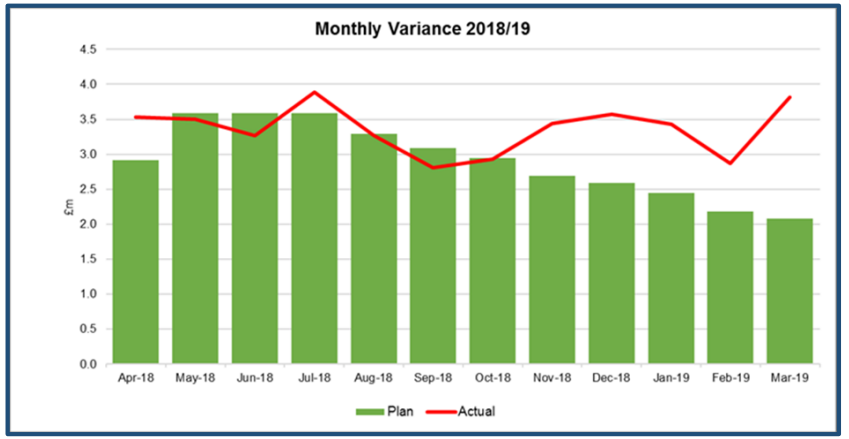
Savings achieved for the 2018/19 financial year are £38.3m against a plan of £45.0m (85.1% achieved), a shortfall of £6.7m. This is mainly due to under-delivery on the following Savings Programme Groups: MHLD (£2.5m); Transactional (£1.8m); Workforce (£2.2m).

Identification of savings opportunities for 2019/20 and future years is progressing and have been included in the Health Board's 2019/20 Financial Plan. The plan identifies a target of £34.5m of savings, £25.0m of which are cash releasing. Delivery of these plans will be closely monitored throughout the year.

Timelines

The final financial position will be submitted to Welsh Government on 26th April 2019 and is due to be signed off by the auditors on 31st May 2019.

The 2019-20 Financial Plans and savings targets have been approved in March's Board Meeting. Delivery of the Health Board's Financial Plan is dependent upon the delivery of savings targets and this is essential to progress towards a sustainable financial position.



Chapter 2 – Finance & Resources

Sickness Absence Rate

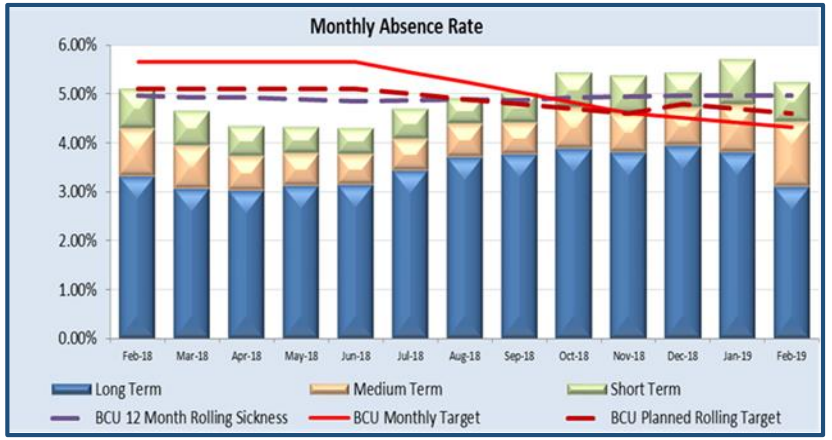
DFM 097	Sickness & absence Rates (% Rolling 12 months)	Target <= 4.5%	Plan	Mar-19	4.98%	Wales Benchmark	2nd	Executive Lead	Sue Green	Status	↓	Months in Exception	6+

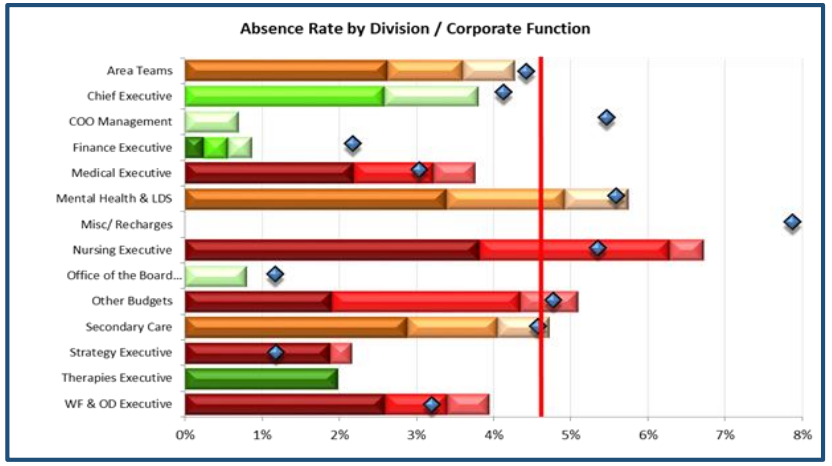
Final performance for 2018/19 is 4.98% which is above the 4.5% target and not where the organisation should be both in terms of staff health and wellbeing or in terms of productive time available to deliver services to our patients and population. The fact that the organisation is the best performing large Health Board and the 2nd best across Wales, is a positive but we are still not where we need to be.

Actions:
A range of actions have been taken over 2018/19 and whilst many have had a positive impact in terms of awareness and availability of health and wellbeing tools and support; understanding of changes in national policy, they have not had the an impact on improving attendance. As such, a detailed review of actions taken to date and those required against the priority areas set: Long term absence; Stress related absence; Musculoskeletal related injury/absence; Workplace accident/injury related absence is underway to ensure a greater level of focus is applied to. Overall analysis undertaken has projected that reductions in each of these categories would have a significant impact on attendance levels and enable sustained delivery of the 4.2% target.
In addition, improvement trajectories are being developed for each division, (using the same methodology as PADR) to enable ownership and closer management and monitoring of the impact of improvement activity.

Outcomes:
Future reports will set out baselines for each of the priority areas together with specific actions to be taken to ensure improvement trajectories are met. At this stage, the Health Board is aiming to achieve the 4.2% target by the end of quarter 2 2019/20

Timeline: Organisational and Divisional trajectories will be in place by the 1st May 2019





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Chapter 2 – Finance & Resources

Mandatory Training

DFM 096	Mandatory Training (Level 1) Rate (%)	Target >= 85%	Plan >= 84%	Mar-19	84.00%	Wales Benchmark	1st	Executive Lead	Sue Green	Status	↑	Months in Exception	6+

The Performance in March 2019 for Mandatory Training Compliance identified an increase of 1% for both level 1 and level 2 training. Currently level 1 is at 84% and level 2 is at 74%.

Actions:

Identify the reason for no increase in level 1 compliance for a consecutive month for Fire, Information Governance and Load Handling by conducting a full review of the provision, attendance records and 'Did Not Attend' rates, including discussion with the subject leads.

Identify staff who show as below a 50% compliance and provide reports to Divisions.

Continue to investigate training methodologies to support Estates and Facilities staff to increase their overall compliance along with a review of their process for ensuring training records are uploaded to ESR.

Outcomes from Actions:

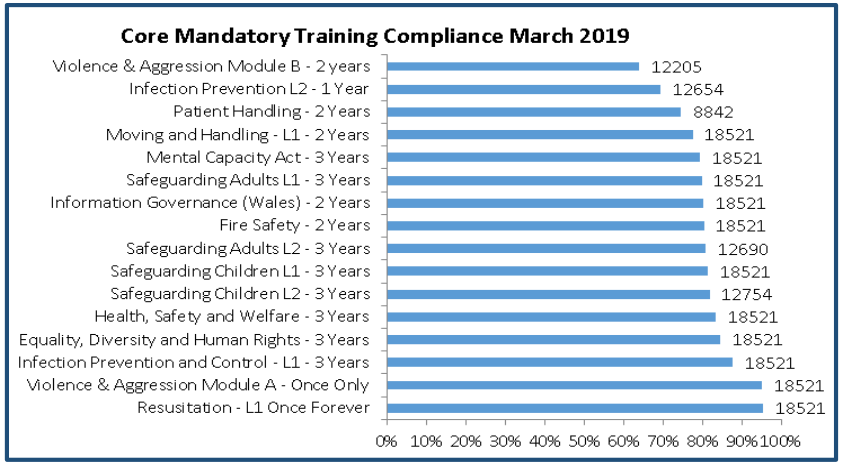
Identifying lack of increase in compliance with subject leads will highlight areas of improvement in order to sustain an increase.

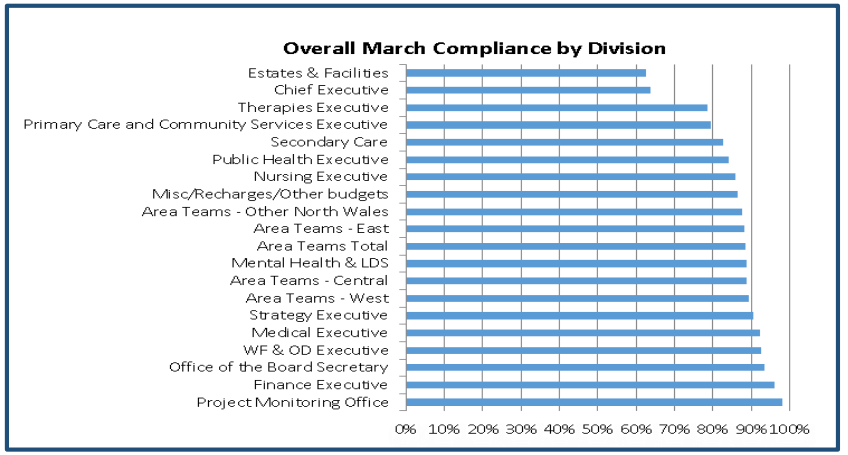
Highlighting staff who are below 50% compliant will allow Divisional managers to support staff to access the relevant training to improve their individual compliance and hence support reaching the organisational target.

Ensuring staff within Estates and Facilities can access appropriate training methodologies will support reaching compliance targets, ensuring records are accurate in ESR will improve data quality.

Timelines:

With amendments to the Improvement Plan especially in terms of revision of provision, attendance records, reviewing areas of poor compliance including individual compliance records and addressing concerns around processes for uploading completed records to ESR, we anticipate being at the 85% target rate for level 1 training by the end of May 2019.





Chapter 2 – Finance & Resources

PADR

DFM 093	PADR Rate (%)	Target >= 85%	Plan >= 65%	Mar-19	67.10%	Wales Benchmark	5th	Executive Lead	Sue Green	Status	↑	Months in Exception	6+

PADR compliance continues to exceed the organisational trajectory with March data reaching 67.1%. The biggest increase was seen in Medical Executive with an increase of 14.5%. Across the organisation 970 staff members were reported as 'never had a PADR' with 431 of new starters not having a 3 month PADR. This totals 1401, a reduction of 189 staff members reported as not had a PADR since February.

Actions: Bespoke training sessions with targeted supervisors in Estates and Facilities on Group PADR with emphasis on how to plan ahead for long term sustainability of PADR's across the Division.

Development of new PADR paperwork and initial consultation with supervisors and managers across the organisation e.g. District Nursing, Catering, Portering and Housekeeping. Further consultation to take place in April to ensure the paperwork is fit for purpose from the users perspective.

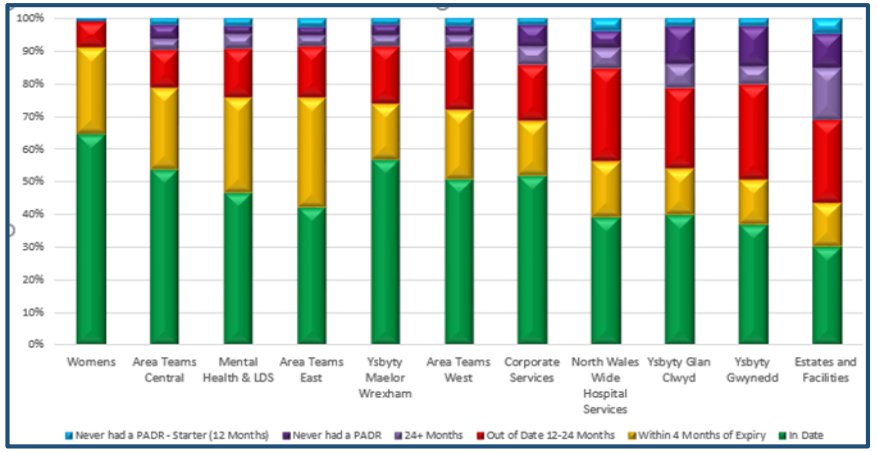
Organisational compliance data in March released as a league table demonstrating Divisional performance, ranking Divisions from highest to lowest.

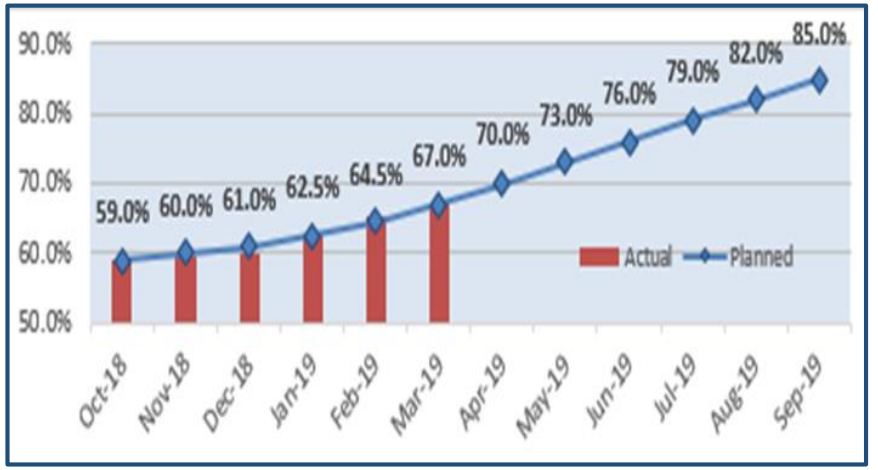
Divisional Improvement trajectories to be shared with all divisions. All Divisions to receive information on staff members in the category of 'within 4 months of expiry' and the impact this would have on their compliance if they were not completed prior to expiry.

Outcomes: Supporting managers with Group PADR and planning ahead will ensure compliance is sustainable and not a short-term 'quick fix'.

Working with managers through consultation to develop the new paperwork will contribute to PADR being seen as a meaningful developmental conversation and lead to more ownership of the process. Providing detailed breakdown and improvement trajectories allows Divisions to proactively manage their compliance to ensure they reach the organisational target of 85% by September.

Timelines: All actions within the 2018/19 PADR Improvement Plan have been met. A new plan for 2019/20 will focus on continuing to support Divisions to reach their planned trajectories with an emphasis on ensuring long term sustainability along with proactive management of compliance at team/department and Divisional level.





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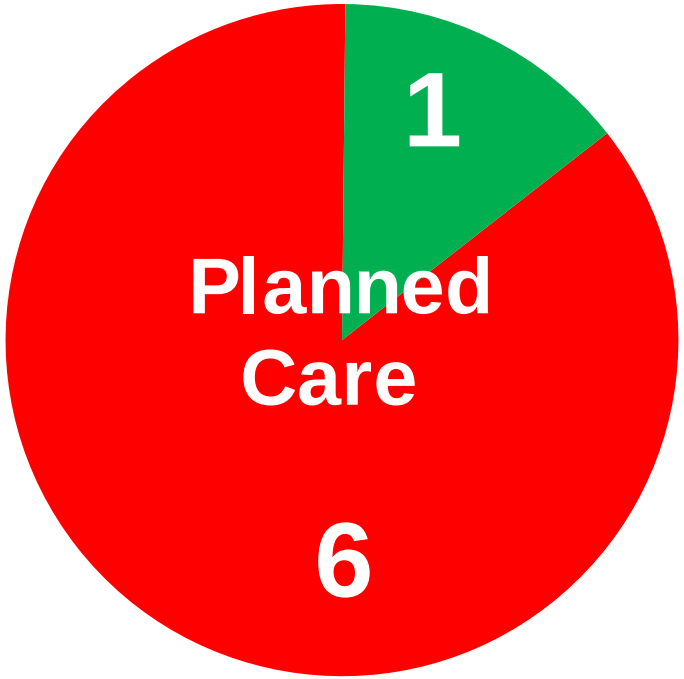
Chapter 3a: Summary

Operational Performance: Planned Care



Measure	Status	(Target)
Referral to Treatment (RTT): < 26 Weeks	84.80%	>= 95%
Referral to Treatment (RTT): > 36 Weeks	6,004	0
Referral to Treatment (RTT): > 52 Weeks	2,325	0
Diagnostic Waits: > 8 Weeks	2,278	0
Follow-up Waiting List Backlog	87,712	75,000
Cancer: 31 Days (non USC Route)	98.90%	>= 98%
Cancer: 62 Days (USC Route)	80.88%	>= 95%

Compared to the previous report of the 7 Measures in this chapter, Performance has improved for 5 and worse for 2.

Chapter 3a – Planned Care | Referral to Treatment

DFM 058	RTT: % of patients waiting less than **26 weeks** for treatment	Target >= 95%	Plan >= 84%	Mar-19	84.80%	Wales Benchmark	7th	Executive Lead	Evan Moore	Status	↑	Months in Exception 6+
DFM 059	RTT: Number of patients waiting over **36 weeks** for treatment	Target 0	Plan	Mar-19	6,004	Wales Benchmark	7th	Executive Lead	Evan Moore	Status	↑	Months in Exception 6+
LM 059A	RTT: Number patients waiting over **52 weeks** for treatment	Target 0	Plan	Mar-19	2,341	Wales Benchmark	N/A	Executive Lead	Evan Moore	Status	↑	Months in Exception 6+

Actions:

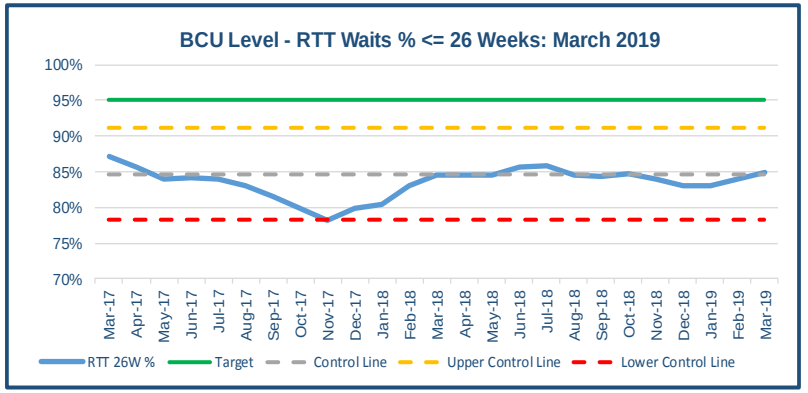
- A BCUHB and site level PTL now in use by the 3 systems at stages of treatment level with a targeted approach for clinically urgent and longest waits as a priority for treatment
- Weekly PTL meetings chaired by the Director of Planned Care in place. In transition towards managing timely delivery of pathways and timely escalation locally supported by risk assessments with mitigation
- RTT weekly trajectories being worked through to include backlog clearance as a time limited activity and "containment" of waits below 36 weeks reducing to 26 weeks. A draft outline is expected in April 19 at site and specialty level
- Refine current D&C tool; aligned to the weekly trajectory to predict performance 6 months ahead for RTT
- Develop RTT dashboard using Power BI to support and strengthen delivery
- Dedicated delivery leads for Planned Care, RTT and follow up to commence on the 23rd April

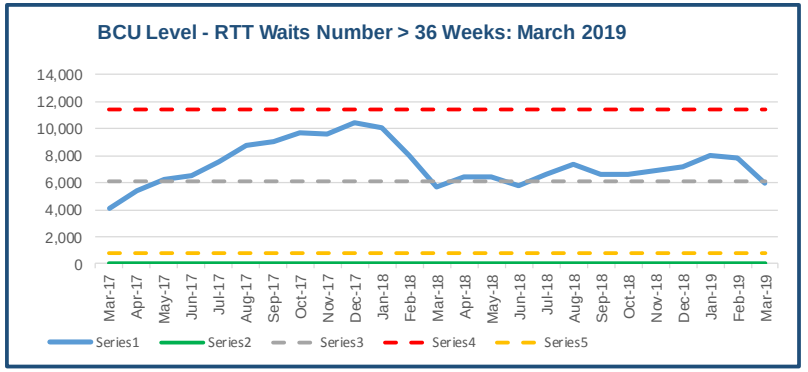
Outcomes:

- Reduced over 36 and 52 week backlog in line with the agreed recovery plan for 2019/20
- Reduced "tip over" rate from 12 month baseline of 36 week plus waits
- Weekly trajectories in use operationally and for planning RTT D&C
- Demand and Capacity (D&C) tool in place operationally for predicting RTT performance

Timelines:

- Draft recovery plan for RTT by 31st May 2019 for FPC approval
- Weekly delivery trajectory in use by 24th April 19
- Reduced backlog of 36 and 52 week waits in Q1 as per recovery plan





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DFM 060	Diagnostic Waits: Number patients waiting over **8 weeks** for a diagnostic test	Target 0	Plan 0	Mar-19	2,278	Wales Benchmark	7th	Executive Lead	Deborah Carter Adrian Thomas	Status	↓	Months in Exception	6+

Actions are focussed on Endoscopy due to the clinical risk associated with delays and the volume of patients waiting for access to the service overall. There were 2,064 breaches of 8 week diagnostics at the end of March 2019.

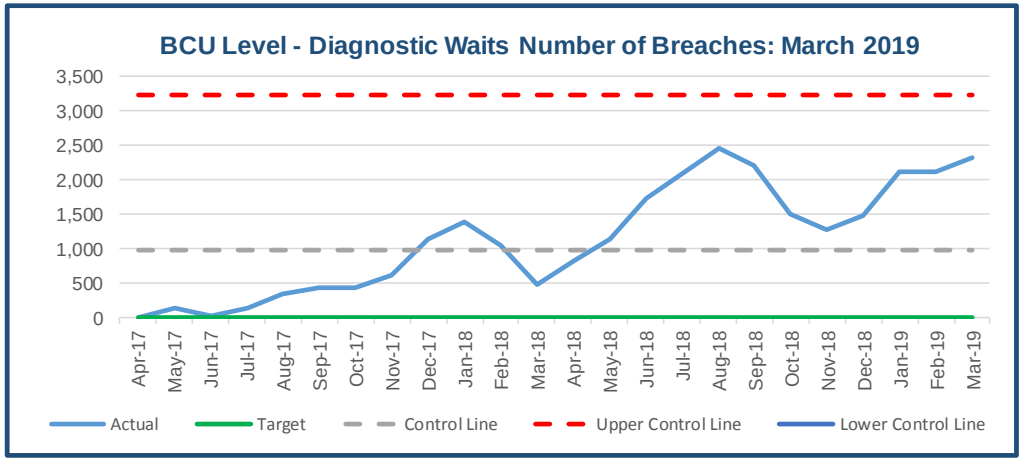
Additional management capacity has been sourced and will commence on 24 April 2019.
A key deliverable will be the production of a plan for sustainable endoscopy services and backlog elimination. The plan will likely have a number of components to it:

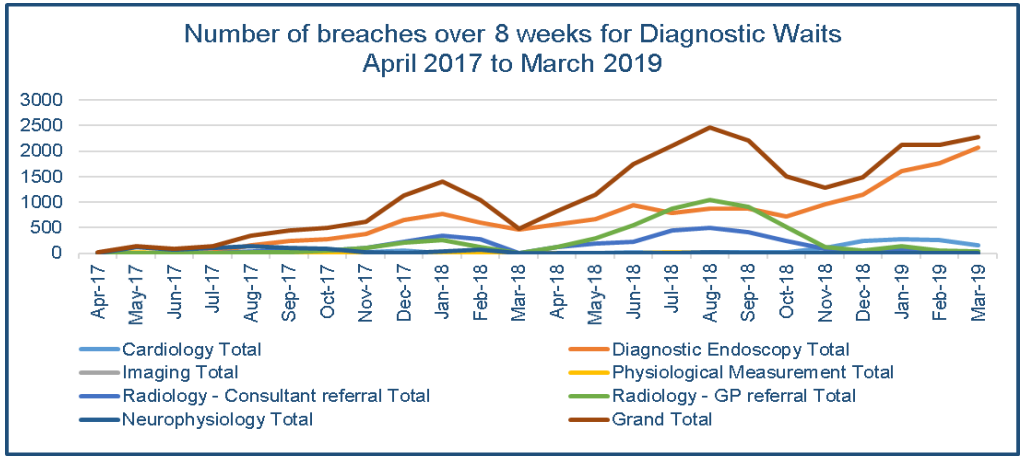
- Multi year insourcing and outsourcing for backlog elimination.
- Workforce expansion including possibly additional training nurse endoscopists.
- Estates issues – a possible scheme at Wrexham Maelor.
- Securing appropriate accreditations.

The Executive Team has made initial decisions to extend the procurement of additional capacity to end May with the expectation that a draft plan will be available then, the funding of which may require discussion with Welsh Government.

Radiology

There were 67 breaches at end of March from a total waiting list of 8,349 patients (representing 99.2% compliance).We are continuing with additional insourced CT and MRI and US sessions. We have established additional US in Llandudno to address the shortfall of capacity in West and Central. We still have some ongoing issues with head and neck US capacity in West and Central because of competing demands for consultant sessions to support breast radiology. We have not been able to secure an alternative provider at this time.





Chapter 3a – Planned Care

Cancer

DFM 071	Cancer:% of patients newly diagnosed with cancer not via USC pathway, treated within **31 days**	Target >= 98%	Plan	Feb-19	98.90%	Wales Benchmark	5th	Executive Lead	Adrian Thomas	Status	↓	Months in Exception	6+
DFM 072	Cancer:% of patients referred via the USC pathway definitively treated within **62 days** of referral	Target >= 95%	Plan	Feb-19	80.88%	Wales Benchmark	5th	Executive Lead	Adrian Thomas	Status	↓	Months in Exception	6+

Actions:

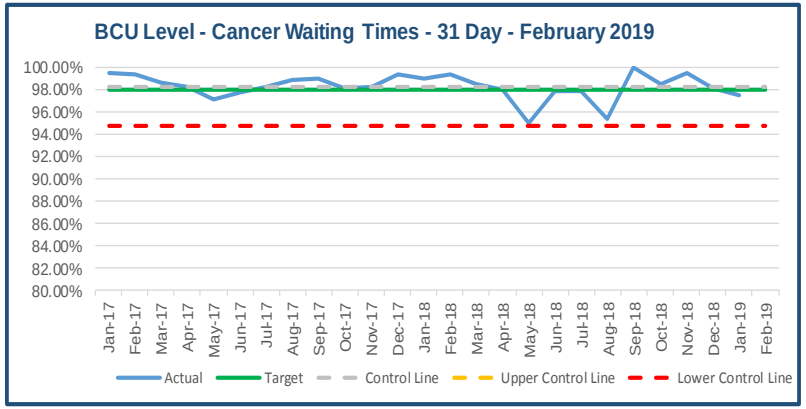
- A BCUHB and site level PTL now in use by the 3 systems at stages of treatment level with a targeted approach for clinically urgent and longest waits as a priority for treatment
- Weekly PTL meetings chaired by the Director of Planned Care in place. In transition towards managing timely delivery of pathways and timely escalation locally supported by risk assessments with mitigation
- RTT weekly trajectories being worked through to include backlog clearance as a time limited activity and "containment" of waits below 36 weeks reducing to 26 weeks. A draft outline is expected in April 19 at site and specialty level
- Refine current D&C tool; aligned to the weekly trajectory to predict performance 6 months ahead for RTT
- Develop RTT dashboard using Power BI to support and strengthen delivery
- Dedicated delivery leads for Planned Care, RTT and follow up to commence on the 23rd April

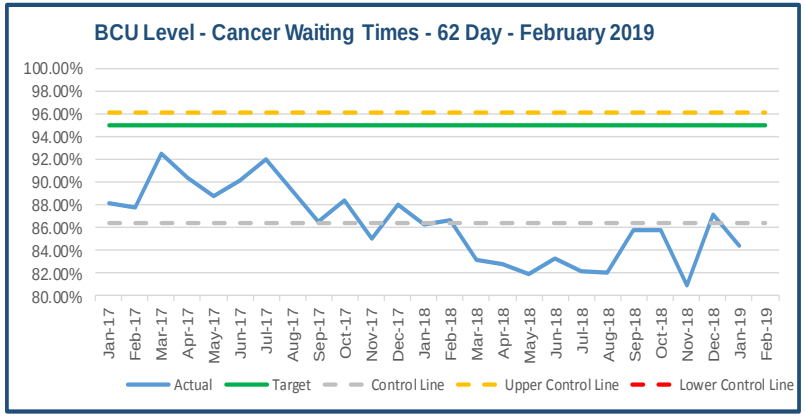
Outcomes:

- Reduced over 36 and 52 week backlog in line with the agreed recovery plan for 2019/20
- Reduced "tip over" rate from 12 month baseline of 36 week plus waits
- Weekly trajectories in use operationally and for planning RTT D&C
- Demand and Capacity (D&C) tool in place operationally for predicting RTT performance

Timelines:

- Draft recovery plan for RTT by 31st May 2019 for FPC approval
- Weekly delivery trajectory in use by 24th April 19
- Reduced backlog of 36 and 52 week waits in Q1 as per recovery plan





Chapter 3a – Planned Care

Follow Up Waiting List 29

DFM 062	Number of patients **passed** their Follow-up due date	Target 0	Plan <= 75,000	Mar-19	87,712	Wales Benchmark	6th	Executive Lead	Deborah Carter	Status	↓	Months in Exception	6+

The follow-up waiting list size and volume of patients overdue their clinically due date varies by site and by specialty. The recent implementation of Wales Patient Administration System (WPAS) has resulted in an increase in the volume of patients on the waiting list due to the different methodology used by the system in creating the waiting list. Given the range of factors driving the waiting list for each specialty, a detailed report will be presented to the Quality, Safety & Experience (QSE) Committee in May 2019. The actions below relate to 3 key specialties and aim to reduce but will not eliminate overdue appointments.

Actions: A risk stratified approach is being taken led by the Secondary Care Medical Director. The highest priority is being given to patients reported as overdue in Ophthalmology and Urology. Clinical validation is taking place to assess risk of harm for the highest risk patients within the Urology overdue appointments. The Eye Care Measure is being introduced to manage patients in accordance to their clinical risk using R1, R2 and R3 stratification to determine priority for scheduling, The Health Bard has been successful in its bid for validation and patient communication resource which will enable targeted patients to be validated to ensure the waiting list is accurate. Also patients will be advised of the changed system to facilitate scheduling by risk value.

The clinical variation meeting at the end of February 2019 confirmed the adoption of Patient Reported Outcome Measures (PROMs) in line with the National Planned Care Programme for management of 12 month reviews of patients post hip and knee replacement surgery to reduce the Orthopaedic backlog.

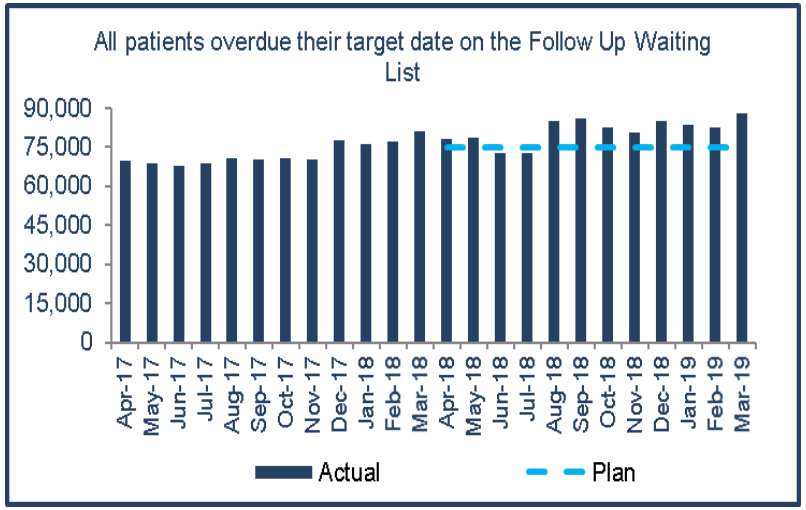
The HB is currently exploring the validation of the follow-up backlog list to ensure a clinically-targeted approach in treating the clinically urgent and longest waits. An update on progress will be provided for the next month.

Outcomes: The actions above will not resolve the entirety of the volume of patients overdue but will address those are greatest clinical risk. The outcomes expected from the above actions:

Urology - understanding of whether any harm has occurred for highest risk Urology patients by 31st March 2019, and escalation of scheduling as appropriate.

Clerical validation of the Ophthalmology waiting list by 30th April 2019 so as to enable the commencement of scheduling by R value to reduce the risk of irreversible harm from May 2019. Cataract pathway with direct listing for day case surgery tested on one site in February 2019, eliminating need for outpatient appointment so as to ensure patients with lower clinical risk can access surgical treatment. This pathway change has been agreed for all 3 sites and will be adopted from April 2019 increasing outpatient capacity for R1 patients. This validation is expected to reduce the overdue waiting list by 15%.

Orthopaedic - use of PROMs for hip and knee reviews at 12 months is expected to increase capacity by 1,500 appointment slots for more urgent cases from May 2019.



Timeline

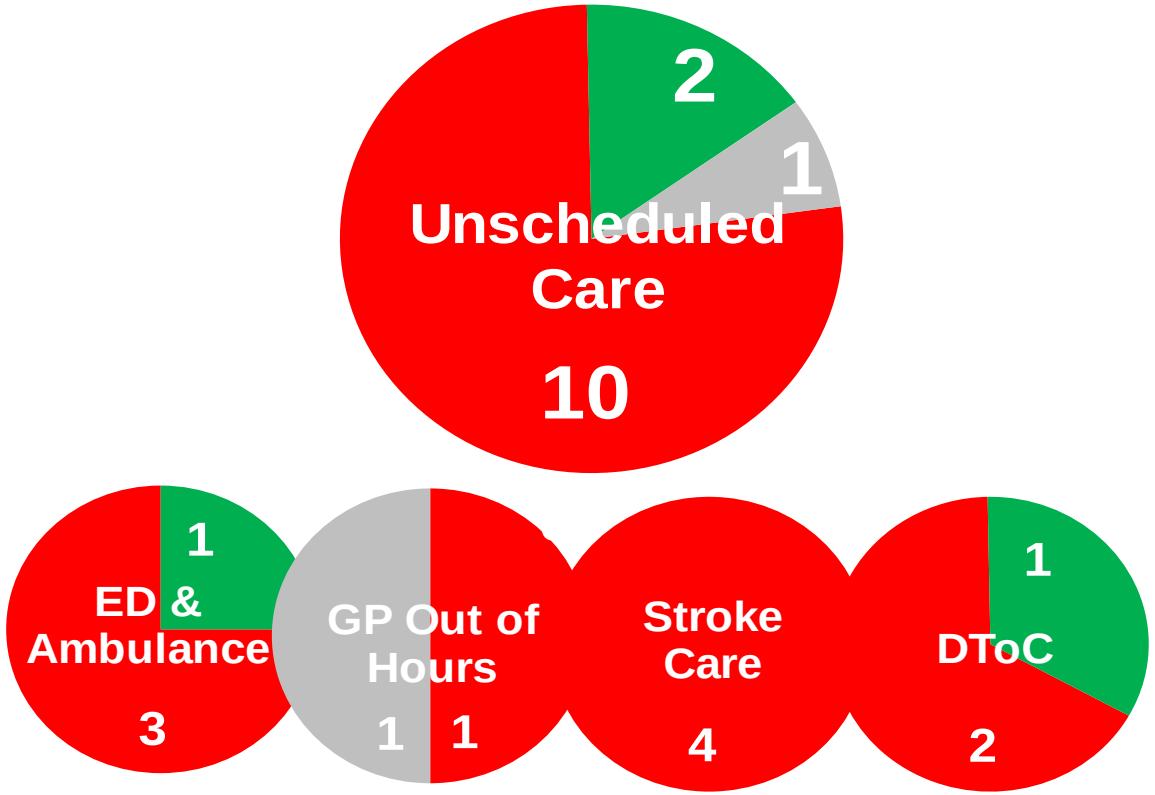
Urology- outcome known by end of March 2019

Ophthalmology- validation expected to be completed by May 2019

Orthopaedics - impact will be realised each month actions are implemented with expected gain being delivered in totality by March 2020

Chapter 3b: Summary

Operational Performance: Unscheduled Care



Measure	Status	(Target)
Emergency Department 4 Hour Waits (inc MIU)	719.00%	>= 95%
Emergency Department 12 Hour Waits	1,608	0
Ambulance Handovers within 1 Hour	438	0
Ambulance Response within 8 minutes	70.40%	>= 65%
Out of Hours: Within 20 Minutes	80.00%	>= 98%
Out of Hours within 60 Minutes	None	N/A >= 98%
Stroke Care: Admission within 4 Hours	50.00%	>=58.7%
Stroke Care: CT Scan within 1 Hour	41%	>= 52.8%
Stroke Care: Review by consultant 24 Hours	81.30%	>= 84.5%
Stroke Care: Thrombolysed DTN < 45 mins	7.70%	Improve
Delayed Transfers of Care (DToC): Patients	70	<= 133
Delayed Transfers of Care (DToC): ITU	7.81%	<= 5%
Discharges within 4 Hours: ITU	49.10%	>= 95%

Compared to the previous report, of the 13 Measures in this chapter, performance has improved for 4 and is worse for 8.

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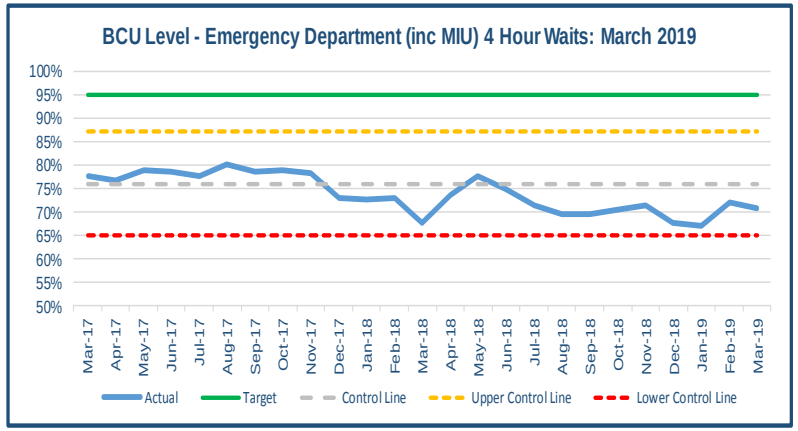
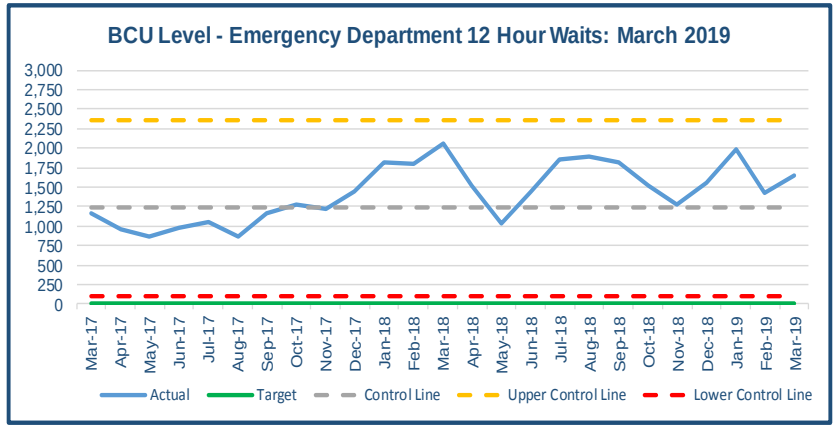
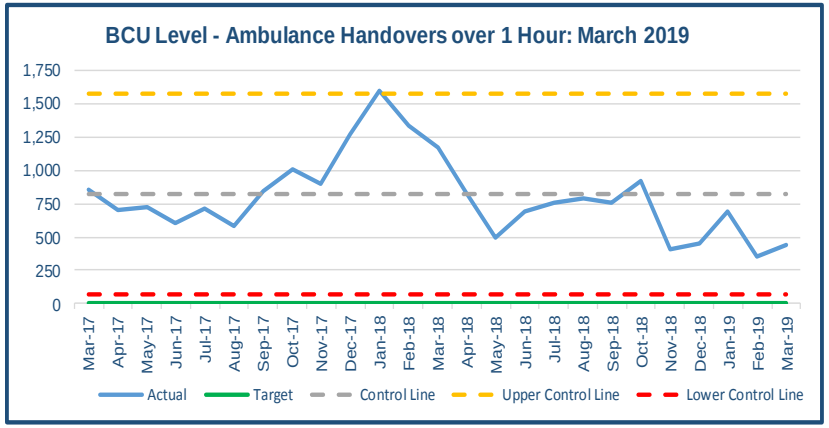
Chapter 3b – Unscheduled Care

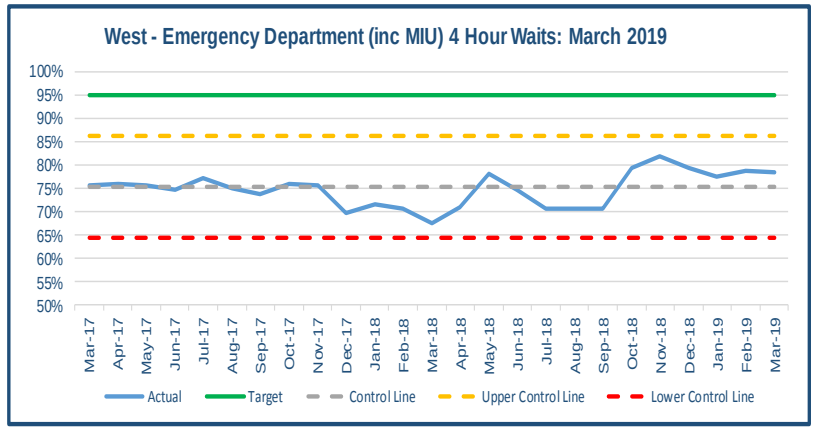
ED & MIU Measures

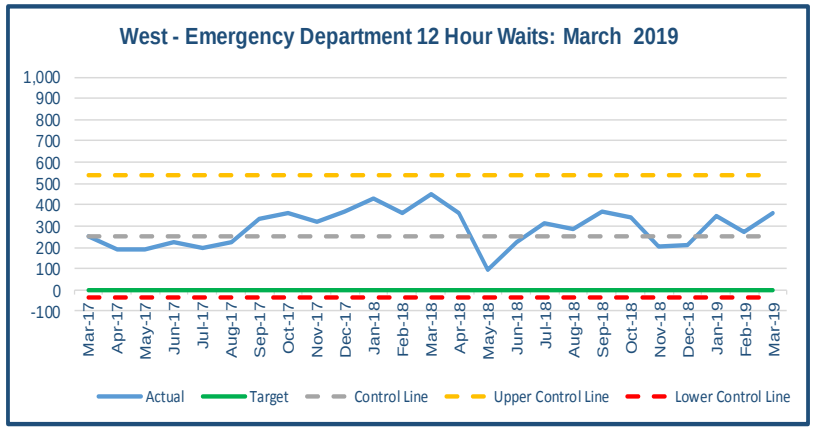
DFM 069	% of new patients spend no longer than 4 hours in A&E (inc Minor Injury Units)	Target >= 95%	Plan 71.73%	Mar-19	71.90%	Wales Benchmark	7th	Executive Lead	Deborah Carter	Status	↓	Months in Exception	6+
DFM 070	% of new patients spend no longer than 12 hours in A&E	Target 0	Plan	Mar-19	1,608	Wales Benchmark	7th	Executive Lead	Deborah Carter	Status	↓	Months in Exception	6+
DFM 068	Number of Ambulance Handovers over 1 hour	Target 0	Plan	Mar-19	438	Wales Benchmark	6th	Executive Lead	Deborah Carter	Status	↓	Months in Exception	6+

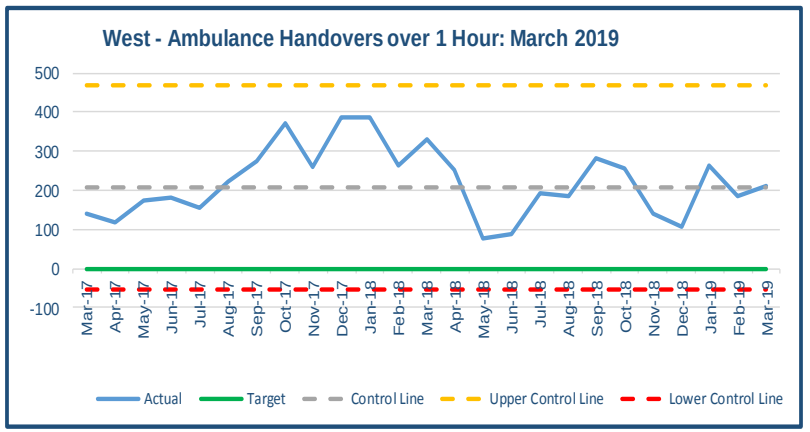






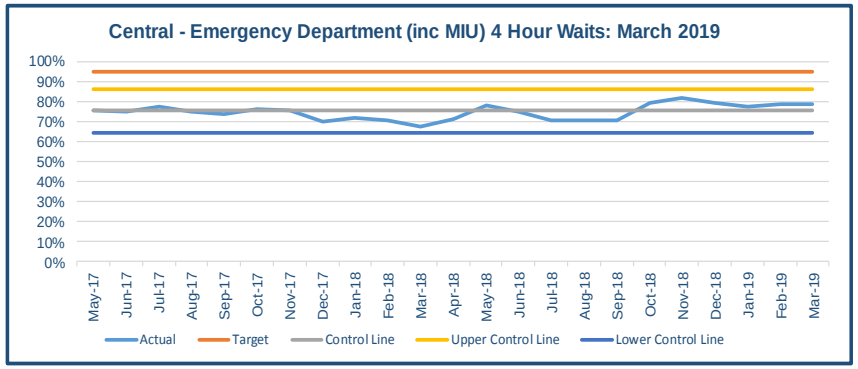


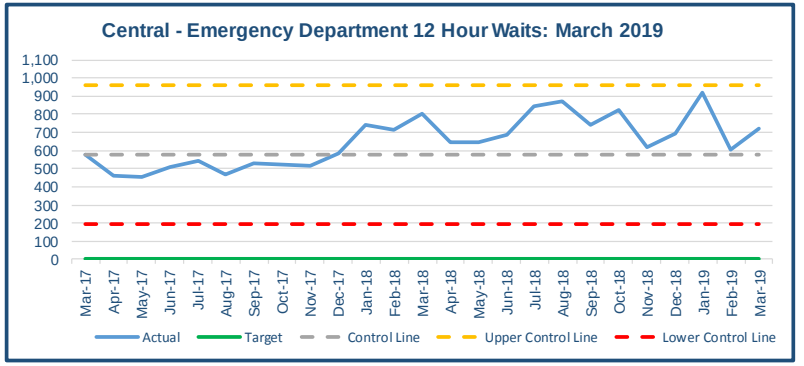


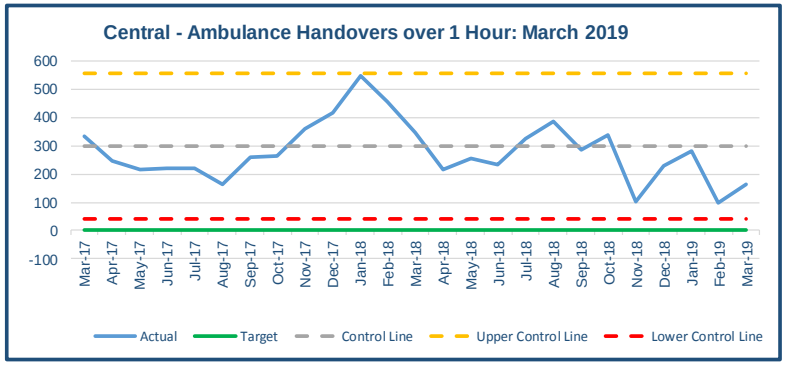


Actions and Outcomes - West Health Economy

- Despite an increase in ED attendances (>450 more patients in March ‘19 than in February ‘19 and March ‘18); the West combined 4 hr performance remained broadly consistent with the previous month (79.1% March v’s 79.2% February). This is almost a 3% performance improvement compared to the same period in 17/18 (76.4%).
- March is the third consecutive month where the deteriorating trend seen in Quarter 3 of 2018/19 has been reversed, and early indications suggest that the improvement is carrying forward into April 2019 with the West reporting a combined performance of 81% Month To Date (06/04/19)
- The team have maintained focus on the tasks within the ‘Building Better Care’ improvement plan. These have included an experienced GP at the point of ED triage to filter and navigate patients who would be better served by accessing alternative pathways or self help; support and upskilling of the triage nurses and increased drive for increasing the public and WAST use of MIUs. Focus on improved flow overnight has reduced the backlog previously experienced, this means that the department is starting each day with fewer over night breaches – though improvements are being seen, there is still much to do.







Actions and Outcomes - Central Health Economy

For the 3rd consecutive month the Ysbyty Glan Clwyd experienced an increase in Emergency Department (ED) attendances when compared with the previous year, with a 2.7% increase seen across the quarter. Following the 6% improvement in 4hr performance from January to February 2019 (70% - 76%) there was a slight dip in performance during March (73%), however improvements to processes continue to be made, building towards longer term sustainable success, and performance was improved from 71% reported in March 2018.

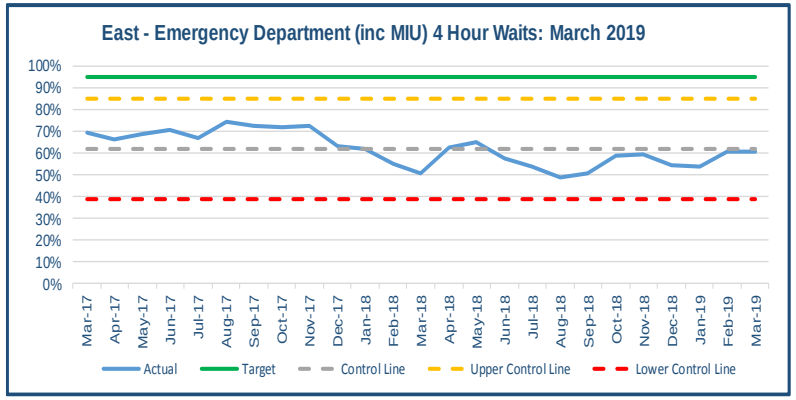
A formal evaluation of the progress chaser role is currently underway, with early feedback that the role has proved beneficial in supporting the team and providing a strong link for the Nurse in Charge and the Medical Team Leader. Whilst the funding provided did not allow the service to be 24/7 as desired, it is anticipated that with sustainable funding that this could become a critical enabler to improving flow within the department and expediting clinical decision making.

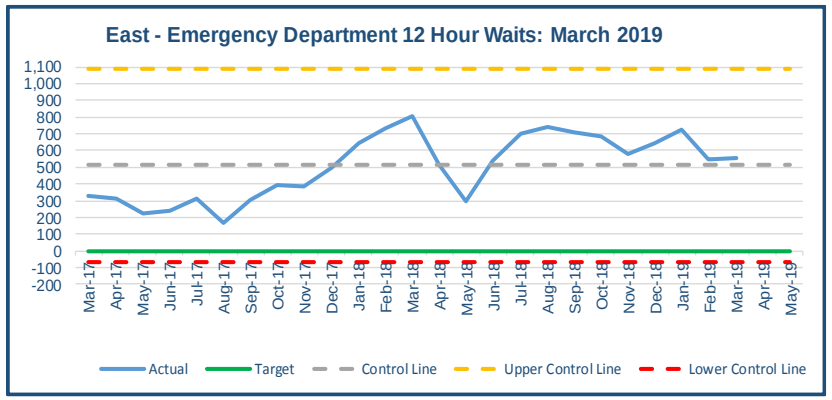
More broadly, the ED team are continuing to progress the development of their new START model (Streaming, Triage, Ambulance Assessment & Rapid Treatment Team). This concept pulls together some existing programmes of work into a more co-ordinated clinical approach that ensures all patients have the best start to the their care.

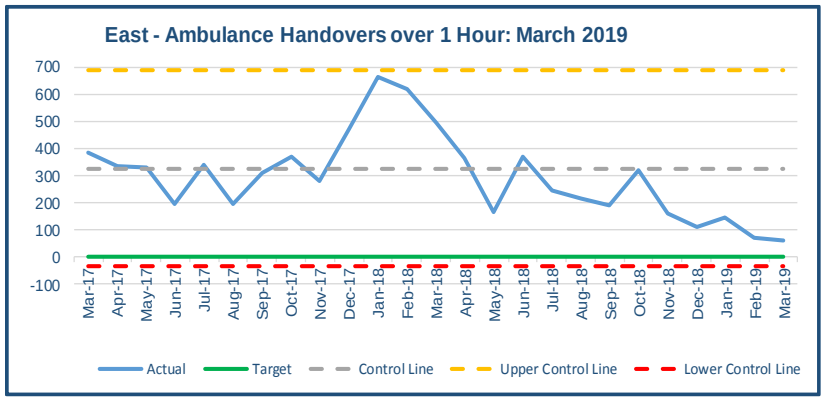
This work is being integrated into our wider Emergency Quadrant (EQ) redesign group, in order to ensure that all interdependencies are understood and that this also aligns with key work around the development of ambulatory care. A key stakeholder event has been arranged by the Site Medical Director for the 1st May, with a task & finish group meeting weekly to prepare, with a recognition that the answer to the challenge lies in longer term transformational change as opposed to incremental improvements.

Chapter 2 – Unscheduled Care

ED & MIU - East







Actions and Outcomes - East Health Economy

- After a better start to the month (first 7 days delivering a combined performance of 71.87%), performance slipped and the month ended with 56.28% ED only and 60.58% combined 9including Minor Injuries Units). On a positive note this compares to 50.44% (type 1 only) and 55.92% (combined) delivered in 2018.
- Minor Injuries contributions had historically averaged between 17-18 per day, which is significantly lower compared to West and Central. This number has improved in the last two weeks of March to an average of 22 patients per day.
- Whilst we have seen a step change of 5% improvement in February & March 2019, there are three key components of work required to make the next significant step change on the site:
- Continued review of MIU capacity / geography to redirect appropriate patients from the ED flow
- Acute medical model / ambulatory care model with workforce redesign to ensure that we assess patients by senior decision makers and appropriately admit
- Ensure that all patients appropriate to be discharged at weekends are reviewed and supported to be discharged

Chapter 3b – Unscheduled Care

Delayed Transfers of Care

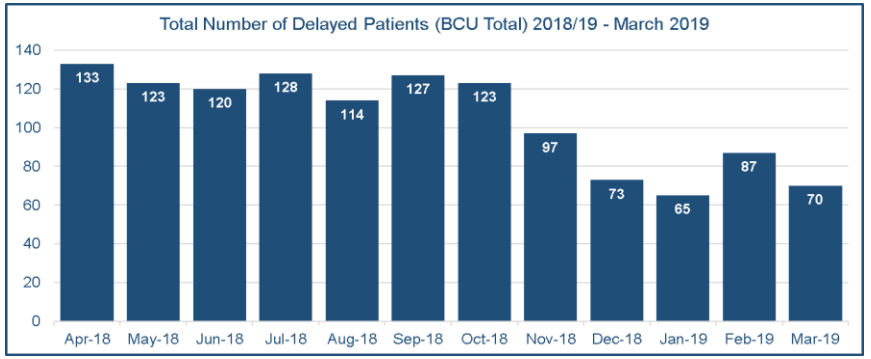
DFM 031	Delayed Transfers of Care(DToC): Rolling 12 months - Number of non-Mental Health	Target <= 1,030	Plan	Mar-19	1,114	Wales Benchmark	7th	Executive Lead	Deborah Carter	Status	↑	Months in Exception	6+
LM 031A	Delayed Transfers of Care (DToC): Non-Mental Health Number of Patients in Month	Target <= 133	Plan	Mar-19	70	Wales Benchmark	N/A	Executive Lead	Deborah Carter	Status	↑	Months in Exception	6+
LM 031B	Delayed Transfers of Care (DToC): Non-Mental Health Bed days	Target <= 2,089	Plan	Mar-19	2,833	Wales Benchmark	N/A	Executive Lead	Deborah Carter	Status	↑	Months in Exception	6+

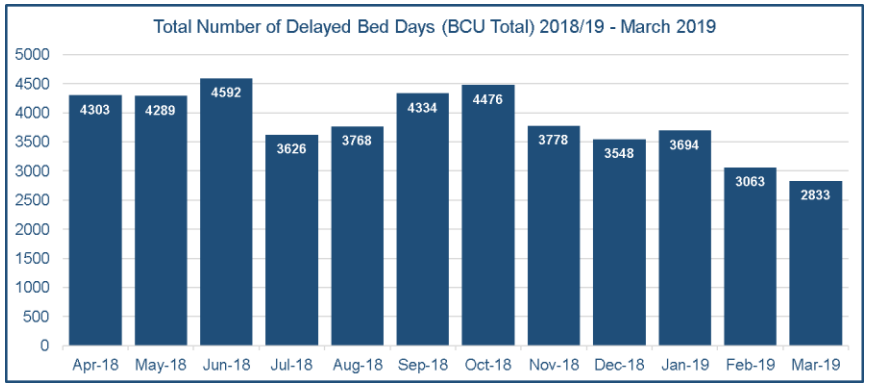
The majority of delays in the acute and community are due to placement and package of care;-

- Waiting General Nursing Home ,General Residential or EMI placement
- Waiting home care package- competency issues identified as now all carers have to be NVQ level 3 to administer medication via PEG

- In addition to weekly and pre-census DToC meetings where all patients are discussed and monitored.
- DToCs are scrutinised daily on site and discussed
- Delays in package of care are escalated to Senior management early.
- MFD's meetings are continuing weekly across all sites

- All above to Improve accuracy and early identification of potential DToC to decrease numbers and length of stay
- To improve early identification of training needs and competency





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Chapter 3b – Unscheduled Care

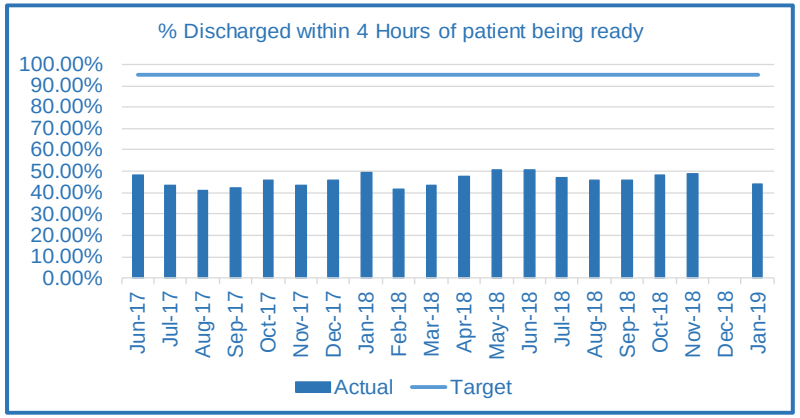
DToC: Critical Care

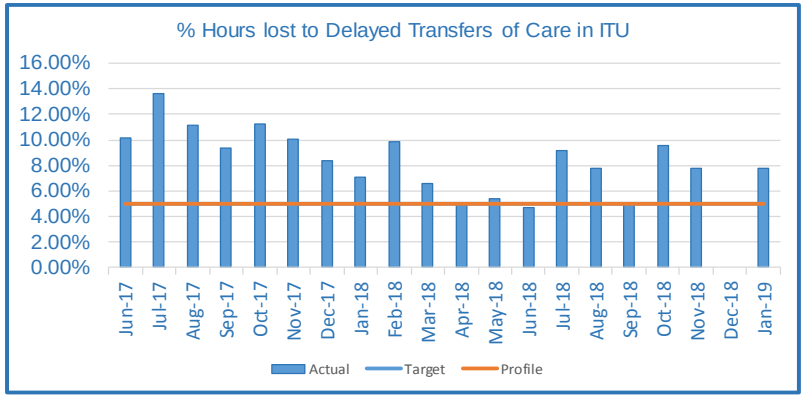
LM 131A	Delayed Transfers of Care (DToC): Critical Care - % hours lost due to ITU DToC	Target <= 5%	Plan <= 5%	Mar-19	7.81%	Wales Benchmark	N/A	Executive Lead	Deborah Carter	Status	↑	Months in Exception	6+
LM 131B	Delayed Transfers of Care (DToC): Critical Care - % Discharged within 4 Hours of patient being ready	Target >= 95%	Plan	Mar-19	49.10%	Wales Benchmark	N/A	Executive Lead	Deborah Carter	Status	↑	Months in Exception	6+

Actions
- Performance shared at each site Safety Huddle.
- 3 DToCs prioritised to ensure ICU “emergency bed”available.
- Unscheduled care workstreams ongoing across all 3 sites to improve overall site patient flow.

Outcomes
- Deterioration in January 2019 with both measures

Timelines
- YG: Increased Level 2 capacity (by one bed) up to end March 2019.
- YGC: Increased Level 2 capacity (by one bed) Mondays & Tuesdays (restricted due to staffing).
- WMH: Increasing Level 3 capacity (by one bed) up to end of March 2019.





