

## Bundle Quality, Safety & Experience Committee 19 March 2019

### AGENDA

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

#### 0 PATIENT EXPERIENCE

0.1 09:30 - QS19/24 Chair's Opening Remarks

0.2 09:32 - QS19/25 Patient Story - Mrs Deborah Carter

*To be shared via DVD*

0.3 09:47 - QS19/26 Listening & Learning From Experience Report - Mrs Deborah Carter

*Recommendation:*

*It is recommended that the Committee:*

*1. Note the progress being made;*

*2. Be offered the opportunity to comment on the draft Strategy (Appendix 1);*

*3. Approve the renaming the Patient Advice & Support Service (PASS) to Patient Advisory Liaison Service (PALS) in line with the national recognised identity of this service by service users.*

QS19.26 Listening & Learning.docx

0.4 10:02 - QS19/27 Discussion with Wales Ambulance Services NHS Trust - Amber Review Report from EASC

*Clare Bevan in attendance - presentation*

QS19.27a WAST presentation.pptx

QS19.27b EASC report\_Amber calls.PDF

#### 1.0 OPENING BUSINESS AND EFFECTIVE GOVERNANCE

1.1 10:17 - QS19/28 Declarations of Interest

1.2 10:18 - QS19/29 Apologies for Absence

1.3 10:19 - QS19/30 Minutes of Previous Meeting Held in Public on 22.1.19 for Accuracy, Matters Arising and Review of Summary Action Log

QS19.30a Minutes QSE 22.1.19 Public V0.03.docx

QS19.30b Summary Action Log QSE Public Live.docx

#### 2.0 FOR DISCUSSION

2.1 10:29 - QS19/31 Public Accounts Committee - Mrs Deborah Carter

*Verbal feedback*

2.2 10:34 - QS19/32 Integrated Quality & Performance Report : Executive Leads

QS19.32a IQPR Coversheet QSE - February 2019 FINAL.docx

QS19.32b IQPR QSE - February 2019 FINAL.pdf

2.3 11:04 - QS19/33 Update on Infection Prevention and Control across BCUHB : Mrs Deborah Carter

*Recommendations:*

*The Committee is asked to:*

*1. Note current performance in relation to key infections, and how BCUHB benchmarks with other Welsh Health Boards.*

*2. Note recent progress with key elements of the Safe Clean Care Campaign.*

*3. Request any further information needed to provide assurance.*

QS19.33 IPC.docx

2.4 11:09 - QS19/34 Health & Safety Update : Mrs Sue Green

*Recommendation:*

*The Committee is asked to note the position outlined in the report.*

QS19.34 Health and Safety Update.docx

2.5 11:19 - Comfort break

2.6 11:29 - QS19/35 Draft Annual Quality Statement 2018-19 : Mrs Deborah Carter

*Recommendation:*

*The Committee are asked to provide feedback on the content of the AQS and to note this is a current working draft document*

QS19.35a AQS coversheet.docx

QS19.35b Annual Quality Statement 2018-2019\_draft.docx

2.7 11:44 - QS19/36 Committee Annual Report 2018-19 : Mrs Deborah Carter

*Recommendations:*

*The Committee is asked to:*

1. Review the draft Annual Report for 2018-19
2. Provide comments and feedback as necessary
3. Approve that Chair's Action can be taken to agree the final version for submitting to Audit Committee

QS19.36a Committee Annual Report\_coversheet.docx

QS19.36b Committee Annual Report 2018-19 V0.02.docx

QS19.36c Appendix 1 ToR V4.0.pdf

QS19.36d Appendix 2 ToR V5.0.pdf

QS19.36e Appendix 3 CoB LIVE version.docx

- 2.8 11:59 - QS19/37 Pharmacy & Medicines Management Annual Quality and Safety Report 2018-19 : Dr Evan Moore

*Recommendation:*

*The Committee is asked to note the report.*

QS19.37 PMM Annual report.doc

- 2.9 12:14 - QS19/38 Mental Health & Learning Disabilities Division Update on Quality Improvement Governance Plan : Mr Andy Roach

*Mr Steve Forsyth in attendance*

*Recommendation:*

*The Committee is asked to note the contents of the report setting out the improvements to date through Special Measures, detail the Quality Improvement & Governance Plan, Appendix 1 being the updated Implementation Plan, Appendix 2 being the driver diagram for the 10 key themes and Appendix 3 the prepared report for Executives attending Public Accounts Committee (PAC) on 4th March 2019*

QS19.38 MHLDS report.docx

- 2.10 12:29 - QS19/39 Quality & Safety in Primary Care : Mr Chris Stockport

*Recommendations:*

*It is recommended that the Committee:*

1. Notes the arrangements in place in relation to Quality and Safety in Primary Care
2. Notes the priorities for Primary Care Quality & Safety in 2019/20
3. Notes the development of future primary care reports to the QSE Committee

QS19.39 Primary Care.docx

- 2.11 12:44 - Working Lunch Break (attendees please make arrangements to bring their own lunch)

- 2.12 12:54 - QS19/40 Clinical Audit Report : Mr Adrian Thomas

*Recommendation:*

*The Committee is asked to approve the Report and Recommendations.*

QS19.40a Clinical Audit\_coversheet.docx

QS19.40b Clinical Audit Paper v.02.docx

- 2.13 13:09 - QS19/41 Special Measures: Review of expectations allocated to the Quality, Safety & Experience (QSE) Committee

*Recommendations:*

*The Committee is asked to:*

1. Review the updated information provided
2. Include within its Chair's Assurance Report a summary of the Committee's discussion regarding the extracts, and a comment on the level of assurance on progress towards meeting the recommendations' requirements
3. Share the Chair's Assurance Report with the Office of the Board Secretary, for submission of relevant information to the SMIF Task & Finish Group.

QS19.41a SMIF coversheet.docx

QS19.41b SMIF Monitoring Log v24.0 Oct 18 to Mar 19 Updated 25.2.19 QSE MARCH 19 EXTRACT.docx

- 2.14 13:14 - QS19/42 Pressure Ulcer Collaborative (Hospital Acquired Pressure Ulcers/HAPU) Update : Mrs Deborah Carter

*Recommendations:*

*The Committee are asked to:*

1. Continue its support for the collaborative approach adopted by the Health Board for future collaboratives.
2. Acknowledge the potential of an increase in HAPU reported initially during the roll out phase.

QS19.42 HAPU.docx

- 2.15 13:29 - QS19/43 Ward Accreditation Dashboard : Mrs Deborah Carter

*Recommendation:*

*The Committee are requested to continue to support through their Leadership of the Ward Accreditation process and maintain a strong commitment to being a part of the Ward Accreditation process.*

QS19.43 Ward Accreditation.docx

- 2.16 13:34 - QS19/44 Stroke Services Update : Dr Evan Moore  
*Recommendation:*  
*The Committee is asked to receive the report and note the improvements that have been made within existing resources.*  
QS19.44a Stroke\_coversheet.docx  
QS19.44b Stroke.docx
- 2.17 13:49 - QS19/45 Care Inspectorate Wales Inspection into Older Adult Services in Wrexham County Borough Council : Mrs Deborah Carter  
*Recommendation:*  
*The Committee is asked to note:*  
 1. The implementation of a new framework of inspection by CIW with HIW  
 2. The overview of the inspection process of Wrexham County Borough Council as the first in North Wales of the National Inspection into Prevention and promotion of independence for older adults living in the community  
 3. The initial feedback of Inspectors the partnership working of the WCBC and BCUHB  
QS19.45 HIW CIW report.docx
- 3.0 FOR CONSENT
- 3.1 13:59 - QS19/46 Policies, Procedures or Other Written Control Documents for Approval
- 3.1 QS19/46.1 Medicines Policy - Dr Evan Moore  
*Recommendation:*  
*The Committee is asked to approve the Medicines Policy MM01 for use within BCUHB*  
QS19.46.1 Medicines policy inc EQIA.docx
- 3.2 QS19/46.2 Medical Gas Staff Responsibilities - Dr Evan Moore  
*Recommendation:*  
*The Committee is asked to approve the Policy*  
QS19.46.2 Medical Gas Staff Responsibilities Policy inc EQIA.docx
- 3.3 QS19/46.3 Non Ionising Radiation Protection Policy - Mr Adrian Thomas  
*Recommendation:*  
*The Committee is asked to endorse the policy.*  
QS19.46.3a Non Ionising Radiation Protection Policy\_coversheet.docx  
QS19.46.3b Non Ionising radiation protection policy v2.0 Dec 2018.docx  
QS19.46.3c Non Ionising radiation protection policy EQIA Revised Feb 2019.docx
- 3.4 QS19/46.4 Physical Restraint Guidelines - Mr Andy Roach  
*Recommendation:*  
*The Committee is asked to approve the amended Physical Restraint Guidelines for implementation within the Health Board.*  
QS19.46.4a Physical Restraint Guidelines\_coversheet.docx  
QS19.46.4b Physical Restraint Guidelines.doc  
QS19.46.4c Physical Restraint Guidelines\_EQIA.docx
- 3.5 QS19/46.5 Proactive Reduction Therapeutic Management Behaviours with Challenge - Mr Andy Roach  
*Recommendation:*  
*The Committee is asked to approve the Policy for implementation within the Health Board.*  
QS19.46.5a Proactive Reduction Therapeutic Management of Behaviours which Challenge Policy\_coversheet.docx  
QS19.46.5b Proactive Reduction Therapeutic Management of Behaviours which Challenge Policy.pdf  
QS19.46.5c Proactive Reduction Therapeutic Management of Behaviours which challenge\_EQIA.docx
- 3.6 14:09 - QS19/47 HASCAS Independent Investigation and Ockenden Governance Review: Progress Report - Mrs Deborah Carter  
*Recommendation:*  
*To note the progress of the recommendations*  
QS19.47a HASCAS & Ockenden\_coversheet.docx  
QS19.47b HASCAS & Ockenden.docx
- 3.7 14:29 - QS19/48 Nurse Staffing Report : Mrs Deborah Carter  
*Recommendation:*  
*The Committee is asked to note the report that a further detailed update will follow in May 2019*  
QS19.48 Nurse Staffing Report.docx
- 3.8 14:44 - QS19/49 Quality Safety Group Assurance Report : Mrs Deborah Carter  
QS19.49 QSG Chair's report Feb 19 v2.0 .doc

- 4.0 14:54 - FOR INFORMATION
- 4.1 QS19/50 An Update on Incidents Which Occur Within BCUHB Which are Classified as Never Events - Mrs Deborah Carter
- Recommendations:*  
*The Committee is asked to:*  
*1. Note that the report is considered at EMG monthly and to other relevant forums*  
*2. Note the Never Events that have occurred*
- QS19.50 Never Event paper Feb 19 v1.docx
- 4.2 QS19/51 Issues Discussed in Previous In Committee Session
- Recommendation:*  
*The Committee is asked to note the information in public*
- QS19.51 In Committee items reported in public.docx
- 4.3 QS19/52 Documents Circulated to Members
- 6.2.19 Follow up action CRR13 Mental Health*  
*14.2.19 QSG Notes January*  
*20.2.19 Ward Accreditation Update*
- 4.4 QS19/53 Issues of Significance to inform the Chair's Assurance Report
- 4.5 QS19/54 Date of Next Meeting
- Tuesday 21st May @ 9.30am in Carlton Court*
- 4.6 QS19/55 Exclusion of Press and Public
- Resolution to Exclude the Press and Public - "That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960."*



**Quality Safety & Experience  
Committee**
**19.3.19**

**GIG  
CYMRU  
NHS  
WALES**

 Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board

*To improve health and provide excellent care*

<b>Report Title:</b>	Listening and Learning From Experience Report
<b>Report Author:</b>	Mrs Carolyn Owen, Head of Service User Experience Mr Peter Morris, Patient Experience Manager (West)
<b>Responsible Director:</b>	Mrs Gill Harris, Executive Director Nursing and Midwifery
<b>Public or In Committee</b>	Public
<b>Purpose of Report:</b>	<p>To share the information and understanding of what it feels like to be a patient/ service user in BCUHB in line with the mandatory responsibility to listen and learn from their experience.</p> <ul style="list-style-type: none"> <li>• Building on Data and Evidence base</li> <li>• Aids in understanding the complexity faced by people on a daily basis</li> <li>• Quality assurance of the patient/service journey of improvements through listening and engaging</li> <li>• Supports service improvements by evaluating the difference we are making</li> </ul> <p>This report aims to:</p> <ul style="list-style-type: none"> <li>• Provide a summary of the patient/service user experience within BCUHB in line with the Health Board's mandatory responsibility to listen, learn and act on feedback (Welsh Government, 2015a).</li> <li>• Describe the overall aim for the Patient and Service User Experience Strategy 2019 -2022 to promote and sustain a shared ambition for patient/service user experience across BCUHB.</li> </ul> <p>Identify key themes and trends, interventions arising from these, and detailing key actions aimed at improving the capacity and capability of BCUHB to listen, learn and act on service user feedback in the 2019/2020 strategy work plan.</p>
<b>Approval / Scrutiny Route Prior to Presentation:</b>	Data shared with divisions and presented to Quality and Safety Group on a monthly basis

<b>Governance issues / risks:</b>	There is a need to strengthen the analysis of data to identify areas for improvement and the mechanisms for monitoring this improvement
<b>Financial Implications:</b>	N/A
<b>Recommendation:</b>	It is recommended that the Committee: <ol style="list-style-type: none"> <li>1. note the progress being made;</li> <li>2. be offered the opportunity to comment on the draft Strategy (Appendix 1);</li> <li>3. approve the renaming the Patient Advice &amp; Support Service (PASS) to Patient Advisory Liaison Service (PALS) in line with the national recognised identify of this service by service users.</li> </ol>

<b>Health Board's Well-being Objectives</b> <i>(Indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)</i>	✓	<b>WFGA Sustainable Development Principle</b> <i>(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.)</i>	✓
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	✓		
<b>Special Measures Improvement Framework Theme/Expectation addressed by this paper</b>			
Engagement			
Health and Care Standards: Standard 6.3, Listening and Learning from Patient Experience. NHS Delivery Framework and Reporting Guidance 2018-2019			

Listening and Learning from Feedback – A Framework for Assuring Service User Experience (WG, 2015b)

### **Equality Impact Assessment**

The All Wales Framework for Assuring Service User Experience has had an equality impact assessment prior to implementation at BCUHB.

The Patient and Service User Experience Improvement Strategy 2019-2022 and the revised Patient Stories policy will undergo the equality impact assessment.

#### *Disclosure:*

*Betsi Cadwaladr University Health Board is the operational name of Betsi Cadwaladr University Local Health Board*

## Key Findings

Overall patient/service users continue to report their experience in a **positive manner** and this is related to the key themes of; *Basic Nursing Care*, *Staff Attitude and Approach*, *Quality of Care* itself and for the first time, from patient comment cards, the *Coordination of Care*; and this is reported similarly across the East, Central and West regions. Although satisfaction levels in each of the acute Emergency Departments (ED) is lower than the acute sites as a whole, there is a significant level of positive satisfaction feedback across all ED areas. There are key targeting improvement plans in place supporting these areas. The negative feedback is likely to be due to demand for services resulting in longer than expected delays in receiving care, and that patient/service user satisfaction is measured mid-pathway and before discharge from ED.

Whilst, long *'Waiting Times'*, *'Delays'*, *'Parking'*, *'Noisy/hot/cold'*, *'Ward Environment'*, *'Lack of Involvement and provision of Information'*, *'Poorly organised/coordinated care'* and very less frequently cited *'Poor Staff Attitude'* are reported to contribute to a **negative experience**.

A key aim in the next quarter is to improve and drive out variation, evaluate the difference that is happening to improve and enhance patient/service user experience.

This report recognises that it has been challenging to link patient/service user feedback to specific service developments/improvements. Going forward, there is a

clear plan to revise and develop the strategic focus of the Listening and Learning Forum to ensure comprehensive and rigorous development in co-production with the BCUHB Performance Improvement team, Workforce and Operational Development (including the Equality team) and the Quality and Safety teams to achieve shared mandatory responsibilities to reflect BCUHB strategic objectives.

### **Key Improvement Actions – The Next Steps**

This report recognises that it is difficult given the current organisational infrastructure to definitively link service user feedback to specific service improvements. This is not to say this is not occurring, but creating an auditable link at present is challenging. Hence a number of actions have been detailed in section 4.2 not least the development and approval of the new Patient Experience Strategy in response the *Review of the BCUHB Patient Experience Function* (Elliot Blanchard Ltd, August 2018) and the subsequent restructuring of the Patient Experience Team in November 2018. As a consequence this report makes the following key recommendations;

- Implementation of bilingual PASS service in the East and West based on the Care to Share model in order to provide BCUHB wide access to *'patient advice and support services.'*
- Development of improved real/near time feedback and reporting systems such that patients and service users are easily able to provide managers and front line staff with the information necessary to support service improvements.
- Use real/near time service user feedback to support service improvement.
- Delivery of a rolling programme of customer care, patient stories and using feedback to improve services, workshops.
- Use 'Feel Good Friday' to share positive feedback with front line staff across all regions on a weekly basis.
- Develop a programme of internal and external engagement activities in order to enhance collaboration and coproduction.
- Provide the leadership and operational support necessary to ensure that BCUHB is compliant with *Accessible Information & Communication for People with Sensory Loss* standards (WG, 2013), in line with the 3 year organisational action plan agreed with Welsh Government (WG) in 2018/2019.
- Ensuring that the work plans developed to support the Patient Experience Strategy, are compliant with the requirements of the Welsh Language Act, Welsh Language Measure (Wales, 2011) and Welsh Language Standards through the implementation of a bilingual PASS service, ensuring that service users are able to provide feedback on their experience in Welsh for example via; Real Time Feedback Systems, NHS Wales Inpatient Satisfaction Service, Care to Share, via Patient Stories etc.
- Ensuring that the work plans developed to support the Patient Experience Strategy adopt where practically possible a tri-lingual approach; that is ensuring that BSL as well as Welsh are given equal prominence with English.
- Review the terms of reference for the Listening & Learning from Experience Group in order to ensure active participation of managers from all operational areas, increased executive accountability and improved capacity within BCUHB to report service improvements made as a result of listening and learning.

## 1. Purpose

BCUHB has a mandatory responsibility to listen, learn and act on patient/service user experience; key policy frameworks include;

- NHS Delivery Framework 2018/2019 (NHS Wales, April 2018)
- Listening and Learning from Feedback – A Framework for Assuring Service User Experience (WG, 2015a)
- Health Care Standards for Wales (WG, 2015b)

This report provides an overview of service user feedback received and the associated themes and trends, as the basis for Quality/Organisational Assurance and Service Development. Data from CRT/Viewpoint™ real time patient feedback system, Patient Comment Cards and Patient Advice and Support Service (PASS) activity is used to provide an overview of service experience and lessons learned and where available data for Q3-2018/2019 is compared with Q2-2018/2019.

This is a report that is being newly produced and will develop further as the improvement strategy for 2019-2022 rolls out.

## 2. Introduction/context

2.1 BCUHB has placed improving patient and service user experience at the heart of the Quality Improvement Strategy (2017 -2020):

*“A promise to learn, a commitment to act: ensuring the patient voice is heard at every level of the service”.*

There is a commitment that patients will be listened to and that feedback from patients and service users will be obtained, published and acted on by BCUHB.

The key national frameworks set out the criteria for health services to demonstrate how they respond to user experience to improve services and ensure feedback is captured, published and demonstrates learning and improvement. The key frameworks include:

- NHS Delivery Framework 2018/2019 (NHS Wales, April 2018)
- Listening and Learning from Feedback – A Framework for Assuring Service User Experience (WG, 2015a)
- Health Care Standards for Wales (WG, 2015b)
- Wellbeing of Future Generations (Wales) Act (WG, 2014a)
- Social Services and Wellbeing (Wales) Act (WG, 2014b)
- Parliamentary review of Health & Social Care in Wales (2018)

BCUHB is committed to continue learning from the valuable experience of those either using a service provided or our staff groups.

The feedback methods within BCUHB are compliant with the Listening and Learning from Feedback – A Framework for Assuring Service User Experience (WG, 2015a) four quadrants; real-time methods, retrospective surveys, proactive/reactive e.g. the use of social media, balancing such as patient stories and surveys undertaken by third parties.

The draft Patient and Service User Experience Improvement Strategy for 2019-2022 (Appendix 1) shares the vision of BCUHB to deliver against four mutually supportive goals, 'the Quadruple Aim':

- Better population health and wellbeing through prevention.
- Better experience and quality of care.
- Better engagement of the workforce.
- Better value from the funding.

The focus is to drive improvement by hearing the voice of the patient/service user and use this to improve the experience and journey.

## 2.2 How We Collect and Use Feedback

BCUHB utilises a wide range of methods to gain patient/service user feedback and demonstrate that when used together they provide a balanced view of Patient and Service User Experience. These methods include:

- Patient Advice and Support Service (PASS)
- Viewpoint real-time feedback
- Comment Cards
- NHS Wales Patient Survey (to recommence quarterly)
- Care to share clinics currently Central only – rolling out during 2019/20 (Appendix 2)
- Patient Stories

Weekly Viewpoint comment reports are produced and disseminated to every ward and department within the areas to provide the Matrons, Ward Managers and clinical leads with a summary of their feedback in relation to the open-ended survey questions. There is an identified risk here as once the information has been disseminated, there is currently no robust mechanism to monitor and measure progress from the information sharing to demonstrating improvement. Going forward the Patient and Service User Experience Strategy work plan will systematically pull together the themes and outcomes for required improvements. Ensuring that negative feedback and learning from concerns are measured and monitored, and the outcome from these reports will inform quality and service improvement.

The golden thread weaving through all of this work is that BCUHB are compliant with national standards. The ward accreditation programme has commenced and the process includes data packs containing the monthly Viewpoint data reports, external visits from HIW and Community Health Council, which provide an opportunity to triangulate the data and provides a 360-degree review of the ward area.

The agreed standards for the ward accreditation include the requirement for the wards to demonstrate using patient experience feedback as an integral part of their quality improvement projects for them to attain ward accreditation.

The monthly reports are shared with all clinical areas for display on the feedback boards (see Appendix 3). The data set is comprised of overall feedback figures and comments collated over the month as shown in the example report in Appendix 4 below.

Each month the feedback return figures are reviewed by the Patient and Service User Experience team to identify any areas where there are limited feedback responses. The team will take an active approach in promoting and facilitating the feedback process.

Viewpoint alerts occur real-time (daily) to highlight any negative feedback. This feedback is shared directly with the senior leads for the specific clinical area for their action. All feedback collected via Viewpoint are anonymous.

The development of the Care to Share clinics is under progression to extend and compliment the real-time feedback method (see promotional poster in Appendix 2). As illustrated in the Care to Share examples in Appendix 5, the clinics offer a system of collecting the patient's view of their experience in a real-time situation whilst they are still an inpatient. This can be extended to include relatives and the staff involved in the person's care as a means of triangulation. Staff responses in three BCUHB Community hospitals has been extremely positive;

*"The feedback is excellent and I am very proud of the staff at \*\*\* Hospital".*

*"Well done to the whole multi-disciplinary team".*

*"Thanks to the PASS team for conducting the review"*

*"This is absolutely the kind of patient experience service we need in our community hospitals and I look forward to the feedback from the other hospitals".*

*"Well done \*\*\*\*\* – once again you have all made us all very proud".*

In addition, as highlighted within the Patient and Service User Experience Improvement Strategy, the introduction of the "You Said, We Did" model will be established across all areas to improve and influence future quality improvement plans. The information will be shared with the patients, carers and relatives by the staff in the posters as illustrated in Appendix 6 below.

The Patient Stories Policy is currently being reviewed, refreshed and revised to be inclusive of protected characteristics and to be trilingual; Welsh, British Sign Language (BSL) and English. Developments are in hand to increase the number of patient stories and develop a digital database to be available on the BCUHB web pages.



### 3. What are Patients/Service Users Telling Us?

**3.1** This report provides an overview of service user feedback received and the associated themes and trends, as the basis for Quality/Organisational Assurance and Service Development. Data from CRT/Viewpoint™ real time patient feedback system, Patient Comment Cards and Patient Advice and Support Service (PASS) activity is used to provide an overview of service user experience and lessons learned and where available data for Q3-2018/2019 is compared with Q2-2018/2019.

The purpose of this report is to analyse themes and trends from service user feedback and provide assurance that lessons have been learned and improvements initiated. It is based on the secondary analysis of the following data sets and patient/service user real time feedback systems.

#### Patient/Service User Experience:

- **CRT Viewpoint real time feedback system**, resulting in a **total of 3,267** responses for Q3 2018/2019.
- **Comment Cards** resulting in a **total of 551 comments**, (220 for Q2 and 231 for Q3).

#### 3.2 CRT/Viewpoint Real-time feedback System;

Patient feedback survey indicates that for BCUHB as a whole service users report an average overall satisfaction rating of 8.74 out of 10 for Q3-2018/2019 compared with 8.43 out of 10 for Q2-2018.

The overall scores (fig 1) show the vast majority of people completing the survey rated their experience as 'excellent'. However a worrying number rated their experience as 'very bad' and further analysis must be undertaken to understand this and identify areas to improve.

Key questions within Viewpoint related to delivery of care (fig 2) also identified areas to improve. This results informed the recent revised Intentional Rounding system implemented across the Health Board, with specific questions related to checking out if patients and carers understand the care they are receiving or being offered.

Fig 1

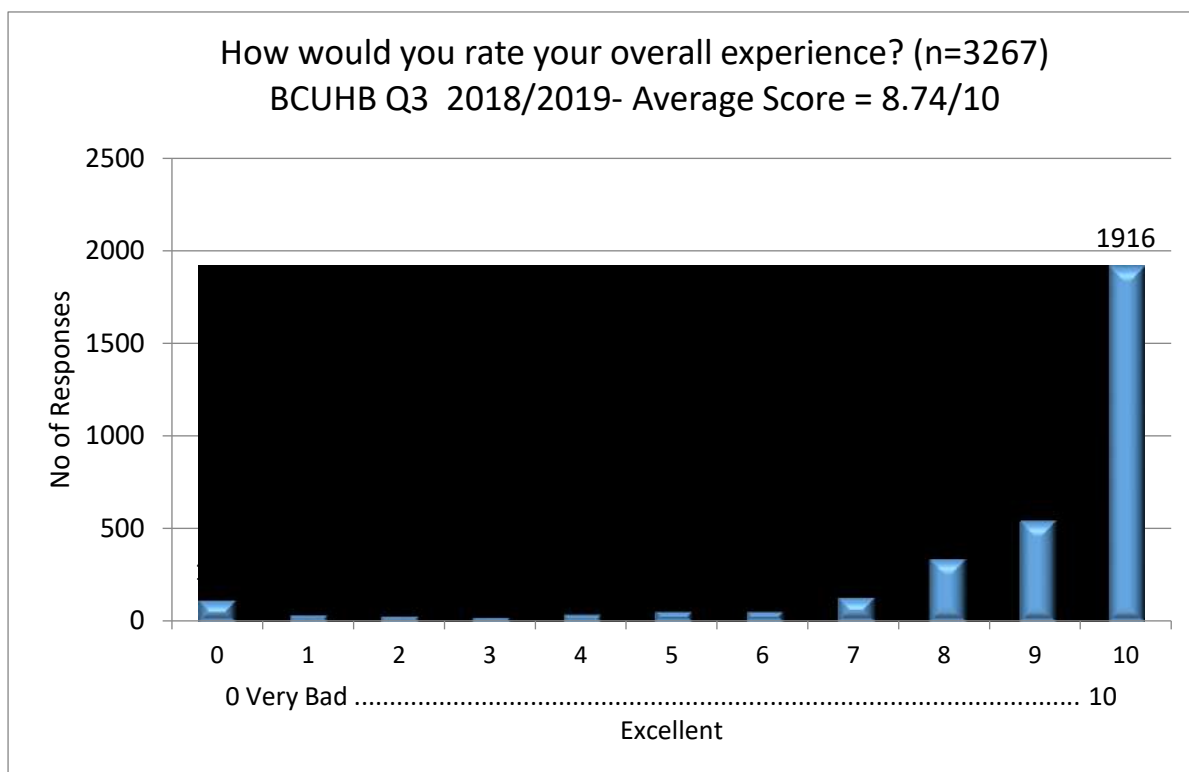
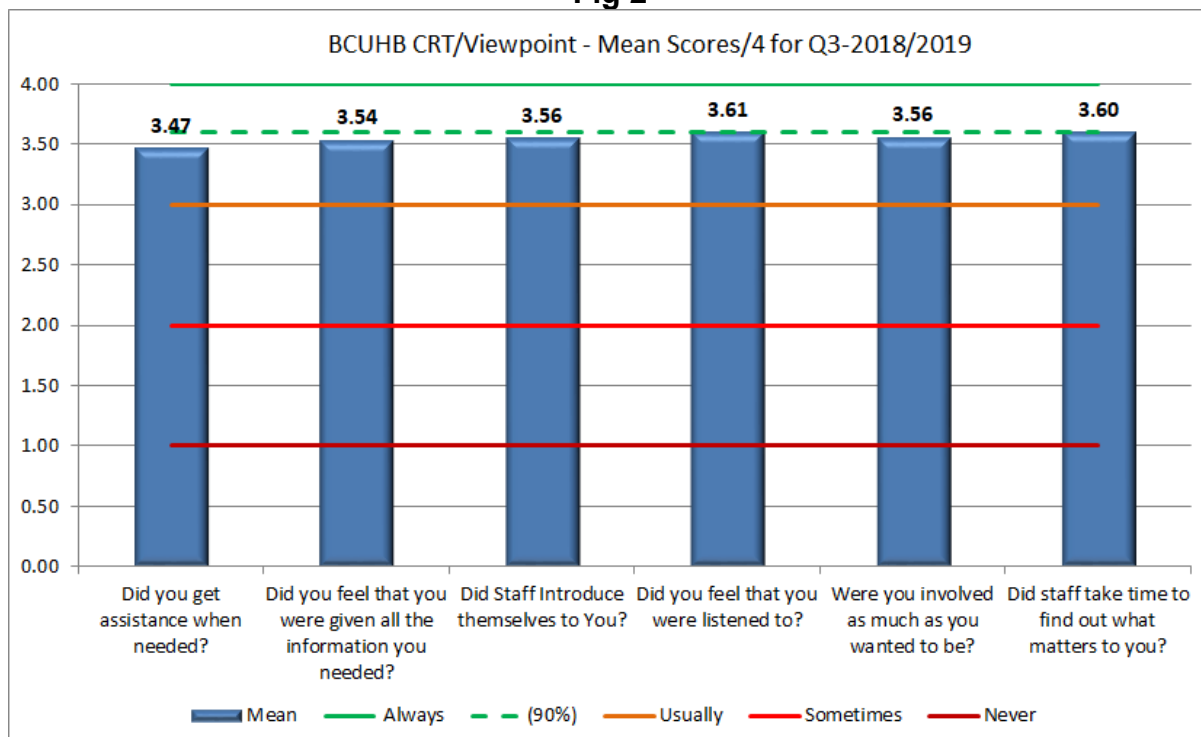


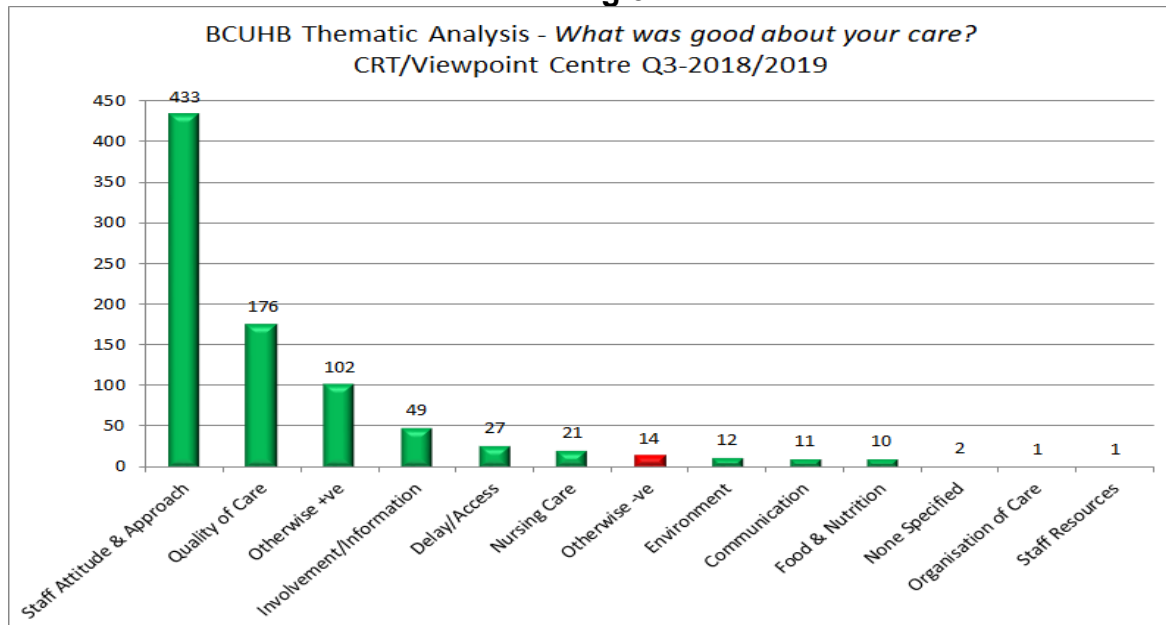
Fig 2



Thematic Analysis of a random sample of responses (n=300) from each operational area in relation to the questions;

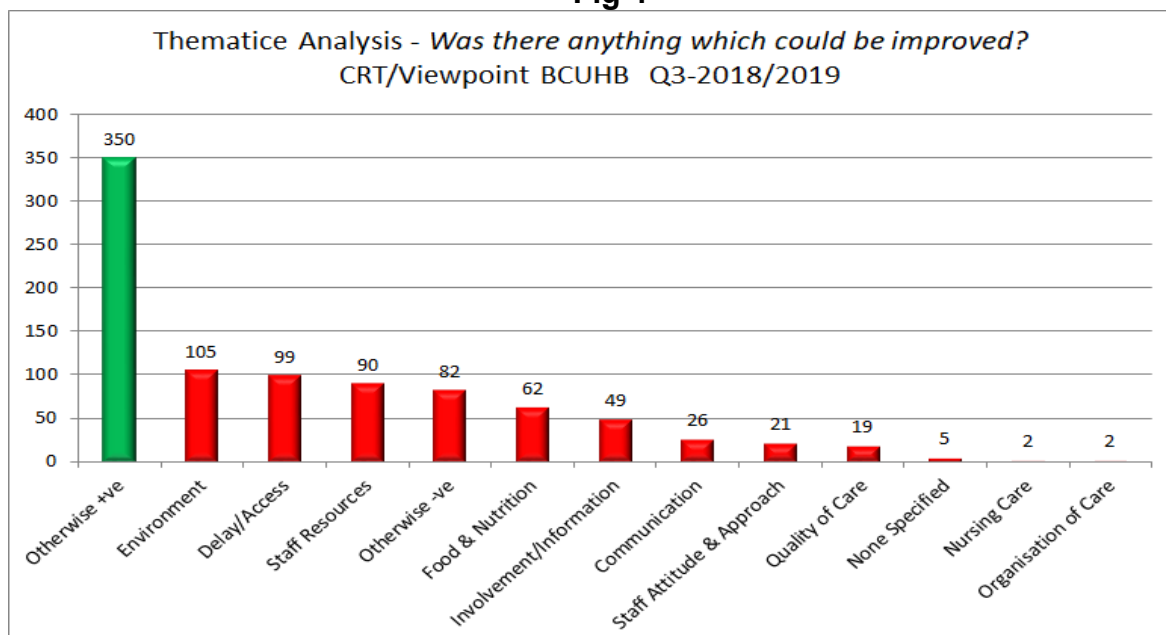
*'What Was Good about your experience?'* - this identified that people most appreciated the staffs attitude and approach, however food, communication and the environment scored low.e following key positive and negative themes (figs 3)

**Fig 3**



*'Was there anything that could be improved?'* - Environment scored highly here as did improving delays and access to services.

**Fig 4**



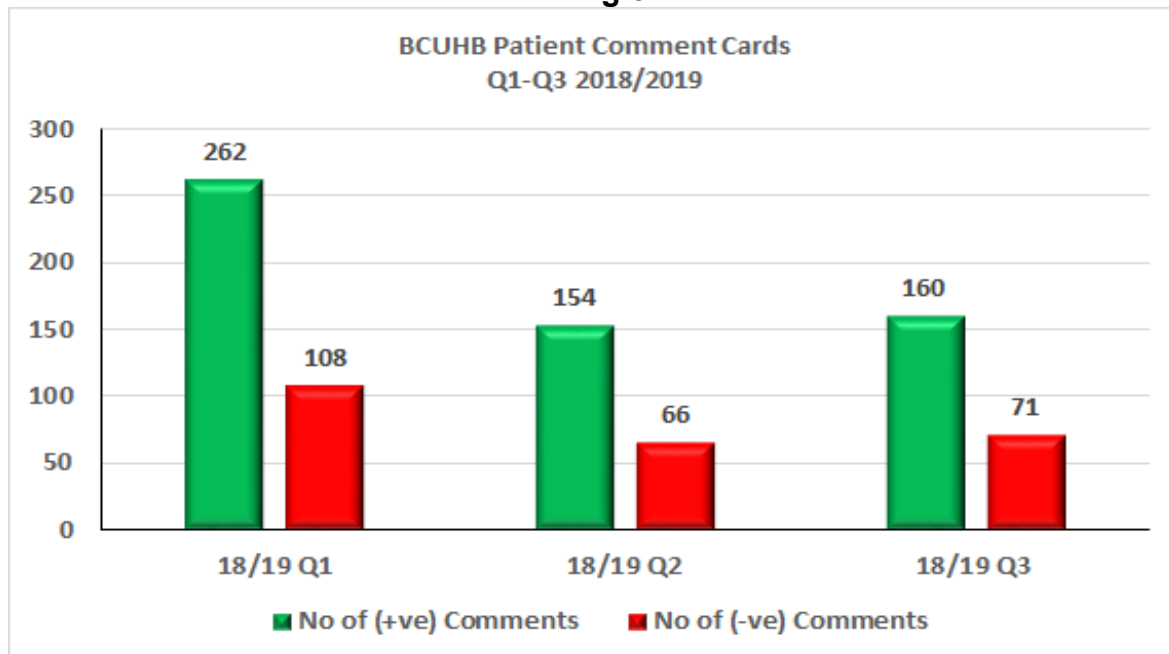
*Special Note; the 'Staff Resources' theme relates to perceptions of the level of resources, and is not an accurate reflection on safe staffing levels.*

Additional work will be undertaken to full understand the detail of what people are saying here and identify learning and improvement areas. These will be presented in future reports.

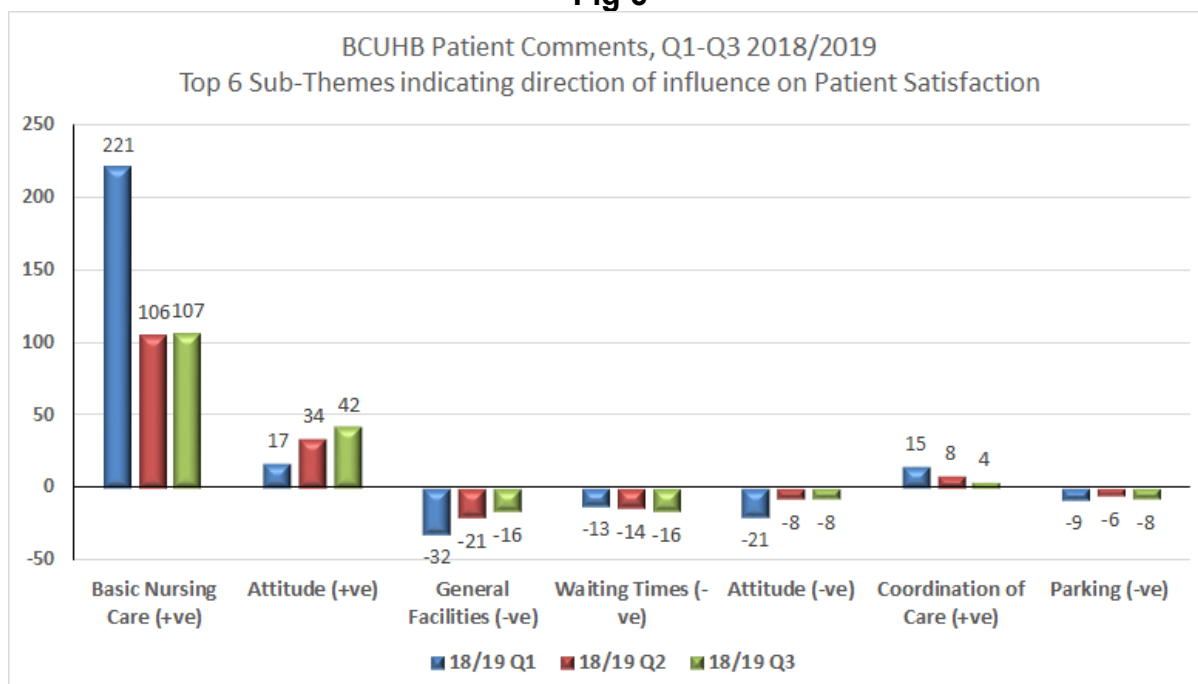
### 3.3 Analysis of Patient Comment Cards;

There has been a fall in the number of comments cards submitted, however this is likely to be as a result of the establishment of other methods, predominantly Viewpoint during the year (fig 5)

**Fig 5**



Analysis of feedback from patient comment cards identifies that '*Basic Nursing Care*', '*Staff Attitude*' and '*Coordination of Care*' contributed to a positive patient experience whereas '*General Facilities (Environment)*', '*Parking*', '*Waiting Times*' and '*(Poor) Staff Attitude*' contributed to a negative experience (Fig 6) . These are in keeping with the results from Viewpoint – real time feedback.