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Chapter 3b – Unscheduled Care

Out of Hours

DFM 055	GP Out of Hours: Urgents triaged/assessed within 20 minutes	Target <= 95%	Plan	Mar-19	80.00%	Wales Benchmark	5th	Executive Lead	Chris Stockport	Status	↑	Months in Exception	6+
DFM 056	GP Out of Hours: Patients prioritised as Urgent seen within 60 minutes of initial clinical assessment	Target <= 95%	Plan	Mar-19	N/A	Wales Benchmark	N/A	Executive Lead	Chris Stockport	Status	N/A	Months in Exception	6+

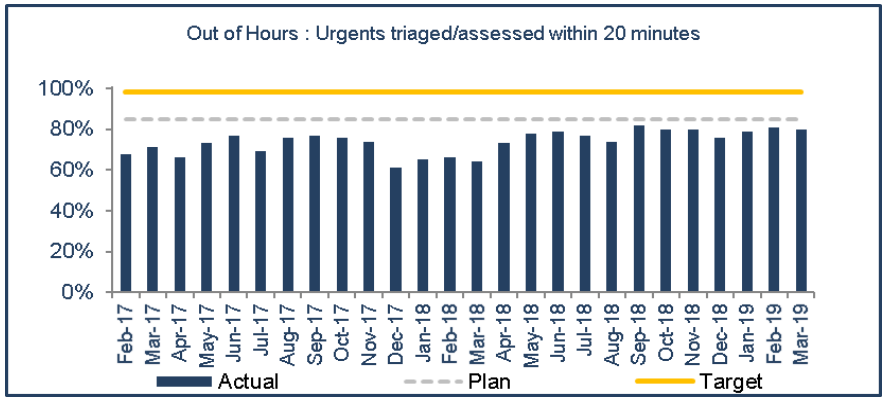
DFM055 Out of Hours: Urgent patients triaged/assessed within 20 minutes

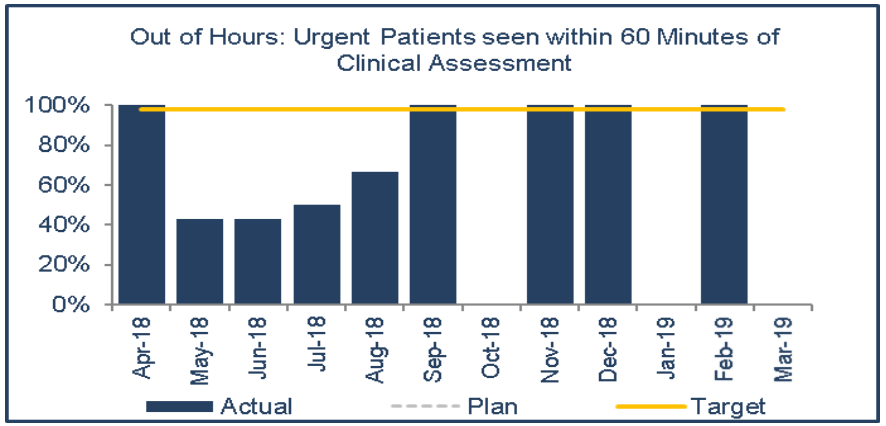
The GP OOH service received 11,703 calls in March 2019 compared to 12,741 calls in March 2018 – a decrease of 1,038 calls (8%). 99% of triage nurse shifts were filled in March 2019 (compared to 98% in February 2019) and 86% of calls assessed as being URGENT were triaged within the 20 minutes performance standard compared to 81% in February 2019. We still have a few triage nurses that are relatively new to the service and we should therefore see an improvement in our performance against this standard over the next 3 months. We are currently carrying a vacancy of 0.83 wte Triage Nurses and adverts will be placed on NHS Jobs later this month.

DFM056 Out of Hours: VERY URGENT patients seen within 60 minutes of initial clinical assessment

For the Month of March 2019:

- There were no VERY URGENT (within 60 minutes) Base Appointments in March 2019.
- There were no VERY URGENT (within 60 minutes) Home Visit in March 2019.





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Chapter 3b – Unscheduled Care

Stroke Care

DFM 063	Stroke Care: % of stroke patients who have a direct admission to an acute stroke unit within 4 hours	Target >= 58%	Plan	Mar-19	50.00%	Wales Benchmark	6th	Executive Lead	Deborah Carter	Status	↓	Months in Exception	6+
DFM 064	Stroke Care: Thrombolysed patients with a door to needle (DTN) time <= 45 minutes	Target Improve	Plan	Mar-19	7.70%	Wales Benchmark	4th	Executive Lead	Deborah Carter	Status	↓	Months in Exception	6+
DFM 065	Stroke Care: % of stroke patients who receive a CT scan within 1 hour	Target >= 52%	Plan	Mar-19	40.70%	Wales Benchmark	6th	Executive Lead	Deborah Carter	Status	↑	Months in Exception	6+
DFM 066	Stroke Care: % patients with suspected stroke seen a stroke specialist consultant within 24 Hours	Target >= 84%	Plan	Mar-19	81.30%	Wales Benchmark	5th	Executive Lead	Deborah Carter	Status	↓	Months in Exception	6+

Actions:

Access to the Acute Stroke Unit (ASU) in March 2019 saw a 5% deterioration across BCU. Ysbyty Glan Clwyd (YGC) and Ysbyty Gwynedd (YG) both saw a deterioration with Wrexham showing a continuous improvement. Whilst all 3 Sites continue to be challenged with USC pressures which affects the availability of the ASU bed, this is having the biggest impact at YGC and YG. There is to be increased focus at the Safety Huddles and greater emphasis with the Site management Team on retaining 2 ring fenced beds each day.

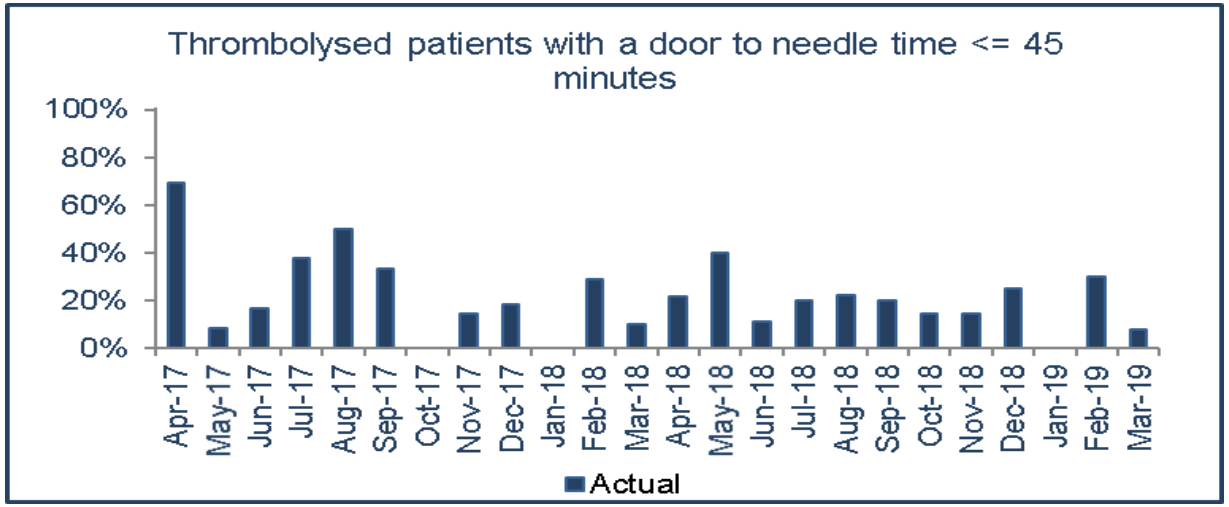
There was a good improvement in the number of patients Thrombolysed in YG and Ysbyty Wrecsam Maelor (YWM). Although YGC had 0%, breach analysis would suggest that this was not due to missed opportunities but patients not appropriate. Door To Needle (DTN) time of 45 minutes has deteriorated with YWM being the only site to achieve any within this time. There is an action plan being developed at all 3 Sites to improve performance following the recent WG DU All Wales review.
In YWM a Rapid Computerised Tomography (CT) Pathway has been developed to improve the 1 hour CT performance and this is being shared across BCU. In Hours with the Clinical Nurse Specialists (CNSs) now Non Medical Requesters the performance has improved, the issue remains out of hours with slow requesting of CTs by Emergency Department (ED) Teams often due to the pressures within the department for other patients. The Action Plans following the Thrombolysis reviews will address this.
Assessment by a Stroke Consultant will continue to vary each month as, out of hours this will only happen when they are On Call. There is a review of the options to introduce virtual wards using Telemedicine to take place over the next 3 months but this would require Job Plan changes and would impact on the GIM medical rotas across BCU.

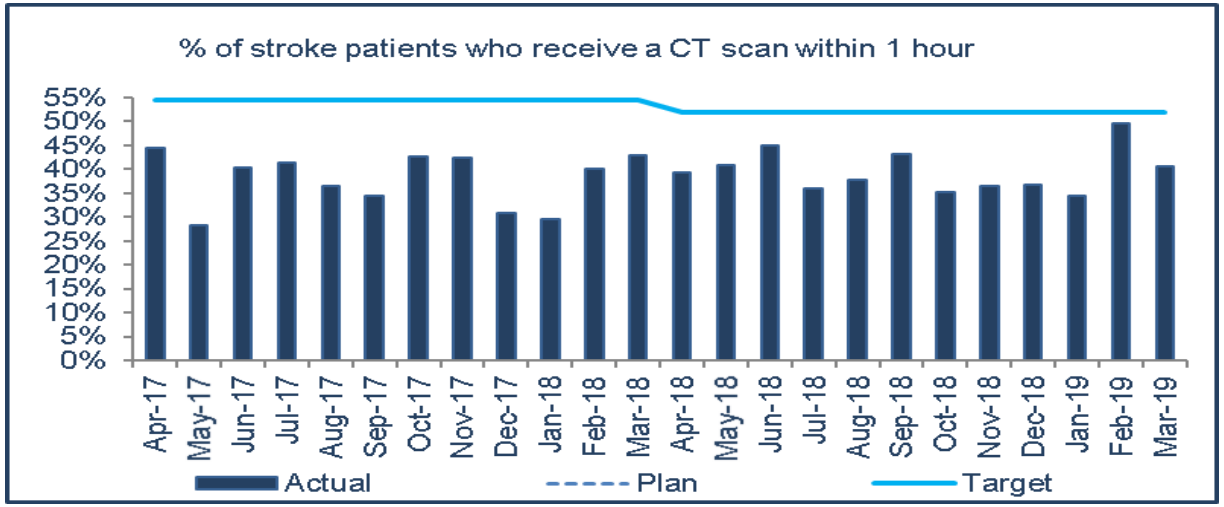
Outcomes:

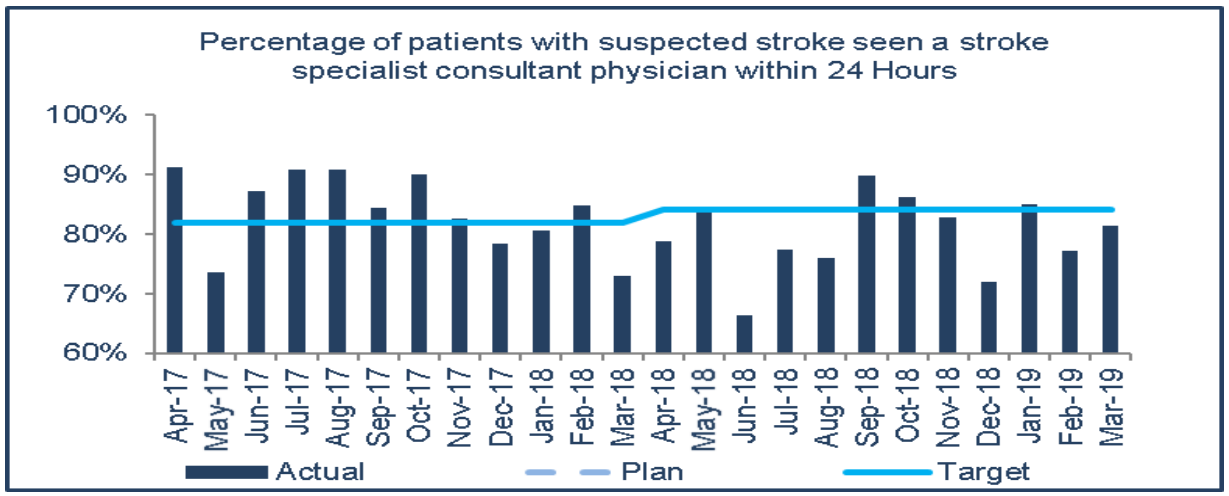
- Improvement in the 4 hour target, evidenced in month
- Improved pathways can be implemented following Review
- Improvement in 1 hr CT target

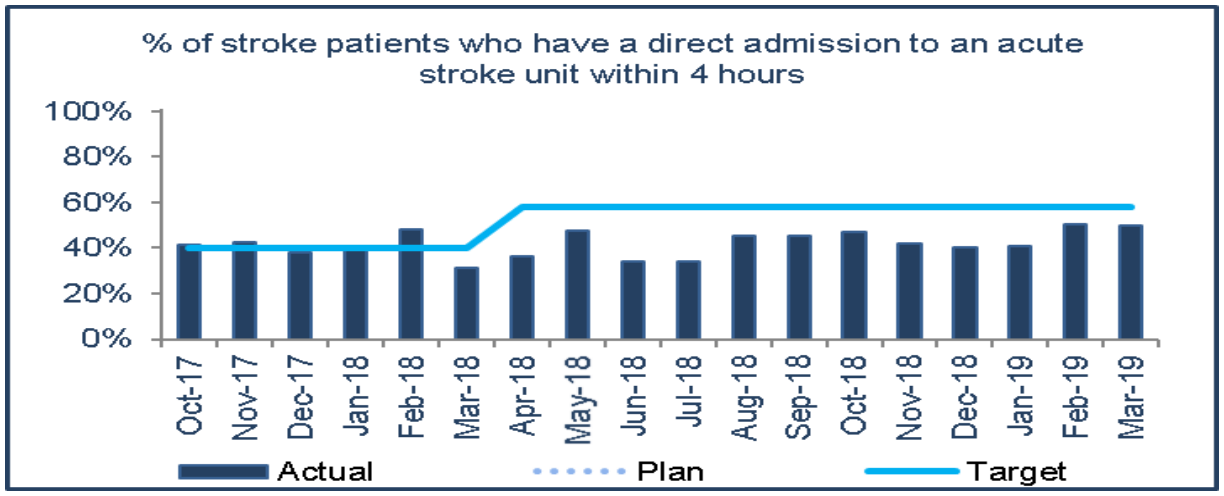
Chapter 3b – Unscheduled Care

Stroke Care - Graphs









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Chapter 5: Summary

Mental Health

Measure	Status		(Target)
MHM1a - Assessments within 28 Days	77.40%	↑	>= 80%
MHM1b - Therapy within 28 Days	67.06%	↑	>= 80%
MHM2 - Care Treatment Plans (CTP)	90.70%	↑	>= 90%
MHM3 - Copy of Agreed plan within 10 Days	100%	→	100%
Delayed Transfers of Care (DToC) Days Number Rolling 12 Months	192	↑	<= 194

Of the 5 Measures in this chapter, performance has improved for 4, and remained static for 1

LM 074A	% of assessment by the LPMHSS undertaken within 28 days of the date of referral: Adult	Target >= 80%	Plan	Feb-19	77.59%	Wales Benchmark	N/A	Executive Lead	Andy Roach	Status	↑	Months in Exception	6+
LM 075A	% of therapeutic interventions started within 28 days following an assessment by LPMHSS: Adult	Target >= 80%	Plan	Feb-19	75.00%	Wales Benchmark	N/A	Executive Lead	Andy Roach	Status	↑	Months in Exception	6+

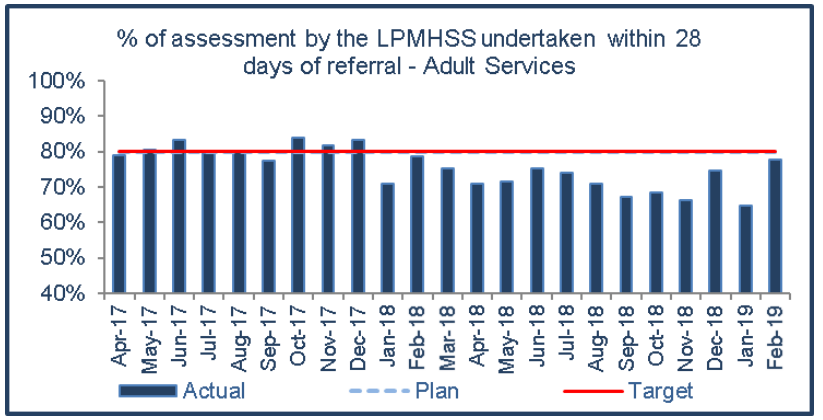
Actions:

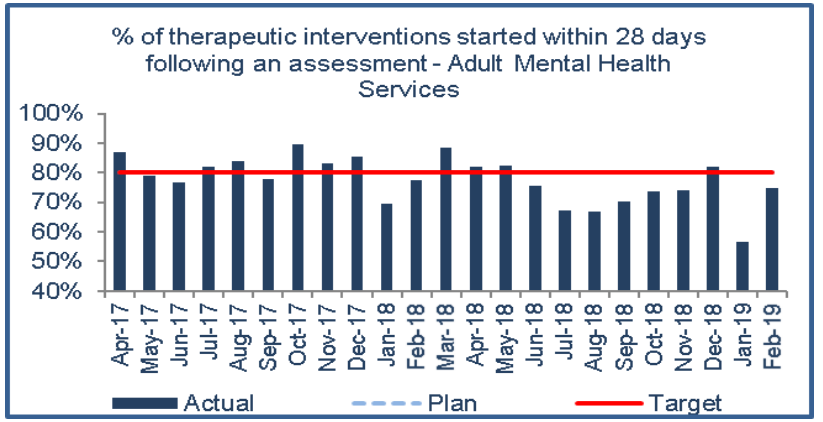
- Patients are treated in turn has been widely adopted which has impacted on performance and is clinically the right action for patients
- Timely weekly reporting direct to teams
- MHM Lead(s) supporting allocated area to increase focus on specific issues / actions plan
- Regular and timely data cleansing & validation
- Closer monitoring & scrutiny of referral activity
- Increased Senior Manager focus & support
- Clinical & Social care staff deployed to focus on areas performing below target
- Exploring other opportunities to respond to demand
- With the exception of East, STR workers are now in post and working through the interventions backlog identifying patients who still require interventions

Outcomes

- Further education
- Correct & validated information
- Teams timely informed and engaged
- Decreased waiting times
- Recruitment

Timelines: Whilst the Division expects to meet the target, the deep dive interventions in relation to the percentage of patients who are assessed and discharged with no therapeutic intervention; means the solution to target achievement is a complete service transformation for this identified group. Timescales will be agreed dependant on pilot opportunities with Primary Care. The Division have twinned with Cardiff & Vale who have already progressed this approach.





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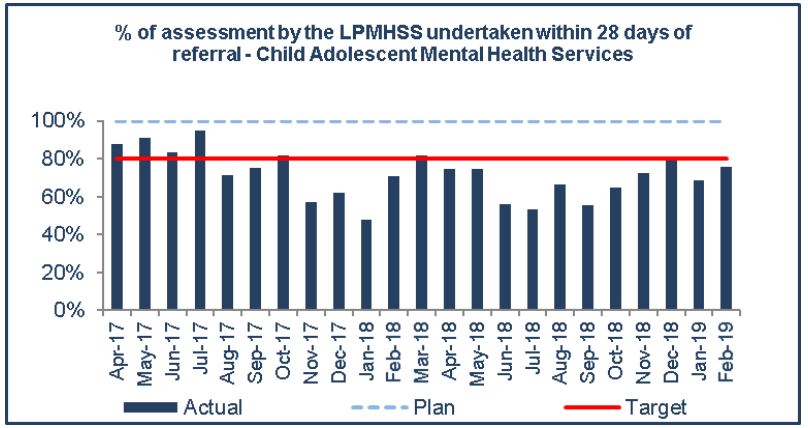
LM 074B	% of assessment by the LPMHSS undertaken within 28 days of the date of referral: CAMHS	Target >= 80%	Plan	Feb-19	75.53%	Wales Benchmark	N/A	Executive Lead	Theresa Owen	Status	↑	Months in Exception	6+
LM 075B	% of therapeutic interventions started within 28 days following an assessment by LPMHSS: CAMHS	Target >= 80%	Plan	Feb-19	36.05%	Wales Benchmark	N/A	Executive Lead	Theresa Owen	Status	↑	Months in Exception	6+

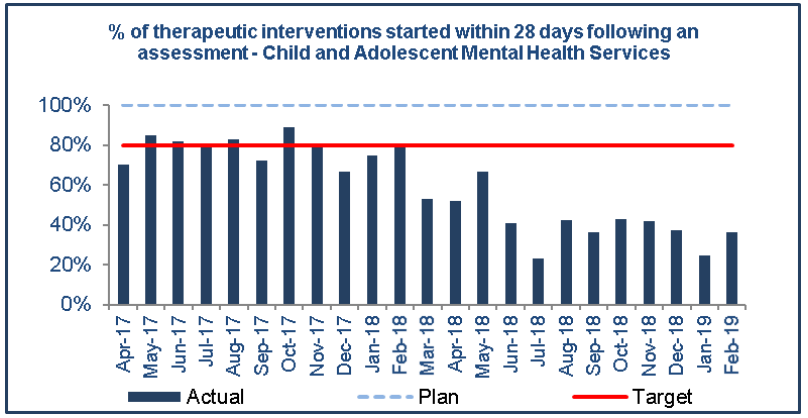
Actions:

- Recruitment day planned for 11th May
- Weekly demand and capacity meetings being held, all teams job planned in accordance with CAPA
- All urgent referrals are assessed within 12 – 24 hours, target is 48 hours.
- Management of long term sickness due to serious illness in Central area
- Planning commenced for implementing the Parliamentary Review Transformation bid focussed on children and young people on the Edge of Care or who are Looked After
- Recurrent Psychological Therapies funding secured – training arranged

Timelines Based on current demand and current/known capacity:

- West: Assessment targets will be maintained. Therapy targets will be met in April 2019
- Central: Assessment targets and Therapy targets will require recruitment to the vacancies, cover for sickness and an additional investment of 6 WTE to meet the current demand during 2019.
- East: Assessment targets will be maintained, Therapy targets will be met in March 2019. Forecasts assume no significant increases in demand or reduction in capacity.





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Chapter 5 – Mental Health

Care Treatment Plan

DFM 085	% of LHB residents (all ages) to have a valid CTP completed at the end of each month	Target >= 90%	Plan >= 90%	Feb-19	90.70%	Wales Benchmark	3rd	Executive Lead	Andy Roach	Status	↑	Months in Exception	6+
DFM 086	Service users assessed under part 3 to be sent a copy of the assessment in 10 working days	Target 100%	Plan	Feb-19	100%	Wales Benchmark	1st	Executive Lead	Andy Roach	Status	→	Months in Exception	N/A

Compliant for both Measures.

Actions

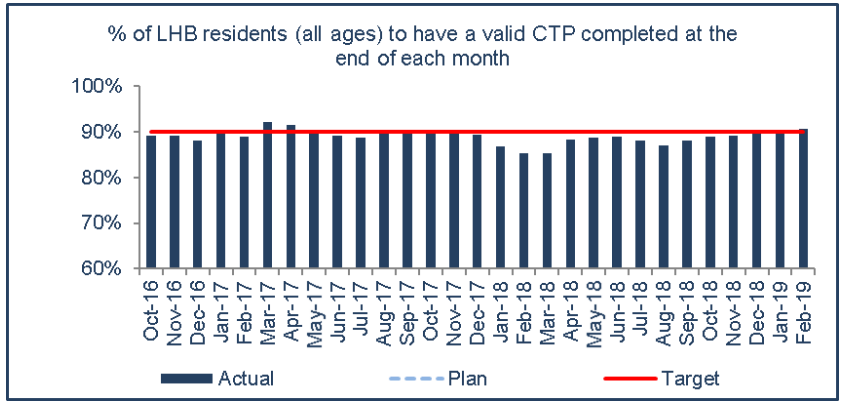
- Detailed & timely reports disseminated to teams and individual care coordinators.
- The Mental Health Measure Leads are aligned to local areas to improve performance and overall quality of services to patients.
- Regular data cleansing & caseload validation
- Close and regular monitoring of activity and compliance rates
- Developed and implemented local action plans to improve targets.

Outcomes

- Further education
- Correct & validated information
- Teams informed and engaged

Timelines

With sustained focus, the Division expects to maintain compliance



Chapter 5 – Mental Health

Delayed Transfers of Care (DToC)

DFM		Target	Plan			Wales		Executive			Months in
030	Delayed Transfers of Care(DToC): Rolling 12 months - Cumulative Number of Mental Health DToC	<= 194		Mar-19	192	Benchmark	6th	Lead	Andy Roach	Status	Exception 6+

The measure is the cumulative number of patients (of all North Wales residents) experiencing delays in transfers of care (DToC) in Mental Health

Actions

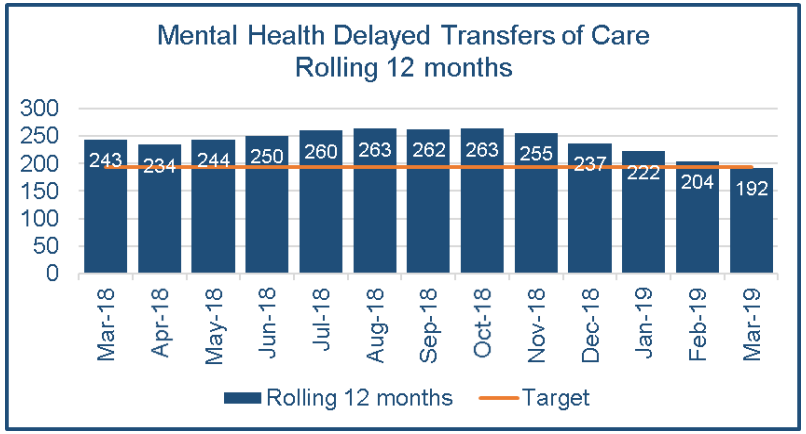
- Strengthened adherence to the DToC procedure across the Division
- DTOC processes have been streamlined and have effective high level scrutiny
- Discussion in the acute care / daily bed management calls / MDT meetings
- Scrutiny at weekly operational / area meetings lead by Heads of Operations
- Greater scrutiny and review
- Regular and timely reporting to Divisional Directors on DToC position
- Closer engagement with CHC and local authorities to address delays and improved accuracy of reporting DToC

Outcomes

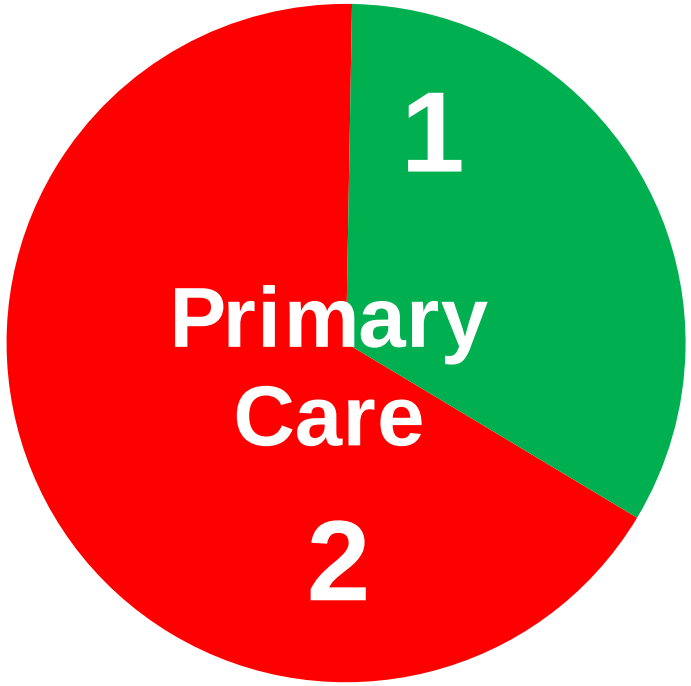
- Reduction in DToC sustained
- Tracked improvement
- Improved experience for patients and their families

Timelines

Actions are underway; process is in place to manage and sustain



Chapter 6: Summary: Primary Care



Measure	Status	(Target)
% GP practices open during daily core hours	92.50%	>= 91%
% GP practices open between 17:00 and 18:30	66.00%	>= 99%
% Population accessing NHS Dentists	49.30%	>= 50%

Key Performance Indicators for Primary Care are being developed and as soon as they have been agreed, they will be published here from May 2019 onwards.

DFM 053	% GP practices open during daily core hours or within 1 hour of daily core hours	Target >= 91%	Plan >= 91%	Q2 18/19	92.50%	Wales Benchmark	6th	Executive Lead	Chris Stockport	Status	↑	Months in Exception	6+
DFM 054	% GP practices offering appts between 17:00 and 18:30 everyday (Monday to Friday)	Target >= 99%	Plan >= 99%	Q2 18/19	66.00%	Wales Benchmark	7th	Executive Lead	Chris Stockport	Status	↑	Months in Exception	6+

Integrated Quality and Performance Report
Health Board Version

March 2019

Appendix A: 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

Health Board **2.5.19**	Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board ***To improve health and provide excellent care***

Report Title:	Finance Report Month 12 2018/19
Report Author:	Ms Sue Hill, Finance Director – Operational Finance
Responsible Director:	Mr Russell Favager, Executive Director of Finance
Public or In Committee	Public
Purpose of Report:	The purpose of this report is to provide a briefing on the financial performance and position of the Health Board for the year to date and forecast for the year, together with actions being undertaken to tackle the financial challenge.
Approval / Scrutiny Route Prior to Presentation:	This report is subject to scrutiny by the Finance and Performance Committee prior to submission to the Board.
Governance issues / risks:	This report does not impact on Governance issues or risks.
Financial Implications:	The Health Board approved an Interim Financial Plan on the 28th March 2018 which would deliver a deficit budget of £35.0m after delivery of £45.0m savings, £22.0m of which were cash releasing. The Health Board's forecast deficit was increased at Month 9 to £42.0m to reflect the significant risks around the underperformance of savings plans and cost pressures around Continuing Healthcare (CHC) and Mental Health. At the end of Month 12 the draft unaudited position for the Health Board is a £41.3m over spend. Of this, £35.0m relates to the Health Board's planned budget deficit and £6.3m represents an adverse variance against the financial plan. The plan for Month 12 was a £2.1m deficit. The actual position was £4.8m, £2.7m higher than plan. The key reasons for the in-month over spend are outlined below. - Under delivery against savings plans across most divisions (£0.9m). - RTT funding clawback (£1.0m), based on activity shortfall (216). - Over spends on CHC (£1.0m) and pay (£0.4m). - Offsetting under spends seen in contracts (£0.6m). The draft unaudited performance for 2018/19 was £0.7m better than had been forecast at Month 11. The positive variance relates to

	reduced expenditure on CHC and Secondary Care compared to what had been forecast. In total, the Health Board received £19.5m funding for additional activity to reduce the long waiting lists this year. £11.3m had been received from Welsh Government for activity up to the end of October, and an additional £8.2m was received in March relating to the second half of the year. However during April, there was a clawback of £1.0m of this funding by Welsh Government as waiting times did not meet the requirement. The clawback related to the final confirmed activity level of 5,916, against a target of 5,700. Savings achieved for 2018/19 are £38.3m against a plan of £45.0m, £6.7m behind the full year target and representing delivery of 85.1%.
Recommendation:	It is asked that the report is noted, including the draft unaudited financial position of £41.3m.

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

7.To listen to people and learn from their experiences			
Special Measures Improvement Framework Theme/Expectation addressed by this paper Costs associated with implementing improvements arising from Special Measures are included within departmental budgets.			
Equality Impact Assessment Not applicable.			

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

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Executive Director of Finance Report Month 12 2018/19

Russell Favager

Executive Director of Finance
Betsi Cadwaladr University Health Board

1. Executive Summary

1.1 Purpose

- The purpose of this report is to outline the financial position and performance for the year to date, confirm performance against financial savings targets and highlight the financial risks and outlook for the remainder of the year.

1.2 Summary of key financial targets

Key Target		Annual Target	Year to Date Target	Year to Date Actual	Achievement
Achievement against Revenue Resource Limit	£000	(35,000)	(35,000)	(41,279)	
Performance against savings and recovery plans	£000	45,000	45,000	38,348	
Achievement against Capital Resource Limit	£000	49,408	49,408	49,393	
Compliance with Public Sector Payment Policy (PSPP) target	%	95.0	95.0	95.0%	
Revenue cash balance (maximum)	£000	8,098	8,098	316	

1.3 Revenue position

- At the end of Month 12 the draft unaudited position for the Health Board is a £41.3m over spend. Of this, £35.0m relates to the Health Board's planned budget deficit and £6.3m represents an adverse variance against the financial plan.

- The plan for Month 12 was a £2.1m deficit. The actual position was £4.8m, £2.7m higher than plan. The key reasons for the in-month over spend are outlined below.

  - Under delivery against savings plans across most divisions (£0.9m).
  - RTT funding clawback (£1.0m), based on activity shortfall (216).
  - Over spends on CHC (£1.0m) and pay (£0.4m).
  - Offsetting under spends seen in contracts (£0.6m).

- The draft unaudited performance for 2018/19 was £0.7m better than had been forecast at Month 11. The positive variance relates to reduced expenditure on CHC and Secondary Care compared to what had been forecast.

- In total, the Health Board received £19.5m funding for additional activity to reduce the long waiting lists this year. £11.3m had been received from Welsh Government for activity up to the end of October, and an additional £8.2m was received in March

relating to the second half of the year. However during April, there was a clawback of £1.0m of this funding by Welsh Government as waiting times did not meet the requirement. The clawback related to the final confirmed activity level of 5,916, against a target of 5,700.

- Savings achieved for 2018/19 are £38.3m against a plan of £45.0m, £6.7m behind the full year target and representing delivery of 85.1%.

1.4 Balance sheet

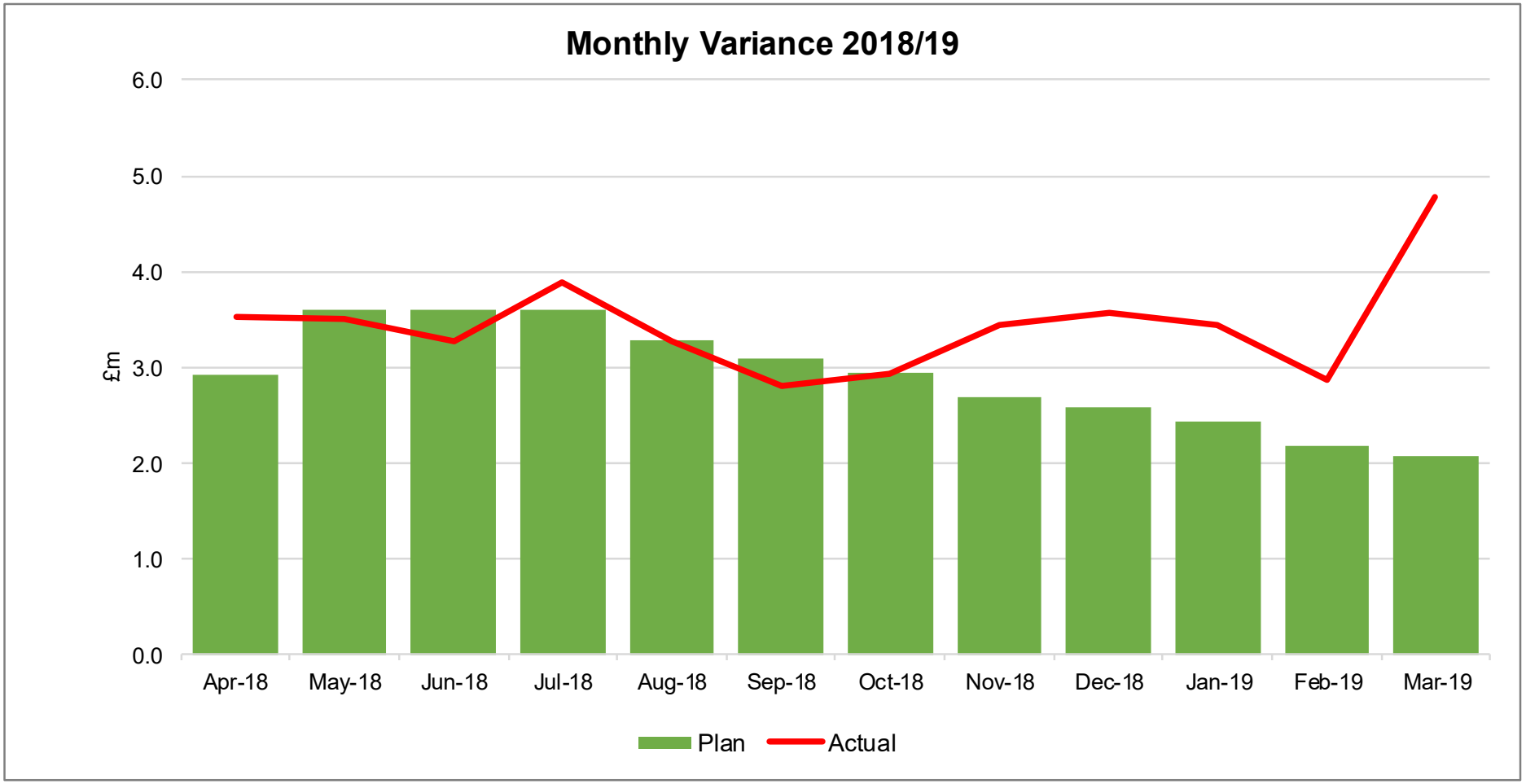
- The Capital Resource Limit for 2018/19 is £49.4m. Expenditure for the year was £49.4m meaning that the Health Board achieved its Capital Resource Limit in 2018/19.

- The Health Board is required to pay 95.0% of non-NHS invoices within 30 days of receipt of a valid invoice. Performance over the year has been variable, however the Health Board has met the required target with a 2018/19 compliance figure of 95.0%.

2. Revenue Position and Forecast

2.1 Health Board performance

- The Health Board's in-month reported position is £2.7m higher than planned, giving a year to date £6.3m adverse variance against the 2018/19 financial plan. The actual versus planned performance for the year is shown graphically below.



2. Revenue Position and Forecast

2.3 Financial performance by division

2018/19 Budget to Actual Variances	West £m	Centre £m	East £m	North Wales £m	Total £m	Commentary
Area Teams	0.8	(0.5)	1.4	(0.4)	**1.3**	Month 12 saw a £0.9m deterioration from February, with a £1.1m in-month over spend. Under delivery of savings has had a reduced impact this month, with £0.1m of unachieved savings contributing to the March position. Continuing Healthcare (CHC) is the key issue this month, worsening by £1.0m in March, with an in month over spend of £0.8m (£2.2m for the year). This primarily relates to the West Area. The total 2018/19 CHC over spend is partly offset by an under spend of £0.6m on Funded Nursing Care (FNC). Overall, there is a £0.3m under spend on pay in the month, with agency costs totalling £0.5m, slightly above the 2018/19 average. Primary Care Prescribing is £0.3m over spent in March, whilst Secondary Care drugs have reduced giving rise to a £0.1m under spend in month.
Contracts				(3.8)	**(3.8)**	Contracts are reporting an under spend for the year of £3.8m, with a £0.6m favourable position in-month. The March position primarily relates to the local English contracts which are showing a £0.6m under spend (£0.2m over spent for the year). WHSSC is also under spent in the month by £0.2m, £4.5m for 2018/19. These have been counterbalanced by pressures on Non-Contracted Activity (NCA).
Secondary Care	0.4	2.8	3.2	0.5	**6.9**	The in-month over spend for the division is £0.1m, a decrease of £0.5m on the February position. Failure to achieve savings plans has been the significant issue once again this month, with £0.6m of the in-month over spend relating to non-delivery against savings targets (£4.2m for the year). Pay costs are over spent by £0.3m (£3.3m for 2018/19), a significant proportion of which relates to Wrexham and arises from high nurse agency usage. Agency costs in total have increased by £0.5m from Month 11, with a total spend of £2.4m (£21.4m for the year). Both medical and nurse agency costs have risen in March; medical by £0.3m from February, with an in month spend of £0.9m and nursing by £0.1m to a £1.3m spend for the month. Offsetting under spends have been seen in income and establishment costs.

2. Revenue Position and Forecast

YTD Budget to Actual Variances	West £m	Centre £m	East £m	North Wales £m	Total £m	Commentary
Mental Health				4.3	**4.3**	Mental Health is over spent by £0.9m in Month 12, with a total over spend of £4.3m for the year. CHC remains the key issue, with an in month over spend of £0.5m (£3.5m for the year). Savings plans have also under achieved, by £0.4m in the month. Drugs costs remained a pressure, with an adverse variance of £0.1m in the month, £0.7m for the year. Pay costs were balanced in the month (£1.5m over spent for the year). Agency spend for 2018/19 totalled £4.2m, partially offset by vacancies.
Corporate				(2.8)	**(2.8)**	The position for the year improved by £1.3m in Month 12, predominantly within Estates & Facilities. There have been improvements in Estates non-pay expenditure, utilities, rates rebates and gains from year-end stock takes for oil. The milder weather has allowed for lower utilities costs than previously forecast. There have also been lower than anticipated costs within Finance for systems costs (ESR) and within Director of Primary Care for CHC costs, as managed via the contract with Powys. Informatics costs have continued with the under spend trend in relation to slippage on staff recruitment on systems projects.
Provider Income				(1.0)	**(1.0)**	Over performance in income from Non Contracted Activity and Overseas Visitors offsets Road Traffic Act and Compensation Recovery Unit income shortfalls.
Other				1.4	**1.4**	Other budgets include Reserves, Losses, Medical Education, R&D and Capital Charges.
Variance from Plan	**1.2**	**2.3**	**4.6**	**(1.8)**	**6.3**	
Planned Deficit					**35.0**	
Total					**41.3**	

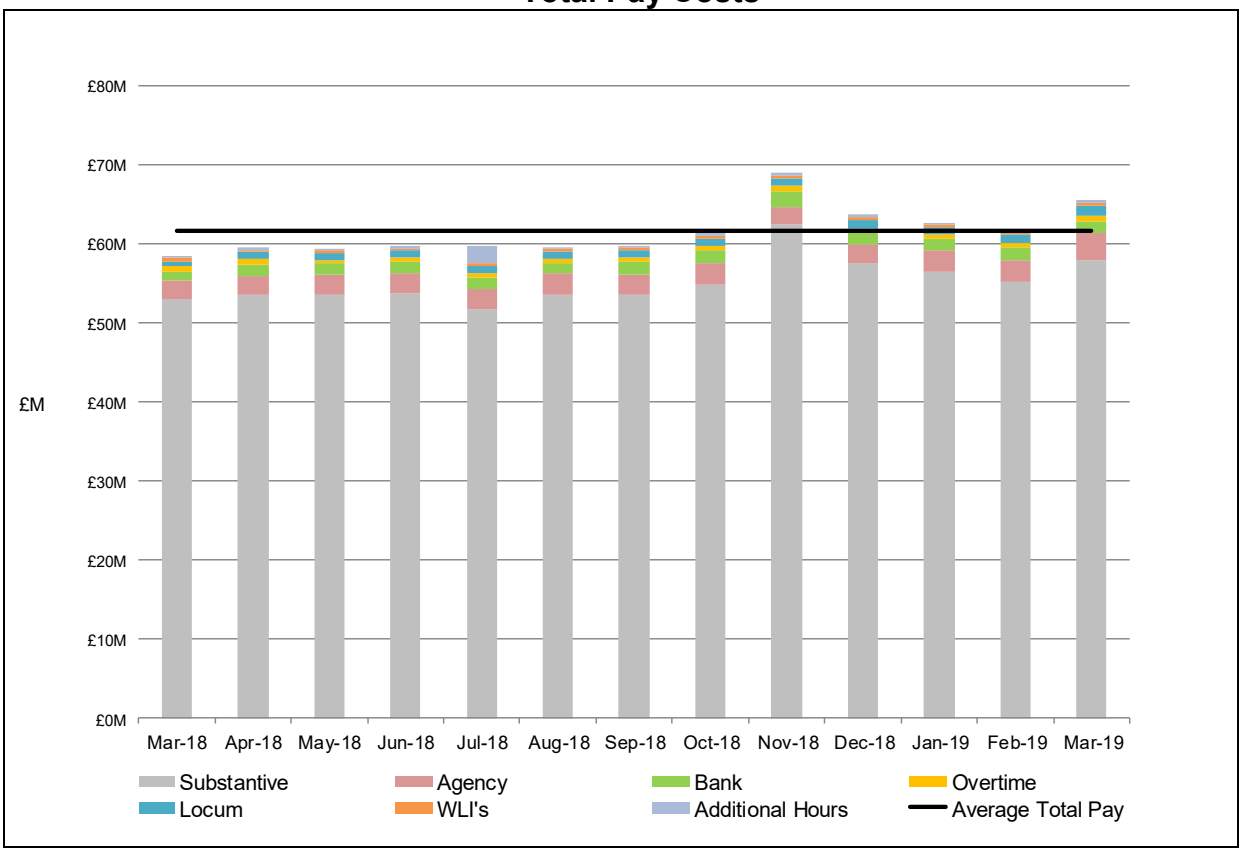
2. Revenue Position and Forecast

2.5 Pay

- Total Health Board pay (excluding Primary Care functions) is £721.5m, which is an under spend against plan of £1.7m.

- March's pay expenditure has increased by £3.7m from the previous month. The majority of this increase relates to an accrual for holiday pay entitlement linked to overtime and additional hours worked (£1.8m), combined with an increase in agency spend and additional work funded through RTT.

Total Pay Costs

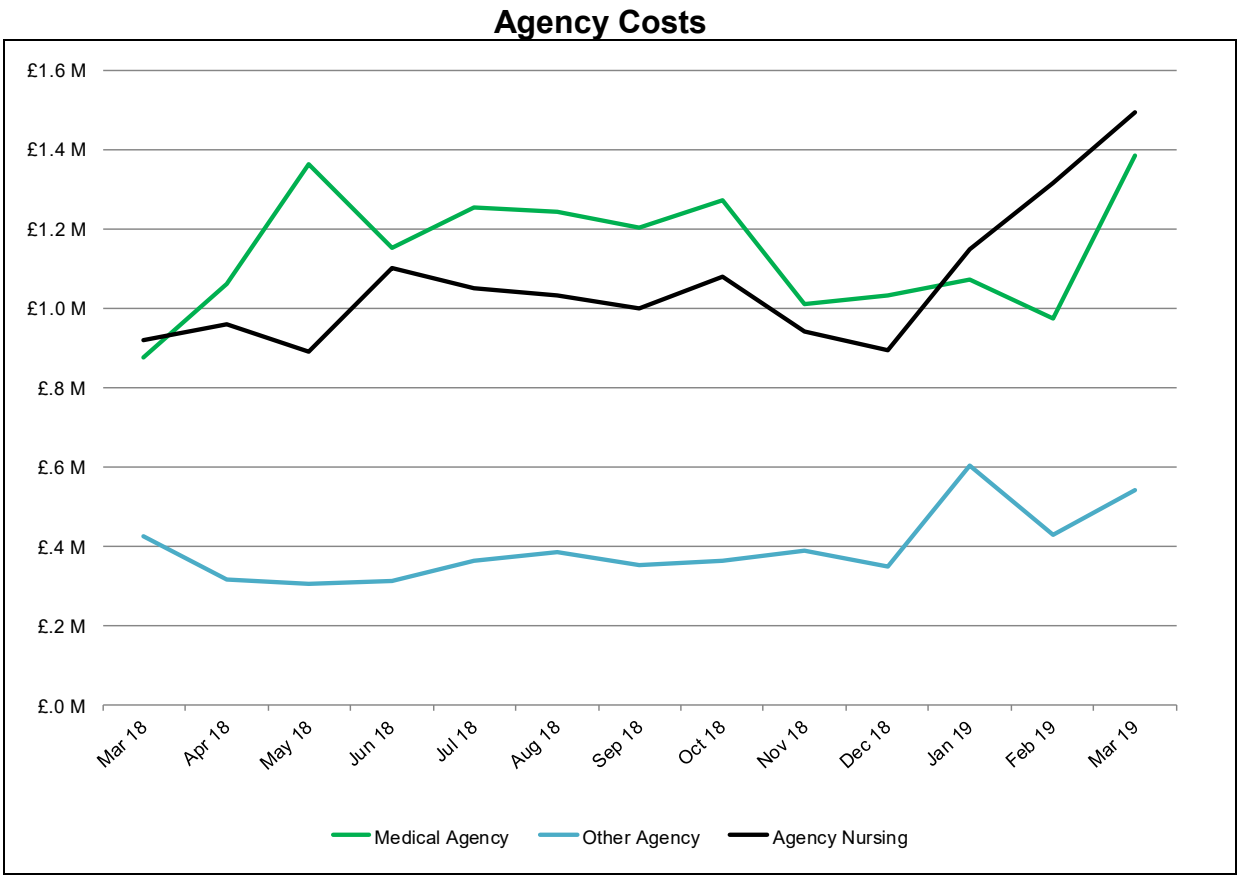


- Expenditure on agency staff for Month 12 is £3.4m, representing 5.2% of total pay, an increase of £0.7m on February. March saw the highest agency spend for the year as a whole, with total agency spend for 2018/19 amounting to £31.6m.

- Medical agency costs increased by £0.4m from February to an in-month spend of £1.4m. The areas primarily responsible are Ysbyty Glan Clywd (£0.4m), Ysbyty Gwynedd (£0.2m), Mental Health (£0.3m) and Women's Services (£0.2m) accounting for 78.7% of the month's spend. Spend on medical agency for 2018/19 totalled £14.0m.

- Nurse agency costs were £1.5m for the month, a £0.2m increase from the prior month. Agency nurses continue to support the sustained pressures arising from unscheduled care and provide cover for the large number of vacancies in Secondary Care. The use of agency nurses is particularly an issue for Wrexham (£0.9m in month) and Ysbyty Glan Clwyd (£0.4m in month), which together account for 86.7% of these costs in March (81.3% for the year). Spend on nurse agency for 2018/19 totalled £12.9m.

2. Revenue Position and Forecast



2.6 Non-pay

- Non-pay costs in Month 12 are £91.7m, an increase of £18.7m on the prior month. A large proportion of the rise is due to year-end adjustments, with £7.1m relating to an Intermediate Care Fund (ICF) accrual, matched off with Welsh Government income. A further £2.4m related to Continuing Healthcare (CHC), where £3.9m was for retrospective claims, £0.5m increased costs in Areas teams, plus £0.5m for Supreme Court and creditor provisions, offset by £2.3m creditor discounting. Additional spend arose from year end WHSCC contract adjustments (£4.1m), within General Medical Services (GMS) where the IM&T refresh invoice was higher than anticipated (£1.0m), again matched with funding, and increased drugs costs in Primary and Secondary Care (£1.7m).

- Total non-pay to-date is £894.2m giving a cumulative over spend of £13.0m against the planned budget.

- The over spend is largely driven by CHC (£5.1m), Primary Care drugs (£3.2), Clinical and General Supplies (£2.0m), Secondary Care drugs (£1.7m) and transport and travel costs (including Non-Emergency Patient Transport Service - NEPTS) (£1.3m), combined with slippage on savings schemes (£6.7m). These are offset by under spends in Primary Care (£5.3m) and Healthcare Services Provided by Other NHS Bodies (£5.6m), the latter of which incorporates the WHSCC contract.

3. Savings

3.1 Savings plans

- The financial plan set for the Health Board for 2018/19 identified a savings requirement of £45.0m to deliver a deficit budget of £35.0m; £22.0m of this was cash releasing.

- The total value of savings schemes delivered in year is £38.3m or 85.1% of the Health Board's £45.0m overall target, a shortfall of £6.7m. The shortfall in delivery is largely due to under-delivery on Mental Health (£2.5m), transactional (£1.8m) and workforce schemes (£2.2m), offset by over-performance on Medicines Management schemes (£2.5m).

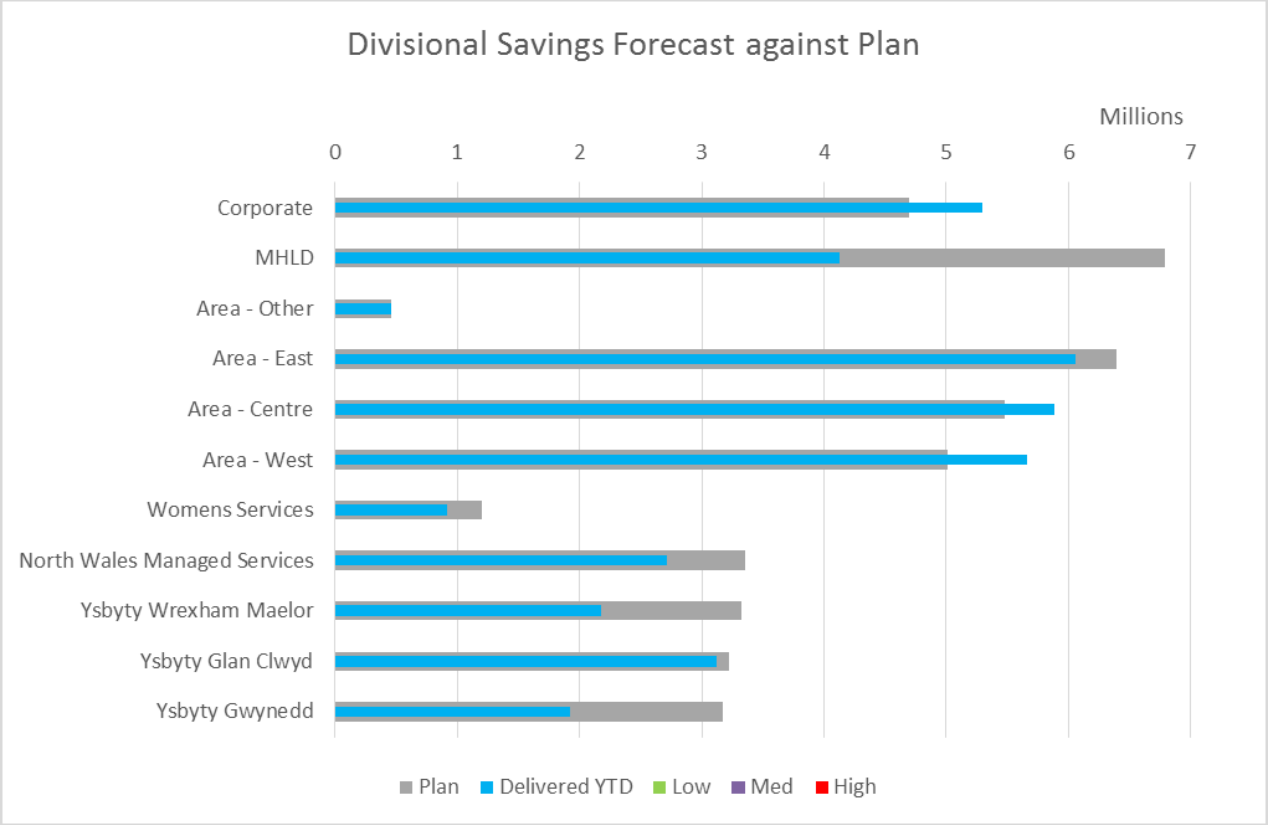
- The final outturn for 2018/19 was in line with the forecast year-end position reported in Month 11.

- The Table below presents the savings plans by division and risk rating.

2018/19	Savings Target	Savings Identified	Excess / (deficit) of savings identified	YTD Plan (£45m)	YTD Delivered	Variance	Rest of Year Delivery	Forecast Delivery	Forecast Risk Rating			
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	Action YTD £'000	Low £'000	Med £'000	High £'000
Ysbyty Gwynedd	3,172	3,172	0	3,172	1,928	(1,244)	0	1,928	1,928	0	0	0
Ysbyty Glan Clwyd	3,738	3,220	(517)	3,764	3,121	(643)	0	3,121	3,121	0	0	0
Ysbyty Wrexham Maelor	3,322	3,322	0	3,322	2,179	(1,142)	0	2,179	2,179	0	0	0
North Wales Managed Services	3,581	3,357	(224)	3,593	2,713	(880)	0	2,713	2,713	0	0	0
Womens Services	1,198	1,198	0	1,198	921	(277)	0	921	921	0	0	0
Secondary Care Divisional	70	0	(70)	0	0	0	0	0	0	0	0	0
Secondary Care	**15,080**	**14,269**	**(811)**	**15,048**	**10,863**	**(4,186)**	**0**	**10,863**	**10,863**	**0**	**0**	**0**
Area - West	5,012	5,012	(0)	5,012	5,661	649	0	5,661	5,661	0	0	0
Area - Centre	5,474	5,474	0	5,474	5,885	411	0	5,885	5,885	0	0	0
Area - East	6,395	6,395	(0)	6,395	6,058	(337)	0	6,058	6,058	0	0	0
Area - Other	458	458	0	458	458	0	0	458	458	0	0	0
Area Teams	**17,339**	**17,339**	**(0)**	**17,339**	**18,062**	**723**	**0**	**18,062**	**18,062**	**0**	**0**	**0**
MHLD	7,594	6,790	(804)	7,614	4,123	(3,491)	0	4,123	4,123	0	0	0
Corporate	4,987	4,692	(295)	4,998	5,300	302	0	5,300	5,300	0	0	0
Divisional Total	**45,000**	**43,090**	**(1,910)**	**45,000**	**38,348**	**(6,652)**	**0**	**38,348**	**38,348**	**0**	**0**	**0**

3. Savings

3.2 Savings performance by division



3.3 2019/20 Savings Plans

- The 2019/20 planned savings were presented to the Board at the end of March 2019, alongside the budget for the year ahead.

- Work has continued with Directorates and Divisions to develop robust project plans for the identified schemes. Quality and Equality are being developed and schemes are being entered onto the project management system when they have been risk rated, against the Finance Delivery Unit guidance, as green or amber and have a clear project plan. Work is ongoing to progress red pipeline schemes into a green or amber status so that they can be included in the plan.

- The Health Board has developed an Improvement Programme, which will be in place from the beginning of April 2019. The Executive Team has approved an organisation and governance structure proposal for improvement. This outlines the Executive lead for each of the improvement themes, along with the structure, objectives and scrutiny these will have to provide the assurance for delivery.

- The Board has approved enhanced monitoring arrangements for the savings programmes from 2019/20 by establishing a sub-group of the Finance and Performance Committee. The membership will comprise of an Independent member, Executive and Director and will be chaired by the Chief Executive. The first of regular monthly meetings will be held in April 2019.

4. Balance Sheet

4.1 Cash

- The closing cash balance as at 31st March 2019 was £4.0m which included £3.7m of cash held for capital expenditure. The revenue cash balance of £0.3m was within the internal target set by the Health Board.

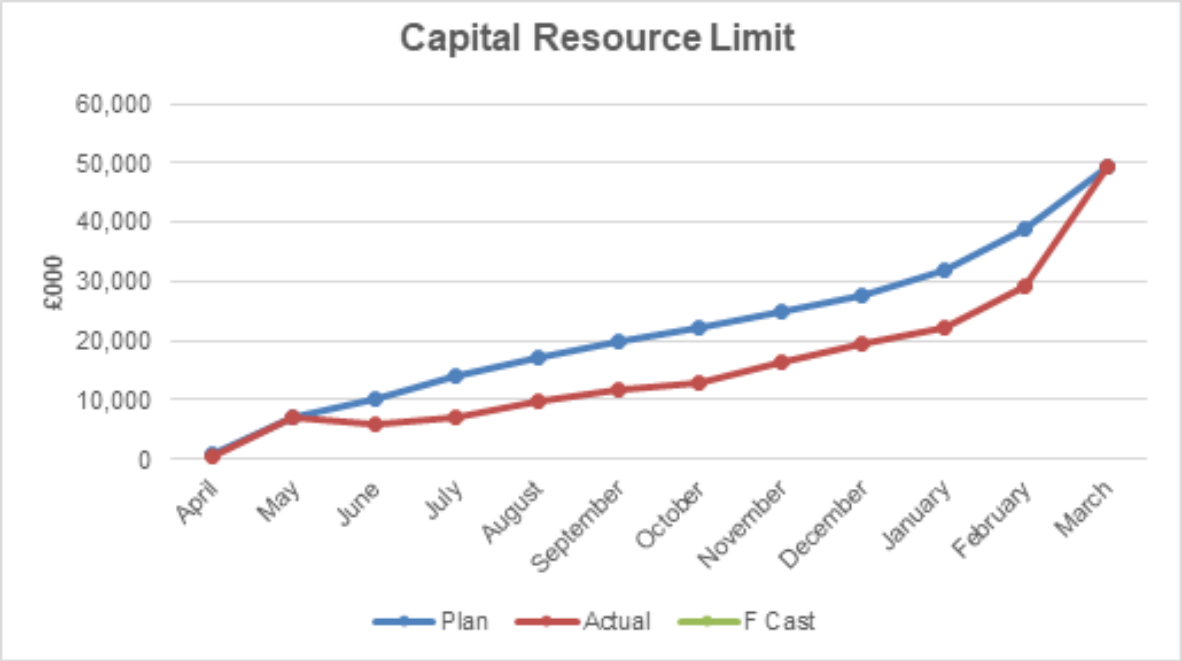
4.2 Accounts payable

- The Health Board is required to pay 95.0% of non-NHS invoices by number within 30 days of receipt of a valid invoice. Performance over the year has been variable, however the Health Board has met the required target with a 2018/19 compliance figure of 95.0%.