**Fig 6**

### 3.4 Patient Advice and Support Service (PASS)

Analysis of activity derived from the PASS service in Ysbyty Glan Clwyd (YGC) indicates that the aspect of service which resulted in the resolution of enquiries related to the themes detailed in Fig 7:

**Fig 7**

Sub-Theme	18/19 Q1	18/19 Q2	18/19 Q3	Total
Coordination of Care (-ve)	92	98	87	277
Waiting Times (-ve)	78	107	64	249
Communicating in a timely way (-ve)	37	24	25	86
Receiving Information (-ve)	29	22	27	78
Attitude (-ve)	17	18	12	47
Basic Nursing Care (-ve)	17	12	7	36
Miscellaneous (-ve)	7	3	10	20
General Facilities (-ve)	5	2	1	8
Coordination of Care (+ve)	2	2	1	5
Parking (-ve)	1	1	1	3
Communicating in a timely way (+ve)	0	1	1	2
Infection Control (-ve)	1	1	0	2
Basic Nursing Care (+ve)	1	0	0	1
Nutrition (-ve)	0	1	0	1
Receiving Information (+ve)	0	0	1	1
Staff Levels (-ve)	1	0	0	1
<b>Total</b>	<b>288</b>	<b>292</b>	<b>237</b>	<b>817</b>

The PAS Service has operated in YGC/central area for over a year now and lessons have been learnt regarding the operation of the service in this time and how best it can support service users – this is explored further in section 4 of this report.

The summary report of the activity and issues identified and dealt with by the PASS is provided to the Hospital Management Team monthly for them to lead the necessary improvement work.

### 3.5 Summary of Narrative Data collected

Based on the data analysed service users are more likely to report their experience in a positive than a negative manner. The factors which contribute to a positive patient experience are on the whole different to those which contribute to a negative one. The exception to this being ‘*Staff Attitude*’ which whilst often reported as contributing to a positive patient experience it is also reported as contributing to a negative experience. *This reinforces the importance of staff attitude as an essential element of effective ‘customer care’.* The factors contributing to a positive and negative patient experience are summarised in Figs 8, with Fig 9 giving some examples of narrative received from patients.

**Fig 8**

Factors reported as contributing to a Positive Patient Experience “What do we do Well?”	Factors reported as contributing to a Negative Patient Experience “What are the opportunities for improvement?”
<ul style="list-style-type: none"> <li>• Quality of Care</li> <li>• Staff Attitude &amp; Approach</li> <li>• Basic Nursing Care</li> <li>• (&lt;&lt;) Food &amp; Nutrition</li> <li>• (&lt;&lt;) Coordination of Care</li> <li>• (&lt;) Information/Involvement</li> </ul> <p><u>Key:</u></p> <p>(&lt;) Less Frequent (&lt;&lt;) Very Less Frequent (&gt;) More Frequent (&gt;&gt;) Much More Frequent</p>	<ul style="list-style-type: none"> <li>• Waiting Times (Access &amp; Delays) <ul style="list-style-type: none"> <li>▪ (&gt;&gt;) Coordination of Care</li> <li>▪ Unacceptable Waiting Times</li> </ul> </li> <li>• Environment (General Facilities, Parking, Ward Environment)</li> <li>• (&gt;) Food &amp; Nutrition</li> <li>• Information &amp; Involvement <ul style="list-style-type: none"> <li>▪ Receiving Information</li> </ul> </li> <li>• Communication in a Timely Way <ul style="list-style-type: none"> <li>▪ Communication with patient other than consent</li> <li>▪ Communication with family</li> </ul> </li> <li>• Organisation/Coordination of Care</li> <li>• &lt;&lt; Staff Attitude &amp; Approach <ul style="list-style-type: none"> <li>▪ Staff Attitude</li> </ul> </li> </ul>

Fig 9 - in the words of our patients

<b><i>"What do we do Well?"</i></b>	<b><i>"What are the opportunities for improvement?"</i></b>
<p><i>"The whole experience. Staff are good, food is good, staff have time for you to talk to you."</i></p> <p><i>"All staff were very helpful, nothing was too much trouble. From beginning to after surgery. I felt cared for and important."</i></p> <p><i>"The staff taken time to listen to you. They are very caring and sympathetic. I have always been made to feel that I am 100% important."</i></p> <p><i>"Everyone was so kind and caring and I can't thank them enough. They are angels working in such difficult conditions."</i></p> <p><i>"Understanding care staff who anticipated my needs and involved me throughout my care and treatment plan."</i></p> <p><i>"We were seen by a triage nurse almost immediately and then asked to wait half an hour to be seen, staff were very friendly and helpful"</i></p> <p><i>"The whole of A and E do [an] amazing job and they did an amazing job with me"</i></p> <p><i>"My care went far beyond my medical needs. I could fault nothing!"</i></p> <p><i>"Helped me get over my loss and my sadness and harmony myself. Helped change my medication."</i></p> <p><i>"Professionalism of nursing and support staff; caring attitude of staff to patients and family; staff interaction with patients and relatives; staff displaying understanding and support during a difficult time; ward cleanliness."</i></p>	<p><i>"Let us know more what is going on the ward. Sit there and don't know what going on sometimes."</i></p> <p><i>"Staff to spend more time with me"</i></p> <p><i>"Yes nicer nurses who care"</i></p> <p><i>"Listen more"</i></p> <p><i>"Liaison between wards and pharmacy seems non-existent. The waiting time for medication on discharge is a disgrace!"</i></p> <p><i>"Too long a wait for your tablets when leaving."</i></p> <p><i>"Waited over 20 hours for a bed on ITU from Resus".</i></p> <p><i>"Communication, one person saying one thing and the other saying something else".</i></p> <p><i>"Information being passed on incorrectly. Kept waiting over 20 minutes for nebuliser on ward. No one came into the bay for over 2 hours one time."</i></p> <p><i>"From ringing a bell to getting attention needs to be improved with more staff. Lunch time is a very bad time to be needing attention."</i></p> <p><i>"I felt that there was conflicting information given on one issue. Could explain if required to."</i></p> <p><i>"More nurses and staff on the wards... To hire more staff, really short staffed."</i></p> <p><i>Evening corridor lights could be turned off earlier - Free TV.</i></p>

<p><i>"Care was excellent, everything explained clearly and precisely. made to feel very comfortable"</i></p> <p><i>"Nothing good about breaking a hip but from the ambulance men to doctors and nurses, helpers, cleaners everyone has been wonderful and caring!"</i></p> <p><i>"Yes - was made to feel I was in good hands, nothing was too much trouble. Excellent patient care."</i></p> <p><i>"All staff were lovely and friendly and made me very comfortable. Thank you so much."</i></p> <p><i>"Every member of staff was incredible in the care, safety and delivery of my daughter. They were kind, empathetic and understanding staff who made a very anxious time into an enjoyable experience."</i></p>	<p><i>"My wife should have had bloods taken this morning to facilitate blood transfusion later. The phlebotomist failed to ascertain that wife was in the shower and never returned."</i></p> <p><i>"Communication between different specialities."</i></p> <p><i>"Patient communication."</i></p> <p><i>"I sometimes felt the ward was understaffed, so sometimes I felt a nuisance when I needed something"</i></p> <p><i>"Introduce Themselves With Their Names"</i></p> <p><i>"When a Patient Comes To A and E with a mental illness they should be treated as a normal person"</i></p> <p><i>"More prompt attention for toileting needs especially at night but understand extremely busy."</i></p>
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#### 4. What have we done with this feedback?

##### 4.1 Sharing of information

- All comments received via the comment card system are shared with the relevant ward/department and followed up if improvement actions are identified;
- Feedback from services users accessing the Patient Advice and Support Service (PASS), which currently operates in the Centre, is forwarded to the relevant operational managers in order to facilitate a collaborative problem solving and real time resolution of 'inquiries', thus enabling BCUHB to listen, learn and act on what service users are telling us. A monthly report is provide to HMT;
- Feedback from CRT/Viewpoint system is provided to the ward/department managers on a weekly basis, aggregated by speciality, and escalated to the relevant matron/speciality managers. The requirement to display and act on such feedback is a required component of the new ward accreditation system currently being rolled out throughout BCUHB;
- Feedback in relation to the experiences of service users with protected characteristics as defined by the Equality Act (UK, 2010) are provided on a



quarterly basis to BCUHB's operational and strategic equalities groups, and disseminated to operational managers;

- Feedback is provided to the Quality and Safety Group each month and three times a year to the Quality, Experience and Safety Committee.
- Patient Feedback data is provided monthly to each division as part of their Quality and Safety data packs.

## **4.2 Improvement actions**

The BCUHB Patient and Service User Experience Strategy 2019-2022 aims to reflect the voice of patients and service users that access all BCUHB services. It does not sit in isolation but is intrinsically working in partnership with clinical divisions, corporate services and patient partners to ensure that there is a cohesive patient journey through all areas.

The improvement actions outlined below build on existing interventions in order to develop a framework which provides improved organisational assurance in relation to BCUHB's mandatory responsibility to listen, learn and act on service user feedback.

## **4.3 Development of a Patient Experience Strategy and Patient Experience Function**

The Patient Experience Team was restructured in December 2018 in order to provide an improved organisational capability to listen, learn and act on patient feedback. This works closely with the Complaints and Incidents functions to ensure triangulation of data. The subsequent updated Patient Experience Strategy, which is currently being drafted, identifies a number of key interventions which are to become common to each operating region within 2019/2020.

### **4.3.1 PASS (PALS) Service**

Funding has been approved to roll out the PASS service to the East and West from April 2019, and the roll out will incorporate a 'Care to Share' model. This is a patient focussed approach in which the PASS officer utilises a semi-structured interview with patients and other service users within a given location, in order to provide service managers with feedback in relation to '*what was good about their experience*' and '*what could be improved*'. Thus, facilitating feedback and action planning which places the voice of the patient at the centre of the process and therefore a strong emphasis on service improvement and change.

It is deemed advantageous to rename the PASS service ensuring it is in line with the nationally recognised PALS (Patient Advisory Liaison Service). This report requests that the title change is approved.

### **4.3.2 Collecting and Using Feedback**

In order to ensure that patients, their families, carers and other service users are given easily accessible opportunities to provide feedback on their experiences of using our

services; the Patient Experience Team will in each region utilise the following approaches;

- CRT/Viewpoint Real Time Feedback System
- NHS Inpatient Satisfaction Survey
- Patient Comment Cards
- Patient Stories – with a firm emphasis on developing a more extensive library of digital stories with clear outcomes/service improvements
- Care to Share PASS Model (see above)
- Have your say events; You Told Us/We did...
- Analysis of Incidents, Complaints and Negligence Claims where appropriate. Such that these provide an appropriate balance of *Real-Time*, *Retrospective*, *Proactive/Reactive*, and *Balancing* feedback frameworks commensurate with BCUHB's responsibility to listen, learn and act on feedback.

#### **4.3.3 Facilitating Service Improvement**

Learning from service user feedback so that managers and front line staff 'see' and 'do things' differently in a sustainable and patient focussed manner clearly underpins improved experience, governance and organisational performance.

Within 2019/2020 the patient experience team will;

- Ensure the effective reporting and triangulation of service user experience feedback to operational managers and front line staff, in near/real time where possible, as outlined in section 4.1, in order to support organisational improvement efforts such as; reducing Health Acquired Pressure Ulcers (HAPUs), Falls, Medical Device and Medication Errors, Improving Nutrition & Hydration, Improving Dementia Care, and improvement projects arising from Ward Accreditation Efforts.
- Deploy the Care to Share PASS model in the East and West to ensure parity across all regions.
- Develop the intra and inter organisational relationships necessary to develop and adopt patient/service user centric approaches to service improvement.
- Provide targeted training on the use of service user feedback to drive and sustain service improvement.
- Continue to support and develop the Ward Accreditation Scheme.

#### **4.3.4 Training, Education and Service Development**

The greatest leverage for change in many cases rests with the human element of the health care system. To support the improvement efforts cited above, it is essential that managers and front line staff continue to be aware of the impact that their behaviours have on the experiences of our service users, and are supported to make changes where necessary. The provision of near/real time feedback will undoubtedly support this process, however within 2019/2020 the Patient Experience Teams in each region will build on the success of customer care programmes to deliver a planned sequence of training sessions in the following key areas;

- Customer Care,
- Using Service User Feedback to improve services
- Using Patient Stories to improve services

#### **4.3.5 'Feel Good Friday' - Developing a Motivated Workforce**

Whilst training and development is clearly important in this respect, it is also critical that positive feedback is shared with front line staff; because such feedback is overwhelmingly representative of the experience of most patients and other service users, (see section 3 above).

Within 2019/2020 the Patient experience teams in each region will build on the success of *Feel Good Friday*; which provides a certificate of achievement to the ward/department who are deemed to have had the most motivational comment of the week! These are selected by the Patient Experience Teams in each of the regions, and publicised on social media.

#### **4.3.6 Engagement**

The Patient Experience Strategy is built around the guiding principles of collaboration and coproduction and recognises that the capacity for change rests with managers, front line staff, patients and other service users. In practice the impetus, insight and learning required for this process will require the Patient Experience Team to develop and sustain a number of key relationships and networks some important examples include;

- *Internal Engagement*
  - Operational Managers
  - Regional and Organisational Governance (QA) Teams
  - Transforming Health Care Team
  - Workforce and Organisational Development
  - Service Improvement and Programme Management Office
  - Engagement Team/Regional Officers
  - Communication Team
  - BCUHB Quality Improvement Hub
- *External Engagement*
  - Primary Care Cluster Development Teams
  - All Wales Service User Experience Forums
  - Welsh Heads of Service User Experience Forum
  - NHS Wales Senior Officers Group
  - Centre for Sign Sight and Sound, Vision Support
  - Other centres of excellence

#### **4.3.7 Accessible Information and Communication for People with Sensory Loss (WG, 2013)**

The Patient Experience Team will in 2019/2020 continue to provide the leadership and operational support necessary to ensure that BCUHB is compliant with these standards, in line with the 3 year organisational action plan agreed with Welsh Government (WG) in 2018/2019. Key interventions will include ensuring the provision of British Sign Language (BSL) video for critical information contained on BCUHB's intra and internet pages and for inclusion within real time feedback systems.

### 4.3.8 Welsh Language Standards

BCUHB provides an exemplar of practice in relation to ensuring that the *'positive offer'* of accessing and receiving health care services in Welsh is an everyday reality for our service users. The Patient Experience Strategy will in 2019/2020 build on this work by ensuring;

- The provision of a bilingual PASS service
- That service users are able to provide feedback on their experience in Welsh for example via; Real Time Feedback Systems, NHS Wales Inpatient Satisfaction Service, Care to Share and via Patient Stories.

A guiding principle of the Patient Experience Strategy will be the adoption of a tri-lingual approach to listening, learning and acting from service user feedback. That is ensuring that BSL as well as Welsh given equal prominence with English.

### 4.3.9 Listening and Learning from Experience Group

The Terms of Reference (TOR) for this group will be reviewed and the group relaunched in Q2-2019/2020 to ensure active participation of managers from all operational areas, increased executive accountability and improved capacity within BCUHB to report service improvements made as a result of listening and learning.

### 4.3.10 BCUHB Wide

#### Theme 1 - First and Lasting Impressions

- The embedding of 'my name is' principle of customer care.
- The development and roll out of customer care training sessions in all regions.
- (See also Safe Clean Care and Ward Accreditation below)

#### Theme 2 - Receiving care in a Safe, Supportive, Healing Environment

- Continued utilisation and main streaming of patient safety huddles in all regions
- Safe Clean Care principles embedded in all areas.
- Development and embedding of the new Ward Accreditation Framework and associated action planning.
- Following on from the above the use of service user feedback data to support service improvement relating to reducing Health Acquired Pressure Ulcers, reducing Health Acquired Pressure Ulcers (HAPUs), reducing Falls, reducing Medical Device and Medication Errors, improving Nutrition & Hydration, improving dementia care.
- Development of Dementia Friendly ward environments, (see also John's Campaign and Positive Person approach).
- Establishment and monitoring of safe staffing levels in areas.

### Theme 3 - Understanding of and Involvement in Care

- Standardisation of ward notice boards in line with Ward Accreditation standards in order to provide critical information to patients, staff and other service users including a summary of recent service user feedback.
- The BCUHB Muscular Skeletal Joint Service Advisory Group (MSK JAG) has been established to bring together key service user stakeholders. Predominantly third sector MSK groups e.g. Arthritis Action UK, Lupus UK, RSI Action, Scleroderma and Raynaud's UK etc.
- Continued support and funding for the Accessible Health Care Service which provides support for service users with sensory loss in accessing and using services in line with the requirements of the Accessible Communication and Information Standards (WG, 2013).
- Following on from the above the continued development and deployment of the Sensory Loss Toolkit to all areas including managed GP practices in the Centre and West.

### 5. Next steps

Critical to improving BCUHB's capability to listen, learn and act on service user feedback, and therefore its capacity to respond to its responsibilities is the rapid development and approval of the Patient Experience Strategy and Improvement plan. As articulated in previous sections key elements include:

- Implementation of bilingual PASS service in the East and West based on the Care to Share model in order to provide BCUHB wide access to *'patient advice and support services.'*
- Development of improved real/near time feedback and reporting systems such that patients and service users are easily able to provide managers and front line staff with the information necessary to support service improvements.
- Use real/near time service user feedback to support service improvement.
- Delivery of a rolling programme of customer care, patient stories and using feedback to improve services, workshops.
- Use 'Feel Good Friday' to share positive feedback with front line staff across all regions on a weekly basis.
- Develop a programme of internal and external engagement activities in order to enhance collaboration and coproduction.
- Provide the leadership and operational support necessary to ensure that BCUHB is compliant with *Accessible Information & Communication for People with Sensory Loss* standards (WG, 2013), in line with the 3 year organisational action plan agreed with Welsh Government (WG) in 2018/2019.
- Ensuring that the work plans developed to support the Patient Experience Strategy, are compliant with the requirements of the Welsh Language Act, Welsh Language Measure (Wales, 2011) and Welsh Language Standards through the implementation of a bilingual PASS service, ensuring that service users are able to provide feedback on their experience in Welsh for example via; Real Time Feedback Systems, NHS Wales Inpatient Satisfaction Service, Care to Share, via Patient Stories etc.

- Ensuring that the work plans developed to support the Patient Experience Strategy adopt where practically possible a tri-lingual approach; that is ensuring that BSL as well as Welsh are given equal prominence with English.
- Review the terms of reference for the Listening & Learning from Experience Group in order to ensure active participation of managers from all operational areas, increased executive accountability and improved capacity within BCUHB to report service improvements made as a result of listening and learning.
- Develop consistent , equitable relationships with BCHB Quality, Nursing and Allied Health Professionals (QNAP) in:
  - IP&C (Infection prevention and control)
  - Information Governance & Risk (Inc Datix)
  - Quality
  - NHS National Safeguarding Team
  - NHS Centre for Equality and Human Rights
  - Concerns, Claims and Redress (PTR)
  - Corporate Safeguarding
  - 'Patient Safety Week' will take place from the 3<sup>rd</sup> June 2019 across BCUHB with numerous key events planned to support patient/service user feedback, demonstrating that lessons are learnt, with staff listening and taking action to improve care and service delivery.

<b>7.</b>	<b>Recommendations</b>
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It is recommended that the Committee:

- note the progress being made;
- be offered the opportunity to comment on the draft Strategy (Appendix 1);
- approve the renaming the PASS to PALS in line with the national recognised identify of this service by service users .

## References

Accessible information and Communication Standards for People with Sensory Loss (WG, 2013)

Health Care Standards for Wales (WG, April 2015a)

Listening and Learning from Feedback – A Framework for Assuring Service User Experience (WG, 2015b)

NHS Delivery Framework and Reporting Guidance – 2018/2019 (March 2018, WG)

Patient Experience Review – Betsi Cadwaladr University Health Board, (Elliott Blanchard Ltd, August 2018)

**APPENDIX 1****Draft Patient and Service User Experience Improvement Strategy 2019-2020**



**GIG  
CYMRU  
NHS  
WALES**

Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board



**Gwranddo  
Listen**  
Stango a Sioeddi  
Listen and improve

## **Patient & Service User Experience Improvement Strategy 2019 - 2022**



### **Listening and Learning from Patient Feedback**



Page 1

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- 1 The Aim
- 2 National Drivers
- 3 Listening and responding to feedback
  - 3.1 Partnership Experience
- 4 Our Ambitions
- 5 How will Patient Experience be reported?

## 1. INTRODUCTION

### The Aim of the Patient Experience Improvement Strategy:

The vision of this BCUHB Patient Experience Improvement Strategy reflects the NHS Wales' framework to deliver against four mutually supportive goals, 'the Quadruple Aim':

- Better population health and wellbeing through prevention.
- Better experience and quality of care.
- Better engagement of the workforce.
- Better value from the funding.

BCUHB is committed to engaging with our patients and service users to listen and learn from their experiences to become improvement focussed on care pathways gaining insight especially from vulnerable, protected and underserved groups.

The strategy will be the blueprint of the work improvement plan to drive Patient Experience to reflect the voice of the patients and service users that access BCUHB services. Patient Experience feedback is fundamental to BCUHB to understand how care and treatment has made them feel which provides a learning platform for service improvements. Capturing the range of views gives balanced feedback data that will demonstrate 'what we do well' and provide insight into 'areas to improve'. By developing systems to 'listen and learn' from Patient Experience will enable BCUHB to reduce the need for patients and service users to formally complain by incorporating active listening, resolving and seeking resolution in real-time. BCUHB staff will be empowered by having an understanding of the voice of the patient to take action.

## 2. NATIONAL DRIVERS

BCUHB has a mandatory responsibility to listen and learn from patient/service user experience; key policy frameworks include:

- NHS Delivery Framework 2018/2019 (NHS Wales, April 2018)
- Listening and Learning from Feedback – A Framework for Assuring Service User Experience (WG, 2015a)
- Health Care Standards for Wales (WG, 2015b)
- Wellbeing of Future Generations (Wales) Act (WG, 2014a)
- Social Services and Wellbeing (Wales) Act (WG, 2014b)
- Parliamentary review of Health & Social Care in Wales (2018)

The plan includes how we meet some of the recommendations of the Parliamentary review of Health and Social Care in Wales (2018) and the Welsh Government's *National Framework for Assuring Service User Experience (2015)*.

BCUHB has placed improving patient and service user experience at the heart of the Quality Improvement Strategy (2017 -2020) *"a promise to learn a commitment to act: ensuring the patient voice is heard at every level of the service"*. There is a commitment that patients will be listened to and that feedback from patients and service users will be obtained, published and acted on by BCUHB.

In line with the 'Assuring Service User' framework the Patient Experience team are striving to improve the quality of feedback by analysis and reporting the rich data from feedback. The following diagram reflects the four quadrants of the All Wales model:





### 3. HOW WE COLLECT AND USE FEEDBACK

The overall intention is to provide diversity of methods for patients, their family and carers to feedback on BCUHB services. Patient Experience feedback data is collected through a number of different frameworks including: the Real-time feedback survey system, retrospective inpatient postal survey, Comment Cards, Patient Stories, compliments and letters, 'Care to Share' via the Patient Advice and Support Service and 'Have your Say' engagement events; but also from complaints, clinical negligence claims and patient safety incidents.



The aim of this strategy is to enable BCUHB to develop the existing feedback and reporting systems to ensure that staff, managers, the Board and stakeholders are able to access the collated Patient Experience data to facilitate Quality Assurance and Service Improvement. This will demonstrate BCUHB's commitment to continuous listening, learning and improvement. This information aligns with the four domains of the Assurance for Service User Experience Framework (WG, 2015a): Real-Time, Retrospective, Proactive/Reactive and Balancing as illustrated.

#### PROACTIVE

**Patient Advice & Support Service (PASS)** – Patient Advice & Support Service (PASS) was piloted in the Central region in July 2017. Following its success the service will be rolled out to the East and the West from April 2019.

**'Care to Share':** The PASS service has initiated 'Care to Share' clinics on various wards across both Acute and Community hospital sites. The clinics provide patients, carers and relatives with an opportunity to raise any concerns/issues they have around care and treatment with a view to resolving. There is an opportunity to speak informally with the Ward Manager and PASS officer during the allocated timeslot. The Care to Share clinics are to be advertised with posters and flyers displayed on the wards, bays, cubicles and corridor areas.



**Have your Say:** To be established across outpatients clinical areas on all sites in order to gather the service user feedback on the services we provide to help us improve and influence future plans.

The feedback received will be shared with clinical areas. Should the report highlight negative feedback an action plan will be devised and implemented to demonstrate 'listening and learning' from Patient Experience. The information will be shared with the patients, carers and relatives by the staff in "You said, we did" display



posters.

**Increasing the management of 'enquiries':** The introduction of the PASS service across BCUHB regions will enhance the ability to respond to enquiries from patients, carers and relatives in real-time to seek resolution and satisfactory outcomes. Therefore providing a pathway to avert the need for formal complaints to be raised whenever possible.

**Customer Care and Patient Stories training:** Monthly sessions in each BCUHB region for clinical and administrative staff in collaboration with the BCUHB Corporate Nurse Education team. The focus of the Customer Care training is to identify the key components effective customer service within the NHS and strategies to:

Staff will meet the needs of customers professionally, courteously and efficiently by:

- Treating all customers with respect and courtesy.
- Listening to what patients and service users have to say.
- **Personalising** services to the needs and circumstances of each patient and service user where practical.
- Always doing what they say they are going to do, or by updating the appropriate people promptly if things change, offering an explanation for the change
- Responding to enquiries promptly and efficiently.
- Consulting patients and service users about their service needs

Patient Stories training equips staff to successfully capture and share experiences. Capturing the 'lived experience' is fundamental to understanding the challenges faced and also the lasting impact of a care pathway. Developing a trilingual digital library of patient stories utilising **audiocity** software, videos and British Sign Language (BSL) which would be accessible via BCUHB website.

**Supporting Quality Improvement:** It is essential that the voice of the patients and service users is placed at the heart of BCUHB service improvement models. This approach is integral to engendering sustainable change in line with BCUHB's core values and policy directives. Patient Experience feedback will be utilised in key service improvement projects including:

- Reducing Health Acquired Pressure Ulcers (HAPUs)
- Reducing Falls
- Reducing Medical Device and Medication Errors
- Improving Nutrition & Hydration
- Improving Dementia
- 'John's Campaign'
- Improvement Projects arising from Ward Accreditation
- End PJ paralysis
- ICAN (MHL) projects

#### REAL TIME PATIENT EXPERIENCE FEEDBACK:

**Viewpoint:** BCUHB utilises Viewpoint™ to provide real-time service user feedback to staff and managers as the basis of quality assurance, ward accreditation and service improvement in line with its mandatory responsibilities (WG, 2015a; WG, 2015b). The survey questions

reflect the WG validated service user questions and updated Framework for Assuring Service User Experience 'Your NHS Wales Experience' questionnaire (2018). The real-time survey needs to be available in electronic and paper formats within all BCUHB wards and departments in both Acute and Community hospitals.

Real-time feedback is critical in ensuring that the voice of the patients, carers and relatives reach staff and managers in a timely manner. To support BCUHB service improvement projects the Patient Experience team will ensure that this data is accessible to triangulate with other key quality metrics. The Patient Experience team will continually review the functionality and value for money offered by the current and/or any replacement system in order to ensure that it is fit for purpose. Specifically that the real-time feedback is:

- Accessible at ward/departamental level to staff and managers across BCUHB
- Triangulated with Complaints, Incidents, HARMS metrics to build a comprehensive picture of 'what our service users are telling us' via the BCUHB IRIS dashboard
- Encourage the involvement of patients, carers, relatives, volunteers and other service users in the provision of experience feedback

Sharing complimentary correspondence and ensuring daily 'alerts' are systematically shared and distributed with key relevant staff.

#### RETROSPECTIVE:

**Social media:** The Patient Experience team monitor, capture and share patient feedback and use Facebook to demonstrate the positive experiences and compliments received. BCUHB's Communications team and the Workforce and Organisational Development (WoD) staff support this work to enhance the reputation by promoting and celebrating a positive view of the organisation.



**NHS Wales Patient Satisfaction Postal Survey:** The survey is administered quarterly to a random sample of 1,000 inpatients. BCUHB obtains a high response rate to this survey of approximately 35%. The Patient Experience team will ensure that feedback from this survey is triangulated with real-time feedback in order to ensure that the retrospective views of patients after discharge is reported and shared with staff and managers in a timely manner.

**Newsletter:** A quarterly Patient Experience newsletter to develop a continuous engagement model capturing 360° experiences to share with service users and stakeholders to promote open and honest communication. This will be available online via the BCUHB website and in paper format. The golden thread influencing all the various Patient Experience feedback formats is to ensure links to Secondary and Community Care, Mental Health and Learning Disabilities, Women's and Children Services are Primary Care actively reflect care pathways of BCUHB patients.

## BALANCING:

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

**Patient Stories:** Patient stories can be a powerful tool to improve services, gain feedback and highlight the patient's experience. Stories are about learning and actively listening to patients, relatives and carers. Patient stories will ensure that the patient's voice is recognised as being centrally important in the drive for service improvement. This work is being supported by the Communications team and further developments are planned with regards to increasing the number of patient stories and development of the patient stories digital database.

**Engagement Events:** The Patient Experience team will attend and present at BCUHB engagement events to network with the third sector, stakeholders and relevant groups to promote 'Have your Say' events. National Patient Experience network events will be attended to build effective working relationship with other Health Boards and Trusts. The Patient Experience team will support the joint Macmillan / BCUHB 'Transforming Cancer Pathways' project.

**Strategic Relationships:** The Patient Experience team will build

effective, collaborative and engaging external networks with Public Health Wales, Welsh Ambulance Service Trust (WAST), the Children's Commissioner, the Older People's Commissioner, the Welsh Language Commissioner, the North Wales Community Health Council and Equalities leads across Wales. By sharing our ambition with stakeholders 'we can and should do better' because we are listening and engaging to continuously improve Patient Experience by actively evaluating the difference we are making.

The Patient Experience team will revise and develop the strategic focus of the Listening and Learning Forum to ensure comprehensive and rigorous development in co-production with the BCUHB Performance Improvement team, *WoD* (including the Equality team) and the Quality and Safety teams to achieve shared mandatory responsibilities to reflect BCUHB strategic objectives.

## 3.1 STAFF EXPERIENCE:

BCUHB is committed to achieving excellent staff experience as part of the quadruple aim. In order to deliver excellent care and treatment staff need to have a positive work environment to support the outstanding commitment and drive demonstrated across BCUHB consistently. By having the voice of the patient at every level enables staff to recognise the positive impact and difference they can all make every day.

## 4. OUR AMBITIONS

To develop the capacity of the organisation to listen and learn from feedback as the basis for developing in a co-productive manner, services which are better able to meet the needs of patients and other service users. The Patient Experience Team will:

1. To enable and engage with patients, carers and their families to encourage feedback on how they feel about their experience of BCUHB services.
2. Develop clear, accurate and relevant reports to share Patient Experience feedback with BCUHB staff, managers, and the Board to support and inform service improvement.
3. The development of the PASS service will support the timely resolution of enquiries to enable effective communication between staff and patients, carers and their families. This will promote immediate learning and positively influence the services. Therefore, reducing the need to raise systemic formal complaints.
4. Triangulate Patient Experience feedback to identify trends and themes, which celebrate best practice and identify areas to improve. Ensuring that BCUHB staff receive clear information that allows understanding to take action on what patients and service users are telling us about their experiences.
5. Raise the profile of the Patient Experience work streams and the reputation of BCUHB both locally and nationally.

The ambition of the BCUHB Patient Experience team is to work locally and nationally to develop and deliver a model of collecting and

reporting feedback that ensures the views, opinions and experiences of how patients, carers, relatives and service users 'feel' is heard from ward to Board by 'seeing services through the eyes of our patients'.

## 5 How will Patient Experience be reported?

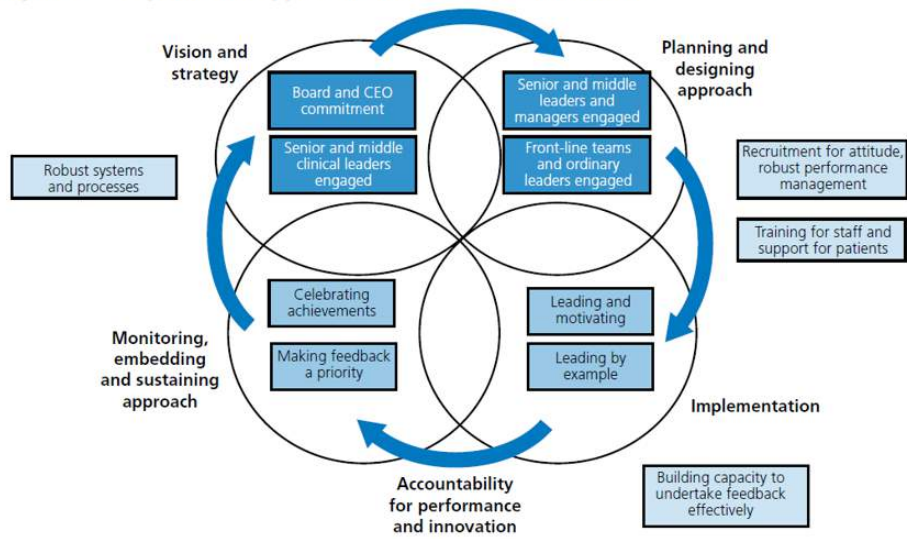
Patient Experience feedback data will be reported to obtain a balanced understanding of 'what it feels like to be a patient or service user' accessing BCUHB services. The approach to collecting patient and service user feedback must be robust, relevant, and timely and reflect the principles of the Welsh Government Framework Welsh Government's *National Framework for Assuring Service User Experience (2015)*. It will facilitate learning, improvement and celebrate best practice.

This strategy promotes and supports the need to use data effectively to build upon the foundations of the Ward Accreditation programme. The Patient Experience data will triangulate feedback from complaints, clinical negligence claims, patient safety incidents, compliments and patient surveys to provide a comprehensive 360° report. Feedback from patients and service users is captured and measured through a broad range of initiatives consistent with this framework for gaining and reporting on service user feedback (as illustrated in the following cycle matrix).

The Patient Experience team will produce relevant weekly, monthly and quarterly reports to all levels of BCUHB staff to ensure the patient voice is heard.



**Figure 3 – A systematic approach to embed use of feedback**

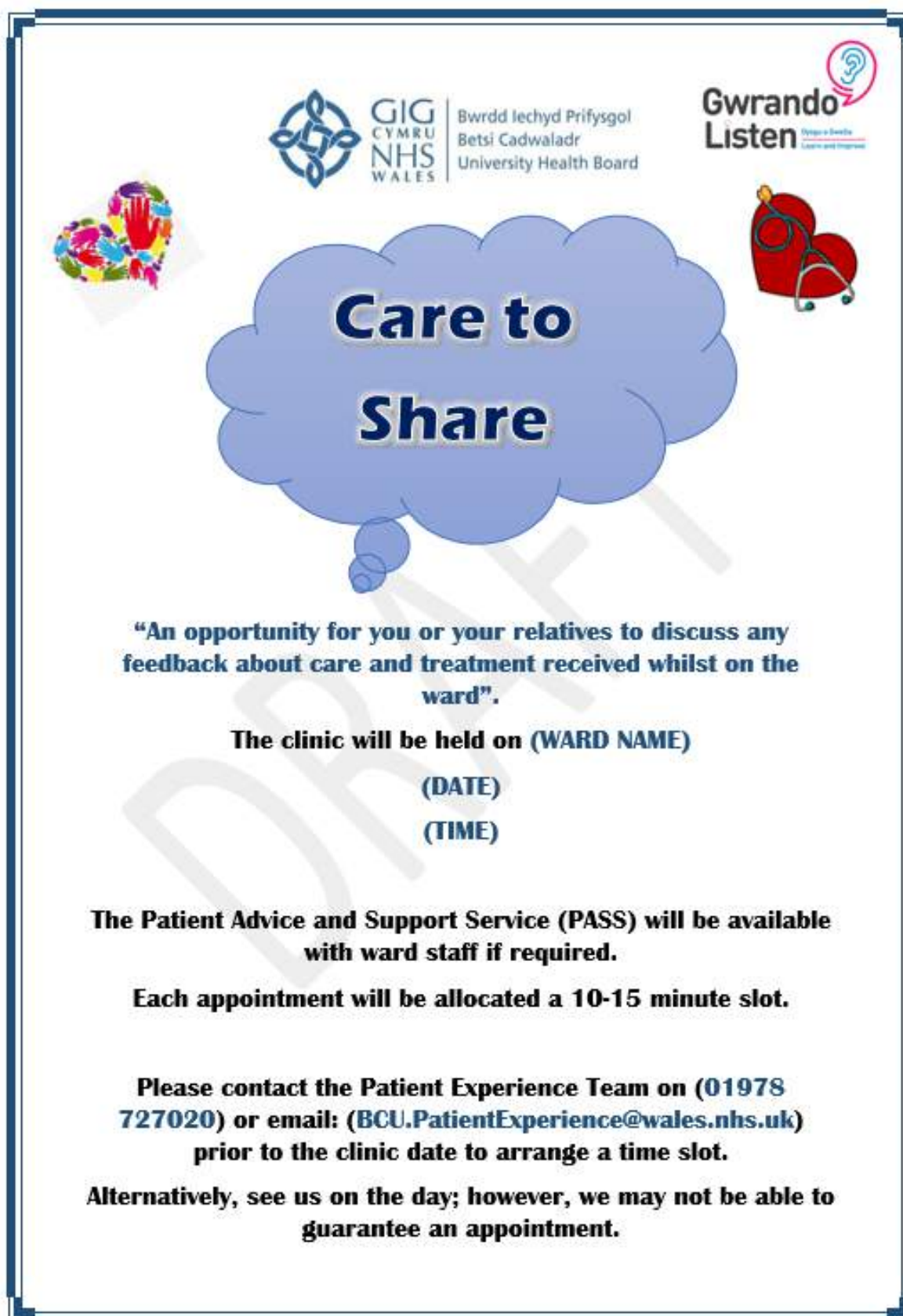


Source: Karen Ashton, South Central Strategic Health Authority

[http://www.nhssurveys.org/Filestore/documents/DH\\_Understanding\\_what\\_matters.pdf](http://www.nhssurveys.org/Filestore/documents/DH_Understanding_what_matters.pdf)

## APPENDIX 2

Poster illustrating the Care to Share clinics programme



The poster is titled "Care to Share" in a large blue cloud. It features logos for GIG Cymru NHS Wales, Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board, and Gwranddo Listen. There are also decorative icons: a heart made of hands on the left and a red heart with a stethoscope on the right. The text describes the clinic as an opportunity for feedback, provides a template for the clinic details, and includes contact information for the Patient Experience Team.

**GIG Cymru NHS Wales** | Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

**Gwranddo Listen** Ysgrifwch i Gwranddo Listen a pharhau

**Care to Share**

**"An opportunity for you or your relatives to discuss any feedback about care and treatment received whilst on the ward".**

**The clinic will be held on (WARD NAME)**  
**(DATE)**  
**(TIME)**

**The Patient Advice and Support Service (PASS) will be available with ward staff if required.**

**Each appointment will be allocated a 10-15 minute slot.**

**Please contact the Patient Experience Team on (01978 727020) or email: (BCU.PatientExperience@wales.nhs.uk) prior to the clinic date to arrange a time slot.**

**Alternatively, see us on the day; however, we may not be able to guarantee an appointment.**

## APPENDIX 3

## Example of the Ward Accreditation boards across BCUHB clinical areas

[illegible]

## APPENDIX 4

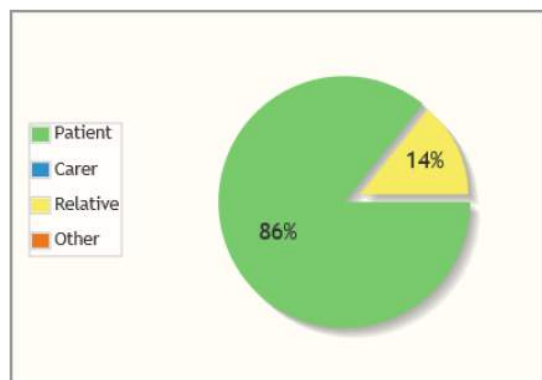
### Example of a recently completed Monthly Viewpoint Report

SAUJGynae Ward					Current PI	
Monthly Report						
	Nov	Dec	Jan		Performance Indicator from Previous Month	
Did staff introduce themselves to you?	100%	100%	100%		➡	0 %
Do you feel you were listened to?	94%	100%	100%		➡	0 %
Were you given all the information you needed?	93%	100%	89%		➡	-11 %
Did you get assistance when needed?	100%	100%	100%		➡	0 %
Were you involved in decisions about care?	88%	100%	100%		➡	0 %
Did staff take the time to understand what matters to you	94%	100%	100%		➡	0 %
How would you rate your overall experience?	88%	83%	100%		➡	17 %
Total Responses	17	6	23			

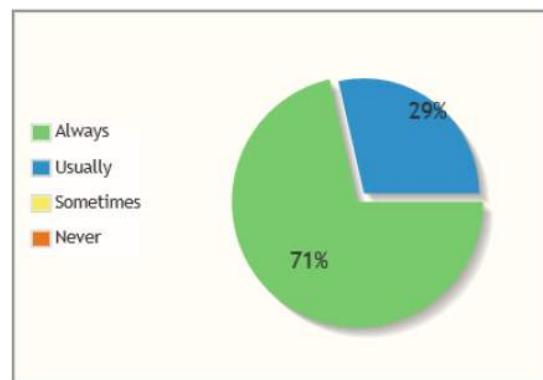
■ Excellent: 90%
 ■ Satisfactory: 80%
 ■ Poor: 80%

#### Pie Charts

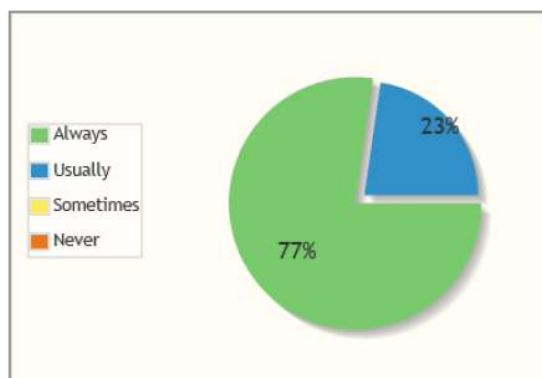
Completing the survey as a: (21)



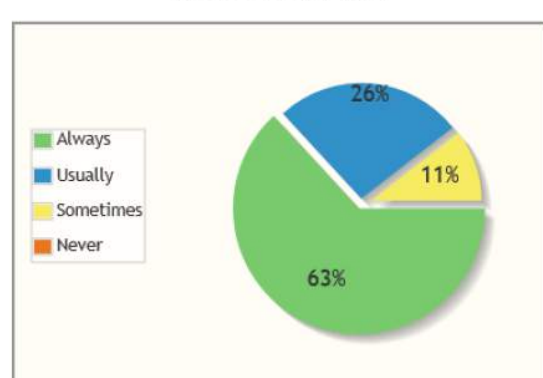
Did staff introduce themselves to you? (21)



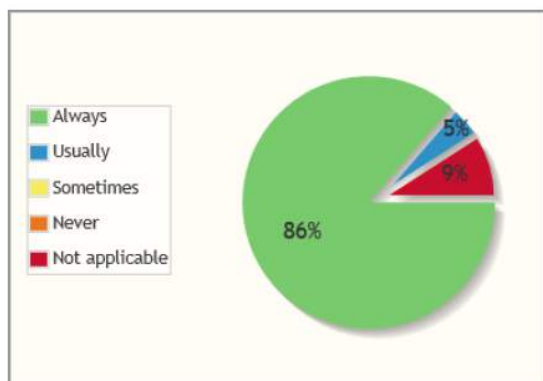
Do you feel you were listened to? (22)



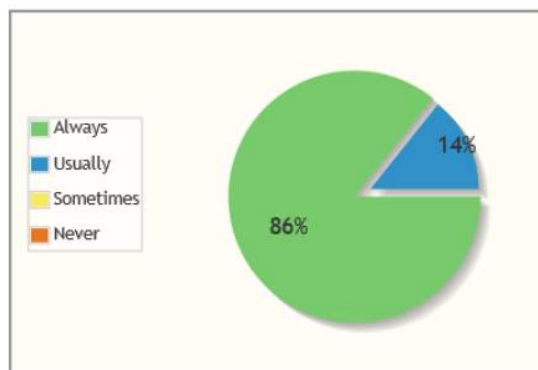
Were you given all the information you needed? (19)



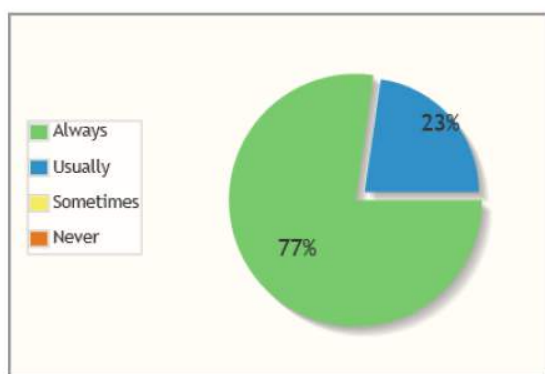
Did you get assistance when needed? (22)



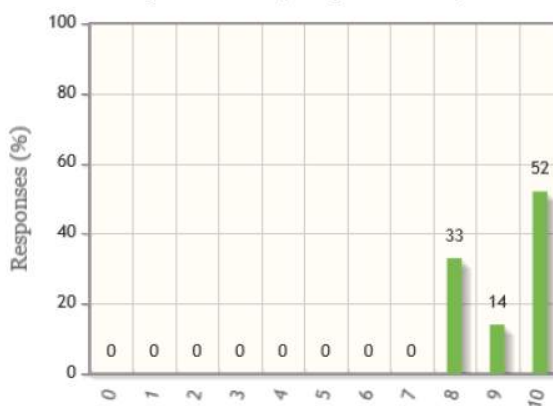
Were you involved in decisions about care? (21)



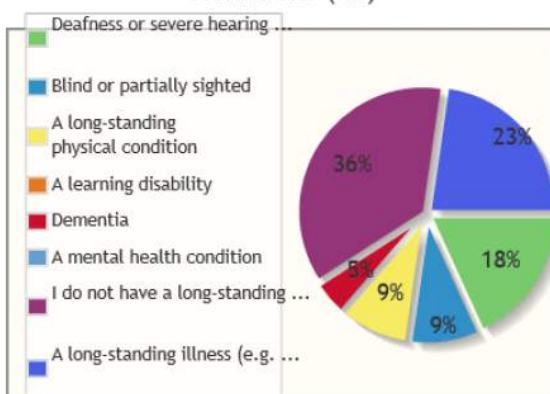
Did staff take the time to understand what matters to you (22)



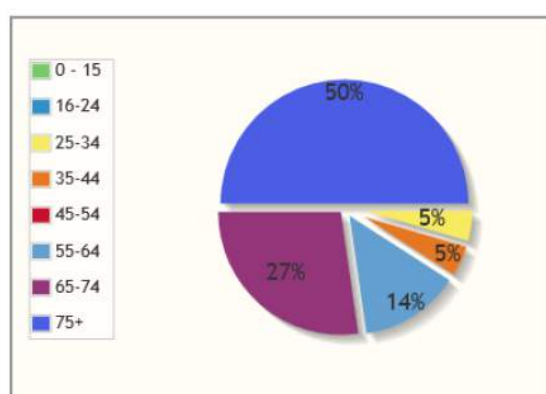
How would you rate your overall experience? (Response: 21)



I have the following long standing conditions (22)



My age is: (22)





What was good about your care?	Jan		
		Staff attitudes.	SAU/Glyndwr Ward 30/01/2019 15:43:34
		I think all the staff are very supportive, kind and helpful. Sometimes it's hard to get a clear picture from the doctors. However, I would like to praise the explanation given to me by one of the junior doctors. Also, the registrar helped us understand the working of arranged medicine.	SAU/Glyndwr Ward 30/01/2019 15:29:04
		The way the staff worked together very well.	SAU/Glyndwr Ward 30/01/2019 15:23:06
		Here when I needed you, thank you.	SAU/Glyndwr Ward 30/01/2019 15:14:56
		Staff all really good.	SAU/Glyndwr Ward 30/01/2019 15:08:26
		Everyone I came across from Blair Bell to Simpson, to Labour Ward to Lawson Tait have been amazing. Nothing was ever a problem, they were always on hand to help even though they are clearly very busy. I can't praise the staff enough. Thank you!	SAU/Glyndwr Ward 23/01/2019 18:16:55
		Getting better.	SAU/Glyndwr Ward 23/01/2019 18:09:08
		Friendly staff.	SAU/Glyndwr Ward 23/01/2019 18:01:34
		Care was very good.	SAU/Glyndwr Ward 23/01/2019 17:47:16
		Standard of care has been second to none, by all staff. Thank you.	SAU/Glyndwr Ward 23/01/2019 17:42:04
		The care my father has received over the past 6 weeks has been fantastic! Thank you to everyone.	SAU/Glyndwr Ward 23/01/2019 17:31:59
		Welcome and attentiveness to my needs. Took attention and explained everything to me.	SAU/Glyndwr Ward 23/01/2019 17:26:21
		The service, help, consideration and the food.	SAU/Glyndwr Ward 23/01/2019 17:08:55
		The care that I received was excellent and cannot praise the staff on the great work they do. Thank you to all doctors and nurses, for the care I received on surgery.	SAU/Glyndwr Ward 10/01/2019 11:13:50
Was there anything that could be improved?	Jan		
		Given the impression everyone makes a great effort to be professional.	SAU/Glyndwr Ward 30/01/2019 15:29:04
		No.	SAU/Glyndwr Ward 30/01/2019 15:23:06
		Wait for a bed.	SAU/Glyndwr Ward 23/01/2019 18:01:34
		Food. Repetitive and not suitable for people with not much appetite!	SAU/Glyndwr Ward 23/01/2019 17:47:16
		Not to any of the staff on Glyndwr Ward. I found the menus very repetitive. Change the menu!	SAU/Glyndwr Ward 23/01/2019 17:26:21
		Some of the food menus. Bad experiences with one of the agency nurses, i.e. fitted very small catheter tube in [unreadable comment].	SAU/Glyndwr Ward 23/01/2019 17:17:58
		A&E Department far too many hours spent there before being admitted into hospital.	SAU/Glyndwr Ward 10/01/2019 10:40:44
		Departmental communication.	SAU/Glyndwr Ward 30/01/2019 15:43:34
		Sort out the menu, what I have had has been OK but so repetitive. Hardly any choice. Also get the menu right. Give the patient what they ordered.	SAU/Glyndwr Ward 23/01/2019 18:09:08
		Not that I can think of at this present time.	SAU/Glyndwr Ward 10/01/2019 11:13:50
Any comments in relation to your protected characteristics	Jan		
		Equality aspects - excellent.	SAU/Glyndwr Ward 30/01/2019 15:29:04
		No comment.	SAU/Glyndwr Ward 30/01/2019 15:43:34

## APPENDIX 5

Examples of Care to Share feedback collected January to February 2019

## CARE to SHARE

Acute hospital, Ward \*

Patient Advice & Support Officer (PASO)

DATE	TIME OF VISIT	THEME	ISSUE/COMPLIMENT	ACTION/OUTCOME
20/02/2019	1045hrs	First and lasting impression	<b>Patient A</b> – Patient was very complimentary of all aspects of her care, the very helpful and cheerful staff, and nurses in particular, porters, domestics have all been treating her as a human and her lasting impression is that of very friendly and professional nurses and Doctors.	Info to be passed to Ward Sister and Matron of the Ward
		Safe Support Healing Environment	Patient stated that her environment has been very clean, well maintained, the domestics are cheerful and polite and the nurses always have a smile on their faces, she also stated the food was superb, plentiful and always hot and on time.	Compliment to be passed to ****Head of Hotels Services (Central) and **** Catering Manager Central.
		Understanding and involvement	Patient felt that she was listened to in every aspect of her care, she did say that she was confused some weeks ago and became confrontational with staff and the consultant, but did	Info to be passed to Ward Sister and Matron and Heads of Nursing.  PASO spoke to Ward sister who confirmed this will happen later on today as a routine referral.

DATE	TIME OF VISIT	THEME	ISSUE/COMPLIMENT	ACTION/OUTCOME
			<p>apologise for her behaviour soon afterwards con. Her partner was present and he stated that the Ward sister was always at hand to ask if they feel they need support or answers on any aspect of his partners care, They did say that they were told about a member of the Cardiology team coming to see them sometime today but had heard nothing, PASO said he would chase up with Ward sister.</p> <p>Overall the patient and family were very impressed with the level of care and support given by staff and could not fault the Hospital for anything. More treatment is required and patient may be with us for some time yet.</p>	
20/02/2019	1100hrs	<p>First and lasting impression</p> <p>Safe Support Healing Environment</p>	<p><b>Patient B</b> – Patient was again very complimentary of most aspects of their stay in Ward *, she stated that there were some teething issues when she first arrived on the ward but is hopeful that these have been ironed out after intervention from the Ward sister.</p>	<p>Info to be passed to Ward Sister and Heads of Nursing and Ward Matron.</p> <p>Info to be sent to *</p>

DATE	TIME OF VISIT	THEME	ISSUE/COMPLIMENT	ACTION/OUTCOME
		Understanding and involvement	<p>Room was very clean, bright and airy, the cleaners were always cheerful and had time for a quick chat, no problem with the staffing levels and feels that Ward was run very well, her main point was the lack of communication at times which hindered her treatment and care pathway for a few days until resolved by the Ward sister yesterday, she feels that she was listened to but only after her daughter had to raise her concerns about delay in being seen by the specialist. She was seen today and feels that her treatment and communication is back on track and complimented the Sister for listening and giving resolution.</p> <p>Patient feels that a corner has been turned today and is hopeful that her treatment and care will now be a smooth process with improved communication, she felt that if there were issue she could raise to the Ward sister with whom I think she places a lot of trust and respect.</p>	<p>PASO discussed with Ward sister who was fully aware of previous issue.</p> <p>PASO informed Ward sister of this and she was aware of the patient's needs.</p>

DATE	TIME OF VISIT	THEME	ISSUE/COMPLIMENT	ACTION/OUTCOME
20/02/2019	1120hrs	First and lasting impression	<p><b>Patient C</b> – Patient was very impressed with the stay he has had on Ward *, all the staff have been polite, professional and approachable and he stated nothing had been too much trouble for the nurses in delivery of his care.</p> <p>Patients stated that the ward was the cleanest and friendliest he has seen for a long time, everybody has had a smile on their faces and treated people with care and dignity.</p>	<p>Informed Ward sister at time of visit. Will also pass onto Matron and Head of Nursing</p>
		Safe Support Healing Environment	<p>The food he described as superb with plenty of choice and portion size is just right, nutritious and tasty there is also lots of hot drinks or cold jugs of water if needed.</p>	<p>Compliment to be sent to *****</p>
		Understanding and involvement	<p>Patient believes that Ward 5 is a very safe and supporting environment, where patients have a chance to rest and recover from surgery in a warm, friendly environment.</p> <p>Patient was a little miffed that the TV was not working but said that this was addressed by nursing staff some days ago</p>	<p>Ward sister informed at time of visit who said it had been reported to Estates.</p> <p>Info to be passed to Ward sister and Matron.</p>

DATE	TIME OF VISIT	THEME	ISSUE/COMPLIMENT	ACTION/OUTCOME
			<p>and are waiting to have the TV system fixed.</p> <p>Patient has been kept abreast of treatment and care and was very impressed with the professionalism and communication by all he has encountered. Nurses and Doctors have helped him so much through constant communication. Overall a lovely friendly Ward with great caring staff.</p>	

### **Summary**

Date of visit was 20/02/2019, PASO was \*\*\*\*\*

PASO arrived on the Ward at 1045hrs, Ward sister gave PASO all information required to conduct the Care to Share in the Hospital, PASO was given free access to go to any Ward he liked and speak to anyone who he encountered.

The Environment was clean, bright and very welcoming, the response was professional and cooperative and I thank staff for support on this visit and in particular Ward Sister \*\*\*\*.

## CARE to SHARE

\*\*\*\*\*Community Hospital

Patient Advice &amp; Support Officer (PASO)

DATE	TIME OF VISIT	THEME	ISSUE/COMPLIMENT	ACTION/OUTCOME
13/0/2019	1530hrs Ground floor Female Wing	<p>First and lasting impression</p> <p>Safe Support Healing Environment</p> <p>Understanding and involvement</p>	<p><b>Patient A</b> – Patient was very complimentary of all aspects of her care, the very helpful and cheerful staff, clinical, nurses, porters, domestics have all been superb and his lasting impression is that of a very well run and patient friendly hospital.</p> <p>Patient stated that her environment has been very clean, well maintained, the domestics are cheerful and polite and the nurses always have a smile on their faces, she also stated the food was excellent, plentiful and always on time, her only issue was that she struggled to eat the food due to swallowing difficulties.</p> <p>Patient felt that she was listened to in every aspect of her care, felt encouraged to ask questions if unsure on any aspect of her care. The Patients niece was present and she made several compliments about her auntie's care and said</p>	<p>Info to be passed to Ward Senior &amp; Sisters and Heads of Community Nursing.</p> <p>Compliment passed to ****, Head of Hotels Services (Central) and ****, Catering Manager Central. PASO spoke to Ward sister who was aware of the patients eating difficulties and actions taken to resolve.</p> <p>Info to be passed to Ward Senior &amp; Sisters and Heads of Community Nursing.</p>

DATE	TIME OF VISIT	THEME	ISSUE/COMPLIMENT	ACTION/OUTCOME
			<p>that the family were well informed of the patients care pathway. They felt confident that if any questions arose they would feel confident to approach staff to ask and get a professional and timely response.</p> <p>Overall the patient and family were very impressed with the level of care and support given by staff and could not fault the Hospital for anything.</p>	
13/02/2019	1545hrs Ground Floor Male Wing	<p>First and lasting impression</p> <p>Safe Support Healing Environment</p>	<p><b>Patient B</b> – Patient was again very complimentary of all aspects of their stay in CBCH and in particular his Ward. Nursing staff and clinical staff are very professional, know their trade very well and deliver a great service under immense pressure. Patient is an ex Nursing Auxiliary who plied his trade for some 40+years. He stated that hospital s get unwarranted and unnecessary negative press and could not find fault in his care.</p> <p>Ward was very clean, bright and airy, the cleaners were always cheerful and had time for a quick chat, no problem with the</p>	<p>Info to be passed to Ward Senior &amp; Sisters and Heads of Community Nursing.</p> <p>Info to be sent to Greg Bloor</p> <p>Comment to be sent to Karl Berry</p>



DATE	TIME OF VISIT	THEME	ISSUE/COMPLIMENT	ACTION/OUTCOME
		Understanding and involvement	<p>staffing levels and feels that Ward was run very well and prioritised patients' needs very well. The Hospital was a safe and warm place to be with staff that smiled a lot, and that he said was important for patients.</p> <p>The food he was very impressed with and was tasty, plentiful and nutritious, best he had had in a long history of hospital admissions.</p> <p>Patient knew from admission to today, what is going on in his treatment and care and again has no fault to find with any aspect of care, communication or the hospital as a whole. Would like information in relation to purchasing/loaning a wheelchair for his use. His sister is also an inpatient in the Hospital and he is actively encouraged to assist with feeding and visits to her which he is very impressed with.</p>	PASO informed Ward sister of this and she was aware of the patients need and this has already been initiated
13/02/2019	1620hrs Ground floor Female Wing	First and lasting impression	<b>Patient C</b> – Patient's daughter was present and spoke on behalf of the patient, she was very impressed with the journey the patient has been on, all the	Informed Ward sister at time of visit who was aware of the situation.

DATE	TIME OF VISIT	THEME	ISSUE/COMPLIMENT	ACTION/OUTCOME
		Safe Support Healing Environment	<p>staff have been polite, professional and approachable and he stated nothing had been too much trouble for the nurses if she had needed anything. She did mention that there was a slight breakdown of communication a few weeks ago in relation to discharge to an EMI care home, but staff sorted the problem out very quickly and cannot fault the response.</p>	<p>Compliment to be sent to Karl Berry</p>
		Understanding and involvement	<p>Patients family stated that the ward was the cleanest and friendliest she has been on, everybody from the nurses to doctors have had a smile on their faces and treated her with lots of care and dignity.</p> <p>The food she described as fantastic with plenty of choice and portion size is just right, lots of cold jugs of water if needed.</p> <p>Patient's daughter said that her mother and family have been kept abreast of treatment and care and were very impressed with the patients current condition, she said</p>	<p>Ward sister informed at time of visit.</p> <p>Info to be passed to Heads of Community nursing.</p>

DATE	TIME OF VISIT	THEME	ISSUE/COMPLIMENT	ACTION/OUTCOME
			<p>they have noticed a vast improvement in her health and well-being.</p> <p>Nurses and all involved have helped her so much through constant reassurance and communication. Overall a lovely friendly hospital with great caring staff. Would recommend CBCH to anybody needing to go to a Community Hospital.</p>	

### **Summary**

Date of visit was 13/02/2019, PASO was \*\*\*\*

PASO arrived at the Hospital at 1500hrs, staff introduced themselves on arrival and PASO was made to feel comfortable from the outset. Senior Nurse and Ward sister gave PASO all information required to conduct the Care to Share in the Hospital, PASO was given free access to go to any Ward he liked and speak to anyone who he encountered.

The Environment was clean, bright and very welcoming, as were the staff and the sense of a close knit friendly place was evident from the outset, several patients and family members mentioned that on arrival they are given a booklet about the history of Colwyn Bay hospital and all said that it was a fantastic idea and promoted the Community Hospital well.

For a first visit and without the staff knowing what the "Care to Share" entailed fully, the response was fantastic and cooperative and I thank staff for an initial visit that has left a First and lasting impression of the care and enthusiasm shown to improve Patient Experience for patients and relatives in a warm, friendly Hospital.

## **CARE to SHARE**

\*\*\*\*\* Community Hospital \*\*\*Ward. Patient Advice & Support Officer (PASO).

DATE	TIME OF VISIT	THEME	ISSUE/COMPLIMENT	ACTION/OUTCOME
15/02/2019	13:45	First and lasting impression	<b>Patient A</b> – stated that staff were very polite and friendly. Their interaction ‘keeps me alive’.	Info to be passed to Ward Senior & Sisters and Heads of Community Nursing.
		Safe Support Healing Environment	Patient stated that the ward was kept very clean, to an exceptional level. He had even witnessed night staff cleaning whilst patients were sleeping. Patient advised that he regularly witnessed staff cleaning their hands between patients. The patient advised that on the whole, the food was very nice – especially the puddings!	Compliment passed to Greg Bloor, Head of Hotels Services (Central) and Karl Berry, Catering Manager Central.
		Understanding and involvement	The patient advised that both the doctors and nurses took their time to explain his treatment and were happy to answer any queries he had regarding his care.	Info to be passed to Ward Senior & Sisters and Heads of Community Nursing.
15/02/2019	13:50		<b>Patient B</b> – Patient was again very	Info to be passed to Ward Senior &

DATE	TIME OF VISIT	THEME	ISSUE/COMPLIMENT	ACTION/OUTCOME
		First and lasting impression	complimentary of all aspects of their stay in HCH. The patient advised that the staff were very attentive and good at their roles.	Sisters and Heads of Community Nursing.
		Safe Support Healing Environment	The patient advised that the ward was thoroughly cleaned every day. The patient stated that she regularly witnessed staff cleaning their hands between patients. The patient has one minor issue, which was her preference for wholemeal bread. She had asked if she could have wholemeal and informed this wasn't possible. However, on the whole, the patient is satisfied with the facilities and environment.	Information passed to Ward Sister directly after Care to Share, who confirmed that the patient's requests can be accommodated and will ensure the option of wholemeal bread is available immediately. Info to be sent to **** *****.
		Understanding and involvement	The patient has difficulty hearing, therefore staff were communicating via a notebook at the side of the patients bed, as	Info to be passed to Ward Senior & Sisters and Heads of Community Nursing.

DATE	TIME OF VISIT	THEME	ISSUE/COMPLIMENT	ACTION/OUTCOME
			the patient is unable to sign. Despite the communication barrier, the patient advised that she felt listened to and involved in her care.	
15/02/2019	14:00hrs	<p>First and lasting impression</p> <p>Safe Support Healing Environment</p> <p>Understanding and involvement</p>	<p><b>Patient C</b> – advised that she found the staff very nice and caring and that they were professional in all aspects of the patients care.</p> <p>The patient advised that whilst she hadn't seen staff cleaning hands between patients, it is possible that they do so as she hadn't paid much attention to this aspect of her care. The patient stated that staff were very nice and polite. The patient also stated that the food was very good – much better than in YGC!</p> <p>Again the patient advised that staff took their time to explain her treatment pathway and felt listened to and involved with all aspects of her care.</p>	<p>Info to be passed to Ward Senior &amp; Sisters and Heads of Community Nursing.</p> <p>Compliment to be sent to **** *.</p> <p>Info to be passed to Ward Senior &amp; Sisters and Heads of Community Nursing.</p>

**Summary**

Date of visit was 15/02/2019, PASO was \*\*\*\*

PASO arrived at the Hospital at 13:40, staff introduced themselves on arrival and PASO was made to feel comfortable from the outset. Ward Sisters gave PASO all information required to conduct the Care to Share in the Hospital, PASO was provided with a list of patients across both wards who had capacity and would be happy to provide feedback.

The Environment was clean, bright and very welcoming. Staff were very attentive and welcoming to PASO.

For a first visit and without the staff knowing what the "Care to Share" entailed fully, the response was fantastic and cooperative and I thank staff for an initial visit that has left a first and lasting impression of the care and enthusiasm shown to improve Patient Experience for patients and relatives in a warm, friendly Hospital.

## APPENDIX 6

Poster: 'To listen and then to act' in line with 'You said We Did' implementation

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

**Gwranddo Listen** Listen & Improve

**Have Your Say**

**We value your opinion**

Your ideas/experiences/suggestions can help us make improvements to the service you receive.

We also welcome compliments, which are fed back to staff and are received with gratitude.

**You said:**

**We did:**

We appreciate your feedback. Please talk to a staff member about your patient experience.





CYMRU  
WALES

# Amber Review

A REVIEW OF CALLS TO THE WELSH AMBULANCE SERVICE  
CATEGORISED AS AMBER

# Background

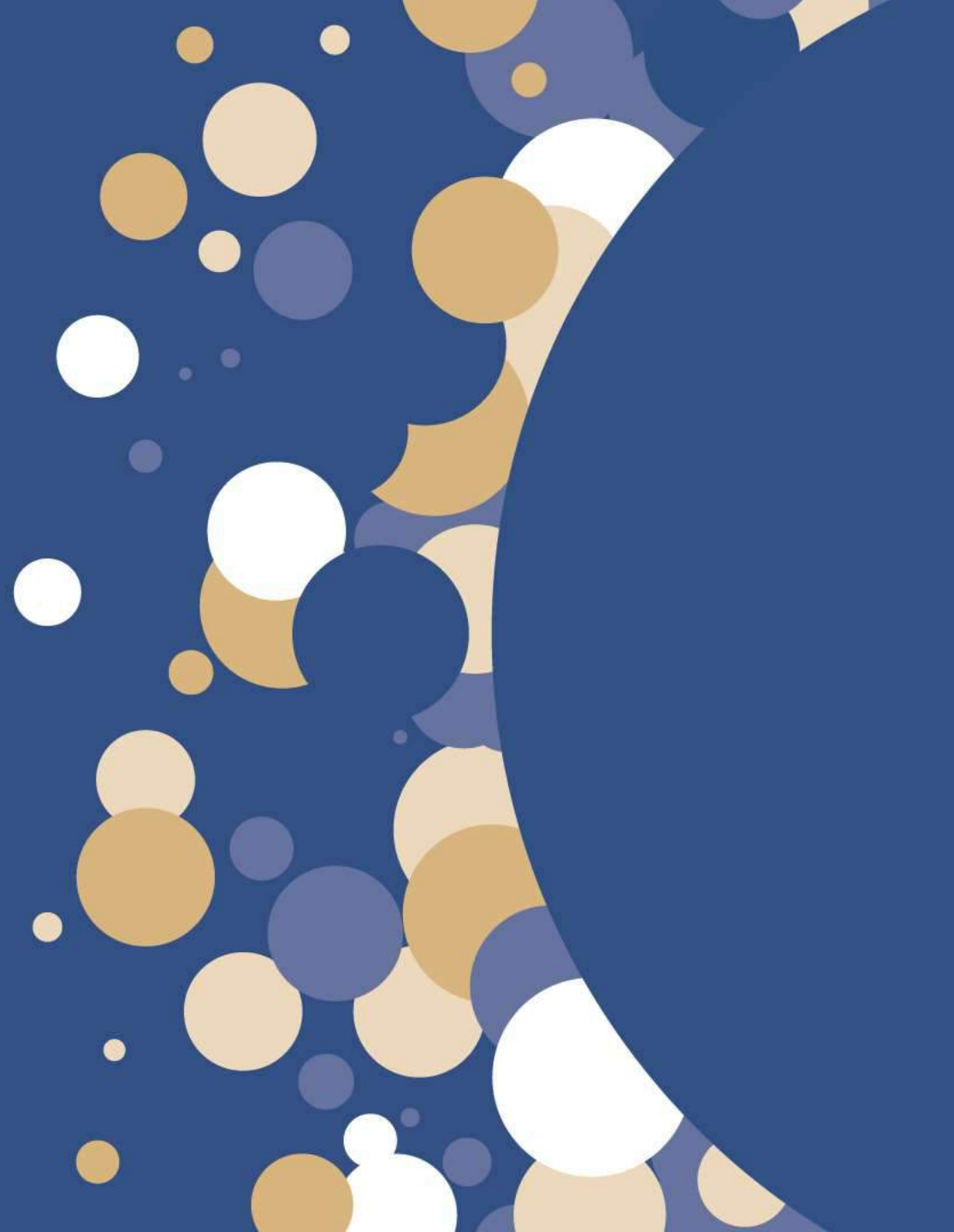
- Independent review launched in May 2018
- Two main areas addressed
  - Is there a systemic problem with the Amber category that is resulting in worsening outcomes for patients?
  - Are patients in the Amber category waiting too long for an ambulance response and if so, what is the impact on their health and experience?

# Approach

- The review is set out in four sections:
  - Explaining Amber
  - Exploring Amber
  - Delivering Amber
  - Improving Amber
- Each section contains a comprehensive narrative to address the two key issues for the review
- Staff and patient feedback is embedded into each section
- Expert reference panel was established to support review team

AMBER REVIEW

# Explaining Amber



# The Clinical Response Model for Ambulance Services in Wales



## Red

The 'Red' category of call is for immediate life-threatening conditions where a person is in imminent danger of death.



## Amber

The 'Amber' category of call is for those patients with serious conditions that are not immediately life-threatening, but which are urgent and may need treatment and care at the scene or rapid transport to a healthcare facility



## Green

The 'Green' category of call is for non-serious conditions which can often be managed by other health services, including healthcare advice or through self-care.

## EXPLAINING AMBER

# Clinical Response Models in other health systems

### Call Categories Wales

- Immediately Life-threatening
- Serious not Life-threatening
- Neither serious or Life-threatening



### Call Categories Scotland

- Immediately Life-threatening
- Serious not Life-threatening
- See, Treat & Refer
- Hear, Treat & Refer
- Non-Emergency

### Call Categories England

- Life-threatening calls
- Emergency Calls
- Urgent Calls
- Less Urgent Calls

EXPLORING AMBER

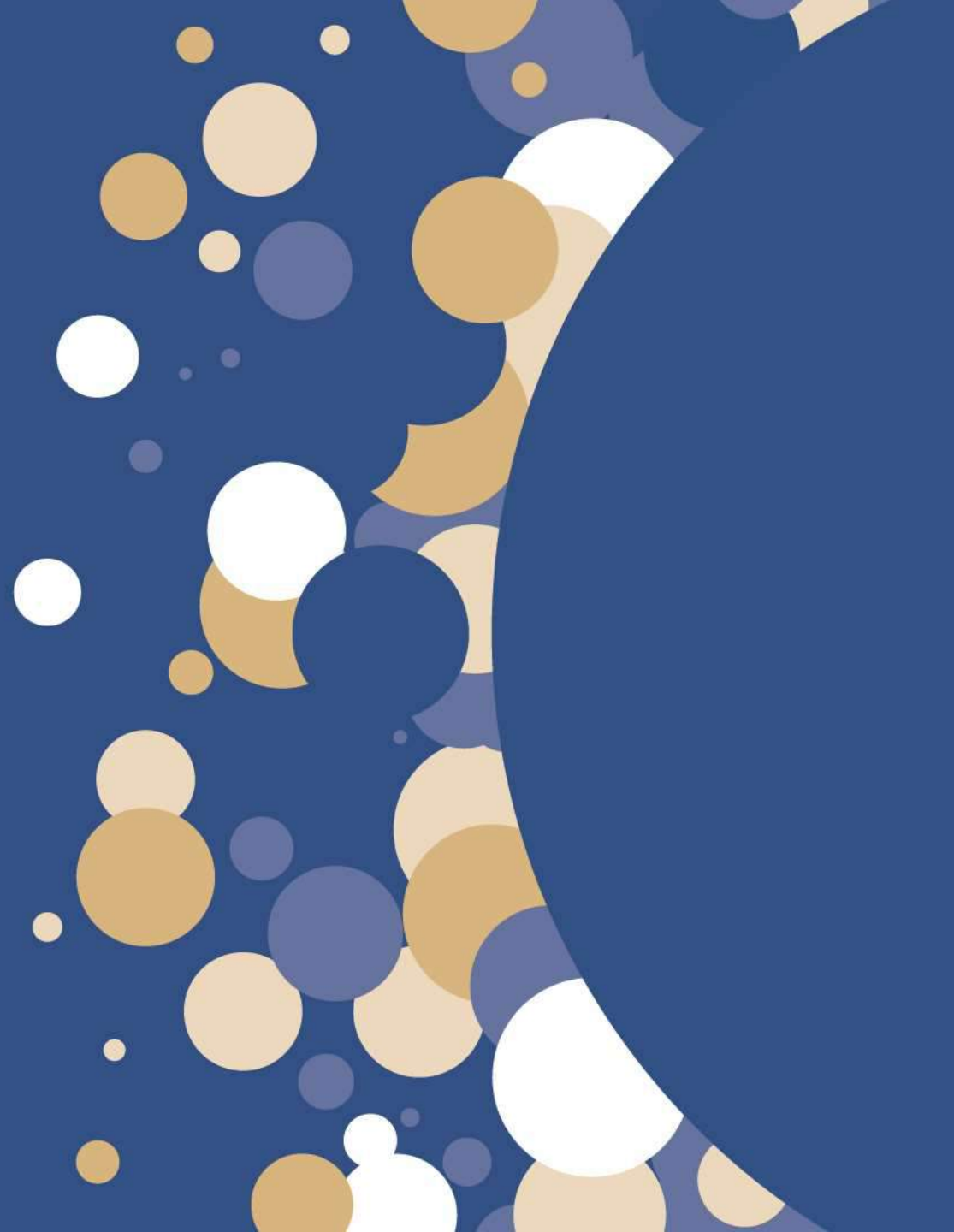
# Findings for Explaining Amber

- The prioritisation of calls is complex
- There is a range of different responses depending on the patient's condition
- Ambulance staff felt frustrated by the restrictive nature of the prioritisation system
- The public felt that it was important to get the best response for their condition, even if this was not the quickest