4.3 Capital expenditure

- The Capital Resource Limit for 2018/19 is £49.4m. There has been significant investment in a number of key projects including the YGC redevelopment, the SuRNICC, the redevelopment of the Emergency Department in YG, the Substance Misuse Elms development, the MRI scanner and the Hybrid Theatre in YGC. In addition, the Health Board has received allocations for upgrades across the Health Board estate and IT.

- Expenditure for the year was £49.4m meaning that the Health Board achieved its Capital Resource Limit in 2018/19.



5. Conclusions and Recommendations

5.1 Conclusions

- The Health Board's forecast was increased from a deficit of £35.0m to £42.0m in Month 9, following discussions with the Accountable Officer and Chairman. The increased forecast reflected the significant risks that the Health Board faced around delivery of the planned savings and increased activity and cost pressures for Mental Health and CHC.

- At the end of Month 12 the draft unaudited position for the Health Board is a £41.3m over spend, £0.7m below the forecast. Of this, £35.0m relates to the Health Board's planned budget deficit and £6.3m represents an adverse variance against the financial plan.

- The draft unaudited performance for 2018/19 was £0.7m better than had been forecast at Month 11. The positive variance against this forecast relates to reduced expenditure on CHC and Secondary Care.

- During March, the significant issues contributing to the over spent position were under delivery against savings plans across most divisions (£0.9m), over spends on CHC (£1.0m) and pay (£0.4m) and the RTT funding clawback (£1.0m) based on activity shortfall of 216, offset by under spends in contracts (£0.6m).

- Savings delivered £38.3m of the £45.0m Health Board target, a shortfall of £6.7m. Non-achievement of the savings targets had a detrimental effect on the Board's financial performance for the year.

- In total, the Health Board received £19.5m funding for additional activity to reduce the long waiting lists this year. £11.3m had been received from Welsh Government for activity up to the end of October, and an additional £8.2m was received in March relating to the second half of the year. However during April, there was a clawback of £1.0m of this funding by Welsh Government as waiting times did not meet the requirement. The clawback related to the final confirmed activity level of 5,916, against a target of 5,700.

- There are a number of critical financial risks which are being carried forward and will need to be carefully managed in 2019/20, including:

  - Individual Packages of Care.
  - Pay costs, particularly agency costs associated with waiting times and performance.
  - The need to develop and deliver savings schemes which move from the historical one year transactional type schemes to more transformational ones necessary to deliver medium term financial sustainability.

- The issue of the potential significant financial impact of English Tariff Changes on WHSSC commissioned services has not been concluded and remains a risk going into 2019/20.

- The turnaround methodology and approach implemented within the Health Board is critical to improving financial performance going into 2019/20 and in future

years. Welsh Government's investment in turnaround in is supporting the programme management of savings and transformation. The focus on savings delivery is being maintained throughout the organisation.

- The Health Board's annual accounts are being prepared in accordance with the timescales established by the Welsh Government and will be submitted by the deadline of 26th April 2018. The figures contained within this report remain draft, pending the completion of the audit review by the Wales Audit Office. The final position will be reported to the Audit Committee in May.

5.2 Recommendations

- It is asked that the report is noted, including the draft unaudited financial position of £41.3m.

Health Board **2.5.19**	GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board ***To improve health and provide excellent care***

Report Title:	Mental Health Assurance Report
Report Author:	Mr Steve Forsyth, Director of Nursing Mrs Lesley Singleton, Director of Strategy & Partnerships Mr Adrian Jones, Assistant Director of Nursing
Responsible Director:	Mr Andy Roach, Director, Mental Health and Learning Disabilities
Public or In Committee	Public
Purpose of Report:	To provide assurance around the updates for Mental Health and Learning Disability services, and provide evidence of the progress that is being made towards providing a safe, evidence based and quality service.
Approval / Scrutiny Route Prior to Presentation:	Divisional Directors
Governance issues / risks:	Number of Welsh Government reportable incidents that are overdue closure
Financial Implications:	Update combined within the report, financial controls met
Recommendation:	The Board are asked to note the contents of the report

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

communities - to achieve their own well-being			
5.To improve the safety and quality of all services	**x**	5.Considering impact on all well-being goals together and on other bodies	**x**
6.To respect people and their dignity	**x**		
7.To listen to people and learn from their experiences	**x**		
Special Measures Improvement Framework Theme/Expectation addressed by this paper Mental Health			
Equality Impact Assessment Not necessary this report is to provide assurance to the Board on actions being undertaken within the MHLD			

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

INDEX

1. PURPOSE

This paper provides an update on the development and implementation of Betsi Cadwaladr University Health Board (BCUHB) Mental Health Learning Disability Division's (MHLD) Strategy and Quality Improvement and Governance Plan (QIGP), which is a specific requirement of the Special Measures Improvement Framework (SMIF). The purpose of this paper is to provide assurance to the Health Board that ongoing progress is being made within the Mental Health and Learning Disabilities Division. In particular, there will be key updates on the "Together for Mental Health" Strategy, the Quality Improvement and Governance Plan, TODAYiCAN and external assurance HIW actions.

The paper will detail the progress against meeting the following objectives:

- Working to prevent mental health crises by focusing on early intervention and promoting emotional resilience
- Developing local alternatives to admission: crisis cafes, sanctuaries, strengthened home treatment services, step-down services
- Reviewing and improving the routine processes of bed management and patient flow
- Working with criminal justice service to divert demand arising from the police, via section 136 arrangements, street triage or control room-based mental health staff
- Working with voluntary and third sector agencies to review their role with people at risk of severe mental health crises
- The development of a clear plan for the future of our mental health services represents a significant step forward
- Reduce the number of detentions of people under s.136 of the mental health act
- Reduce the number of placements of local people outside North Wales

The document details improvements reported through to the Quality Safety Experience committee in March 2019 and the Public Accounts Committee March 2019. The paper sets out the intended methodology and implementation time scales to progress the MHLD Division from good to great. Appendix 1 provides the updated actions in the QIGP and Appendix 2 provides the 10 key themes for improvement that provides the stimulus for change across the Division. Appendix 3 provides an updated collection of achievement for the MHLD Division.

2. INTRODUCTION

Mental health services in North Wales are changing. The mental health strategy is focused on improving child and adult mental health, narrowing the gap in life expectancy, and ensuring parity of esteem with physical health, all of which is fundamental to unlocking the power and potential of communities across North Wales. Shifting the focus of care to prevention, early intervention and resilience and delivering a sustainable mental health system in North Wales requires simplified and strengthened leadership and accountability across the whole system. Enabling resilient communities, engaging inclusive employers and working in partnership with the third sector will transform the mental health and well-being of North Wales residents. Undertaking system wide change and shifting the culture across multiple organisations is complex and takes not only time but also constant focus to maintain the long-term, sustainable gains.

Progress in North Wales has been guided by the values of co-production and prudent health care. This has meant that the changes taken place become meaningful for the people we serve. The practice of involving people with lived experience has radically changed across North Wales**.**

The Mental Health & Learning Disabilities Division is committed to shifting the direction and the pace of change to provide a safer and more purposeful service for patients and their carers across the whole of North Wales. Working closely with our 3rd sector organisations and our statutory partners has been key in ensuring that new initiatives are embedded and become standard practice.

Through the TODAYiCAN team, MHLD are reaching out to staff and encouraging teams to take ownership for their ideas and use the TODAYiCAN methodology to make changes. Recognising that collectively small changes can have a huge impact on the culture, the services we deliver and patient/carer experience, we are noticing that more and more staff are talking about TODAYiCAN and the connection with the Mental Health Strategy.

The further embedding of the Triumvirate model of clinical and management Leadership to support governance arrangements has further reaped rewards in the early part of 2019. Triumvirates are taking ownership for the delivery of services within their areas and working autonomously. Our Mental Health Strategy as evidenced by partnership working drives this new approach to care delivery.

3. BACKGROUND

The mental health strategy was developed in 2016 at a time when the BCUHB MHLD Division was facing numerous challenges. With any service, there is a risk that issues with the organisation and quality of services will lead to difficulties in recruitment and retention of staff, which in turn exacerbates the problems in service organisation and quality. The Health Board was determined to use the process to arrest that risk in BCUHB. At this point in time the strategy was developed to address the following key concerns:

- Demand for services exceeding capacity to respond
- Offering services in an integrated and holistic way
- A real focus on recovery and rehabilitation
- Explore ways to address clinical governance issues due to limited availability of modern information and communication systems
- Recruiting and retaining staff

The challenges BCUHB face as an organisation and a region are all interconnected, complex and challenging and require a partnership approach to achieve the outcomes required. Our strategy for addressing them is therefore equally interconnected.

The Mental Health & Learning Disabilities Division is committed to shifting the direction and the pace of change to provide a safer and more purposeful service for patients and their carers across the whole of North Wales. Working closely with our 3rd sector organisations and our statutory partners has been key in ensuring that new initiatives are embedded and become standard practice.

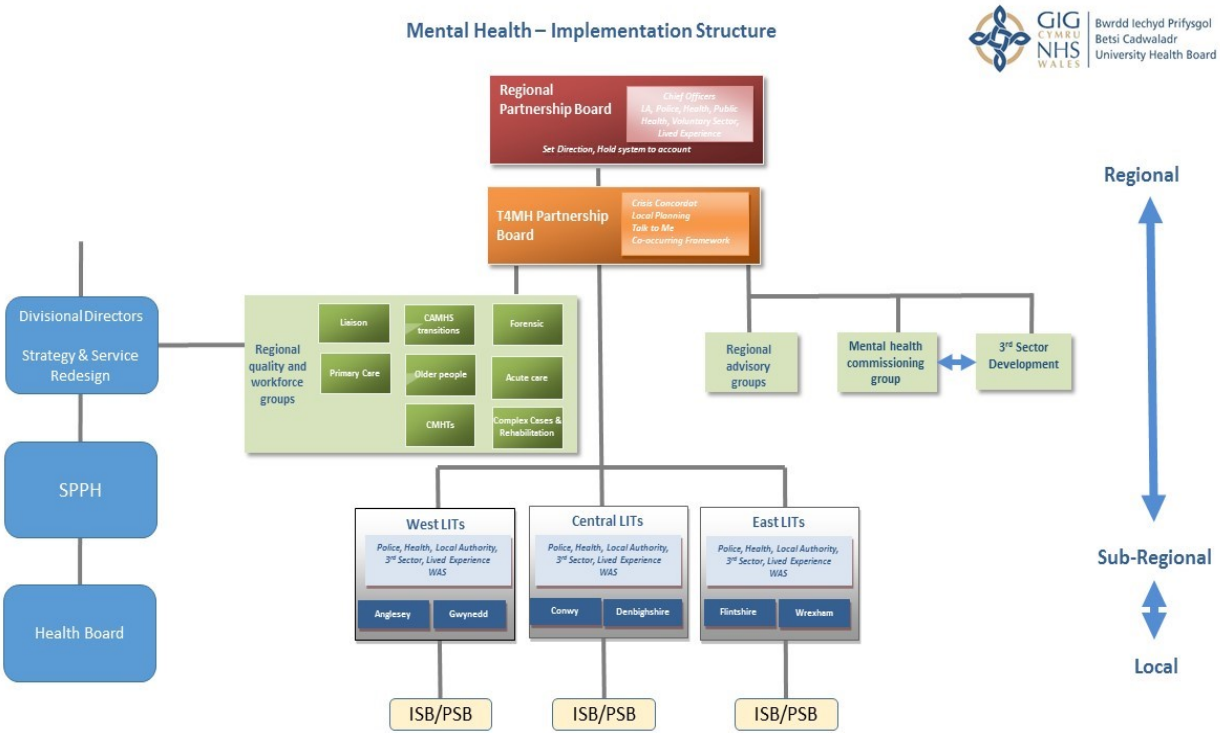
Key Issues

- Continued progress against the Special Measures Improvement Framework linked to the Mental Health Measure and out of area placements
- Continued delivery of the Quality Improvement Governance Plan as detailed in Appendix 1
- Delivery of the mental health strategy and work of the transformation group, Local Implementation Teams and whole systems approach
- Concerted effort on managing the Serious Untoward Management process to reduce the breach position for Welsh Government reported incidents
- Sustained improvement over a three year period on a range of initiatives as detailed in Appendix 3

4. Mental Health Strategy

Progress in North Wales has been guided by the values of co-production and prudent health care. This has meant that the changes taken place become meaningful for the people we serve. The practice of involving people with lived experience has radically changed across north Wales.

The Mental Health Strategy has matured in both the structure and clarity of intent but also the level of integration with our partner agencies. Central to this success has been the work of the Local Implementation Teams (LITs) linking both local and regional partnerships.



Mental Health Services have a strong track record of collaboration with all key stakeholders and by building on these partnerships and working closer with the 3rd sector, service users and carers, it will be possible to draw on many more resources and insights that already exist to promote and improve mental health. It is essential to bring together commissioners, providers and specialists from across the system together, to develop relationships and

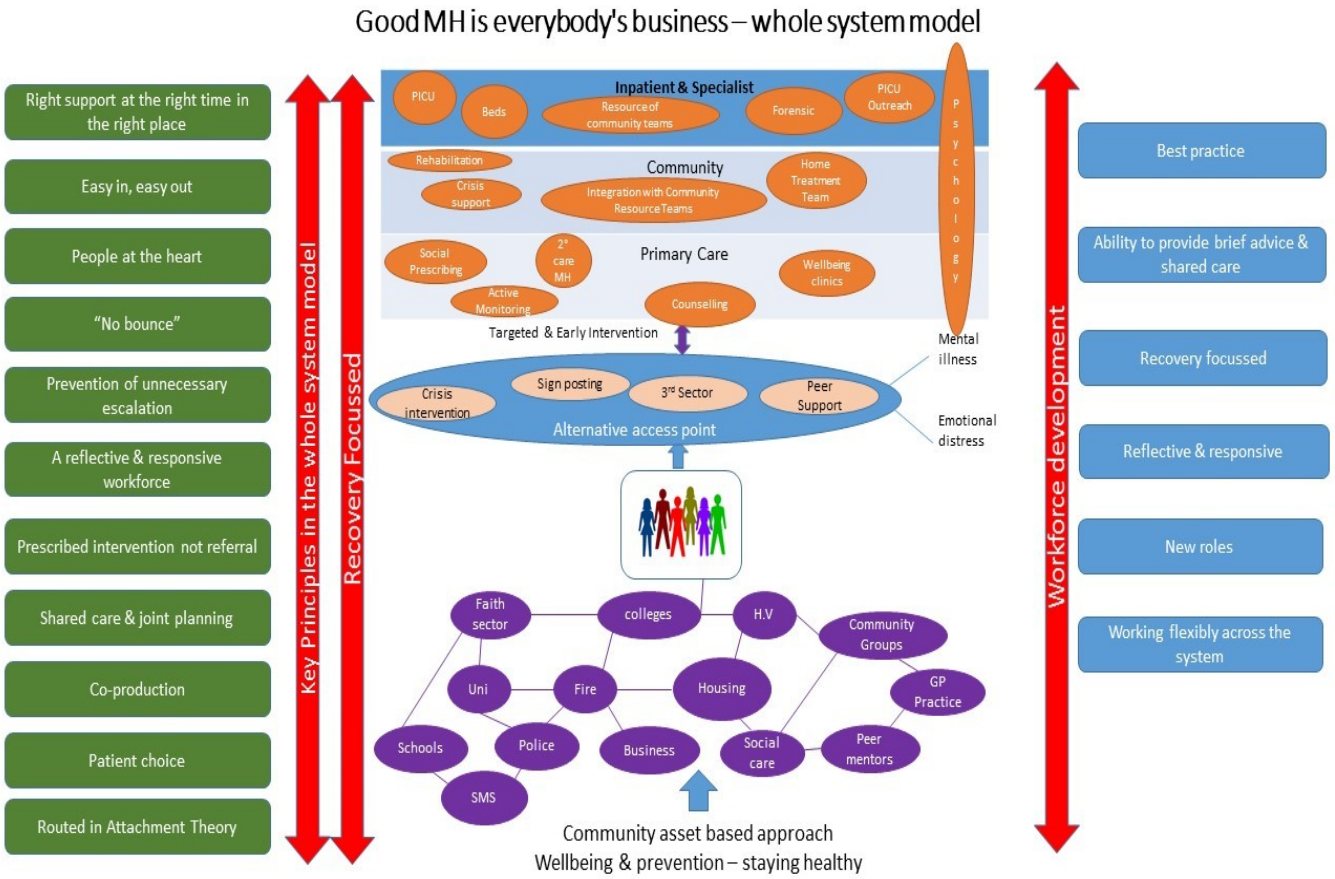
creating an environment, which facilitates collaborative working. Opportunities exist at an organisational level through strengthening the role of the regional quality and workforce groups, ensuring that they work collaboratively draw on expertise and guidance and provide the sense checking on proposals and plans.

There is a need to review how we commission services and new models of services in localities and across North Wales so that commissioning is expanded beyond specialist services to community based settings. The allocation of funding also needs to happen in a timely manner given the timescales involved for delivering the project, we need to consider if, under the current arrangements we are able to do this efficiently. It is essential that the 3rd sector and people with lived experience play a greater part within this process. Again opportunities exist to work closely between the specialist commissioning team and the regional commissioning board.

A further example of delivery for the mental health strategy is the Mental Health Transformation Project in the design and implementation an integrated pathway to support people in crisis and proactive management of crisis. The project will work with criminal justice services to provide an effective integrated response to people with mental health needs who encounter police services. Transformation will also take place for Community Mental Health Teams and the role of the third and independent sector with supporting people at risk of severe mental health crisis including digital technology solutions.

Local Implementation Teams are tasked with implementing the required change and to work with ‘Clusters’ within their area to embed the changes effectively. However there is clearly the need to establish an effective mechanism so that knowledge and challenge reaches across Local Implementation Teams, Clusters and other organisations and networks outside of ‘traditional’ health and social care services such as housing, criminal justice agencies, third sector, all of whom play an important role in promoting well-being and good mental health. Three transformation leads are now in post.

One of the aims of the mental health strategy has been whole systems working. This has progressed since the last Health Board report with emphasis on a ‘community asset based approach’.



As a sign of further evidence of confidence and delivery in North Wales, Welsh Government has considered the feasibility and viability of moving the proposed Individual Placement Support research project. This project sits comfortably within the Mental Health Strategy due to the strong focus on integrating local services.

The MHLD Division has recently completed a tender for the evaluation of the implementation of the Mental Health Strategy. The MHLD Division will draw on lessons learned from the implementation of the Together for Mental Health Strategy and work closely with transformation projects and regional partners.

5. ASSESSMENT OF THE CURRENT SITUATION

Realising the vision of the Health Board through implementation of the strategy is at the heart of the service. This responsibility of delivering this is in the context of resource restraint within the public sector. However, that has only strengthened the Health Board's resolve to work together across health and social care, with the wider public service and with the voluntary and community sector so that we get the most from every pound that we spend in North Wales.

5.1 Developing the model

The Health Board has focused on breaking down the barriers that prevent the integration of care around the needs of individuals. It is clear that we can no longer address the physical, mental and social needs of a person from within separate silos that primarily reflect the needs of organisations rather than those of people and the places they live in.

"We can talk to each other about our problems and if we need support with anything we can get that with no judgement. I know how much it's benefitting my mental health as I always feel so good after I've been running" Ruth (2018) a service user who is benefitting from North Wales' first Couch to 5k running group for people with mental health problems, which was established by our Ynys Mon Community Mental Health Team

This is the belief that has powered the system to consider the way community-based models of care will be in local areas. Through the establishment of Local Implementation Teams, the Health Board has the means to deliver a far more preventative outlook and begin to shift the balance from a secondary care focus and to delivery of a richer set of services in the community. This will in turn support the implementation of an integrated model of care across secondary care services.

It has been agreed by the Mental Health Partnership Board that the approach to implementation should be bottom-up, and be rooted in the communities across North Wales, with the default being local, rather than regional implementation structures. The reasons for this being preferred are:

- The intent of the strategy is to prioritise actions that promote public mental health and wellbeing. Most of these will need to be planned and delivered at local level.
- There are numerous historic and current differences between the communities and resources across the various parts of North Wales. It is essential that collaborative working reflects those differences, and builds on differing local strengths and assets.
- Most of our staff and services are based within local teams and services, rather than regional systems and structures. A locally-driven process will find it easier to engage staff, to facilitate closer working relationships, to build trust, and thereby to promote the cultural change we are aiming to achieve.
- For service users and their families likewise, engagement with processes of change will be much easier if this is primarily being handled at local level.

LITs have lead responsibility for implementation of the Mental Health Strategy for North Wales in their area.

Specifically, each LIT has:

1. Identified initial priorities, knowledge known and required, and future areas of work to be taken forward to meet strategic expectations locally.
2. Shared information locally so that there is an in-depth understanding of need, and transparency about resources available, efficiencies required and quality of expected outcomes.
3. Comply with the programme management and reporting arrangements to ensure the Together for Mental Health Partnership Board is aware of progress against the implementation of agreed actions, and the associated risks to delivery, and of any mitigation taken.
4. Agreed the accountability and scrutiny processes for delivery of the actions, including those areas which may require local scrutiny through existing mechanisms, for example ISB.
5. Capture, celebrate and share positive practice and learning to spread innovation around all aspects of mental health.

6. Identifying areas where help may be required from the regional advisory groups or the Quality and Workforce Groups (such as out of hospital support, primary care mental health, suicide prevention).

5.2 Improving governance arrangements

An effective leadership, governance and accountability framework has been put in place which has now progressed to a substantive structure. The substantive management structure was operationalised during April and May 2018 which saw the significant investment in the new triumvirates on each site. These new roles consist of Heads of Operation, Heads of Nursing and Clinical Directors realising the ambition of visible leadership on each site which is clinically lead and managerially supported. The new structure creates new roles that have clear lines of accountability and reporting and ensures that there is a consistent approach across the division.

As part of our development and implementation of the mental health, learning disabilities and substance misuse strategies and in line with the overall Health Board strategy, Living Health, Staying Well it is important that our management and leadership structures are aligned to the overall objectives within them. Working to improve outcomes, drive out health inequalities, improve quality, safety, effectiveness and experience of our services for the population of North Wales are all key objectives. The delivery of these objectives as close to the person's home is a key deliverable. Ensuring care is available closer to home will be achieved through better integration with external and internal partners but ensuring we are developing community assets to support the pathways is an important success factor. With this in mind the development of our approach to localism is critical. Our service delivery, supported by an effective management structure will ensure real success in this approach.

The Wales Audit Office and HIW governance review in 2017 highlighted the progress made by the Health Board to strengthen quality assurance arrangements in regards to mental health services including appointments to key leadership positions and the development of a quality and safety structure although it recognised that it would take time for the arrangements to become established and effective.

The leadership, governance and management structure builds on the stability already in place. The Health Board is confident that the BCUHB thematic quality and assurance improvement plan will further underpin and strengthen the transformation agenda for service user experience. Important themes have been identified for this work, which will be supported by improved capacity and capability guided by a robust programme management methodology.

Governance and Risk Management arrangements: findings from internal audit

The MHLD Division implemented a new governance framework in September 2018, shortly after this launch MHLD received an internal audit review in November 2018 with the report received in March 2019 pertaining to the newly introduced governance arrangements. The Division received assurance ratings that gave limited assurance and reasonable assurance ratings within each of the domains. The report reflects the bedding in of the new management arrangements and compliance against standards of governance. In response, the Division has placed rigour into the conduct and reporting of governance meetings, particularly meeting attendance and exception reporting using Health Board templates. The sub groups reporting to the Quality Safe, Effective, Experience and Leadership Group have aligned with recommendations within the

internal audit report. A MHLD Risk and Governance Lead has commenced employment to provide additional capacity to the governance team.

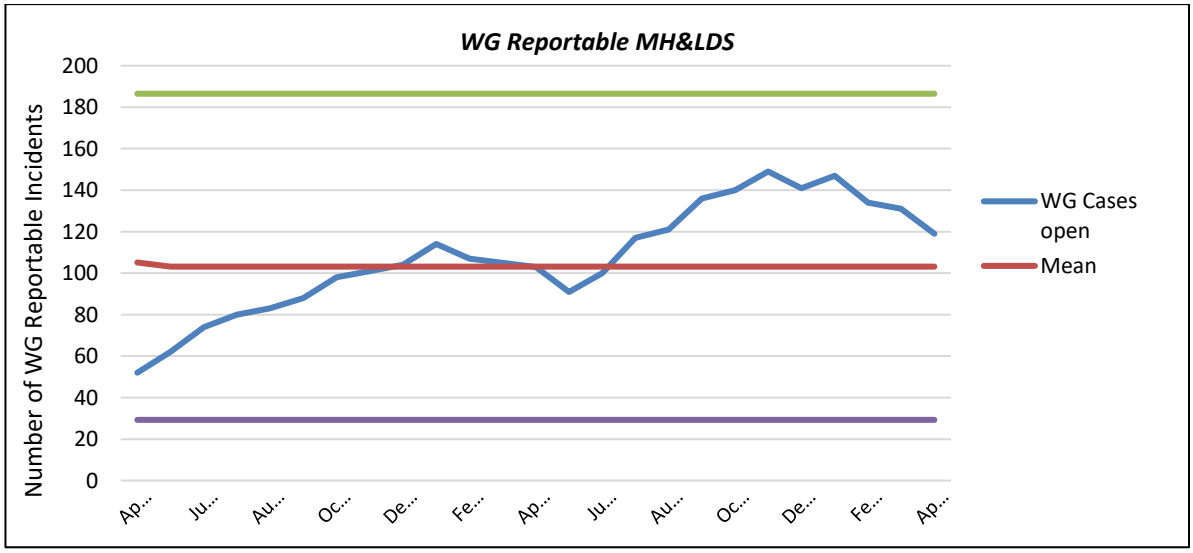
The MHLD Division has also received an audit review by Corporate Risk and Assurance. The review conducted through interview with the Head of Governance and Compliance, interrogation of the Datix system Incident and risk register modules, risk management documentation and divisional intranet pages.

An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review. The MHLD Division's overall assurance rating has improved from 'moderate' in February 2018 to the current 'substantial' rating in February 2019. This reflects improvements to the risk management arrangements, structure and the provision of a risk management procedure.

Serious Incident Management

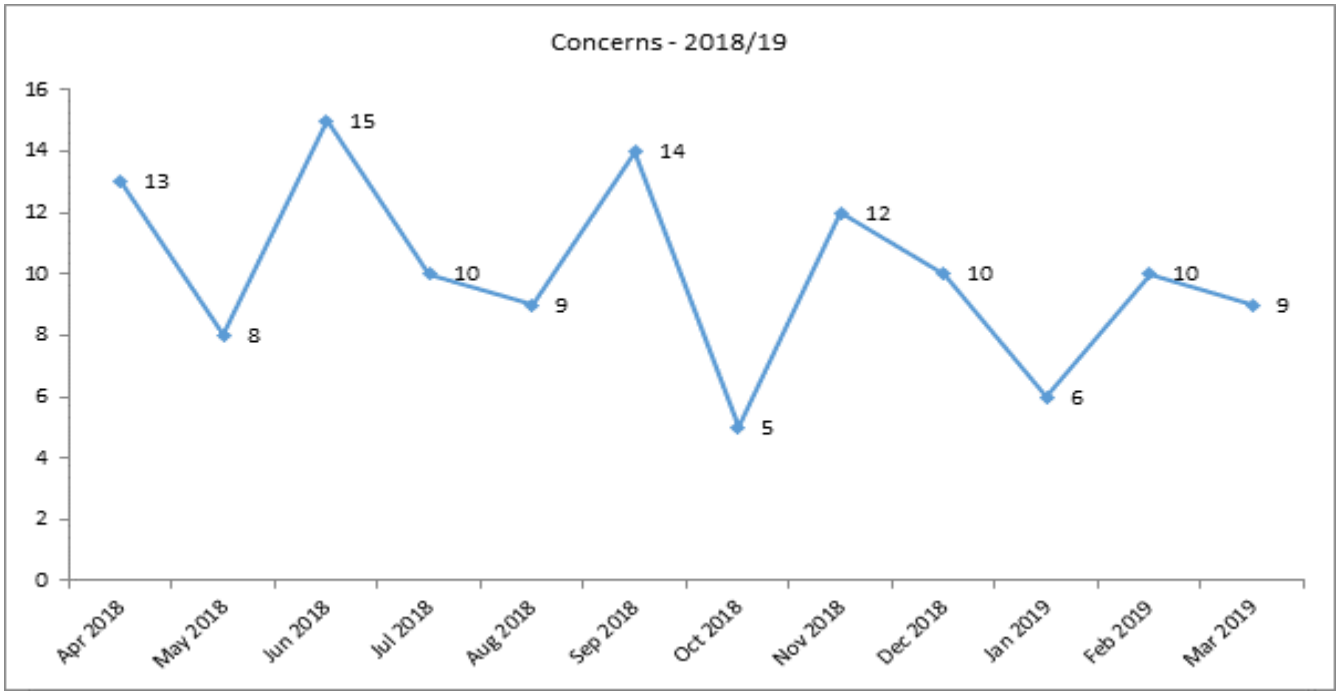
Serious Incident management remains a closely monitored priority for the Division. Since December 2018 the number of WG reportable incidents has decreased from 147 to 119 (see fig 1).

Fig1



Concerns update

The MHLD Division continues to show good improvement over the management of concerns with a downward trend in the number of complaints received. In the month of March 2019, the Concerns Team received 9 formal complaints.



Between April 2018 and March 2019 consent, confidentiality or communication remains, the most received to date for the year.

6. DELIVERING THE STRATEGY – PROGRESS AGAINST OBJECTIVES

The Health Board has made significant progress on the Mental Health Learning Disability Division's Quality Improvement and Governance Plan. The progress against the initial objectives are detailed below:

6.1 Objective - Working to prevent mental health crisis by focusing on early intervention and promoting emotional resilience

- LIT's engaging with public and services to create mental health awareness and signposting package for key areas – barbers4mentalhealth project is the initial project with plans to target businesses across North wales then to explore potential for taxi firms. Occupational Therapists at Healthy Prestatyn are now engaged with LL19 Barbers to provide outreach and signposting support and a Bangor based barber has Abbey Road trialling a drop in service on a monthly basis North Wales Barbers in a bid to tackle male suicide North Wales Barbers in a bid to tackle male suicide.
- Raising awareness, tackling stigma and encouraging open conversations about mental health through the I CAN campaign. This has included working with the media to portray the real life experiences of people with mental health problems in order to give hope and advice to others who may be struggling. Examples of this can be seen in the press releases issued on Malan Wilkinson, Sue Rogers, and Sharlotte Jones, which have all been widely covered by the local, regional and national media.
- Partnership work with Bangor University through the Profi Project to raise awareness of mental health issues among secondary school pupils
- Supporting third sector providers with grants to help people focus on keeping well, and following the five ways to wellbeing. A number of independent resource centres offer

daily support for people who might struggle with their mental health. By keeping people active and engaged with peer mentors, they are able to develop resilience.

- A number of GP clusters are also funding 'Active Management'- a MIND programme of early intervention and support for patients at a GP surgery for up to 6 weeks. The service equips patients with the tools to build their own resilience. There has been positive feedback from GPs who have seen good outcomes for patients.

6.2 Objective - Developing local alternatives to admission: crisis cafes, sanctuaries, strengthened home treatment services, step-down services

- Model for crisis cafes being trialled across 3 DGH sites over the winter pressures period 2018 to provide proof of concept for model to be rolled out across community settings.

- Working with the third sector to develop capability and capacity within the third sector to provide alternative solutions to admission. A third sector colleague has been appointed to project manage the 'alternative to ED' project across all three acute sites from January for 4 months as a pilot project.
- Currently joint meetings of the Q&W groups for Acute care and CMHT are planned to explore strengthening Home Treatment Team activity to prevent admission, with a plan to submit a crisis team business case for July 2019.
- Further strengthening of Mental Health Measure performance will continue through 2019

Improved compliance Measure Health Measure

Mental Health Measure Part 1b - Reducing the backlog of people waiting

Table 2 outlines an average of quarter of capacity is being used to address the backlog of patients waiting over 28 days and the impact of staffing issues already outlined has added to the existing capacity issues of the teams. Over 80% of interventions in Anglesey were on their waiting pateint backlog in February 2019. Typically we are seeing an uplift in performance post the reporting submission date due to a delay in validation, further focus will be placed on the need for timely reporting in order to more accurately reflect the divisions activity in month.

Table 2. Part 1b Intervention compliance by Local Authority - validated October 2018 position

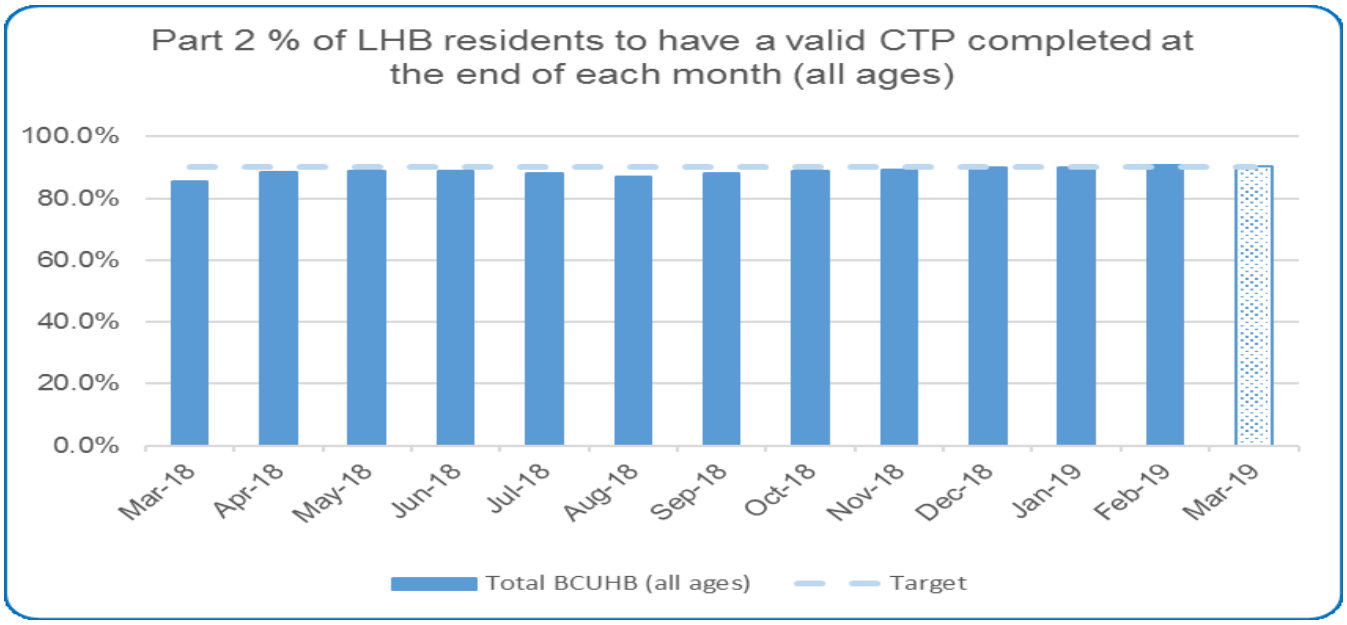
Part 1b Interventions - Feb 19	Mon	Gwynedd	Conwy	Denbighshire	Flintshire	Wrexham	Total
Discharges in Month	67	251	146	214	122	184	984
MHM Compliant Interventions	3	31	54	66	55	43	252
MHM Backlog Interventions	13	17	23	11	3	17	84
Total Interventions undertaken	16	48	77	77	58	60	336
MHM Compliant (%)	18.75%	64.58%	70.13%	85.71%	94.83%	71.67%	75.00%
MHM Backlog (%)	81.25%	35.42%	29.87%	14.29%	5.17%	28.33%	25.00%

Mental Health Measure Part 2 and 3

Part 2 of the measure achieved in February 2019 the first time the target has been achieved since October 2017. We typically achieve just under the target each month but we have not dropped below 85% in the last 2 years and only August of 2018/19 saw us drop below 88%.

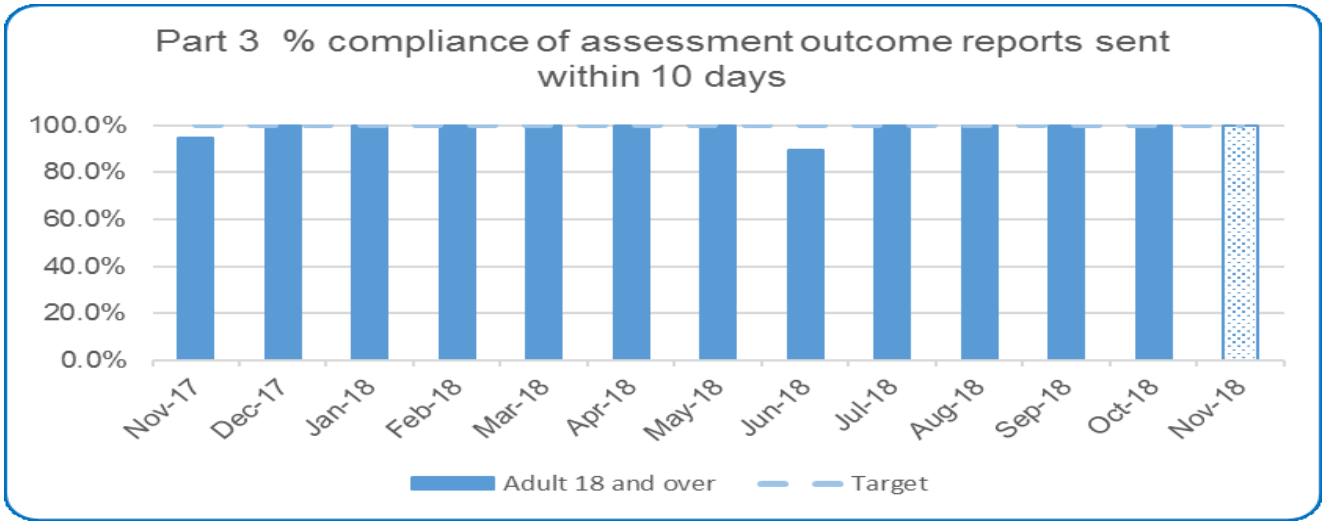
Individual elements of the validated Month 11 (Feb 2019) position show both Older Adults and Learning Disabilities compliant with the target reporting 95.3% and 98.4% respectively. Adults reported 89.3% and CAMHS 92.7%.

Chart 3. Part 2 compliance – percentage of LHB residents to have a valid CTP completed at the end of each month (*dotted bar for March denotes unvalidated position)*



Part 3 is demonstrating achievement of the 100% target across all areas and sustaining this position remains a priority for the services.

Chart 4. Part 3 compliance – percentage of assessment outcome reports sent within 10 days



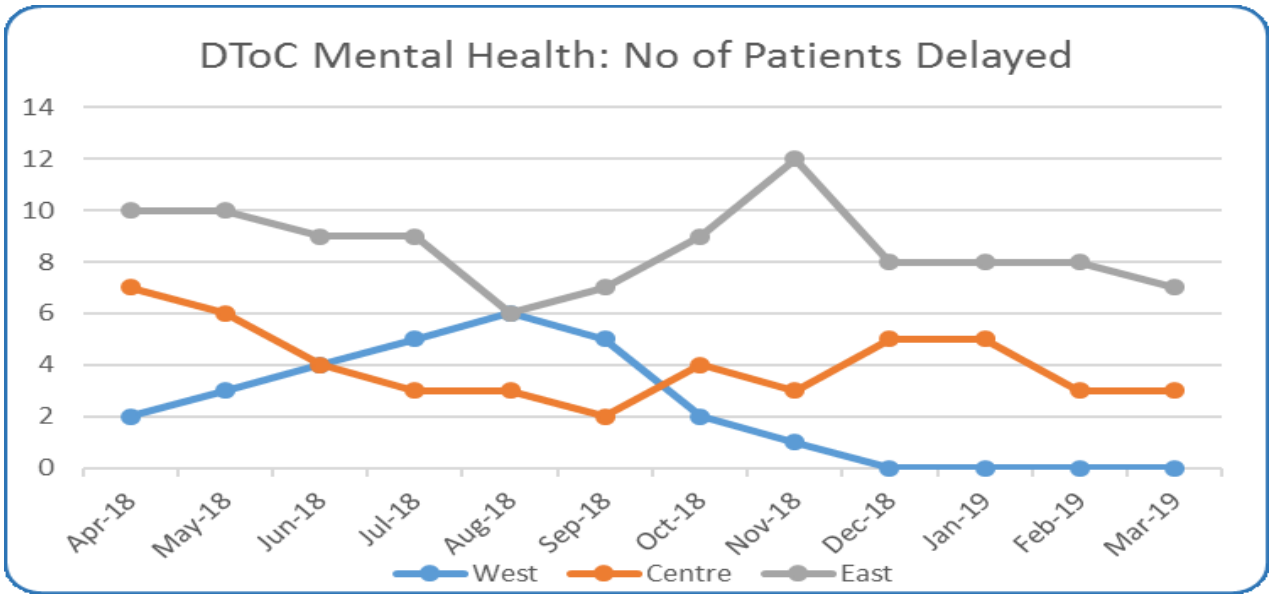
6.3 Objective - Reviewing and improving the routine processes of bed management and patient flow

Review and analysis undertaken on patient flow and bed usage to understand the current situation and inform the clinical model for inpatient and community services. This work has supported both the development of the Strategic Outline Case for the Ablett redesign and also the development of the service model.

Delayed Transfer of Care

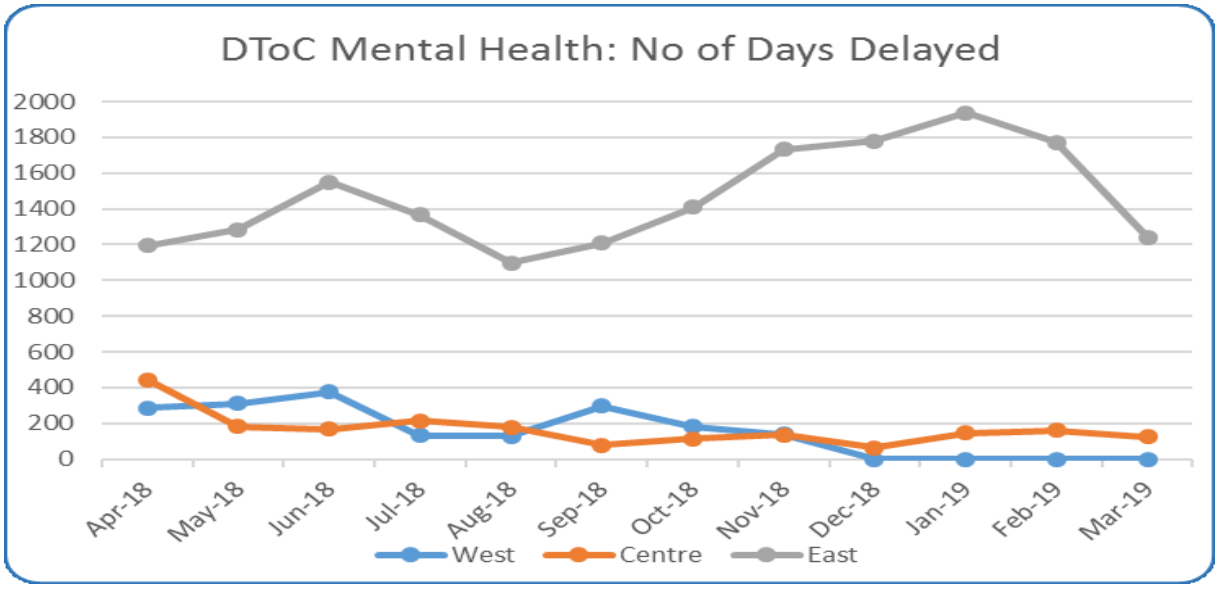
The actual number of delayed MH patients for March is reduced from the previous reporting month to 10, this represents a total reduction of 9 people considered to be classed as DToC patients from April 2018 which is a positive trend.

Chart 5. Mental Health DToC - No of patients delayed



The number of bed days has decreased from 1932 in February to 1365 in March;

Chart 6. Mental Health DToC - No of days delayed



The East area continue to face the pressures they have encountered throughout 2018/19 with insufficient or unsuitable readily available placements for its most complex patients many of whom have both physical and mental health needs.

6.4 Objective - Working with criminal justice service to divert demand arising from the police, via section 136 arrangements, street triage or control room-based mental health staff

- Finance secured for mental health triage in joint communications centre where practitioners will take calls from public, police and WAST to ensure advice and support available to provide appropriate outcomes. A service manager has been appointed and going through recruitment process and the team to be appointed.
- Improving the education of police officers will be achieved through the delivery of a 2-day classroom based training program in partnership of CANIAD, local authorities and BCUHB

6.5 Objective - Working with voluntary and third sector agencies to review their role with people at risk of severe mental health crisis

- There are a range of third sector providers of services across North Wales, and the Division work with agencies on a local and regional level including CAIS and Hafal.
- Three ICAN Urgent Care Centres (UCC) have been opened across the three DGH sites to provide an alternative to hospital based assessments. It is aimed at those people who are 18+ and experiencing emotional distress
- The centres are on site near to the Emergency Departments and accept referrals from the ED staff on duty. Crucially the ICAN centres are quieter and less hectic compared to a busy ED. It provides a safe space for the patients to sit with someone and receive emotional support, advice and signposting to relevant services.

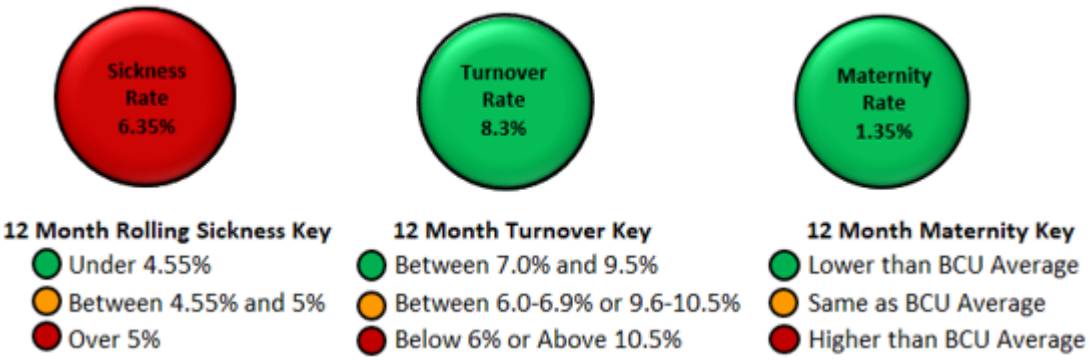
6.6 Objective - The development of a clear plan for the future of our mental health services and workforce represents a significant step forward

- The Quality and Workforce for Acute care group has a 3-year delivery plan. The group is currently reviewing the evidence base for the acute care model for mental health in North Wales. This will include consideration of PICU provision and supporting s136 activity through a psychiatric decisions unit to provide an alternative to use of police detention. The group has actively contributed to the Strategic Outline Case for redevelopment of the mental health site in Glan Clwyd Hospital.
- Agreeing community models of care - During 2017 the Division worked in collaboration with the 1000 Lives team in a focused programme with Adult CMHT teams to develop an understanding of issues considered important to those involved in directly delivering mental health services in the community. The work to redesign services for mental health is now being progressed through the implementation of the Together for Mental Health in North Wales (T4MHNW) strategy and new models of care being developed through our Quality and Workforce Groups.
- Focused on engaging frontline staff and operational managers, training to develop skills and processes required to understand service demand and capacity in order to improve the flow into and from CMHTs was delivered in September 2018. Work has continued over the autumn and will carry on through the early part of 2019. The learning from the work of our teams will be used to support improvements in the delivery of care within the current system and also the work of our Quality and Workforce Group to redesign services.
- Improved controls over the establishment with more substantive staff and greater adherence to mandatory training

The Mental Health & Learning Disability Division has a budgeted wte of 1,972.42. There are currently 1,799.81 contracted wte indicating there are 172.61 wte vacancies across the Division.

The greatest number of vacancies appears against Band 5 Registered Nurses, showing 62.33wte vacancies. This equates to 71% of the total nursing vacancies for MHLD Division and 36% of all MHLD vacancies. However, the impact of implementing an inpatient establishment review once progressed through consultation and recruitment of new graduate nurses is likely to fill these vacancies by September 2019.

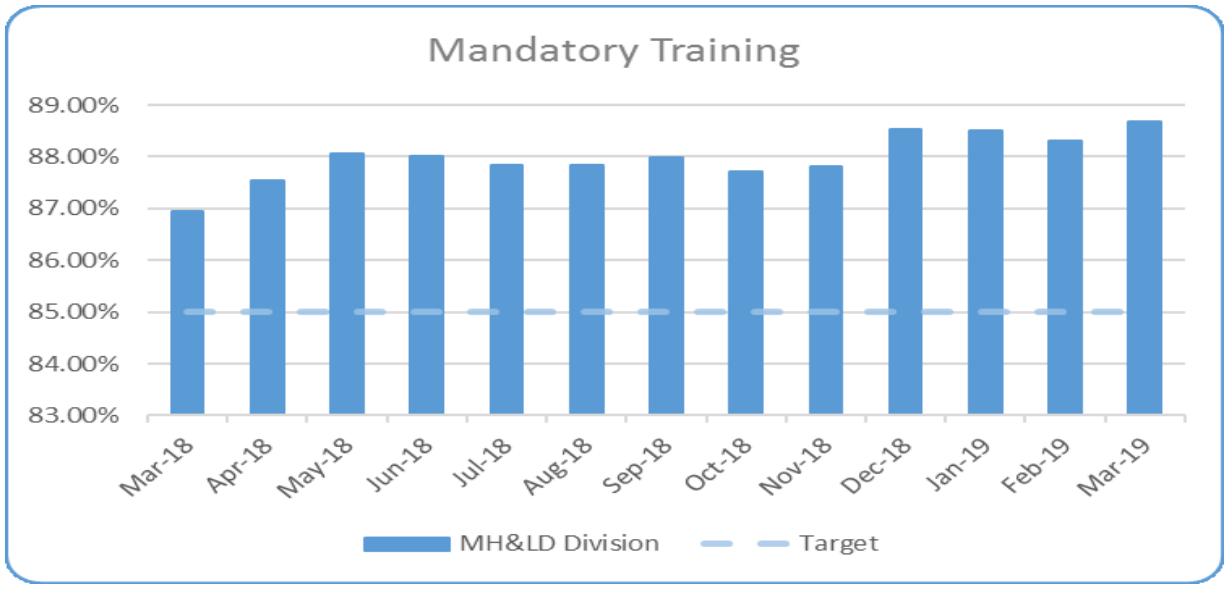
Workforce trends indicate we have further improvement measures to ensure sickness rate remains controlled.



Mandatory Training

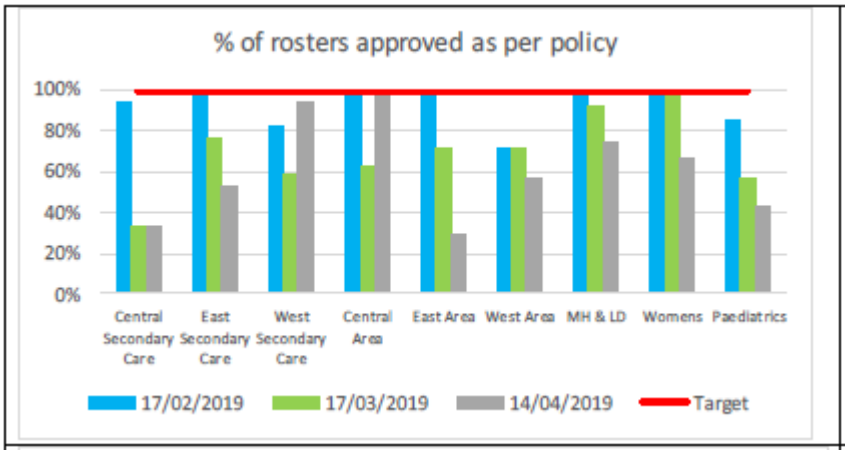
The division has been compliant against mandatory training throughout the year as shown in chart 8 and this is a huge step change in ensuring our workforce is supported to fulfil duties and demonstrates accomplishment against organisation requirement.

Chart 7. Mental Health & Learning Disabilities Mandatory Training compliance

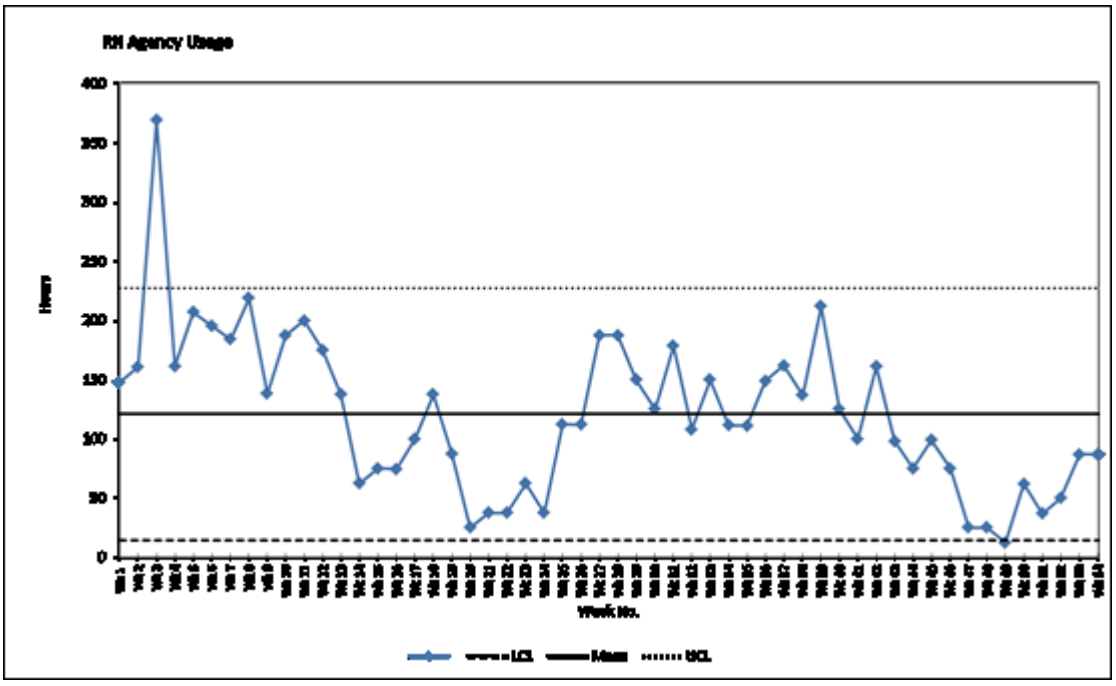


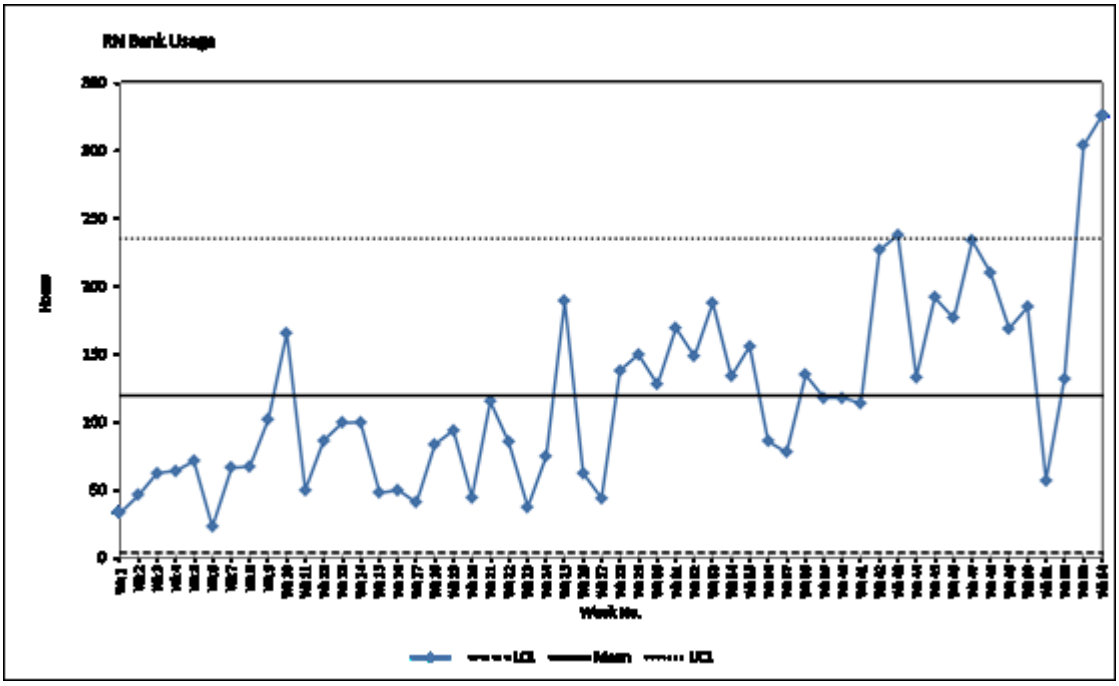
MHLD controls over the establishment

The MHLD Division continues to exercise controls over the approval of the e roster. Compared to the Health Board we do compare favourably.



The MHLD Division has made considerable progress in avoiding the use of agency staffing for registered nurses and this consistent progress shown in the Figures below. We expect this climate change to continue as we embed the establishment review and continue our recruitment into substantive posts.





The MHLD Division has recently completed an establishment review using All Wales mental health tools and benchmark analysis.

Regulation

The MHLD Division completed a NMC revalidation audit February/March 2019 and looked at a random sample of revalidation files from across the MHLD division.The audit covered the reflective discussion and confirmation elements of the revalidation process. 100% of staff files selected had revalidation portfolios in place and met or exceeded the requirements set out by the NMC.

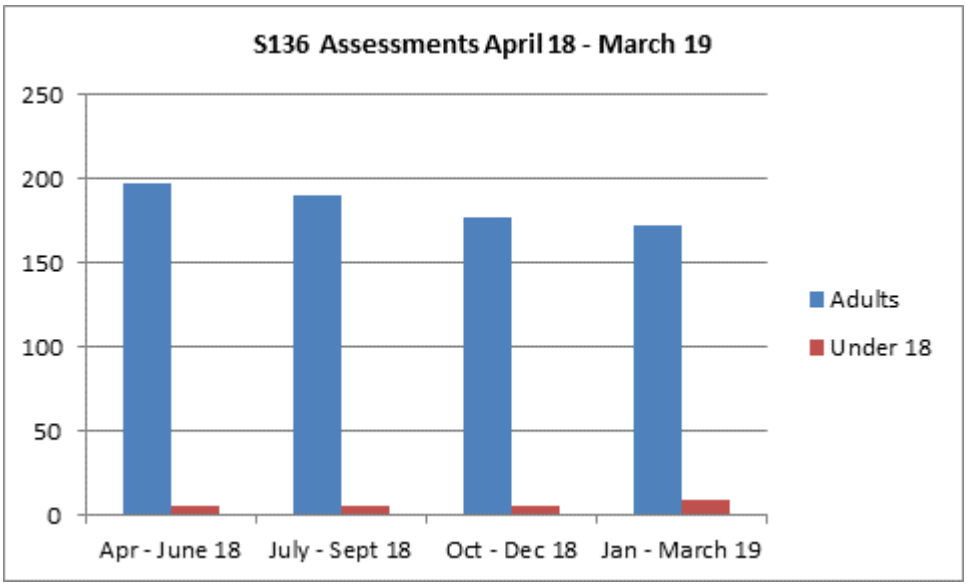
Financial Performance

A high-level analysis of financial performance across pay, non-pay, CHC and drug costs comparing 2017/18 to current run rate shows a positive position. This will continue through the year and it is important to note that the MHLD Division met its agreed financial total for the financial year. A key message is the substantial reduction in agency costs and out of area placement costs.

6.7 Objective – Reduce the number of detentions of people under s.136 of the mental health act

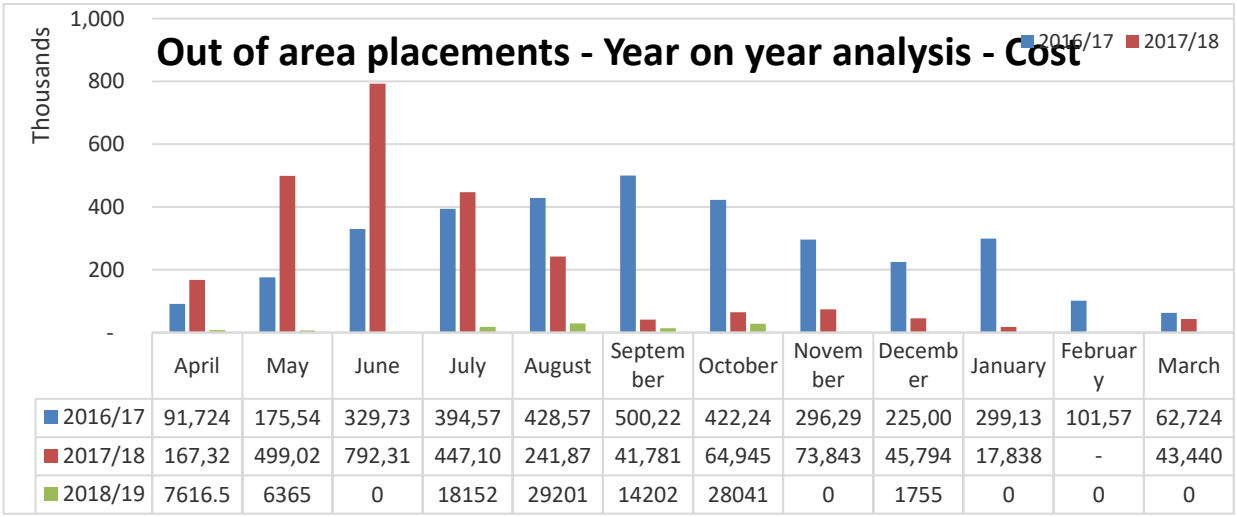
- BCUHB is supporting the police with training and providing alternative options for the police to utilise, enabling the person to get the right care, from the right staff, in the right place at the right time.
- For 2018/19 an increased use of s136 in adults across North Wales as we await the bedding in of new interventions
- A total of 9 under 18's were brought to hospital places of safety for assessment during the last quarter of this financial year (18/19) A total of 25 under 18 assessments were conducted this financial year which is a 50% decrease on the last financial years figures.

- Quarterly figures have demonstrated a steady decease of <18 detentions during the past 12 months.

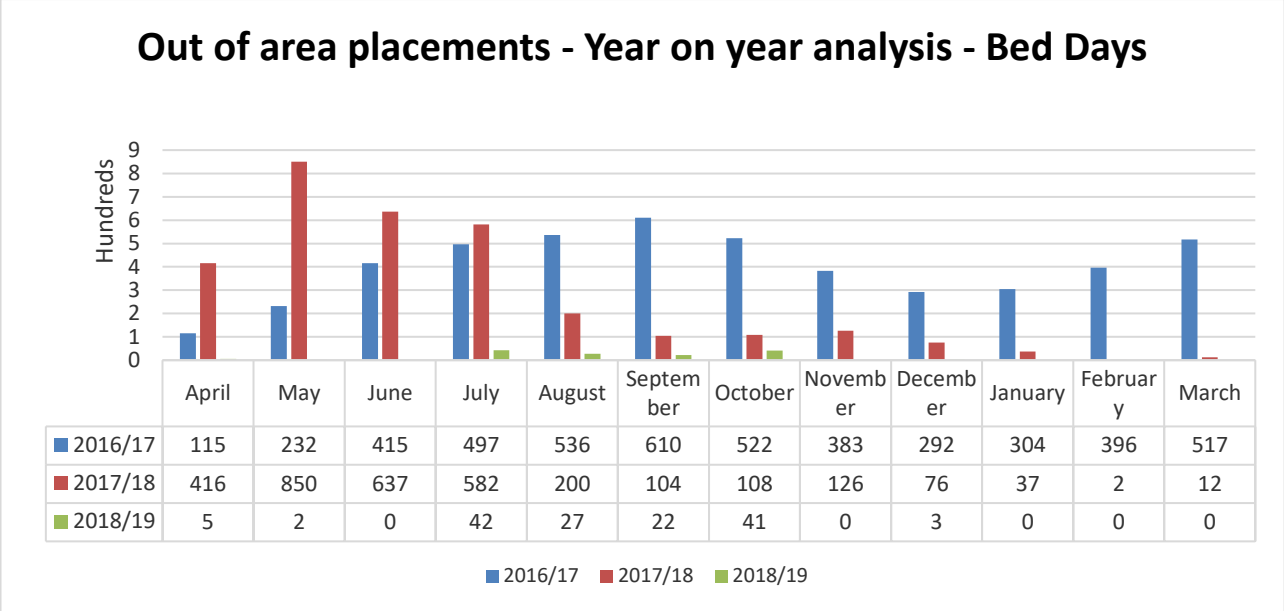


6.8 Objective – To reduce the number of placements of local people outside North Wales - comparison of Years 2016/17, 2017/18 and 2018/19

- SMIF action 4 relates to out of area beds and as the following charts show, there has been a sustained reduction in cost and bed days compared to previous years. This is a huge achievement for the MHLD Division and for people who use our services across north Wales.
- Patients are now rarely placed outside of North Wales for routine acute care (Figure 1). Numbers are reviewed daily and all patients prioritised for repatriation at the earliest opportunity.



	April	May	June	July	August	September	October	November	December	January	February	March
2016/17	91,724	175,54	329,73	394,57	428,57	500,22	422,24	296,29	225,00	299,13	101,57	62,724
2017/18	167,32	499,02	792,31	447,10	241,87	41,781	64,945	73,843	45,794	17,838	-	43,440
2018/19	7616.5	6365	0	18152	29201	14202	28041	0	1755	0	0	0



	April	May	June	July	August	September	October	November	December	January	February	March
2016/17	115	232	415	497	536	610	522	383	292	304	396	517
2017/18	416	850	637	582	200	104	108	126	76	37	2	12
2018/19	5	2	0	42	27	22	41	0	3	0	0	0

7. CONNECTING THE STRATEGY AND QUALITY IMPROVEMENT

The Health board is using a 90-day improvement cycle with clear actions which are owned by all staff who work across the organisation. The delivery vehicle will be for the most part the existing governance arrangements within the MHLD Division, the established triumvirate management teams, Local Implementation Teams and the Quality and Workforce groups. The governance groups have been reinvigorated with updated terms of reference, empowered chairs and membership to bring about the change required. Each of the governance groups will be structured so that the agenda addresses the quintuple aim of Quality, Safe, Experience, Effective and Leadership themes, also known as the Quality SEEL (QSEEL).

BCUHB is driving forward change through a unique exercise that incorporates a clear brand of the 'TODAY ICAN' approach (**Figure 7**) which sees the bridging of the ICAN MHLD strategy with the Quality Improvement methodology of TODAY. This approach combines the values of the 'last 1000 days' movement, recognising patient time as the most important currency in health and social care and an approach that places an emphasis on the value of staff leading an active part in the change process. We are communicating this approach widely across BCUHB through a dedicated communications strategy.

With the revised substantive clinical leadership and management structure now in place within the BCUHB MHLD Division, each of the local and regional triumvirates have control over their delivery of TODAYiCAN. The Health Board has appointed dedicated project management support to enable the triumvirates to engage with the Quality Improvement Governance Plan and produce the Divisional Action Plan (DAP). The DAP will be scrutinised and assured by Local Implementation Teams and Quality and Workforce Groups. We have focused the 90-day change facilitator at the triumvirate group to include Heads of Service, Heads of Nursing and Clinical Directors and Clinical Leads. We have also arranged for a wider number of our change champions to be trained so that we encompass a bottom up approach.

In essence, through dedicated facilitator support across all levels of BCUHB, each of the triumvirates will deliver on QIGP with accountability held through each of the Divisional Directors.

Figure 7

TIME Is the most important currency in healthcare. How to maximise time, minimise wasted time and prioritise patients' time.

OWNERSHIP Is about taking responsibility, understanding what you can influence and gaining support

DIAGNOSTICS Is understanding what good looks like then being able to assess care and activity against that and identify potential problems

ACTIONS Identifies some of the things that are already prioritising patients' time. How to engage others in meaningful change

YOU Is about understanding yourself, the impact you can have and how to influence others to make change

Our work is supported by Professor Brian Dolan OBE, the originator of the #EndPJParalysis Campaign. Professor Dolan OBE is Director of Service Improvement in Canterbury District Health Board & Director of Health Service 360 working in the UK, New Zealand & Australia.

We have made significant progress with this work through a successful training programme of the area triumvirates in October 2018.This also included all participants undertaking DiSC profiling and the first time the triumvirates have undertaken organisational development, other psychometric tests were also included such as a mini MBTI.

In addition to this programme of training in October 2018, an all-day conference opened by Chief Nursing Officer (CNO) Jean White and Executive Director of Nursing & Midwifery Gill Harris was attended by 80+ BCUHB staff was held to introduce the TODAY change methodology. The feedback from these sessions has been overwhelming positive and it is clear that staff involved have been inspired by TODAYiCAN.

December the 20th 2018 was the BCUHB MHLD official launch of the TODAYiCAN programme which was oversubscribed, with 130 staff attending the event. This event has spearheaded our approach to mainstream this new way of approaching change across the wider BCUHB MHLD Division workforce. A further event took place in April 2019 with over 130 staff in attendance.

***"To say today was an inspiration would be an understatement! So many thought provoking and motivating discussions around how we can make a difference!"* –** Leah Devlin – Physiotherapist

Photo: Staff from the area triumvirates have made a number of #TODAYICAN pledges

7.1 Engaging staff and communicating the message

A staff engagement event at the start of 2019 was dovetailed into the TODAYiCAN masterclass to value staff time. The event focused on themes from the Staff survey and results are currently being analysed by colleagues in Organisational Development (OD). The OD team have future staff engagement sessions planned co-facilitated with the TIC team to reach a wider reach of staff. Opportunities to use staff engagement tools through digital media will also be progressed.

Patient and carer involvement continues to be a key part of communication. Caniad now send representatives to the local QSEEL meetings, which have been a valuable opportunity to share important feedback within the appropriate forums.

BCUHB representatives have committed to attending CANIAD forums. Not only is this forging stronger relationships with CANIAD but is also promoting positive relationships with other 3rd sector organisations. The last forum attended was constructive as it allowed the TIC team to create a plan of action for Caniad to gain patient and carer feedback on “always events”.

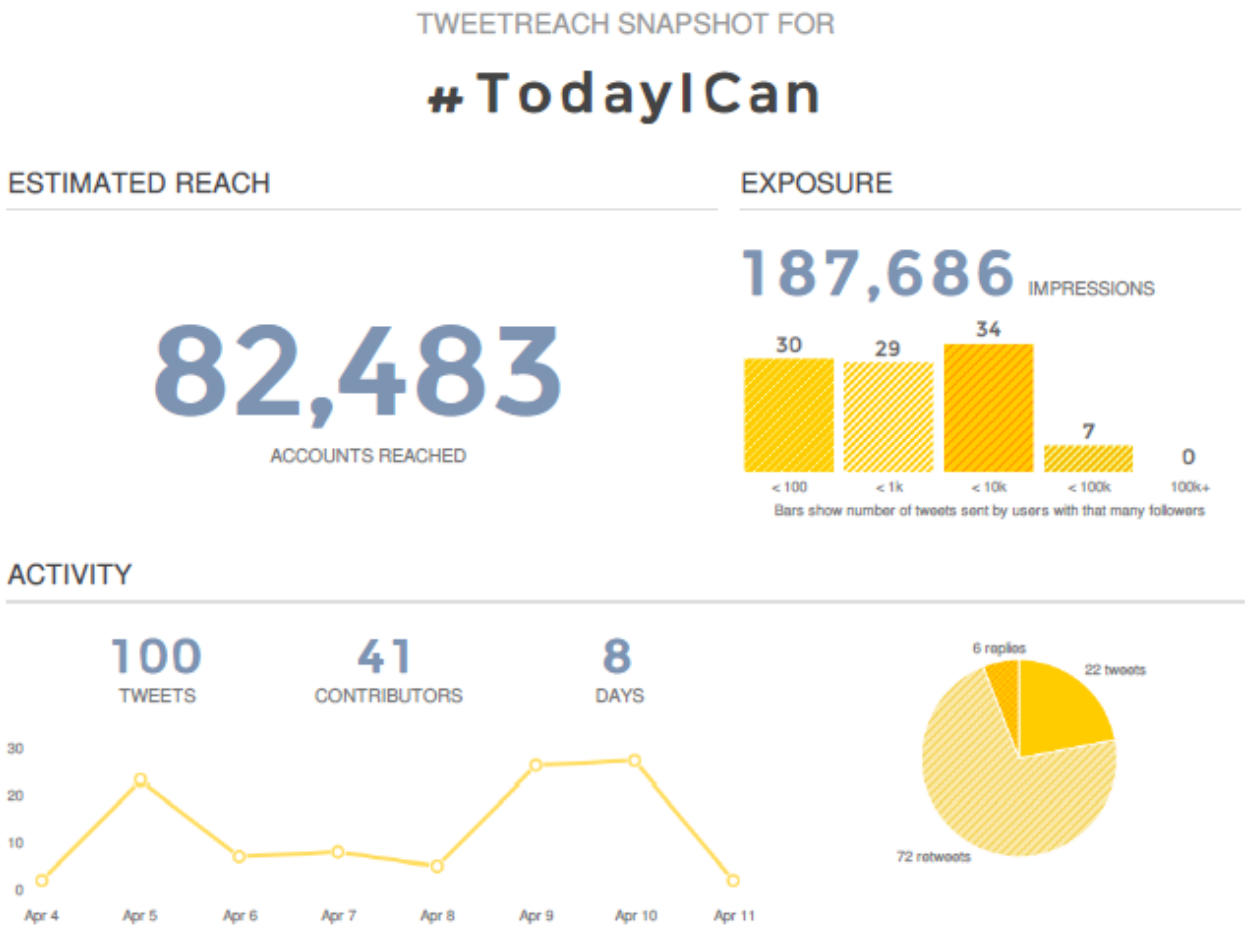
In January 2019, the Digital team released the BCUHB Staff App. The staff app was developed in response to feedback that staff rarely use IT in work but all use SMART phones. The TIC team have used this platform to promote staff achievements, training events, new ideas and promotional material.

A communications hub has been established on the BCUHB website and intranet to provide further information on #TODAYiCAN and the methodology that underpins it. This can be accessed at http://howis.wales.nhs.uk/sitesplus/861/page/74459

Within this, an online repository has been established to record the initiatives that will form part of the area team plans, accessed at

https://www.smartsurvey.co.uk/s/TODAYICAN. This provides staff with an opportunity to describe how they have used the TODAYiCAN methodology to introduce simple changes to their working practices, and estimate the amount of time saved for both staff and patients as a result.

Even at this early stage of implementation, there is clear evidence that the TODAYiCAN approach is gaining traction with staff from across the MHLD Division. The webpages have been visited more than 1,400 times, and the #TODAYiCAN hashtag has had an average weekly reach of more than 50,000 accounts on Twitter since its launch in October 2018.



Examples of some of the changes that have been introduced include:

- Providing an outline of the principles of TODAYiCAN in every local meeting with the aim of it becoming embedded in our everyday language;
- Introducing TODAYiCAN performance boards which reflect how patient and staff time is being saved;
- Making greater use of video conference facilities so time which was previously spent travelling to and from meetings can be used to support patient care;
- Development of a daily safety huddle using the principles of TODAYiCAN and risk based escalation training;
- Development of a co-produced sexual safety policy within the MH&LD Division based on the principles of TODAY ICAN;

- Working with North Wales Police to provide a telephone triage service and face-to-face response for vulnerable people experiencing a mental health crisis over the Christmas period.

7.2 Impact of Mental Health Strategy inspired by TODAY ICAN methodology and 10 key themes for improvement

Since the first launch of the TODAYiCAN masterclass in December 2018, there has been a huge increase in momentum in the way that staff have embraced TODAYiCAN methodology. The 2nd Masterclass took place on 3rd April 2019 with an attendance of in excess of 130 delegates. On this occasion, staff within MHLD were able to highlight their QI projects to the delegates to demonstrate how using TODAYiCAN helped them make meaningful changes. To date over 350 delegates have attended the masterclasses. This shows how change is becoming part of the climate and culture of the Division as we positively embrace a new way of working.

The full TODAYiCAN change facilitator team (TIC Team) are now in post and actively supporting the Triumvirates in making changes linked to the Divisional Action Plan. A training plan has also been created and distributed which advertises local TODAYiCAN training events which are delivered by the TODAYiCAN team.

Our awareness raising has helped barbers support customers who may be experiencing mental health difficulties has been widely covered by the national media. Based on the principles of TODAYiCAN, the awareness drive will enable barbers spot the warning signs of mental health problems in their customers, along with best practice guidance on how to listen, give helpful advice, and signpost to support services.

TODAYiCAN has also inspired Joe Lewis, a nurse on the Ablett Unit at Glan Clwyd Hospital, to run 5km each day during November to raise money to fund additional therapeutic activities so that patient time in hospital can be better utilised to support recovery. Joe's 150km challenge has inspired other staff across the BCUHB to embrace the principles of TODAYiCAN in their everyday work.

Nurse nears end of run fundraiser

By Suzanne Kendrick
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@Suzanne_RJ

A MENTAL health nurse who saved a mum-of-one from taking their own life has been attempting to run five kilometres every day during November to raise money to fund therapeutic activities.

Joe Lewis, based at Glan Clwyd Hospital's Ablett Psychiatric Unit, has been fitting in runs around 12-hours shift.

Money raised through his 150k challenge will help buy new equipment to support

■Joe Lewis is a staff nurse at the Ablett Unit Glan Clwyd Hospital

Positive Interventions Clinical Support Service Restrictive Interventions

The MHLD Division is committed to delivering high quality care and as such has invested significant resources to ensure that this commitment prevails and that service-users are supported and receive the best possible care during times of crisis or when needs are complex. The consolidation of these resources is overseen and coordinated by the rebranded Positive Interventions Clinical Support Service (PICSS) which has over the last two years been significantly overhauled and has being re-modelled to meet modern service requirements.

The Positive Interventions Clinical Support Service has introduced new initiatives and strategies which will ensure that the division complies with national guidelines (NICE NG10 and NG11, DoH - Positive & Proactive Care 2014, MHA Code of Practice 2016) and enhances the quality of care through the development of clinical practices. The Positive Interventions Clinical Support Service has restructured and now has a designated Operational Lead and Clinical Lead who together ensure the effective operation of the department, collate, analyse and synthesise RPI data, support safeguarding procedures and promote a restrictive intervention reduction programme. Two instructors on delivering training programmes in this field support them.

Learning disabilities' V&A services offer a comparable service although this currently facilitated by means of whole-time clinicians who have responsibilities to V&A prevention on a part-time basis. The MHLD Division approaches the prevention and therapeutic management of V&A in several ways:

Positive Engagement

With the support of the division, the leads have evaluated the existing care plan formats for managing aggression, violence or other challenging behaviours and concluded that standards were inconsistent throughout the division and did not meet current NICE guidelines. The guidelines stress the importance of adopting person centred care which focuses on the strengths of individuals, promotes the inclusion of service users and carers in care provision whilst ensuring dignity, respect and compassion prevail. In response, the leads developed a person centred behavioural support plan and trialled its use on the OPMH wards. These care plans were extremely well received by staff and service-users and carers reported that inclusion in their loved ones care was a positive experience. Person Centred Behavioural Support Plans

have now been introduced across BCUHB to identify behaviours, triggers and reasons for behaviour.

Learning Disabilities Service prepare in depth Positive Behavioural Support Plans for all patients with challenging behaviour and individual Restrictive Physical Intervention Plans as required.

Working in Partnership

From a perspective of quality assurance, the division is keen that standards of care match the best service providers in Wales' NHS. To this end, the division has promoted clinical networking so that reciprocal learning and development can occur.

In April 2016, clinicians from the seven Welsh Health Boards who shared a professional interest in the reduction of violence and aggression, formed the Proactive Reduction of Restrictive Interventions Clinical Effectiveness Group (PRRICE).

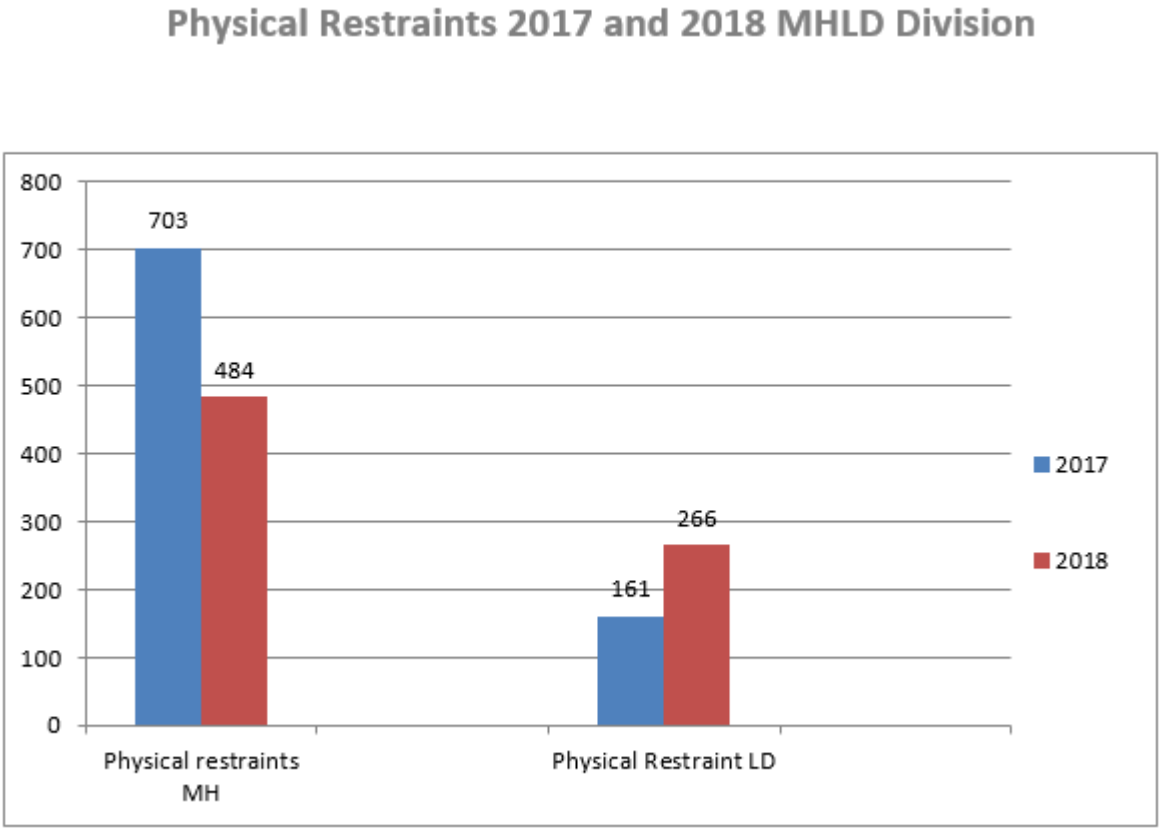
Key to the success of the PRRICE group's aims is the involvement and representation of service-user. The group has established a good working relationship with HAFAL and aims to develop a new national training syllabus in the prevention and therapeutic management of violence. This will replace the current outdated Module D of the All Wales NHS Violence and aggression Training Passport and information Scheme. Moreover, the group is working in partnership with Public Health Wales to strengthen resources and work towards common goals.

Quality Assurance

Restraint record forms replaced with a revised DATIX record has cut delays thereby ensuring that the review of incidents are timely and allow for earlier interventions. Freed up from training duties, the mental health leads are now able to quickly respond to concerns, review clinical incidents and escalate any learning opportunities. The leads have worked closely with wards to ensure that restrictive practices are lawful and of the highest standard. OPMH services have been the focus of significant interaction to safeguard this vulnerable population.

There is a new Policy on the Proactive Reduction & Therapeutic Management of Behaviours which Challenge NHLD 0047 and a revised Physical Restraint Policy 0049 to guide BCUHB staff in the safe use of restraint.

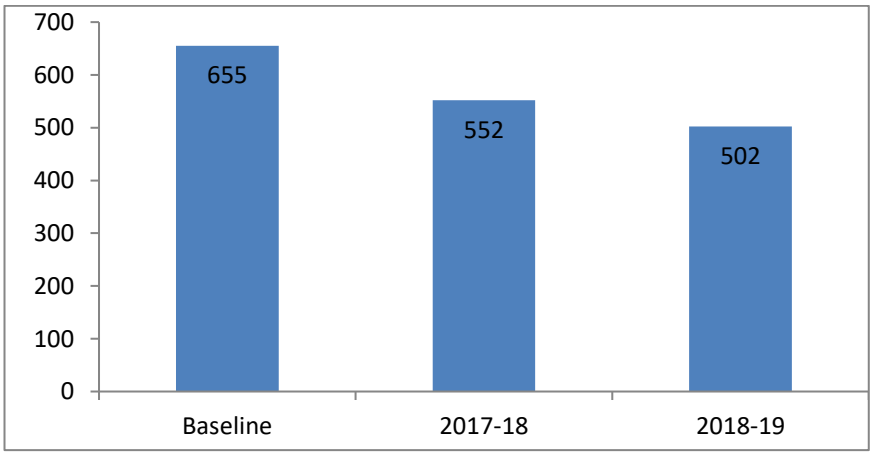
The chart below shows the reduction in the number of restraints for mental health from 703 in 2017 to 484 in 2018 but there is an increase in LD's restraints from 161 in 2017 to 266 in 2018.



Falls Management

The MHLD Division continues to work on falls reduction across all of our wards. The MHLD Division has just completed a two-year programme aimed at reduction of falls, harm and improvement in post fall management. Based on the review of 1,709 eligible in-patient falls the MHLD Division can claim greater assurance regarding patient safety for three reasons:

- There has been a reduction in falls by 24% over a two year period
- Harm caused by falling has reduced by 30%
- There is a significant improvement in post falls management



Post Falls Management

Alongside reducing the number of falls the plan included a need to provide greater assurance regarding the clinical management of a fall after it had happened. The required actions were set out visually as the 'Big Red Wall' (Image 1) such as the person checked for potential injury, escalation for a medical examination and medical examination undertaken.

Triumvirates collectively define objectives for each improvement area in a facilitated learning and change environment.

One of the key variations in the QIGP is a shift of focus from having a Local delivery plan (LDP) for each triumvirate to having a Divisional Action Plan (DAP). This was a decision to ensure that the progress of actions reduces risk in multiple plans. Below sets the progress of the actions from December 2018 for the QIGP.

Using the opportunity to have the Triumvirates participate in the 90-day cycle meetings, key priorities mapped out against the 10 key themes in QIGP (see appendix 2). All Triumvirates have been able to define the priorities in their local area as well as establish cross-geographical objectives.

Setting Quality Indicators, defining what good looks like

Through ward accreditation, process quality indicators are embedded. Examples such as bare below the elbows, information governance, observation and style of engagement, patient feedback.

The co-produced Quality Strategy will set out quality indicators that are relevant to the MHLD services and identify the ways in which these will be measured. The MHLD division are currently working with Caniad to undertake patient and carer feedback forums to establish “Always events”. Always events defined as “those aspects of the patient and family experience that should always occur when patients interact with healthcare professionals and the health care delivery system”.

Action plans to identify achievements, leads, plans to progress, support required, options appraisals, prioritisation, risk mitigation to support delivery, outcomes of completion

Reducing the risks of duplication associated with the Triumvirates managing several actions, which pushes against the principles of TODAYiCAN, a measurable **Divisional Action Plan (DAP)** would be more meaningful and fit for purpose than a Local Delivery Plan.

The key benefits of having the DAP are:

- There is just one plan which sets out clearly the progress of each action for each area using a RAG rating system
- Reduction in duplication of work as one area will have cross divisional responsibility to achieve certain actions
- Triumvirates can compare own performance against those in other areas
- One action plan can be reviewed and managed with appropriate version control

The DAP has been created and is reviewed at each 90 day cycle progress meeting. This is an appropriate forum to review the progress as Triumvirates are able to offer peer advice and guidance and shared learning to help overcome obstacles and barriers to delivery goals. The DAP reflects the recommendations from HIW, HASCAS and Serious Incident action plans.

Implementation of Ward Accreditation

The MHLD Division are fully involved with the BCUHB ward accreditation process and this improvement journey will feature within the DAP. Managers from across the division have attended sessions on the ward accreditation process, monthly metrics and Quality improvement methods. We are working closely with the Quality Improvement Team to ensure that the metric questions are adapted to meet the needs of the division. So far the area accredited from the division has been awarded with Silver, with plans in place to ensure that all MHLD wards by the end of August 2019.

Establish a Steering group for developing and the launch of the Quality Strategy

A steering group, assembled in March 2019 to progress the Quality Strategy will be co-produced with members of Caniad Forum have fully supported the motion of co-producing the strategy. Work has commenced to seek feedback from service users and carers to establish the views of what should be considered as “Always Events” in MHLD services. These Always Events will feature in the Quality Strategy.

It is imperative that we ensure the staff feel that the Quality Strategy has the representation and views from the full range of staff in order for it to have the value. Whilst the date of the quality Strategy launch is set for July 2019, there is a need to ensure that the planning and consultation is done thoroughly and to a good standard. It is proposed that this re-set for September 2019 when the launch will coincide with the Divisional Governance Conference.

Care pathways

The co-occurring framework was launched across MHLD and HMP Berwyn in April 2019, which will have significant impact on the way that patients are referred into treatment and how their treatment is jointly managed between substance misuse and mental health.

Transfer of care upon release from substance misuse services in the prison to the community have been praised by Prison Inspectors and there has been acknowledgement that strong relationships between community clinical teams in North Wales and substance misuse ensure safe and meaningful discharge.

The older adult CMHT team in Wrexham has just launched a pilot project to improve health outcomes for patients on antipsychotic medication and requiring physical health checks. The pilot will evaluate the significance of trained staff visiting patients in their homes and undertaking ECG, bloods analysis for review.

As part of the 90-day cycle, a key priority is for the Acute Care Pathway to be updated and relaunched following ratification at the MHLD Policies Group.

Patient/Carer experience

Following the first steering group meeting for the Quality Strategy, CANIAD have embraced the opportunity to consult with patients and carers to help identify “Always Events” which will feature in MHLD’s commitment to deliver high quality care.

The MHLD has engaged with family members and representatives from the HASCAS stakeholder improvement group. This is a significant development, which is enabling real time feedback, and enabling embedded change, a real example of this was following a request that more focus given to implementing Behavioural Support Plans (BSP) for patients. This is something that has been captured in the DAP and will be addressed across the division.

Our next area to focus on is to improve the numbers of patient and carer experience feedback forms. Teams have improved their rates of response and others need the support of the TIC team, who are meeting with Corporate’s Patient Engagement Team to develop a plan to support areas where improvement is required.

It is important to note that the Secondary Care Nurse Directors are at the stage of completing terms of reference to ensure scrutiny over themes and trends for those people with a LD receive care to meet their needs. This group will have expertise from the MHLD Division to advise and form part of the membership.

Older person’s dementia care

Following a successful pilot and partnership working with Bangor University, funding secured and dementia friendly name badges ordered for all staff working on Dementia wards. There has been good news stories shared about the pilot in the media and demonstrates that cost effective and simple improvements can be significant for patients and their families.

The National Early Warning System Training (NEWS) has been implemented for all staff on Older Adults inpatient wards and staff assessed. The Standard Operating Procedure for the use of NEWS has been to HASCAS stakeholder group and is due to be presented to QSG. NEWS will support improved detection of deterioration and enable a greater focus on physical health when people are admitted to inpatient wards.

There has been an approved advert for an Advanced Nurse Practitioner (ANP) in Older Adult Mental Health. The role of the ANP will be to improve the physical health of older Adults with dementia.

End of Life (EOL) and dementia care

We continue to work in partnership with MacMillan, BCUHB Specialist Palliative Care Services, and report to the HASCAS stakeholder group. The EOL framework and guideline are approved and EOL training is ongoing for all registered nurses working in OPMH wards. Of the fifty-seven registered nurses, 68% have completed the training or are booked into the next sessions. Family overnight rooms are available on each of the three 'dementia wards' and this is a huge boost for north Wales families so they can remain with their loved ones at this critical time of their lives.

Physical healthcare and OPMH wards

Working closely with clinicians from acute healthcare we have jointly authored a new guideline for the management of physical health on OPMH wards and, the HASCAS stakeholder group have had the opportunity to review and comment. The guideline focuses on four patient groups. Consultation has closed and the guideline presented at Policy Approval Group on the 3rd May 2019.

Workforce

Staff consultation for tier 5 and 6 staffing groups in MHLD is currently underway. Following the consultation period, the next stage of the process in workforce redesign will be implemented in close partnership with unions and WOD.

A presentation has been prepared to present to the QSG and Health Board for the commissioning of Schwartz Rounds within the MHLD division. Schwartz rounds are accredited deliver thematic discussions for clinical and non-clinical staff. The rounds are designed to discuss and normalise the emotional experiences that staff endure as part of their roles. There is a strong evidence base to show the positive impact of Schwartz rounds on staff resilience, compassion and ultimately wellbeing.

A key focus over the next 90 day cycle is the initiation of HCSW forums and Ward Manager forums. So far, LD staff who currently led LD HCSW forums have been consulted for advice and lessons learnt. Staff engagement sessions will commence to shape the format and configuration of the sessions.

Trained Listening Leads act as the link co-ordinator between the staff group and senior managers. The last Listening leads meeting took place on 26th February 2019. In the next quarter, we will be growing the number of Listening Leads in each of the 4 area teams and also bringing about local listening leads meetings to encourage wider levels of communication and staff engagement. The "Be Proud Pioneer Programme" is now being rolled out. The MHLD service have gained 6 places on the very first cohort which is due to start in March 2019.

In February 2019, BCUHB celebrated **Mental Health Nurses Day** to thank and recognise the hard work and commitment of our MHLD nurses. This attracted significant media attention and captured amazing feedback from people within our communities reflecting on their positive experiences of MHLD services from individuals.

We also celebrated 100 years of **Learning Disability Nursing** on St David's Day, a huge success with staff, people who we deliver care to and families joining in on a jubilant day.

Safeguarding and public protection

The MHLD Division has continued to progress the safeguarding agenda with an established safeguarding forum and membership of health board safeguarding governance arrangements. Across the division, all adult at risk records are reviewed weekly for inpatient services and this has now progressed to include community services.

The MHLD level 3 Adult Safeguarding mandatory training will commence May 2019 with a refreshed content including county lines, modern slavery, PREVENT, self-neglect and sexual safety.

The Division is involved in a co-produced project with CANIAD exploring the issue of in-patient mental health sexual safety. That work is progressing well. A group of users of services and practitioners have undertaken a qualitative research project. That has identified a consensus understanding of sexual violence and the barriers that prevent sexual safety from becoming an 'always event'. That work has been accepted for publication in *Issues in Mental Health.*
The second phase of the project addresses those barriers. As part of that we have developed a novel approach towards democratic social research by combining the principles of Appreciative Inquiry and 'TODAYiCAN'. The workshop outcomes are submitted for academic publication to *Journal of Psychiatric and Mental Health Nursing* and, are being worked on within co-production task and finish groups.

Environment

The Section 136 suite in Heddfan is approaching the final stages of completion to produce an environment fit for purpose. Also our OPMH ward have just had a mural painted to help distract patients who become distressed. Using the premise of a "treasure hunt", patients can spot an image in the mural and look for additional matching images. Patients and staff as a successful distraction tool have already used the mural completed by a staff member on the ward.

Medicines Management

The Mental Health Medicines Management sub group (MHMMSG) supports the Mental Health and Learning Disability Division to ensure that all aspects of medicines use are safe, clinically efficacious and cost effective.

The MHMMSG oversees formulary compliance, new drug applications and update of clinical guidelines ensures that standards are achieved and maintained. The MHMMSG has also led on and disseminated POMHUK prescribing audits in collaboration with the Clinical Effectiveness group, which helps monitor clinical practice against NICE guidance and benchmarks practice across the UK. The MHMMSG has produced an action plan going forward into 2019-20 and the emphasis is on improving education and training around medicines management, and improving communication and implementation of guidance on medicines related issues across the Division. A medication microguide has been purchased from a WRVS gift and is in development to provide clinical pathways and patient-friendly information to users via mobile phones. A key priority as part of the 90-day cycle is to conduct reviews of Clozaril, Depot and Lithium clinics.

The MHLD has recently purchased Mediwell machines that will be implemented across the Division to provide assurance of stock control. The MHLD have also engaged with the corporate

Medicines Management Collaborative to ensure the maintenance and audit standards of medicines storage and administration.

8. EXTERNAL REVIEW AND FEEDBACK

It is important to reflect the recent inspectorate visits that have determined a clear improvement year on year of the services delivered, whilst there is always room for improvement. However, focusing on what we do well Health Inspectorate Wales (HIW) have said the following:

Site	HIW Feedback
Ablett Unit 2019 [see appendix 4]	• Patients that we spoke with were complimentary of the care received • Staff interacted and engaged with patients respectfully • Ablett provided a suitably decorated and furnished environment • Established governance arrangements are in place that assisted staff in the provision of safe and clinically effective care • Staff were positive about working at the hospital and the support they received from colleagues • Staff were enabled to complete additional relevant training. • Support arrangements for patients on Tegid to help maintain their independence and dignity • Arrangements for the storage of medication • Mental health service provision within the health board to help meet the needs of its population. • No immediate assurance issues identified by HIW. HIW stated “We saw clear management and leadership which were supported by the health board's organisational structures. There was commitment from the health board to continuously improving its service. We observed a committed staff team at the hospital who spoke of improved staff morale and evidenced a good understanding of the needs of the patients at the hospital”.
Bryn Hesketh 2017	• Leadership at Bryn Hesketh was strong • Staff were dedicated to maximising the patient experience • Refurbishment had improved the dementia friendliness of the hospital • Legal documentation under the Mental Health Act and Deprivation of Liberty Safeguards was compliant with the relevant legislation.
East CMHT 2017/8	• We found the quality of patient care and engagement to be good and service users spoke positively about the support they received. • Good engagement with service users and families • Person centred approach with service users involvement in some aspects of the planning and delivery of care

	• Staff committed to providing a good service • Good team working • Good access to social, employment and educational services • The service users we spoke with during our inspection were positive about the services they received. They described good accessibility of all the people who work within the team. Service Users said they felt included and respected. Also, that they were provided with choice and said they valued the consistency of the support they received.
Hergest 2018:	• Patients that we spoke to were complimentary of the care received • Staff interacted and engaged with patients respectfully • Established governance arrangements that assisted staff in the provision safe and clinically effective care. • We saw clear management and leadership which were supported by the health board's organisational structures. We observed a committed staff team who spoke of improved staff morale and evidenced a good understanding of the needs of the patients at the hospital.

Community Health Council visits

There have been no visits by the Community Health Council to Mental Health facilities during 2019. To ensure progress against recommendations and actions, each of the area management triumvirate teams report through progress at local QSEEL.

9. NEXT STEPS

The responsibility for the strategy (ICAN) and the Quality Improvement (TODAY) methodology (TODAY ICAN) is shared jointly across three levels, the Mental Health Division; BCUHB and the wider health and care system encompassing all partners (existent and new). Much of what is planned here, to be implemented successfully, requires the active support and commitment of partners working together across North Wales. Within that, some actions can be taken forward by BCUHB more independently.

TODAYiCAN confirms our aim to offer a comprehensive range of services which:

- Promote health and wellbeing for everyone, focussing on prevention of mental ill health, and early intervention when required;
- Treat common mental health conditions in the community as early as possible;
- Are community-based wherever possible, reducing our reliance on inpatient care
- Identify and treat serious mental illness as early as possible;
- Manage acute and serious episodes of mental illness safely, compassionately, and effectively;
- Support people to recovery, to regain and learn the skills they need after mental illness

- Assess and treat the full range of mental health problems, working alongside services for people with physical health needs;

TODAYiCAN therefore commits us to a wide range of specific actions and ambitions. Significant amongst those are:

- New services and approaches will be available to promote good mental health: promotion of the five ways to wellbeing; schools-based programmes; employer-based approaches; welfare rights and money advice
- Peer support services will be available as a step-down option from statutory community care
- Social prescribing will be more widely available, promoting access to education, exercise, personal and creative development
- There will be new integrated teams to manage very common co-morbidities between physical and mental health, for example anxiety and COPD
- We will improve the availability of a range of psychological therapies, including online therapeutic interventions
- People experiencing first episode psychosis will have access to the full range of NICE-approved interventions
- There will be alternatives available to inpatient admission for those able to manage safely in more intensive community situations
- All ward environments will be fit for purpose, safe and humane
- Information about patients' history, and care and treatment plans will be available in real-time to all staff working with them
- There will be a realistic and sustainable fit between our service commitments, and the numbers and skills of staff to deliver them
- We will ensure full and effective governance of both our commissioned services, and those we directly provide
- Develop and Launch the MHLD Quality Strategy September 2019
- Implement proposed staffing and workforce redesign models to provide a modern, fit for purpose services offering better care for patients
- Continue progress against PTR and SUI management so we remain within Welsh Government requirements

We look forward to developing closer and stronger working relationships with our partners at all levels of our respective organisations to ensure the continued successful implementation of this strategy.

10. CONCLUSION

The Health Board has urgently focused on reviewing the mental health and learning disabilities division and the development and implementation of a strategy for the division that will deliver sustainable services for the future. This has included significantly improving operational planning including co-production, partnership working, and a transformational review of the service model.

BCUHB has focused on strategy and service change for people who require support for their mental health and wellbeing. Our direction of travel has been supported by Special Measures and it has led to a fundamental shift in the way services are planned and provided.

The priority in developing the Mental Health Strategy in conjunction with the Quality Improvement methodology (TODAY I CAN) has been to ensure ownership and commitment from all stakeholders. Our aim is to develop age inclusive services which deliver person centred care for the population of North Wales.

APPENDIX 1

MHLD Division
Quality Improvement & Governance Implementation Plan (QIGP)

✓ Completed ✓ Underway ✓ Overdue

ACTION	TIMESCALE	LEAD PERSON	PROGRESS REPORT	FURTHER ACTION
▪ Launch of the QIGP within area triumvirate: • Celebration of progress to date. • Fusion of I CAN and TODAY = TODAY ICAN. • Inform of change methodology. • Introduction to the format and template of Local Delivery Plan tool (LDP). • Collaboration on the governance structure to ensure robust scrutiny and implementation of the LDP. • Review of QIGP, internal and external reviews and reports that identify the themes and trends to develop LDP	September 2018	MHLD Director of Nursing, Director of Operations, Director of Transformation, Director of Partnerships, Medical Director, Director of Psychological Therapies	Action Complete Successful procurement of Healthcare 360 to provide training and consultancy to the project Successful cohort of training completed for 90 day facilitator training with a follow up day to consolidate preparation to develop local plans Development of a web page to record TODAY ICAN initiatives launched and in place	✓
▪ Advertisement and recruitment of 1.0 WTE band 8a Change Agent Lead and 4.0 WTE band 5	July 2018 for advertisement	Director of Nursing MHLD	Action complete Recruitment complete with the West Service Improvement	✓

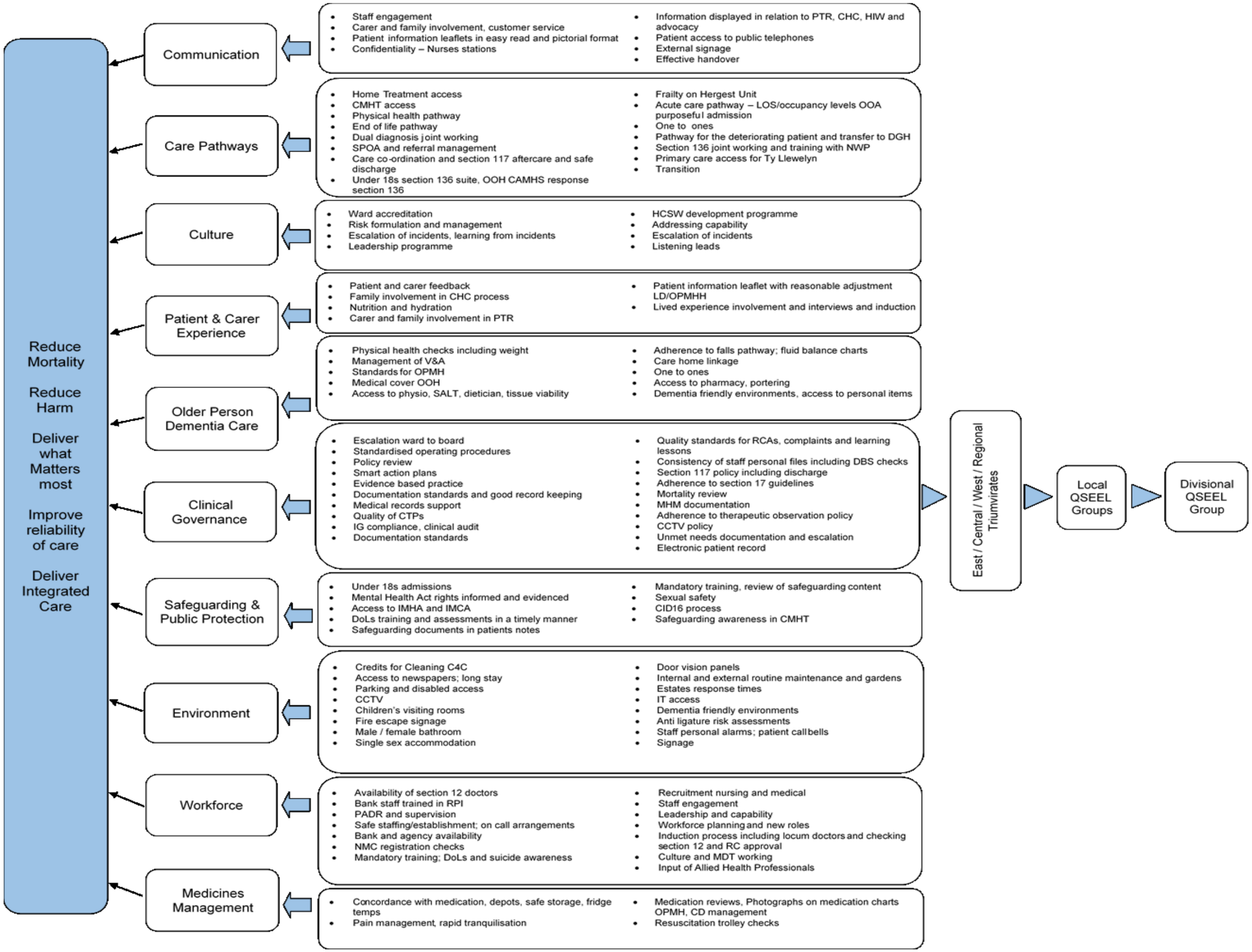
Change Champion Support Managers			Facilitator commencing in April 2019	
▪ Intake of first Change Lead agents cohort – TODAY: • Triumvirates (HOP, HON, CD's) • Safeguarding • Nurse Consultant • Academic Lead • Head of Governance • Investigating team officers.	September 2018	Director of Nursing MHLD	<u>Action complete</u> Training event has taken place in October	✓
▪ Intake of first Change champion agents – TODAY: Operational staff	September 2018	Director of Nursing MHLD	<u>Action complete</u> This training has taken place in December 2018	✓
▪ Terms of Reference for implementation groups (Area Quality & Safety Group). Refreshed ToR to encompass work streams and all agendas to be set to reflect the triple aim: 1) Safe 2) Experience 3) Effectiveness Reflecting also the BCUHB values.	August 2018	Chairs of Area Quality and Safety Groups Head of Governance	<u>Action complete</u> The weekly PTR meeting has been replaced with a local TODAYWECAN (TWC) meeting and exception reporting through to Divisional TWC There have been local QSEEL meetings in each of the 4 area teams and these report through to Divisional QSEEL	✓
▪ Benchmark survey on how the MHLD see change, empowerment, barriers, ability to implement and sustainability.	September 2018	Communication Lead – Patrick Roberts	<u>Action complete</u> Part of the 90 day facilitator training was to complete a DISC questionnaire and this provided a profile on how we see change and influencing style.	✓

▪ Cycle of change methodology implemented – continuous cycle of improvement with change champions undertaking champion training to ensure the #TODAY ICAN ethos is thoroughly embedded	September 2018	Director of Nursing MHLD, Director of Operations, Director of Partnerships, Director of Transformation, Medical Director	<u>Action Complete</u> Change agent training completed December 2018	
▪ Power of 5 testing – show and see.	August 2018	Communication strategy – Patrick Roberts	<u>Action Complete</u> This action is now embedded as a communication method amongst Senior Leaders and change champions	
▪ Each triumvirate to collectively define the objectives for each improvement area in a facilitated learning and change environment.	December 2018	Heads of Nursing, Clinical Director, Head of Operations	<u>Action Complete</u> In sessions facilitated by Healthcare360 the Triumvirates identified their key priorities in each area to help focus the direction of travel	
▪ 2/52ly TODAY Lead change agents accountability meetings with Brian Dolan and DoN MHLD	December 2018	Director of Nursing MHLD	The Improvement Lead for TIC meets every 6 weeks with Healthcare 360 for support and progress reviews	
▪ Setting quality indicators, defining what good to great looks like.	December 2018	Heads of Nursing, Clinical Director, Head of Operations	Ward Accreditation commenced which captures safety and quality indicators. The quality indicators will be defined in the final Quality strategy	
▪ LDP action plans to identify achievements, leads, plans to progress, support	December 2018	Heads of Nursing, Clinical Director, Head of Operations	<u>Action Complete</u> Guided by an overall plan (DAP) which is progressed	

required, options appraisals, prioritisation, risk mitigation to support delivery, outcomes of completion			through the 4 area teams progress is monitored and tracked by the TIC team using a 90 day cycle
▪ Implementation of MHLD ward accreditation.	February 2019	Heads of Nursing	The first MHLD ward Talisein received silver accreditation. Boards have now been designed
▪ Presentation of LDP to area Quality and Safety Group	February 2019	Heads of Nursing, Clinical Director, Head of Operations	Plans to use LDPs have been amended and Divisional Action Plans used instead. DAP to be made available to QSG in May 2019
▪ LDPs presented to MHLD QSE	February 2019	Heads of Nursing	actions are progressed by providing updates from the TIC team who tracks progress against the DAP. DAPS will be made available in all future reports
▪ Sign off of LDP at Divisional Director meeting	March 2019	Director of Nursing MHLD	Regular updates are provided to Divisional Directors on progress of the actions relating to 10 key themes. DAPS will be made available in all future meetings
▪ Monitoring of LDP's through QSE & Divisional Directors	May 2019 & monthly review	Director of Nursing MHLD, Director of Operations, Director of Partnerships, Director of Transformation, Medical Director	The Director of Nursing will provide QSE reports which evidence the completion of actions against the 10 themes and progress on DAP

20)	Establish steering group to develop MHLD Quality Strategy	March 2019	Heads of Nursing, Clinical Directors, Head of Operations	Steering group membership has been identified and awaiting date to commence
21)	Launch of the completed MHLD Quality strategy	July 2019	Director of Nursing, MHLD	Further updates will be provided following steering group meetings
22)	Production of TODAY I CAN progress report for Health Board and Welsh Government	October 2019	Director of Nursing, MHLD	To be finalised nearer the date.

Appendix 2


Reduce Mortality
Reduce Harm
Deliver what Matters most
Improve reliability of care
Deliver Integrated Care
Communication
Staff engagement
Carer and family involvement, customer service
Patient information leaflets in easy read and pictorial format
Confidentiality – Nurses stations
Information displayed in relation to PTR, CHC, HIW and advocacy
Patient access to public telephones
External signage
Effective handover
Care Pathways
Home Treatment access
CMHT access
Physical health pathway
End of life pathway
Dual diagnosis joint working
SPOA and referral management
Care co-ordination and section 117 aftercare and safe discharge
Under 18s section 136 suite, OOH CAMHS response section 136
Frailty on Hergest Unit
Acute care pathway – LOS/occupancy levels OOA purposeful admission
One to ones
Pathway for the deteriorating patient and transfer to DGH
Section 136 joint working and training with NWP
Primary care access for Ty Llewelyn
Transition
Culture
Ward accreditation
Risk formulation and management
Escalation of incidents, learning from incidents
Leadership programme
HCSW development programme
Addressing capability
Escalation of incidents
Listening leads
Patient & Carer Experience
Patient and carer feedback
Family involvement in CHC process
Nutrition and hydration
Carer and family involvement in PTR
Patient information leaflet with reasonable adjustment LD/OPMHH
Lived experience involvement and interviews and induction
Older Person Dementia Care
Physical health checks including weight
Management of V&A
Standards for OPMH
Medical cover OOH
Access to physio, SALT, dietician, tissue viability
Adherence to falls pathway; fluid balance charts
Care home linkage
One to ones
Access to pharmacy, portering
Dementia friendly environments, access to personal items
Clinical Governance
Escalation ward to board
Standardised operating procedures
Policy review
Smart action plans
Evidence based practice
Documentation standards and good record keeping
Medical records support
Quality of CTPs
IG compliance, clinical audit
Documentation standards
Quality standards for RCAs, complaints and learning lessons
Consistency of staff personal files including DBS checks
Section 117 policy including discharge
Adherence to section 17 guidelines
Mortality review
MHM documentation
Adherence to therapeutic observation policy
CCTV policy
Unmet needs documentation and escalation
Electronic patient record
Safeguarding & Public Protection
Under 18s admissions
Mental Health Act rights informed and evidenced
Access to IMHA and IMCA
DoLs training and assessments in a timely manner
Safeguarding documents in patients notes
Mandatory training, review of safeguarding content
Sexual safety
CID16 process
Safeguarding awareness in CMHT
Environment
Credits for Cleaning C4C
Access to newspapers; long stay
Parking and disabled access
CCTV
Children's visiting rooms
Fire escape signage
Male / female bathroom
Single sex accommodation
Door vision panels
Internal and external routine maintenance and gardens
Estates response times
IT access
Dementia friendly environments
Anti ligature risk assessments
Staff personal alarms; patient call bells
Signage
Workforce
Availability of section 12 doctors
Bank staff trained in RPI
PADR and supervision
Safe staffing/establishment; on call arrangements
Bank and agency availability
NMC registration checks
Mandatory training; DoLs and suicide awareness
Recruitment nursing and medical
Staff engagement
Leadership and capability
Workforce planning and new roles
Induction process including locum doctors and checking section 12 and RC approval
Culture and MDT working
Input of Allied Health Professionals
Medicines Management
Concordance with medication, depots, safe storage, fridge temps
Pain management, rapid tranquilisation
Medication reviews, Photographs on medication charts OPMH, CD management
Resuscitation trolley checks
East / Central / West / Regional Triumvirates
Local QSEEL Groups
Divisional QSEEL Group

Appendix 3: BCUB BE PROUD - Key Achievements 2016 - 2019

Ysbyty Gwynedd becomes first acute hospital in Wales to receive 'Dementia Friendly' status

Ysbyty Gwynedd is the first acute hospital in Wales and only the second in the UK to receive official recognition from the Alzheimer's Society for working towards its dementia friendly standards.

Hospital staff have carried out a range of activities and 'dementia friends' training sessions to help colleagues understand more about dementia and how it affects patients and their families.

All of our other community and acute hospitals are working towards achieving these important Alzheimer's Society standards.

Read more: http://www.wales.nhs.uk/sitesplus/861/news/50131

Memory Services receive top accolade from the Royal College of Psychiatrists

We are proud to be the only Health Board in Wales that has Memory Services which have been fully accredited by the Royal College of Psychiatrists.

The Royal College of Psychiatrists' 'Memory Services National Accreditation Certificate' has been awarded to all three of our memory services in recognition of their exemplary practice across key areas identified by mental health professionals, and following feedback from service users, carers and GPs.

Our three memory teams provide an assessment and diagnostic dementia service for people who have early onset of memory problems, and a wide range of person centred support following diagnosis.

Read more: http://www.wales.nhs.uk/sitesplus/861/news/46840

Partnership work with Bangor University's School of Psychology to help people with dementia maintain their skills

We are working in partnership with Applied Behaviour Analysis students from Bangor University's School of Psychology to help patients with dementia maintain their skills and improve their quality of life.

For the past two years, Masters level ABA students have been working in partnership with the ward's multidisciplinary team of staff to find ways to enable patients to maintain their skills; decrease their distress; and train staff and care givers on new approaches to support them.

Read more: http://www.wales.nhs.uk/sitesplus/861/news/49141

Introducing Dementia Care Mapping

Central to our drive to improve the quality of dementia care has been an investment in Dementia Care Mapping, with a number of our staff receiving training from the University of Bradford.

Dementia Care Mapping is an innovative observational tool which is helping our staff deliver truly person centred dementia care.

The framework helps staff record the quality of life and quality of care from the perspective of the person with dementia, providing valuable feedback for staff which is being used to drive continuous improvements across our Older Persons Mental Health wards.

Using Dementia Care Mapping over the past five years has shown a marked cultural change across wards as they have moved to adopt a more positive and person centred approach.

Making our Older Persons Mental Health Wards more dementia friendly

Welsh Government funding has enabled us to transform our three dementia specific wards to make them truly dementia friendly environments.

The significant refurbishment programme has enabled us to meet national quality standards on dementia supportive environments set out by the King's Fund – an influential health and social care charity.

The recently completed improvement work includes new flooring, signage and colour schemes which incorporate the latest guidance from the Royal College of Psychiatrists, with dedicated family rooms established to support our commitment to open visiting.

Read more: http://www.wales.nhs.uk/sitesplus/861/news/48612

Improved safety on our inpatient wards

We have overseen an £8m programme of anti-ligature and environmental improvements across our inpatient estate.

The multi-million pound work has seen improvements introduced at eight different sites and in twenty three different ward environments, which has all been completed whilst clinical teams have continued to provide care.

Treating people with lived experience as equal partners as we work to improve our services

We have continued to develop our approach to co-production as we work towards ensuring that everything we do sees people with lived experience as equal partners.

Through Caniad, a service user involvement organisation we established in 2016, service user and carers are represented at every level of implementation of the *Together for Mental Health*

in North Wales strategy, enabling people with a lived experience to have their voices heard and hold us to account on our progress.

We have also established a number of feedback tools such as service user forums and carer champions groups, which enable people with lived experience to provide regular feedback which is helping to drive service improvement.

Introduction of Value Based Interviewing

Patients and carers now play an active part in the recruitment of new mental health and substance misuse staff in North Wales. Service users and their carers now routinely sit on interview panels and ask candidates a range of questions to assess their values, behaviours and motives.

The move forms part of ongoing efforts to give people with a lived experience of mental health and substance misuse issues a stronger voice while ensuring that candidates' values align with those of the health board.

Read more: http://www.wales.nhs.uk/sitesplus/861/news/48130

Reducing assaults on mental health staff

Thanks to the innovative work of our specialist violence and aggression prevention nurses, assaults on staff working in mental health services have reduced by almost 50% in the last five years.

The team lead preventative work that includes the establishment of person centred behaviour support plans for at risk patients, and violence and aggression training for frontline mental health staff.

The team are now leading national work to address the problem with Health Boards across Wales.

Read more: http://www.wales.nhs.uk/sitesplus/861/news/46525

Barbers mental health training to cut male suicide

We recently launched a training programme for workplaces which is aimed at giving people the basic skills, knowledge and confidence to provide mental health support.

Initially aimed at North Wales barbers, the training will help spot the warning signs of mental health problems in their customers and provide best practice guidance on how to listen, give helpful advice, and signpost to support services.

We hope to roll the initiative out to other workplaces across the region in the coming months.

The training drive forms part of our ambitious integrated mental health strategy, which places a strong emphasis on working to prevent mental health crises by focussing on prevention and promoting emotional resilience

Read more: http://www.wales.nhs.uk/sitesplus/861/news/49858

North Wales' first running club for people with mental health problems

Our Anglesey Community Mental Health Team recently founded a *Couch to 5k* running group for people struggling with mental ill health, which is thought to be the first of its kind in North Wales.

It has been established by Betsi Cadwaladr Health Board's Anglesey Community Mental Health Team with the aim of breaking a cycle of mental illness and physical ill health.

Those taking part in the group say it is helping them manage and improve their anxiety, low mood and self-esteem, make new friends, and improve their physical and mental health.

Read more: http://www.wales.nhs.uk/sitesplus/861/news/48746

National recognition for patient falls reduction initiatives

A Wrexham based hospital matron has been recognised for dramatically reducing the number of falls sustained by elderly patients with mental health problems.

Mike Shone, from Wrexham Maelor Hospital's Heddfan Unit, was named the runner up at the Chief Nursing Officer for Wales awards, which celebrate the innovative ideas and excellent practice of NHS staff.

Mike and his team were recognised for introducing a new approach which led to a 67% reduction in patient falls on the Heddfan Unit's two older person's mental health wards during 2017.

In 2017/18, all but one of our mental health wards achieved a 20-30% reduction in falls.

Mike's approach has proven so successful that it is now being rolled out to other older person's mental health wards across Betsi Cadwaladr Health Board.

Read more: http://www.wales.nhs.uk/sitesplus/861/news/48698

Preventing hospital acquired infections through the Safe Clean Care campaign

The Mental Health & Learning Disabilities Division has embraced the Safe Clean Care campaign, which is focused on significantly improve the safety and care of patients who visit and stay at our hospitals by reducing rates of hospital acquired infections.

Read more: http://www.wales.nhs.uk/sitesplus/861/news/47434

Introducing the 'life changing' 'Moving On In My Recovery' programme

We have successfully introduced the 'Moving on in My Recovery' programme which is helping people achieve a sustained recovery form drug and alcohol addiction.

Unlike many traditional recovery programmes, Moving On In My Recovery has been developed with service users based on what worked for them in recovery. It is delivered by people with a lived experience of addiction, alongside staff from Betsi Cadwaladr Health Board's treatment services.

Read more: http://www.wales.nhs.uk/sitesplus/861/news/48334

Embracing the Paul Ridd Foundation learning disability care bundles and logos

We have adopted the 'Paul Ridd Foundation' logos and care bundles to ensure that staff across BCUHB are aware of the reasonable adjustments they may need to make when caring for a person with a learning disability.