AMBER REVIEW

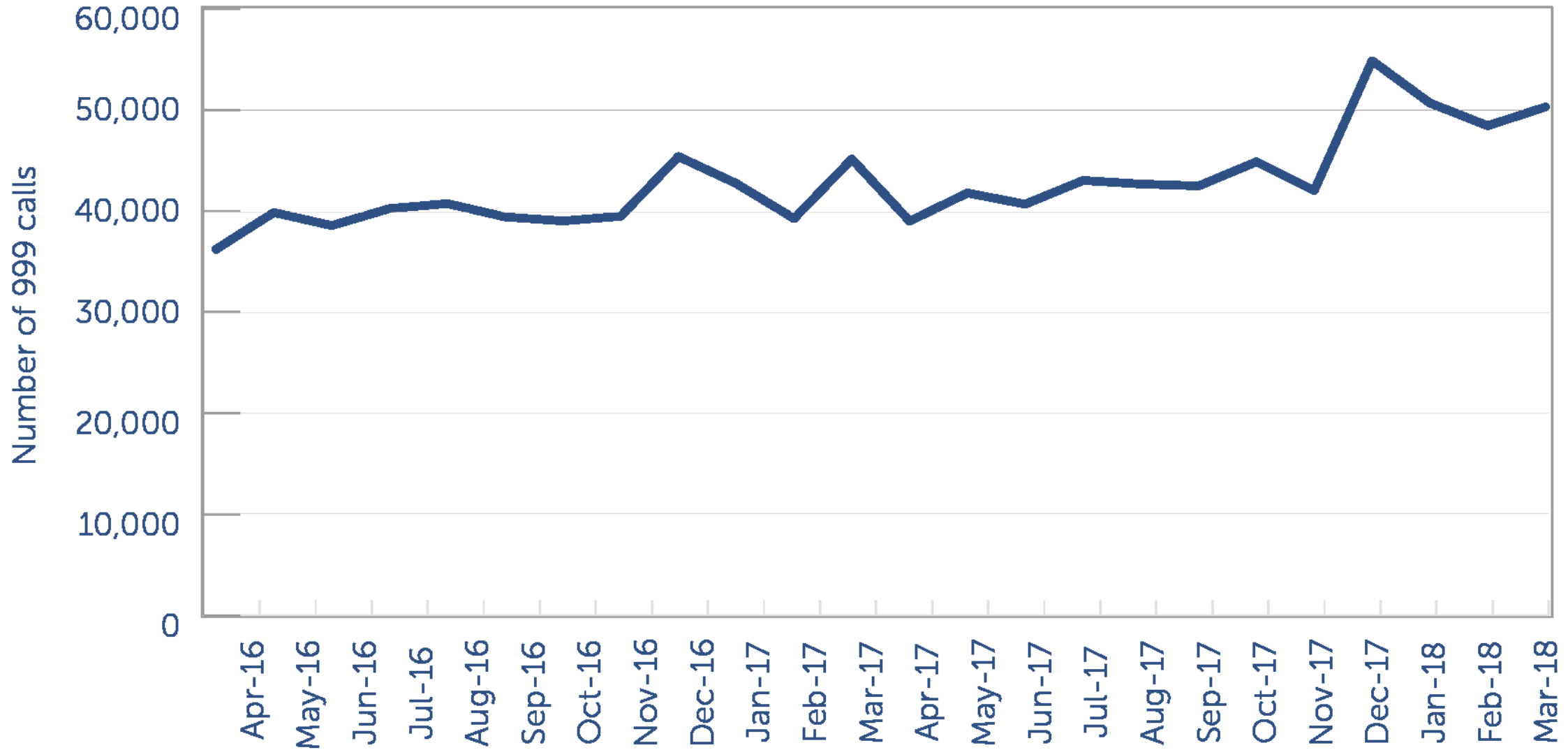
# Exploring Amber





EXPLORING AMBER

# Calls

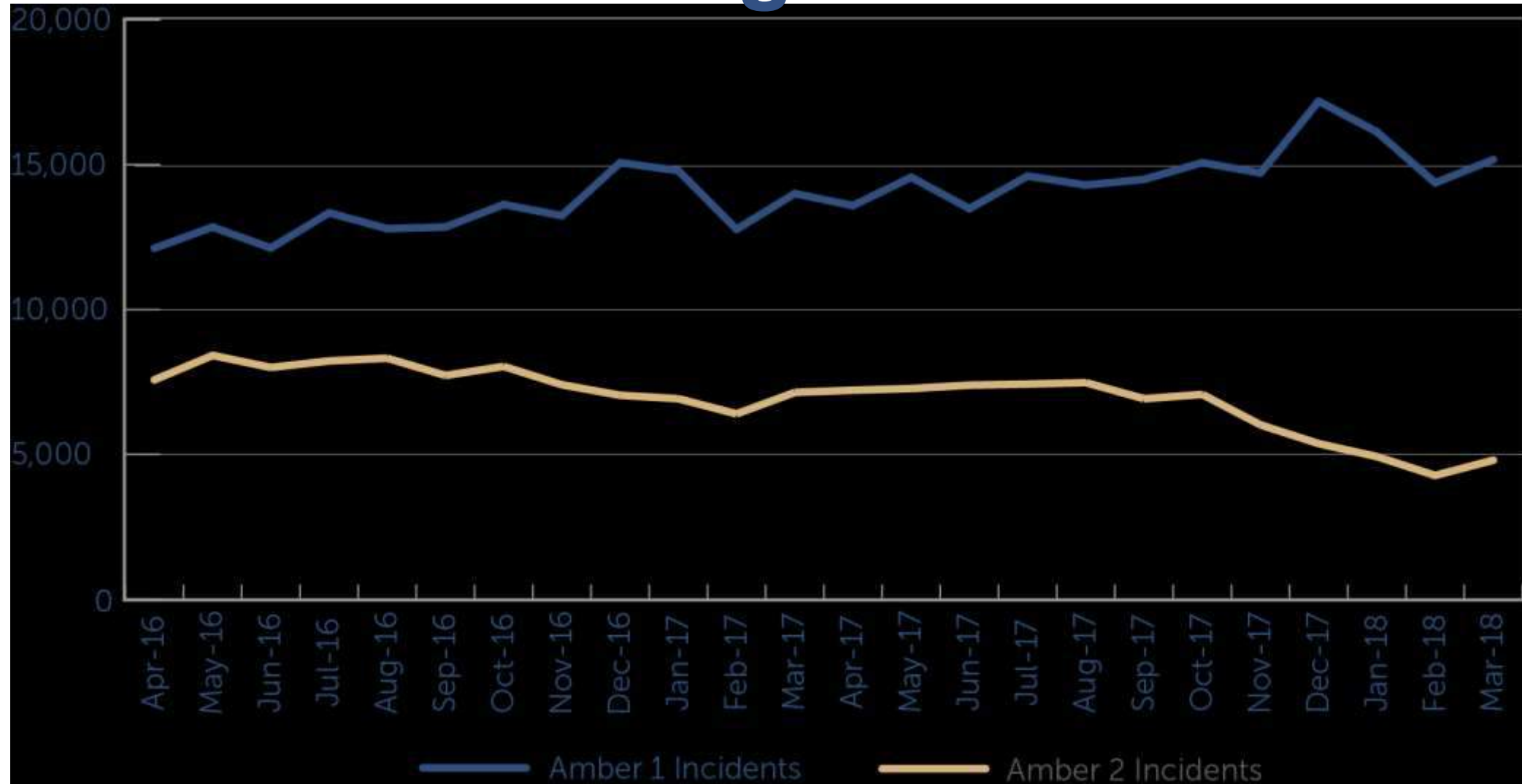


EXPLORING AMBER

# Incidents



# Ambulances being sent to Incidents

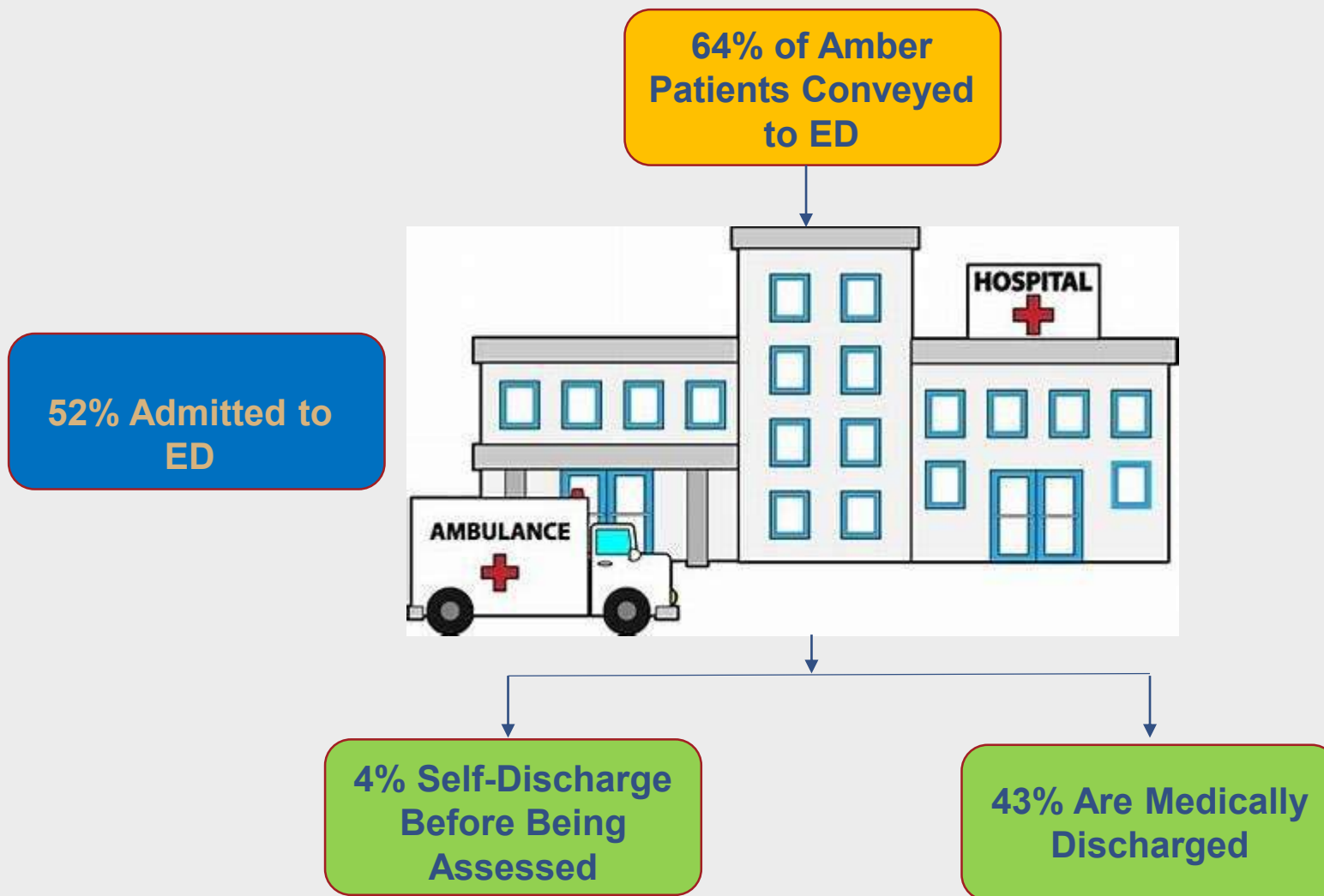




GIG  
CYMRU  
NHS  
WALES

Ymddiriedolaeth GIG  
Gwasanaethau Ambiwlans Cymru  
Welsh Ambulance Services  
NHS Trust

# Exploring Amber



EXPLORING AMBER

# Findings for Exploring Amber

- There was increased demand in the Amber category.
- Ambulance staff felt that expanding the numbers and roles of clinicians in the control room was essential.
- Receiving a quick ambulance response but ensuring this is the right response for your condition is important to the public.
- The public support ambulance services doing at much as possible to avoid the need for them to go to hospital.

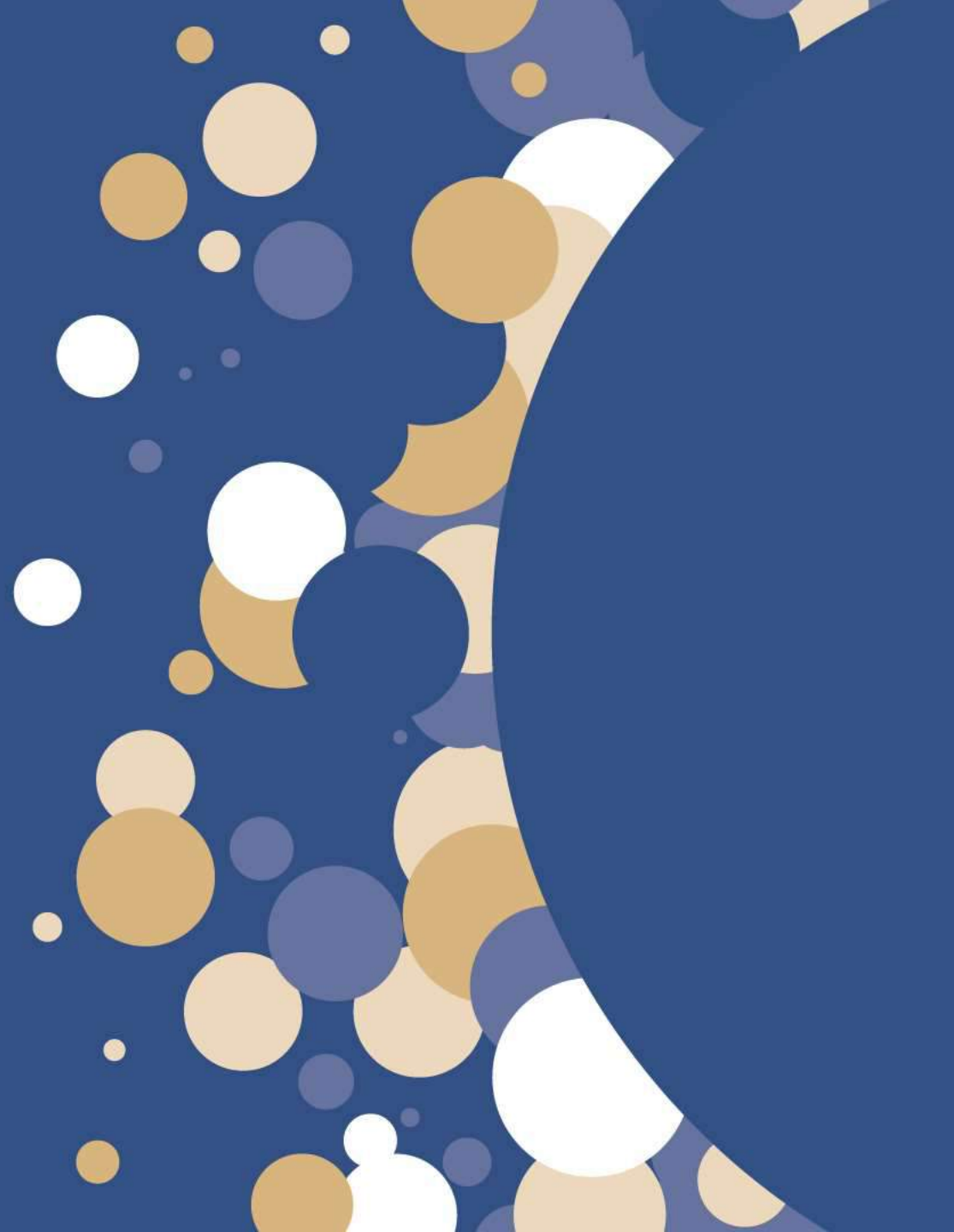
EXPLORING AMBER

# Findings for Exploring Amber

- Staff require more information on alternative services.
- Measures of quality are as important as response times.
- Measurement of the ambulance service should be refined to reflect the whole patient journey.
- Measures should be developed in partnership with patients.
- Members of the public wish to be supported and be better informed when making a 999 call.
- More patients in the Amber category are having their incident resolved or closed over the phone.

AMBER REVIEW

# Delivering Amber







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NHS  
WALES

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Gwasanaethau Ambiwylans Cymru  
Welsh Ambulance Services  
NHS Trust

# Delivering Amber

## Average Ambulance Availability in BCU:-



**28 Ambulances**

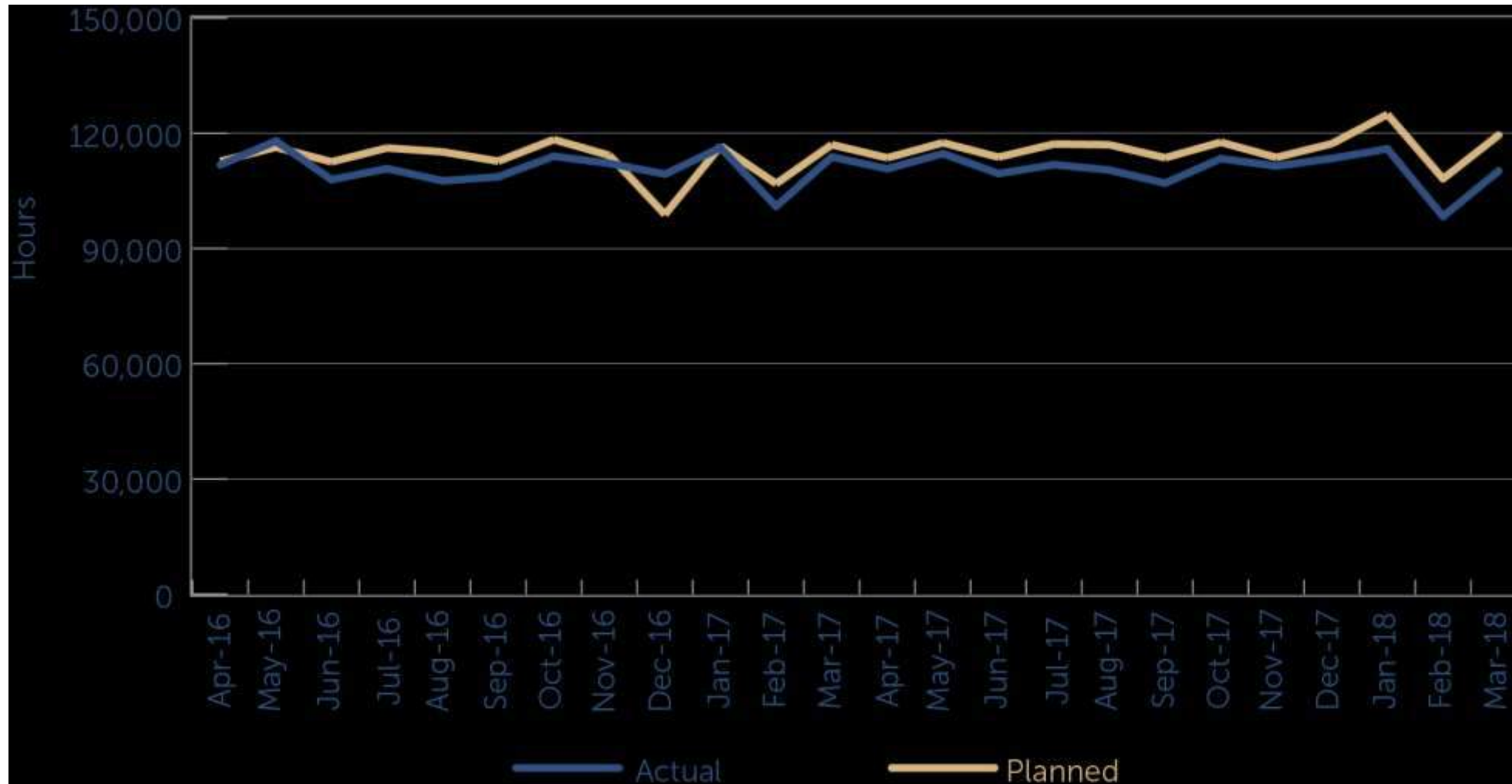


**5 Rapid Response Vehicles**

The data displayed is representative only, and based on average values over the two years of the Review.



# Having enough capacity - staff

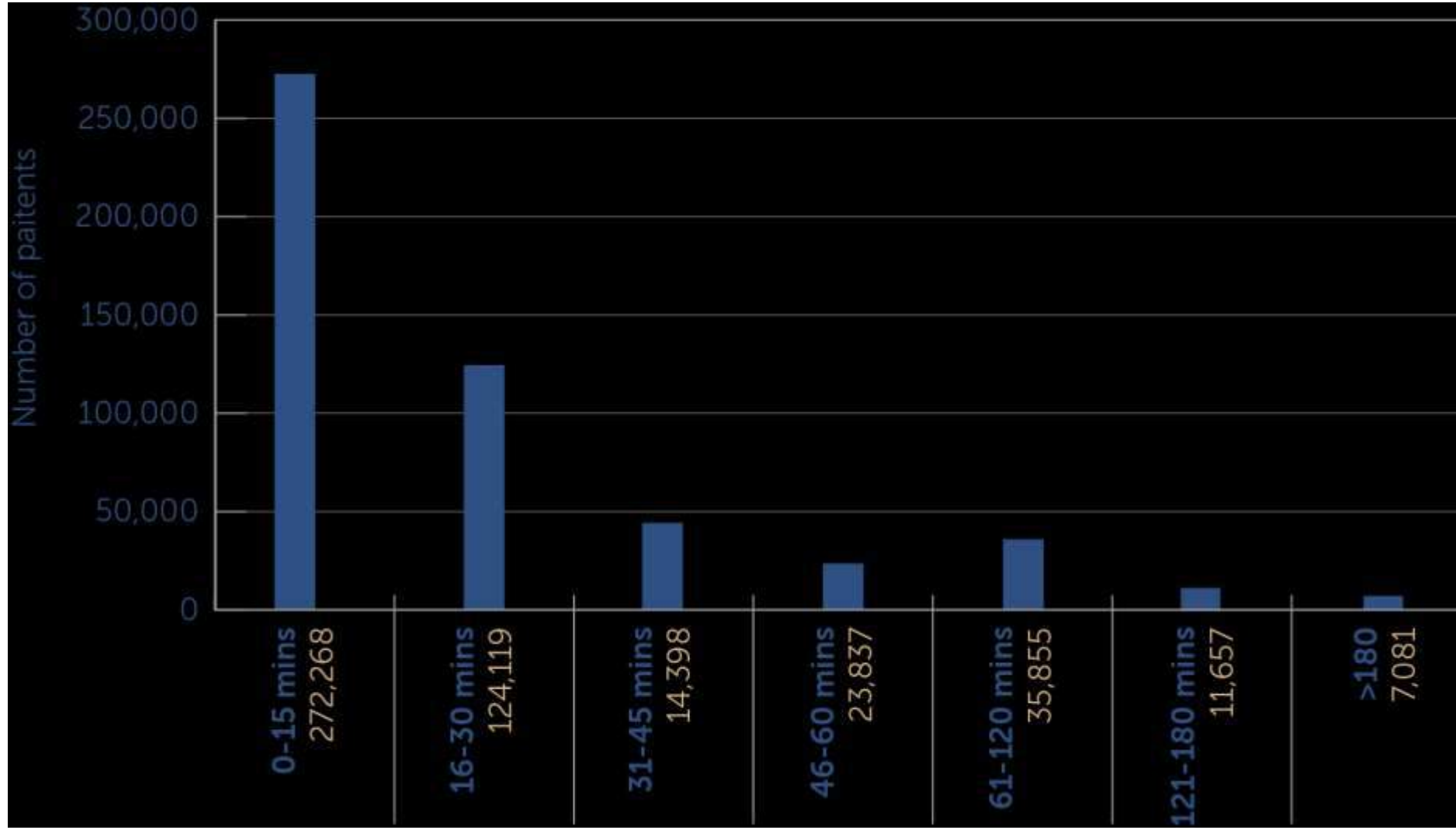


DELIVERING AMBER

# Losing capacity - sickness

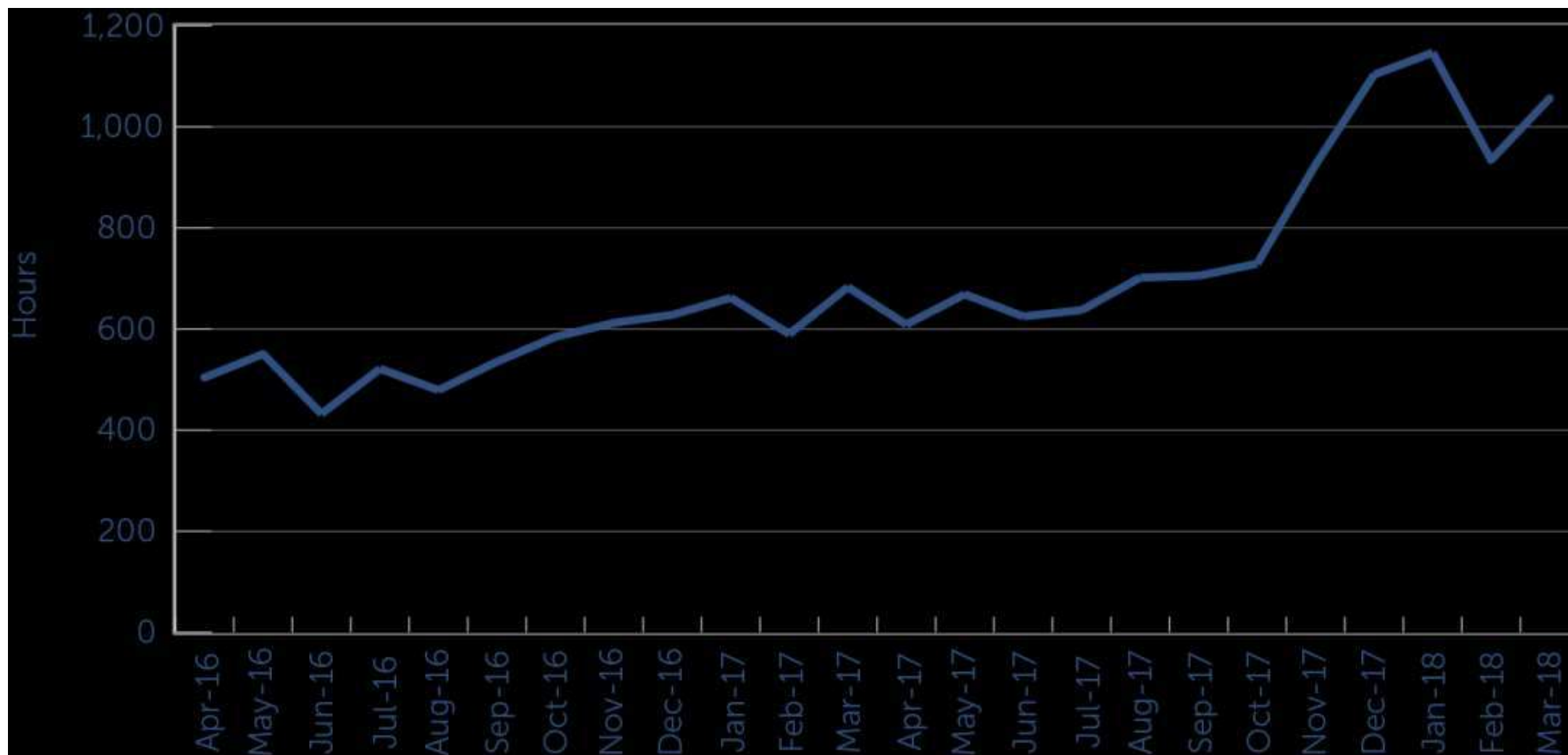


# Losing capacity - Ambulances waiting too long outside hospitals

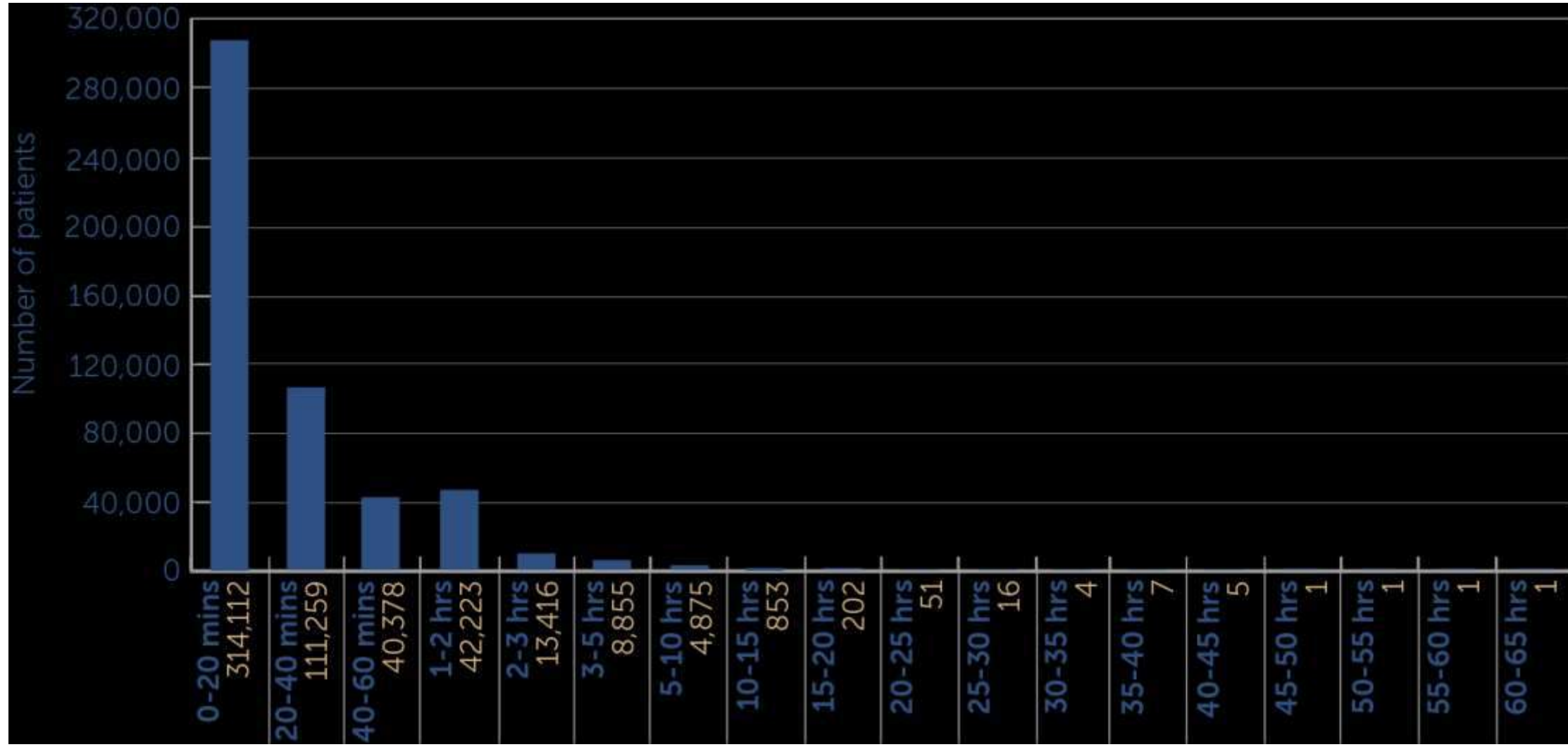


DELIVERING AMBER

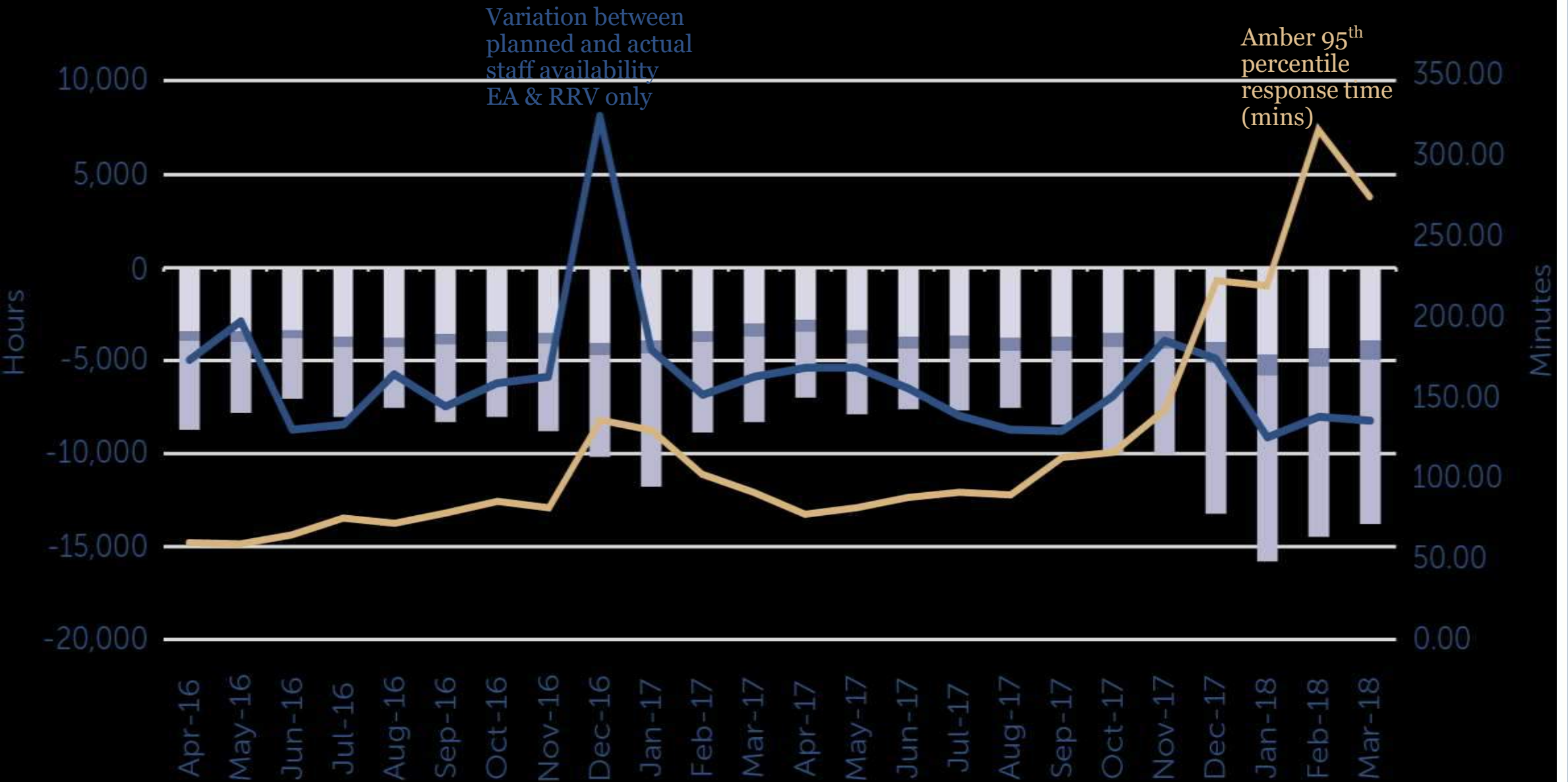
# Losing capacity - Ambulances getting ready for the next incident



# Consequence of lost capacity - waiting time for ambulances



## DELIVERING AMBER



# The integrated information environment

Clinical expertise

Welsh Ambulance  
Computer Aided  
Dispatch system

Welsh Ambulance  
patient clinical  
record

Emergency  
department  
data

Hospital  
data

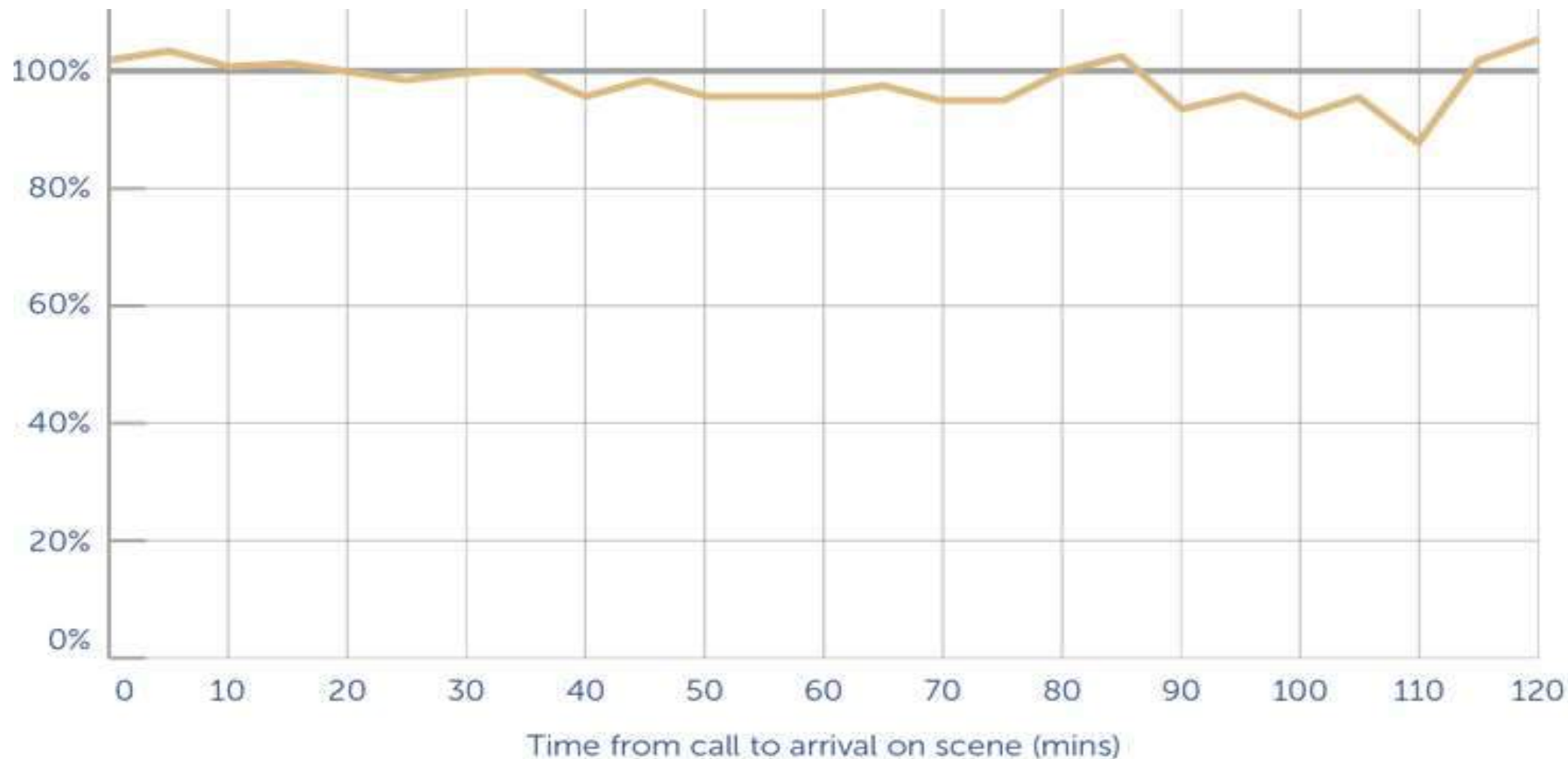
National  
statistics

Analytical expertise



## Do long waits cause harm?

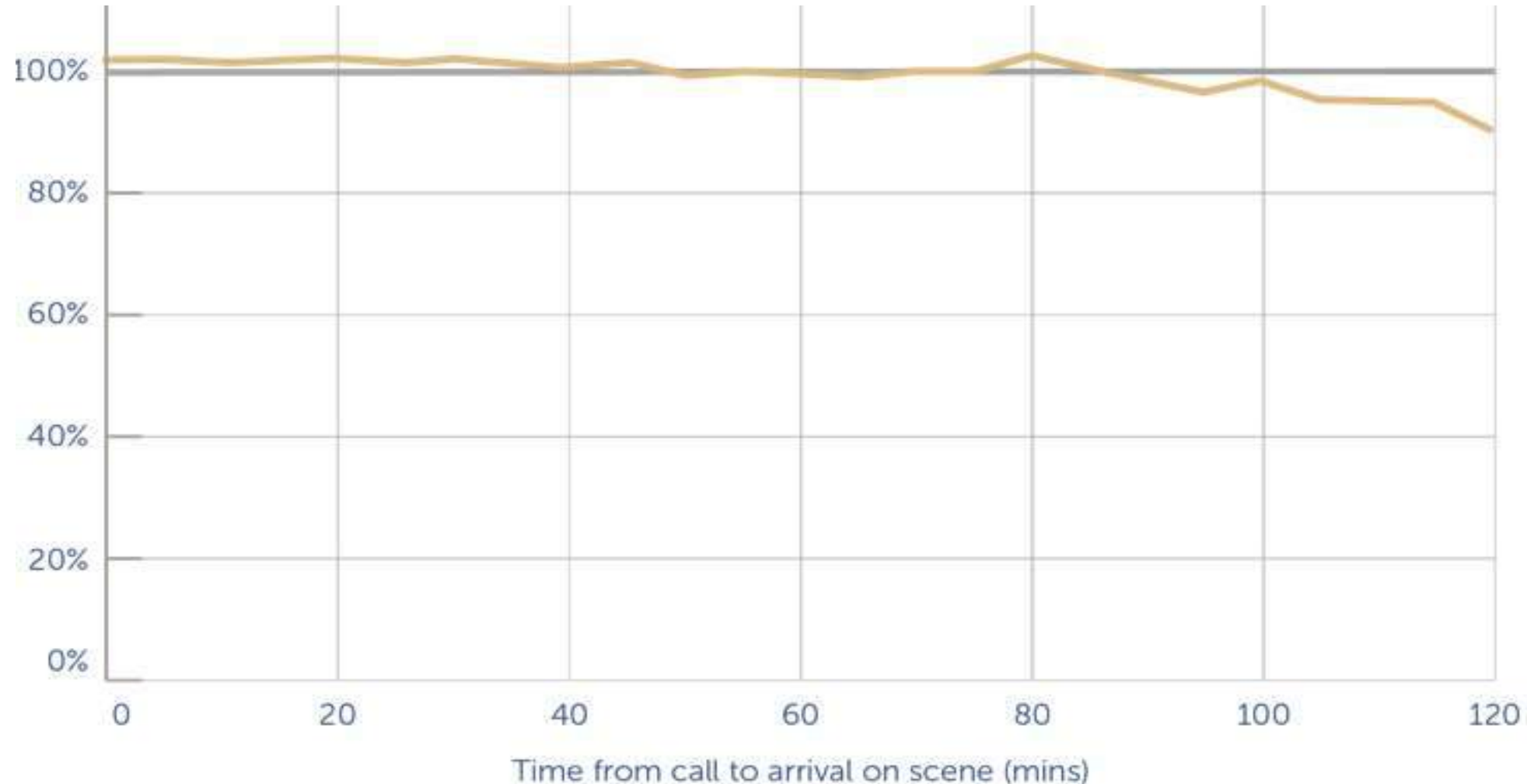
### First National Early Warning Score Ratio by Response





# Do long waits cause harm?

## Conveyance Ratio by Response time



## Do long waits for an ambulance cause harm?

INDICATOR	FINDING
First presenting National Early Warning Score Ratio	Those responded to within 20 minutes have a higher National Early Warning Score than those responded to after 20 minutes
Conveyance Ratio	Conveyance ratios are in line with what would have been expected
Admission Ratio	No evidence that longer response times have an effect on admission ratios
Cardiac Arrest Report Form	Those patients with an element of the Cardiac Arrest Report Form completed were attended to quicker than those without
Recognition of Life Extinct	Response times for Recognition of Life Extinct patients were not dissimilar to non-Recognition of Life Extinct patients

## Do long waits in an ambulance cause harm?

INDICATOR	FINDING
Difference between the average First and Last National Early Warning Score during hospital handover delay	On average patients' National Early Warning Score reduced during their time in the ambulance, as we may expect when being cared for by skilled ambulance staff and ED
Difference between the average First and Last Pain score during hospital handover delay	On average pain scores reduced between the first set of observations outside the hospital and the last set of observations before the handover as we may expect when being cared for by skilled ambulance and ED staff

DELIVERING AMBER

# Findings for Delivering Amber

- Funding for ambulance services has increased
- The ambulance service does not always deliver sufficient resources to meet demand
- The time ambulances are waiting outside hospitals has increased
- Sickness levels remain high
- Emotional and psychological wellbeing of staff is important
- Call handlers should be supported, especially during periods of increased activity

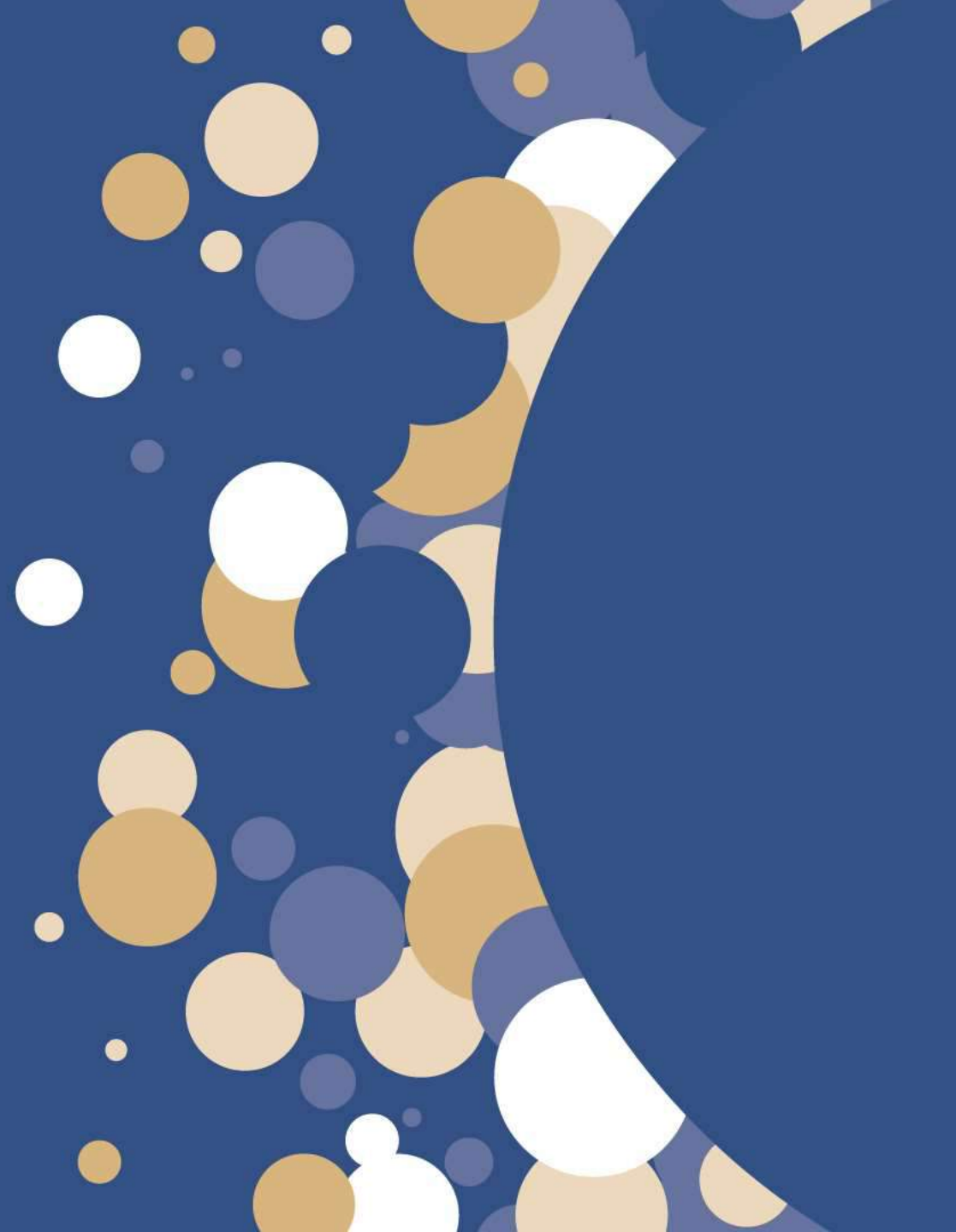
# Findings for Delivering Amber

- Resource availability is the foremost factor in providing an appropriate response
- A lack of resource availability can result in longer waits for some patients
- There has been an increase in the number of Serious Adverse Incidents reported
- The clinical response model is a valid and safe way of delivering ambulance services
- Members of the public support the principles of the clinical model
- The length of time you wait for an ambulance response in the Amber category, does not appear to correlate with worse outcomes

AMBER REVIEW

# Improving Amber

This section considers the findings of the Amber Review and highlights opportunities for improvement.