Jayne Nicholls founded the Paul Ridd Foundation in memory of her late brother, who died following failures in his care at a South Wales hospital. She said:

"Betsi Cadwaladr Health Board should be commended for playing a leading role in working with us to establish a common standard in the care of people with learning disability when they are admitted to hospital.

"There are some very driven staff in North Wales who are committed to working with us and other Health Boards across Wales to deliver meaningful change in the care of people with learning disabilities."

Read more: http://www.wales.nhs.uk/sitesplus/861/news/45440

Perfect 100% score for BCUHB Learning Disability team in Royal College of Psychiatrists re-accreditation

Staff from Mesen Fach Ward at Bryn y Neuadd Hospital, Llanfairfechan, have been recognised by the Royal College of Psychiatrists for the exceptional support provided to people with learning disabilities across North Wales. The team became the first learning disability service in the UK to receive accreditation from the Royal College of Psychiatrists in 2011.

Following a rigorous audit of the service and feedback from patients, carers and other healthcare professionals which resulted in a perfect 100% score across all measures, the team have been re-accredited with the Quality Network for Learning Disabilities award.

Read more: http://www.wales.nhs.uk/sitesplus/861/news/47052

Helping mentally disordered offenders leave their violent pasts behind them

Staff at our Ty Llywelyn Medium Secure Unit say they have seen “huge changes” in the behaviour of service users who have taken part in ‘Life Minus Violence’ therapy, which supports patients to respond to difficult situations in a non-aggressive way.

Over the past two years, a number of service users who have a history of aggressive behaviour have undergone intensive weekly sessions aimed at giving them the skills to recognise why they may become aggressive and strategies to prevent them turning to violence.

The innovative therapy programme has played a key role in preparing service users for discharge back into the community, with many patients reporting that they can now recognise their emotions more effectively and the circumstances in which they may become aggressive.

Read more: http://www.wales.nhs.uk/sitesplus/861/news/45933

Establishing the North Wales Perinatal Mental Health Service

In 2017 we established the North Wales Perinatal Mental Health Service, which provides prediction, prevention, detection and treatment of mental health problems affecting women in pregnancy and the postnatal year.

Research shows that up to 20% of women develop a mental health problem during pregnancy or within a year of giving birth.

A large part of the Perinatal Mental Health team’s role is to educate and train staff in all services that pregnant women come into contact with.

Recent funding secured from the Welsh Government’s Transformation Fund will enable us to expand the service.

Making suicide and self-harm prevention in North Wales communities ‘everyone’s business’

We are working with our partners and people with lived experience of mental health problems to implement our suicide and self-harm prevention strategic action plan, which aims to make the issue ‘everyone’s business’.

The plan is targeting priority groups across North Wales which include men in mid-life; older people over 75 years with depression and a physical illness; children and young people with a background of vulnerability; people in mental health services and people with a history of self-harm.

Amongst the priority actions in the plan are improved outcomes for people experiencing a mental health crisis, further training for professionals who frequently come into contact with people at risk of suicide or self-harm and an improvement in data on suicide and self-harm in North Wales.

Read more: http://www.wales.nhs.uk/sitesplus/1002/news/47627

Celebrating our award winning staff

We are proud of the achievements of a number of our dedicated staff who have achieved national and international recognition for their exemplary practice over the past two years.

Our Consultant Psychiatrist Dr Rob Poole received a lifetime achievement award from the Royal College of Psychiatrists in recognition of his tireless work to improve mental health services for deprived and marginalised people.

Cemlyn Roberts, a Healthcare Support Worker who supports adults with learning disabilities, was named the Royal College of Nursing's 'Healthcare Assistant of the Year' in recognition of his 'patient, kind and caring' approach to supporting people with learning disabilities who are anxious about visiting their GP.

Consultant Psychiatrist Dr Alys Cole-King is the first person from the United Kingdom to be awarded the prestigious Ringel Service Award from the International Association for Suicide Prevention (IASP) for her innovative support of people at risk of suicide in North Wales and further afield.

Learning Disability Nurse Jean Morgan was named the winner of the Paul Ridd Foundation's Primary Care and Community Support Award for her dedication in ensuring that people with learning disabilities have their voices heard and their health needs responded to.

Staff from the Ablett Psychiatric Unit at Glan Clwyd Hospital have scooped a top award from North Wales Police for their partnership work to keep vulnerable patients safe and reduce the need for police assistance.

Many more of our staff have received recognition at the Betsi Cadwaladr University Health Board Achievement Awards.

Psychiatric Liaison teams recognised for working to the highest national standards

Our three Psychiatric Liaison teams are accredited by the Psychiatric Liaison Accreditation Network (PLAN) via the Royal College of Psychiatrists', demonstrating the high standard of care provided to people with mental health needs who are admitted to our general hospitals. BCUHB is the only health board in Wales to achieve this.

The Psychiatric Liaison teams work 24/7, 365 days a year offering assessments and brief interventions where there are concerns about the mental health of a person who has attended our District General Hospitals.

Recent developments have seen all three teams become more multidisciplinary, while ever closer partnership work with North Wales Police and the Welsh Ambulance Service is driving improvements in the support they are able to offer.

Supporting the rights of carers to stay with loved ones who have dementia through John's Campaign

In 2016 Betsi Cadwaladr University Health Board was the first in Wales to formally adopt John's Campaign: which supports the right of a carer to stay with an individual with dementia in hospital.

The Mental Health & Learning Disabilities Division has embraced John's Campaign, establishing dedicated family rooms on our Older Persons Mental Health Wards and welcoming the open visiting policy which was introduced across BCUHB in 2018.

The open visiting policy has removed restricted visiting hours, offering increased flexibility for families, friends and carers in recognition of the important role they can play in helping many of our patients get better.

Read more: http://www.wales.nhs.uk/sitesplus/900/news/45875

Helping patients recover closer to home

During 2017/18 we achieved a 96 per cent reduction in the number of days our patients spent at mental health units outside of North Wales. This was a key priority in our mental health strategy *Together for Mental Health in North Wales*.

The significant reduction enabled us to make a saving of almost £3m, but more importantly, it ensured that more patients could receive care and treatment closer to the support network of friends and family.

We have sustained this progress in 2018/19.

Assaults on mental health staff halved in five years

Assaults on our Mental Health & Learning Disability Division staff have reduced by 50% between 2013-14 and 2017-18, with a 16% reduction achieved in the last year.

This significant reduction is a direct result of our investment in a team of specialist nurses who work proactively with frontline staff, carers and patients to improve standards of care.

Central to the Positive Interventions Clinical Support Service's (PICSS) approach is helping frontline staff meet the needs of their patients in the least restrictive way. The four strong team help to establish person-centred behaviour support plans for at risk patients, which take account of their individual wishes and needs as well as encouraging the involvement of relatives and carers.

They also deliver violence and aggression prevention training to all frontline staff, which gives them the skills to safely deescalate difficult situations and recognise triggers which can lead to patients exhibiting challenging behaviour

BCUHB is one of only a small number of NHS providers in the UK to employ such a team on a full time basis.

Read more: http://www.wales.nhs.uk/sitesplus/861/news/50615

Celebrating the first Mental Health Nurses' Day

We marked the first national Mental Health Nurses' Day by inviting the general public to tell us how our mental health nurses have touched their lives.

We were inundated with supportive messages from current and former service users, their carers and family members.

Amongst those to provide positive feedback was Malan Wilkinson from Caernarfon, who says she wouldn't be here today without the support of our mental health nurses.

She said: "I would like to thank our mental health nurses for all their hard work. Without their care and understanding, I doubt I'd still be here. The impact they have had on my life seems near immeasurable. They supported me when I needed it most, but they also gave me faith. Faith that I could come through the dark episodes by working alongside them.

Read more: http://www.wales.nhs.uk/sitesplus/861/news/50416

Dementia friendly name badges introduced following Bangor University research

Following research conducted by Applied Behaviour Analysis students from Bangor University, staff working on our Older Persons Mental Health Wards have adopted new 'dementia friendly' name badges to help to build relationships between staff and patients.

The new badges, which use a large black font on a high contrast yellow background, have been specifically designed to make them easier for patients with dementia to read. They have been introduced following concerns that names of staff are difficult to remember by people with dementia and that the information shown on traditional NHS name badges is complex and difficult for patients with dementia to read.

Read more: http://www.wales.nhs.uk/sitesplus/861/news/50380

Establishing dedicated facilities for end of life care on our Older Persons Mental Health Wards

All three of our dementia specific wards now have dedicated facilities to provide suitable end-of-life care.

This forms part of our efforts to improve the quality of Older Person's Mental Health services and act on the recommendations of external reports by the Health and Social Care Advisory Service and health investigator Donna Ockenden.

This has seen us significantly increase spending on these services, while improving staff training, care practices, and our approach to involving family members and carers.

A new end of life care framework has also been introduced for patients on dementia wards as well as new staff training. There is also a new joint assessment to be undertaken by families and clinicians to ensure that all the persons needs can be met on the ward.

Read more: http://www.wales.nhs.uk/sitesplus/861/news/50354

Establishing I CAN Mental Health Urgent Care Centres at our three main hospitals

We have established CAN Centres at Ysbyty Gwynedd, Glan Clwyd Hospital and Wrexham Maelor Hospital. The centres provide an alternative to formal hospital based assessment and care for people over the age of 18 who are experiencing low level social and mental health difficulties outside of usual working hours but don't need to be treated at an Emergency Department or by a Mental Health Practitioner.

Their introduction is part of our ambitious plan to improve mental health support in North Wales which has seen a number of organisations including BCUHB, North Wales Police, local authorities, Welsh Ambulance Service and mental health charities working much more closely together in order to establish a seamless integrated urgent care system for people who experience a mental health crisis.

Read more: http://www.wales.nhs.uk/sitesplus/861/page/97914

Improving standards of care on our inpatient mental health wards

Reports from recent unannounced inspections of the Hergest Unit at Ysbyty Gwynedd and Ablett Unit at Glan Clwyd Hospital by Healthcare Inspectorate Wales show that standards of care and staff morale on our inpatient mental health units are improving.

The inspection report from HIW's unannounced visit to the Ablett Unit, which was published on April 17th 2019 [appendix 4], found that patients received safe and effective care which was delivered by staff who were committed to meeting high standards.

They also noted that staff morale had increased significantly since their visit in February 2018, and the unit benefitted from clear management and leadership.

Ablett Unit staff were praised for delivering a range of therapeutic activities, and working closely with community services to support patients' recovery.

NHS Mental Health Service Inspection (Unannounced)

Ysbyty Glan Clwyd

Ablett Unit

Betsi Cadwaladr University

Health Board

Inspection date:

16 - 18 January 2019

Publication date: 17 April 2019

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Contents

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that people in Wales receive good quality healthcare

Our values

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

- **Independent**
- **Objective**
- **Caring**
- **Collaborative**
- **Authoritative**

Our priorities

Through our work we aim to:

Provide assurance:	**Provide an independent view on the quality of care**
Promote improvement:	**Encourage improvement through reporting and sharing of good practice**
Influence policy and standards:	**Use what we find to influence policy, standards and practice**

1. What we did

Healthcare Inspectorate Wales (HIW) completed an unannounced mental health inspection of the Ablett Unit within Betsi Cadwaladr University Health Board on the evening of 16 January 2019 and following days of 17 and 18 January. The following sites and wards were visited during this inspection:

- Dinas - Adult acute mental health admission ward
- Tegid - Older person functional mental health ward
- Cynnydd - Male locked rehabilitation ward

Our team, for the inspection comprised of one HIW inspector, three clinical peer reviewers (one of whom was the nominated Mental Health Act reviewer) and two lay reviewer(s). The inspection was led by a HIW inspection manager.

During this inspection, we reviewed documentation for patients detained under the Mental Health Act 1983 in order to assess compliance with Act.

HIW explored how the service met the Health and Care Standards (2015). Where appropriate, HIW also consider how services comply with the Mental Health Act (1983), Mental Health (Wales) Measure (2010), Mental Capacity Act (2005) and Deprivation of Liberty Safeguards.

Further details about how we conduct NHS mental health service inspections can be found in Section 5 and on our website.

2. Summary of our inspection

Overall, we found evidence that the Ablett Unit provided safe care, delivered by committed staff.

Improvements had been made to the environment of care which benefited the patient experience. However, further developments are required to ensure that the hospital reflects future service provision needs.

This is what we found the service did well:

- Patients that we spoke with were complimentary of the care received
- Staff interacted and engaged with patients respectfully
- Provided a suitably decorated and furnished environment
- Established governance arrangements that assisted staff in the provision of safe and clinically effective care
- Staff were positive about working at the hospital and the support they received from colleagues
- Enabled staff to complete additional relevant training.

This is what we recommend the service could improve:

- Support arrangements for patients on Tegid to help maintain their independence and dignity
- Arrangements for the storage of medication
- Mental health service provision within the health board to help meet the needs of its population.

3. What we found

Background of the service

Ablett Unit provides NHS mental health services at Ysbyty Glan Clwyd, Rhuddlan Rd, Bodelwyddan, Rhyl LL18 5UJ within Betsi Cadwaladr University Health Board.

The service has three wards:

- Dinas, an acute admission mental health ward which comprises of two areas, Dinas Male with 10 beds and Dinas Female with 10 beds
- Tegid, an older person mixed gender functional mental health ward with 10 beds.
- Cynnydd, a male locked rehabilitation ward with eight beds.

The Ablett Unit has a dedicated Section 136 Suite[1].

[1] Section 136 gives the police the power to remove a person from a public place, when they appear to be suffering from a mental disorder, to a place of safety. A Section 136 Suite is a designated place of safety.

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.

We observed that staff interacted and engaged with patients appropriately, and treated patients with dignity and respect. Patients that we spoke with confirmed this.

Patients were supported in a range of activities, both within the hospital and the local community, which provided them with the opportunity to engage in a rehabilitative programme of care that promoted recovery and independence.

However, there are bed capacity pressures within the health board's mental health provision that can impact upon the timeliness of care. The health board must continue to develop its model of care and in-patient capacity to ensure it meets the needs of its population in a timely manner.

Staying healthy

Each of the four wards had occupational therapy and activity co-ordinator input. These teams provided activities that were appropriate to each specific ward; be it the acute admission, male rehabilitation or older person functional wards. It was pleasing to hear from the patients and staff that we spoke with during the inspection, that they thought highly of the input from the occupational therapy team and the activity co-ordinators.

The occupational therapy team worked across the in-patient wards at the Ablett Unit and the local Home Treatment Team[2]. This enabled collaborative working within the community and hospital of occupational therapy assessments along the patient pathway which addresses barriers to discharge.

The Ablett Unit had a wide range of activities available to patients both on the ward, hospital grounds and within the local community. It was evident that there was great emphasis on utilising community services as part of rehabilitative programme of care. Where possible the wards worked with community based organisations which would enable patients to continue to engage with the organisations following their discharge from hospital.

The Ablett Unit had Activities of Daily Living (ADL) kitchens so that the occupational therapist could assess patients' abilities and needs. These facilities enabled patients to maintain and learn skills. Patients were able to, be supported when required, shop for ingredients and products as part of developing healthy eating, cooking and budgeting skills.

Cynnydd had an onward ADL kitchen equipped with two ovens with oven-top hobs. However, neither of the extractor fans were working, therefore there could be an unnecessary build-up of steam, smoke and odour within this area.

Patients from Dinas and Tegid accessed the ADL kitchen that was located within the centralised Ablett Unit activity area. This had two ovens with oven-top hobs, however, one oven was out-of-order at the time of the inspection and therefore, limited the opportunities for patients in this kitchen.

Cynnydd had a range of accessible facilities on the ward which enabled patients to participate in activities and therapies on the ward, these included a pool table, table tennis and arts and crafts.

Patients from Dinas and Tegid accessed the hospital's centralised activity area which we observed to be regularly utilised throughout the inspection. However, staff did state that it was difficult to motivate some patients from these wards, to leave the ward areas to participate in activities.

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[2] Home Treatment Teams are made up of specialist mental health professionals who can respond to acute mental health problems by providing intensive home based therapies and support as a safe alternative to admission as an inpatient.

Patients were encouraged to participate in exercise activities as part of healthy living, this included walks, cycling, swimming and accessing the local gym. We saw a number of patients utilising these activities during the inspection. It was positive to note that Cynnydd worked with other rehabilitation services within the health board to facilitate joint activities.

Patients' records evidenced detailed physical healthcare being provided to patients.

Improvement needed

The health board must ensure that there are working extractor fans within Cynnydd ADL kitchen.

The health board must ensure that all appliances within the central ADL kitchen are working.

Dignified care

We observed that all staff interacted and engaged with patients appropriately and treated them with dignity and respect throughout the inspection.

The staff we spoke with were passionate about their roles and enthusiastic about how they supported and cared for the patients. We heard staff speaking with patients in calm tones throughout our inspection. We observed staff being respectful toward patients including prompt and appropriate interaction in an attempt to prevent patient behaviours escalating.

Patients' dignity was supported by gender specific ward areas. Further to this, Cynnydd is now a male rehabilitation ward, whereas during our previous inspection this was mixed gender and posed difficulties to maintain patient gender separation, and appropriate gender balance of staff.

Whilst Dinas is a mixed gender ward, there is a clear division between the male and female sides of the ward, where the ward is divided by a hospital corridor with a set of doors each side to enter each area. We were informed that on occasions if there was too great of demand for male beds, that a male patient may use a bedroom on the female side of the ward. Whilst this is not ideal, the bedroom used would be the closest one to the nursing station at the entrance to the female side of the ward. Staff would also be able to secure a ward door in-between the bedroom that the male patient was using, and the remaining female bedrooms to prevent direct access between the two bedroom areas.

Tegid is a mixed gender ward with designated gender bedroom areas. However, at the time of the inspection the bathroom and toilet on the male side of the ward were out-of-order. This meant that male patients had to access the facilities on the female side. We were informed during the inspection feedback session with the senior health board staff that the bath had been repaired during the inspection, and the required works around the toilet would be completed the following week.

Despite the repair to the bath this facility was not suitable with the use of a hoist. Therefore, patients who would require a hoist were unable to use the bath on the ward.

The toilet on the female side of Tegid was too narrow to support patients to enter and use the toilet, if using a walking aid such as, a Zimmer frame. Staff stated that on occasions they have had to support a patient in the toilet whilst leaving the door open which impacts significantly on the patient's privacy and dignity. This needs to be addressed promptly, so that staff can provide the required support to some patients when using the toilet, without impacting on their dignity.

Both Tegid and Cynnydd had individual bedrooms. Dinas accommodation was mostly individual bedrooms apart from one shared two bedded room on the male side of the ward, and two shared two bedded rooms on the female side.

The individual bedrooms provided patients with an appropriate level of privacy. Beds within shared rooms were separated with curtains which provided only the most basic form of privacy.

It was positive to note that the health board had undertaken refurbishment of the ward environments, including bedrooms, bathroom and toilets, which assisted in providing the wards with a brighter and more modern feel, than we saw during our previous inspections, despite the structural limitations of the hospital. In addition, ward staff had shown a strong willingness and commitment by undertaking additional decoration to the ward environments, which further enhanced their appearance.

The Ablett Unit had an additional room near Dinas with a single bed that could be utilised if a patient admission was required and the ward was fully occupied. The health board referred to the additional bed on each of the wards as an escalation bed.

The health board had a policy for the use of escalation beds across its service. Senior managers within the health board confirmed that there was ongoing capacity and demand analysis being undertaken.

Whilst we understand the necessity in providing a bed to maintain a patient's safety during a necessary admission, the health board must ensure that there is sufficient in-patient capacity within the health board to meet the needs of its population. This must be undertaken without impacting upon dignified care, with the use of escalation beds or sleeping patients in opposite gender bedroom areas.

On the whole it was evident that the health board and its staff were currently maintaining the privacy and dignity of patients within the structural constraints of the physical environment. It was positive that senior managers within the health board provided an overview of the planned developments for the hospital, and their visions for the future provision to further improve the environment of care to meet the needs of its population.

The Ablett Unit had a Section 136 Suite where the police could bring people for a Mental Health Act assessment. The Section 136 Suite was adequately equipped to provide comfort and safety for a person awaiting and undergoing an assessment. However, as identified on our previous inspection, the location of the Section 136 Suite impacted upon Cynnydd to which it was adjoined.

When the Section 136 Suite was in use, the staff nurse facilitating the Section 136 would use the clinic room on Cynnydd as their base therefore, restricting access to the clinic for Cynnydd staff. Whilst the health board had provided an alternative room for the medication trolley to be stored securely during these times, the arrangement was far from ideal.

In addition, patients on the ward could see through to the Section 136 area and staff stated that the presence of police officers within this area had on occasions disturbed patients on the ward. It was also said that if the person within the Section 136 Suite was presenting with challenging behaviours, that this disturbance could be overheard on the ward and was unsettling for some patients. The above issues also impacted on the privacy and dignity of the person.

The health board had considered these areas of concern in the plans for the redevelopment of the Ablett Unit, however, in the meantime it needs to review the current Section 136 Suite arrangements and consider what further improvements can be taken to lessen the impact upon Cynnydd for both patients and staff.

Improvement needed

The health board must ensure Tegid ward has a bath that can be used with a hoist.

The health board must ensure that toilet facilities on Tegid allow for patients to be supported by mobility aids and/or staff members.

The health board must review the current Section 136 Suite arrangements and consider what further improvements can be made to lessen the impact upon Cynnydd, for both patients and staff.

Patient information

There was a range of up-to-date information available within the hospital.

Notice boards on the wards provided a wide range of detailed and relevant information for patients in both English and Welsh, this included information on the Mental Health Act, advocacy provision and how to raise a complaint.

However, there was no information displayed on the role of Healthcare Inspectorate Wales and how patients and staff could contact us.

Improvement needed

The health board must ensure that there is information displayed on the role of Healthcare Inspectorate Wales and how to contact us.

Communicating effectively

Through our observations of staff and patient interactions, it was evident that staff ensured that they communicated appropriately and effectively with patients. Staff took time to have discussions using words and language suitable to the individual patient. Where patients remained unclear, or what they were trying to communicate was misunderstood, staff would patiently attempt to explain what they had said.

For individual meetings, patients could have assistance from external bodies to provide support and guidance, such as solicitors or advocacy. With patients' agreement, their families and/or carers could also be present.

Patients we spoke with confirmed that staff communicated clearly and that they understood their care.

Each ward had daily planning meeting every morning to arrange the activities, within the hospital and the community, alongside other activities and meetings, such as care planning meetings, tribunals, medical appointments, etc.

Timely care

For Dinas and Tegid each morning there were Acute Care Meetings with multidisciplinary team members and representatives from the community services. Each patient being cared for at the hospital was discussed in turn, along with patients that may need admission if they required greater support and interventions than what could be provided within the community.

For Cynnydd these meetings were held twice weekly; these being less frequent was appropriate to reflect the longer duration that patients will remain in the care of rehabilitation services.

We attended one meeting and observed detailed discussions around individual patient care and how best to meet their needs. There was a clear focus on timely patient recovery and appropriate discharge.

During our inspection the adult acute ward (Dinas) at Ablett and other acute wards across the health board were at full occupancy. The escalation bed at Ablett was being utilised on occasions to manage patient flow. Staff confirmed that full occupancy was a regular occurrence and that this was the case for other mental health wards within the health board. Across the health board, occupancy levels were monitored daily by senior management.

As noted during previous inspections, due to the bed occupancy levels, there were occasions when patients were being admitted to a ward within the health board that had an available bed, instead of the ward at the patient's local mental health hospital. Any Out of Area Placements were monitored daily by senior management, so that attempts to return the patient to their local hospital could be facilitated as soon as possible.

The occupancy levels and demand on the capacity of the mental health service, caused delays to patients accessing timely care within their local mental health hospital most appropriate to their needs.

In addition, there was a frequent use of the Section 136 Suite; this increased the demand on the health board's mental health service with unscheduled mental health assessments. Each shift there was a Duty Manager whose role incorporated the management on the Section 136 Suite and facilitated the assessment. Where the person was assessed as requiring admission to hospital, at least one staff member would be required to remain with the patient

in the Section 136 Suite, until a bed became available at Ablett or another hospital. This then impacted on the staffing levels within the ward.

The health board monitored the use of the Section 136 Suite and engaged with the local police to ensure local protocols were followed to meet the needs of the individuals and both services.

Individual care

People's rights

Legal documentation to detain patients under the Mental Health Act or the use of Deprivation of Liberty Safeguards was compliant with the relevant legislation. However, we identified areas for improvement with regards to the Mental Health Act Code of Practice for Wales; this is detailed further in the Monitoring the Mental Health Act section of the report.

Patients could also utilise the Independent Mental Health Advocacy (IMHA) service, where a representative could be contacted via telephone or when they attended the hospital. Staff and patients commented favourably upon the input of the advocacy representatives.

Listening and learning from feedback

Staff throughout the inspection stated that they regularly deal with patients' requests and concerns as they occur on the ward. We observed this to be the case throughout the inspection on each of the wards and staff were compassionate yet professional in dealing with patient requests.

Patients were able to provide feedback using a feedback form "Tell Us…. We'll Listen" which was available at the hospital. Information was also available on the NHS Putting Things Right.

It was also positive to note that there were carers champions and with regular Carers Champion meetings held.

Delivery of safe and effective care

We considered the extent to which services provide high quality, safe and reliable care centred on individual patients.

The refurbishment of the hospital had on the whole provided a suitably furnished environment with furniture, fixtures and fittings. However, there remains limitations to the improvements that can be made without significant structural work.

There were established clinical governance and audit arrangements in place at the hospital. This assisted staff to provide safe and clinically effective care, however, improvements are required in respect of the storage of medicines.

Patient records contained comprehensive documentation for assessing, providing and reviewing care that evidenced clear multidisciplinary working.

Safe care

Managing risk and promoting health and safety

There were established processes in place to manage and review risks, and to maintain health and safety at the hospital. This assisted staff to provide safe and clinically effective care.

The Ablett Unit is located within the grounds of Ysbyty Glan Clwyd with its own entrance and staffed reception during the day. During the evening and night, the entrance to Ablett Unit is secured to prevent unauthorised entry. A telephone number was displayed to contact the unit when the entrance was closed. However, this required the person to have access to a phone. The health board should consider installing an intercom to assist communication with the wards.

The health board had undertaken significant anti-ligature refurbishment to mitigate the risk of patient self-harm. In response to our previous inspection the health board had also installed observation panels on bedroom doors and nurse call buttons within the bedrooms, so that patients could summon assistance if required.

Staff wore personal alarms which they could use to call for assistance. Since our previous inspection the health board had relocated the nursing office on Tegid which staff reported had aided observations. However, the lines of observation were still restricted due to the physical structure of the ward. The health board shared their proposed long-term plans to redevelop the Ablett Unit to further improve the environment of care.

On the whole the furniture, fixtures and fittings on each of the wards were appropriate for the intended patient group. However, on the female side of Dinas there was significant damage to seating and some damage to sofas and chairs on the male side. Also, as detailed in the dignified care section of the report, there were limitations in being able to provide support to patients on Tegid, to use the bath or the female toilet.

Each ward had its own garden area that patients could access. Since our previous inspection, the health board had significantly improved the Tegid garden area and resurfaced the space with all-weather flooring. The health board also had plans to improve other garden spaces at the hospital.

There were established systems in place for assessing and monitoring patients' level of agitation, and staff were trained in recognised Restrictive Physical Intervention (RPI) techniques for managing patient behaviours. We reviewed training statistics which showed that there were high completion rates for permanent ward staff.

An electronic system was in place for recording, reviewing and monitoring incidents. Incidents were entered on to the system that included the names of patient(s) and staff involved, a description, location, time and length of the incident. Any use of restraint was documented. There was a hierarchy of incident sign-off with regular incident reports produced and reviewed so that the occurrence of incidents could be monitored and analysed.

Improvement needed

The health board must confirm that all damaged furniture on Dinas has been repaired or replaced.

Infection prevention and control

There were established systems of regular audit in respect of infection control in place. This was completed with the aim of identifying areas for improvement so that appropriate action could be taken where necessary. Staff confirmed that

cleaning schedules were in place to promote regular and effective cleaning of the hospital and were aware of their responsibilities around infection prevention and control.

Throughout the inspection, we observed that the hospital was visibly clean and free from clutter. There were hand hygiene products available in relevant areas; these were accompanied by appropriate signage. Cleaning equipment was stored and organised appropriately. Staff also had access to infection prevention and control, and decontamination Personal Protective Equipment (PPE) when required.

The training statistics provided by the health board evidenced that the compliance rate for staff at Ablett Unit for Infection Prevention and Control was in excess of the organisational compliance rate target of 80%; with Dinas compliance above 90% and Cynnydd above 95%.

Nutrition and hydration

Patients were provided with meals at the hospital making their choice from the hospital menu, and they also had access to drinks and fresh fruit on the wards. The patients we spoke with were positive about the food provided.

As stated earlier, patients also had the opportunity to use the ADL kitchens to provide their own meals.

Medicines management

Overall, medicines management at the Ablett Unit was safe and effective. There was regular pharmacy input and audits undertaken that assisted the management, prescribing and administration of medication at the hospital.

On the whole medication was stored securely with cupboards and medication fridges locked and medication trolleys secured. However on Dinas staff were unable to lock one medication cupboard. We also noted that on one occasion the individual drawers on the medication trolley were left unlocked within the clinic room. These jeopardised the security of medication.

There was evidence that there were regular temperature checks of the medication fridge and ambient room temperature of clinics to ensure that medication was stored at the manufacturer's advised temperature.

There were appropriate arrangements for the storage and use of Controlled Drugs and Drugs Liable to Misuse. These were accurately accounted for and checked as required.

The Medication Administration Records (MAR Charts)[3] we reviewed, contained the required patient information, and where applicable included a copy of the most recent Mental Health Act consent to treatment certificate(s).

On the whole MAR Charts were signed and dated when medication was prescribed and administered, and a reason recorded when medication was not administered. We reviewed a large sample of MAR Charts across the Ablett Unit, however, on three occasions it was noted that the record of administration of medication had not been completed.

The clinic room on Tegid was small with insufficient storage. It also lacked its own medication fridge and storage for Controlled Drugs. Therefore, medication that required refrigeration and Controlled Drugs were being held within a central clinic room at the Ablett Unit, which meant that registered nurses had to leave the ward to collect certain medication when required. It was confirmed that authorisation for the purchase of a medication fridge had been approved which when installed would assist staff.

Improvement needed

The health board must ensure that all medication cupboards are locked when not in use.

The health board must ensure that there is a medication fridge on Tegid.

Medical devices, equipment and diagnostic systems

There were regular audits of resuscitation equipment undertaken on each of the wards when required, which documented that all resuscitation equipment was present and in date. Each ward had ligature cutters that were stored in designated places.

Safeguarding children and adults at risk

[3] A Medication Administration Record is the report that serves as a legal record of the drugs administered to a patient by a health care professional. The Medication Administration Record is a part of a patient's permanent record on their medical chart.

There were established processes in place to ensure that staff at the Ablett Unit safeguarded vulnerable adults and children, with referrals made to external agencies as and when required.

There were regular reports that were reviewed by senior managers within the health board to enable them to analyse information and monitor the progress of individual cases.

Child visiting was facilitated off the wards in a designated room which was child friendly with paintings on the walls and a selection of toys and games available. This provided a safe area for child visitors.

Effective care

Safe and clinically effective care

Overall, we found governance arrangements in place that helped ensure that staff provided safe and clinically effective care for patients. The arrangements for the hospital disseminated from ward level through to the executive board. These governance arrangements facilitated a two way process of monitoring and learning.

As detailed throughout the report the health board needs to address the deficiencies identified during the inspection and these are detailed, along with the health board's actions, in Appendix C.

Record keeping

Patient records were mainly paper files that were stored and maintained within the locked nursing office, with some electronic documentation, which was password protected. We observed staff storing the records appropriately during our inspection.

We reviewed a sample of patient records across the wards. Patient records contained comprehensive documentation for assessing, providing and reviewing care. Staff made detailed daily entries in records and when required fully completed relevant physical health assessment tools such as pressure sores and nutrition etc. It was evident that staff from across the multidisciplinary teams wrote detailed and regular entries that provided a live document on the patient and their care.

It was noted that some multidisciplinary team members and wards had stamps or stickers with their General Medical Council (GMC) or Nursing and Midwifery Council (NMC) registration number, to aid identifying their entry within patient

records. This is considered noteworthy practice and the health board should consider expanding this to all clinical areas.

Whilst patient files were well organised on Dinas and Cynnydd this was not the case for Tegid. The patient records that we reviewed on this ward were disorganised with information filed in the incorrect section, or missing altogether. This could cause issues with communicating pertinent patient information between the teams, and accurate records of patient care and treatment.

Improvement needed

The registered provider must ensure that patient records on Tegid are systematically organised and contain all relevant patient information.

Mental Health Act Monitoring

We reviewed the statutory detention documents of a total of eight patients across all three wards. We also reviewed the governance and audit processes that were in place for monitoring the use of the Mental Health Act.

It was evident that the detentions reviewed had been applied and renewed within the requirements of the Act. The reason why detention was necessary was documented. It was also positive to note that copies of the Approved Mental Health Professional[4] (AMHP) were available in the patient records. However, we did identify that for one patient that a copy of the renewal of their detention was not in the most recent ward file as would be expected; this was rectified during the inspection.

Whilst there was clear evidence of capacity assessments being regularly completed on Tegid. These were not in place during our review of patient files on Dinas.

[4] An Approved Mental Health Professional is a person who is authorised to make certain legal decisions and applications under the Mental Health Act 1983.

The Mental Health Act Administration Team were organised and proactive in monitoring the use of the Act within the hospital. There were clear records of planning patients' appeals against their detentions. It was noted however, that medical, nursing and social circumstances reports from individual professionals were not always received by the deadline date, which resulted in the Mental Health Act department having to chase reports. This can jeopardise the scheduled hearings being held, and therefore being postponed to a later date.

The above issue was also identified at an inspection in 2018 elsewhere within the health board. Since then the Mental Health Act Administration Team had developed an information leaflet for clinicians, to provide clear guidance on their responsibilities in providing the required information in a timely manner.

Medication was provided to patients in line with Section 58 of the Act, Consent to Treatment. Consent to treatment certificates were kept with the corresponding MAR chart. This meant staff administering medication could refer to the certificate to ensure that medication was prescribed under the consent to treatment provisions of Section 58 of the Act.

Whilst it was evidenced that patients were being informed of their rights under the Act on detention, there was no record of ongoing provision of rights as directed by the Mental Health Act Code of Practice for Wales (Revised 2016). The Mental Health Act Administration Team had developed a form for teams to complete, to evidence that rights were being regularly read but they were not being completed by staff. This means that patients may not be fully aware of their rights under the Act.

All patient leave from hospital had been authorised by the responsible clinician, on Section 17 Leave authorisation forms along with patients signing the forms and receiving a copy. Cynnydd had developed a patient detail log for Section 17 Leave, which provided staff with details of planned destination, clothing description, estimated time of return and other notable information, should a patient not return when expected to. This is noteworthy practice and the health board should consider sharing with other relevant wards and hospitals.

Improvement needed

The health board must ensure that copies of all detention papers are available in the current patient's record.

The health board must ensure that capacity assessments are completed, and that copies of these are available in the patient's record.

The health board must ensure that all disciplines submit their hearing reports in

a timely manner.

The health board must ensure that there is a record of what information the patient has received under Section132 of the Act, along with the details and outcome of the discussion, as guided by the Code, chapter 4.

Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision

We reviewed the care plans of a total of eight patients.

The Care and Treatment Plans reflected the domains of the Welsh Measure with measurable objectives and were regularly reviewed. Overall individual Care and Treatment Plans drew on a patient's strengths and focused on recovery, rehabilitation and independence. Care plans included good physical health monitoring and health promotion.

Care plans were developed with members of the multidisciplinary teams and encouraged patient involvement. To support patient care plans, there were a range of patient assessments to identify and monitor the provision of patient care, along with risk assessments that set out the identified risks and how to mitigate and manage them. However, each patient's Care and Treatment Plan was not written from the patient's perspective but written about the patient. It's important that Care and Treatment Plans are written from the patient's first person perspective to reflect that it is the patient's Care and Treatment Plan.

The health board's risk assessment documentation (part B) used by ward staff within the Ablett Unit, was different to that used by the mental health liaison team[5] located on the same hospital site. This meant that there was some unnecessary duplication of assessment when a patient was admitted via the liaison team to a ward within the Ablett Unit.

[5] Mental health liaison team provide mental health assessment and treatment for people who are inpatients in general hospitals or for those who may go to an A&E department and are in need of a mental health assessment.

Improvement needed

The health board must ensure that Care and Treatment Plans are written from the patient's first person perspective.

The health board must review the range of risk assessment documentation that is being used and where possible amend to a more uniform format.

Mental Capacity Act and Deprivation of Liberty Safeguards

Where required, staff had referred to the local authority to apply Deprivation of Liberty Safeguards for applicable patients. It was evident that the process was being applied appropriately.

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.

We saw clear management and leadership which were supported by the health board's organisational structures. There was commitment from the health board to continuously improving its service.

We observed a committed staff team at the hospital who spoke of improved staff morale and evidenced a good understanding of the needs of the patients at the hospital.

Governance, leadership and accountability

There were defined systems and processes in place to ensure that the Ablett Unit focussed on continuously improving its services. This was, in part, achieved through a rolling programme of audit and its established governance structure, which enabled nominated members of staff to meet regularly to discuss clinical outcomes associated with the delivery of patient care.

As stated earlier, there were established health board systems in place for recording incidents and complaints. Arrangements were in place to disseminate information and lessons learnt from these to staff at the hospital and the wider health board.

Through our conversations with key senior individuals and other members of staff, there was clear leadership and vision for the Ablett Unit (and as part of the wider health board), to focus on development of the service to best meet the needs of the population. This included the challenges faced by the structural restrictions of the current building and wider constraints across the health board's mental health service; particularly pressures on bed capacity.

It was positive to note that the health board had acted upon recommendations of our previous inspections and improved the environment of care within the physical restrictions of the current building. The health board provided

assurance that they were committed to further improve the environment of care at the hospital. The health board shared detailed redevelopment plans for the Ablett Unit that they expect to address the current shortfalls of the site and provide an environment that not only reflects a modern in-patient mental health service, but one that is adaptable to future service provision needs.

As with other areas within the health board, wards at the Ablett Unit were commencing the health board's ward accreditation programme with the aim to ensure high quality, safe and compassionate care. To provide a process of assurance from ward to board and include an Awarded Status, based on the level of success achieved.

On the whole staff spoke positively about the support from colleagues across the disciplines and they stated that morale had increased significantly since the previous inspection. We found that staff were committed to providing patient care to high standards.

It was positive that, throughout the inspection, staff engaged openly and were receptive to our views, findings and recommendations.

Staff and resources

Workforce

The Ablett Unit had established ward teams that evidenced good team working and motivated individuals to provide dedicated care for patients.

There were detailed workforce planning arrangements in place to monitor and manage current and future staffing position, including leave commitments and any long term sickness forecasts.

Each shift had allocated staffing establishment that could be increased to reflect changes in the needs of the patient group. When staffing rotas were unable to be filled by the substantive ward teams, the shortfalls in the shift were referred to the health board's bank system which sourced temporary staff when required.

Staff commentated favourably on the willingness of the ward teams to support each other across the hospital. This enabled the hospital to utilise the staffing resources appropriately to reflect the needs of the wards. During the night shift, there was further emphasis on the ward staff at the Ablett Unit, to work as one team to provide assistance; this included all three wards, the Duty Manager and the mental health liaison team.

We reviewed staff training; it was evident that this was being monitored by the ward managers and senior management, with high compliance in mandatory training. Staff spoke positively of opportunities to access additional training specific to providing care for patients within mental health services.

Statistics provided evidenced that nearly all staff had completed annual appraisals and that senior management were monitoring to ensure that any overdue appraisals were completed. Staff also had regular supervision which again was monitored by the health board to ensure that this was completed throughout the year.

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 NHS mental health services

Our inspections of NHS mental health services 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.

HIW inspections of NHS mental health services will look at how services:

- Comply with the Mental Health Act 1983, Mental Capacity Act 2005, Mental Health (Wales) Measure 2010 and implementation of Deprivation of Liberty Safeguards
- Meet the Health and Care Standards 2015

We also consider other professional standards and guidance as applicable. These inspections capture a snapshot of the standards of care within NHS mental health services.

Further detail about how HIW inspects mental health and the NHS can be found on our website.

Appendix A – Summary of concerns resolved during the inspection

The table below 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 on this inspection	Not applicable	Not applicable	Not applicable

Appendix B – Immediate improvement plan

Service: Ysbyty Glan Clwyd

Unit: Ablett Unit

Date of inspection: 16 – 18 January 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
No immediate assurance issues identified	Not applicable	Not applicable	Not applicable	Not applicable

Appendix C – Improvement plan

Service: Ysbyty Glan Clwyd

Unit: Ablett Unit

Date of inspection: 16 – 18 January 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 there are working extractor fans within Cynnydd ADL kitchen.	1.1 Health promotion, protection and improvement	Minor works form has been received by Estates and will progress the work through to completion.	Matron Regional Services	April 30th 2019
The health board must ensure that all appliances within the central ADL kitchen are working.	1.1 Health promotion, protection and improvement	A replacement appliance has been ordered. All other appliances are in good working order.	Service Manager	Complete

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure Tegid ward has a bath that can be used with a hoist.	4.1 Dignified Care	Following consultation with our patient group a decision has been taken to remove the bath and replace with a shower.	Service Manager	May 30th 2019
The health board must ensure that toilet facilities on Tegid allow for patients to be supported by mobility aids and/or staff members.	4.1 Dignified Care	Four toilets in total. Two of these are suitable for able bodied older persons, two toilets located in separate bathrooms suitable for older persons who require mobility aids and or staff assistance.	Service Manager	Complete
The health board must review the current Section 136 Suite arrangements and consider what further improvements can be made to lessen the impact upon Cynnydd, for both patients and staff.	4.1 Dignified Care	The relocation of the 136 suite is included in the Ablett redevelopment plan In the short term other options are being explored to relocate the S136 suite.	Head of Operations and Service Delivery	October 31st 2019
The health board must ensure that there is information displayed on the role of Healthcare Inspectorate Wales and how to contact us.	4.2 Patient Information	The health board have contacted HIW to request approved contact information posters and have been informed that this is not available at the present time. HIW will forward information to the Division as soon as it becomes available.	Business Support Manager	Awaiting official HIW information posters

Improvement needed	Standard	Service action	Responsible officer	Timescale
Delivery of safe and effective care				
The health board must confirm that all damaged furniture on Dinas has been repaired or replaced.	2.1 Managing risk and promoting health and safety	New furniture has been ordered.	Service Manager	Complete
The health board must ensure that all medication cupboards are locked when not in use.	2.6 Medicines Management	Regular spot checks being carried out to ensure compliance with Medicine Management Policy.	Modern Matron	Complete
The health board must ensure that there is a medication fridge on Tegid.	2.6 Medicines Management	Medication fridge has been ordered.	Modern Matron	March 31st 2019
The registered provider must ensure that patient records on Tegid are systematically organised and contain all relevant patient information.	3.5 Record keeping	Ward clerks have been trained in correct record management procedures. The ward clerks have received training from medical records and spot checks and matron audits are taking place.	Business Support Manager	March 31st 2019
The health board must ensure that copies of all detention papers are available in the current patient's record.	Application of the Mental Health Act	Detention papers are filed in patients' records, compliance check carried out by audit.	Modern Matron	April 30th 2019

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that capacity assessments are completed, and that copies of these are available in the patient's record.	Application of the Mental Health Act	Capacity Assessments are filed in patients' records, compliance check carried out by audit.	Modern Matron	April 30th 2019
The health board must ensure that all disciplines submit their hearing reports in a timely manner.	Application of the Mental Health Act	The Matron will ensure that dedicated time will be allocated for Practitioners to complete reports in a timely manner. Escalation process put in place for non-compliance.	Modern Matron	April 30th 2019
The health board must ensure that there is a record of what information the patient has received under Section132 of the Act, along with the details and outcome of the discussion, as guided by the Code, chapter 4.	Application of the Mental Health Act	Patient Rights (Section 132) are filed in patients' record, compliance check carried out by audit.	Modern Matron	April 30th 2019
The health board must ensure that Care and Treatment Plans are written from the patient's first person perspective.	Monitoring the Mental Health Measure	Ongoing training being provided by Head of Nursing. Compliance check carried out by audit. The Acute Care Pathway is being reviewed to include a prompt.	Head of Nursing Modern Matron Head of Operations & Service Delivery	May 31st 2019
The health board must review the range of risk	Monitoring the	The WARRN risk assessment	Service Manager	March 31st.

Improvement needed	Standard	Service action	Responsible officer	Timescale
assessment documentation that is being used and where possible amend to a more uniform format.	Mental Health Measure	documentation is the agreed tool in use across the Division. A review will be undertaken to ensure all assessments are in this agreed format with no deviation.		
Quality of management and leadership				
No areas for improvement were identified.	Not applicable	Not applicable	Not applicable	Not applicable

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 representatives

Central Services:	**Gaynor Kehoe**	**Head of Operations & Service Delivery**
	Tom Regan	**Head of Nursing**
	Jonathan Morris	**Service Manager Adult Mental Health**
	Karen Jowitt	**Service Manager Older Persons Mental Health**
	Huw Jones	**Modern Matron**
	Kathryn Thomas	**Business Support Manager**
Regional Services:	**Carole Evanson**	**Head of Operations & Service Delivery**

Paul Hannah	**Head of Nursing**
Simon Allen	**Service Manager Forensic and Rehab**

Date: 7 March 2019

Health Board

2.5.19

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

To improve health and provide excellent care

Report Title:	HASCAS independent investigation and Ockenden governance review: progress report
Report Author:	Claire Brennan, Head of Office
Responsible Director:	Mrs Deborah Carter, Interim Executive Director of Nursing & Midwifery
Public or In Committee	Public
Purpose of Report:	The paper provides the progress updates as at the end of Q4 against the recommendations arising from both the HASCAS independent investigation and the Ockenden governance review
Approval / Scrutiny Route Prior to Presentation:	HASCAS & Ockenden Improvement Group and Quality, Safety & Experience Committee
Governance issues / risks:	Additional resources required have been identified for a number of recommendations to progress the work identified to deliver improvements and address the recommendations.
Financial Implications:	A paper will be submitted to Executive Team setting out the additional resources and any related costings, including any additional workforce requirements, for their approval.
Recommendation:	To note the progress of the recommendations

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

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

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

HASCAS & Ockenden Recommendations – update report for Health Board meeting 2nd May 2019

Recommendation	Current position	Progress update	Risks
HASCAS 1: Integrated Care Pathways Operational Lead: Reena Cartmell Associate Director of Nursing *'An integrated service review is required to map the needs of the older adult and those with dementia across north Wales. This review needs to involve all stakeholders (from the statutory, independent and voluntary sectors) and those with performance responsibilities. The review should include all care and treatment settings (not just those) confined to mental health and older adult services) in order to ensure that all interventions are integrated and that patients, service users and their families do not encounter service barriers that prevent them from receiving access to the care, treatment and support that they need'.* **Ockenden 1: Integrated Service Model for Older People and those with Dementia** Operational Lead: Reena Cartmell Associate Director of Nursing *The patient pathway for service users of older people's mental health was fragmented from the 'birth' of BCUHB in 2009 and remains fragmented today from the perspective of many service users, service user representatives and carers (as of the end of 2017).* *As of the end of 2017 there has been insufficient evidence seen by the Ockenden review team that the patient pathway and the systems, structures and processes of governance underpinning service provision for vulnerable older people at BCUHB is improving. The current service model remains fragmented with multiple service providers across health, social care, the voluntary sector and other independent sectors.*	On track to deliver	*Following Executive approval the HASCAS Recommendations 1, 2 and 3 and Ockenden Recommendations 1, 8, 12 and 14 will be managed collectively under one monthly working group meeting. This method will evidence the interdependencies of the work-streams and comprehensively capture the work underway, strengthening governance with a whole system approach. Terms of Reference for the working group have been re-drafted, with membership noted but this is not considered to be an exhaustive list.* • An initial review has been undertaken as a desktop exercise with a drafted plan that illustrates the breadth of existing work programmes developed in partnership in relation to the older person and those with a diagnosis of Dementia. The respective work programmes have individually engaged with wider stakeholders and the findings of this high level initial review will be tabled at the forthcoming working group meeting. The Improvement Lead has, as part of this review, met with stakeholders to scope the review findings for presentation and consultation following the agreement at the forthcoming meeting. To note, the review identified outcome care as being central to an integrated service model. • BCUHB's response to the HASCAS and Ockenden recommendations and all clinical actions will support other strategic programmes for older people such as the North Wales Regional Plan (Area Plan) and the Integrated Care Fund revenue plan. Progress is reported below on the following actions which aim to integrate the clinical pathway between physical health and OPMH; • A **draft pathway** has been developed by BCUHB – '*Meeting the Physical Health Needs of People Admitted to an Older Person Mental Health Ward*' (January 2019). Further work to strengthen the pathway includes elements around the family and a criteria for repatriation from the acute ward back to the OPMH ward. This draft document requires further consultation and engagement which is now being taken forward awaiting stakeholder feedback. To support this development clinical teams from Care of the Elderly Services and OPMH have met to determine the service changes required to support further our OPMH patients. This has resulted in the identification and support for further ward based clinical sessions for physical assessment by appointing Advanced Nurse Practitioners (ANP) to assess the physical health needs of older persons on mental health wards and the development of an integrated pathway for rapid response. These ANP posts are now being advertised. • An **improvement programme of work** is in development with support from consultant psychiatry and medical staff to review and revise the clinical pathways between Emergency Department and Care of the Elderly (COTE). Outcome measures are being developed in line with the drafted pathway above in order to help measure service change. The Improvement plan will also be shared with the OPMH Quality and Workforce Group for support, spread and sustainability. • A **scoping exercise** will be undertaken in April with senior nurses from all three Emergency Departments, SAU and AMU across BCUHB to examine older persons experience and pathways has been considered as an important next step. Discussions held with the Nurse Director of Secondary Care and meetings are planned for the forthcoming month. • Meeting has taken place with the Director of Primary Care and Associate Director of Quality Assurance to agree a way forward for the development of an older persons service gap analysis through the support and engagement of Area Directors. • **Stakeholder Engagement** has commenced to discuss integrated care pathways and service models. A draft implementation plan of potential actions that support HASCAS / Ockenden deliverables has been shared with members of the Stakeholder Group for their review and comments.	Timescale to achieve review of a broad range of services - Joint and clear action plan including milestones and timelines to be developed. Progress regularly reported to Improvement Group Workforce capacity and resource for transformation (reducing duplication / conflicting agendas) - Ensure joint responsibility of translating strategy into action via an improvement sub-group and map out all forums/groups involved. Sustainability and differing standards of quality and safety of services (across health, social care, third sector and commissioned services) - Design a set of agreed principles in partnership along with quality and safety standards to inform the model of care and strategy

Recommendation	Current position	Progress update	Risks
HASCAS 2 : Dementia Strategy Operational Lead: Chris Lynes, Area Nurse Director (West) *BCUHB is required to develop a detailed and costed action plan to support the implementation of its Dementia Strategy; the plan should be developed in partnership with the Regional Partnership Board response to the Welsh Government's new Dementia Plan. This work should be undertaken in conjunction with (HASCAS) Recommendation 1. The action plan should incorporate the consequent implications and requirements for all clinical services (not just the mental health directorate) in all care and treatment settings (community, primary and secondary care).* **Ockenden 8: Dementia Strategy** *The dementia strategy should be developed to work across all relevant clinical services across BCUHB not just within the MH&LD division. The dementia strategy should incorporate care across home, primary care and secondary care.*	On track to deliver	• The Regional Partnership Board have agreed to develop an integrated North Wales Dementia Strategy for the 6 Local Authorities and BCUHB setting out joint aims and objectives. This work is being led by project support from the Regional Collaborative Team and BCUHB Director of Partnerships (MH&LD). • Meetings have been arranged at director level to discuss the opportunities for BCUHB to work with the Regional Partnership Board in terms of the older persons work streams and how we may successfully update QSE with consideration to some operational challenges. • The BCUHB dementia strategic action plan that has been developed requires further work to consider costings which will be undertaken through the Dementia Strategy Group and this will feed into the wider North Wales strategy. • Work has been undertaken to scope a range of work programmes across BCUHB with partner organisations which will be overseen by the Dementia Strategy Group that is being established and led by the Deputy Director of Nursing. HASCAS Recommendation 2, Ockenden Recommendation 8 and Ockenden Recommendation 14 have been consolidated and the following main action points identified; **Action 1. Clear Governance 'Ward to Board'** Action required to have in place a single point of governance arrangements that underpins all service provision and encourages continuous improvement, lessons learnt and transparent reporting from ward to board level. • BCUHB are in the process of establishing a third sector partner's group with Alzheimer's Society and the Carers Trust to shadow all BCUHB's Dementia transformation work. • A task and finish group is in the process of being established in response to BCUHB's Dementia Audit Plan (2018-2020) to undertake audits and all future reporting from 'ward to board'. • BCUHB have launched a 'dementia feedback toolkit' for service users. This will be developed further by involving community services and expecting services to undertake their own performance management arrangements to report directly to Area Directors. The work streams under BCUHB's Dementia Friendly Organisation Plan will also be included within the audit process. • The HASCAS/Ockenden working group are also reviewing the process of gathering self-service feedback in order to have in place one single point of data to help with ward to board reporting **Action 2. Evidence based policies and clinical standards**. Action identified for a BCUHB wide systematic approach in reviewing all current policies relating to older people and those with Dementia (dovetails with Ockenden recommendation 12 and Ockenden recommendation 3). • Review of clinical policies is to be undertaken, which will be led by the Dementia Consultant Nurse upon their commencement in June. • The appointment to a second Dementia Nurse Consultant post for BCUHB has been successful, commencement date awaited to help support this piece of work. **Action 3: Sustained culture around Dementia.** Action required to embed the 'Dementia Care Pathway' across all BCUHB services and the BCUHB 'Dementia Friendly Organisation Action Plan' • The BCUHB 'Dementia Friendly Organisation Action Plan' applies evidenced based practice such as the 'King's Fund National Quality Standards' for the Dementia supportive and enabling environments. • The action plan is scheduled for completion by end of Q4 2018-19 – further upscaling to be shared across all BCUHB pan wide services to ensure implementation is consistent within	

Recommendation	Current position	Progress update	Risks
		both primary and secondary care, such as the mental health liaison service within general hospitals. • The 29 recommendations from the Royal College of Psychiatrists National Audit of Dementia in general hospitals is pivotal within 'BCUHB's Dementia Friendly Organisational Plan' and we will continue to adopt the principles of the 'John's Campaign' in all work streams to this effect. • In agreement with Bradford University, BCUHB has innovated the use of dementia care mapping as a measure of cultural change and published this work in an international peer reviewed social research journal. **Action 4. Over reliance on antipsychotic medication.** Action required for a detailed BCUHB 'Costed Care Plan' of all therapies, non-medical interventions and treatments available to older people with a diagnosis of Dementia. • BCUHB's response to 'Dementia Therapies Action Plan' has been drafted with further work ongoing in relation to obtaining stakeholder engagement and a gap analysis to inform the costed action plan. This dovetails with the work of HASCAS recommendation 10 to reduce the use of antipsychotic medication • A task and finish group is in the process of being established. **Action 5. Independent Oversight** Action required to identify an independent clinical Dementia specialist who would be willing to oversee this implementation programme and provide independent clinical input and oversight. • To be progressed. **Action 6. Capacity & Capability of the Workforce** Action required to foster a fit for purpose workforce with sufficient training, strategic and board oversight with focus on continuous recruitment and retention. (dovetails with Ockenden recommendation 1) • BCUHB will continue to train staff as 'dementia friends' champions and actively run sessions to support this. There are 10 dementia friendly communities across North Wales this needs to be up scaled; there are a further 9 dementia friendly communities which are working through the foundation criteria to become accredited by the Alzheimer's society. • Dementia friends' sessions will also be included in all mandatory dementia training across BCUHB. • BCUHB will have representation in every dementia supportive community project group. A project plan will be developed to outline the above ambitions with clear measurable outcomes, timescales and a governance structure. **Action 7. Accessing Information** Action required to ensure readily available information for patients, carers and representatives about services available, ensuring most up to date information is accessible on BCUHB intranet. • Referrals are now routinely made to the Carers Trust for any individual with a diagnosis of dementia, from BCUHB's memory clinics. • A scoping exercise will be taken forward via the HASCAS/Ockenden working group to review all current BCUHB information ensuring that present and future public information is compliant with 'Accessible Communication' standards as per action 8 of the Welsh Government Audiology Framework for Action • Dementia Helpline has been launched across BCUHB providing 24hr advice, information and support.	

Recommendation	Current position	Progress update	Risks
		Action 8. Dementia Strategy Action required to develop an achievable strategy for older people with Dementia making it a relevant part of everyday care and clinical practice of people with Dementia, across all services. (dovetails with Ockenden recommendations 8 & 12 and HASCAS recommendation 2). • BCUHB Dementia Strategic Action Plan 2018-2020 developed which is yet to be costed. • Monitoring the above action plan and developing sound governance arrangements around its delivery plays a key part of the HASCAS/Ockenden work group. A plan will be developed in the next few months to this effect. • The Action Plan will also be reviewed and measured against the WAG (2018) Dementia Action Plan for Wales. • A BCUHB Clinical Dementia Strategy Work Group is in the process of being established by a dementia improvement lead, which intends to provide input into the wider regional 'Area Plan' by supporting the development of the Regional Partnership Board Dementia Strategy for North Wales. **Action 9. Regional approach to Dementia** Action required to subsume this implementation plan and develop alongside the North Wales Social Care and Wellbeing Service Improvement Collaborative. • Ensure that all work programmes within this implementation plan compliments and does not duplicate any Integrated Care Funding (ICF) programmes that are currently providing transformational work across BCUHB. • In addition, this implementation plan will work alongside our partnership programmes: • BCUHB's *Together for Mental Health Strategy* • The North Wales Social Care and Community Health Workforce Strategy (RPB, 2018) • North Wales Population Assessment: Older People and Dementia. • North Wales 'Area Plan'. A representative of the North Wales Social Care and Wellbeing Service Improvement Collaborative will be attending the working group meeting in May to update on the partnership approach to the North Wales Dementia Strategy.	
HASCAS 3: Care Homes and Service Integration Operational Lead: Reena Cartmell Associate Director of Nursing *The current Care Home workstreams need to be incorporated into a single action plan, which in turn should dovetail into the pre-existing BCUHB mental health and dementia strategies.*	On track to deliver	Actions have been progressed to develop a single action plan for all care home work-streams and audit outcomes to dovetail with recommendations H1, H2, H3, O1, O8, O12 and O14. This is further supported by planned joint BCU and Care Home Integration Events which are taking place across North Wales to improve our integrated working practices to support our Older Person. A single plan has been developed for all care home work-streams and includes an 'update' section to report progress achieved so far as well as opportunity to evidence improvements against the actions listed. This broadly includes: • Implementing the newly developed "Quality Services: Delivering What Matters" (RPB, 2018) alongside the BCUHB Quality Monitoring Tools for North Wales Care Homes and drafted Quality Assurance Framework for Care Homes. • Review implementation of the "Care Homes for Older People: North Wales Market Shaping Position" (2018) and action plans. • Monitor the delivery of recommendations created by "Care Closer to Home Work Programme: Integrated Medium Term Plan for 2019/22 – financial and workforce strategy". • Develop a delivery plan to fully implement the "Quality Assurance Framework for Care Homes" developed by the CHC Corporate Team. • Care Home event held between Care Home Managers and BCUHB clinical ward staff to discuss ways to improve relations, safe discharges and celebrating successes in older person's care. This will also help inform a gap analysis for clinical pathway future development (dovetails with HASCAS recommendation 1). Action plans are being developed following this meeting.	