# Recommendations

- Measures of quality and response time should continue to be published although they need to reflect the patient's whole episode of care
- Measures should be developed in collaboration with patients
- There should be a programme of engagement to ensure clarity on the role of emergency ambulance services and how calls are prioritised and categorised
- NHS services in Wales must improve and simplify their offering of alternative services
- There must be sufficient numbers of clinicians in the contact centres to ensure patients receive the most appropriate level of care

# Recommendations

- The ambulance service must ensure that planned resources are sufficient to meet expected demand
- The ambulance service must deliver against its planned resource
- Health Boards must take appropriate actions to ensure that lost hours for ambulances outside hospitals reduce
- The longest waits for patients in the community must be reduced



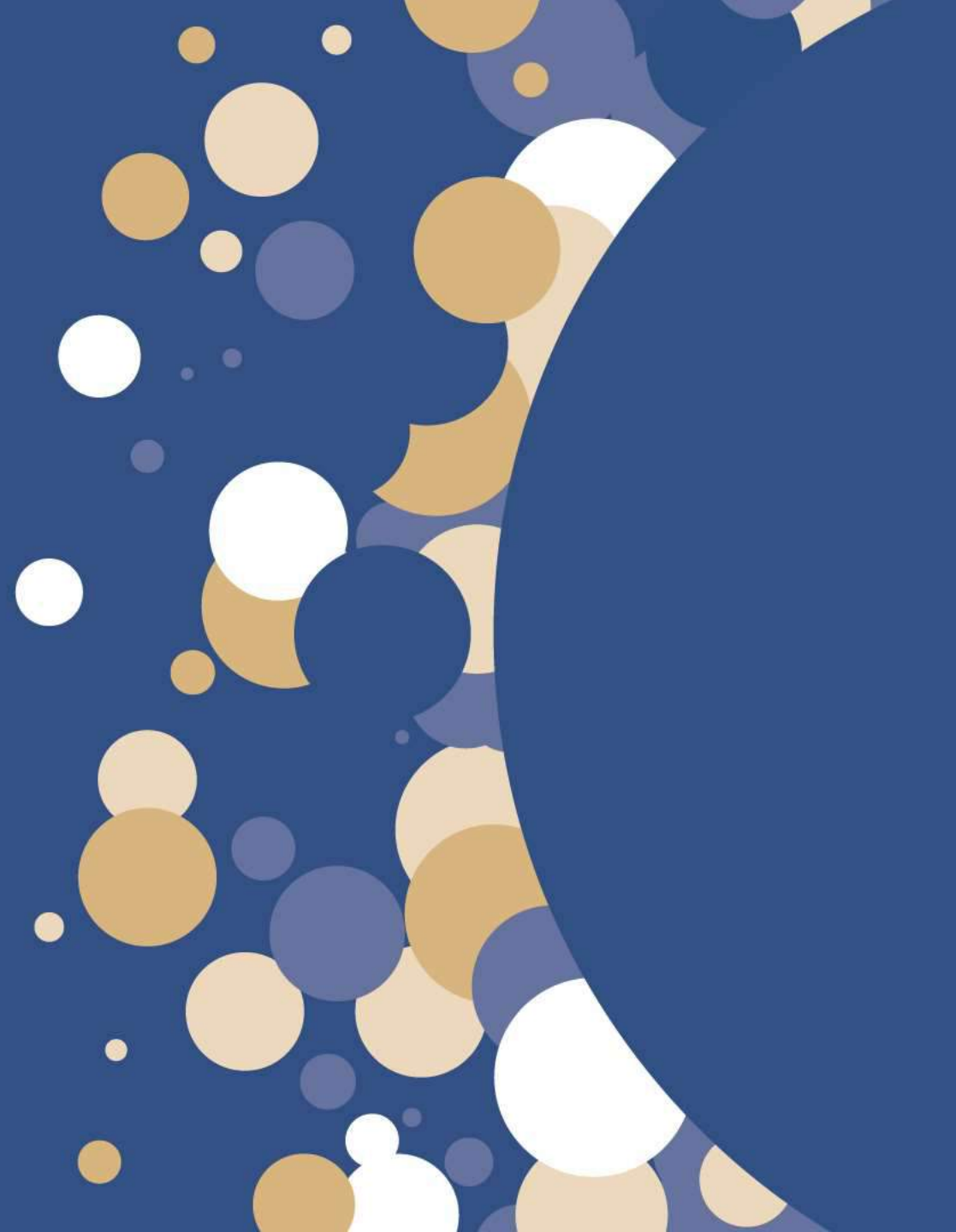


AMBER REVIEW

# Thank you

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# Further work

- Understand the change in activity and explore opportunities for improvement in: - number of calls - patient cancellations - re-categorisation - refusals of treatment and transportation
- The role of the clinical support desk within the wider unscheduled care system should be reviewed
- A review should be undertaken by the Chief Ambulance Services Commissioner to support the Welsh Ambulance Service to maximise front line staff availability

# Further work

- There should be a review of the Serious Adverse Incidents reported and Regulation 28 notices received over the most recent winter to ensure lessons are learnt and shared
- A review should be undertaken by the Chief Ambulance Services Commissioner to support Health Boards to minimise lost hours to handover delay
- The Chief Ambulance Services Commissioner will develop and implement a long wait reduction programme





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Pwyllgor Gwasanaethau  
Ambiwlans Brys  
Emergency Ambulance  
Services Committee

# Amber Review

A REVIEW OF CALLS TO THE WELSH AMBULANCE SERVICE  
CATEGORISED AS AMBER

---

SHANE MILLS & ROSS WHITEHEAD • OCTOBER 2018

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**Members of the Expert Reference Group**

**NHS Wales Informatics Service**

**Welsh Ambulance Service NHS Trust**

**National Collaborative Commissioning Unit**





THE AMBER REVIEW HAS BEEN COMMISSIONED BY MR STEPHEN HARRHY,  
CHIEF AMBULANCE SERVICES COMMISSIONER AND DIRECTOR  
OF THE UNSCHEDULED CARE PROGRAMME FOR NHS WALES



## Foreword

I am pleased to present this report as the culmination of a rapid and extensive review of the Amber response category. The ambulance service in Wales is a highly visible part of the NHS landscape and the move away from time based targets to focus on quality of care was an historic shift in ambulance service measurement. This shift has undoubtedly resulted in some questions being raised about the impact of these changes on the quality and safety of care that is delivered to the citizens of Wales.

As a result of this and as part of the recommendations of an independent review, the Emergency Ambulance Services Committee and I were committed to undertaking a clinically led review of the Amber category.

The Review is broad and covers every aspect of the ambulance service response to Amber patients and has identified a number of findings and recommendations that can be incorporated into the commissioning plan as we continue to develop and improve ambulance service delivery in Wales.

The Review provides me with assurance that ambulance services in Wales are getting to the sickest patients first and therefore I see no reason to recommenced wholesale changes to the Clinical Response Model.

In this review we have been presented with information which follows a patient's journey from their call to the ambulance service to their discharge from hospital. I am assured from this information that the majority of patient outcomes are not affected by ambulance response times. This is not to say that a small number have been affected or had poor experiences and I am determined to address these.

As both the Chief Ambulance Services Commissioner and the Director of the Unscheduled Care Programme I am pleased that the findings of the review support the direction of travel in NHS Wales to focus on whole system measurement and quality.

There are opportunities for health services, staff and the public to work together to ensure we have an ambulance service that is used and delivered effectively.

I would like to take this opportunity to thank Shane, Ross, other members of the review team and contributors to this Review. Without the support and dedication of each individual and organisation we would have been unable to deliver such a comprehensive review in such a short space of time.

*Stephen Harrhy*

---

## Executive summary

This report sets out the findings from the Amber Review launched in May 2018. There are two main areas that are addressed in the Review, based on the issues raised by the health service, the public, media and other stakeholders.

Firstly, is there a systemic problem with the Amber category that is resulting in worsening outcomes for patients. Secondly, are those patients, whose condition places them within the in the Amber category waiting too long for an ambulance response and if so what is the impact on their health and experience.

Qualitative and quantitative methodologies were used in this Review in order to deliver the depth and breadth of understanding needed to address these areas. The timespan of the Review was 1 April 2016 – 31 March 2018 in order to ensure access to all the relevant information.

The Review is set out in four sections, Explaining, Exploring, Delivering and Improving Amber. These sections aim to provide a comprehensive

narrative to address the two main areas. Staff and patient feedback is embedded within each section.

The Welsh Ambulance Service is an essential component for delivering care in a complex adaptive system. Models, measurement and targets for Ambulance service delivery across the UK are becoming increasingly disparate, although there is a general trend towards reducing the emphasis on response targets as the primary outcome measure.

When asked, ambulance staff and the public support the principle of the Welsh model ‘to get the best response even if this is not the quickest response’.

Calls to the Welsh Ambulance Service are increasing and more work needs to be done to understand this. The Public support ambulance services doing as much as possible to avoid the need for them to go to hospital and staff feel they require more information on accessing alternative services.

Sickness levels remain high, reinforcing the need to ensure the emotional and physical wellbeing of staff is supported, especially call takers during periods of increased activity.

The Welsh Ambulance Service is taking less people to hospital despite an increase in calls although there is agreement that more can be done by both the service and the wider NHS.

The public agreed that the continued focus for the Welsh Ambulance Services must be quality of care. To support this the current ambulance quality indicators will be reviewed.

A pioneering way of following a patient journey from call to discharge was developed and used. This has provided assurance that the majority of patient outcomes have not been effected by ambulance response times although a small number have been effected and some patients will have had poor experiences.

The majority of patients categorised as Amber receive a prompt response and Ambulance services in Wales are getting to the sickest patients first although there are opportunities to enhance and improve the system. We found that increasing delays in ambulance response is due to the availability of resources not the clinical response model.

There is a compelling need for NHS Wales to work collaboratively and focus on providing a safe, timely and effective ambulance service.



# Summary of Findings

## Explaining Amber

- The prioritisation of calls is complex.
- There is a range of different responses depending on the patient’s condition.
- Ambulance staff felt frustrated by the restrictive nature of the prioritisation system.
- The public felt that it was important to get the best response for their condition even if this was not the quickest.

## Exploring Amber

- There was increased demand in the Amber category.
- Ambulance staff felt that expanding the numbers and roles of clinicians in the control room was essential.
- Receiving a quick ambulance response but ensuring this is the right response for your condition is important to the public.
- Further work is required to explore the relationship between cancellations and re-categorisations and ambulance response.
- Further work is required to explore the relationship between hoax calls, refusals and ambulance response.
- The Public support ambulance services doing as much as possible to avoid the need for them to go to hospital.
- Staff require more information on alternative services.
- Measures of quality is as important as response times.
- Measurement of the ambulance service should be refined to reflect the whole patient journey.

- Measures should be developed in partnership with patients.
- Members of the public wish to be supported and be better informed when making a 999 call.
- More patients in the Amber category are having their incident resolved or closed over the phone.

## Delivering Amber

- Funding for ambulance services has increased.
- The ambulance service does not always deliver sufficient resources to meet demand.
- The time ambulances are waiting outside hospitals has increased.
- Sickness levels remain high.
- Emotional and psychological wellbeing of staff is important.
- Call handlers should be supported, especially during periods of increased activity.
- Resource availability is the foremost factor in providing an appropriate response.
- A lack of resource availability can result in longer waits for some patients.
- There has been an increase in the number of Serious Adverse Incidents reported.
- The clinical response model is a valid and safe way of delivering ambulance services.
- Members of the public support the principles of the clinical model.
- The length of time you wait for an ambulance response in the Amber category, does not appear to correlate with worse outcomes.
- There are further opportunities to use the Integrated Information Environment.

# Summary of Recommendations

- Measures of quality and response time should continue to be published although they need to reflect the patient’s whole episode of care.
- Measures should be developed in collaboration with patients.
- There should be a programme of engagement to ensure clarity on the role of emergency ambulance services and how calls are prioritised and categorised.
- There must be sufficient numbers of clinicians in the contact centres to ensure patients receive the most appropriate level of care.
- The ambulance service must ensure that planned resources are sufficient to meet expected demand.
- The ambulance service must deliver against its planned resource.
- Health Boards must take appropriate actions to ensure that lost hours for ambulances outside hospitals reduce.
- The longest waits for patients in the community must reduce.





# Summary of Further work

- Understand the change in activity and explore opportunities for improvement in:
  - number of calls
  - patient cancellations
  - re-categorisation
  - refusals of treatment and transportation
- The role of the clinical support desk within the wider unscheduled care system should be reviewed.
- Health boards and the Welsh Ambulance Service should work together to ensure the current alternative services to hospital admission are being effectively used.
- A review should be undertaken by the Chief Ambulance Services Commissioner to support the Welsh Ambulance Service to maximise front line staff availability.
- A review should be undertaken by the Chief Ambulance Services Commissioner to support Health Boards to minimise lost hours to handover delay.
- The Chief Ambulance Services Commissioner will develop and implement a long wait reduction programme.
- There should be a review of the Serious Adverse Incidents reported and Regulation 28 notices received over the most recent winter to ensure lessons are learnt and shared.
- The Integrated Information Environment should be used to identify opportunities for improvement within the unscheduled care services.

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THE AMBER REVIEW – OCTOBER 2018

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## NOTE

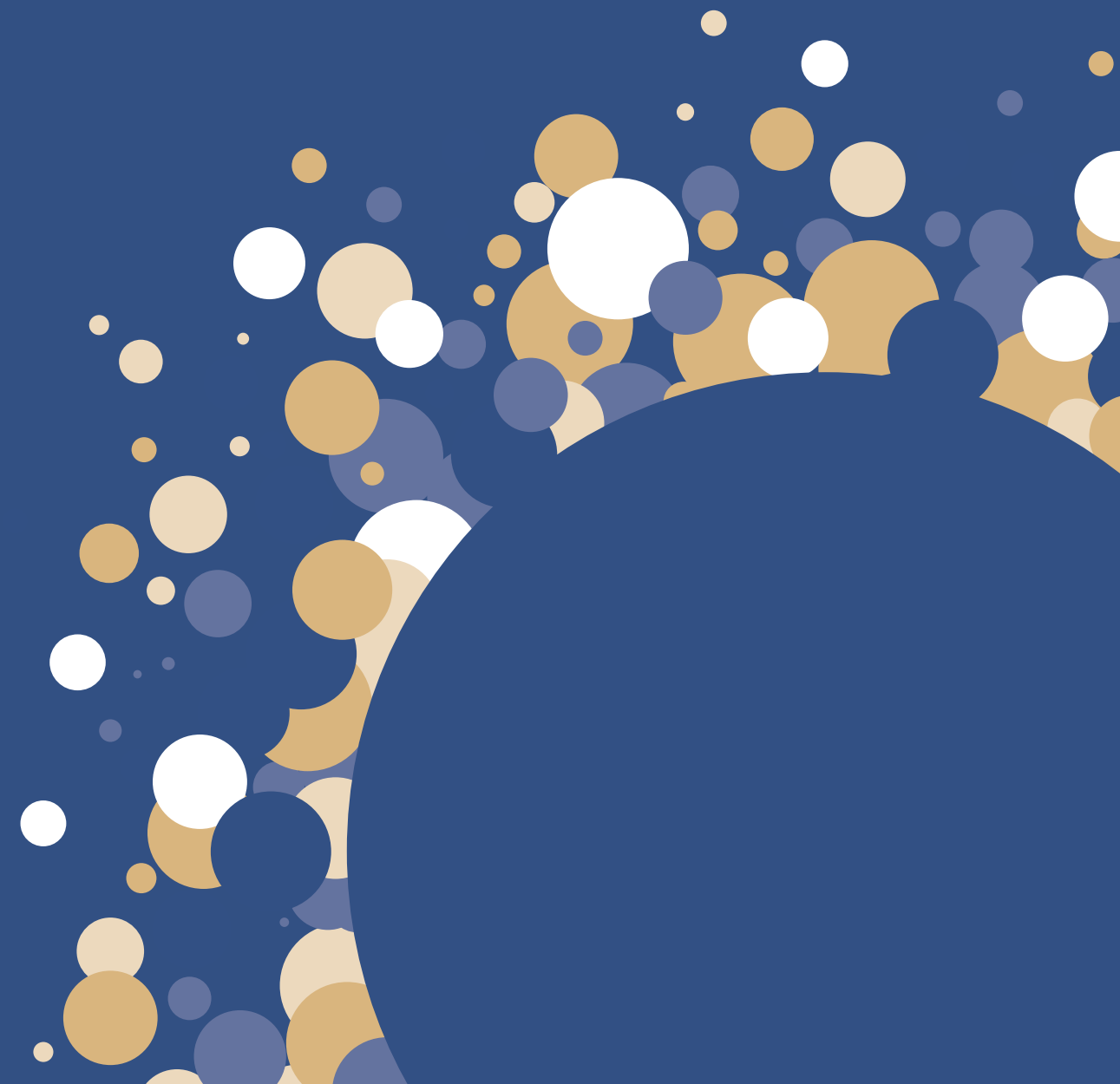
Please note that through this report we make reference to the opinions or reflections of ambulance operational staff or managers. These statements have been taken as part of focus groups (total 20 staff) or during individual interviews with 5 operational managers and whilst those opinions or reflections may be valid for those individuals or groups, they are not necessarily representative of the whole Welsh Ambulance Service workforce. These staff are referred to as operational managers or operational staff within the report.

Also note that any reference to 'the public' or 'public opinion' in this report, unless otherwise stated, are from YouGov Plc. Total sample size was 1000 Welsh adults. Fieldwork was undertaken between 31st August - 3rd September 2018. The survey was carried out online. The figures have been weighted and are representative of all Welsh adults (aged 18+).

There is a significant amount of data and information regarding emergency ambulances services currently available and whilst every effort has been made to validate all the data and information within this Report and align it to publicly available data there is the possibility of discrepancy.

# Preface

**In this section we explain the background to the Amber Review and the structure, methodology and limitations of this report.**



## 1 Background

The emergency ambulance services in Wales are operated by the Welsh Ambulance Services NHS Trust which is commissioned, on a collaborative basis, by the seven health boards through the Emergency Ambulance Services Committee and the Chief Ambulance Services Commissioner who acts on the Committees behalf. Commissioning in this context means the needs of the citizens of Wales are identified and the ambulance services planned and secured to meet those needs.<sup>1</sup>

Every time a call is made to the official emergency 999 telephone line, the staff in one of Wales’s three ambulance clinical contact centres use information about the nature of the patient’s illness or injury to ensure they are provided with the right assistance. Contact centre staff are supported to gather this information through sophisticated software and a coding system which helps them to send an emergency ambulance, when needed, to the most urgent cases first. Since October 2015, in order to identify which cases are the most urgent, each call is placed in one of three categories. There categories are ‘Red’ (immediately life-threatening), ‘Amber’ (serious but not immediately life-threatening) or ‘Green’ (not serious or life-threatening). This way of categorising calls and sending the right medical help is termed as the ‘clinical response model’.

An independent review<sup>2</sup> undertaken in 2017 supported the introduction of the new clinical response model and found it was delivering benefits for ambulance service patients. The review made a number of recommendations for further improvement to the model, including:

*“Review the call categories outside Red, in particular the Amber category. There is concern that this group is too large and not sufficiently discriminatory in terms of prioritising patients with high acuity illness, and that for some calls this is resulting in unacceptably long waits.”*

The significant interest across the political and public spectrum in the quality and safety of the ambulance response, particularly for patients whose condition places them within the ‘Amber’ category has been recognised by Emergency Ambulance Services Committee and the Chief Ambulance Services Commissioner. The commitment to undertake a review was included in the Committees 2018/19 ‘Integrated Medium Term Plan’.<sup>3</sup>

The Welsh Government and the Cabinet Secretary for Health and Social Services also recognised the public interest and supported the Chief Ambulance Services Commissioner in requesting a clinically led review of the ambulance service response to patients categorised as ‘Amber’. This Report is the outcome of that review.

## 2 Structure of the Report

The Report is presented in four sections:

### Part A – Exploring Amber

In this section we explain the Welsh Ambulance Service clinical response model, how ambulance calls are prioritised and the public and staff understanding of the Amber category.

### Part B – Exploring Amber

In this section we follow the CAREMORE®<sup>4</sup> ‘five step pathway’ used by Welsh Ambulance Services, starting from a patient making a 999 call for ambulance services to being taken to hospital. It demonstrates the changes that have occurred with calls and incidents in the Amber category over time.

### Part C – Delivering Amber

This section considers how Welsh Ambulance Services are using their resources to meet the demands placed on it. It will also explore what happens when the daily demand cannot be met and some patients end up waiting a long time for an ambulance and what effect that may have on their health and experience.

### Part D – Improving Amber

This section considers the findings of the Amber Review and highlights opportunities for improvement.

The full terms of Reference for the Amber Review are available in **Appendix I**.

Any discussion on ambulance services inevitably involves specialist terms, explanations, charts and statistics. We did not want to interrupt the flow of the report with exhaustive or technical explanations or to overwhelm the reader with detailed analysis, tables or charts. Therefore the main body of the Report is written, wherever possible, in non-technical language. The Technical Appendices expands on specific elements from the main body, providing supplementary detail and/or supporting data. Any cross reference from the main body of the Amber Review to the Technical Appendices is denoted by a small ‘●’ just above the line of text with an accompanying technical appendix section, for example: **02**

### 3 Limitations of the Amber Review

The Amber Review has been concluded within 6 months and we have attempted to engage with a representative range of stakeholders. We recognise that there is a need for wider engagement and a broader range of stakeholders will be included in the further work recommended by this Report.

The time period granted for the Amber Review has defined the depth and breadth of research and analysis. We have received assurance from members of the Expert Reference Group that the research underpinning the Review is of a high level and sufficient for the purposes of the production of this report.

There is a significant amount of data and information regarding emergency ambulances services currently available in the public domain and whilst every effort has been made to validate all the data and information within this Report and align it with that which is publicly available, there is the possibility of discrepancy.

Although both of the authors are employed by NHS Wales they have endeavoured to be as objective as possible whilst undertaking the Review.

### 4 Methodology

We have delivered a Report underpinned by a robust evidence base supported by staff experiences and patient opinions. We have used public information sources, supplemented by specific requested information from Welsh Ambulance Services to analyse and appraise the activity and operations of the Service over the last two years.

We established an Integrated Information Environment <sup>01</sup> for the Review to enable data across the emergency care journey to be expertly analysed alongside clinical inquiry and discussion. We agreed on a two year time period to enable longitudinal and seasonal comparisons, agreeing on 1st April 2016 to 31st March 2018 to utilise the most recent validated information.

To assist us in developing the Amber Review methodology and validating the findings, we convened an Expert Reference Group consisting

of a range of individuals with expertise and experience in academic research, operational management, unscheduled care and emergency ambulance services. The Expert Reference Group invitees are listed in **Appendix III**.

We commissioned the Picker Institute to support us to collect Welsh Ambulance staff views through one to one interviews and focus groups and public opinion through an online survey.

We have provided summarised findings throughout this Report and delivered pragmatic, focused recommendations for future areas of health service delivery, health policy and academic enquiry.

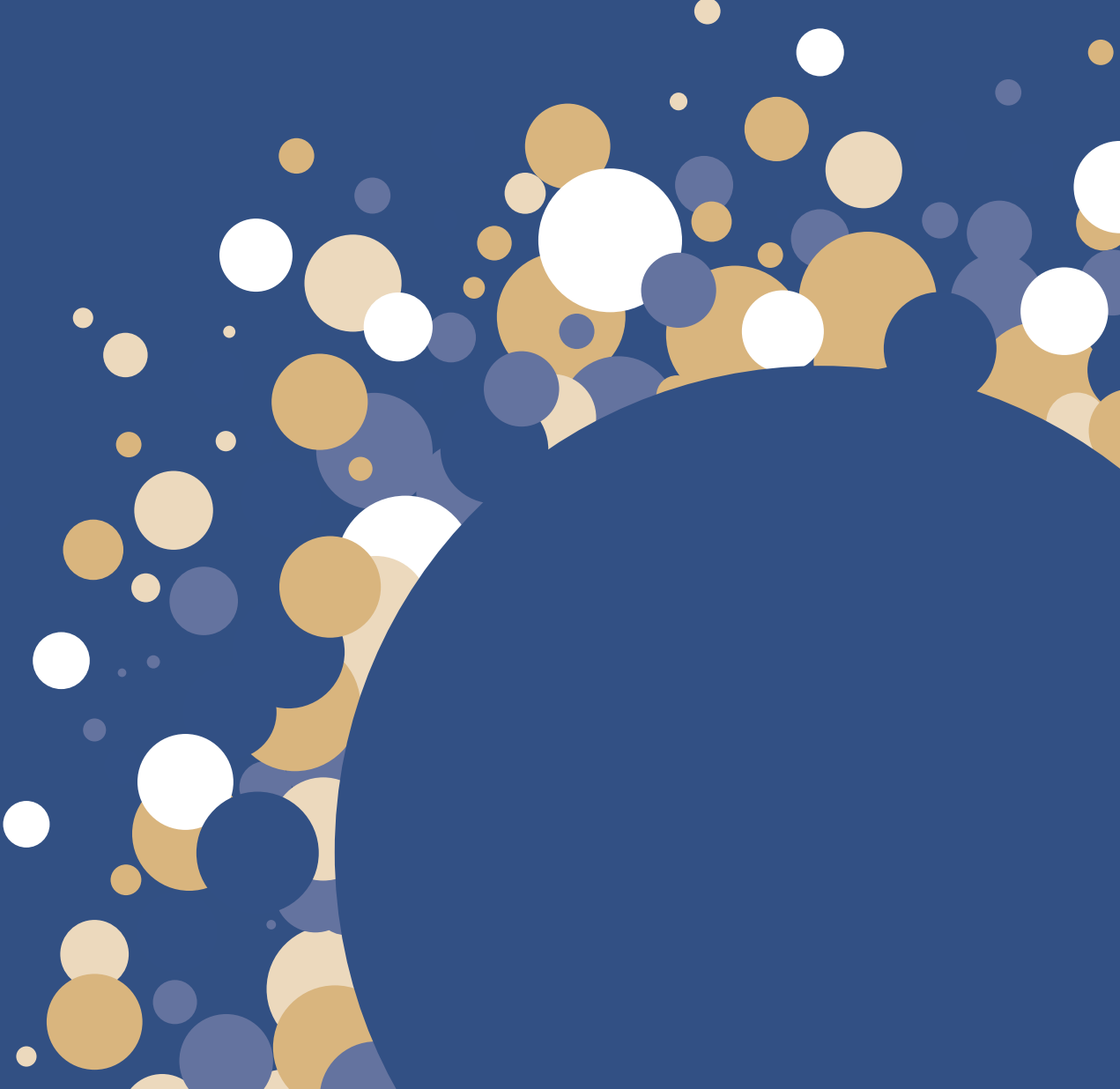
The methodology for each element of the Review is shown in **Appendix II**. ●



PART A

# Explaining Amber

In this section we explain what the Welsh Ambulance Service clinical response model is in Wales, how ambulance calls are prioritised and the public and staff understanding of the Amber category.



## 5 The Clinical Response Model for Ambulance Services in Wales

In 2001, after a comprehensive UK wide review,<sup>5</sup> ambulances services moved away from a historical system where vehicles were dispatched on a ‘first come first served’ basis to one where calls were prioritised and categorised into ‘A’ (immediately life-threatening), ‘B’ (serious but not immediately life-threatening) and ‘C’ (neither serious nor life-threatening).

Although the priority was changed, the success or failure of the ambulance services continued to be measured by the time taken for the ambulance service to reach the scene of an incident.<sup>6</sup>

In Wales the 2013 McClelland Review of Welsh Ambulance Service<sup>7</sup> recommended that the Welsh Government move from the exclusive eight minute response time target, to a more ‘intelligent’ set of indicators that put a greater emphasis on patient outcomes and experience. The McClelland review also recommended a different approach to the commissioning of ambulance services which resulted in the establishment of the Emergency Ambulance Services Committee and the appointment of a Chief Ambulance Services Commissioner. <sup>02</sup>

Following the McClelland Review and after due consideration, the Welsh Government <sup>8</sup> in 2015 approved of a new approach for measuring the response to 999 calls.

This new approach, termed the ‘clinical response model’ moved away from categorising calls by ‘A’, ‘B’ and ‘C’ and introduced three new categories:<sup>9</sup>

● **Red**

The ‘Red’ category of call is for immediate life-threatening conditions where a person is in imminent danger of death.

● **Amber**

The ‘Amber’ category of call is for those patients with serious conditions that are not immediately life-threatening, but which are urgent and may need treatment and care at the scene or rapid transport to a healthcare facility.

● **Green**

The ‘Green’ category of call is for non-serious conditions which can often be managed by other health services, including healthcare advice or through self-care.



92% of responders felt that  
**“getting the best response for my condition even if this is not the quickest response”**  
was an important element of the ambulance service.

The clinical response model gave the ambulance service the ability to fully assess and prioritise patients before sending an ambulance. <sup>03</sup>

The clinical response model was evaluated in 2017 and, although there were recommendations for improvement, the evaluation found that

*“The principles used to develop clinical model...are sound”* and *“the right direction of travel.”*<sup>10</sup> <sup>04</sup>

One of the principles of the clinical response model is getting “the best response for my condition even if this is not the quickest” and during the Amber Review public survey 92% of citizens stated that this was an important element of the ambulance service.

Welsh Ambulance Services managers interviewed for the Amber Review believed that the introduction of the clinical response model prompted staff to think more about the individual patient rather than “meeting a target” and that ambulance services were now more “patient centric and quality focused”.

**[The Introduction of the clinical response model made services] “patient centric and quality focused”.**  
Operational manager

## 6 Clinical Response Models in other health systems

There is variation in how health services in different countries respond to emergency ambulances calls. Ambulance services in England have an Ambulance Response Programme which sets out national ambulance service standards. These standards are designed to improve ambulance services by ‘targeting the right resource to the right patient’. The Ambulance Response Programme has four categories: Life-threatening calls, Emergency Calls, Urgent Calls and Less Urgent Calls.<sup>11</sup>

In Scotland a new clinical response model was introduced for the Ambulance Service in November 2016. The model focuses on improving patient survival and treatment rather than measuring the time it takes to respond. The principle of the model being to ‘send the right response to meet need’. Under the model call handlers spend more time with patients to better understand their health needs and ensure they send the appropriate response for their condition. The new model has five categories: Immediately Life-threatening, Serious not Life-threatening, See, Treat and Refer, Hear, Treat and Refer and Non-Emergency.<sup>12</sup>

During the facilitated focus groups undertaken for this Review, staff stated that it didn’t really matter what “colour the call was” (with the exception of red), the issue was making sure calls were “sorted and prioritised correctly and accurately”.

**“If you’ve got a thousand calls coming in, it doesn’t matter what colour coding they are, they have to be triaged, but you’ve still got the same poorly patients, whether they are a red call or whether they are an amber call.”**

Operational Manager

Given the variation across the UK of category names, we feel that there should be consultation with the public to ensure the colour designations given to the call categories in Wales, and now used widely in the media and official publications, are the most appropriate descriptors or whether clinical categories (Immediately Life-threatening etc.) or other terms would give greater clarity to the public.



## 7 Measures and targets

The justification for using response time as a service measure is based on research on the relationship between time and clinical outcome for specific clinical conditions like cardiac arrest. For patients experiencing a cardiac arrest there is evidence of a relationship between delay in resuscitation and survival.<sup>13</sup>

A UK study of response time and outcomes in patients considered to have life-threatening emergencies found no difference in mortality rates with response time longer than 8 minutes after adjusting for a range of patient and service characteristic.<sup>14</sup> None of the available evidence demonstrates a direct relationship between ambulance response times and patient outcome in terms of mortality when it comes to other conditions, life-threatening or not.<sup>15,16,17</sup>

The value of a response time as a measure of the impact and quality of ambulance service care is therefore questionable<sup>18</sup> but, not just in the UK but internationally, the organisation and operational design of ambulance services have been dominated by the need to meet these standards. This does not mean that time is not important and the relationship between time and care has been established for a number of conditions such as acute myocardial infraction and stroke.<sup>19,20</sup> Ambulance services have a

vital role to play in the overall journey of the patient with these conditions, but it is providing treatment at scene and delivering patients to an appropriate facility that has an impact on outcome.

Ambulance services in England have three response targets for categories below ‘Red’, which are similar, but with important differences to the Welsh Ambulance Service categories of ‘Amber’ and ‘Green’.

Although some studies have shown that imposed targets can improve aspects of NHS performance,<sup>21</sup> ambulance services in Scotland have, like those in Wales, moved away from response targets. In these countries targets, for the categories outside of Red, have been replaced by the measurement of response times, outcomes, care quality and patient experience. It has been stated that if health services are preoccupied with hitting targets then the actual journey an individual patient experiences becomes secondary; performance is determined against crude indicators, not the expectations and experience of those using the service.<sup>22</sup>

As part of a study paramedics described the role of response time targets in ambulance service culture as “an obsession” and “ludicrous”. They



felt targets dominated service delivery and took priority over factors which they saw as more important such as the quality of care provided or patient outcomes.<sup>23</sup>

Using targets instead of measures has been rejected by some as they give no incentive to achieve more than the target so in fact the “minimum becomes the maximum”.<sup>24</sup>

Benchmarking, a process by which a health service can measure and compare its own processes with those of others, and ideally with

those that are leaders in a particular area, is useful in improving understanding and quality.<sup>25</sup>

We recognise the usefulness of benchmarking against other ambulance services, but believe the introduction of time based targets may create a distraction from understanding the patient’s journey from call to treatment. Later in this Report we explore how Clinical Indicators that span a patient’s whole episode of care co-developed with patient representative groups should be considered.



## 8 Prioritising calls

When you call 999 a telephone operator will ask you which emergency service you need. In a medical emergency in Wales you will be connected to the local ambulance service clinical contact centre unless all the call handlers in that centre are already busy, then calls are directed to any available 999 call handler in Wales. <sup>05</sup>

Once the call is connected to the ambulance service they are asked questions such as “is the patient breathing” to identify immediately life threatening emergencies that may require a ‘Red’ categorisation.<sup>26</sup>

After ruling out a ‘Red’ categorisation, the call handler will ask some additional questions to determine the priority for dealing with the incident and to help provide the right advice. The Welsh Ambulance Service, as with many other emergency services in the United Kingdom and across the world, use a set of “protocols”. These protocols contain key questions and instructions for the call handler to provide a standardised way of classifying the type and medical urgency of the call. The set of protocols used in Wales is called the Medical Priority Dispatch System <sup>06</sup> and is the same system used by thousands of ambulance services across the world.<sup>27</sup>

The Medical Priority Dispatch System generates a specific set of letters and numbers, called a ‘dispatch code’, that is made up of three or four pieces of information, each of which is explained below:

- 1st piece is a number that indicates the specific condition that may be present after initial questions to the caller, for example Abdominal Pain/Problems, or Animal Bites/Attacks.
- 2nd piece is either E, D, C, B, A or Ω, and indicates how many crews are needed, their “expertise” and “how rapidly they are needed” for that patient’s condition. For example ‘E’ means “closest vehicle with lifesaving equipment” and Ω means “refer to alternative care.”<sup>28</sup>
- 3rd piece is a number relating to further specific information about an individual patient’s condition, for example “not alert” or “clammy.”<sup>29</sup>
- 4th piece, only present with certain codes, provides very specific details that may be required in some situations, for example, whether it is a stabbing or shooting situation. This is important as a safe distance for knives is different than that for guns.