Recommendation	Current position	Progress update	Risks
		• Include Care Home providers within the design of a North Wales Training Programme to make ESR modules accessible (dovetails with Ockenden recommendations 12 & 14). • CIW/HIW Review (November 2018) into Support for North Wales Care Homes Action Plan is being developed, Area Directors are co-ordinating a response to the HIW / CIW action plan by end of April to prioritise any outstanding and close off any completed actions. • A single action plan is being developed to capture all recommendations in relation to care homes.	
Ockenden 12: Older Persons Long Term Clinical Strategy Operational Lead: Reena Cartmell Associate Director of Nursing *Develop a clear plan for the clinical services of older people to improve training across the workforce, set clinical standards and uniformity with a solid foundation of evidenced based policies and procedures*	On track to deliver	• The Older Persons Long Term Clinical Strategy is fully dependant on the delivery of actions as set out in the HASCAS and Ockenden Reports. Recognising all elements of the report findings and recommendations, a draft plan has been developed working closely with Stakeholder engagement. Further work is required to build on the drafted document and this will be followed by wider consultation. • Work has commenced on shaping the long term clinical strategy by setting out the desired principles, regulatory requirements, Tawel Fan legacy and baseline data. • Merging work streams 1 2 and 3 recently to avoid duplication and silo working has further supported the overall progress towards a Long Term Clinical Strategy. This includes the development of governance processes, audit and performance management, ward to board reporting, review of all clinical policies, staff training and an older person's right based culture for clinical standards of care. Three task and finish groups are currently being established to co-ordinate programs of work.The partnership event outcome will also be key to shaping future delivery of services along with further engagement opportunities across all clinical BCUHB services to help set the direction of travel. The BCUHB dementia strategy / action plan will underpin this work. • A comprehensive training programme is being developed for BCUHB staff in relation to older persons care and Dementia with support from Bangor and Glyndwr Universities. • Engagement with the Care Home independent sector following the care home events held in March will also help to inform the clinical services strategy in relation to the review and redesign of services in partnership. • The Dementia Nurse Consultant commencing in June will be embarking on the review of clinical standards and uniformity working to the Executive Deputy Director of Nursing, with a focus on leadership, education, research and clinical practice to support the long term clinical strategy.	
HASCAS 4 Safeguarding Training Operational Lead: Michelle Denwood, Associate Director Safeguarding *BCUHB will revise its safeguarding training programme to ensure it is up to date and fit for purpose. The updated training programme will incorporate all relevant legislation and national guidance* *BCUHB will engage with all prior safeguarding course attendees to ensure that they are in receipt if the correct and updated guidance. The responsibility for this will be overseen by the relevant BCUHB Executive Director with responsibility placed on all clinical service managers from all of the clinical divisions within the organisation* *BCUHB has not been able to ensure staff attend safeguarding training sessions in the numbers required.*	Risk to delivery needs attention	• Following a Scoping activity to determine key areas to support the revision and update of current training packages, all existing Safeguarding Training packages have been refreshed and updated in line with current legislation. The Social Services, and Well Being Act Wales and the Mental Capacity Act are now fully reflected. The impact of this activity was recognised Nationally and the Ask and Act Training for VAWDASV (Domestic Abuse) developed by Corporate Safeguarding has been accepted as a National Training package for Wales until a National package is developed. • To ensure the organisation is aware of the learning environment developed by Corporate Safeguarding and captures the organisation continuously a Monthly Bulletin had been developed and implemented in March 2018. This process has again been reviewed and 4 of the 12 monthly bulletins specifically targets education, learning and updates relating to legislation and policy and procedure • To ensure key areas with low training compliance rates are targeted both as escalation and as support, training data is scrutinised and reported via the Safeguarding Reporting Framework and into Area/Secondary Care /Divisional governance forums. • As part of the Reporting Framework a Safeguarding Training Task group has been established with clear Terms of Reference that include delivery of this HASCAS	TNA is a complex piece of work to be completed comprehensively. Systems and Teams need to work collaboratively which can be challenging. There are challenges with conflicting priorities and system integration – however progress is being made and we are committing to completing this process comprehensively.

Recommendation	Current position	Progress update	Risks
there are multiple factors involved which will require a detailed and timed action plan with external oversight.		recommendation and met 20th March 2019. Terms of reference have been updated to reference the delivery of objectives to meet the recommendations. • A Training Needs Analysis (TNA) is due to be undertaken setting out the Safeguarding Training requirements across the health board and is working towards completion by end of May 2019. This will reference the intercollegiate document for adults and children. Once complete this will drive and inform the Training Strategy and programme for 2019-20. • A Safeguarding Induction package has been developed for delivery at Board level. This includes a declaration, which sets out the most senior level of commitment to Safeguarding in the organisation. This will be completed by 31st May 2019. Continued progress, which is outside the scope of the recommendation . • An Annual Training Report is being produced for 2018-19,it will identify areas of non / low compliance in Safeguarding and will feed into training planning for the forthcoming year. The Annual Training plan will be ratified at the next Safeguarding Governance and Performance Group (SGPG) 18 April 2019. • ESR does not permit the monitoring of Level 3 Safeguarding Training and VAWDASV which affects the accuracy of compliance reporting Safeguarding remain engaged to support amendment to this tool and identification of activities to support the clarity of training data	
HASCAS 5 Safeguarding Informatics and Documentation Operational Lead: Michelle Denwood, Associate Director Safeguarding *BCUHB has conducted an audit on the compliance of filing safeguarding information in patients' casenotes. BCUHB will ensure that the consequent recommendations it set in relation to informatics in its BCUHB Corporate Safeguarding Team Safeguarding and Protections of People at Risk of Harm Annual Report 2017-18 are implemented namely;* • *The use of the dividers to be re-iterated in safeguarding training, briefings, and other communication activities and a key annual audit activity;* • *Process of secure storage of strategy minutes of strategy meetings and outcomes of referrals to be revisited at safeguarding forums with legislative guidance from Information Governance;* • *Team and ward managers to continue to include safeguarding documentation in team meetings and safety briefs.* *BCUHB will reconsider how clinical teams should record safeguarding information and the quality of the information provided.*	On track to deliver	• Health Records department are working with the Associate Director of Safeguarding lead 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 incorporates sign off element for safeguarding in line with the safeguarding team. • Initial work undertaken to review the approach for the transition to digitalisation system from paper records. Focus for the next month will be to ensure assurance that safeguarding information within the current paper processes are robust. • Safeguarding Training incorporates the safe storage of safeguarding information. A level 3 Record management training is also included within the Safeguarding Training portfolio. • A review of record management takes place when cases are discussed, supervision and support is provided. As part of the enhanced activity record management takes place when areas/departments identify high levels of safeguarding activity, this is managed and co-ordinated by a governance framework and SOP. • The Internal Audit Department are to undertake a records management Audit and the management of Safeguarding documentation has been included within the scope. • As part of the Communications Strategy, a quarterly Safeguarding Bulletin specific to education and learning is being cascaded with an emphasis on developing a Learning Organisation. The first revised edition was published in March 2019 and a six month evaluation will take place which will consider impact, audience, and distribution of the Safeguarding Bulletin. The Monthly Safeguarding Bulletins provide reference, advice and guidance relating to records management and remains a key activity of dissemination of information by Teams and Ward managers. The annual audit activity 2019-2020 will capture compliance Continued progress, which is outside the scope of the recommendation. • Work has been undertaken to triangulate Datix Reporting and Referral Data, with further work to be undertaken to ensure that the two systems interface seamlessly, and the process is more robust.	Digital informatics and the management of clinical records is an organisational risk based upon the challenges relating to the availability of different systems of which do not support the identification of risk or sharing of information.

Recommendation	Current position	Progress update	Risks
		• An Annual Safeguarding Report for 2018-19 is being produced which includes a specific section on BCUHB Adult at Risk referrals, that enables the identification of trends and the consolidation of information to assist with the understanding areas that are under-performing. This will be reported to and ratified by Safeguarding Governance and Performance Group on 18 April 2019, before being submitted to QSE in May 2019 for further scrutiny and dissemination. • The Lead Practitioner multi agency pilot is underway and will be implemented across BCUHB and all six Local Authorities, supported by the NW Safeguarding Board. • 70 BCUHB staff across MHLD have been identified to undertake the training. Six training dates are scheduled for April and May and the Lead Practitioner role will 'go live' following this. A six-month evaluation is planned, which will determine the next steps. • The next steps are to develop a Safeguarding presence on the staff App to ensure engagement with practitioners. • Safeguarding are working collaboratively with Corporate Communications to develop a Safeguarding web presence once the new Web is live in July 2019.	
HASCAS 6 Safeguarding Policies & Procedures Operational Lead: Michelle Denwood, Associate Director Safeguarding *The BCUHB Corporate Safeguarding Team Safeguarding and Protection of People at Risk of Harm Annual Report 2017-2018 identified that there were priority actions required in relation to safeguarding policies and procedures. This investigation recommends that these priority actions are incorporated into the action plan consequent to the publication of this report. The actions are;* • *To identify those policies, procedures and SOPs that firmly sit within the Safeguarding remit and those that should be the responsibility with internal and external partners* • *Agree a priority list and activity timeframe to review documents within the parameters of corporate safeguarding* • *Provide safeguarding expert advice to internal and external partners in order that those documents are reviewed appropriately and in line with local and national policy band legislative safeguarding frameworks;* • *Agree a governance structure and reporting framework for all safeguarding policies, procedures and SOPs;* • *Update and maintain the Safeguarding Policy webpage;* • *Continue to actively participate in the Policy and Procedure sub group of the Regional Safeguarding Boards*	On track to deliver	• Good progress has been made in the management and control of Safeguarding policies. To ensure identification of all P&Ps in the Safeguarding remit have been identified and supported by a Safeguarding policies and procedures register has been developed which will manage version control and the publishing of policies in a timely and accurate way. • To ensure the governace structure is in place and in accordance with organisational procedure the Safeguarding Business Manager (SBM) is linking in with the Board Secretary and the Policy on Policies (PoP) and their work on developing a central repository as part of this process. • A priority list has been identified with Phase 1 completed.The following procedures and guidance were requested for approval at QSG and have been submitted separately and were agreed. They were ratified at the Safeguarding Governance and Performance Group on 31 January 2019. – **The Adult at Risk Procedure** - ratified for publication and builds on the guidance issued by Welsh Government. (HASCAS 8.3) – **Safeguarding Supervision Procedure** - BCUHB Supervision – **Female Genital Mutilation (FGM)** Standard Operating Procedure – **Best Interest Meeting Guidance** - Deprivation of Liberties (DoLS) • In addition, to the above policies, the following processes were approved at Safeguarding Governance and Performance Group in January 2019 and subsequently implemented: – Procedural Response to Unexpected Death In Childhood (PRUDIC) which is published in line with National guidance. – Safeguarding Team, Area Domestic Abuse Workplace Safety Group, Terms of Reference (ToR) – Safeguarding Supervision Procedure – Safeguarding Only Supervision • Full engagement takes place across the organisation and with participation at the North Wales Safeguarding Adult Training Sub Group, this ensures internal and external expertise is captured.	

Recommendation	Current position	Progress update	Risks
HASCAS 7: Tracking of Adults at Risk across North Wales Operational Lead: Michelle Denwood, Associate Director of Safeguarding *BCUHB will work with multi-agency partners through the North Wales Adult Safeguarding Board, to determine and make recommendations regarding the development of local safeguarding systems to track an individual's safeguarding history as they move through health and social care services across North Wales in order to ensure ongoing continuity of protection for that individual.*	On track to deliver	• BCUHB are working in collaboration with North Wales Safeguarding Adult Board to coordinate a Task and Finish Group for shared learning with regard documentation and communication. This Task and Finish Group is now disbanded due to completion as agreed by the North Wales Safeguarding Adult Board. Continued progress, which is outside the scope of the recommendation. • The development of the Lead Practitioner role has been supported through this group. This role will retain oversight of the Patient Pathway and is being implemented in MHLD as a pilot. • The Adult at Risk Procedure has been written and ratified at Safeguarding Governance and Performance Group on 31 January 2019. • The development of supporting report templates, aide memoirs for strategy meetings and case conferences are currently under consultation. April 2019 • Work has been undertaken to triangulate reporting / referral data against the Datix reporting to ensure that the systems are cross referenced and will be completed by end March 2019. • A Safeguarding Performance Dashboard is now published which includes consolidated data reports on Adult at Risk which triangulates data by area and by organisation. This Performance Dashboard then feeds into the Safeguarding Reporting Framework for scrutiny and review. This will be completed by mid-April 2019	This is a challenging recommendation due to the diverse nature of operational processes, services and IT systems.
HASCAS 8: Evaluation of Revised Safeguarding Structures / Ockenden 6: Safeguarding Structures Operational Lead: Michelle Denwood, Associate Director of Safeguarding *BCUHB will evaluate the effectiveness of its new safeguarding structure in the fourth quarter of 2018/2019. This will be overseen by Welsh Government.*	Risk to delivery needs attention	• The safeguarding structure has been submitted to Establishment Control and is awaiting approval. Whilst this is pending, there has been implications for staffing, and cover. Short-term mitigation action and cover arrangements have been implemented to ensure service continuity but a more permanent solution is required. The approval is urgent as the Ockenden recommendation from Welsh Government instructed that the implementation of the structure should be completed by March 2019 and this is now overdue. Appointments have been made to Best Interest Assessors (BIA) within the organisational change policy. Full implantation required completion of a specialist course to achieve the qualification and application of the role. • Implementation of the Named Doctor Adults at Risk remains outstanding and however positive discussions have taken place with the Office of the Medical Director to pursue this post with pace. A full review of the DoLS service is required and is captured within recommendation 12	The current structure of the Safeguarding Team does not allow it to operate an out of hours/on call service. – Support from Director of Nursing to establish a structure and revised working pattern and on-call system to strengthen service provision.
HASCAS 12 Deprivation of Liberties Operational Lead: Michelle Denwood, Associate Director of Safeguarding *BCUHB will conduct a formal audit and provide a progress report in relation to the 2017-2018 action plan. This will include a review of any barriers to implementation (such as office accommodation) together with a timed and resourced action plan to ensure full implementation can be taken forward in 2018-2019.* **Ockenden 9: Deprivation of Liberties** *BCUHB will complete a review of the 2017-18 DoLS work plan*	On track to deliver	• A review of the current service and structure remains active as the demand, complexity and challenging nature of this specialist service requires a sound infrastructure to meet the needs of the client group and organisation. The date of completion for start of the consultation is June 2019. • Much activity has been undertaken around the Deprivation of Liberties (DoLS) provision. This includes the appointment of five Best Interest Assessors (BIA). There are six posts available, so currently one vacancy. All of whom have completed Level 7 specialist training to support them in their role. • We have an agreed governance and training programme for DoLS signatories which incorporates the role of signatories to be transferred to the office of the Executive Nurse Director. This has resulted in an increase in named signatories training has been provided with a list of names for 40 potential signatories. This requires a formal register to establish the active and available numbers of trained signatories available for the organisation. This activity incorporates a governance and training framework which is the first in wales. A quality assurance framework will be developed to ensure quality and standards are in line with legislation. It has now been confirmed that accountability for the Mental Capacity Act (MCA) remains with the Office of the Medical Director.	The implementation of a revised DoLS structure, due to the recognition of the organisational demands and the required service delivery based upon the annual data of applications, training statistics, findings within reviews will have a cost pressure as the service is under resourced. The current resource cannot maintain the demand, high risk and complexity of cases.

Recommendation	Current position	Progress update	Risks
		• DoLS Structure is under review which is based on activity, assurance and accountability and this information will form part of the review. • The Associate Director, Safeguarding has engaged on an individual level the HASCAS Stakeholders allocated to the Safeguarding recommendation with a view to understanding their expectations and specific areas of interest. Work is being undertaken on this to ensure that engagement is meaningful and productive. Further information will be shared at the end of April.	
HASCAS 9: Clinical Records Operational Lead: Dylan Williams, Chief Information Officer *Restructure and redesign of paper records archiving and retrieval systems*	Currently will not deliver to plan	New centralised ATHR service is on track for the new financial year - OCP concluded its formal consultation period; Job Comparison completed, JE banding returned, all SOPs reviewed and under consultation with relevant professionals (will strengthen the checks on comingling). The service is on track for June. This will provide the gatekeeping for prevention of co-mingling, complementing the other actions. JD/PS for the 8b *Deputy Head of Health Records* has been reviewed following agreement to fund within Informatics and is being progressed via the recruitment process and is anticipated that this post will be in place by July. . Additional project management resource required to support this 8b post is outstanding but being presented alongside al project management requirements to enable actions to deliver the HASCAS & Ockenden recommendations. Therefore the action to *'Baseline - storage, processes, management arrangements & standards compliance, for all types of patient records'* and *'Present business case for PAN-BCUHB compliance with legislation and standards in patient records management'* which currently remains on hold with a view to progress in July.	**R9 Risk 1** : The risk that the required resource to undertake and sustain the work for all R5 and R9(i) and (ii) is not provided *Update:* – Chief Information Officer has prioritised funding to secure the senior 8b *Deputy Head of Health Records* post required which will now go through the recruitment process; – Resource requirement highlighted for a Project Manager to support delivery of recommendation **R9 Risk 2** : The risk that the embargo on the destruction of all casenotes due to the 'Infected Blood Inquiry' and 'oncology information file within the acute' will further impact on the availability and safe management of patient records – Impacts have been baselined across all record types (custodians) in BCUHB in readiness for a national meeting being held on 05/03 to (i) assess if a risk based approach can be applied and (ii) identify any local or national funding sources. – Storage has reached critical point in some storage for acute records already – with offsite storage being procured to address in the short to medium term (additional cost pressure on Health Records budget). **R9 Risk 3:** The risk that we do not know the number of patient casenotes that contain comingled documents and may inadvertently act on incorrect information, or provide incorrect information as part of a ATHR request (SAR) whilst we progress with the actions to address *Update:* – The ATHR under GDPR work within the programme will consider in its modelling work opportunities to strengthen checks on comingling until the actions R9 can progress fully (progress dependent on addressing Risk 1)

Recommendation	Current position	Progress update	Risks
HASCAS 10: Prescribing and Monitoring of Anti-psychotic medication Operational Lead: Berwyn Owen, Chief Pharmacist *A) The updated BCUHB 2017 antipsychotic prescribing guidance will be kept under review and be subject to a full audit within a 12 month period of the publication of this report.* *B) BCUHB will continue to work with care homes across North Wales to provide practical clinical advice, guidance and training so that residents with behaviours that challenge can be supported and kept safe with the minimal amount of anti-psychotic medication possible. The effectiveness of this should be built into the antipsychotic prescribing guidance audit.*	Risk to delivery, needs attention	Ai) The BCUHB MM010 guidance has been audited across all OPMH dementia wards in March 2019 with full report on the results pending. (http://howis.wales.nhs.uk/sitesplus/861/document/416663) 18_302 Formic Proforma.pdf • Aii) A CAIR (checklist for antipsychotic initiation and review form) has been developed and distributed to all OPMH and CMHT teams across MH&LD division in October 2018. Reminders and communications to ward staff has improved implementation across OPMH dementia wards. Work is ongoing to continue to implement the use of the CAIR form and highlight best practice, particularly in care homes. The CAIR form and a letter has also been circulated to GPs and practice pharmacists. • Aiii) An All Wales audit is to be undertaken 2019-20 in primary care to identify the number of people with dementia who are prescribed antipsychotics. This will be captured and benchmarked across Wales using Auditplus software on GP systems. Despite feedback to Awmsg it does not capture non-drug interventions around de-escalation. CEPP National Audit - Antipsychoti • Bi) A proforma is in development to report on the use of anti-psychotics and length of treatment which is being progressed through the care home subgroup of primary care pharmacists and will identify support and intervention required for care homes. • Bii) A community pharmacy care homes National Enhanced Service (NES) is in place to monitor antipsychotic use in care homes and increase the number of pharmacies signed up to the NES • Biii) Discuss with the Associate Director of Nursing regarding use of an Adverse Drug Reaction (ADRe profile) for use within care homes which has demonstrated a significant reduction in falls in Swansea to align with work ongoing for Recommendation 3.	Lack of pharmacy staff to deliver training for safe use of antipsychotic and support review • Resource requirement to support implementation of recommendations. • Paper to be submitted to executive team. Community pharmacist uptake of the NES for care homes has been minimal so far. Care homes not trained to deliver care that reduces need for antipsychotics • MDT bid in place to support this (links to recommendation 2) • GP audit is not mandatory although they are being strongly recommended to support this.
HASCAS 11: Evidence Based Practice Operational Lead: Dawn Sharp, Deputy Board Secretary *BCUHB will conduct a review of all clinical policies to determine the ratification processes that were conducted together with an assessment of the appropriateness of content and currency; this will include all hard copy policy documentation still retained in clinical areas, and all electronic documentation held currently on the BCUHB intranet.*	On track to delivery	• This recommendations dovetails with Ockenden 3 (see below). • A review of the overarching policy on policies has been undertaken and the new policy adopted and launched. This sets out new ratification processes. • A new intranet page has been established and documentation will be migrated on to it as each document is reviewed and updated. The new policy on policies and intranet site advises users that local hard copies of documents should not be retained. • Further sessions have been held with Governance Leads and most recently the NW managed clinical services group to discuss the new policy and the review and transfer of documents to the new intranet site. A series of individual meetings continue to take place with each Lead to agree transfer of documentation, communication plan for key staff and removal of old links. • Staff have been reminded that all clinical policies should be developed using a person centred approach. • Existing Policies are being reviewed to ensure that the evidence-base in relation to the older adult and/or those with dementia is specified and if necessary separate clinical policies and procedures will be developed with input from experts. • A Project Initiation Document (PID) has been drafted and a detailed GANTT chart is being populated to ensure there are clear timelines documented as each cohort of policies and other written control documents are agreed for transfer by the relevant leads. Following agreement at the last meeting, discussions have taken place with the Communications Team regarding use of the Staff App to host the new Intranet page. This will be possible if	

Recommendation	Current position	Progress update	Risks
		the page is moved to the Internet. As a consequence this Group took a decision at the last meeting to defer the transfer of all documentation to the new site to avoid having to reload all documentation to the new external website. The new website is expected to 'go live' in July 2019. Leads are being advised of the change in direction that all policies and other WCDs will be hosted on the external website. As a result of this a desktop exercise will be undertaken to review documentation against the new standards in terms of Welsh Language translation.	
Ockenden 2a: Quality Impact Assessment Operational Lead: Dawn Sharp, Deputy Board Secretary *QIAs (where the clinical implication of financial savings plans are assessed by Executive members of the BCUHB board) were 'still in the process of refinement' (as of Spring 2017). Evidence is required of focussed Board attention going forward.*	On track to delivery	• An update to HASCAS/Ockenden Improvement Group in January confirmed that a system is in place for Quality Impact Assessment (QIA) of savings schemes. Progress will be measured from samples of completed QIAs and a record of outcomes and as part of the internal audit programme 2019/20. The audit is timetabled for Q1-2 in the draft IA plan for next year which was approved by the Audit Committee on 14th March 2019.	
Ockenden 2b: Integrated Reporting Operational Lead: Dawn Sharp, Deputy Board Secretary *There is a need for further urgent and sustained Board attention to full integration of the systems, structures and processes underpinning financial, corporate and clinical governance and the Board will need to assure itself that it has effective integration and timely oversight and scrutiny of workforce planning, financial planning, performance and quality going forward.*	On track to delivery	• Revised integrated reporting arrangements have been agreed in principle and are being tested over the next six months to ensure that they provide a more robust and effective accountability mechanism. The outcome from the first health economy reviews was circulated to divisions beginning March and a feedback session with divisions was held at the end of March to review and learn from the process and Accountability Review meetings have now been set for June 2019.	
Ockenden 3: Policy Review Operational Lead: Dawn Sharp, Deputy Board Secretary *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.*	On track to delivery	• This recommendation dovetails with HASCAS Recommendation 11 (above) and will be progressed in tandem with the other recommendations in the report relating to corporate governance. • Under the sponsorship of the Executive Director of Nursing and Midwifery, and with the Deputy Board Secretary acting as the operational lead, a programme of work commenced in July 2017 to review existing arrangements for the creation, cascade, access and storage of policies, guidance documents, protocols, and other written control documents. • The breadth, volume and complexity of the work was recognised and it was agreed that in order to progress the work successfully, governance/policy leads would need to be identified in each Directorate. This was achieved in Autumn 2017 and an initial training session was held with the leads in November 2017 to outline the requirements to review all policies and procedures both clinical and non-clinical within their remit and bring them up to date, or confirm that they remained extant. In doing so leads were asked to identify current locations of all policies to be removed both, in paper copy or online, on the Health Board's intranet pages. • In relation of BCU wide clinical policies the Corporate Nursing Team have undertaken a clinical policies mapping exercise to determine the location and current status of all clinical policies. These clinical policies have been risk assessed in terms of prioritising those that require urgent review under the direction of the Executive Clinical Directors. In line with the existing policy on policies the Quality, Safety and Experience Committee of the Board must approve clinical policies. From August 2018 an additional step has been added to the ratification and approval process with all new or refreshed clinical polices being scrutinised by the Quality and Safety Group to ensure they are fit for purpose and are evidence based.	Clinical staff not being aware of the transfer of key policies to the new site • Targeted communication plan for each transfer to be agreed with the leads. Redirect system to be in place (from existing location) where possible Resources to review policies and bring them up to date (across the wider organisation) • Meetings have and continue to take place with leads to agree programme of transfer of documentation to the new site and to prepare communication plans and identify any issues

Recommendation	Current position	Progress update	Risks
		• Work has also been undertaken to construct a new intranet page which will host all Health Board wide policies and other associated documentation in one location making the documents more accessible and easy to find.	
Ockenden 10: Reviewing external reviews Operational Lead: Dawn Sharp, Deputy Board Secretary *BCUHB needs to undertake a review of all external reviews (including those by HIW, the NHS Delivery Unit and others) where any findings, recommendations and requirement may have concerned older people and specifically the care of older people with mental health concerns.* *The exercise needs to be completed across all Divisions and all sites by the end of the second quarter 2018/2019, (the end of September 2018) and reported to the BCUHB Board by November 2018.*	On track to delivery	• . 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. It was agreed at the 29th January meeting of the Improvement Group that a period of time will be required for embedding this work and as a result this action should continue to remain open to ensure ongoing monitoring.	
Ockenden 14: Board Development Operational Lead: Dawn Sharp, Deputy Board Secretary *The work of Swaffer and the WHO/ United Nations should be introduced to the Board in a Board seminar/ Development day in the second quarter of 2018-19 and a programme of introduction to the whole of BCUHB should commence in the third quarter of 2018- 19 with reports to the Board on the introduction and utilisation of 'Prescribed Dis-engagement' every quarter.*	Delivered	• The Executive Director of Nursing and Midwifery determined that this ambition would be best met by the full Board participating within a dementia friendly awareness session which was delivered on 10th January 2019. • Whilst this action has been completed for Board members, the Executive Director of workforce & OD agreed to take forward an action consider how to incorporate dementia awareness sessions into the induction programme. • Improvement Group on 29.1.19 agreed for this action to be closed but the Executive Director of Workforce and OD agreed to take forward an action with the workforce team to consider how to incorporate dementia training into the mandatory training programme. A session for those on the Executive Management Group who have not already received the training at the Board session is also being arranged.	
HASCAS 13: Restrictive Practice Guidance Operational Lead: Steve Forsyth Director of Nursing MH&LD *BCUHB will provide assurance that all older adults and those with dementia are in receipt of lawful and safe interventions in relation to restrictive practice management across all care and treatment settings within the BCUHB provision.*	On track to deliver	• The Task & Finish Group for Recommendation 13, led by the Director of Nursing for Mental Health & Learning Disabilities, is well established with agreed Terms of Reference that ensure focus on the objectives to respond to and provide assurance in response to Recommendation 13. The group has progressed all actions, which are now all completed and awaiting sign off from the Stakeholder and Improvement Groups. • In line with national guidance, BCUHB has two policies in place to support clinical staff in the safe management of behaviours which challenge and are intended to be read in conjunction i) *'Proactive Reduction & Therapeutic Management of Behaviours which Challenge'* is a new policy written to address the requirement to take all reasonable precautions to minimise incidence of behaviours which challenge services, in line with statutory and mandatory directives. This focuses on proactive approaches to prevent challenging behaviours from occurring along with therapeutic management techniques. ii) '*Physical Restraint Guidelines'* have been amended to comply with newly published national guidelines and provides guidance on the safe use of physical restraint as a last resort when all other options have been exhausted • The two policies are based on the most up-to-date evidence based practice and are written to ensure compliance with national guidance such as NICE guidelines NG10, the Mental	Risk of training staff in All Wales RPI passport D BCUHB for restraining patients when preventative measures, care planning, positive behavioural support planning and therapeutic relationships are paramount. Risks include updates, not applying restraint on a regular basis, debriefing, observations during restraint, lack of mental health expertise. – Patients who are distressed because of a deterioration in mental health issues/symptomology and are a patient within our acute physical healthcare setting, will be assessed by liaison psychiatry and support sort from the MHLD Positive Interventions Clinical Support Service (PICSS) – If a patient is so distressed and requiring RPI, assessment and or treatment the appropriate clinical pathway will be followed involving clinical advice from MHLD professionals for the most appropriate and least restrictive environment.

Recommendation	Current position	Progress update	Risks
		Health Act 1983 Code of Practice for Wales and the All Wales NHS Violence and Aggression Training Passport and Information Scheme. • The policies have been produced following consultation with service-user representative groups and emphasise the importance of delivering compassionate, safe, dignified and respectful care and encourages practitioners to co-work with the patient and carers in the formulation of person centred care plans • Both policies have been reviewed via the Health Board's Professional Advisory Group (PAG) and Quality Safety Group (QSG) in January and are to be submitted for final approval to the Quality Safety & Experience (QSE) Committee in March. A benchmarking exercise has been completed for all areas against policy implementation and a further review will be undertaken to ascertain how the new policies and changes have been embedded. • Work undertaken to prioritise a restrictive intervention reduction strategy across the Health Board. A benchmarking exercise has been conducted to identify areas where staff are involved with Restrictive Practice Intervention. Ratified policies have been uploaded onto the intranet and proactive corporate training launched to ensure that BCUHB adopts a proactive approach commensurate with the recommendations in national guidelines and ensure staff are supported in proactively managing behaviours that challenge (and reduce the need for restraint). This training programme is being delivered with the support of specialists from MHLD before the corporate training team assume full responsibility. • Specialist PICSS reduction leads identified in all divisions and leads will develop a plan to raise awareness to prepare for organisational readiness. Training programme for PICSS leads in MHLD has been rolled out with organisational readiness being routed through Recommendation 13 task & finish group, Nurse Directors, Health & Safety, Governance teams task & finish group and Quality Safety Group. • Work is now complete in ensuring that all incidents of restraint are recorded across BCUHB. Datix has been developed to include a specific field for recording physical restraint incidents and a training programme developed to support staff in its use. An increase in data capturing on Datix has been used to develop and inform the baseline data on RPI and benchmark against RPI policy.	
HASCAS 14: Care Advance Directives Operational Lead: Dr Melanie Maxwell, Associate Medical Director *BCUHB will conduct an audit to establish how many patients and their families have advance directive documentation within their clinical records together with care plans in relation to choice and preference about end of life care*	On track to deliver	• Monitoring process commenced November 2018 and is ongoing to continue to capture data on End of Life paperwork for inpatient deaths, this includes What Matters, future care plans, ACP, treatment escalation plans, care decisions, DNACPR etc. This will provide baseline data for improvement work and also identify patients for more in-depth review. • An end of life case note review for inpatient notes has been arranged for 18th April with clinical staff from acute and mental health teams and is based on the 5 priorities of care for the dying person. • A meeting is being arranged to review progress with End of Life recommendations and identify any gaps and further improvement work. • Discussions held with stakeholder group member who will attend the meeting to discuss the findings of the case note review.	
HASCAS 15: End of Life Care Environment Operational Lead: Dr Melanie Maxwell, Associate Medical Director *Improve end of life environment on OPMH wards and associated guidance training*	On track to deliver	• The EOL / OPMH pathway has been developed alongside a standard operating procedure (SOP), an MDT / relatives joint risk assessment and a dedicated training module. The draft SOP was presented to Stakeholder Group in January 2019 for input and minor amendments made from stakeholder feedback • The SOP includes real time audit of the process. The low number of deaths on an OPMH ward makes this realistic. The SOP identifies when DATIX is to be used. • Relative rooms have been developed on each OPMH 'organic' ward. • Bespoke end of life care training programme developed for all older person Registered Nurses commenced 6th December 2018. Ongoing evaluation underway.	Staff not being released for training. – Training is mandated on OPMH wards for Registered Nurses.

Recommendation	Current position	Progress update	Risks
		• Work in relation to End of Life Care has been presented to a number of group / committees across BCUHB and identified some minor changes to the SOP and a gap in knowledge to access community stores at weekends • Agreement received for the recruitment of a dementia specialist Admiral Nurse to provide expert practical, clinical and emotional support to families living with dementia. This is being progressed in partnership with St Kentigerns' Hospice for End of Life care and will be joint funded by MH&LD / Area and the Hospice for a 2 years.	
Ockenden 2c Workforce Development Operational Lead: Sue Green, Executive Director of Workforce & Organisational Development *BCUHB will need to provide significant amounts of targeted workforce and organisational development support in the form of extra team members to support the MH&LD and specifically OPMH with recruitment and retention expertise across medical, nursing and support services going forward. The MH&LD will need to utilise this support to creatively explore different ways of working and new and effective ways of recruiting and retaining staff. There will need to be efficient, timely and effective recruitment processes in place at all times to support MH&LD going forward.*	Risk to delivery, needs attention	• An Improvement Lead Programme Manager and three TODAY ICAN Change Facilitators commenced in roles within the MH&LD division in January 2019 with a fourth facilitator due to start in April 2019. • In February 2019 the first cohort of Learning Disability HCSWs attended and participated in a dedicated HCSW forum to receive news, updates and a chance to reflect on the importance of their role in delivering quality patient care. • Tier 5 / 6 restructuring has been signed off by Divisional Directors, consultation process commenced March 2019 • Workforce strategy was approved by BCUHB Health Board meeting in March 2019. • A nurse recruitment day was held on Monday 11th February for MH&LD (and incorporating HMP Berwyn), following which 21 out of 32 applicants were offered vacancies.	
Ockenden 4a: Staff Engagement Operational Lead: Sue Green, Executive Director of Workforce & Organisational Development *The BCUHB board and the MH&LD divisional senior management team is recommended first to ask front line staff 'what does the term 'staff engagement' mean to you, 'what would effective staff engagement look like for you?' and then to develop a system of bespoke meaningful and sustained staff engagement first across mental health and specifically older persons mental health. The Board may then wish to consider how effective their engagement is with staff across BCUHB and decide whether a new Board approach is required to staff engagement across the whole of BCUHB*	Risk to delivery, needs attention	• Listening leads have been recruited and trained across the MH&LD division, who are the link co-ordinator between staff and senior managers and discuss the concerns and issues of staff directly with the Director of MH&LD. • Using the TODAY ICAN methodology, MH&LD staff are continually encouraged and empowered to make small changes, which collectively have a huge impact on patient care and experience. Care has been taken to ensure that the Division are introduced to the impact that some of the smaller initiatives have had on patients and the quality of care that they have received as well as some of the divisional wide service developments. • The first *'BeProud'* Pioneer Programme commenced in March, teams from the following areas attended: Carreg Fawr Rehabilitation Unit, Bryn Y Neuadd Hospital Complex Needs Services Bryn Y Neuadd Hospital Hydref Ward, Older person's mental health services, Heddfan Unit, Wrexham Ogwen Ward, Unscheduled Care, Ysbyty Gwynedd Conwy Ward, Unscheduled Care, Ysbyty Gwynedd Intensive Care Unit, Ysbyty Wrexham Maelor Emergency Department, Ysbyty Wrexham Maelor Care of the Elderly Ward 2 Ysbyty Glan Clwyd Emergency Department, Ysbyty Glan Clwyd Pharmacy Department Ysbyty Glan Clwyd • Action plans to improve staff engagement and drive change has already commenced within the teams. The teams are being supported on a regular basis through contact with their sponsor who is a senior manager within their service. nTo further improve staff engagement, the "*Be Proud Pioneer Programme*" is now being rolled out with priority teams identified and the MHLD service have gained 6 places on the very first cohort, which is due to start in March	IT issues identified which prevents the Be Proud survey reaching BCUHB staff. – Go Engage investigating a workaround. Team level surveys will not be affected as manual entries can be made in the4 interim period

Recommendation	Current position	Progress update	Risks
		2019 and will receive regular mentoring and support from OD representatives. Using an evidence based cultural diagnostic tool to help improve and measure levels of staff engagement across the organisation, the Pioneers will be able to work with senior managers to make changes. This tool will enable Organisational Development to support individual teams to help build levels of engagement and ultimately improve both team effectiveness and organisational performance. • A Mental Health Nurses celebration event was held on 21st February to thank and recognise the hard work and commitment of our MHLD nurses. • 100 years of Learning Disability Nursing was celebrated during an event held on St David's Day • In February 2019 the first cohort of Learning Disability HCSWs participated in a dedicated HCSW forum which provided protected time for HCSW's to receive news, updates and a chance to reflect on the importance of their role in delivering quality patient care. • Site visits have been undertaken by divisional directors to ensure visibility and engagement on an individual basis. • Workforce are arranging Lessons learnt stakeholder sessions by end of March 2019	
Ockenden 4b & 4c: Staff Surveys Operational Lead: Sue Green, Executive Director of Workforce & Organisational Development *The Ockenden review team was informed that the NHS staff survey across Wales is completed every 3 years and is next due in 2019. WG may wish to consider an annual staff survey in line with that carried out in England.* *Aside from any potential decision by WG, the BCUHB Board should commence a formal annual BCUHB staff survey starting with the all Wales staff survey at BCUHB on an annual basis from 2020.*	Risk to delivery, needs attention	• The NHS Wales Staff Survey is currently under review in terms of its content, administration and execution. The Cabinet Secretary has been clear of the expectation that staff locally need to be involved in driving the change and improvements required to improve experiences at work. NHS Wales has historically facilitated pan-organisational surveys bi-annually which have been contracted out to organisations who have provided pan-NHS Wales and organisational reports. There has also been access to the results database to allow more localised interrogation of the data, but this has not allowed organisations to drill down fully to team and departmental level in a meaningful way. • Following a decision by the Welsh Partnership Forum in November 2018, in line with Welsh Government strategies, the national Staff Survey Project Group has been charged with implementing approaches which develop and build an "in-house" ongoing sustainable approach to measuring colleague experiences. The new approach will help develop the NHS Wales culture so that colleagues regularly give and receive feedback. The first workshop to gather views across the NHS community was held on the 11th February 2019. • The MHLD Division have created an Improvement Plan in response to the NHS wales Staff Survey 2018. The Organisational Improvement Plan along with all Divisional Improvement Plans submitted to the Board in March 2019. • The Board approved the Staff Survey Organisational Improvement Plan along with Divisional Improvement Plans in March 2019, these will be monitored through the Workforce Improvement Group chaired by the Executive Director Workforce & Organisational Development • The Board approved the Staff Engagement Strategy in August 2016. The strategy identified key activities and achievements required to successfully realise the strategy. 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. • Following a procurement process the Go Engage tool was procured. This tool was developed by Wrightington, Wigan and Leigh NHS Foundation Trust and has been rebranded for BCUHB as 'ByddwchynFalch / BeProud' in order to maintain consistency with the Proud of theme adopted as part of the staff engagement strategy. The tool offers: – a simple way to understand the science behind staff engagement in terms of cause and effect – Clear practical recommendations to improve staff engagement – Regular trend analysis – not a once a year/two years snapshot in time. – Ability to act quickly on data, 2 week turnaround from close of survey to presentation of results	

Recommendation	Current position	Progress update	Risks
		– Organisational and team level diagnosis of culture	
Ockenden 4d: Clinical Engagement Operational Lead: Sue Green, Executive Director of Workforce & Organisational Development *BCUHB must take urgent and sustained steps to ensure the continued involvement of all clinical colleagues in the leadership and management of BCUHB*		• The second BCUHB Medical and Dental Conference held in partnership with the Welsh NHS Confederation and BMA Wales took place on 7th March 2019 to support clinical engagement. The conference included attendance and presentations from senior executive managers from each organisation and included discussion about how to engage with Medical and Dental staff better to deliver for our patients. • Following on from feedback, a 3rd Medical and Dental Conference is to be scheduled for September / October 2019 and to be held in partnership with the Welsh NHS Confederation and BMA Wales. • Clinical Leads are invited to attend engagement meetings twice a year • Ad-hoc 3D engagement events have been held across the organisation with medical staff • Similar themes have arisen from all of the above events. All actions are to be compiled into one action plan	•
Ockenden 13: Culture Change Operational Lead: Sue Green, Executive Director of Workforce & Organisational Development *There will need to be sustained, visible (in clinical areas), stable leadership within MH&LD division over a longer period of time to ensure that the culture within mental health and specifically OPMH continues to develop in a positive way.* *The cultural change that is necessary towards dementia needs to happen across BCUHB and to happen from Board to Ward. This cultural change needs to happen not just within MH&LD but everywhere within BCUHB where care and treatment may be provided to persons with dementia, their families and friends.*	Risk to delivery, needs attention	• Dementia friendly awareness session held with Health Board members on 10th January 2019 led by a Consultant Nurse (Dementia) and a Service User National Champion. Further training programme being developed to roll out dementia friends awareness session. A Safeguarding Induction package has also been developed for delivery at Board level by end May 2019 • In line with the BCUHB Dementia Strategy, the three Emergency Departments outpatients department, COTE and orthopaedic are involved in the 'Dementia Friendly Hospital' accreditation programme as part of our strategic partnership with the Alzheimer's society. Within this programme it is acknowledged that any visit to hospital can be distressing for a person affected by dementia as alongside any anxiety is the diminished ability to fully make sense of what is happening and why. Ysbyty Gwynedd is the first acute hospital in Wales to be accredited 'Dementia Friendly' by the Alzheimer's society. • The emphasis on the Dementia Friends initiative from the Alzheimer's society will continue to be embedded in these departments and there is an expectation that all staff become dementia friends. • TODAY ICAN was formally launched on 20th December 2018 with a division wide TODAY ICAN conference which was attended by 130 delegates. Guest speakers Professor Brian Dolan OBE and Lynda Holt introduced the TODAY ICAN change methodology. A second event took place on 3rd April 2019 with good attendance. • TODAY ICAN team have completed "train the trainer" by Prof B Dolan on 14th January 2019. A delivery plan has been developed to roll out further staff training in more localised areas to increase awareness and knowledge of Quality Improvement methodology • The newly appointed Improvement Lead Programme Manager and three TODAY ICAN Change Facilitators have received "Train the Trainer – TODAY I CAN" training to enable them to spread, embed and deliver localised training. • As part of the Quality Improvement and Governance Programme (QIGP), a Quality Improvement Strategy will be developed in consultation with staff, partners and people with lived experience of using our services. The strategy will assure our stakeholders of our continued determination to focus on delivering high quality patient care and challenging ourselves to achieve the highest of standards. It is aimed to launch the strategy in July. • 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	

Recommendation	Current position	Progress update	Risks
		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.	
Ockenden 5: Partnership Working Operational Lead: Sally Baxter, Assistant Director Health Strategy *BCUHB needs to work effectively at a strategic level with the voluntary sector and a wide range of multi-agency partners to develop, provide and sustain services to older people and older people with mental health needs and dementia across North Wales.*		• In September 2018 a presentation was made to the Stakeholder Reference Group on the key elements of the existing third sector strategy of the Health Board and key considerations for discussion. A proposed timeline for refresh of the strategy has been updated which included work alongside the three year plan, including engagement, during quarter 1. • • Recommendations are being progressed to improve the management of the third sector conrtracts and devolve budget management to divisions. Alongside the budget setting process, the existing proposals to strengthen commissioning arrangements for the third sector will be reviewed and an implementation plan identified. A paper has been developed which will be submitted to Executive Team after discussion with divisional leads • Meetings have been held with Chief Officers of the Community Voluntary Councils (CVCs) to discuss the development of the overall strategic approach to relationships with the third sector. Engagement sessions with CVC third sector forums are underway to consider partnership issues and to allow a broader discussion on priorities for action and the Health Board response to these. • 1:1 meetings are being held with stakeholders who have expressed an interest in this area of work, to shape the key issues being developed • This dovetails with the work ongoing for HASCAS recommendation 3 in relation to integrated care pathways	Complexity of the Health Board presents challenges in developing a fully embedded approach – Develop a set of principles to be adopted across the Health Board Partnership approaches differ across the 6 counties – Ensure corporate arrangements are supportive of and link closely with county based arrangements Objectives need review and refresh to reflect the wider strategic approach – Include wider strategic development within objectives
Ockenden 7: Concerns Management Operational Lead: Deborah Carter, Associate Director Quality Assurance *Whilst it is acknowledged that on many occasions since 2009, BCUHB has made an effort to improve the timeliness of responses to concerns in line with the requirement of Putting Things Right (2011) this has not yet been sustained on an ongoing and long term basis.* *It is clear that the BCUHB Board have very little knowledge of the **actual** everyday experience of families, service users and service user representatives who try to make complaints to BCUHB as an organisation. Service user representatives also raised the reluctance of families and service users to complain and the fear they have of complaining.*	Risk to delivery needs attention	• Work is progressing to respond to the actions identified to better manage concerns in a timely and effective manner. • Revised trajectories have been set to deliver real time management of complaints and incidents by the end of June 2019, which are monitored weekly via the incident review meeting. • The number of open and overdue incidents has decreased by 989 from 6,130 in October 2018 to 5,141 in April 2019. There has also been a decrease in the number of open Welsh Government closure forms from 611 in January 2019 to 402 at the beginning of April 2019. • A bilingual online complaints form is now live on the BCUHB internet since January 2019 • A revised format for reporting listening and learning to the Quality Safety & Experience committee has been agreed • A draft patient experience strategy has been shared with the Community Health Council for comment. • A revised Putting Things Right (PTR) 1 policy has been submitted to QSE Chair for chairs action ahead of May committee meeting. • Standard Operating Procedure for writing a complaint response has been implemented within the corporate concerns team	Capacity within divisions to prioritise investigation and report writing for Concerns (against operational priorities) – Trajectories developed by division to deliver required deadlines by week commencing June 17th; No WG incidents overdue by end of June 2019 No complaints graded as 1 or 2 overdue No more than 15 complaints g raded as level 3 overdue No more than 30 complaints graded as 4/5 overdue No more 5 complaints overdue by over 6 months and must be grade 5 Quality of historic information to support robust learning – Training and support in place for investigation of new cases. Corporate team offering support to divisions to review historic cases, identify learning and move to closure
Ockenden 11: Estates OPMH Operational Lead: Rod Taylor, Director of Estates & Facilities		• A multi Directorate/Divisional working group that includes Operational Estates, Estate Development and Mental Health and Learning Disabilities has been established and Terms of Reference have been submitted to the over- arching Improvement Group.	Project management capacity – Paper to go to executive team for review of resources required

Recommendation	Current position	Progress update	Risks
BCUHB should prepare a detailed estates inventory across the care settings for all of older people including but not limited to OPMH. Firstly this should include clarity and specificity of all outstanding estates issues including outstanding repairs and estates issues raised as concerns with internal audits and external reviews and inspections. *The estates inventory should be prepared for each ward, clinic, department, inpatient unit and hospital department where care is provided to older people and older people with mental health issues. This includes where care is provided to people with dementia.* *The estates inventory should include for each area an audit based on the work for Enhancing the Healing Environment.*		• A site-by-site schedule (inventory) of outstanding repairs and maintenance work for MH&LD buildings has been completed. Work is progressing through Operational Estates to complete any outstanding jobs and the schedule is update monthly to monitor progress and reported 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 completed. • Outcome awaited following submission of funding bids for Discretionary Capital for 2019/20 to the Capital Working Group for consideration within the Health Boards 2019/20 Discretionary Capital programme. This work will support work stream 2. • As part of Estates and Facilities budget setting process for 2019/20, bids have been submitted for an additional £200k of recurring revenue funding to address any remaining outstanding repair/planned maintenance work within MH&LD buildings. • A multi Directorate / Divisional working group comprising membership from Operational Estates, Estate Development and Mental Health and Learning Disabilities is leading on the delivery of the work streams 1) and 2), initially for OPMH Facilities and thereafter for all ward areas within in-patient facilities. Terms of Reference have been drafted and will be reviewed and updated as the work streams progress. The objectives and progress against each workstream is set out below; **Workstream 1** • <u>Develop the site by site schedule (inventory) of outstanding repairs and maintenance work and the implementation of actions to address these.</u> A site-by-site schedule (inventory) of outstanding repairs and maintenance work for MH&LD buildings has been completed. Work is progressing through Operational Estates to complete outstanding jobs by the end of March 2019 and the schedule is updated monthly to monitor progress which is reported to the HASCAS & Ockenden Improvement Group. • <u>Review recent and previous external audits and inspections (HIW & CHC) relating to MH&LD OPMH facilities to determine outstanding actions.</u> A detailed inventory of previous HIW & CHC audits and inspections relating to MH&LD OPMH facilities has been prepared and all outstanding actions have now been completed. • <u>This baseline assessment will establish the level of resources required both in regards to revenue and capital funding to address the programme of work required.</u> Funding bids for discretionary capital for 2019/20 have been submitted to the Capital Working Group for consideration within the Health Boards 2019/20 Discretionary Capital programme. This work will support work stream 2. As part of Estates and Facilities budget setting process for 2019/20, bids have been submitted for an additional £200,000 of recurring revenue funding to address any remaining outstanding repair/planned maintenance work within MH&LD buildings. **Workstream 2 – this will commence in April 2019** i) <u>Develop the Enhancing the Healing Environment (EHE) assessment across all wards within MH&LD OPMH facilities.</u> ii) <u>Determine the scope of work and resources required at each facility.</u> King's Fund dementia environment audits will occur across 2019 as part of the broader dementia friendly hospitals programme.	Capital and Revenue funding to undertake identified works – Funding bids have now been included within the 2019/20 Draft Discretionary Capital Programme – Revenue funding bids have been included within Estates and Facilities budget cost pressures for 2019/20

Health Board **2.5.19**	GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board ***To improve health and provide excellent care***

Report Title:	Service Strategy update
Report Author:	Mrs Sally Baxter, Assistant Director – Health Strategy
Responsible Director:	Mr Mark Wilkinson, Executive Director of Planning and Performance
Public or In Committee	Public
Purpose of Report:	As set out within the Three Year Outlook and 2019/20 Annual Plan approved by the Health Board on 28 March 2019, the Board has committed to develop a Service Strategy by September 2019. This brief document on the development of a Service Strategy is intended to update the Board on the approach proposed for development and the issues which need to be addressed
Approval / Scrutiny Route Prior to Presentation:	A discussion paper was taken to the Strategy, Partnerships & Population Health (SPPH) Committee on 2 April 2019 which shared some of the messages from other areas to facilitate discussion and help shape the approach.
Governance issues / risks:	Development of a clear Clinical Services Strategy is a requirement under the Special Measures Improvement Framework and also within the NHS Wales Planning Framework. Failure to develop an effective Clinical Services Strategy may lead to inability to progress the transformational change required to address the challenges described in the overarching ten-year strategy, **Living Healthier, Staying Well**, and the 3 Year Outlook.
Financial Implications:	Financial implications are not identified at this stage. However failure to develop an effective strategy may act as a barrier to delivering sustainable longer term service configuration.
Recommendation:	The Board are asked to consider the paper and the requirement to develop a Clinical Services Strategy, and provide comments to facilitate the development of the process.

Health Board's Well-being Objectives *(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)*	√	**WFGA Sustainable Development Principle** *(Indicate how the paper/proposal has embedded and prioritised the sustainable development principle in its development.*	√

		Describe how within the main body of the report or if not indicate the reasons for this.)	
1.To improve physical, emotional and mental health and well-being for all	✓	1.Balancing short term need with long term planning for the future	✓
2.To target our resources to those with the greatest needs and reduce inequalities	✓	2.Working together with other partners to deliver objectives	✓
3.To support children to have the best start in life	✓	3. Involving those with an interest and seeking their views	✓
4.To work in partnership to support people – individuals, families, carers, communities - to achieve their own well-being	✓	4.Putting resources into preventing problems occurring or getting worse	✓
5.To improve the safety and quality of all services	✓	5.Considering impact on all well-being goals together and on other bodies	✓
6.To respect people and their dignity	✓		
7.To listen to people and learn from their experiences	✓		
Special Measures Improvement Framework Theme/Expectation addressed by this paper Strategic and service planning			
Equality Impact Assessment Equality Impact Assessment has been undertaken on the overarching Living Healthier, Staying Well strategy, the 3 Year Outlook and the individual service specific strategies identified. Refresh and review will be undertaken as necessary as the strategy develops.			

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

SERVICE STRATEGY UPDATE
2 May 2019

1. Purpose of report

As set out within the Three Year Outlook and 2019/20 Annual Plan approved by the Health Board on 28 March 2019, the Board has committed to work towards the development of a Service Strategy by September 2019.

This brief document is intended to provide an update on the proposed approach and high level timescales for delivery.

2. Introduction

In March 2018 the Health Board approved the ten-year strategy, **Living Healthier, Staying Well: Our Strategy for the Future.** Within the strategy it was confirmed that there was further work required to shape the detailed actions within all programmes, and particularly in respect of acute hospital services. Amongst actions identified were: the need to address increasing demand; improve care and response times in emergency departments; work to reduce waiting times and make best use if resources, including specialist hospital staff.

The intention to review, refresh and confirm a more detailed Service Strategy was set out in the Three Year Outlook. The production of a Clinical Services Strategy with detailed service-specific plans, supported by an enabling estates strategy, is a requirement within the Special Measures Improvement Framework and it is important that the Health Board develops a clear model for clinical services that will provide the basis for future sustainability.

It is essential that the service strategy secures the support of key stakeholders including Welsh Government.

The production of a clinical strategy is also an explicit requirement within the NHS Planning Framework. The Framework confirms that:

“All NHS organisations must have a clinical services strategy, approved by their Board. It should clearly set out their long-term vision for how they will meet the needs of the communities they serve. A longer term strategy of each organisation is critical for setting the direction of travel and providing the context within which key strategic decisions about the shape of services and the use of resources can be taken. These include population projections and analysis to inform decisions about service models, pathways, workforce planning, finance and infrastructure investment.”

This paper sets out the background to the development of the Clinical Services Strategy for BCUHB and the next steps which will move us further towards the provision of high quality, sustainable healthcare.

3. Context and learning from other areas

Health Boards across Wales have been developing local clinical services strategies to set the context for their long-term plans to address the needs of the population. In order to inform the approach to be taken within BCUHB, we have liaised with other Boards which have made good progress towards the development and implementation of clinical services strategies, to discuss the methodologies adopted, the learning from their experiences and the outcome of the strategic programmes.

The key learning points identified include the following:

- Establishing a clear and compelling case for change – identifying the challenges faced and the reasons why transformation is required.
- Shared understanding of priorities and principles which will underpin the strategy
- Maintaining a focus on population health needs and outcomes
- Ownership of the strategy development process at Executive Team and Board level
- Strong clinical leadership, supported by broad and inclusive clinical engagement
- Clear and consistent communication within the organisation, with partners and stakeholders, and the public
- Building on established strategic partnerships and shared priorities
- Enabling safe space to think, to discuss and to develop ideas
- Broad involvement of service users, carers, and the general public, maintaining openness and honesty regarding the challenges and what needs to be achieved

Further detail on the learning from other areas was shared and discussed at the Strategy, Partnerships and Population Health Committee in April 2019. These points are consistent with previous experience within BCUHB and broader principles of effective strategy development.

4. Developing the BCUHB Service Strategy – the next phase

In keeping with the overall improvement approach being established by the Health Board, the work to develop the Clinical Strategy will adopt and adapt the 3D methodology already embedded within the Health Board. This process consists of three distinct steps within the process of engagement – **Discover, Debate** and **Deliver**.

During the next few months the Health Board will initiate the Discover phase. This will include a number of parallel steps:

April - July:

- review of our current service strategies which support **Living Healthier, Staying Well**: maternity, primary care, out of hours, care closer to home, population health, and some acute specialties
- Review of the evidence used and assumptions made in developing the overall acute services elements of **Living Healthier, Staying Well**

- Review of the technical modelling work undertaken to date including capacity modelling, assessment of potential impact of the shift towards health improvement and care closer to home

May – August:

- Broad clinical engagement under the leadership of the Medical Director and working with professional representative bodies, including the Healthcare Professional Forum
- Engagement with partnership forums, including the Regional Partnership Board and Public Services Boards, to build on the current areas of shared vision and priorities
- Hold “Discover” sessions with stakeholder and community groups, including representatives of service users, carers and public

The Discover phase should address

- Alignment across service strategies
- Interdependencies
- Fit with **A Healthier Wales**
- Sustainable workforce and financial sustainability

By September, we will report to the Board on whether the strategy is fit for purpose and requires a simple refresh; or whether a more significant programme of review and revision is required to ensure sustainable plans for the future.

Should a further programme of work be necessary, we will more formally enter into the ‘Discover’ and ‘Debate’ phases of development, in which we will hold a wide conversation on potential future scenarios.

It should be noted that this does not mean that nothing will change during this ‘Discovery’ phase. There are a number of programmes of work already established which will be working towards recommendations, and some areas previously approved which will be implemented.

The outcome of this work will describe the way forward in clear terms and our timeline for transformational change. This will lead to the development of a target operating model, which will be supported by finance, estates and workforce strategies.

5. Recommendation

The Board are asked to consider the paper and the requirement to develop a Clinical Services Strategy, and provide comments to facilitate the further development of the process.

Health Board **02.05.19**	GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board ***To improve health and provide excellent care***

Report Title:	Reducing smoking prevalence to improve population health – an update on progress
Report Author:	Mrs Delyth Jones, Principal Public Health Officer Mrs Jo Charles, Associate Director Public Health
Responsible Director:	Miss Teresa Owen, Executive Director of Public Health
Public or In Committee	Public
Purpose of Report:	The purpose of this report is two-fold: 1) To describe the Health Board's current provision and performance of smoking cessation services. This is a key component of the Board's Living Healthier Staying Well strategy and supports the current Board focus on unscheduled care performance given that smoking causes approximately 5% of all hospital admissions in people aged 35 and over. 2) To update Board members on our approach to the implementation of Smoke Free Premises and Vehicles (Wales) Regulations 2018, as required under the Public Health (Wales) Act 2017.
Approval / Scrutiny Route Prior to Presentation:	This work has featured in the Health Board's annual plan for 2018/19 with updates on progress presented at the Health Improvement, Health Inequalities Transformation (HIT) group meeting. The paper was also considered by the Strategy, Partnerships & Population Health Committee on 2.4.19.
Governance issues / risks:	The Health Board's Corporate Risk Register (001) highlights the risk if population health issues such as smoking cessation are not fully addressed. Equality Impact Assessments (EQIA) have been undertaken for both Help Me Quit (HMQ) in Hospital Service and HMQ for Baby Service during their development.
Financial Implications:	Reducing smoking prevalence in BCUHB brings financial benefits to individuals, communities and the NHS. Currently 7% of the NHS health care expenditure is attributed to smoking related conditions.

	It is expected that there will be financial implications for the Board in the delivery of Smoke Free Premises and Vehicles (Wales) Regulations 2018. However, as the consultation summary report has not been received from Welsh Government, these cannot be costed at this stage.
Recommendation:	The Board is asked to: **Note** the opportunity for continued improvement against current Tier 1 performance in relation to smoking cessation and the critical importance of continued investment in smoking cessation services to reduce the burden of disease in North Wales. **Note** the service developments across the Health Board **Endorse** the approach being taken to ensure all our hospital sites become smoke free through the delivery of the Smoke Free Regulations.

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

Leadership and Governance & Strategic and Service Planning
Equality Impact Assessment EQIAs have been undertaken on smoking cessation services recently developed in the Health Board. As services evolve and develop, EQIA's will be undertaken to ensure that known differences in smoking prevalence and in uptake of smoking cessation services are addressed.

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

Title of Paper

Reducing smoking prevalence to improve population health update – An update on progress

1. Purpose of report

The purpose of this report is two-fold:

1) To describe the Health Board's current provision and performance of smoking cessation services. This is a key component of the Board's Living Healthier Staying Well strategy and supports the current Board focus on unscheduled care and planned care performance, given that smoking causes approximately 5% of all adult hospital admissions.

2) To update Board members on our approach to the implementation of Smoke Free Premises and Vehicles (Wales) Regulations 2018, as required under the Public Health (Wales) Act 2017.

2. Introduction

Smoking is the leading cause of preventable ill health and avoidable premature mortality in Wales. Smoking also remains one of the main causes of inequalities in health, with smoking rates in the most deprived areas over double those of the least deprived areas.

It is estimated that smoking causes approximately 5% of all hospital admissions in people aged 35 and over, and that smoking accounts for 7% of the NHS health care expenditure in Wales. It is estimated that the cost for BCUHB is approximately £172 million per year.

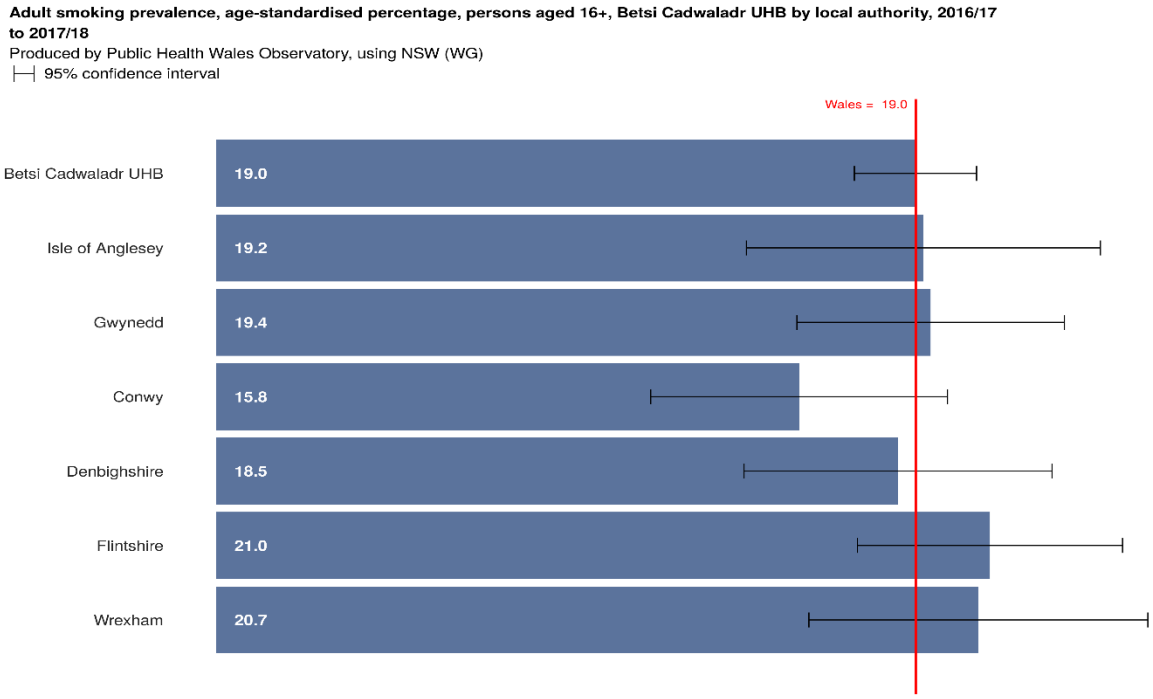
Passive smoking also has considerable impact, especially on babies and children, and reducing exposure through supporting pregnant women, parents and families to quit smoking has substantial benefits in the early years and beyond.

It is reported that the majority of smokers wish to stop smoking, and there is strong evidence that those who access services are four times more likely to succeed. Smoking cessation services with pharmacotherapy (Nicotine Replacement Therapy - NRT) support are highly cost-effective in terms of Quality Adjusted Life Year (QALY) or life-year gained at £2,000, which is 1/10th of the NICE cut off for a good value intervention at £20,000 per QALY.

Lowering smoking prevalence is a key action in the Welsh Government's Tobacco Delivery Plan for Wales 2017-20 which has set an ambition to reduce the prevalence of smoking to 16% by 2020.

The percentage of adults smoking across Wales is decreasing, however, adult smoking prevalence across BCUHB is still at 19%. Variation can be seen across the counties ranging from 15.8% in Conwy to 21% in Flintshire. (**See Figure 1**)

Figure 1: Adult smoking prevalence, age-standardised percentage persons aged 16+, Betsi Cadwaladr Health Board by local authority, 2016/17



Welsh data indicates that the national prevalence target of 16% is unlikely to be met by 2020. This indicates that further focussed work needs to be undertaken to stop young people from starting to smoke and to improve both the numbers of smokers accessing services, and the proportion of those who are successful in quitting.

3. The Smoking Cessation system – national and local

Across Wales, it has been recognised that to meet the reduction in prevalence there is a need to work as a system with a specific focus on delivering high quality integrated smoking cessation services. Health Boards across Wales are key partners in developing this system alongside Welsh Government, Public Health Wales and the Wales Centre for Pharmacy and Professional Education.

The key components of the integrated smoking cessation system for Wales are identified in **Figure 2**.

Figure 2: Key components of the smoking cessation system for Wales

A number of the identified components are being developed nationally, with partners providing input and influence. In BCUHB, the Principal Public Health Practitioner attends monthly national meetings to ensure full alignment and to optimise the smoking cessation system. Progress against the six components is summarised below at a Wales level:

- A single client management system to record patient progress and outcomes is being developed. It is expected that this will be implemented by 2020
- A single national brand for marketing has been agreed since April 2018. This is known as Help Me Quit (HMQ) and agreed branding is in place for all smoking cessation services in Wales. This development built upon work undertaken in North Wales on a previous campaign which identified the benefits of a single brand and consistent marketing. The marketing of all HMQ services via social media and other forums is now undertaken once for Wales.
- A set of minimum service standards have been further developed and will be formally launched in April.
- A common data set has been agreed for all service providers.
- A national HMQ hub has been developed which is the contact centre for all services can be accessed at: https://www.helpmequit.wales/
- The Health Board continues to develop and review its services based on the needs of smokers. Section 3.1 provides the current detail.

3.1 Current local service organisation

This section of the report provides the current detail.
Leadership of smoking cessation services is the responsibility of the East Area team. To strengthen co-ordination of services across a BCUHB Tobacco Control group was established last year to co-ordinate activity and provide a focus for this priority. The group is chaired by the Assistant Director Primary Care and Commissioning- East.

The group has focussed its efforts on supporting and challenging the performance of existing services to deliver the quality required to meet targets. As services evolve work will be focussed on supporting the development of a quality integrated cessation service for the population.

In North Wales there are currently three providers of smoking cessation services, BCUHB, Community Pharmacies and Stop Smoking Wales provided by Public Health Wales.

3.1.1 BCUHB

HMQ for Baby Service

Funding was provided to Midwifery Services to develop the HMQ for Baby Service in April 2017. This funding employs 6 WTE Stop Smoking Support Workers (SSSW) to offer 1-1 specialist intensive smoking cessation support to women and others in the household who smoke.

Help Me Quit in Hospital

The Help Me Quit in Hospital service was established in April 2018 with national Respiratory Health Implementation Group funding. This funding employs 3.0 WTE Stop Smoking Practitioners across the three general hospitals and is hosted by Respiratory Services. The service provides intensive behavioural support to cardiac, respiratory and diabetes in-patients who are motivated to quit smoking during their in-patient stay.

The funding for this service will end in December 2019, and a business case has been submitted to maintain the service and to extend its offer to all in-patients and staff.

HMP Berwyn
BCUHB's Health and Wellbeing team at HMP Berwyn provide a full 12 week smoke-free programme through an approved clinical protocol for use at the prison. It allows the supply of nicotine replacement therapy by trained smoke free advisors whilst also undertaking the novel digital "Breaking Free from Smoking" intervention being used in UK prisons.

3.1.2 Community Pharmacy

The Health Board commissions community pharmacies across North Wales to deliver smoking cessation support. The Level 2 service provides Nicotine Replacement Therapy (NRT) only, whilst the Level 3 service offers one to one behavioural support with appropriate NRT and ongoing advice and support. These enhanced services were

first developed in North Wales, and similar services are now offered across all Health Board areas.

Geographical distribution of commissioned pharmacies is good across North Wales. As of March 2019, the Health Board commissions 115 pharmacies to provide the Level 2 service.

3.1.2 Stop Smoking Wales (SSW) (Public Health Wales)

SSW is a national service. The SSW advisors deliver a six-week behavioural support programme to smokers who want to quit smoking, usually in a group setting.

SSW advisors have supported the delivery of the Help Me Quit in Primary Care project in partnership with General Practices. This improvement project proactively targets smokers inviting them into the practice to discuss their smoking with an advisor. During this project an increase in the numbers of smokers accessing services and achieving success has been reported. Data is awaited at the end of the financial year.

A national review of the smoking cessation system in Wales was undertaken last year to look at whether the current system was optimal for delivering the national prevalence target. Work is currently underway across the public health system to look at the configuration of services to meet the needs of the local population. Potentially this could mean that all smoking cessation services in the future could be fully integrated under the leadership of the Health Board.

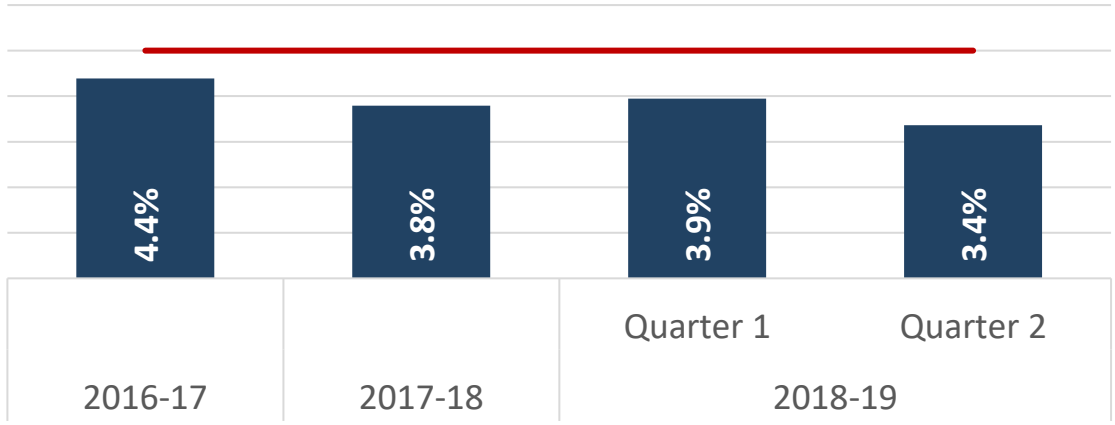
3.2 Current Performance

The NHS Wales Tier 1 smoking cessation performance targets for all Health Boards are:

- 5% of smokers to make a quit attempt via smoking cessation services and,
- at least 40% carbon monoxide (CO) validated quit rate at 4 weeks for treated smokers

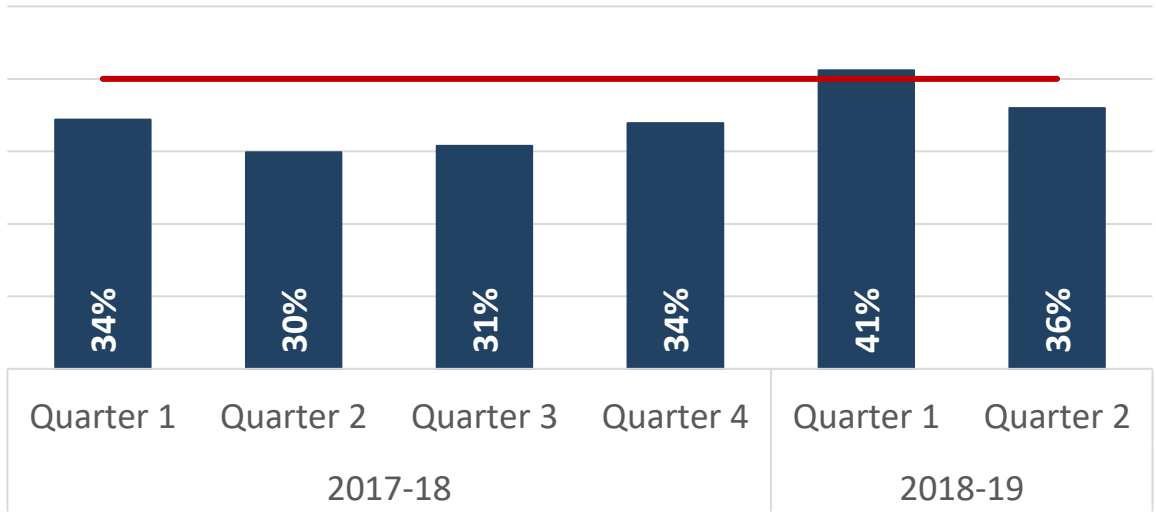
In BCUHB there are an estimated 105,700 adult smokers and our current annual treatment target is 5,252. Tier 1 performance against both targets are shown in **Figures 3 & 4.**

Figure 3: Progress against the Tier 1 target of 5% of treated adult smokers, BCUHB 2016 - Q2 2018



Red line shows Tier 1 Target: 5% of treated adult smokers

Figure 4: Progress against the Tier 1 target of 40% of treated smokers quit at 4 weeks (CO-validated) in BCUHB 2017 - Q2, 2018



Red line shows Tier 1 Target: 40% of treated smokers quit at 4 weeks (CO-validated)

It is anticipated that BCUHB will achieve a 4% rate for treated smokers by year end. This is in line with the trajectory submitted to Welsh Government (18/19 plan), but falls short of achieving the 5% target. During 18-19 the 40% target was achieved in Quarter 1. Our plan going forward is that we will consistently achieve the 40% target.

In 2017/18 (the latest period for which robust comparative information is available), our achievement against the Treated Smokers target was the second best in Wales at 3.8% (Cwm Taf University Health Board reported the highest performance at 4.6%).

Our confirmed Quit Rates, however were reported amongst the lowest in Wales during 17/18.
To support service performance management and reporting the Information Department have developed a Tobacco Control Dashboard which is in its final stages of development. The new dashboard includes progress against the Tier 1 targets for both treated smokers and CO-validated quits at 4 weeks including summaries over time, by area and smoking cessation service. The work has also included analysis at cluster and GP practice level for Help Me Quit for Baby, Help Me Quit in Hospital and Pharmacy Level 3 services. The completed dashboard will be published on Information Reporting Intelligence System (IRIS) in the coming months and therefore will be accessible to a wide range of users across the Health Board.

4. **Smoke Free Premises and Vehicles (Wales) Regulations 2018**

To build on the success of other national interventions aimed at "de-normalising" smoking and accelerate progress towards matching best international prevalence, Welsh Government is continuing to pursue other legislative opportunities.

The Public Health (Wales) Act 2017 laid down the legislative framework for widening the extent of smoke free sites across Wales. Welsh Government (WG) consulted on the draft Smoke Free Premises and Vehicles (Wales) Regulations 2018 last year, and these are due to come into force later this year.

Informal advice suggests that the consultation summary report and final regulations will be published in May 2019 with legislation coming into force by the Autumn 2019.

Key provisions in the draft Regulations of direct relevance to the Health Board are:

- Extension of smoking ban to outdoor areas of hospital grounds and the requirement for Health Boards to work with Local Authorities to agree enforcement strategies (with fixed penalties for anyone smoking on site).
- Removal of an exemption from previous legislation that allows designation of a room in which patients and residents of mental health units may smoke, and replacing it with one that would expire 18 months after the new Regulations come into force.
- Conditions relating to areas designated for smoking in hospital grounds ***should*** an organisation use their discretion to provide such areas. Our response to the consultation in line with other Health Boards did not support the inclusion of this discretionary element, on the grounds that the NHS needs to be an exemplar in delivering the smoke free social norm vision.
- Provision of signage within clearly marked boundaries in a prominent position at or near the main entrance, to include following text "It is against the law to smoke in these hospital ground" together with a legible graphic representing a burning cigarette enclosed in a circle with a bar across circle which crosses the cigarette symbol. As under previous legislation, it will be an offence to fail to provide sufficient signage both inside buildings and in grounds.

- The Public Health (Wales) Act (Section 11, Sub-section 6) specifically notes that "…*premises used to any extent as a dwelling, are not smoke-free by virtue of this section"*, and thus means that staff residences on hospital grounds are exempt.

A multidisciplinary task and finish group, chaired by the Executive Director of Public Health has been established to take the work forward and will report to HIIT. The group includes members from across the organisation and Public Protection Departments, Local Authority. Based on our current understanding of the Regulations, the plan will need to deliver the following elements by Autumn 2019:

- Hospital sites will be smoke free with no designated smoking areas
- Hospital sites will have enforcement mechanisms in place, as agreed with Local Authority partners
- All sites will have signage which meets or exceeds the recommended standards
- An updated Smoke free policy (WP33)

Also by January 2021:

- All mental health units will be completely smoke free, and (where these are located on hospital sites) without outdoor smoking areas.

A robust communication and engagement plan will be fundamental to deliver this change as a voluntary smoking ban is already in place in all our hospital grounds, however compliance is variable.

5 Recommendations

It is recommended that the Board:

Note the opportunity for continued improvement against current Tier 1 performance in relation to smoking cessation and the critical importance of continued investment in smoking cessation services to reduce the burden of disease in North Wales.

Note the service developments across the Health Board

Endorse the approach being taken to ensure all our hospital sites become smoke free through the delivery of the Smoke Free Regulations.

Health Board **2.5.19**	GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board ***To improve health and provide excellent care***

Report Title:	Pharmacy & Medicines Management Annual Quality and Safety Report 2018-19
Report Author:	Louise Howard-Baker Assistant Area Director for Pharmacy & Medicines Management (East) Medicines Safety Officer
Responsible Director:	Dr Evan Moore Executive Medical Director
Public or In Committee	Public
Purpose of Report:	To provide an annual statement to the Committee on Pharmacy & Medicines Management's Quality and Safety using the Health & Care Standards Framework.
Approval / Scrutiny Route Prior to Presentation:	Quality, Safety & Experience Committee 19.3.19
Governance issues / risks:	The risks highlighted in the report cover: • Pharmacy support to Mental Health Division; • The replacement of the pharmacy robots in Ysbyty Gwynedd and Wrexham Maelor; • Medicines shortages; • Pharmacy support to cancer services in Bangor and Wrexham; • Recruitment;
Financial Implications:	None
Recommendation:	The Board is asked to note the report.

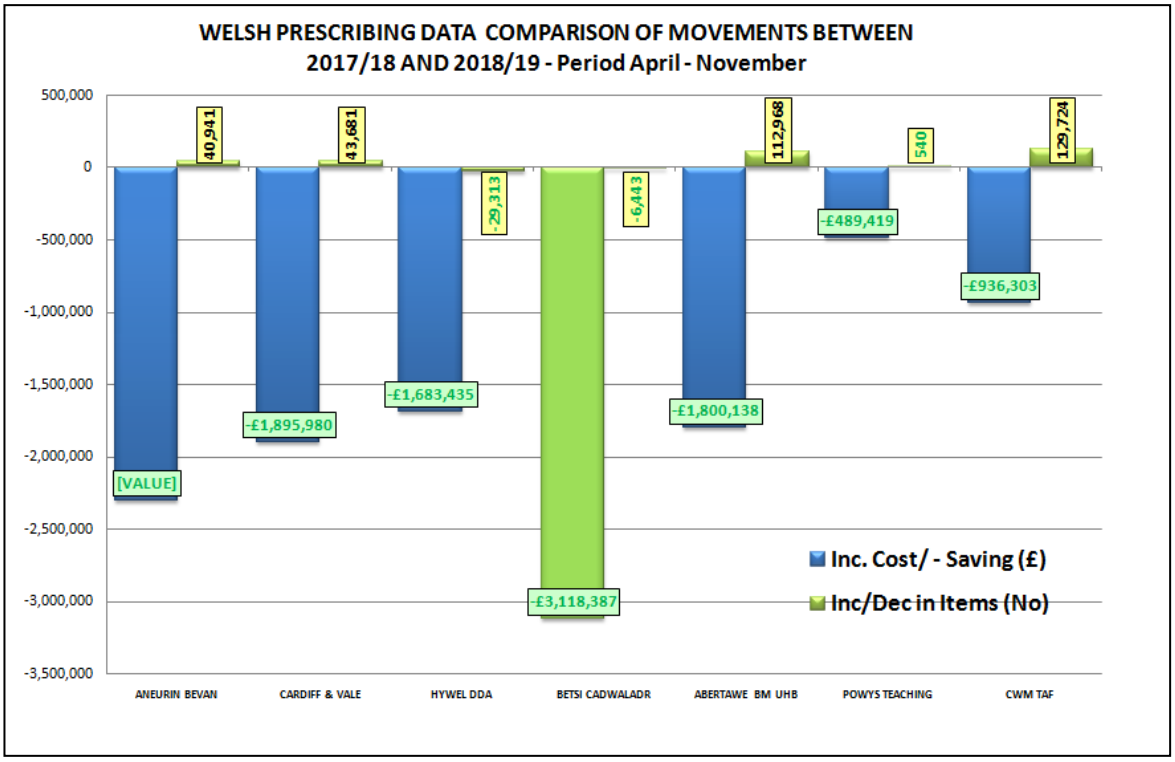
Health Board's Well-being Objectives *(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)*	√	**WFGA Sustainable Development Principle** *(Indicate how the paper/proposal has embedded and prioritised the sustainable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

3.To support children to have the best start in life		3. Involving those with an interest and seeking their views	✓
4.To work in partnership to support people – individuals, families, carers, communities - to achieve their own well-being	✓	4.Putting resources into preventing problems occurring or getting worse	✓
5.To improve the safety and quality of all services	✓	5.Considering impact on all well-being goals together and on other bodies	
6.To respect people and their dignity	✓		
7.To listen to people and learn from their experiences	✓		
Special Measures Improvement Framework Theme/Expectation addressed by this paper Leadership and governance			
Equality Impact Assessment Not required for annual update report			

Pharmacy & Medicines Management Annual Quality and Safety Report 2018-19

1.0 Executive Summary

2018 has proved both a challenging and a rewarding year for Pharmacy and Medicines Management. Set a steeper savings target than 2017-18 of nearly £8m, the forecast is that more than £10m will be delivered in 2018-19. The prescribing costs are falling at a greater rate in primary care in BCUHB compared to all other areas in Wales and are now lower than most England CCGs (see Appendix1):



- The number of items dispensed or supplied in the three acute hospitals increased by 10% to over 1.6 million
- There were over 32,000 interventions, mostly to clarify or correct prescribing, so that patients could receive the correct medication at the right dose, by the right route and at the right time.
- Almost 90,000 doses were prepared of readymade antibiotics, pre-prepared syringes of high risk medicines, cancer treatments and parenteral nutrition for neonates and adults.

The number of whole time staff increased to 440 pharmacists, pharmacy technicians, pharmacy assistants, store managers, clerical assistants and medicines management nurses. This increase was in two main areas:

- Support for the the procurement and Homecare team to provide scrutiny and governance.
- Support to the managed GP practices to oversee safe prescribing processes.

Role extensions of pharmacists and pharmacy technicians to support other healthcare professionals now include:

- Prescribing (Gastroenterology, Rheumatology, Dermatology, Mental Health, Movement Disorders, Microbiology, Haematology, Cancer, Respiratory, Cardiology, Pain Management)
- Administration of medicines in a community hospital (in development).
- Support for GP practices to ensure that prescribing is safe and cost effective.
- Ensuring that safety monitoring of medicines is undertaken.
- Ensuring that safe prescribing processes are in place.
- Care home support

In 2018, Pharmacy & Medicines Management in BCUHB won:

- BCUQI Conference Poster of the Year Award 2018
- 3 BCUHB Achievement Award Nominations; 2 winners
- Runner up poster in the Innovation in Health category at the Sharing Training Excellence in Medical Education (STEME) conference.
- Wales Chief Pharmacists' Symposium Best poster Winner

The NEWT guidelines, produced by the pharmacy department at the Wrexham Maelor Hospital were recently referenced in the Professional Guidance on Administration of Medicines in Healthcare Settings January 2019 which was produced Royal Pharmaceutical Society and the Royal College of Nursing and a contract to supply the NEWT guidelines to a large community pharmacy multiple was negotiated.

A key risk to BCUHB is medicines shortages (see Page 6), although to date plans have quickly been put into place to mitigate any harm to patients. Recruitment of pharmacy staff in parts of the region is challenging, particularly, when other parts of the healthcare system are looking to pharmacy for additional support. There is some frustration that despite submitting workforce plans, the additional resource to train pharmacists and technicians is not forthcoming from Health Education and Innovation Wales (HEIW).

This annual report has been set around the themes of the Health and Care Standards to deliver person centred care.

Governance, Leadership and Accountability

Pharmacy staff working in primary and secondary care are managerially accountable to their respective Area Directors.

The Chief pharmacist retains a small governance team which supports him to dispense his obligations to corporately deliver the safe management of medicines including controlled drugs, technical services including quality control and assurance, formulary, Individual Patient Funding Requests, policies and procedures, procurement and Homecare services.
The Chief Pharmacist also retains the responsibility for Workforce Development, Education & Training and Strategic Vision.

A project is underway to develop a strategic vision for pharmacy and medicines management.

Two large pieces of work are underway to comply with new legislative requirements;

1. Wholesale Dealer's Authorisation, which is an MHRA requirement to enable BCUHB to supply to outside organisations e.g. Welsh Ambulance Service Trust; hospices, private hospitals. This is a huge undertaking to overhaul all the standard operating procedures and policies relating to the procurement, receipt and ongoing supply of medicines.
2. Falsified Medicines Directive (FMD). New EU legislation came into place in February 2018, to prevent falsified medicines getting into the supply chain. All ethical medicines are now registered by their manufacturers so that they can be traced. New procedures have to be in place by all pharmacies and eventually by GP practices, so that the medicines are decommissioned from the registry before supply or administration to patients.

Staying Healthy

1.1. Health promotion Protection & Improvement

Choose Pharmacy

An IT application funded by Welsh Government, Choose Pharmacy is used to support community pharmacy delivered services. To date these include:

- The Common Ailments Scheme
- Discharge Medication Review
- Flu vaccination
- Emergency Medicines Supply

Community Pharmacies are required to ask patients what they would have done if these services were not available, when they present for a consultation.

In January 2019, BCUHB became one of three pathfinder sits in Wales for a Sore Throat Test and Treat service.

There are several milestones set BT Welsh Government that BCUHB needed to achieve:

1. The Choose Pharmacy Platform is fully rolled out and utilised providing universal access to the common ailments service.

- All eligible 147 (95%) Community Pharmacies have been commissioned to provide the Common Ailments Enhanced Service (CAS).
- 7 (5%) pharmacies could not be commissioned because they lack a suitable consultation room, or insufficient space to add one. All of these pharmacies are within 5 miles of another pharmacy commissioned to provide the CAS.

As a result of the CAS:

- 6,787 GP, OOH appointments, or self attendance at emergency departments were avoided (Nov 2017 – Oct 2018).

There is ongoing work to monitor and promote the uptake of the CAS service, including at cluster level to engage contractors to work closely to increase signposting and utilisation.

2. Full implementation of the 2018-19 community pharmacy NHS flu vaccination delivery programme.

The flu vaccination service has been in place for a few years. In 2018 the specification was reviewed and redistributed to all community pharmacies in North Wales. The service is operated using a BCUHB approved Patient Group Direction, which is a legal direction to allow the supply and administration of a Prescription Only Medicine by a non-prescribing healthcare professional.

By November 2018, 118 (77%) Community Pharmacies had been commissioned to provide the community pharmacy NHS flu vaccination delivery programme:

- 10,286 eligible patients had been vaccinated an increase of 54% since 2017.
- Of these 1,619 or 16% had not received the flu vaccine in the year 2017-18.

3. Community pharmacies open longer to meet assessed local need, enabled by optimal use of extended opening hours enhanced services.

A planned Pharmaceutical Needs Assessment due date has now been extended as a result of delays caused by regulations not being in place. Pharmacy and Medicines Management are currently exploring and working with Cluster Leads to identify the local need for extended hours.

In the Central Area, support was given to a pilot to extend opening hours in a Community Pharmacy in Rhyl for the benefit of all patients registered locally. Until the service review at the end of March 2019, there is now a pharmacy open in Rhyl for an extra 12 hours per week:

- Until 8pm Monday to Friday (Historically the latest opening was 6pm).
- On Sundays from 4pm to 6pm (Historically there was no pharmacy open).

4. People are able to access an emergency supply of medication enabled by optimal use of enhanced services.

Patients who run out of their prescribed medicines before they have requested a repeat prescription from their GP are at risk of harm from missed doses of medication. In place for 4 years now, 139 (90%) of pharmacies are able to provide a service to access an emergency supply of their repeat medication, giving extra capacity to GP practices and Out of Hours services.
In the 12 months to 30th November 2018 there were 14,549 items supplied to 9,546 patients as emergency supplies in BCUHB. These patients declared that their alternative strategy would have been:

Number of Patients that indicated what their alternative strategy would have been if this community pharmacy service was not available			
Attendance at A&E	**Contact GP OOH Services**	**Contacted own GP**	**Gone without Medication**
758	3,232	1,540	3,868

Safe Care

2.1 Managing Risk and Promoting Health & Safety

Two Patient Safety Notices remain open from 2016: PSN015 and PSN030.Both relate to medicines storage and are referred to in this report under section *2.6 Medicines Management*. This situation is similar to all the Wales Health Boards.

Business continuity

National shortages of medicines during 2018-19 have been one of the main challenges to service delivery and patient safety. In many instances there has been no warning and critical medicines have been involved, such as diuretics used in emergencies, various medicines in mental health and local anaesthetics used for diagnostic procedures. The medicines procurement lead pharmacist and national procurement contracting team have been managing over a 100 commonly used medicines that have “out of stock” status over the last year. More recently, concerns around the pharmaceutical supply chain contingency in the UK has become evident when a batch of Clexane® (Enoxoparin) used to prevent and treat venous thromboembolic events, failed its quality testing and the impact was an immediate “out of stock” position in the UK. A full system Health Board wide change has been implemented and led by the pharmacy safety and procurement team which required nurse & patient training and communication to all stakeholders affected. Prescribing advice has been made available in a timely manner to clinicians to safeguard patients.

The challenges around planning for a no deal EU-Exit has been another priority in order to mitigate any further risk to the medicines supply chain. Welsh Government the other devolved nations and NHS England are working closely with the Department of Health who set up a National Operational Response Centre to ensure there is a co-ordinated approach to medicines supply across the UK.

Homecare

In 2018, a business case was approved for a dedicated Medicines Homecare administration team for the Health Board. The team, recently recruited is part way through setting up a governance procedure for managing Homecare approvals aligned to the Medicines Governance team. Patients now have a single dedicated contact for Medicines Homecare queries within the Health Board to escalate and manage any concerns to improve their experience.

The number of patients receiving their medicines via homecare continues to grow. The total expenditure of these medicines was in excess of £11 million and in 2018 the VAT savings for the 2,402 patients who receive their medicines via this supply route are in the region of £2.2 million for the Health Board.

Further national collaborative work is underway to achieve “Once for Wales” service level agreements for new medicines approved for homecare supply. With this brings tighter control on standards and aspired service quality for patients.

Extending Homecare opportunities to other specialist treatments via the Homecare supply route for 2019 will allow patients to access their treatment closer to home.

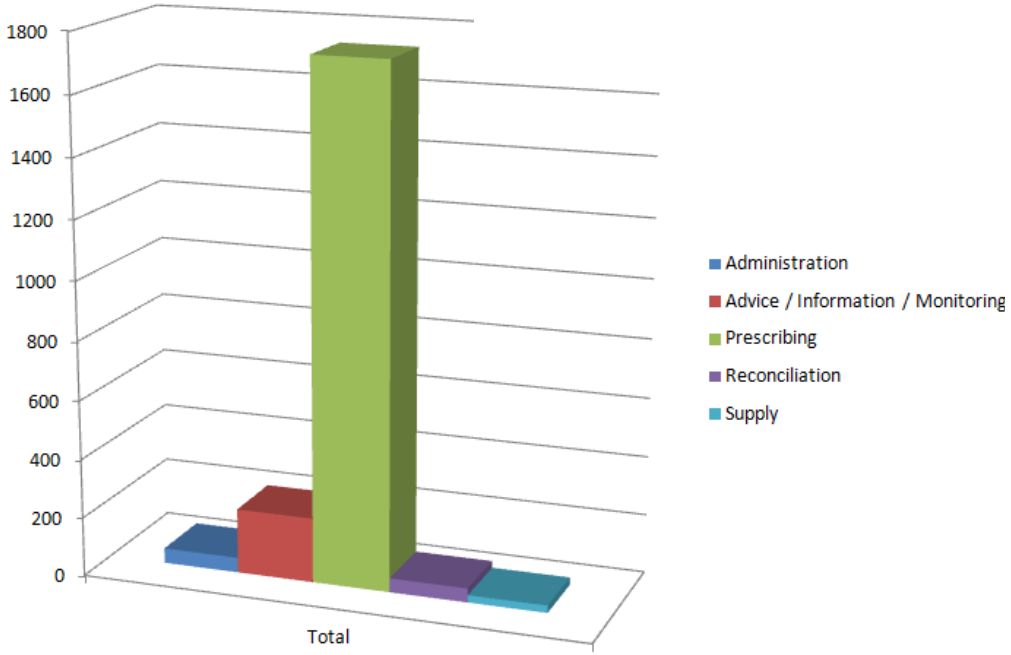
Interventions

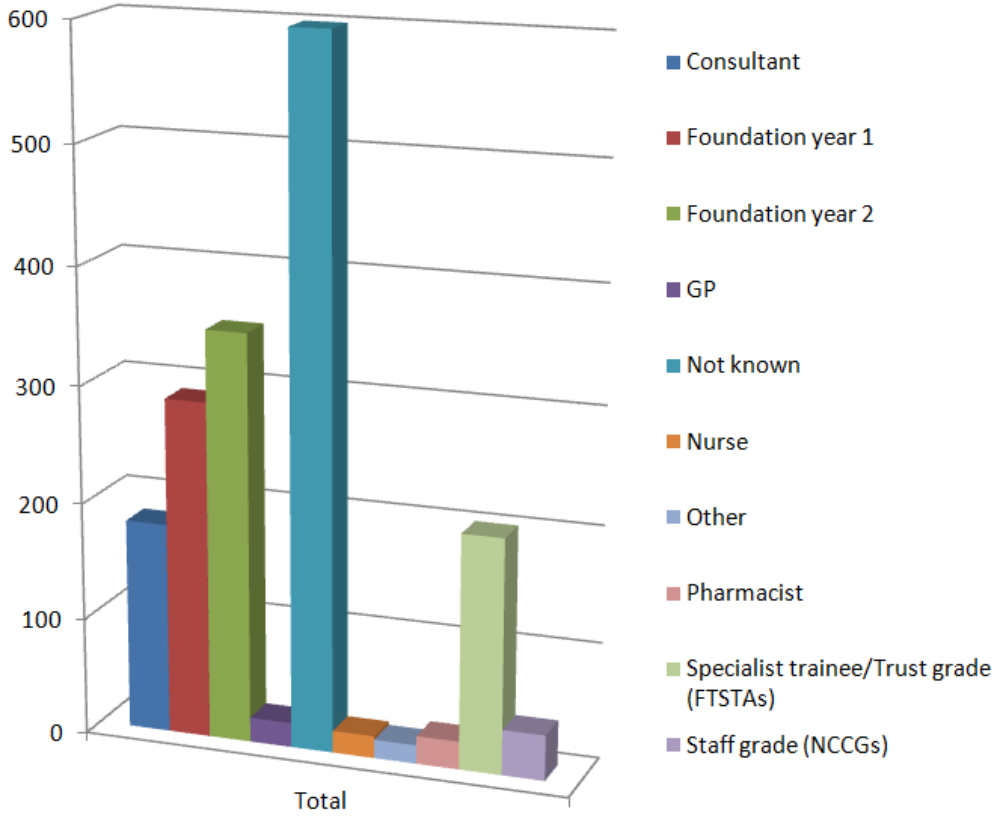
Pharmacists and some pharmacy technicians record their interventions (contributions to care) onto a Welsh database on one day per month. These equate to more than 32,000 interventions per year based on the current reporting rates. The cost avoidance of actual reported interventions for 2018 was over £500,000* or approx £42,000 per day.

*Based on the EQUIPP study

Top 10 Drugs 2018

Enoxaparin	5.57%
Apixaban	2.16%
Omeprazole	1.83%
Ciprofloxacin	1.61%
Paracetamol	1.39%
Vancomycin	1.39%
Clarithromycin	1.03%
Tazocin	0.99%
Atorvastatin	0.84%
Aspirin	0.70%





2.3 Falls

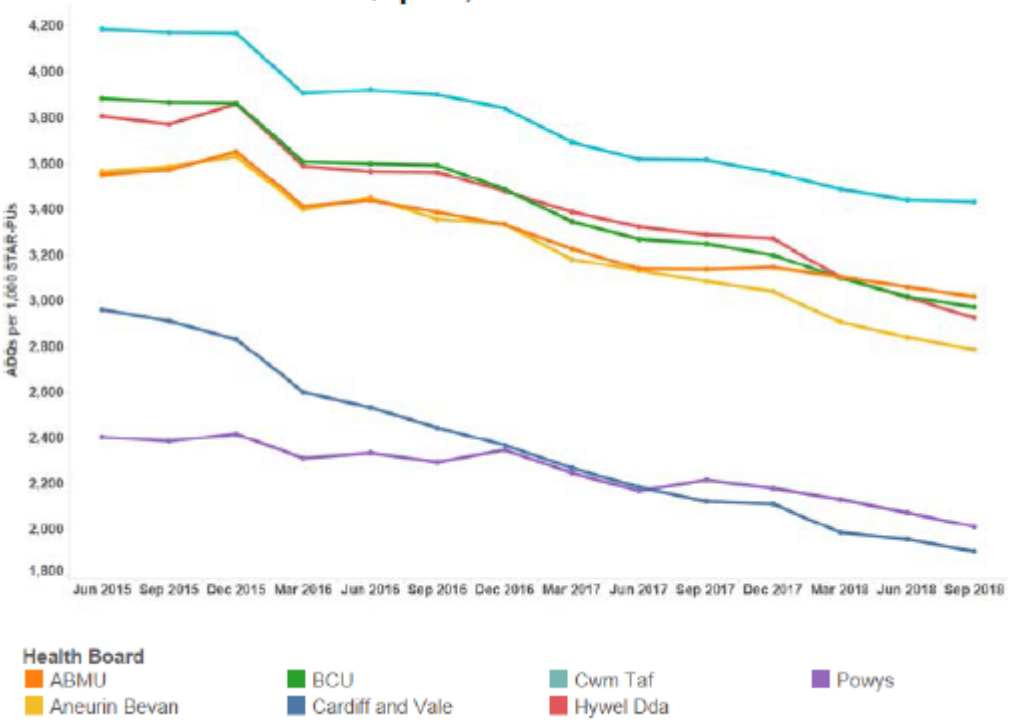
Pharmacy and Medicines Management is a member of the strategic falls group. At YGC, patients who have been admitted following a fall, or who have had a fall in the ward are referred to a pharmacist for a review of their medication. Any recommendations are highlighted to the medical team.

The graph below demonstrates the continued steady progress across North Wales to reduce the use of hypnotics and anxiolytics, which are known to significantly increase the risk of falls. There have been reductions of prescribing in all 14 cluster areas, giving an overall reduction in total usage of 8.56%. We continue to focus plans on the 10% of practices with the highest prescribing rates to improve further. BCUHB is the green line ranked 5th best in Wales.

The Primary Care Pharmacy and Medicines Managment teams in each area work in collaboration with the Prescribed Medication Support Service referring patients to the service for review and ongoing support.

In addition, Pharmacist Independent Prescribers while reviewing patients during their medication clinics and will discuss hypnotics and anxiolytics as necessary and initiate a reduction where appropriate and possible.

Figure 1. Trend in hypnotic and anxiolytic prescribing ADQs per 1,000 STAR-PUs



2.6 Medicines Management

Medicines Storage – PSN015 & PSN030

Patient Safety Notices 030 and 015, issued in 2016, set the standards for medicines storage on wards in NHS Wales. BCUHB has invested a significant amount of Welsh Government capital implementing ward automation in its hospitals. The majority of acute wards and some community hospitals have fully automated medicines storage. The remaining acute wards (Womens and Paediatrics) community hospitals and

mental health wards are included on the annual capital plan in order to complete this programme.

Ysbyty Glan Clwyd is going through a programme of asbestos removal and modernisation, so the ward treatment rooms, where medicines are stored are being brought up to the required standards.

The remaining hospitals are not imminently due for major refurbishment. The treatment rooms were constructed without doors. As a result, it has not been possible to install air-conditioning if the temperature exceeds 25^{o}C. A programme to install doors, with swipe card access is to take place in 2019.

BCUHB's aim to reduce medication related harm is being taken forward by a Medicines Management Collaborative. To date the collaborative work is being run in 16 acute wards, mental health wards and a minimum of 3 community hospitals.

Measured with run charts, improvements in compliance have been demonstrated in the following areas:

- Fridges are locked.
- Daily monitoring of fridge temperatures.
- Controlled Drug ordering books are locked away when not in use.
- Controlled Drug keys are with the nurse in charge and separated from the main bunch of keys.
- All medicines are locked away and not left out in any areas (e.g. bedside).
- All Medicines Cupboards are locked.

Table to demonstrate BCUHB compliance with PSN015 and PSN 030

	East Area				West Area				Central Area		
	WMH	ED	Mental Health	Community Hospitals	YG	ED	Mental Health	Community Hospitals	YGC including ED	Mental Health	Community Hospitals
Medicines storage cupboards											
CD cupboards											
Medicines fridges											
Patients own POD lockers				N/A							N/A
Secure access-Utility room											
Fluid storage			N/A	N/A			N/A			N/A	N/A
Room Temperature Monitoring											
Fridge Temperature Monitoring											

Controlled Drugs

The BCUHB Controlled Drugs Local Intelligence Network met three times in 2018. Through this group, the Accountable Office discharges his duty to oversee the use of controlled drugs in North Wales. The membership is multidisciplinary and multiagency and is a forum for sharing information relating to the handling, prescribing, storage, use or possible abuse of Schedule 2 and 3 drugs. This will include any concerns, incidents, prescribing trends or actual system failures.

Prescribing

An area identified for improvement in BCUHB is a reduction in the number of prescribing errors. Poor prescribing has a direct impact on administration of medicines. If the prescription is incorrect, the nurse may either administer the wrong medication, or there may be delays or omissions because the dose or directions are wrong or unclear.

A workshop with doctors of all grades is planned in early March to develop an action plan, which will be overseen by the Safe Medication Steering Group.

Medicines administration

A Nursing Medicines Management Improvement Plan is in place. A significant piece of work was undertaken by the Nursing Associate Director, Quality Improvement and colleagues from nursing and pharmacy to explore themes from incident reporting, external reports (HASCAS, Ockenden) and inspections (HIW).

A nursing collaborative has been set up to run the quality improvement programme, with membership which includes the areas (community hospitals), acute site nursing teams, medicines management nurses and pharmacists. The work of the collaborative is being overseen by the Safe Medication Steering Group.

The Medicines Management nurse from the Wrexham Maelor Hospital won the 'Clinical Teacher of the Year' category at the 2018 BCUHB achievement awards for the one to one support and mentoring she offers nurses if they have been involved with a medication error, or where there are concerns surrounding the nurse's capability to remain in their current area of work.

Agency nursing staff were identified as being responsible for many of the medicines administration errors in the Wrexham Maelor after reviewing the themes from Datix incident reports. Working with the Nurse Bank Manager, an agreement was secured to offer bespoke intravenous medication administration training for agency nurses. It was quickly realised that there were problems releasing night staff and so evening training sessions were organised to improve access. This also necessitated gaining agreement from the Wrexham Maelor night sisters to be able assesses the competency of the agency nurses in preparing and administering intravenous medication. As a result there has been a noticeable reduction in reported agency nurse medication errors.

Community Hospitals

The responsibility for Llandudno Hospital transferred from West to Central Area during 2018. The central Pharmacy & Medicines Management team have used opportunities for workforce redesign to establish a consistent level of pharmacy support for patients and nursing staff. Further work is being explored to support Llandudno Hospital, which is experiencing staff shortages with prescribing pharmacists and medicines administration by pharmacy technicians.

Serious Incidents

There were 10 catastrophic or major incidents involving medicines from Feb 1st 2018-Jan 31st 2019. All were the subject of a serious incident review and were closed with lessons learnt.

- 5 in took place in acute hospitals, 3 were prescribing and 2 were administration errors.
- 4 took were as a result of dispensing errors in community pharmacy
- 1 was a prescribing error in a GP practice

Some of the lessons learned include:

- Ensuring that medication is accurately checked with the patient at the bedside.
- Additional clinical pharmacy checks in place for prescribed chemotherapy.
- Patients waiting for a bed whilst being held in the emergency department are regularly reviewed and are referred to a pharmacist for medication check.

Medicines Information

The Medicines Information and Advice (MI) service promotes the safe, effective, economical and rational use of medicines within the health board, with a strong emphasis on promoting quality patient care and ensuring patient safety. The MI Service is available Monday to Friday, 9-5 and is contactable via phone, in person or via e-mail, and a bilingual helpline is available for patients. It deals with a huge range of enquiries each year. In the last 12 months, over 1000 enquiries were answered across the Health Board. These enquiries varied in complexity with over 80% requiring specialist skills and interrogation of multiple resources and professional judgement. Responses to the ongoing user survey indicate a high satisfaction rating and that the answers from the MI team contributed to patient care. An All Wales Medicines Information Pharmacist external audit reported that the queries answered had a positive impact on patient outcome and patient safety.

Examples of Queries handled by the Medicines Information Service in 2018:

- 63 queries related to fridge temperature breaches.
- Should ideal or actual body weight be used when calculating renal function to dose Direct Oral Anti-Coagulants(DOAC)?
- What is the DOAC of choice for a patient with tricuspid atresia?
- How should edoxaban be managed in the peri-operative period?
- Is there a drug interaction between warfarin and horse chestnut?
- Intravenous administration of ascorbic acid for mushroom toxicity.
- Magnesium supplements for Huntingdon's disease.
- Hydrocotisone 1% ointment for extravasation.
- Ulipristal dose for obese patients.
- Steroid dose for nitrofurantoin-induced lung disease.
- Conversion from amobarbital to temazepam.
- Injecting triamcinolone into oesophageal peptic strictures.

Queries about complementary medicines have seen the MI team research the available evidence for herbal teas, homeopathic remedies, barley grass, rosehip, charcoal, phynova, St. John's wort, co-enzyme Q10, taurine and cranberry.

Ten enquiries regarding cannabidiol oil have been posed in the last year; these have included potential interactions with prescribed medication, a potential adverse effect

(deranged Liver Function Tests LFT), when to stop the preparation before surgery and whether the supplement is available to be prescribed within BCU (it is not).

The safety of drugs in use pre-pregnancy include queries on psychoactive medicines such as amisulpiride, clozapine, aripirazole and various antidepressants.

The service answers queries regarding the evidence of safety for drugs used during pregnancy and lactation as well as potential effects from paternal use. Enquiries during 2018 have included prospective enquiries on how to treat conditions such as:

- Otitis externa,
- Allergic rhinitis,
- Threadworm
- Hypercholesteraemia in pregnancy
- Whether R-CHOP (a particular combination of anti-cancer agents) chemotherapy could be used for a pregnant woman newly diagnosed with lymphoma.

Adverse Drug Reactions and Medicine Related Adverse Incidents

Suspected medication-related admissions have been tracked by Wrexham Maelor Hospital Pharmacists since April 2006 in a safety programme devised and led by one of the Patient Safety Pharmacists. Despite being constrained by limited resources, the programme has prompted some notable positive local/national changes in practice benefiting NHS Wales' patients, staff and beyond. This scheme has helped reveal which medicines cause admissions, identify root causes to help guide preventative strategies and increase learning opportunities as well as reveal deficiencies in e.g. common reference text or awareness of certain drug interactions. Some root causes are complex and not easily fixed despite best efforts. A Welsh Medicines Resource Centre (WeMeReC) distance learning module on this topic in 2015 revealed that 99% of GPs (200 surveyed) wanted feedback about medication-related admissions for learning purposes.

Policies & Procedures, PGDs

In response to the HASACS report, BCUHB medicines management policies have been extensively revised during 2018 and guidance strengthened for areas that were highlighted as being inadequate The existing BCUHB Medicines Code has undergone significant review and has now been replaced with the Medicines Policy. In particular, standards for medicine storage have been reviewed in line with national Patient Safety Notices and All Wales guidance. A separate Injectable Medicines Policy has been developed, providing a more robust framework and is available for healthcare staff when prescribing, preparing and administering injectable medicines. Work continues to develop the current guidance for unlicensed medicines into a BCU Policy. It is anticipated this work will be completed early in 2019.

A revised BCUHB Corporate Governance Policy for the Management of Policies, Procedures and other Written Control Documents was published in September 2018. This document sets out how all BCU wide policies and written control documents are to be ratified. The medicines management governance process is currently being reviewed to ensure documents ratified via the Medicines Policies and Procedures Subgroup of the Drugs and Therapeutics Group are subject to more extensive rigor and scrutiny to comply with corporate standards.

Effective Care

3.1 Safe & Clinically Effective Care

DTG

The BCUHB Drug and Therapeutics Group (DTG) met twelve times in 2018. DTG has 40 members drawn from across BCUHB including primary and secondary care doctors, nurses (medicines management), midwives, a dentist, a physiotherapist independent prescriber, pharmacists (clinical and primary care medicines management),a patient, finance and Association of the British Pharmaceutical Industry (APBI) representative respectively.

57 new medicine applications for new drugs to be added to the Formulary were approved and two were declined. Over the same period, 111 applications to treat individual patients with drugs which were not on the BCUHB formulary were approved and 11 were not approved. Applications came from prescribers across BCUHB and tertiary centres.

NICE & AWMSG Impact Assessment Group

BCUHB is fully compliant with the directions of the Welsh Health Circular 2017 (001) to make NICE and All Wales Medicines Strategy Group (AWMSG) positively appraised drugs available with 60 days of the recommendation.

In 2018, 52 new AWMSG/NICE drugs were considered to see where they fit into a treatment pathway, who the most appropriate prescriber is likely to be and whether the prescribing should remain in secondary care or whether it is suitable for GP prescribing, either solely, or with a shared care agreement in place. From a financial perspective, the impact assessment includes service capacity and whether an existing treatment is likely to be replaced. The spend is monitored and resources are drawn down to the responsible budget holder.

Of the 52 new drugs that have gone through this process there were:

Number of drugs	Speciality
33	Cancer
3	Rheumatology
1	Cardiology
4	Dermatology
1	Sexual Health
1	Urology
2	Gastroenterology
3	Nephrology
1	Mental Health
3	Neurology

HMP Berwyn

2018 was HMP Berwyn Pharmacy's first full year of operation. It continued to provide a comprehensive service to patients including but not limited to:

- Medicines reconciliation on arrival;
- Pharmacist clinical review of every medicine prescribed;
- Medicines optimisation support with a focus on substance misuse involving prescription medicines;
- Technician-led dispensing and accuracy checking;

- Integrated medicines administration working alongside registered nurses and healthcare support workers;
- Room medication check-ups;
- Electronic temperature monitoring of all ambient and refrigerated medicines storage;
- Medicines information service;
- Responding to intelligence sharing by Her Majesty's Prison and Probation Service (HMPPS) HMP Berwyn security department;
- Mandatory drug testing reporting;
- Secretariat for HMP Berwyn Medicines Management Group;
- Discharge medication planning and communication;
- Supporting the education of pharmacy staff across BCUHB and NHS Wales including rotations of staff into HMP Berwyn;
- Inducting new HMPPS supervising officers on medicines optimisation and their role in supporting staff and patients with all-things medicines-related;

As a high-tech, novel pharmacy service that has been designed to be completely integrated into a multi-disciplinary healthcare team, it has been subject to a number of visits. These have included a number of House of Commons Select Committees with Members of Parliament greatly interested in the team's novel work. There have also been Governing teams from other prisons, Treasury civil servants allocated to the new future prisons, England and Wales-wide Independent Monitoring Board and HMPPS Non-Executive Directors.

As well as receiving a number of visits, the department has made key contributions to the following: Drug and Alcohol Strategy, Medicines Management Group, Health Operational Leaders, Quality/Safety/Performance, Controlled Drugs Local Intelligence Network, Secure Environment Pharmacy Group, Health and Justice Pharmacy advisory group, Polypharmacy guideline development, Complex men and Substance Misuse Service (SMS) Clinical decisions meetings.

Most recently patient feedback following a pharmacist consultation provided specific thanks for the pharmacist's helpful contribution to the patient's understanding of his critical medication which he'd been previously non-adherent with.

Mental Health

The pharmacy funding for mental health services having originally been based on a redistribution of the pharmacy provision to Bangor and Wrexham when Denbigh Infirmary was closed has not kept pace with the increased activity.

Despite a considerable expansion into new services including Older Person's Mental Health, Community Mental Health Services, Home Treatment Teams, scant resources have gone to Pharmacy and Medicines Management. The HASCAS report noted failings in a number of areas of medicines management, although it was acknowledged that the pharmacists did what they could within their capacity.

Cancer Services

There is a similar picture of under-resource in pharmacy support for oncology and haematology in Bangor and Wrexham, where the workload has increased in the last few years.

Cancer treatments are becoming ever increasingly complex and targeted to patients with particular genetic anomalies. In the last year, all 33 new treatments approved by NICE or AWMSG for cancer were linked to Patient Access Schemes which requires additional paperwork to be completed by pharmacists for individual patients so that

the medicines are eligible to be obtained at the negotiated price. Failure to do this risks BCUHB losing out on significant sums of money.
The new version of Chemocare will be rolled out across BCUHB ensuring standardisation of treatment protocols and improved safety for patients.

Prescribing Indicators

1. Safety indicators:

Twelve indicators were selected to identify patients at high risk of adverse drug reactions and medicines-related harm in primary care. The searches are run on the GP practice computers to identify patients at high risk of an adverse drug event to attend for a medication review.
BCUHB has improved on all but two of the indicators during 2018/19:

- Current prescription of oestrogen-only hormone replacement therapy in a woman without any hysterectomy read code increased by 4%
- Patients ≥65 prescribed an antipsychotic as a percentage of all patients aged ≥65 increased by just over 5%.

In addition, there are four specific safety indicators comparing the prescribing of sleeping tablets (hypnotics and anxiolytics – see Section *2.3 Falls Prevention*) and analgesics as there is widespread concern about the appropriate use and review of these medicines, together with the potential for dependence, diversion and misuse. BCUHB has improved in 3 out of 4 these indicators with a reduction in prescribing of hypnotics and anxiolytics, tramadol, opioids patches but a similar picture to all health boards is seen with an increase in gabapentin and pregabalin prescribing.

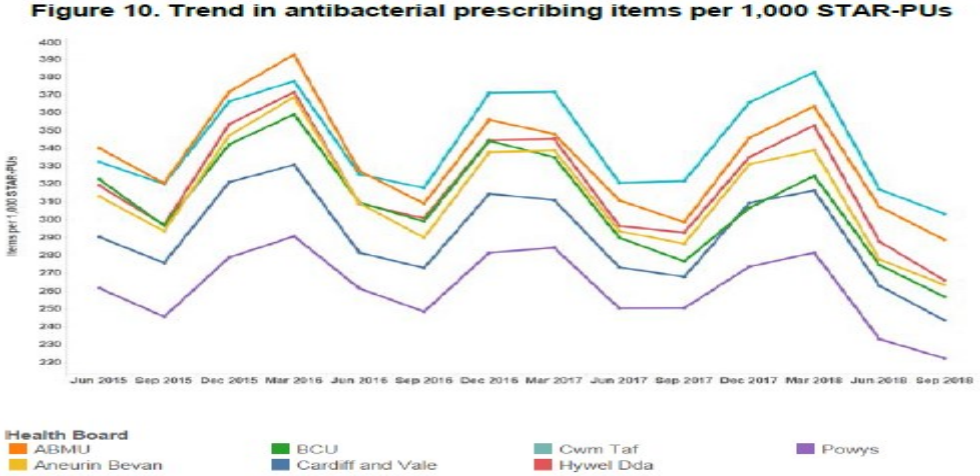
The last safety indicator monitors the reporting of adverse events by completion of yellow card reports. The Yellow Card Scheme is vital in helping the MHRA monitor the safety of all healthcare products in the UK, to ensure they are acceptably safe for those that use them. BCUHB has delivered a 12% increase in yellow card reports this year a total of 140 reports in total.

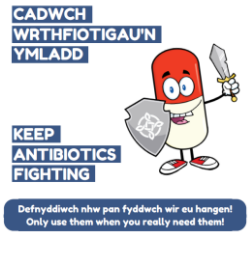
2. Antimicrobial stewardship:

These three indictors benchmark the prescribing of antibiotics across Wales. The widespread and often excessive use of antimicrobials is one of the main factors contributing to the increasing emergence of AMR.

A steady decline in prescribing of antibiotic items per 1000 STAR-PU can be seen across North Wales. There have been reductions of prescribing in all 14 cluster areas, giving an overall reduction in total antibiotic usage of 14.1%. There will be a focus on the 10% of practices with the highest antibiotic prescribing rates to improve further. BCUHB is the green line ranked 3rd best in Wales.

Figure 10. Trend in antibacterial prescribing items per 1,000 STAR-PUs





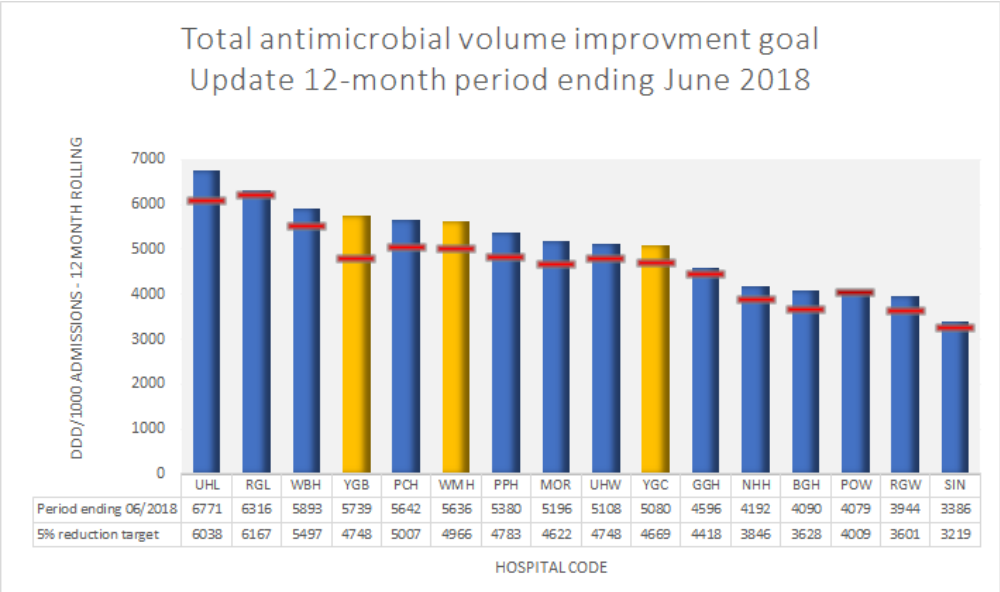
Some of the interventions that have been undertaken to achieve this reduction include:

- Urinary Tract Infection (UTI) Project
  Focusing on the sending of Mid Stream Urine (MSU) samples for analysis and stopping the use of urine dipsticks as a diagnostic test for a UTI in those aged over 65 years in care homes and now in community hospitals. This project has been a collaboration of the antimicrobial pharmacists with the hydration team and GP practices and has included a review of patients on prophylactic antibiotics, training sessions and targeted visit by the microbiologist and antimicrobial pharmacists.
- A project to evaluate the use of C-reactive protein (CRP) point of care testing (POCT) for lower respiratory tract infections proved highly successful in reducing antibiotic prescribing in a GP practice on Anglesey. Additional funding to purchase a further 10 machines was provided by Welsh Government. The majority of the practices have demonstrated a reduction in their prescribing and the study has demonstrated that POCT is a useful diagnostic tool to support clinicians in primary care.
- The Chief Medical Officer sent a letter to all practices indicating their prescribing rates, which resulted in one cluster, Dwyfor, requesting support to tackle their high prescribing.

Future work includes:

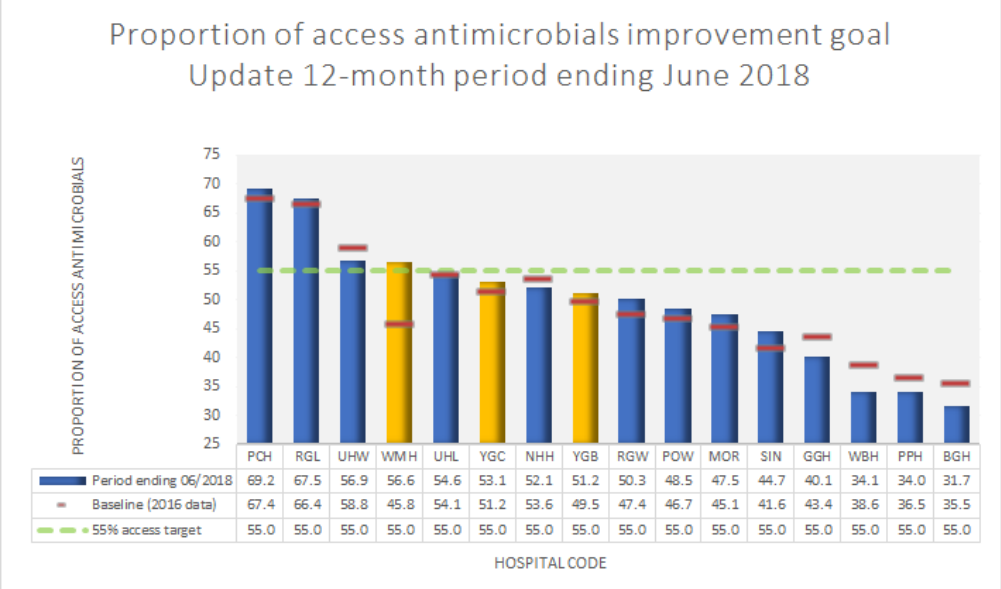
- The microbiologists will be starting reviews of patients with long term cellulitis in community hospitals.
- Primary care visits and additional support from antimicrobial pharmacists to target the top 10% highest antibiotic prescribing practices to raise awareness, increase audit and patient reviews.

There is good and bad news in secondary care. All three hospitals have seen a rise in the overall quantity of antimicrobials being prescribed, so none have achieved the 5% reduction target set by WG.



	UHL	RGL	WBH	YGB	PCH	WMH	PPH	MOR	UHW	YGC	GGH	NHH	BGH	POW	RGW	SIN
Period ending 06/2018	6771	6316	5893	5739	5642	5636	5380	5196	5108	5080	4596	4192	4090	4079	3944	3386
5% reduction target	6038	6167	5497	4748	5007	4966	4783	4622	4748	4669	4418	3846	3628	4009	3601	3219

However the antimicrobial pharmacists have set about to restrict access to certain antibiotics (World Health Organisation Access Antimicrobials) by removing ward stocks and as a result, all three acute hospitals have improved, with Wrexham surpassing the target for this indicator. An Antimicrobial Restriction Policy has been produced to support this agenda.