The Medical Priority Dispatch System has approximately 1,900 codes that can be generated in response the caller’s answers. These codes are added to and amended by the International Academy of Medical Priority Dispatch in response to the information and evidence provided to them by the services that use the system.

Of these 1,900 codes 62% fall in the Amber category. Amber 1 codes account for around 14% of the codes and covers such things as recent strokes (within 4 hours) and chest pain. Amber 2 codes account for around 48% of the codes and covers such things as falls and less-recent strokes (over 4 hours).

What this does not mean is that all the people contacting ambulance services who believe they, or someone with them, is experiencing a stroke will be prioritised in the stroke protocol or as Amber, as other symptoms such as unconsciousness may mean that the call is categorised as another condition with a higher priority code, such as Red.

The system prioritises the urgency of a call comparative to others, but does not determine what type of vehicle to send or whether to send that vehicle under blue lights. This is left to each individual ambulance service as they are configured differently and have different resources, demographics and geography.<sup>30</sup>

In Wales the group who determines how the ambulance service responds to a particular code is called the Clinical Prioritisation Assessment Software Group. This group allocates codes to one of the Red, Amber, Green classifications. It also uses sub-categories for a total of five classifications (Red, Amber 1, Amber 2, Green 2 and Green 3).<sup>31</sup>

This group also determines the best response, (called “the ideal response”) or next best response, (called “suitable response”) for each individual code. These ideal or suitable responses could be a clinical telephone assessment, rapid response vehicle, emergency ambulance or a specialist resource. It should be noted that where

an ambulance resource is available it should be dispatched without delay.

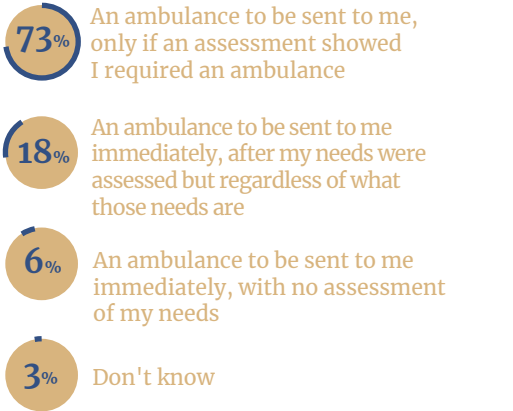
As an example – most codes related to stroke have Emergency Ambulance as the ‘ideal’ response. This is because, in order for these patients to receive the best level of care in a timely manner, they need to be transported to a hospital, therefore they need a vehicle with the capability of transport them safely.

Conversely a Rapid Response Vehicle is considered a ‘suitable’ response to stroke calls, as, although the staff member is able to assess and reassure the patient, the vehicle has very limited transportation capabilities.

Continuing to use stroke as an example: staff in the contact centre may send an emergency ambulance, as it’s the ideal response, to a call related to stroke even though a Rapid Response Vehicle, a suitable response, is closer.



Which ONE, if any, of the following would you expect to happen when contacting the emergency ambulance service via 999?



Welsh Ambulance operational staff taking part in focus groups for the Amber Review (shortened ‘operational staff’) The majority of the Welsh Ambulance operational staff agreed that the Medical Priority Dispatch System “worked well” as an initial starting point to sort calls, although some felt that the inability for call handlers to deviate from the system was “restrictive”.

The operational staff acknowledged that once the code had been generated then they had “some flexibility” to ask questions but many lacked confidence to do this and were worried about the “consequences”.

Some Welsh Ambulance Service managers felt there was a lack of public understanding of the need to prioritise resources in some way and this can “cause friction with the public”.

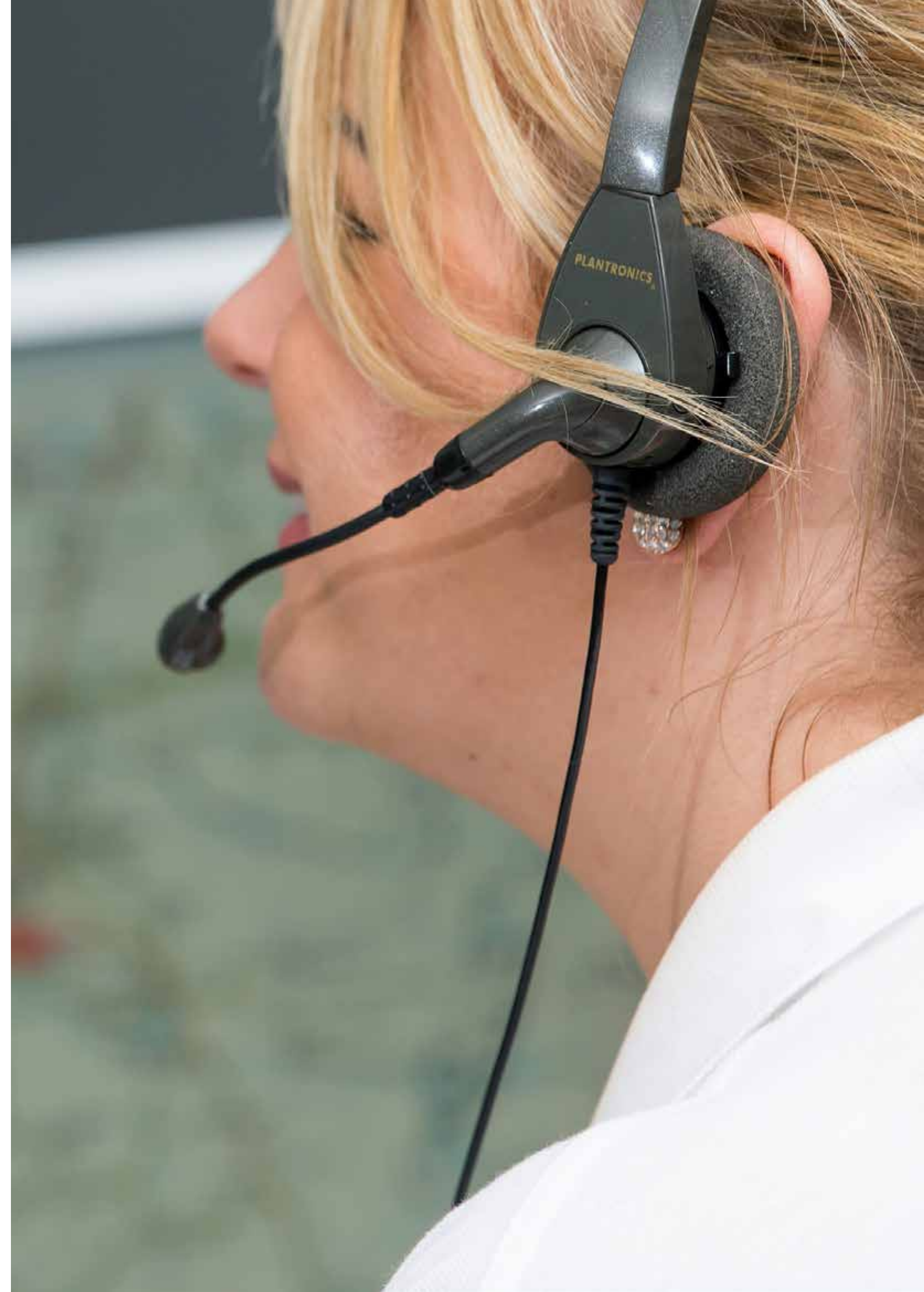
However, in contrast some operational staff felt that in general when calling 999 the public were “beginning to accept” being asked some other information and being told that the condition they are calling about “doesn’t warrant an ambulance straight away”.

The majority (73%) of the public understand that they will be assessed before an ambulance is sent. (see box) although 6% think there should be no assessment at all.

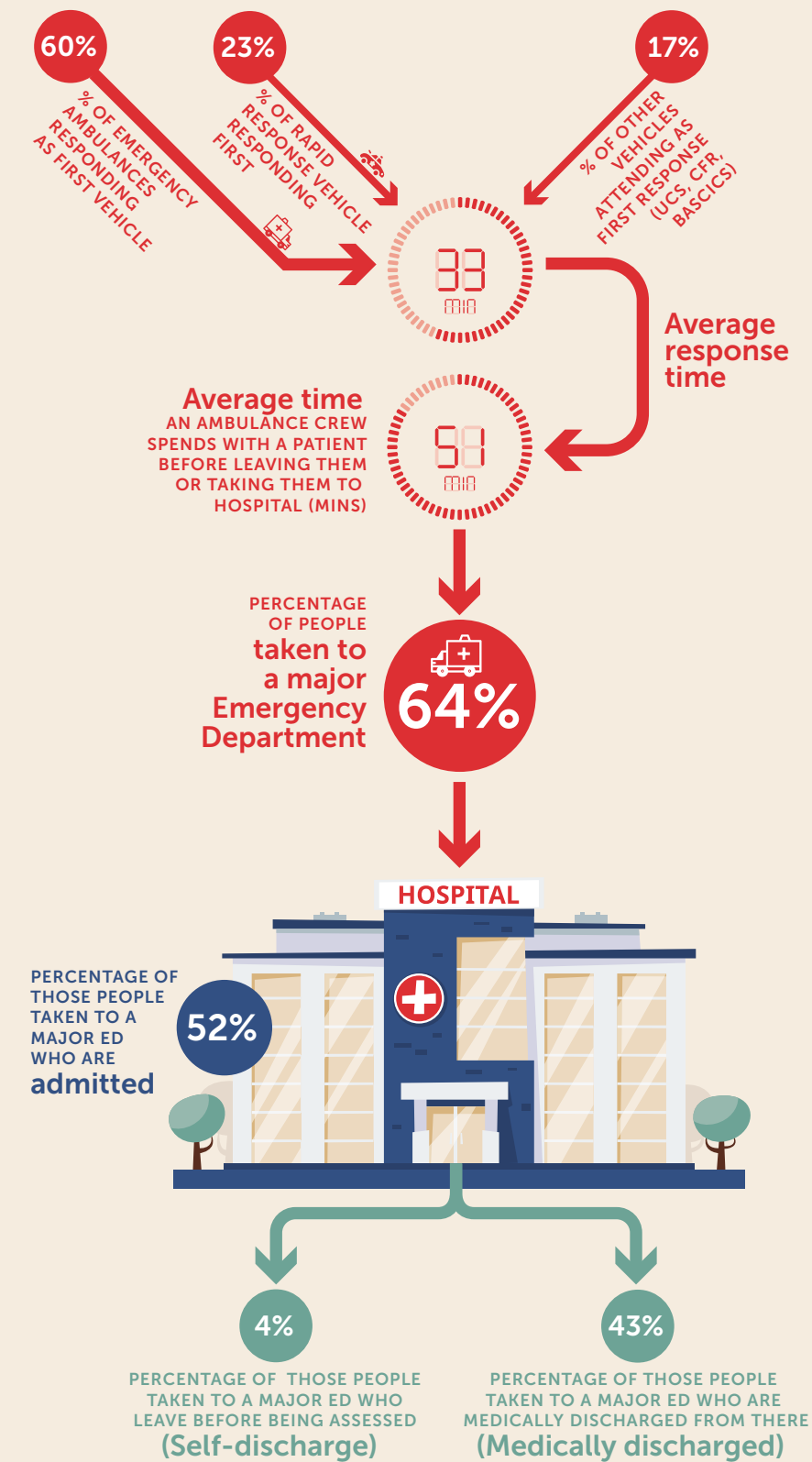
We found during the Amber Review that prioritisation of calls is complex and even where calls are in the same category, such as Amber, there is a range of different responses depending on the patient’s condition. We acknowledge the need for further public education on how calls are prioritised. ●

## 9. FINDINGS FOR EXPLAINING AMBER

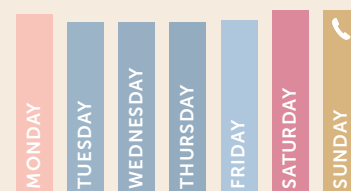
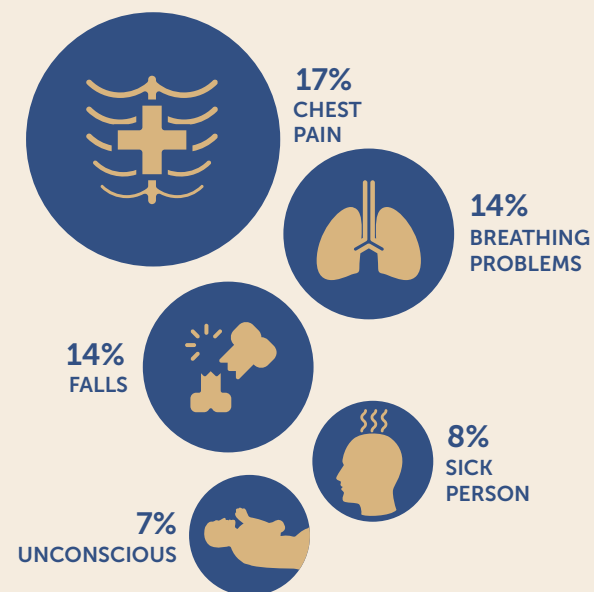
- The prioritisation of calls is complex
- There is a range of different responses depending on the patient’s condition
- Ambulance staff felt frustrated by the restrictive nature of the prioritisation system
- The public felt that it was important to get the best response for their condition even if this was not the quickest
- Restrictive nature of the prioritisation system



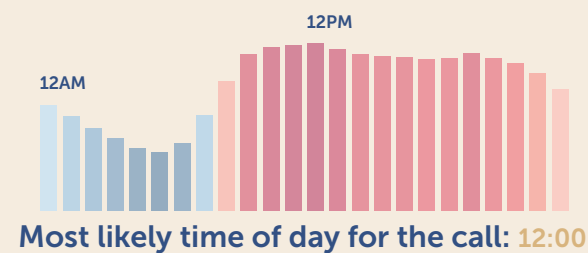
# Amber in numbers



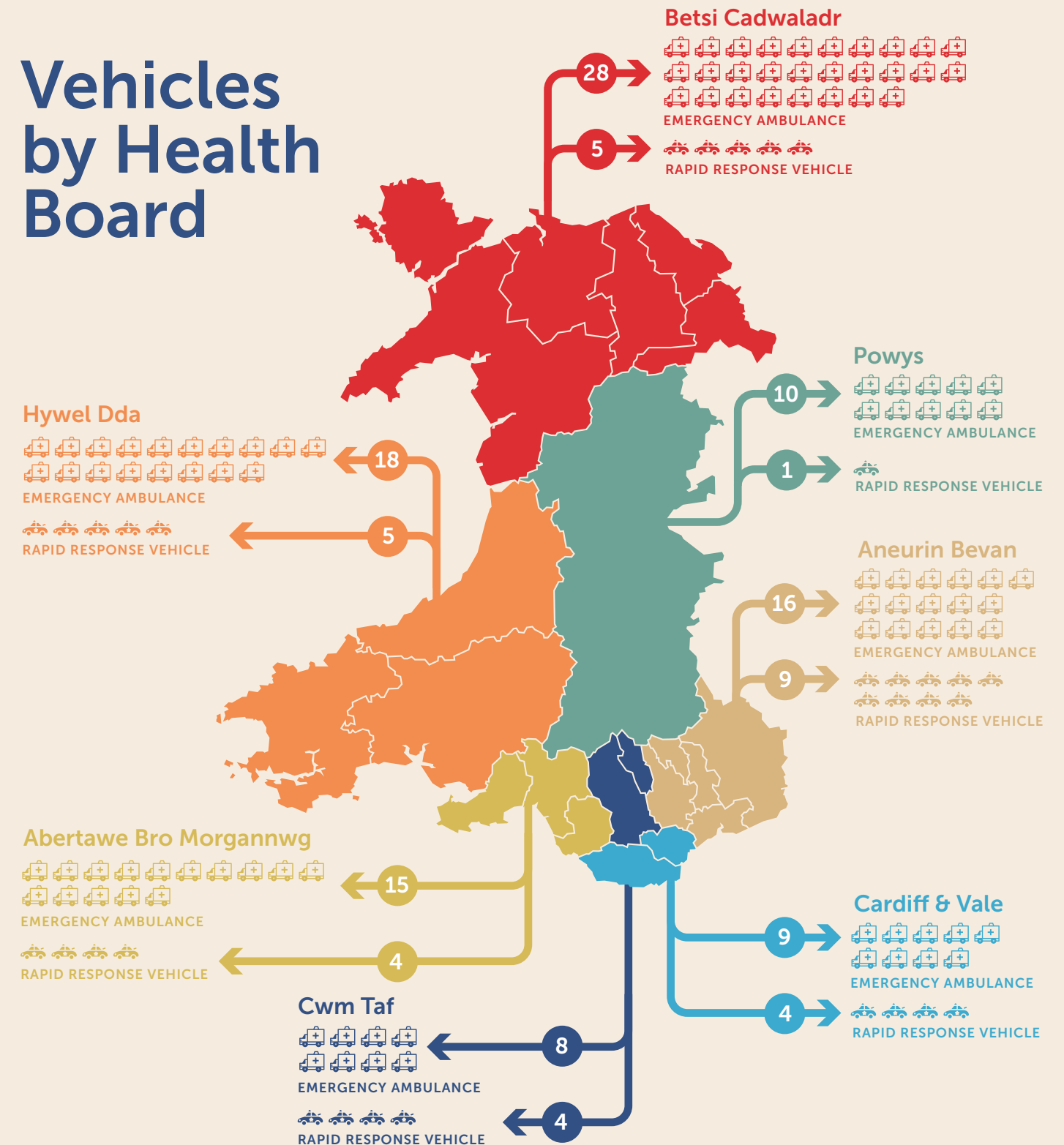
## Top 5 reasons for Amber calls



Most likely day of the week for a call: **Sunday**



## Vehicles by Health Board

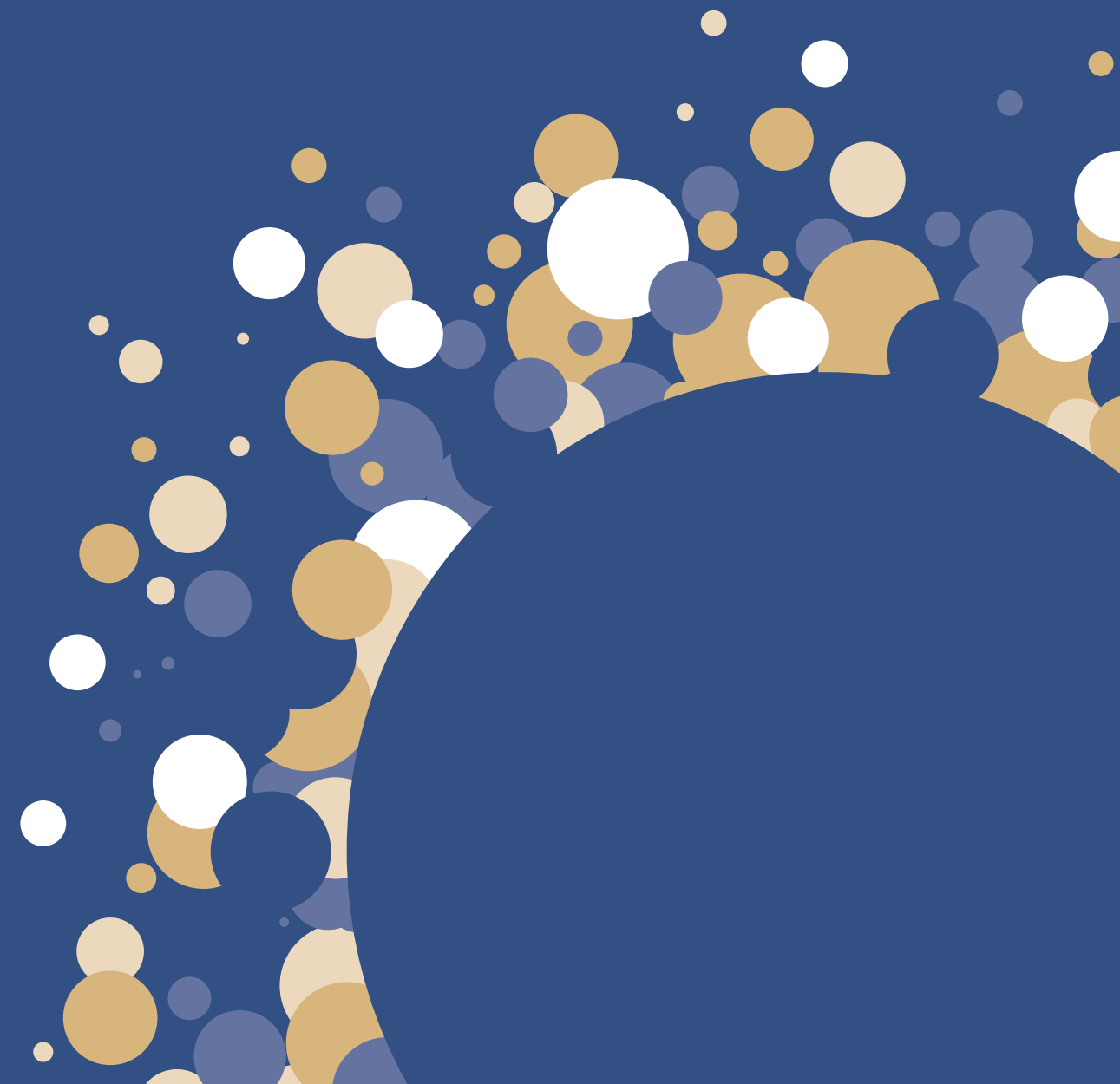


THE DATA DISPLAYED IS REPRESENTATIVE ONLY, AND BASED ON AVERAGE VALUES OVER THE 2 YEARS OF THE REVIEW

PART B

# Exploring Amber

In this section we follow the CAREMORE®<sup>32</sup> 'five step pathway' used by Welsh Ambulance Services, starting from a patient making a 999 call for ambulance services to being taken to hospital. It demonstrates the changes that have occurred with calls and incidents in the Amber category over time.





CAREMORE® FIVE STEP PATHWAY



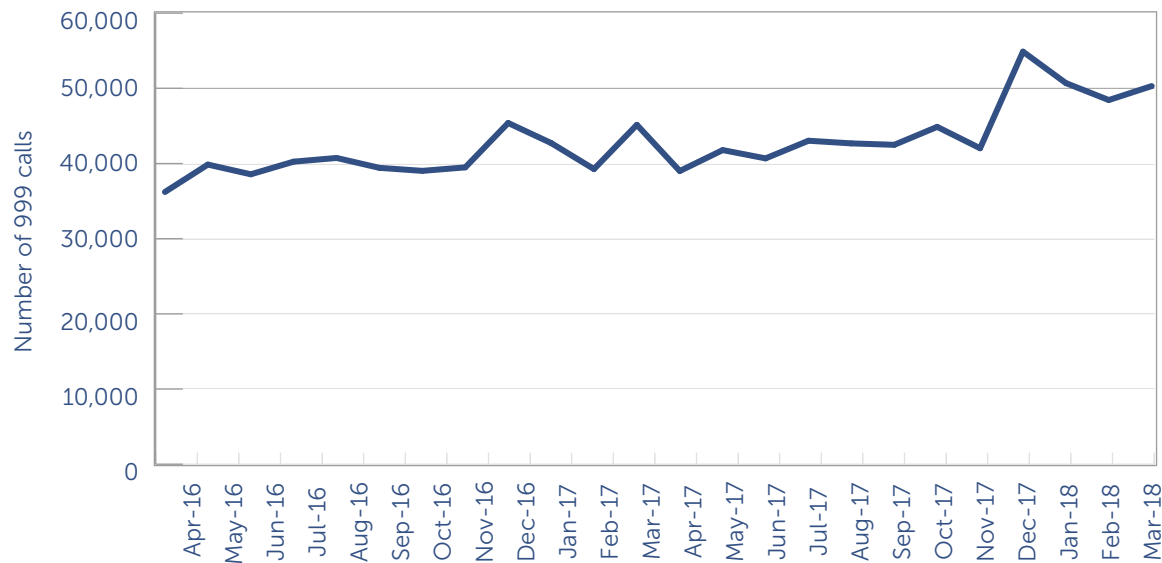
Step 1  
Help me choose

10 Public calls to ambulance services

The number of 999 calls to Welsh Ambulance Services has increased from April 2016 to March 2018 as shown in **Figure 1**. In 2016/17 the total

number of 999 calls to WAST was 486,085 and in 2017/18 it was 540,891, an increase of 11.3%. 07

● FIGURE 1: NUMBER OF 999 CALLS ANSWERED



“When patients don’t know what to do they’ll ring 999”

Operational staff

The reasons for this increase in the number of calls to ambulance services experienced in many countries<sup>33</sup> is multifaceted but could include: <sup>34, 35, 36, 37, 38, 39</sup>

- Wales has an **ageing population** which can mean more frailty, more dependency, more people with chronic conditions and more people with multiple conditions that require multiple treatments or interventions.
- Complex **social issues** such as poverty, a lack of personal social support, increased separation from close family, diminished access to transport and increasing alcohol related problems.
- There may be some **cultural issues** with some people’s desire for a convenient ‘easy access’ solution to their health concerns that allow them to bypass perceived or actual complex community pathways and access to primary care services.
- There may be issues with **local care provision** – people may not understand how to directly access the range of primary care services available. They may be directed to urgent care services by other services such as NHS Direct or Out-of-Hours/In-hours GP services.
- Daily, weekly or **seasonal peaks** in demand.
- There could be people who are **calling ambulances services back** to find out

when the ambulance will arrive, to tell the ambulance service that the situation has changed or to cancel the ambulance.

- Multiple people calling ambulance services about the **same incident**.

Effectively managing the number of calls to ambulance services will improve performance throughout unscheduled care services and potentially deliver better health outcomes for patients.<sup>40</sup>

Operational staff felt that a “large volume of calls” to the service could be “prevented” through better public education.

Operational staff said that they believed ‘the public’ viewed the emergency 999 number as a ‘fall back system’, saying; “When patients don’t know what to do they’ll ring 999, so some education learning there would be good”.

Operational staff mentioned that the public had “a lack of knowledge” of alternative services, in particular Minor Injury Units. One staff member stated that Minor Injury Units were “the best kept secret of the health service”.

We feel that there should be a clearer understanding of demographic, socio-economic, health related and other factors behind in the rise in the number of people calling the Welsh ambulance service as it is crucial to improving the management of future demand.



## 11 Other callers to the ambulance service

The majority of calls to the Welsh Ambulance Service are made by the general public, however a substantial number are made by the police or other healthcare services like GPs and nursing homes.

Welsh Ambulance Services see primary care health services as a key partner in delivering sustainable patient care,<sup>41</sup> although some operational staff felt the ambulance service was used as a “safety net” by some GPs. The 2013 McClelland Review found that call handlers did not feel empowered to challenge GP calls. We support the work of the Chief Ambulance Services Commissioner in promoting effective collaboration between primary care and emergency ambulance services.

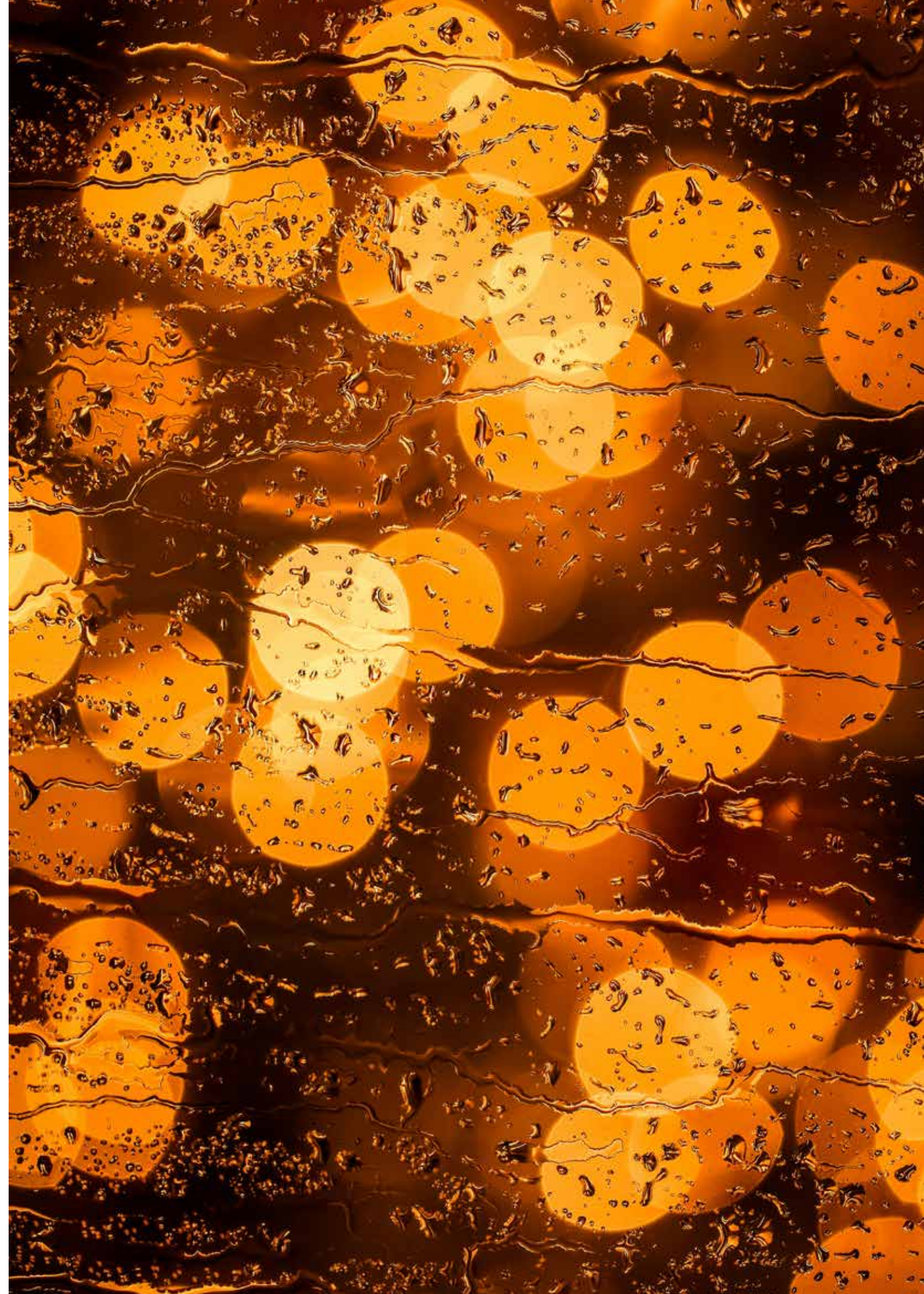
Nursing homes for older persons are another service that frequently call the ambulance service. Operational staff believed that there was a significant number of calls from nursing homes for patients that had fallen. Operational staff felt it would be beneficial for all nursing homes to have a defibrillator, lifting cushions and be trained in resuscitation. The Welsh Ambulance Service is already working closely with some nursing homes in specific areas of Wales to try and reduce calls, usually by providing lifting equipment and training and the expansion of this work should be explored.

The Police force is also a substantial user of ambulance services, not surprisingly as they are typically dealing face to face with the public or are called to incidents and accidents. Operational staff felt that some police officers do not fully understand how the prioritisation process works although ambulance clinicians are increasingly present in some police control rooms to provide advice and support.

Operational staff were frustrated with persons calling ambulance services because of alcohol intoxication as the “paramedics go out and end up just putting that person in a taxi to get them home”.

Operational staff felt they had “a lack of training” to be able to deal with calls from persons experiencing mental distress. They suggested a trained mental health professional working in the contact centre would “help alleviate a lot of pressure”.

We recognise that Welsh Ambulance Services have recently appointed a mental health lead to explore opportunities to improve staff confidence in dealing with callers with mental distress. We believe part of this role should be to better understand the demand from those with substance misuse, drug or alcohol issues and transient mental distress, often combined as ‘mental health’ as they require different responses from health and social care services.



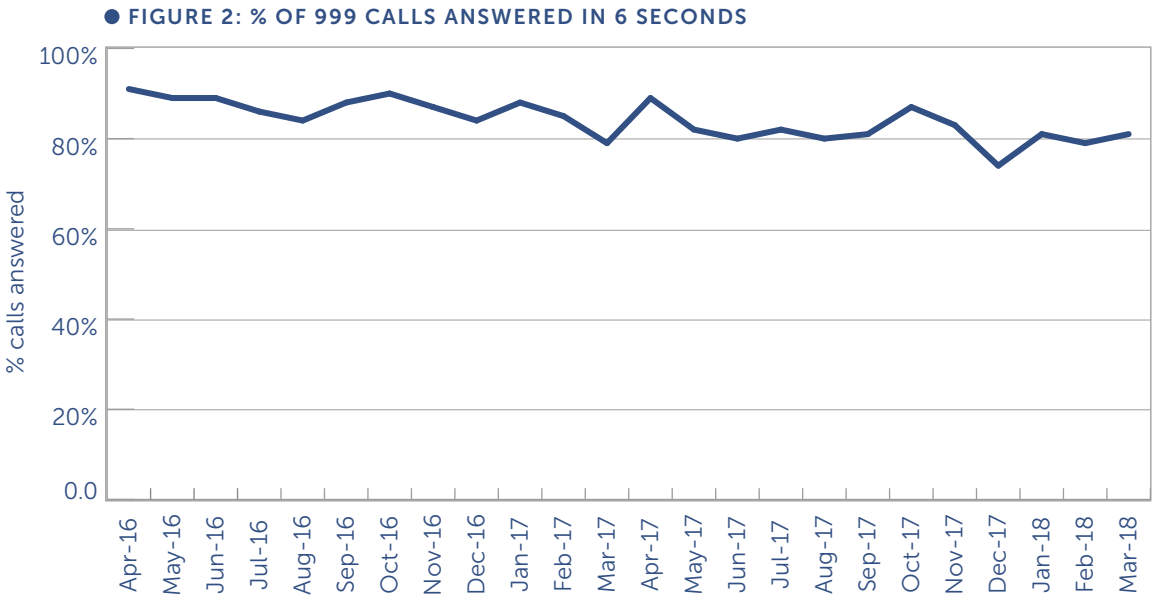


Step 2  
Answer my call

12 Answering a 999 ambulance call

When someone calls the ambulance service through the emergency 999 number call handlers make every effort to answer the call as quickly as possible. The Welsh Ambulance Service track the number of calls that take less than 6 seconds to answer as an internal measure.

Figure 2 shows performance against this measure for two years from April 2016 to March 2018 and demonstrates a downward trend over that period.

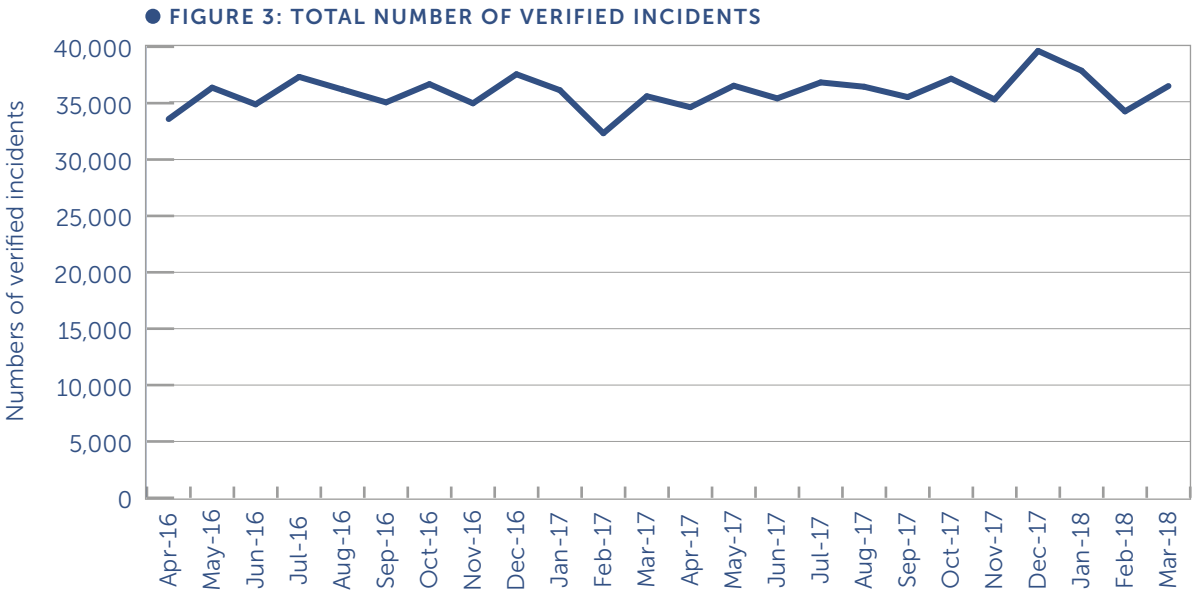


Answering ambulance calls promptly is a difficult task, especially given the 11% increase in number of calls. Operational staff talked about how they regularly go “off shift worrying about a patient” and about needing more support for their own emotional and mental health when dealing with “extreme pressures” day to day.

Operational managers felt that contact centre staff were “undervalued” and that call handler duties are “extremely stressful and anxiety inducing”. We support the need to safeguard the emotional and physical wellbeing of staff, particularly after distressing calls, and understand that Welsh Ambulance Services already have several initiatives in this area which should be sustained and developed.

13 Ambulance Verified Incidents

Figure 3 shows that verified incidents have risen at a reduced rate compared to calls. Overall there has been 2.2% increase in verified incidents when comparing 2016/17 and 2017/18.



The reason there has been an 11% increase in calls answered but only a 2.2% increase in incidents needs to be understood. Reasons could include: multiple people ringing to report the same incident, calls passed to other ambulances

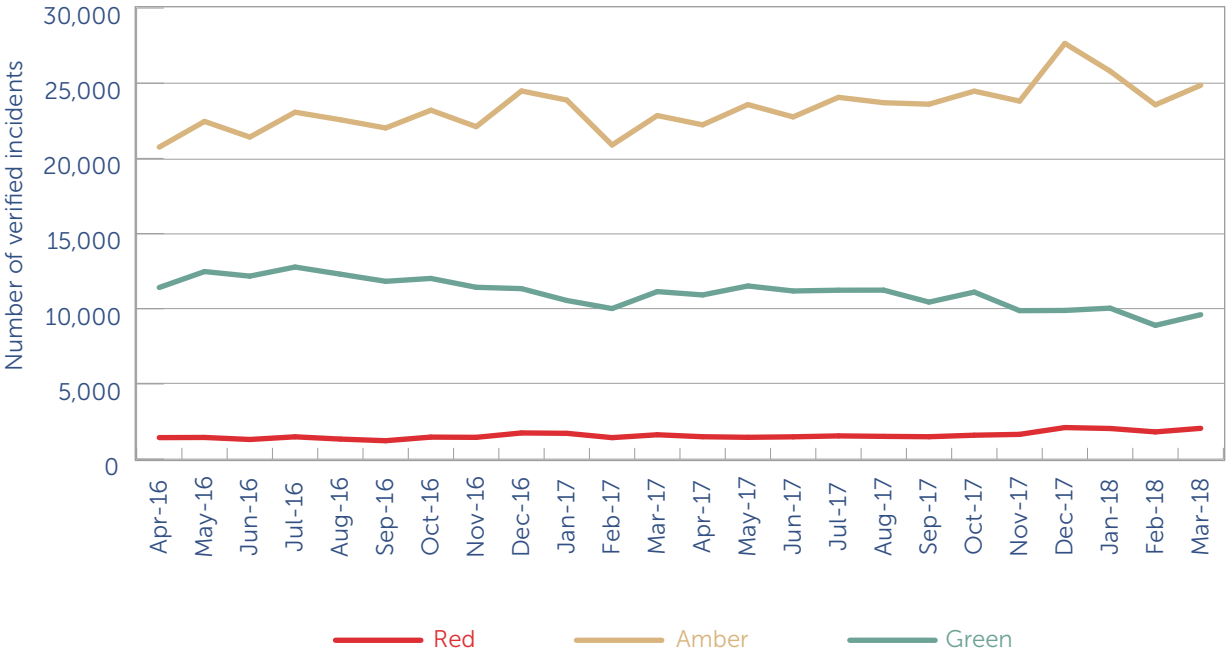
services, calls abandoned prior to assessment, cancelation requests and people re-contacting ambulances services to get an update on a previous call.

14 Incidents by category

The overall 2.2% rise in incidents discussed in the previous section, has not been uniform across all categories. Those incidents categorised as Red have seen a rise of 14.6%, Amber has seen a

rise of 7.6%, and there has been drop of 9.7% in incidents categorised as Green. These variations are illustrated in the **Figure 4**.

● FIGURE 4: TOTAL NUMBER OF VERIFIED INCIDENTS BY RED/AMBER/GREEN CATEGORY



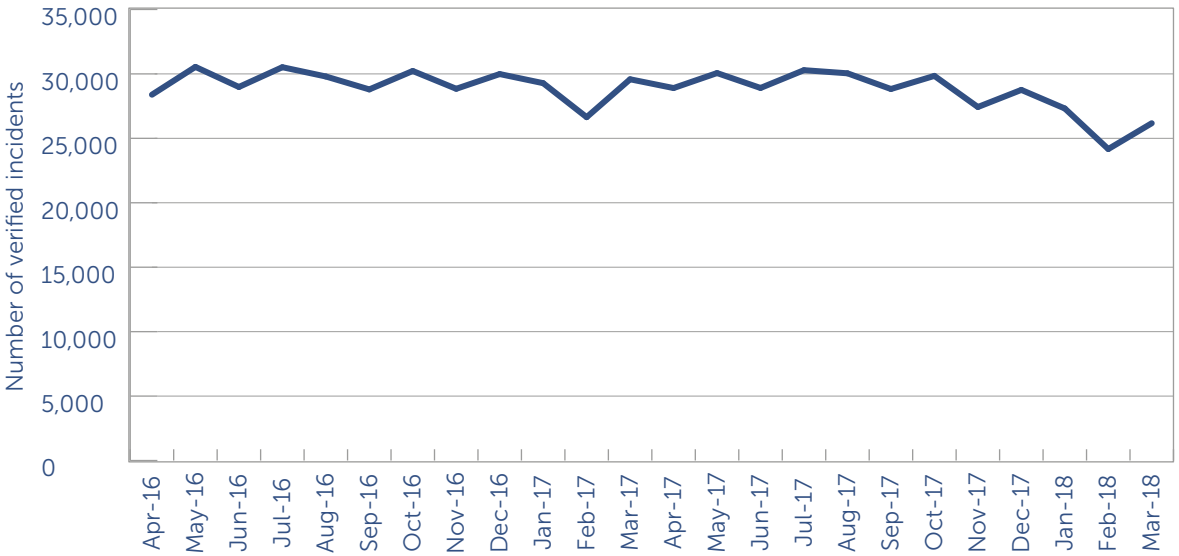
Understanding why there has been a rise across the Red and Amber categories and a reduction in Green can support planning and delivery of ambulance and wider unscheduled care services.

Step 3  
Come to see me

15 Ambulances being sent to Incidents

The number of Amber incidents requiring an ambulance to be sent\* has risen 1.2% between 2016/17 and 2017/18 as shown in **Figure 5**.

● FIGURE 5: TOTAL NUMBER OF VERIFIED INCIDENTS THAT RESULTED IN AN ATTENDANCE AT SCENE

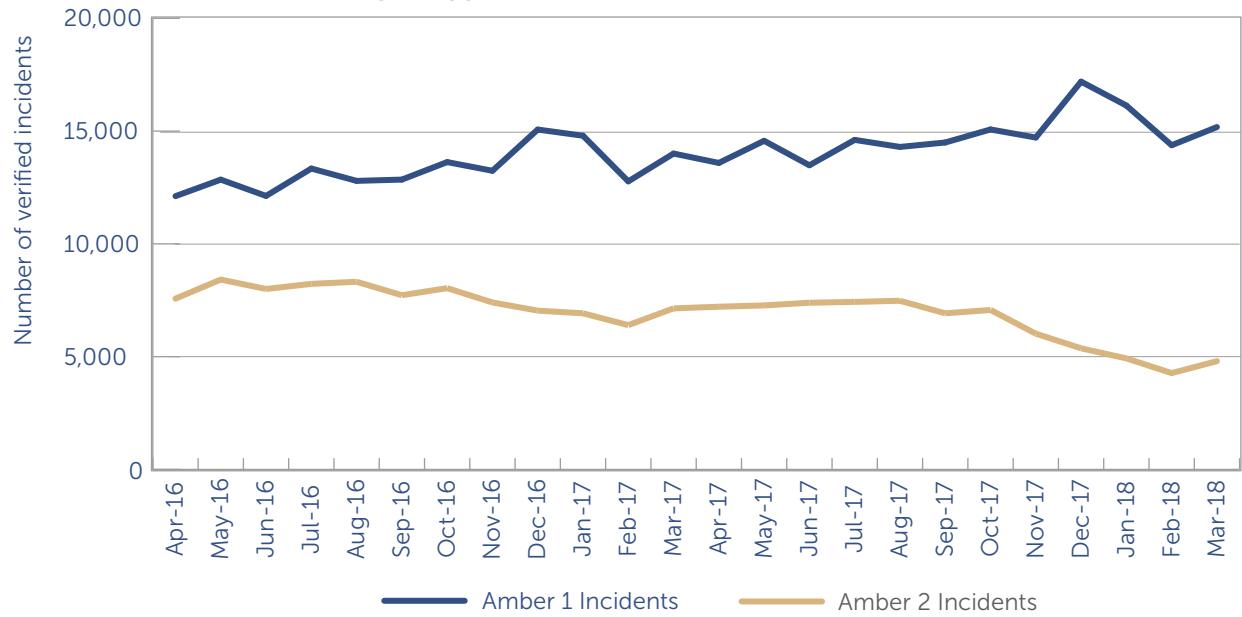


\* In this review for simplicity we refer to ‘ambulances attending or ambulances being sent’ as an Emergency Ambulance as it is the most common vehicle. Note that there are other ambulance resources (E.G. Rapid Response Vehicles, Air Ambulances)



The overall increase in incidents that have required an emergency ambulance to attend between those incidents categorised as Amber 1 (increase of 11.4%) and Amber 2 (decrease of 16.5%) as shown in **Figure 6**.

● **FIGURE 6: NUMBER OF AMBER 1 AND AMBER 2 VERIFIED INCIDENTS THAT RESULTED IN AN ATTENDANCE AT SCENE**



One of the reasons the 2.2% rise in the number of verified incidents has not resulted in an equivalent rise in the number of emergency ambulance being sent to patients is the expansion of the 'clinical support desk' within the ambulance contact centres. <sup>05</sup>

Introduced after the McClelland review of ambulance services in Wales in 2015,<sup>42</sup> and funded by Welsh Government, this clinical support desk team of nurses and paramedics provide clinical triage and advice to callers.<sup>43</sup>

Operational staff suggested that there are opportunities to use the clinical support desk as part of an extension of the clinical response model. An example given by staff was that after identifying a code as not immediately life-threatening calls would be "taken by a trained clinician who can ask relevant questions" and provide the right support.

Operational staff felt that having more clinicians in the contact centre would be "extremely useful" as they can use "clinical judgement" to ensure the appropriate prioritisation of incidents. Contact centre clinicians could also "give callers an honest estimation of how likely they are going to wait" and "recommend alternative pathways".

Contact centre staff also felt that in future Advanced Paramedic Practitioners (a new initiative where paramedics with advanced skills attend incidents) could "help teams within the contact centres" although some staff felt that this initiative needed "more clarity".

The Amber Review survey found that 88% of the public thought it was important that ambulance services provide medical advice on the phone that avoids the need for an ambulance to attend an incident.

Another possible reason for the variation between the number of verified incidents and the number of ambulances being sent is callers cancelling the ambulance prior to its arrival. There has been a 129.5% increase in these cancellations between 2017/18 and 2016/17. There is a need to explore the relationship between these cancellations and long waits for emergency ambulances.

**88%**  
of patients think it's important that  
**ambulance services provide  
medical advice on the phone**  
that avoids the need for an ambulance



## Step 4

### Give me treatment

## 16 When the Ambulance arrives

When an ambulance arrives at an incident the patient's clinical condition will be assessed and treated, if possible, at the scene. If the patient's condition requires it, they will be taken to either the nearest hospital emergency department or to a specialist centre.<sup>44</sup>



of the public think it is important that ambulance services do as much as possible to avoid the need for me to go to hospital

The majority of the public think it is important that ambulance services do as much as possible to avoid the need for them to go to hospital. We propose that Welsh Ambulance staff be supported to recognise the significant contribution they deliver to a patient's health and wellbeing. The time they spend with a patient should bring value and deliver the best outcomes possible whether treatment at the scene or when taken directly to a health facility.

There may be opportunities to work in partnership with the public about how they can help ambulance staff before and when they arrive at the scene of the incident.

Ambulance staff normally treat patients with no prior knowledge of their conditions or medical history. It would support ambulance staff to treat more people at the scene of the incident if they had access to patient information such as medication, allergies and medical history.<sup>45</sup>

Sometimes when an ambulance arrives at an incident the patient cannot be found, they may have decided they no longer required help or it could have been a hoax call. Between 2016/17 and 2017/18 there was a 17.5% increase in the number of times a patient wasn't present when the ambulance arrived.


Sometimes when an ambulance arrives the patient 'refuses to be treated', or taken to the hospital by the ambulance crew. We recognise that further work is required to understanding the reasons for refusal and guide the development of better services to meet patient needs.

## 17 Measuring quality

There are a broad range of conditions categorised as Amber and, alongside response times, Welsh Ambulance Service and its Commissioner measure interventions being provided through a set of ‘Ambulance Quality Indicators’.<sup>46</sup>

97% of patients told us it is important to measure the quality of the treatment provided to them. We need to ensure that as many patients as possible in the Amber category are covered by clinical indicators.

We also recognise these indicators need to reflect the whole patient journey and be developed in partnership with patient representative groups.

 **97%**  
of the public think  
**its important to measure  
the quality of treatment**

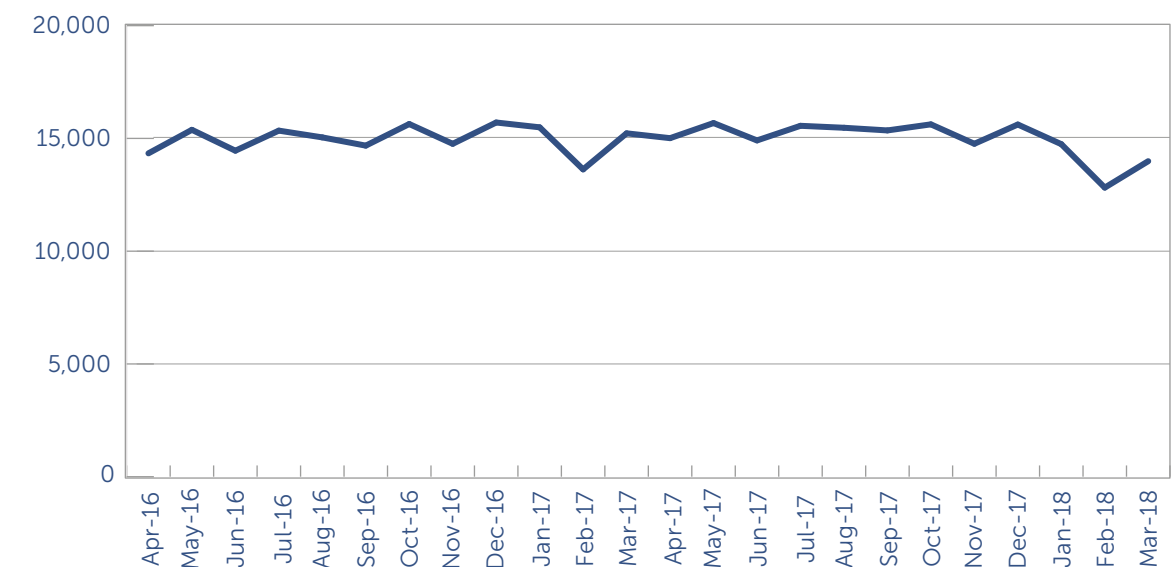
## Step 5 Take me to hospital

## 18 When the Ambulance leaves the incident

Not all patients attended by ambulance crews are taken to hospital. Following assessment and treatment by the crew they may be left at home with advice or referred to a community health service.

There has been a reduction in the number of patients taken to hospital for the Amber category of 0.1% from 2016/17 and 2017/18 as shown in **Figure 7**.

● **FIGURE 7: NUMBER OF VERIFIED AMBER INCIDENTS THAT RESULTED IN A CONVEYANCE TO HOSPITAL**



We recognise the important of the ambulance service reducing the number of patients being transported to hospital and all opportunities to improved this should be explored.

Another factor which may impact on the number of patients taken to hospital is to ensure operational staff are led by competent and empowering clinical managers.<sup>47</sup> Over the last three years Welsh Ambulance Services have developed a ‘clinical leadership model’ to improve staff clinical support. We would want to measure the impact of this model on patient outcomes.

An additional factor in reducing the number of patients being taken to hospital is the availability

of other health and social care services to support the patient.

Operational staff admitted that they “do not always know what pathways are available” and “how to help them access them”.

It has been found that making sure staff have access to an easily navigable up to date electronic register of services<sup>48</sup> helps them to access alternative community or health services. Welsh Ambulance Services staff stated they had a partial register in place but there was “a need to be able to know more” about them so staff can access them and direct callers “to the right service”. We recognise that NHS Wales is currently adopting a national directory of services.





## 19 Arriving at the Hospital

Once they arrive at hospital, normally at the emergency department, ambulance staff will pass on medical information to hospital staff and transfer the patient and therefore the responsibility for their ongoing care, to the department.<sup>49</sup>

Such transfers of care from one set of clinical staff to another are normally labelled as ‘handovers of care’ or colloquially as just ‘handover’. There can be a delay in handing over patients between ambulance services and the emergency department and this is discussed in the ‘Delivering Amber’ section.

52% of patients thought they would be seen quicker in the Emergency Department if they arrived by ambulance. Work should be undertaken to ensure the public understands that assessment at the emergency department is based on clinical need and not by the mode of arrival.

We recommend that there should be a programme of public education, consultation and engagement on the role of emergency ambulance services as well as how calls are prioritised and categorised.

## 20 FINDINGS FOR EXPLORING AMBER

- There was increased demand in the Amber category.
- Ambulance staff felt that expanding the numbers and roles of clinicians in the control room was essential.
- Receiving a quick ambulance response but ensuring this is the right response for your condition is important to the public.
- Further work is required to explore the relationship between cancellations and re-categorisations and ambulance response.
- Further work is required to explore the relationship between hoax calls, refusals and ambulance response.
- The Public support ambulance services doing at much as possible to avoid the need for them to go to hospital.
- Staff require more information on alternative services.
- Measures of quality is as important as response times.
- Measurement of the ambulance service should be refined to reflect the whole patient journey.
- Measures should be developed in partnership with patients.
- Members of the public wish to be supported and be better informed when making a 999 call.
- More patients in the Amber category are having their incident resolved or closed over the phone. ●

## PART C

# Delivering Amber

**This section considers how Welsh Ambulance Services are using their resources to meet the demands placed on it. It will also explore what happens when the daily demand cannot be met and some patients end up waiting a long time for an ambulance and what effect that may have on their health and experience.**

## 21 Demand and Capacity – overview

In the previous section we discussed the number of people calling ambulances, the number of incidents, the incidents being closed over the phone and ambulances being sent to patients. This collection of activities can be termed the ‘demand’ placed on the Ambulance Service.

In order to give the best possible response to patients the Welsh Ambulance Service needs to meet this demand which, at various degrees, is present every hour of every day. The service needs to have the right number of people in the clinical contact centres answering calls and managing incidents and the right number of emergency ambulances and other vehicles on the road at the right time. These staff and vehicles are the ambulance service’s ‘capacity’.

Matching demand and capacity is a fundamental requirement for delivery of first-class modern health and social care services.<sup>50</sup>

Welsh Ambulance Services should have the right capacity available to match the daily demand. Sometimes events occur (for example road traffic

accident with multiple vehicles) which cannot be foreseen and produce a brief spike in demand but otherwise demand follows a generally predictable pattern.

When Welsh Ambulance Services do not have enough capacity to meet the demand this can create a ‘gap’ and sometimes this gap can be closed, by bringing in extra capacity or by changes in process, but sometimes it cannot. When this demand /capacity gap cannot be closed it results in problems delivering the required response to patients and therefore some patients wait longer.

There are two main reasons why a ‘gap’ between demand and capacity can occur. The first is not having the necessary capacity in the first place, either through lack of investment or having issues with organisation planning and the second is by losing capacity through ambulances waiting too long outside hospitals, preparing ambulances for the next incident and staff sickness. Each of these reasons will be discussed further in this report.

## 22 Having enough capacity – Investment

As with all parts of the NHS in Wales, every year the ambulance service receives funding to run their services<sup>51</sup> and this funding needs to match their aims and objectives<sup>52</sup> which in the ambulance services case is set by the commissioners.

The clinical response model also provides a mechanism for enabling ambulance services to better use the resources they have for the benefit of patients,<sup>53</sup> which the Welsh Ambulance Service has started to do, for example by becoming more efficient at sending the right type of vehicle and reducing the number of vehicles sent to incidents.

As well as the normal annual funds and uplifts for inflation, over the last few years the Welsh Ambulance Services has received additional funds from the Welsh Government and commissioners

to support initiatives such as avoiding taking patients to hospital, ensuring more patients are cared for at home and expanding the clinical support desk.

This increase in funding is shown by comparing Welsh Ambulance Services revenue for patient care activities in 2017/18, which was £167 million compared to 2016/17 when it stood at £156 million. Comparing staff working for Welsh Ambulance Services across the two years also shows an increase from 2,982 in 2016/17 to 3,059 in 2017/18.<sup>54</sup>

Commissioners should continue to provide the Welsh Ambulance Services with the level of funding to deliver the right level and quality of patient care and that the funding received is dedicated to front line service.



Welsh Ambulance Services funding  
**£156 million in 2016/17**  
**£167 million in 2017/18**

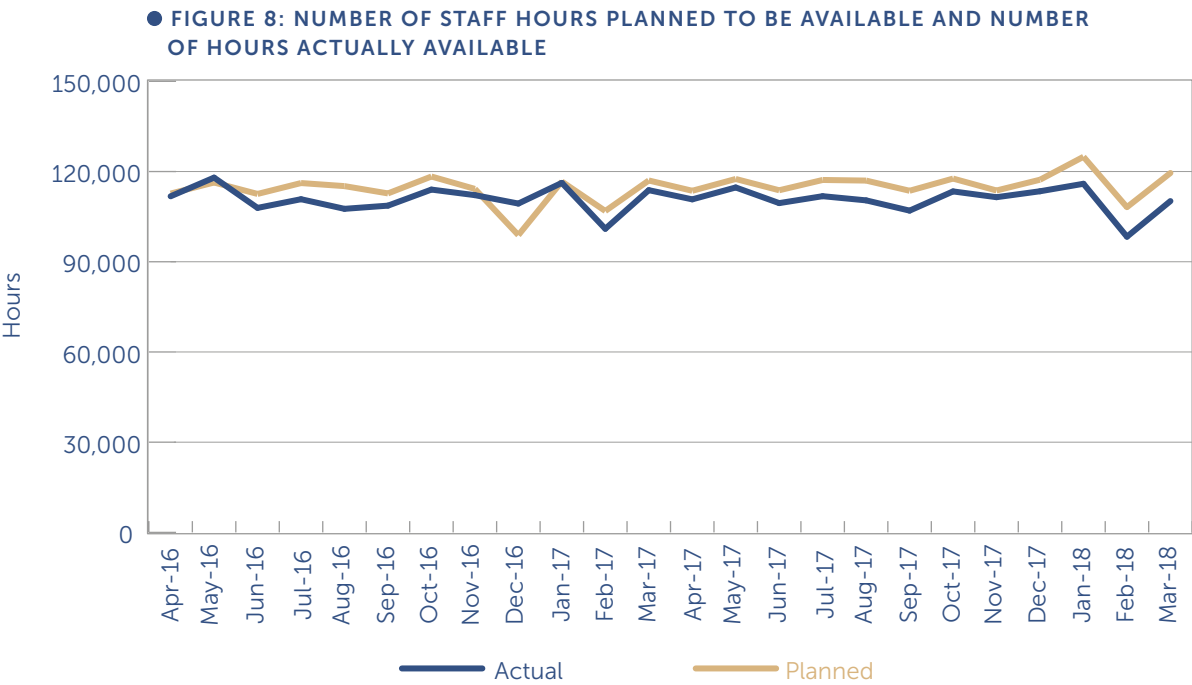
## 23 Having enough capacity – Staff availability

A challenge for any ambulance service is ensuring the right number of staff with the right skills are available at the right time to match the demand for services.

Scheduling of staff to ensure there are sufficient crews to meet daily demand is a complex task due to regulations relating to various aspects of staff management. These regulations include limits on the number of consecutive work hours, the number of shifts worked by each employee and restrictions on the type of shifts assigned.<sup>55</sup>

The number of staff hours that Welsh Ambulance Services plan to be made available per day once factors such as sickness levels, holiday allowance, training time and other anticipated non-availability has been taken into account is called the ‘planned’ staff availability.<sup>56</sup> It would be challenging for an ambulance service to always get a precise match between planned staff and the actual staff availability but any sizable or continuous variation may be a problematic.

**Figure 8** shows that the total planned and the actual staff availability for every month between April 2016 and March 2018.



**Figure 8** shows that on average actual staff availability was 3.3% below the planned staff availability.

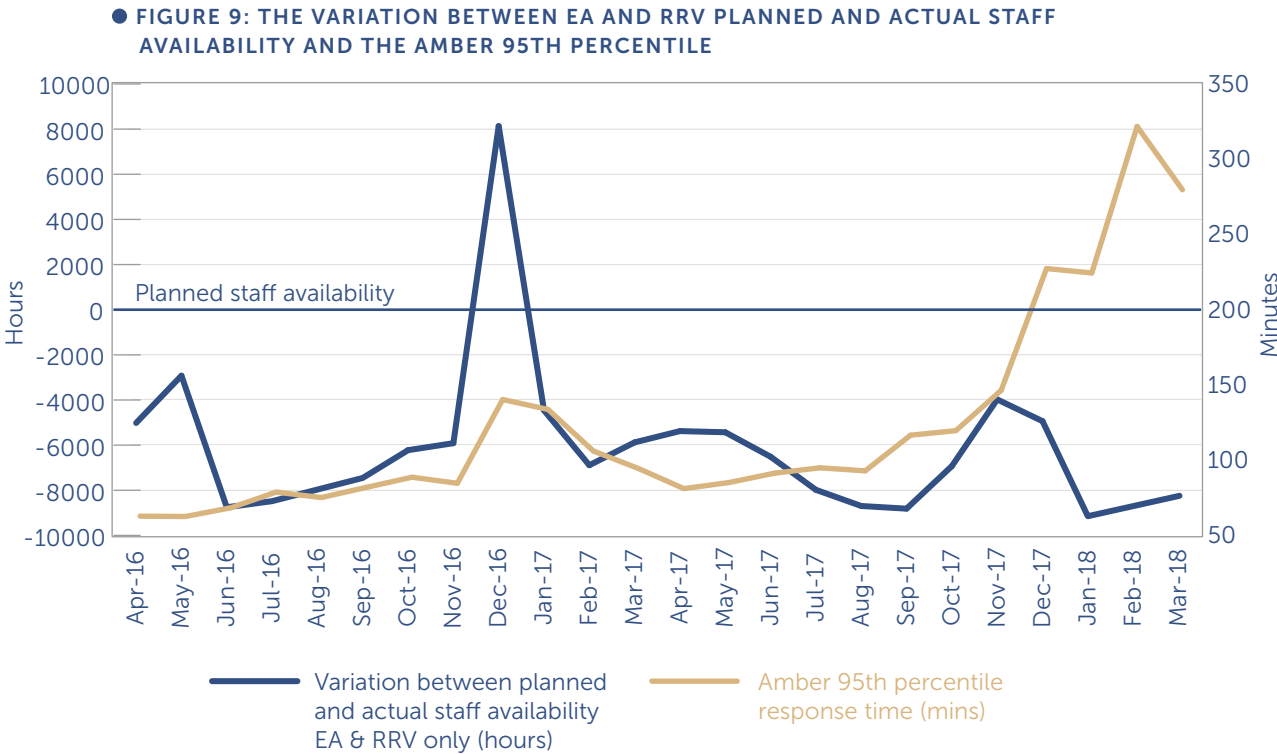
We need to understand the impact of this difference between planned and actual staff availability , particularly with emergency ambulances and reflect that staff spoke about how many ambulances were deployed at any one time and how this “seems to be fewer than it used to be even with an aging population and an increase in emergency calls”.

The Welsh Ambulance Service acknowledge that there are issues in planning for staff availability and they commissioned a ‘Demand and Capacity Review’ in 2016 and have begun to implement the findings from this review which includes improving rostering.<sup>57</sup>

The Welsh Ambulance Service can reduce these operational shortfalls by offering employees paid extra shifts. Although this is a normal way for ambulance service to operate it does depend on the willingness of staff to work additional hours, and can increase staff stress and lead to exhaustion.<sup>58</sup>

We were keen to understand the association, if any, of staff availability and the waits that can be experienced for patients whose conditions have been categorised as Amber. **Figure 9** shows the results of comparing the variation in staff availability in hours and the ‘Amber 95th percentile’.\*

\* The ‘95th Percentile’ is calculated as the value below which a certain percentage of patients fall. For example if the 95th percentile for a response time was 20 minutes then 95% of calls would be answered within that time and 5% would wait longer.



**Figure 9** shows that the comparison is indistinct except for the three months of 2018.

**143,677 hours**  
lost to planned/actual gap  
over two years





## 24 Losing capacity – Ambulances waiting too long outside Hospitals

Handovers of care are sometimes governed by measures of time, set locally or nationally,<sup>59</sup> and when the time taken to handover care exceeds this agreed time period it is classed as a ‘handover delay’. The underlying reasons behind handover delays are multifactorial<sup>60</sup> and may include:<sup>61, 62, 63, 64</sup>

- Major incidents making emergency departments and hospitals busy.
- Disrupted management of patient movement within and out of hospitals, including transferring patients from Emergency Departments into wards.
- Patient flow through the hospital.
- Seasonal pressures such as winter flu outbreak.

- Behaviour of professionals in primary care (volume of healthcare professional referrals).
- Reduced staff resources, equipment and capacity in Emergency Departments.
- Physical environment of hospital sites and Emergency Departments.

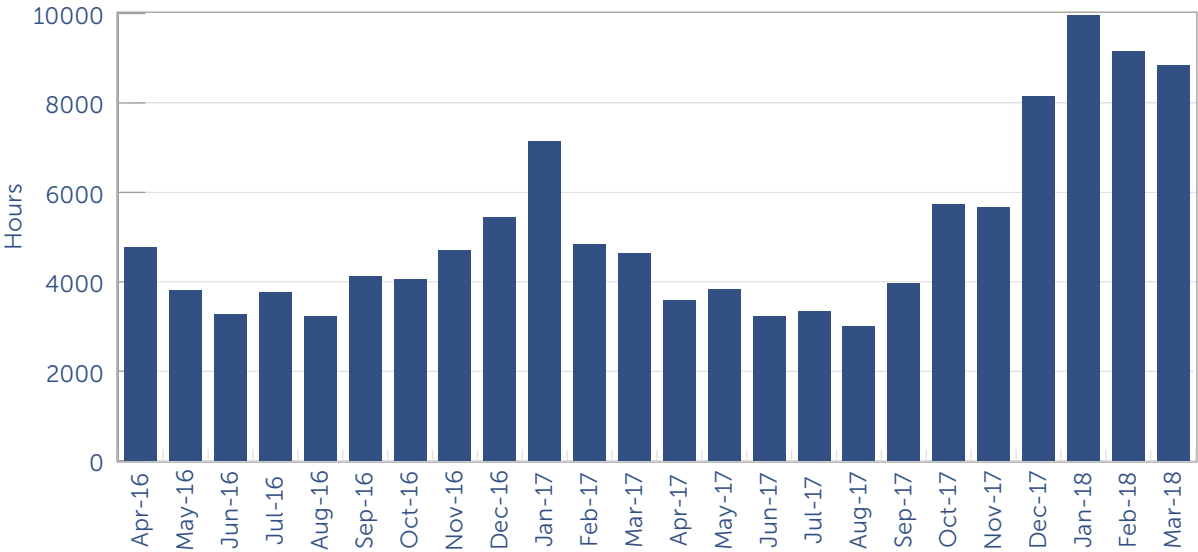
When we try to calculate handover delays we normally convert the time waiting outside of hospital to ‘lost hours’, this means that for that period of waiting the ambulance cannot go to another incident. Calling it a ‘lost hour’ is an operational term and it does not mean that the time the crew spend with the patient is not valued and an important contribution to clinical care.



When we examine the data from April 2016 – March 2018, shown in **Figure 10**, we can see that the number of hours (over 15 minutes) that have been ‘lost’ due to waiting outside of a hospital

has risen over both winters of 2017 and 2018 with January and February 2018 being particularly high.

● **FIGURE 10: THE NUMBER OF LOST HOURS DUE TO DELAYS IN HANDOVER OF PATIENT FROM AMBULANCE TO HOSPITAL**



**122,266 hours**  
lost to handover delays  
over two years

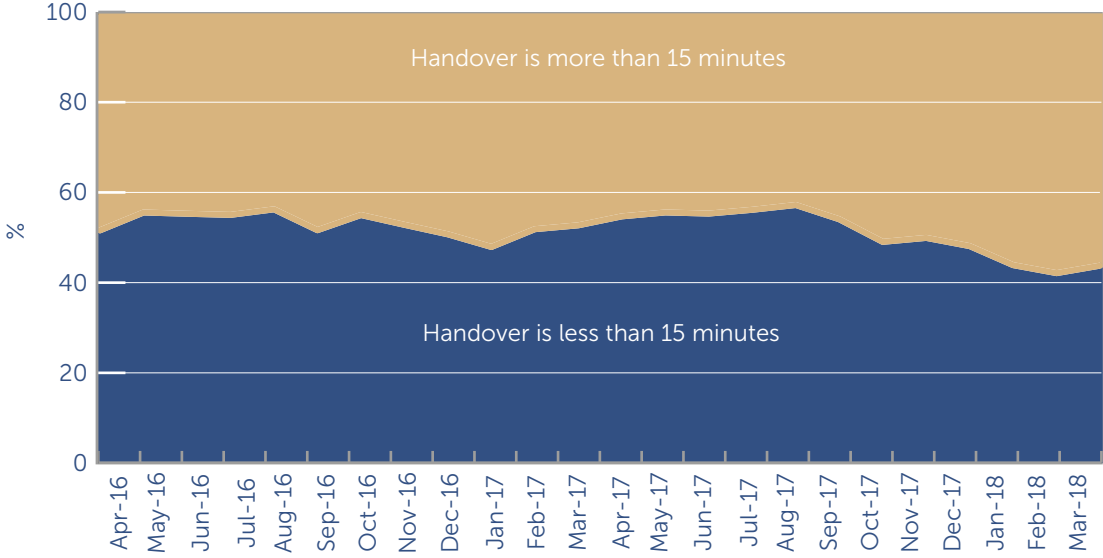


In Wales there is a standard that requires 95% of patients to be handed over in 15 minutes.<sup>65</sup>

**Figure 11** shows the percentage of patients handed over within 15 minutes, and therefore those that

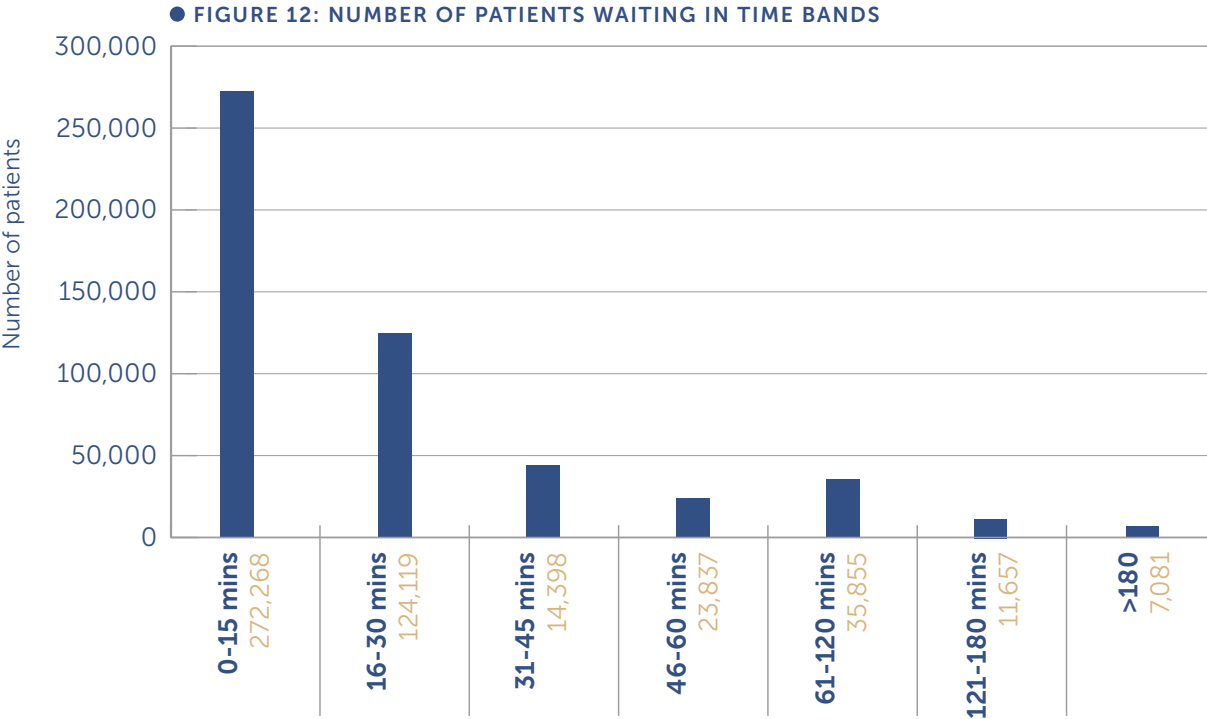
take longer than this. It demonstrates that the target has not been met for two years with 54% of patients being handed over to hospital staff within 15 minutes in April 2016 to 45% in March 2018.

● **FIGURE 11: PERCENTAGE OF PATIENTS HANDED OVER TO HOSPITAL STAFF WITHIN 15 MINUTES OF ARRIVAL**



The 15 minutes target does clearly represent how long some patient may wait in an ambulance

outside of a hospital. **Figure 12** shows the number of patients waiting in time bands.



The consequences of the patient remaining on the ambulance outside of a hospital is that they are being cared for in an environment which is designed and equipped to deal with emergency incidents not for the provision of prolonged periods of care. This means the vehicle lacks toileting and food and water facilities as well as appropriate mattresses and seating supports.

Patients waiting in ambulances outside of hospitals may have a poor experience of care<sup>66</sup> although some have said they were reassured by the continued presence of ambulance staff.<sup>67</sup> We recognise more work needs to be done to understand patient experience although we presume it is not dignified and progressive care if patients are waiting in an ambulance for several hours.

Patients have said they would like to be kept informed during their wait<sup>68</sup> and we support the Welsh Government advice to keep patients and their carers fully informed of the reason for any handover delay and the progress in resolving it.<sup>69</sup>

Handover delays have been associated with high levels of stress for all staff groups, and in particular frustration for ambulance crews waiting with patients outside the hospital.<sup>70</sup>

We recognise that the principal issue with handover delays is that they prevent emergency ambulances from responding to other calls and this is discussed in later in this report.<sup>71</sup>

We recognise the pressure the wider unscheduled care services, especially emergency departments are under, however we need to urgently collaborate as a whole healthcare system to address the issue of handover delays.

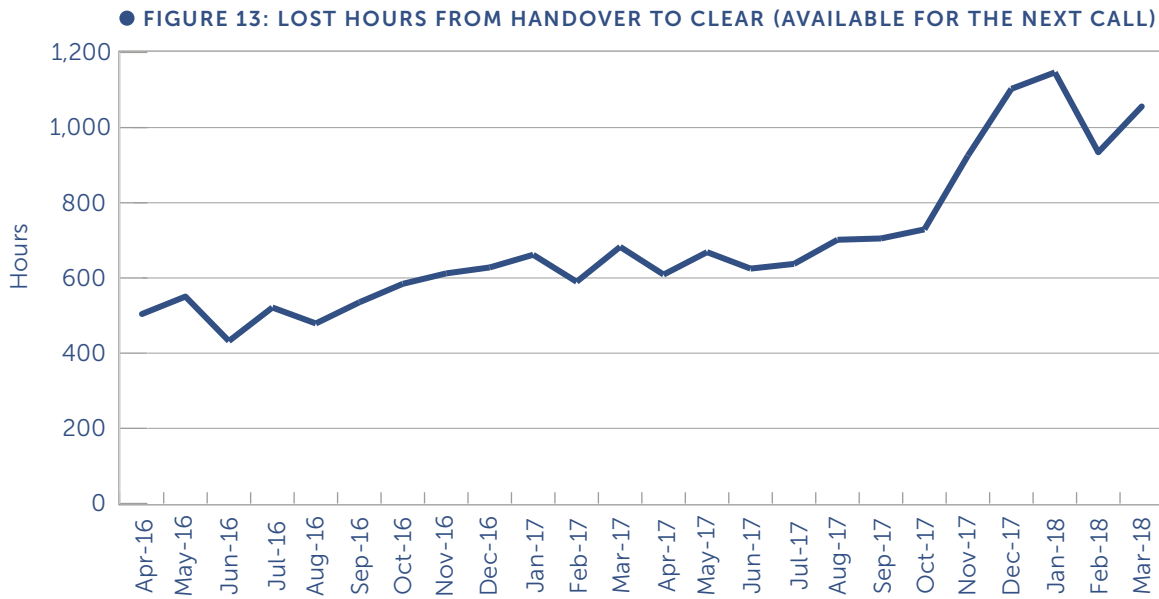


## 25 Losing capacity – Ambulances getting ready for the next incident

After transferring the patient to hospital staff the ambulance crew get the vehicle ready before making themselves available to respond to the next incident (called being ‘clear’). It is important to note it is not always possible to be ready for a new case quickly as staff should be allowed time to emotionally recover after dealing with a stressful incident.<sup>72</sup> They may also need time to restock the ambulance with medication and equipment.

There is an expectation that the ambulance crew take no more than 15 minutes for this activity.

**Figure 13** shows that the number of hours that have been lost from ‘handover to clear’ (above 15 minutes) as reported by Welsh Ambulance Services has risen by 45% and over the two years.



**16,624**  
hours  
from  
handover  
to clear  
over two years

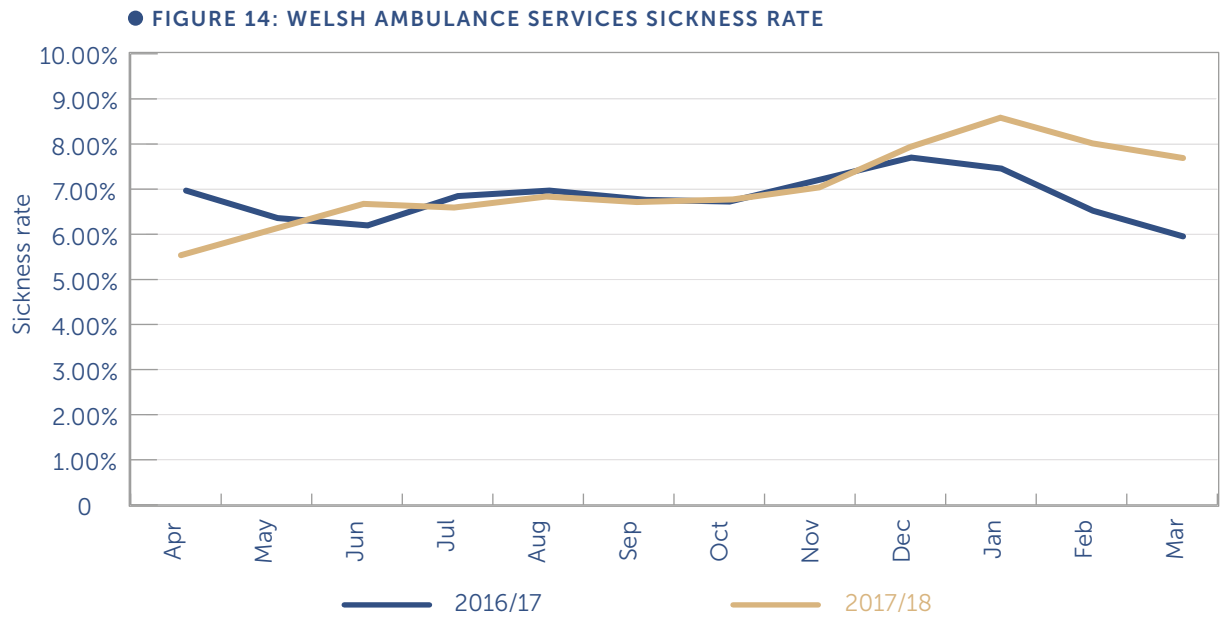
We need to explore the reasons why there should be such a rise in the hours lost to handover, it could be a change of process, or that restocking is taking longer or it could be that staff require longer to recuperate given that they may have cared for patients for a longer period than usual.