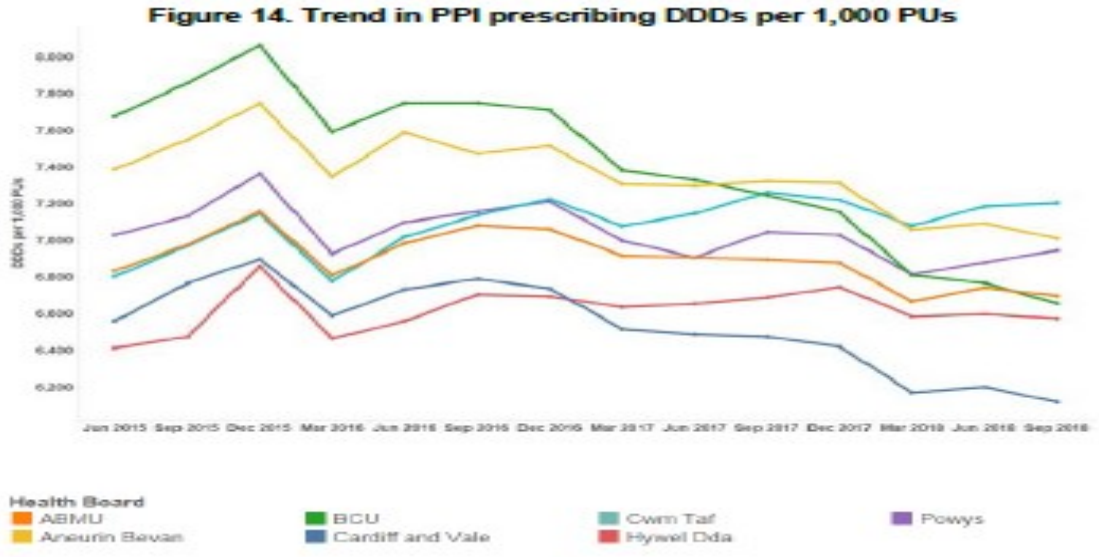


	PCH	RGL	UHW	WMH	UHL	YGC	NHH	YGB	RGW	POW	MOR	SIN	GGH	WBH	PPH	BGH
Period ending 06/2018	69.2	67.5	56.9	56.6	54.6	53.1	52.1	51.2	50.3	48.5	47.5	44.7	40.1	34.1	34.0	31.7
Baseline (2016 data)	67.4	66.4	58.8	45.8	54.1	51.2	53.6	49.5	47.4	46.7	45.1	41.6	43.4	38.6	36.5	35.5
55% access target	55.0	55.0	55.0	55.0	55.0	55.0	55.0	55.0	55.0	55.0	55.0	55.0	55.0	55.0	55.0	55.0

3. Efficiency indicators

Intended to promote cost-effective prescribing, BCUHB's performance has improved in all efficiency indicators. The graph below demonstrates the continued steady progress across North Wales with a significant reduction of prescribing of Proton Pump Inhibitors (PPI) Divided Daily Doses (DDD) per 1000 PU. There have been reductions of prescribing in all 14 cluster areas, giving an overall reduction in total PPI usage of 8.15%. This has been a combined strategy involving primary and secondary care pharmacy teams. Where PPIs have been initiated during an inpatient stay, the pharmacists ensure there is a clear management plan, or the medication is stopped prior to discharge. BCUHB has moved from being the worst, to being ranked 3rd best in Wales.

Figure 14. Trend in PPI prescribing DDDs per 1,000 PUs



BCUHB has improved efficiency with prescribing of insulin and on the biological medicines that support cost effective prescribing in Wales. This has released savings for reinvestment within the health economy.

Hepatitis C

Patients with hepatitis C can now be cured with direct-acting antivirals (DAAs) thereby preventing future complications such as cirrhosis and further spread of the virus. In comparison to older regimens involving interferon, these agents have a greatly improved cure rate, with a lower incidence of side-effects, and a shorter treatment duration of 8-12 weeks in most cases. The World Health Organisation has outlined an aim to eradicate hepatitis C by 2030. To achieve this, BCUHB will need to treat 194 patients per year.

An all Wales treatment guideline followed by Health Boards ensures that the most suitable and cost-effective regimen is chosen for each patient, and that all patients receive equitable access to treatment. So far in 2018-19, 108 patients have either completed treatment, are currently on treatment or will be initiating it soon.

3.2 Communicating Effectively

All patients are offered the opportunity to communicate in their preferred language, in YG we are able to support English, Welsh, Spanish or German.
As part of the refurbishment of the YGS site the pharmacy moved into its new home in May. The new pharmacy is on the ground floor. Following best practice and feedback from patients the new pharmacy incorporates a consultation room which is proving very beneficial.
Recognising that the number of first language Welsh speakers in the department is low the pharmacy has been taking advantage of the Welsh lessons provided by BCUHB increasing the competency of dispensary staff in Welsh and all reception staff are taking a Welsh course.

3.3 Quality Improvement, Research and Innovation

A Medicines Information (MI) and Advice Service project looked at responses to queries regarding advice on the suitability of products which had breached the 2-8^{o}C temperature range set for medicines cold storage. The advice is tailored depending on the time spent outside the recommended range and information in the product licence. An analysis of 'fridge enquiries' from BCU West Area showed that processing these queries avoided an average cost of £2,245.56 per enquiry and extrapolated that up to £200,000 per annum of medicines waste avoidance for BCUHB.

Pharmacy & Medicines Management continue to support the organisation in hosting Clinical Trials of Investigational Medicinal Products, ensuring procedures are in place to enable organisational compliance with the relevant regulations, guidelines and directives. However, there are challenges relating to workforce capacity and capability to support this function and so the staffing model is under review. Some additional pharmacist capacity in oncology will allow a further 8 studies to proceed.

The pharmacy pre-registrations and year 1 and year 2 diploma students all have to complete audits or quality improvement projects. Examples in 2018 include:

- An audit to determine is the All Wales Multi-Disciplinary Medicines Reconciliation Policy is adhered to on adult mental health wards at Wrexham Maelor Hospital
- Oxygen Prescribing in Glan Clwyd Hospital

- Shared Care Agreements and Monitoring of Methotrexate for Rheumatology Patients in a GP surgery
- An audit to determine of Point of Care Testing of CRP is being undertaken according to NICE guidance CG191(Pneumonia in adults: diagnosis and management)

Dignified Care

4.2. Patient Information

All three hospitals have a medicines helpline and bilingual information is provided for patients. All patient information leaflets are produced bilingually.

MTeD (see below) through the "Choose Pharmacy" platform, allows a community pharmacy to view a copy of their patient's discharge letter (with their consent). This improves care planning especially for those patient using compliance aids.

Timely Care

5.1. Timely Access

MTeD (Electronic Discharge Advice Letters)

MTeD is Live in a total of 64 Areas across BCU, which is 43% of the areas identified in the roll out plan. The screen shot below shows the progress made broken down by Area to Live, Not Live and Out of Scope.

In the east, EPOC (Electronic Point of Care) continues to be used by the acute medical wards and in outpatient clinics, with 890 letters sent in January 2019.

The number of discharge letters sent electronically via WCCG for the 4 week period below compares very favourably with the other 2 Health Boards using MTeD.

Week Starting	BCU	Cwm Taf	C&V	Total DAL s Sent
2019/02/04	963	813	1117	3147
2019/01/28	814	903	1137	3089
2019/01/21	1015	906	1118	3302
2019/01/14	838	780	1080	2948

There are plans to visit and train the team at Bryn Hesketh and to assess whether implementation will be possible in Orthopaedics at Abergele Hospital before the end of March.

No further roll out is planned from April, because the Informatics project resource will no longer be available due to the organisational key priorities and the ability to provide the resource.

A dashboard (screen shot below), produced in conjunction with the Information Dept enables service leads to have access to live data showing the status of discharge letters signed and the timescales for completion – e.g. before discharge, within 24 hours etc. It can be filtered by:

- Area
- Ward
- Specialty
- Consultant
- Discharge Destination e.g. home, hospital

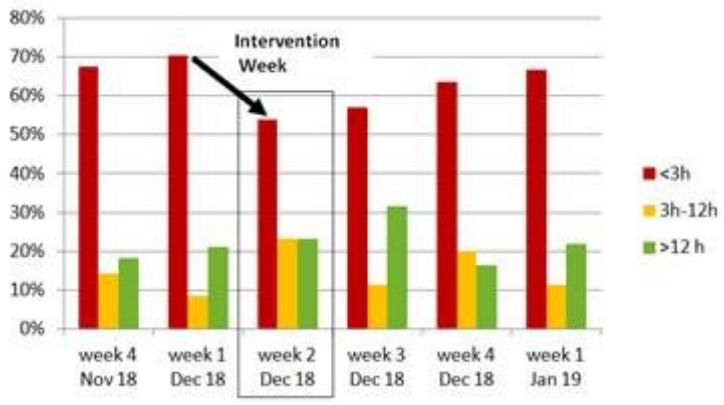
It also identifies patients where the prescription process has not been completed i.e. the record is locked but no discharge letter has been signed or sent to GP. By highlighting these to the ward clerks, the case notes can be recalled and the correct procedure completed.

Improving patient flow

An initiative named “Turning the Tide on To Take Outs (TTOs)” led by the clinical pharmacy team in Ysbyty Gwynedd aspired to increase the number of discharge prescriptions completed the day before a patient’s discharge. It was anticipated that there would be a reduction in the number of delayed discharges, an increase in the number of discharges before 11 a.m. and an overall improvement in workload management by the pharmacy team. In the first week, additional pharmacy resources were allocated to transcribe the TTOs onto the electronic discharge system and prepare discharge prescriptions for the following day. This meant that the ward team workload would shift to the previous day, although overall remaining the same. A significant reduction in the number of TTOs dispensed in the 3 hours immediately prior to discharge was observed. However, the ward clinical teams were not able to maintain this way of working and so a return to the baseline data can be observed by January.

Improved planning (ward teams are currently not able to accurately predict discharge dates) and a review of pharmacy processes would ensure optimal use of MTeD in the discharge process.

At Ysbyty Gwynedd, the secondary care pharmacy team experienced capacity issues as a result of a combination of recruitment problems, high rates of maternity leave, increased complexity of patients and discharge turnover. New ways of working had to be introduced to allow appropriate allocation of the limited resources. This included the development and implementation of a patient prioritisation tool, which allows pharmacists to assess the required interval between clinical reviews. Documentation and regular update of this assessment on the electronic patient management system ensures follow up on patient transfer between wards. Work is ongoing to validate this tool and evaluate the impact of implementation.



By introducing independent medication ordering by qualified medicines management technicians, there is improved flow of work from the wards to the dispensary and removes the need of an additional check by a pharmacist.

Following a trial on a ward in Wrexham and a BCUHB achievement award, three technicians are now funded to work solely on one ward each. Their roles include double checking controlled drugs, intravenous and subcutaneous medication to patients, including insulin and anti-coagulants i.e. high risk medication. This successful pilot showed a reduction in drug omissions, Medicines to take out (TTO) cost savings and prescribing interventions. A TTO turnaround time below 30 minutes and an increase in the number of discharges earlier in the day was also seen.

Individual Care

6.2 Peoples Rights

The pharmacy department at Ysbyty Gwynedd has been involved in 'Project Search' for the last 12 months. It is a one year internship programme supporting people with learning disabilities and / or autism to gain skills and experience to move into paid employment funded as part of the Welsh Government 'Engage to Change' project. Four interns have spent time in the pharmacy at YG to date and one has been successful in gaining an apprenticeship in the department. The project was shortlisted for a BCUHB Achievement Award in 2018. Being part of this project has had a positive impact on the department, raising awareness of learning disabilities and having the opportunity to work in partnership with external organisations

6.3. Listening and Learning from Feedback

A patient at the Wrexham Maelor Hospital provided feedback on the inefficiencies of the outpatient dispensing service. His main concern was that having had to join a very long queue firstly to hand in his prescription he then needed to repeat the process when he returned to collect it. As a result, a prescription hand-in desk and a

separate collection bay were created. The pre-registration pharmacists man the collection bay which enables them to gain and be competence assessed in essential patient counselling experience and provide a much more acceptable service to our patients. The collection bay also doubles up as a hospital staff access point thereby preventing staff wasting valuable time waiting in unnecessary queues.

Feedback

Pharmacist prescribers working in primary care obtain patient views on their consultation via a patient feedback for. Concerns are reviewed and monitored within the governance team and learning from these informs service improvement. Attendance at the Safety Huddle and Putting Things Right weekly meetings provide an opportunity to gain feedback and learning.

Complaints

In 2018 there were:

- 17 AM/MP letters relating to medication
- 1 Formal downgraded to On the Spot (OTS)
- 6 On the Spot (OTS)

Staff and Resources

7.1 Workforce

Medical and nursing recruitment issues have led to an increasing expectation for the pharmacy workforce to step into new roles to deliver improved outcomes for patients and the public. It is therefore vital that the team is developed to work flexibly with other health care professionals so they can respond with confidence to the changes within North Wales' services.

- The pharmacist's role as a front-line health professional is further developing with more time being spent in GP practices, care homes as well as people's homes.
- Advanced Clinical Practice: 15 health board employed pharmacists are training to become prescribers and our strategic plan envisages "general pharmacist practitioners" holding both Chronic disease and Acute conditions clinics within the primary care, community pharmacy and NHS 111 settings, supporting unscheduled and scheduled care.
- 14 community pharmacists in North Wales are training to become Independent Prescribers. They will be able to provide an Acute Conditions Enhanced Service from their community pharmacy stores on registration. BCUHB will provide additional support to enable them to develop their skills and confidence within their area of practice. Work is ongoing with Bangor University to design a 20 credit module on Acute Conditions for Community Pharmacists to further support their development.

As the first organisation in the country to train our Pre-registration Pharmacists in hospital, community and primary care, BCUHB is able to attract candidates who wish to have the experience across three sectors within one year. Provision of the pre-registration programmes for Pharmacists and Pharmacy Technicians ensures that there is a stream of newly qualified professionals to meet staff turnover.

This innovative programme allows us to develop well rounded professionals that are able to work flexibly across different sectors within health and social care. We plan to develop a similar multi-sector training programme for our Pre-registration Pharmacy Technicians from March 2020.

In terms of staff development, there are programmes to develop the clinical and leadership skills of both pharmacists and pharmacy technicians. All three areas have pharmacy technicians undertaking the Pharmacy Clinical Services Professional Diploma at Bradford College, which will allows these individuals to further extend their roles, undertaking tasks that were previously those of a pharmacist.

Several pharmacists are about to complete the All Wales Clinical Leadership in Pharmacy (CLIP) programme, the BCU Leadership master classes and both HEIW multi disciplinary courses - Introduction to Healthcare Leadership and Advanced Leadership courses.

Workforce Performance

	Target/ comparator	BCU	Central	East	West
PADRs (March 2019)	85%	71.5%	84.2%	75.3%	50.3%
Mandatory training (March 2019)	85%	88%	85%	87%	92%
Sickness absence (cumulative 04/19-03/19)	4.55%	3.27%	2.86%	2.30%	4.83%
Maternity rate (February 2019)	BCU average	-	4.49%	2.93%	4.6%
Staff turnover rate (February 2019)		-	13.5%	6.8%	10.7%

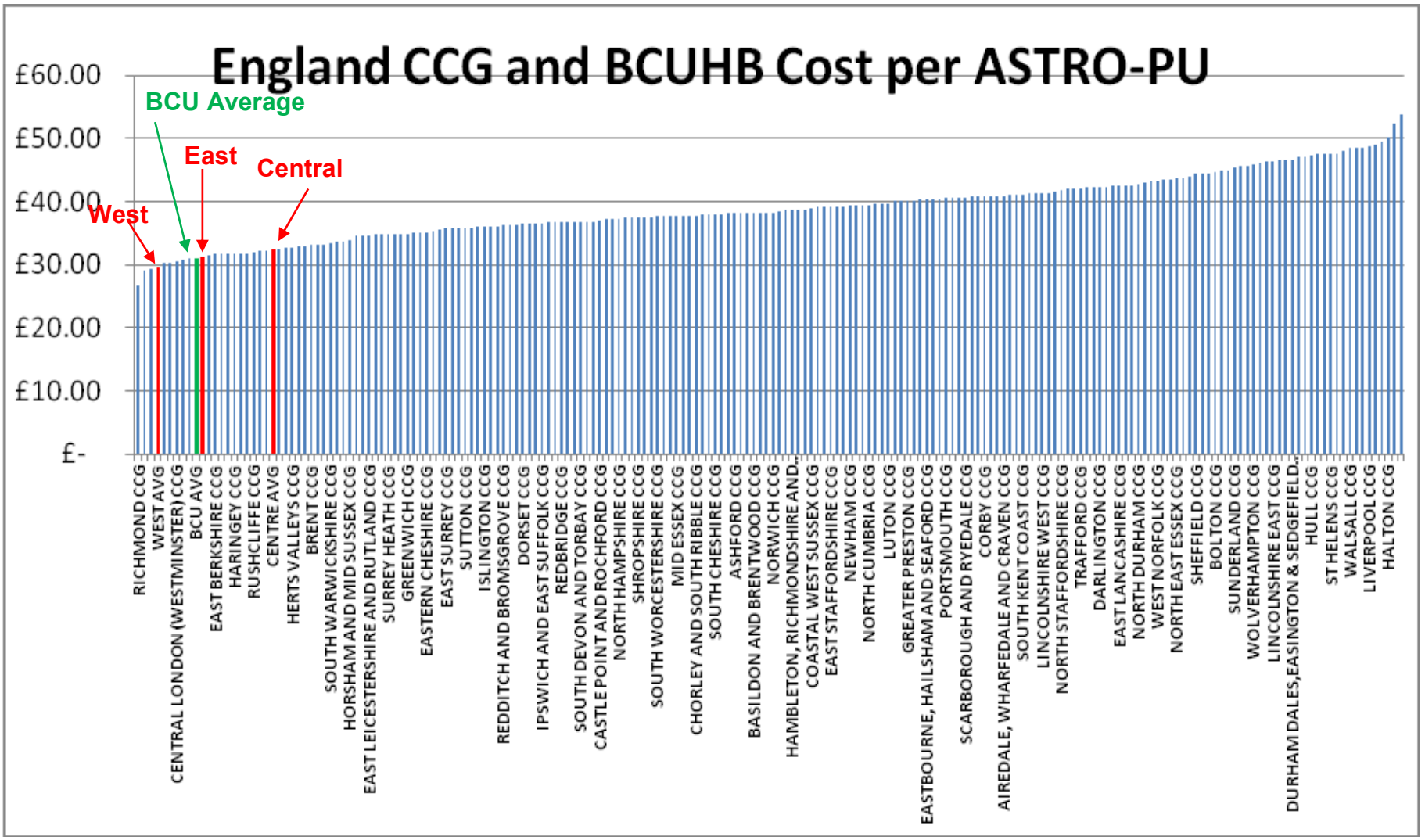
The west has a plan in progress to increase their PADR performance rate, which has fallen as a result of a combination of maternity leave and a high sickness absence rate.

Key Risks

The key risks are relating to medicines management in BCUHB taken from the risk register are:

- Pharmacy support to mental health division. Plans have been submitted as part of the response to the HASCAS and Ockenden reports, or workload managed by other means such as WP10(HP) prescriptions.
- The replacement of the pharmacy robots in Ysbyty Gwynedd and Wrexham Maelor. These are included in the area capital plans
- Medicines shortages, which are covered in section 2 of this report
- Pharmacy support to cancer services in Bangor and Wrexham, which was resolved in April 2019.
- Recruitment; there have been difficulties recruiting to junior pharmacist and pharmacy technician roles in the west and central areas. There is a recruitment strategy in place, supported by WOD, which includes e.g. work placements for students, university fairs.

Appendix 1


England CCG and BCUHB Cost per ASTRO-PU
£60.00
£50.00
£40.00
£30.00
£20.00
£10.00
£-
BCU Average
East
Central
West
RICHMOND CCG
WEST AVG
CENTRAL LONDON (WESTMINSTER) CCG
BCU AVG
EAST BERKSHIRE CCG
HARINGEY CCG
RUSHCLIFFE CCG
CENTRE AVG
HERTS VALLEYS CCG
BRENT CCG
SOUTH WARWICKSHIRE CCG
HORSHAM AND MID SUSSEX CCG
EAST LEICESTERSHIRE AND RUTLAND CCG
SURREY HEATH CCG
GREENWICH CCG
EASTERN CHESHIRE CCG
EAST SURREY CCG
SUTTON CCG
ISLINGTON CCG
REDDITCH AND BROMSGROVE CCG
DORSET CCG
IPSWICH AND EAST SUFFOLK CCG
REDBRIDGE CCG
SOUTH DEVON AND TORBAY CCG
CASTLE POINT AND ROCHFORD CCG
NORTH HAMPSHIRE CCG
SHROPSHIRE CCG
SOUTH WORCESTERSHIRE CCG
MID ESSEX CCG
CHORLEY AND SOUTH RIBBLE CCG
SOUTH CHESHIRE CCG
ASHFORD CCG
BASILDON AND BRENTWOOD CCG
NORWICH CCG
HAMBLETON, RICHMONDSHIRE AND..
COASTAL WEST SUSSEX CCG
EAST STAFFORDSHIRE CCG
NEWHAM CCG
NORTH CUMBRIA CCG
LUTON CCG
GREATER PRESTON CCG
EASTBOURNE, HAILSHAM AND SEAFORD CCG
PORTSMOUTH CCG
SCARBOROUGH AND RYEDALE CCG
CORBY CCG
AIREDALE, WHARFEDALE AND CRAVEN CCG
SOUTH KENT COAST CCG
LINCOLNSHIRE WEST CCG
NORTH STAFFORDSHIRE CCG
TRAFFORD CCG
DARLINGTON CCG
EAST LANCASHIRE CCG
NORTH DURHAM CCG
WEST NORFOLK CCG
NORTH EAST ESSEX CCG
SHEFFIELD CCG
BOLTON CCG
SUNDERLAND CCG
WOLVERHAMPTON CCG
LINCOLNSHIRE EAST CCG
DURHAM DALES,EASINGTON & SEDGEFIELD..
HULL CCG
ST HELENS CCG
WALSALL CCG
LIVERPOOL CCG
HALTON CCG

Health Board **2.5.19**	GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board ***To improve health and provide excellent care***

Report Title:	2019 Annual Nurse Staffing Levels(Wales) Act 2016 Report
Report Author:	Debra Hickman Secondary Care Nurse Director
Responsible Director:	Deborah Carter Acting Executive Director of Nursing & Midwifery
Public or In Committee	Public
Purpose of Report:	To inform the Health Board of the compliance with the Nurse Staffing Act 2016, highlighting any associated harms as a result of staffing breaches in line with the Act and actions taken to mitigate any identified risks.
Approval / Scrutiny Route Prior to Presentation:	The designated person has the responsibility of presenting an Annual review to the Board. Staffing Breaches and Harms are reported monthly via the Secondary Care Quality and Safety Group (QSG) by each Site Director of Nursing, escalation of significant issues are to the designated committee (Quality, Safety & Experience - QSE) via QSG. The annual report, with data up to February 2019 was presented to QSE in March with agreement that the report would be updated and a full year reported to the Board / delegated committee in May 2019. No significant changes were anticipated. QSE noted that this was the third review of nursing establishments since implementation of the act. Reference was made to impending changes to the reporting template. The Chair commented that the existing template was helpful and the Secondary Care Nurse Director has shared the observations with colleagues who are leading the work across Wales.
Governance issues / risks:	1. The Annual review of each of the sections within the Act 25a – 25e as legislated 2. The current vacancy position within the Acute Inpatient wards of which the Act governs 3. The incidences of harm whereby investigation findings identify staffing deficits as a causal or contributory factor and the comparison between the same reporting period 2017/18 4. Future actions required
Financial Implications:	The agreed staffing establishments to meet the requirements of the Nurse Staffing Levels Act 2016 are funded as per appendix 1.

	The funded establishments however do not support additional escalated beds for wards listed appendix 1. This is the 3rd review of nursing establishments since the Act was implemented.
Recommendation:	Note the report.

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

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

Background

In September 2016 the Nurse Staffing Levels (Wales) Act became law, requiring organisations across NHS Wales to calculate and monitor the number of nurses

required to provide appropriate care for patients in acute inpatient settings as set out. In April 2018 the Act came into effect for Adult Acute Medical and Surgical wards.

Statutory guidance was issued in October 2017 providing further information and reporting tools to assist Health Boards to implement the Act. The Act consists of 5 sections which are reported in the attached template, sections 25A to E as specified below:

- 25A refers to the Health Board's overarching responsibility to have regard to providing sufficient nurses in all settings, allowing the nurses time to care for patients sensitively;
- 25B requires the Health Board's to calculate and take reasonable steps to maintain the nurse staffing level in all adult acute medical and surgical wards. The Health Board's is also required to inform patients of the nurse staffing level on those wards;
- 25C requires the Health Board to use a specific method to calculate the nurse staffing level in all adult acute medical and surgical wards;
- 25D relates to the statutory guidance released by the Welsh Government;
- 25E requires the Health Board to report their compliance in maintaining the nurse staffing level for each adult acute medical and surgical ward of which the Health Board is responsible for monitoring (see attachment 1)

The Act wards completed an audit of Patient Acuity in January 2019, which is used to triangulate Nurse Staffing requirements alongside that of activity and professional judgment. The Acuity data was reported back to the Health Board at the end of March 2019 and utilised to inform the judgments made regards staffing requirements for the Act wards. More detailed presentations of the data and analysis are due early May 2019. This will then provide an informed review of the staffing requirements for the Act wards of which will be reported via the Health Boards governance structure in due course.

The Health Board is required to receive an annual comparative review of the preceding 2 years 2017/18 and 2108/19, of which the attached template is required to be submitted to the Board and onwards to Welsh Government.

Health Board / Trust reporting template	
Health Board	Betsi Cadwaladr University Health Board
Reporting Period	1st April 2018 – 5th April 2019
Requirements of Section 25A	The Health Board under section 25a of the Nurse Staffing Levels Act (2016) has an overarching responsibility to provide sufficient nurses to provide timely and sensitive care to patients. Section 25a describes the responsibility of the board to ensure that this is achieved through workforce planning, recruitment and retention strategies and the education and training of nurses. To assure compliance with the act, each acute site undertakes a series of activities of which include the following: • Biannual review of nurse staffing - this process combine's acuity and dependency data applying the Welsh Levels of Care as the means of assessment alongside key quality indicators and professional judgement to determine the required establishment to meet the care needs for the patients in each acute adult medical and surgical ward. • Workforce requirements are reviewed on annual basis in line with current and future site and Health Board wide strategies. Training and Education requirements are commissioned to develop and secure a nursing workforce that is equipped for service and patient needs. • Utilisation of workforce profiling data to ensure focus on recruitment and retention including forward planning and maximising resource and opportunities • Work closely with the commissioned provider for nurse training to secure 'locally grown' nurses into permanent positions upon qualification.

Financial Year 2018/2019			
Date annual report on the nurse staffing level submitted to the Board	17th April 2019		
Number of adult acute <u>medical</u> inpatient wards where section 25B applies	YWM 7	YG 8* *Alaw ward included as an Act ward from Q3	YGC 7
Number of adult acute <u>surgical</u> inpatient wards where section 25B applies	YWM 6 (including Bonney, Women's Division)	YG 5	YGC 6
Number of occasions where nurse staffing level was recalculated in addition to the bi-annual calculation	YWM 0	YG 2 (Tryfan Ward – Gastro & Aran Ward – Endocrine)	YGC 3 (Ward 5 and 3 (now Ward 2) due to changes and the new vascular ward 3)
The process and methodology used to inform the triangulated approach	The process for determining the nurse staffing levels at Betsi Cadwaladr University Health Board has three steps: 1. Acuity and dependency data is collected for a full month for all wards falling under the concern of the act. This data is reviewed and validated by a senior nurse for the directorates. 2. Upon completion and publication, this data is utilised as part of a triangulated method at local ward review meeting. The triangulation includes the review of nursing quality metrics as collated in the Boards Harm dashboard, professional judgement and the Chief Nursing Officers guiding principles. The local review meetings are multi-disciplinary and consider factors such as escalation beds, increases in demand and activity and national focus.		

Financial Year 2018/2019	
	3. A recommendation for the planned staffing establishment for each ward is concluded. This is verified by the Hospital Nurse Director with proposed changes being notified to the designated officer for final approval. For audit purposes each ward completes the designated proforma available within the 'Nurse Staffing levels (Wales) Act 2016' operational guidance as evidence.
Informing patients	Information whiteboards display the planned safe staffing requirements for each ward. The boards are displayed at the entrance to each ward. Patients have access to bilingual Frequently Asked Questions information leaflets, which includes how to raise concerns about the Nurse Staffing Levels.

Section 25E (2a) Extent to which the nurse staffing levels are maintained	
Process for maintaining the nurse staffing levels	The process for maintaining safe nurse staffing levels includes a number of elements of which include: • Adult Acute Nurse staffing and Nurse staffing escalation policies are in place and accessible online for staff to refer to • Roster optimisation – ensuring that all rosters are completed as per policy and that all rosters are constructed correctly to ensure that the correct number of staff are able to be provided • Roster approval process – all nurse rosters are subject to a double approval process monitored by the senior nurse team to ensure safe and effective rosters • Use of temporary workforce – any gaps that cannot be filled by substantive staff are tendered to temporary workforce solutions, in advance to provide the best opportunities of not only securing the shift but attracting suitably skilled and regular staff • Streamlined fast track recruitment for internal staff • Centralised recruitment team to support campaigns for nurse recruitment

Section 25E (2a) Extent to which the nurse staffing levels are maintained	
	• Partnership working with local universities to maximise opportunities for recruitment and retention
Process for monitoring the nurse staffing level	Monitoring nurse staffing levels is a dynamic process across the Health Board, roles and responsibilities are clearly defined both in JD's and supported by Policy for consistency • The nurse in charge of the ward is responsible for the local monitoring of nurse staffing levels with escalation and action as appropriate. A part of the monitoring element includes the maintenance of a live IT staffing tool, which is a visible tool that triangulates live (three times daily) acuity information, actual staffing levels and professional judgement to provide a RAG status for each ward as a guide. • A daily review of the staffing is undertaken across the acute sites to ensure that all areas are meeting the required staffing levels and that any gaps in planned staffing levels are mitigated and that any short term pressures are addressed. This is succeeded by four further staffing huddles. Live staffing data is further utilised during these forums to realign staff where necessary to mitigate risk and shortfall. • Nurse staffing is also discussed at the site safety huddle to highlight any unmitigated risk with actions being decided upon to reduce this risk within this forum. • Quarterly data is collected to review deviations from planned staffing levels and to triangulate theses deviations with any poor performance across the quality indicators.

Section 25E (2b) Impact on care of not maintaining the nurse staffing levels												
Patient harm incidents (i.e. nurse-sensitive Serious Incidents/ Complaints)	**Total number of <u>closed</u> serious incidents / complaints during last reporting period** **Reporting period 2017/18**			**Total number of <u>closed</u> serious incidents / complaints during current reporting period** **Reporting period 2018/19 (To date)**			**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**		
- Hospital acquired pressure damage (grade 3, 4 and unstageable)	YWM 16 closed	YG 23	YGC 29	YWM 37	YG 31	YGC 16	YWM Increase of 21	YG Increase of 8	YGC Decrease of 13	YWM 0	YG 2	YGC 0
- Falls resulting in serious harm or death (i.e. level 4 and 5 incidents)	YWM 12	YG 22	YGC 20	YWM 14	YG 25	YGC 16	YWM Increase of 2	YG Increase in 3	YGC Decrease of 4	YWM 1	YG 1	YGC 3
- Medication related never events	YWM 0	YG 0	YGC 2	YWM 0	YG 3	YGC 1	YWM 0	YG 0	YGC Decrease of 1	YWM 0	YG 0	YGC 0
	Reported omissions of medication by staff (core or agency) reviewed/investigated and action taken											
- Complaints about nursing care resulting in patient harm (*)												

Section 25E (2b) Impact on care of not maintaining the nurse staffing levels				
(*)This information is not required for period 2018/9				
Actions taken	Test of change for falls prevention. Participation in collaborative work for hospital acquired pressure ulcers. Development of medicines management framework. Biannual staffing reviews. Embedding the utilisation of live staffing data Development of nurse staffing escalation policy. Safe clean care programme focussing on the reduction of harm related to infection prevention practices Utilisation of SAFER principles			
Next steps	As a Health Board there has been underpinning work to secure and assure plans for safe staffing and compliance with the act to date, of which is ongoing. There is continual development as greater comprehension and information is gained locally and nationally. However, it is also acknowledged that there are further actions that can be undertaken to develop and further assure the process and importantly focus and measure the actual impact of staffing on patient harm. The board are asked to note and support the following next steps: • Targeted focus of Nurse recruitment including resource to support campaigns • Exploration of a clinical fellowship programme for nurses • Ongoing analytics regards leavers and 'what could we do better?' • Review new roles to support the nursing recruitment pipeline • Expansion of harm avoidance collaborative to assist in reducing variation • Development of a nurse performance dashboard as a further monitoring and assurance tool. • Host staffing act 'masterclass' for senior nurses to ensure that they are up to date and conversant in the requirements of the staffing act. • Further analysis of deviations from previous reporting periods			

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

Appendix 1

Nurse Staffing Act
Act Wards

Ysbyty Glan Clwyd	Ysbyty Wrexham Maelor	Ysbyty Gwynedd
Abergele Ward 6	Bersham Stroke Unit	Aran – Medical
Ward 1	Bonney	Dulas
Ward 11 Respiratory	Cunliffe	Enlli - Orthopaedic
Ward 12 Renal & Diabetes	ENT	Ffrancon
Ward 19 COTE	Erddig Respiratory	Glaslyn
Ward 19a Gynae	Evington Ward	Glyder
Ward 2 CAU/SD	Fleming	Hebog
Ward 4 Cardiology	Lister	Moelwyn
Ward 5 ENT/Urology	Mason	Ogwen Orthopaedic Unit
Ward 7 Orthopaedics	Morris	Prysor
Ward 8 Colorectal	Prince Of Wales	Tegid - Urology/Colorectal
Ward 9 Gastro	Bromfield	Tryfan - Gastro
Ward 14 Stroke	Pantomime	Alaw

Health Board

2.5.19

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

To improve health and provide excellent care

Report Title:	Summary of In Committee Board business to be reported in public
Report Author:	Mrs Kate Dunn, Head of Corporate Affairs
Responsible Director:	Mrs Grace Lewis-Parry, Board Secretary
Public or In Committee	Public
Purpose of Report:	Standing Order 6.5.3 requires the Board to formally report any decisions taken in private session to the next meeting of the Board in public session.
Approval / Scrutiny Route Prior to Presentation:	In Committee Health Board 28.3.19 considered: • Approval of minutes • Consideration of preferred provider for Wrexham managed practices • Approval of lease arrangements for Holyhead GP practice • Briefing on EU Exit preparedness • Assignment of lease for Connah's Quay GP Practice • Briefings - Three Year Outlook and 2019-20 Annual Plan
Governance issues / risks:	It is good governance, and in line with Standing Orders, to report on in-committee business at the next available meeting held in public.
Financial Implications:	None pertaining to this paper.
Recommendation:	The Board is asked to note this paper.

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

3.To support children to have the best start in life	√	3. Involving those with an interest and seeking their views	√
4.To work in partnership to support people – individuals, families, carers, communities - to achieve their own well-being	√	4.Putting resources into preventing problems occurring or getting worse	√
5.To improve the safety and quality of all services	√	5.Considering impact on all well-being goals together and on other bodies	√
6.To respect people and their dignity	√		
7.To listen to people and learn from their experiences	√		
Special Measures Improvement Framework Theme/Expectation addressed by this paper Leadership and Governance			
Equality Impact Assessment No equality impact assessment is considered necessary for this paper.			

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

GIG CYMRU NHS WALES

Pwyllgor Gwasanaethau Ambiwlans Brys
Emergency Ambulance Services Committee

EMERGENCY AMBULANCE SERVICES
JOINT COMMITTEE MEETING

'CONFIRMED' MINUTES OF THE MEETING HELD ON 17 OCTOBER 2018 AT THE EASC OFFICES, HEOL BILLINGSLEY, NANTGARW

PRESENT

Members:

Allison Williams (Vice Chair)	Chief Executive, Cwm Taf UHB
Stephen Harrhy	Chief Ambulance Services Commissioner
Judith Paget	Chief Executive, Aneurin Bevan UHB

In Attendance:

Jason Killens	Chief Executive, Welsh Ambulance Services NHS Trust
Hannah Evans	Director of Transformation, Abertawe Bro Morgannwg UHB
Julian Baker	Director, National Collaborative Commissioning Unit
Shane Mills	National Collaborative Commissioning Unit
Ross Whitehead	Assistant Chief Ambulance Services Commissioner
Stuart Davies	Director of Finance (EASC)
Gwenan Roberts	Interim Board Secretary, Host Body

Part 1. PRELIMINARY MATTERS		ACTION
EASC 18/81	**WELCOME AND INTRODUCTIONS** Allison Williams (Vice Chair) welcomed Members to the meeting of the Emergency Ambulance Services Committee and those present introduced themselves. Allison Williams explained to all present that due to last minute apologies the Committee was not quorate (as required within the Standing Orders). It was **NOTED** that the In Committee meeting had received the draft Amber Review Report.	
EASC 18/82	**APOLOGIES FOR ABSENCE** Apologies for absence were received from Carol Shillibeer, Gary Doherty, Len Richards, Robert Williams, Steve Moore, Tracey Cooper and Tracy Myhill.	
EASC 18/83	**DECLARATIONS OF INTERESTS** There were no additional interests to those already declared.	
EASC 18/84	**MINUTES OF THE MEETING HELD ON 10 JULY 2018** The minutes were confirmed as an accurate record of the meeting held on 10 July 2018.	
EASC 18/85	**ACTION LOG** Members **received** the action log and **NOTED** that progress with some of the related matters would be considered within the agenda or postponed to the next meeting for further discussion. The Committee **RESOLVED** to: **NOTE** the action log.	
EASC 18/86	**MATTERS ARISING** The following items were discussed: • **Emergency Medical Retrieval and Transfer Service (EMRTS)** discussion to be deferred to the next meeting. It was **NOTED** that all Health Boards had a key link member of staff working with the service.	Board Secretary

Part 2. KEY ITEM FOR DISCUSSION		
EASC 18/87	**CHAIRS REPORT** Members **NOTED** that the meeting was primarily concerned with the Amber Review. It was anticipated that an announcement would be made regarding the new Independent Chair before the next meeting in November. Members **RESOLVED** to: **NOTE** the report.	
EASC 18/88	**CHIEF AMBULANCE SERVICES COMMISSIONER'S REPORT** Stephen Harrhy, Chief Ambulance Services Commissioner presented the report. • **National Quality and Delivery Framework agreement for** **- Emergency Ambulance Services (EMS)** **- Non-Emergency Patient Transport services (NEPTS)** **- Emergency Medical Retrieval and Transfer Service (EMRTS)** Members **NOTED** the update and the ongoing work with the new Chief Executive of the Welsh Ambulance Services NHS Trust, Jason Killens. The Frameworks would feature in the Integrated Medium Term Plan (IMTP) and any actions would also take the Amber Review recommendations into account. • **Strategic Commissioning Intentions** Work on the strategic commissioning intentions would take place in line with the development of service plans and the Integrated Medium Term Plan (IMTP); and the recommendations and actions related to the Amber Review. Members **NOTED** that the Directors of Planning had received information from the EAS Team related to the development of the IMTP which would be discussed in more detail at the next meeting. The overarching assumptions with the commissioning intention and allocation letter would be clarified and Stuart Davies **AGREED** to discuss with the Directors of Finance regarding the assumptions for EASC.	*CASC/ EAST/ Jason Killens* *Stuart Davies*

	• **National Programme of Unscheduled Care** – Members discussed the funding allocated for winter pressures and the connection between WAST and the health boards particularly in relation to community paramedic support. Discussion took place on the role of the Advanced Paramedic Practitioner (APPs) within health boards and how this would provide an opportunity to work more closely with community teams, with GPs and also with the GP out of hours services. Members **NOTED** that the business case for APPs had been developed and around 20 staff within WAST were qualified although there would be the issue for backfill. The role for community paramedics would also need to be further discussed. Members **NOTED** that a workforce plan was being developed in WAST and the request from health boards was the need to embed the staff within the GP clusters. It was felt this matter needed further discussion at a future meeting. Members **RESOLVED** to: **NOTE** the report.	*CASC*
EASC 18/89	**PROVIDER ISSUES BY EXCEPTION** There were none.	
EASC 18/90	**AMBULANCE QUALITY INDICATORS (AQI)** Members **NOTED** that the information was now provided by Stats Wales and the data could be used and amended to provide information by health board and NHS Trust area. More work was underway to provide information on a monthly basis. Members **RESOLVED** to: **NOTE** the report.	
EASC 18/91	**EASC MONTH 6 FINANCE REPORT** The report was presented by Stuart Davies. Members **NOTED** that the information was in line with expectation of achieving breakeven at the end of the financial year. It was **NOTED** that the allocation funding was pending. Further discussion took place around understanding where the resources were allocated across the 5 steps and the aim to provide information for the investments to the next level within the schedule was welcomed. Members **RESOLVED** to: **NOTE** the report.	

EASC 18/92	**AMBER REVIEW** Members received and **NOTED** the presentation on the Amber Review. Members **AGREED** to receive the final version at the next meeting and work through the recommendations and the next steps. Members **NOTED** the importance of agreeing who would be leading on the actions required and meeting timescales. Members **RESOLVED** to: • **NOTE** the presentation and • **AGREED** the next steps.	*CASC*
EASC 18/93	**FORWARD PLAN OF BUSINESS** Members received the forward plan of business. Priority areas for the next meeting were **AGREED** as: • EMRTS • Amber Review • Community Paramedics	*ALL*
EASC 18/94	**RECEIVE AND ENDORSE THE CHAIRS UPDATES FROM THE ESTABLISHED EASC SUB GROUPS** Members **AGREED** to receive at the next meeting**.**	
DATE AND TIME OF NEXT MEETING		
EASC 18/80	A meeting of the Joint Committee would be held at 13:30hrs, on Wednesday 13 November 2018 at the National Collaborative Commissioning Unit (NCCU), No 1 Charnwood Court, Heol Billingsley, Parc Nantgarw, Cardiff, CF15 7QZ	Committee Secretary

Signed ……
Allison Williams (Vice Chair)

Date ……

Pwyllgor Gwasanaethau Ambiwlans Brys
Emergency Ambulance Services Committee

EMERGENCY AMBULANCE SERVICES JOINT COMMITTEE MEETING

'CONFIRMED' MINUTES OF THE MEETING HELD ON 13 NOVEMBER 2018 AT THE EASC OFFICES, HEOL BILLINGSLEY, NANTGARW

PRESENT

Members

Chris Turner	Independent Chair
Allison Williams (Vice Chair)	Chief Executive, Cwm Taf UHB
Stephen Harrhy	Chief Ambulance Services Commissioner
Judith Paget	Chief Executive, Aneurin Bevan UHB
Gary Doherty	Chief Executive, Betsi Cadwaladr UHB
Tracy Myhill	Chief Executive, Abertawe Bro Morgannwg UHB
Carol Shillabeer	Chief Executive, Powys Teaching LHB

In Attendance:

Jason Killens	Chief Executive, Welsh Ambulance Services NHS Trust
Sharon Hopkins	Deputy Chief Executive Cardiff and Vale UHB
Karen Miles	Director of Planning and Performance, Hywel Dda UHB
Julian Baker	Director, National Collaborative Commissioning Unit
Shane Mills	National Collaborative Commissioning Unit
Ross Whitehead	Assistant Chief Ambulance Services Commissioner
Ami Jones	Intensivist, Emergency Medical Retrieval and Transfer Service (EMRTS)
Matthew Edwards	EMRTS
Gwenan Roberts	Interim Board Secretary, Host Body

Part 1. PRELIMINARY MATTERS		**ACTION**
EASC 18/96	**WELCOME AND INTRODUCTIONS** Chris Turner welcomed Members to the meeting of the Emergency Ambulance Services Committee and those present introduced themselves.	

EASC 18/97	**APOLOGIES FOR ABSENCE** Apologies for absence were received from Len Richards, Robert Williams, Steve Moore and Tracey Cooper.	
EASC 18/98	**DECLARATIONS OF INTERESTS** There were no additional interests to those already declared.	
EASC 18/99	**MINUTES OF THE MEETING HELD ON 13 NOVEMBER 2018** The minutes were confirmed as an accurate record of the meeting held on 13 November 2018.	
EASC18/100	**ACTION LOG** Members **received** the action log and **NOTED** that progress with some of the related matters. **EASC 18/58:** Allison Williams explained that the Chief Executives would discuss their nomination for the Vice Chair position at their next meeting and provide as soon as possible to the Chair. **EASC 18/79:** It was **agreed** that any further comments on the Amber Review would be received by the Chief Ambulance Services Commissioner by 20 November 2018. Members **noted** that Stuart Davies would discuss the financial consequences with the Directors of Finance regarding the strategic commissioning intentions **(Added to the Action Log)**. The Committee **RESOLVED** to: • **NOTE** the action log.	Allison Williams All Stuart Davies
EASC18/101	**MATTERS ARISING** There were no additional matters arising that had not been contained within the Action Log.	
EASC18/102	**CHAIR'S REPORT** Members warmly welcomed the Chair to his first meeting of the Committee.	

EASC18/103	**CHIEF AMBULANCE SERVICES COMMISSIONER'S REPORT** Stephen Harrhy presented a verbal report on one key area of concern which was the continued poor attendance at the EASC Sub groups – this would need to be addressed otherwise the EASC would increasingly need to deal with more operational rather than strategic matters. A review of the sub groups had been planned for the new year and the options would need to be discussed including potentially consolidating activities. Members **RESOLVED** to: • **NOTE** the update and ensure appropriate representation at sub group meetings.	All
EASC18/104	**PROVIDER ISSUES BY EXCEPTION** Jason Killens raised issues around activity. Members **NOTED** that: • Red activity had increased by 12% from last year although the performance had reduced • Amber activity had increased by 5.9% and in the last 4 weeks there had been a steep increase in activity • Less conveyance to A&E Jason Killens agreed to provide the data collected to Stephen Harrhy. Discussion took place on the use of community paramedics and the need to include this initiative in the IMTP; discussion had taken place in the Planning, Delivery and Evaluation Group to debate on the models across Wales. The difference between the community paramedic and the advanced paramedic was also discussed. It was **NOTED** that further work was progressing with a chief pharmacist and the development of patient group directions (PGDs). Members suggested that this could be a discussion paper in a development session in the future although it was recognised that this was an urgent matter. Members **RESOLVED** to **NOTE** the update.	Jason Killens
EASC18/105	**AMBULANCE QUALITY INDICATORS (AQIs)** Ross Whitehead, Deputy Ambulance Services Commissioner presented the quarterly AQI report.	

	Members **NOTED**: • A major difference to the AQIs presented included that information was available by health board area • The user friendly approach (part of Stats Wales) which would allow for trend information • Analysis would show how variation was being dealt with by different areas • The CASC met with the executive team from WAST on a monthly basis to challenge the variation and progress with changes planned • A different approach in line with the work of the Amber review including patients not conveyed and this as work in progress. Members agreed that having additional information and using the learning from the Amber Review was helpful. It was **NOTED** that the Integrated performance report would also support the work. Members **RESOLVED** to **NOTE** the last latest version of the ambulance quality indicators.	
EASC18/106	**PUBLICATION OF THE AMBER REVIEW AND DELIVERY OF THE RECOMMENDATIONS** The report was presented by Stephen Harrhy and a full discussion was held by Members on the AMBER Review and it was **NOTED** that a lively debate had been held in the Senedd with interest from the press. The Members were asked to **RATIFY** the Chair's Action to publish the Review in line with the agreed expectations. The following issues were discussed and **NOTED**: • An action plan would be developed • The team would meet with the Stroke Association as part of the engagement with patient groups and develop an appropriate model of care • Programme of engagement would be developed to co-create and fully describe the model • How winter funding would be prioritised • Ongoing discussions with the Welsh Ambulance Services NHS Trust (WAST) • Work continued to capture the detail by health board site in terms of lost hours • that clarity would be provided on reasonable expectations for patients • lifting cushions (aids) were being provided to ambulance crews and care homes to safely lift patients following falls	

	• the ongoing pilot involving having mental health nurses in the 999 control room • demand and capacity plans were being developed with the WAST • the Cabinet Secretary was keen to start and action the recommendations at pace. Stephen Harrhy explained that further detail was available to support the recommendations which would be shared; key matters would need to be linked back to the Integrated Medium Term Plans to inform the process. Members felt that the data was helpful particularly by site and the team would be meeting with health boards to discuss ways to progress areas of work. This would include handover delays and the work to develop and implement the winter plan. Members discussed the importance of the link to the IMTP and to reflect in the commissioning intentions. Members felt that the opportunities presented by the data within the report would allow for more bespoke work with health boards in the future. In view of the number of recommendations Members felt it would be helpful to highlight a small number of key areas to deliver ensuring a whole systems approach and also to track progress. Stephen Harrhy explained that a tailored report would be provided for all health boards which would be of interest to Board Committees dealing with performance matters as the information would provide locality based information. The Team were thanked for their work to date to deliver the report. Members **RESOLVED** to: • **NOTE** the ongoing actions related to the Amber Review • **RATIFY** Chair's action to publish the Amber Review report.	Ross Whitehead/ Shane Mills Stephen Harrhy
EASC18/107	**EMERGENCY MEDICAL RETRIEVAL AND TRANSFER SERVICE (EMRTS) SERVICE EXPANSION REVIEW** Stephen Harrhy presented the EMRTS service expansion review report and Members were requested to discuss and **ENDORSE** the preferred option.	

	The Service Expansion Review had been prepared following discussions at recent committee meetings, recommendations made in the Welsh Government (WG) Gateway Review (May 2017) and in response to correspondence from the Chief Executive, NHS Wales (dated 14 June 2018). The service had worked with the EMRTS Delivery Assurance Group (DAG) to explore the options and opportunities to extend the service and to prepare a business case for consideration by EASC to provide advice to the Cabinet Secretary. Members **NOTED** as a key partner, there has been engagement with the Wales Air Ambulance Charity throughout this work. The Chair welcomed Ami Jones & Matt Edwards to give a short presentation on the propose service expansion for EMRTS. Members **NOTED** the overview of the services provided and the aims for the current service. The rationale for expansion was discussed including the unmet need and highlighted areas where a difference could be made for patients. Members **NOTED** the ongoing work with Swansea University in terms of quality measures, population health and undertaking complex analysis for survival rates. Questions raised included the pattern change for maternity, neonatal and children's services and the potential impact. The potential of phasing was discussed and learning lessons at each phase of development. Members felt that the presentation had been helpful to clarify some key operational and medical issues. Members felt it was important to move forward in partnership with the Air Ambulance Charity and need to provide the strategic context, mindful of the desire to increase the service across Wales. The aspects of retrieval were key although the actual process would need to be clarified. Following discussion Members felt that expansion should also include work on major trauma and its impact. A detailed business case would be required to ensure all options were fully considered to move ahead. The options for funding were considered and further discussion would need to take place with the Welsh Government officials.	Ami Jones / Matthew Edwards

	Members discussed the option of the phased approach to the full option of services 24 hours a day over a timescale of the next few years and should align to the three year plan. Members felt in principle that it was important to address the unmet need identified. Other options included having a hybrid approach with other ways of working to provide high quality services for patients across Wales including advanced paramedic practitioners. Members **RESOLVED** to • **NOTE** the work to date and requested further information to ensure a strategic approach.	
EASC18/108	**FORWARD PLAN OF BUSINESS** Members **received** the forward plan of business.	*ALL*
EASC18/109	**RECEIVE AND ENDORSE THE CHAIRS UPDATES FROM THE ESTABLISHED EASC SUB GROUPS** Members **RECEIVED** and **ENDORSED** the following updates: • Emergency Medical Retrieval and Transport Service Delivery Assurance Group (EMRTS DAG) Chair's Summary 18 June 2018 • Emergency Medical Retrieval and Transport Service Delivery Assurance Group (EMRTS DAG) Action Notes 18 June 2018 • Non-Emergency Patient Transport Services (NEPTS) Commissioning and Delivery Assurance Group (CDAG) Action Notes 25 June 2018 • NEPTS CDAG Action notes 23 July 2018 • NEPTS Chair's Summary 23 April 2018 • Joint Management Assurance Group (JMAG) Action Notes 24 April 2018 • JMAG Action Notes 21 Sept 2018 • Quality & Delivery Framework: Planning, Development & Evaluation Group (PDEG) Action Notes 26 June 2018 EASC 17 Oct 2018 • PDEG Chair's Summary 29 Aug 2018 Members **NOTED** that good representation was taking place at the NEPTS DAG but Members were struggling to give feedback into organisations.	All

ANY OTHER BUSINESS		
EASC18/110	**EASC INTEGRATED MEDIUM TERM PLAN (IMTP)** Julian Baker outlined the requirements of the planning framework and sign off by the end of January. A letter had been sent to the Directors of Planning and shared with the Welsh Ambulance Services NHS Trust (WAST) and finance colleagues and shared the process regarding commissioning. Members **AGREED** that when finalised the Chair would sign the IMTP for submission and this action would be ratified at the meeting on 5 February. Members **RESOLVED** to: • **NOTE** the timescale for the EASC IMTP.	Chris Turner
DATE AND TIME OF NEXT MEETING		
EASC18/111	A meeting of the Joint Committee would be held at 13:30hrs, on Tuesday 5 February 2018 at the Bowel Screening Wales, Training Room 1, Unit 6, Greenmeadow, Llantrisant, CF72 8XT.	Committee Secretary

Signed ……
Christopher Turner (Chair)

Date ……

GIG CYMRU NHS WALES

Pwyllgor Gwasanaethau Ambiwlans Brys
Emergency Ambulance Services Committee

Reporting Committee	**Emergency Ambulance Services Committee**
Chaired by	Chris Turner
Lead Executive Directors	Health Board / Trust Chief Executives
Author and contact details.	Gwenan.roberts@wales.nhs.uk
Date of last meeting	5 February 2019

Summary of key matters including achievements and progress considered by the Committee and any related decisions made.

An electronic link to the papers considered by the EAS Joint Committee is provided via the following link: EASC Joint Committee meeting agenda and papers 5 Feb 2019

CHAIRS REPORT

Members **NOTED** that the Chair had met with the Director General of the NHS and with the all Wales Chairs of health boards and NHS Trusts.

CHIEF AMBULANCE SERVICES COMMISSIONERS REPORT

Stephen Harrhy presented an update on the following areas:

- Mental Health staff and the Clinical Desk - Discussions would take place with the Chief Constable of South Wales Police regarding the effectiveness of the clinical desk and how the initiative would work with other emergency services.
- Attendance at Audit Committee – internal audit report on Non Emergency Patient Transport Services (NEPTS)
- Update on emergency medical retrieval and transport services (EMRTS) – the phasing of the ongoing work was discussed and a briefing report would be developed for the Minister (as requested)
- Cross Border and Regional Activity (WAO Report) - as part of IMTP developments, quarter 3/4 (2018/19) this would be discussed further with Powys Health Board.

PROVIDER ISSUES

Jason Killens, CEO of the Welsh Ambulance Services NHS Trust gave an overview of the emerging lessons from the winter plan. Members **NOTED**:

- RED performance was better than last year
- Adverse weather plans worked well – minimal impact
- Good operational performance
- Reduction in handover losses
- Over 20 advanced paramedic practitioners recruited
- Winter schemes were still being implemented with staff for the clinical desk and advanced paramedic practitioners becoming available and having an impact.

AMBULANCE QUALITY INDICATORS

Members **NOTED** the most recently published Ambulance Quality Indicators and received an update on progress with related work to improve and strengthen their presentation and usefulness to Health Boards and Members of the public.

Members **NOTED** plans to hold workshops to help develop a comprehensive integrated performance report from the perspective of the health boards with sufficient detail to be useful and also to describe how the WAST service fits into the unscheduled care system. Members **AGREED** to nominate staff to attend in order that all health boards were well represented.

The key performance information when compared with the previous year showed:

- 999 calls reduced
- Conveyances to hospital reduced
- Lost hours reduced

However, the information was not available on a board by board basis and more granularity would be required to develop a comprehensive report for each health board.

ROLE FUNCTION AND MEMBERSHIP OF SUB GROUPS

The Chief Ambulance Services Commissioner provided an oral update in relation to the role, function and membership of the sub groups of the Committee.

Members were aware of the difficulties for some the sub groups to maintain consistent membership and representation and it was suggested that the sub groups could be streamlined into two groups.

It was suggested that the following sub groups could combine as an overall management group:

- The Quality & Delivery Framework: Planning, Development & Evaluation Group (PDEG) and
- The Joint Management Assurance Group (JMAG)

The aim would be to progress the work of the Committee and provide the necessary governance arrangements as to where decisions could be made. Combining the two groups would help health board staff to attend and to represent their organisations more consistently.

An update would be received at the meeting in May 2019.

EASC INTEGRATED MEDIUM TERM PLAN (IMTP)

The Committee received the Integrated Medium Term Plan for EASC and the report was presented by Stephen Harrhy.

Members **RESOLVED** to:

- **ENDORSE** the EASC element of the IMTP as presented and the Chair's action taken.
- **NOTE** and support the WAST IMTP as received by the Welsh Ambulance Services NHS Trust Board on 29 January 2019 was consistent with the commissioning intentions of the EASC.

AMBER REVIEW IMPLEMENTATION PROGRAMME

Members **NOTED** that work was underway and a small task and finish group had been set up to ensure momentum and pace. Each recommendation had been identified alongside the assurance mechanism and the Committee would provide oversight for the whole programme.

EASC GOVERNANCE UPDATE

Members **NOTED** that Welsh Government officials were working with the Board Secretaries to develop model Standing Orders, this would include for EASC and would be presented to the Committee in due course. Members **AGREED** to provide a nominated deputy for each health board; were aware that the deputies would have delegated voting rights and that all decisions would be subject to a 2/3 majority of voting EASC members present.

Members **received** and **APPROVED** the Risk Register

RECEIVE AND ENDORSE THE CHAIRS UPDATES FROM THE ESTABLISHED EASC SUB GROUPS

Members **RECEIVED** and **ENDORSED** the following updates:

- Emergency Medical Retrieval and Transport Service Delivery Assurance Group (EMRTS DAG) 10 Dec 2018
- Quality & Delivery Framework: Planning, Development & Evaluation Group (PDEG) – Chairs summary 15 Jan 2019.

Key risks and issues/matters of concern and any mitigating actions

- The Committee **NOTED** matters considered within the Risk Register.

Matters requiring Board level consideration and/or approval

-

Forward Work Programme

Considered and agreed by the Committee.

Committee minutes submitted	Yes	√	No	
Date of next meeting	**26 March 2019**			

WELSH HEALTH SPECIALISED SERVICES COMMITTEE
JOINT COMMITTEE MEETING – MARCH 2019

The Welsh Health Specialised Services Committee held its latest public meeting on 26 March 2019. This briefing sets out the key areas of discussion and aims to ensure everyone is kept up to date with what is happening in Welsh Health Specialised Services.

The papers for the meeting are available at:

http://www.whssc.wales.nhs.uk/2018-19-whssc-joint-committee

Action log & matters arising

Members noted the action log.

Chair's Report

The Joint Committee received a written report that covered:

- The appointment of Paul Griffiths and Ian Phillips as Independent Members of the Joint Committee, succeeding Chris Turner and Lyn Meadows;
- The appointment of Dr Kieron Donovan as Interim Chairman of the Welsh Renal Clinical Network, succeeding Prof John Williams;
- The appointment of Dilys Jouvenat and Trish Buchan as Independent Members of the Quality & Patient Safety Committee; and
- The Chair's action taken on 31st January to approve the Integrated Commissioning Plan document for submission to Welsh Government.

The Chair thanked Prof John Williams for the tremendous work that he has done with the Renal Network since its formation.

Managing Director's Report

The Joint Committee noted the content of the Managing Director's report and in particular updates on the status of development of the Cystic Fibrosis service at CVUHB and the new Gender pathway.

Rehabilitation – Monitoring Arrangements for Driving Change
The Joint Committee received a paper that provided an update on how the implementation of monitoring arrangements is driving change in Specialised Rehabilitation services.

Members supported the continued monitoring arrangements within Specialised Rehabilitation services and increased investigation where required.

Integrated Commissioning Plan 2019-22: work plan
The Joint Committee received a paper that presented the WHSSC Integrated Commissioning Plan 2019-22 and outlined the schedule for presenting the funded schemes within it for release of funding.

Members were informed of:

- The WHSSC Integrated Commissioning Plan (ICP) 2019-22 and appendices that have been submitted to Welsh Government; and
- The schedule for presenting the schemes included for funding within the ICP to Management Group for funding release.

Mechanical Thrombectomy – update
The Joint Committee received a paper setting out the progress made for formally commissioning Mechanical Thrombectomy from April 2019.

Members noted the progress made for formally commissioning Mechanical Thrombectomy from April 2019.

Other reports
The Joint Committee received the Integrated Performance Report and the Financial Performance Report. The Joint Committee also noted the update reports from the following joint sub committees and advisory groups:

- Management Group (Briefings);
- Quality & Patient Safety Committee;
- All Wales (WHSSC) Individual Patient Funding Request Panel;
- Welsh Renal Clinical Network; and
- NHS Wales gender Identity partnership Group.