## 26 Losing capacity – Sickness

As in any large organisation there are always a number of staff who have illnesses/accidents which prevent them for working. These rates of staff absence due to sickness are closely monitored in the NHS.

In England it is known that ambulance services have the highest sickness rate in the NHS<sup>73</sup> and Welsh Ambulance Services have the highest sickness rates of any NHS Wales organisation.<sup>74</sup>

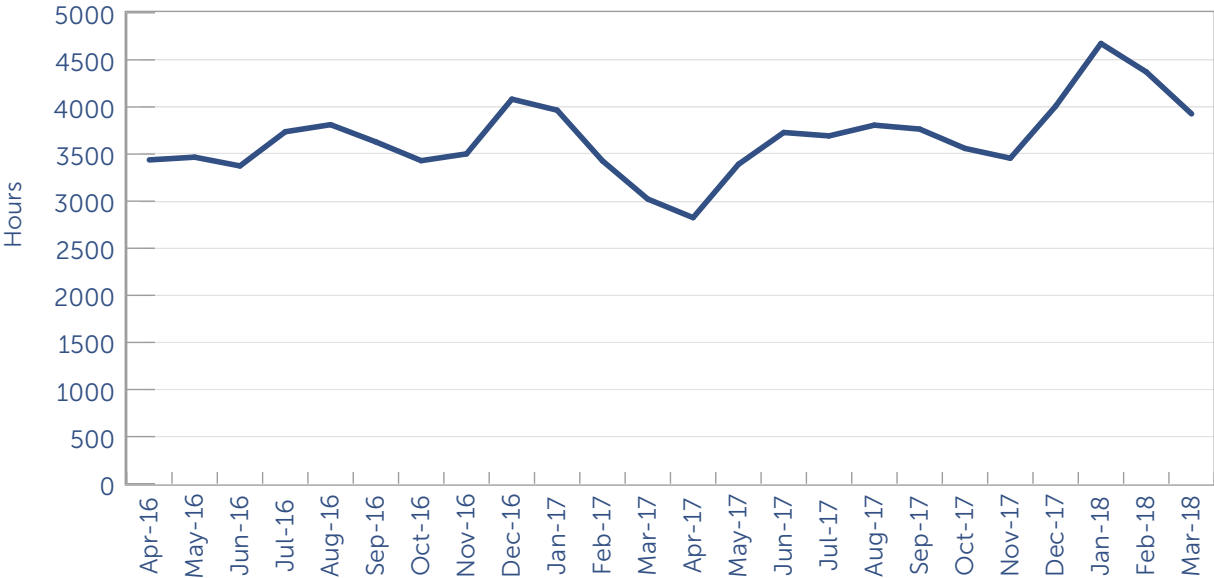
**Figure 14** shows the sickness level for all staff and demonstrates the higher levels through the winter periods. Welsh Ambulance Services acknowledge that through the winter of 2017/18 sickness was the “highest we have experienced for a number of years”.<sup>75</sup>



It is essential to reduce sickness rates as high sickness absence rates contribute to ‘poor resource utilisation’,<sup>76</sup> meaning less capacity.

**Figure 15** the number of hours that have been lost from ‘front line’ staff sickness (excluding management or administrative staff) from April 2016 to March 2018.

● **FIGURE 15: WELSH AMBULANCE SERVICES LOST HOURS DUE TO FRONT LINE STAFF SICKNESS**



We recognise that Welsh Ambulance Services have taken a number of actions to support staff emotional and physical health and reduce sickness rates although some staff felt there was a “lack of support” for their own “mental health”. Staff also discussed the “abuse” they get “day to day”.

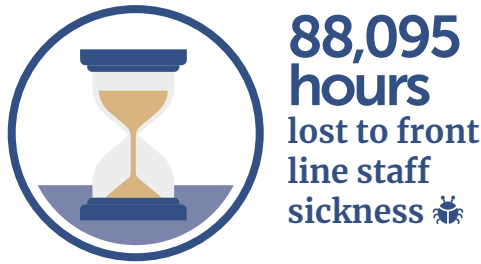
Operational staff talked about how their jobs impacted their health and life outside of work. The staff explored the improved focus on rest breaks and shift finishing times recognising that this benefits staff welfare. Although they also acknowledged that this may have a ‘knock on effect with response times’, by reducing available capacity.

We recognise that some patients will become frustrated with long waits, but abuse cannot be tolerated and we support Welsh Ambulance

Services in ensuring that action is taken against every act of harassment.

Welsh Ambulance Managers also state they have reviewed rosters in order to better fulfil the principles of the clinical response model, although they also said that these changes in shift patterns could affect staff work-life pattern.

We acknowledge that the Welsh Ambulance Service recognises that the health and wellbeing of their staff is “crucial to delivering and maintaining safe, high quality healthcare” and are working with trade union partners to help staff to be as “healthy, well and resilient as possible”<sup>77</sup> although we also recognise the impact of this work is still to be seen in reported staff sickness rates.





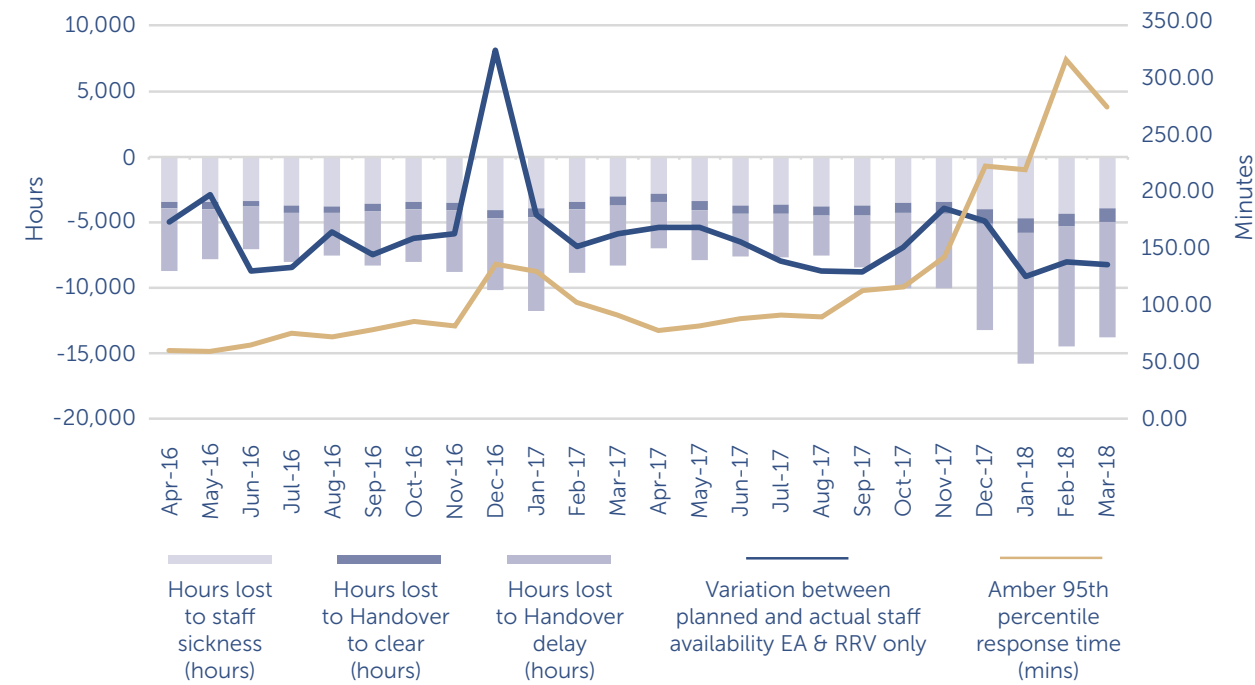
27 Demand and Capacity – impact

We have attempted to discuss the various elements of demand and capacity separately in order to fully explore the contributory factors for each. However, this does pose challenges for understanding how each of these elements

interacts with others to ultimately impact on the response provided to patients.

**Figure 16** endeavours to compare lost hours, resource availability and the Amber 95th percentile.

● **FIGURE 16: COMPARISON BETWEEN LOST HOURS (HANDOVER DELAYS/HANDOVER TO CLEAR/STAFF SICKNESS), EA AND RRV PLANNED AND ACTUAL STAFF AVAILABILITY AND THE AMBER 95TH PERCENTILE**



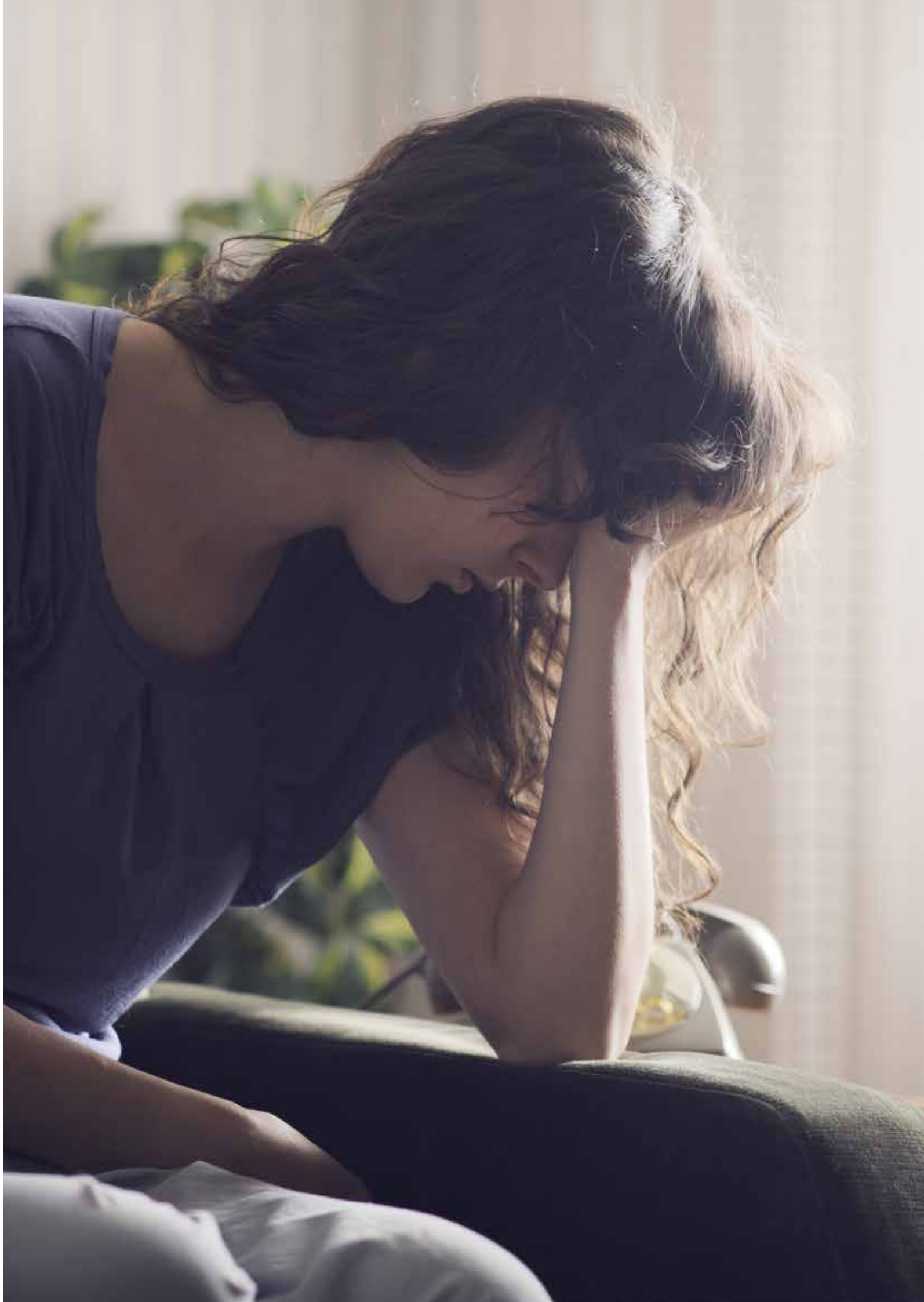
In the winter of 2017/18 we see a combination of circumstances of shortfalls in staff availability and a significant amount of lost hours which resulted in a increase in the length of time some patients are waiting.

Operational staff felt that “resourcing issues” were a major issue and that the response model is not designed for such “restricted resources”

and this issues was exacerbated by “hospital delays”. One staff member summed this issue up by saying:

**“If we had the ideal crews, no hospital delays, we would get to our patients a lot quicker.”**

**Operational staff**

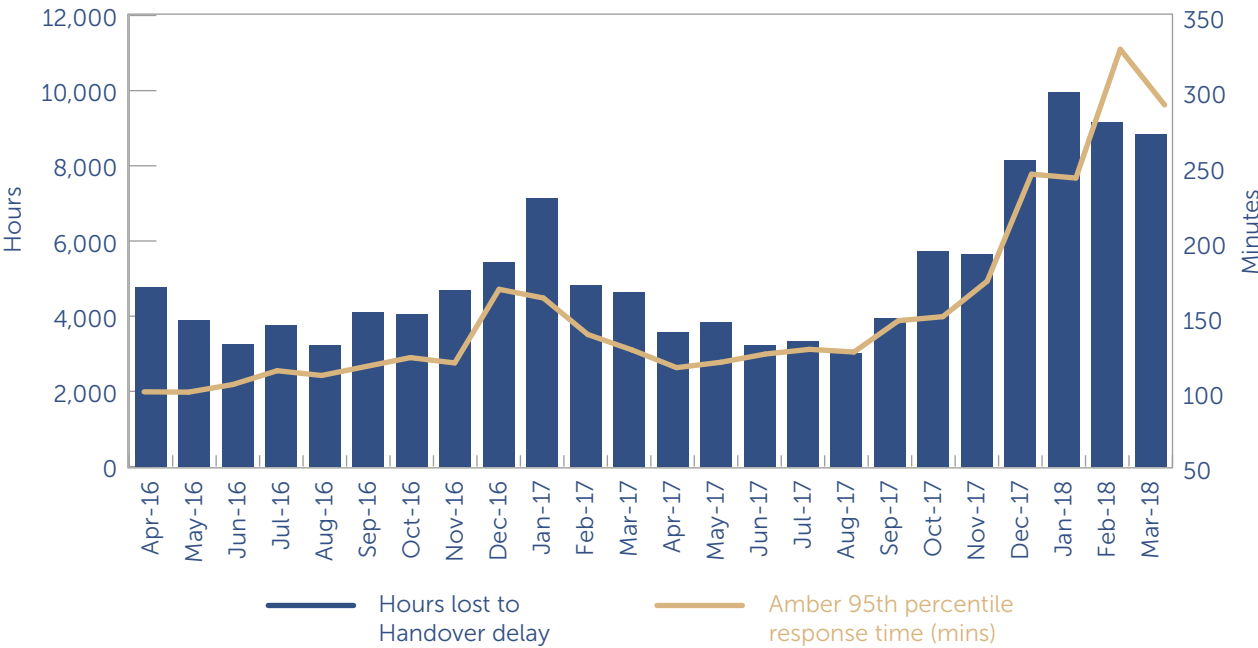


28 Waiting times for ambulances

As stated previously handover delays are a significant contributory factor is the loss of ambulance resources. This loss can manifest

in longer ambulance response times. **Figure 17** shows the relationship between hours lost to handover delay and Amber 95th percentile.

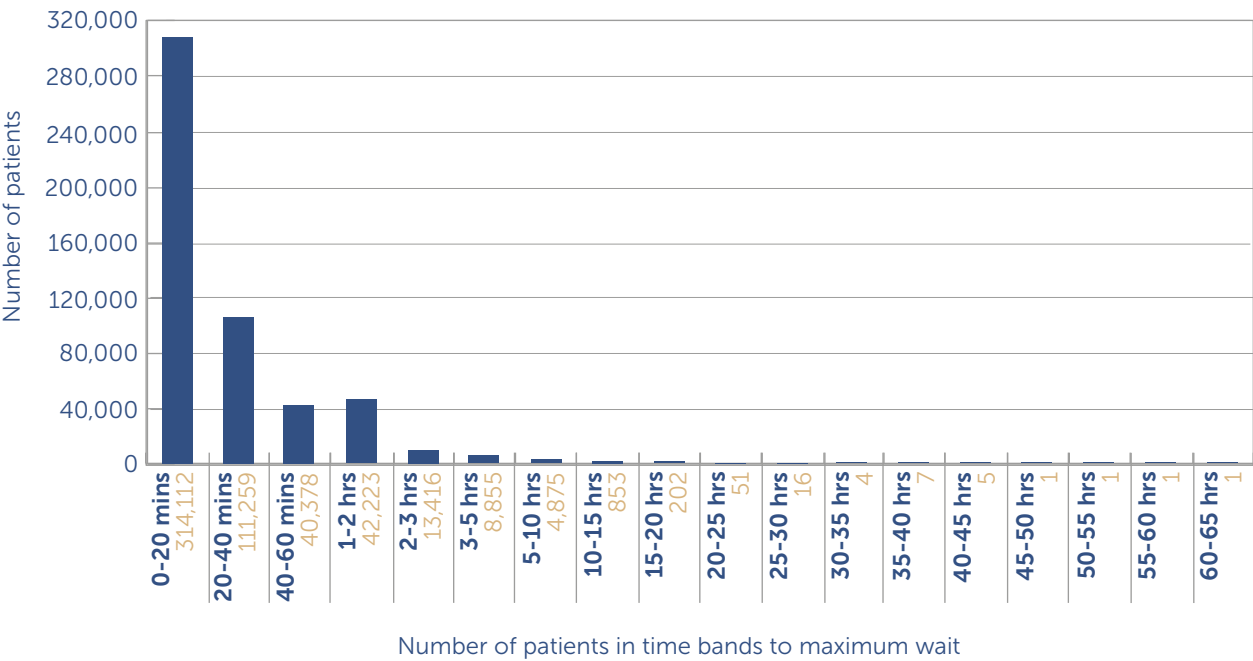
● FIGURE 17: COMPARISON BETWEEN HOURS LOST TO HANDOVER DELAY AND AMBER 95TH PERCENTILE



There were 536,260 incidents categorised as Amber between April 2016 and March 2018. 59% of patient waited less than 20 minutes for

an ambulance and 87% waited less than 60 minutes as shown in **Figure 18**.

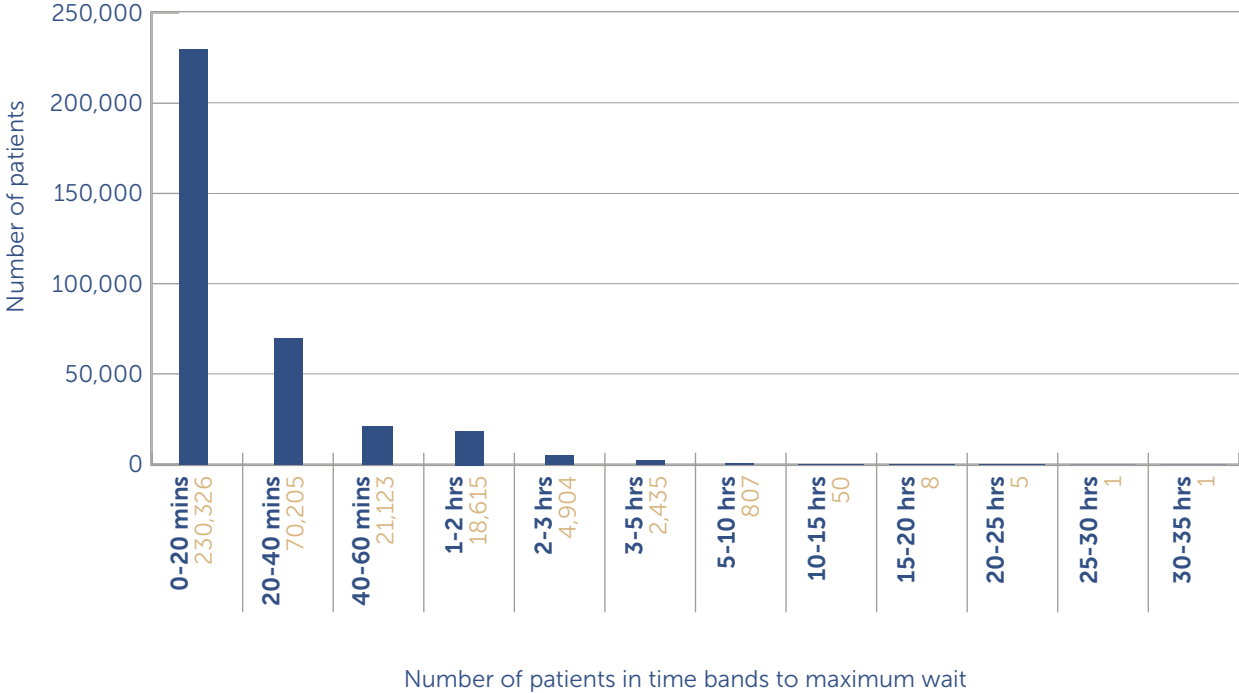
● FIGURE 18: RESPONSE TIME (IN TIME BANDS) FOR PATIENTS CATEGORISED AS AMBER



Within the overall Amber category there is a variance in response time between incidents categorised as Amber 1 or Amber 2. The majority, 65% of Amber incidents, were categorised as

Amber 1 and in this category 66% waited less than 20 minutes for an ambulance response and 92% waited less than 60 minutes as shown in **Figure 19**.

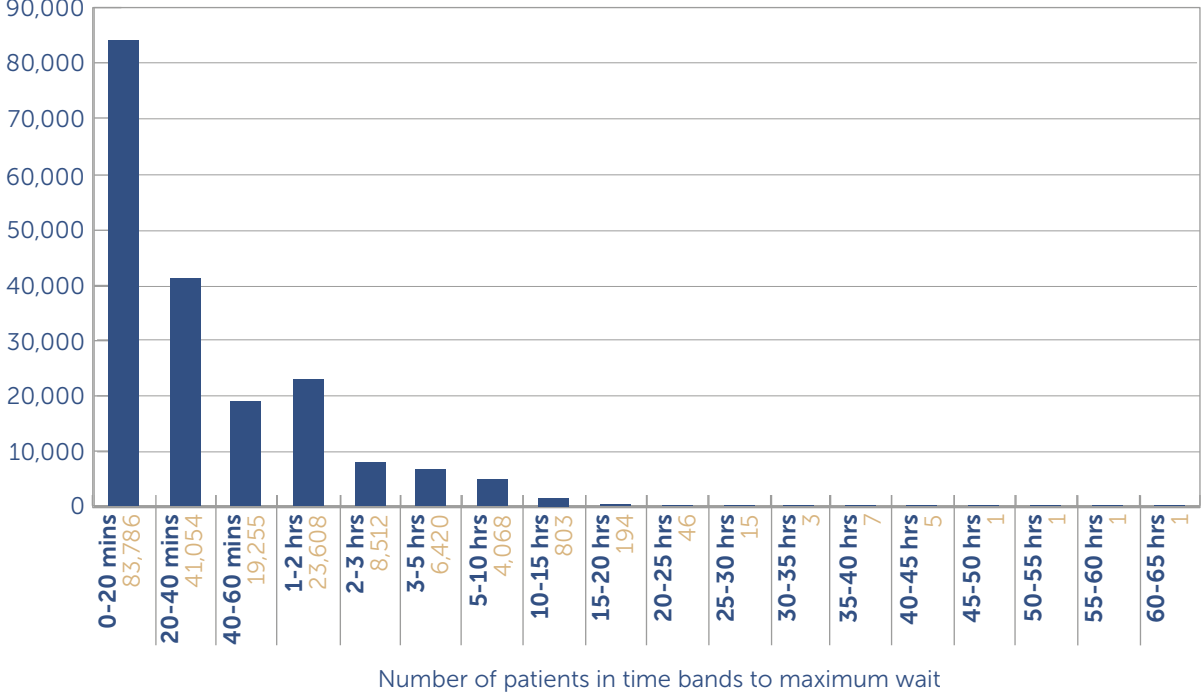
● FIGURE 19: RESPONSE TIME (IN TIME BANDS) FOR PATIENTS CATEGORISED AS AMBER 1



The remaining 35% of the total number of Amber incidents were categorised as Amber 2 and in this category 45% waited less than 20 minutes for an

ambulance response and 77% waited less than 60 minutes as shown in **Figure 20**.

● FIGURE 20: RESPONSE TIME (IN TIME BANDS) FOR PATIENTS CATEGORISED AS AMBER 2



Waiting for an ambulance, even for a short time can cause anxiety and frustration, especially if the patient is on their own, and information provided by the call handler, such as ambulance arrival time and what to do while waiting could reduce uncertainty in a stressful situation.<sup>78</sup>

The Welsh Ambulance Services should consider actions to reduce anxiety whilst patients were waiting with 97% of the public saying they would like to be told the approximate ambulance arrival time.

Contact centre staff may call waiting patients back to ensure their condition has not deteriorated. If during these ‘call backs’ the patient gives new information the call may be re-prioritised. This may re-prioritisation may

also occur if the patient calls back. 88% of the public thought that receiving regular ‘call backs’ from the ambulance service whilst they wait for a response was important. Sometimes when the volume of calls gets very high, these ‘calls backs’ get suspended. The reason for this is to ensure new calls get answered promptly. We believe that patient welfare checks are a vital part of the continuity of care that should be offered by Welsh Ambulance Services and that their suspension during periods of escalation should be reviewed.

The Amber Review has demonstrated that the majority of patients are receiving a timely response, however there is a compelling need for NHS Wales to work collaboratively to ensure a safe, timely and effective ambulance service.



of the public said  
they would like to be told the  
approximate ambulance  
arrival time

## 29 Serious Adverse Incidents

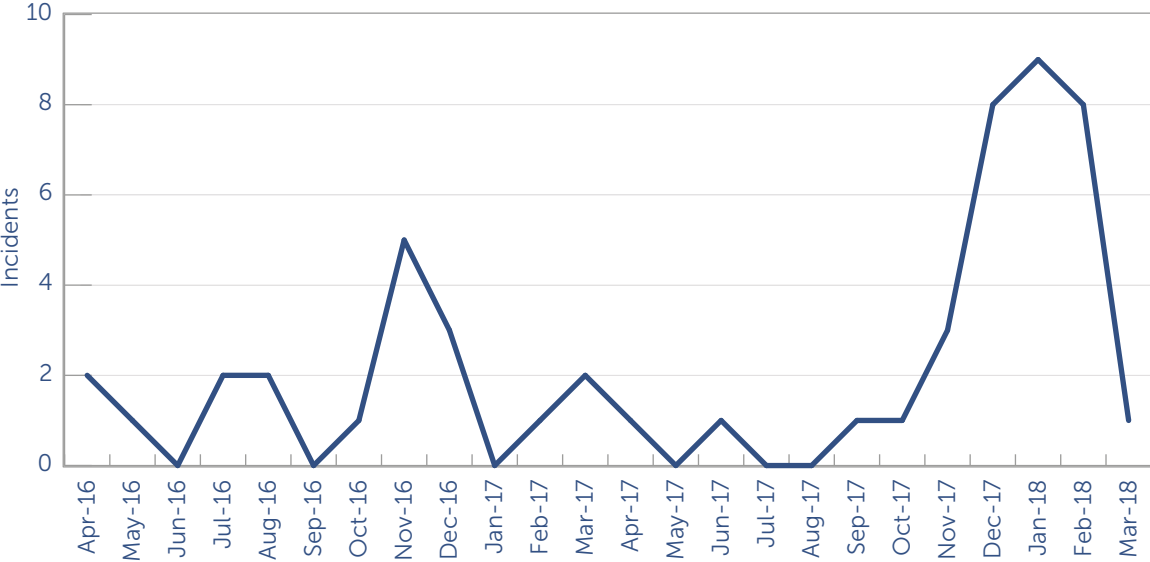
Serious Adverse Incidents are events where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified.<sup>79</sup>

There are policies and guidance in place for all NHS Wales organisations to describe the circumstances in which a Serious Adverse Incidents response may be required to ensure that they are investigated thoroughly and,

most importantly, learned from to prevent the likelihood of similar incidents happening again.<sup>80</sup>

From April 2016 to March 2018 Welsh Ambulance Services reported 90 Serious Adverse Incidents in their ‘Monthly Integrated Quality and Performance reports’.<sup>81</sup> **Figure 21** displays the reported incidents by months over the two year period, there were 28 incidents in 2016/17 and 63 in 2017/18 with a clear rise in the winter 2017 period.

● **FIGURE 21: NUMBER OF SERIOUS ADVERSE INCIDENTS REPORTED BY WELSH AMBULANCE SERVICES**



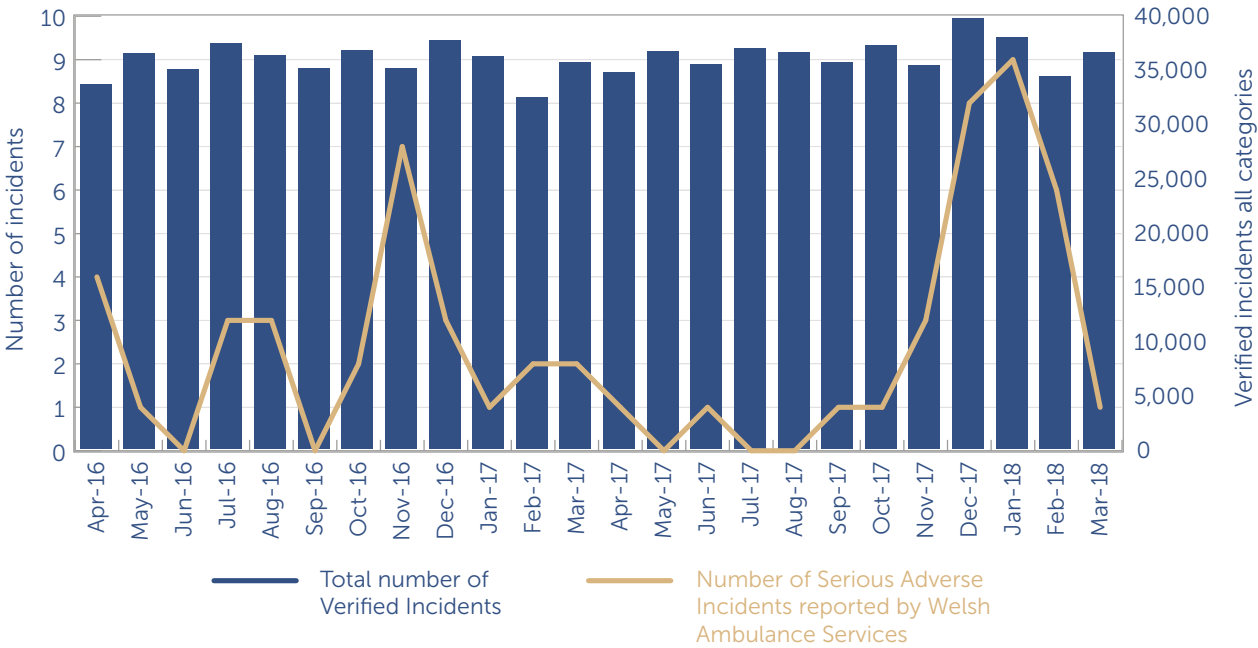




The reason for any rise in Serious Adverse Incidents can be multifaceted and difficult to identify. One of the simpler explanations is that the rise in the number of Serious Adverse Incidents shown in **Figure 21** relates to a rise in the number of verified incidents, the logic being that as demand increases, if the probability of a Serious Adverse Incident remains fixed, then the quantity would rise.

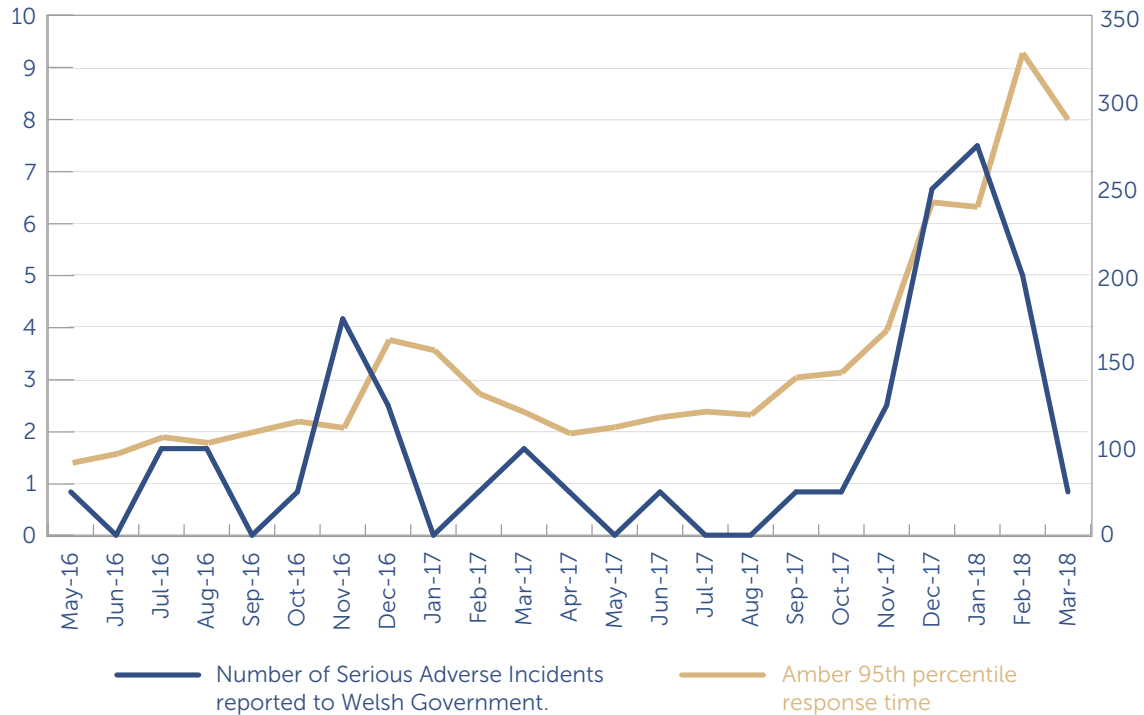
As **Figure 22** shows there does not appear a clear correlation between the number of verified incidents and the number of Serious Adverse Incidents as the number of incidents dropped in November 2016 and November 2017 compared to the previous months, however there was a rise in Serious Adverse Incidents in both months.

● **FIGURE 22: NUMBER OF SERIOUS ADVERSE INCIDENTS REPORTED COMPARED WITH THE NUMBER OF VERIFIED INCIDENT**



Another proposition is that the number of Serious Adverse Incidents can be linked to longer waits for ambulances. **Figure 23** correlates the number of Serious Adverse Incidents against the Amber 95th percentile.

● **FIGURE 23 COMPARISON BETWEEN NUMBER OF SERIOUS INCIDENTS AND AMBER 95TH PERCENTILE**



**Figure 23** shows a rise in the number of Serious Adverse Incidents alongside a rise in the Amber 95th percentile response time. However it is important to note, not all Serious Adverse Incidents are related to patients within the Amber category.

- Hand over delays and availability
- Availability of Staff and Welfare
- Call Centre categorisation and investigation process
- Escalation levels and protected resource

We are also aware that Welsh Ambulance Services have been issued a number of ‘Regulation 28 notices’ between April 2016 and March 2017. A Regulation 28 notices applies where a coroner is under a duty under to make a report to prevent other deaths.<sup>82</sup> Although these notices often state that a single cause cannot be said to have caused a death they have stated that delays could have been a ‘contributory factor’.

The independent board members of Welsh Ambulance Services, concerned at the rise in the number of Serious Adverse Incidents, have undertaken an ‘assurance review’ and found that there was “not just one root cause for each concern”. They found the significant issues to be:

The independent board members are keen to ensure rapid learning from these incidents.

Whilst straightforward correlations may be difficult to detect we are aware that behind every Serious Adverse Incident is either harm, concern or a poor experience of care.

We are eager to ensure that any lessons from Serious Adverse Incidents are learnt and shared, especially around the amber category. We therefore advocate that a further review is undertaken jointly by Welsh Ambulance Services and commissioners into the Serious Adverse Incidents reported and Regulation 28 notices received from December 2017 to February 2018.

### 30 Do long waits cause harm? – Overview

Some patients will have a poor experience whilst waiting a long time for an ambulance and we have discussed in previous sections how this poor experience can be improved.

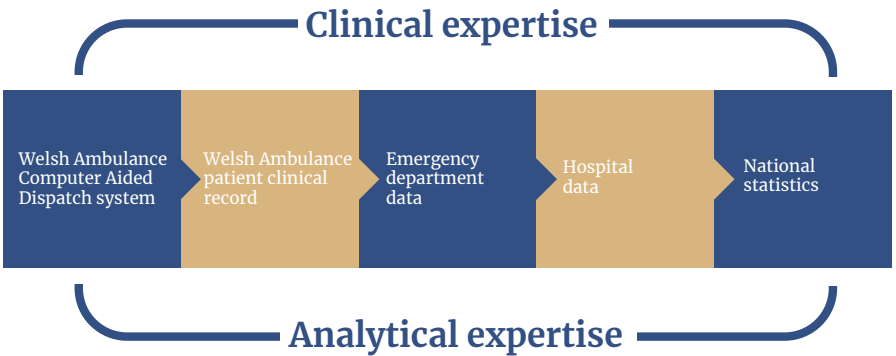
We should note that the statement ‘a long time’ is subjective and will have different value to different people. There is no definition that can be used so in this review we use various measures depending on context.

Nevertheless accepting poor experience and the subjectivity of ‘long waits’ one of the purposes of the Review is to understand if the categorisation of Amber is causing harm to patients. It should

be acknowledged that the relationship between waiting a long time and attributable harm is complex and uncertain.

To generate this understanding of correlation between potential harm and ‘long waits’ we have worked with a range of organisations across NHS Wales to develop an ‘Integrated Information Environment’ which allows us to digitally trace a patient’s journey across their episode of care and to use clinical and analytical expertise to scrutinise this journey and track interventions and outcomes. The data used to develop the Integrated Information Environment is shown in **Figure 24**.

● **FIGURE 24: THE INTEGRATED INFORMATION ENVIRONMENT**



The Integrated Information Environment contains millions of data points and to our knowledge this is the first time in Wales that this has been achieved on this scale or depth. Whilst the analysis within this report focuses on patients presenting to the ambulance service in the Amber category, there are significant opportunities to work in this environment to support developments within the wider health system

as currently there is a clear lack of integrated data across the patient journey.<sup>83</sup> The Clinical Prioritisation Assessment Software Group, mentioned earlier in this report, currently uses ambulance service data and clinical expertise to regularly review codes to ensure they are in most appropriate response category. The Integrated Information Environment should now be used by this group to augment this process.

### 31 Do long waits cause harm? – Outcomes

We have developed a range of indicators that can be used as a proxy measure of harm. We have grouped these to create a cluster of outcome indicators that we have used to explore the following issues:

**Waiting for an ambulance**

There is a perception that longer waits in the community for an ambulance response has a higher propensity to cause harm.

**Waiting in an ambulance**

There is a perception that long handover delays outside of hospitals are causing harm to patients.

For each of the areas there is a logical hypothesis that harm is linearly associated with an increase in volume or time. We aim to explore this hypothesis and understand its validity and applicability to the Amber category.



31.1  
Waiting for an ambulance

When studying the relationship between response times and patient outcomes, it is important to take into account the influence that the clinical response model has on these time-based outcomes. As the clinical response model is designed to reach those sickest individuals first, then we would expect to see the poorest outcomes for patients responded to the quickest. Therefore, in order to analyse the relationship between response and outcomes in a more pure way, we need to first adjust out the effects of the clinical response model, and this can be done through the use of the codes from the Medical Prioritisation Dispatch System mentioned previously in this report.

As also mentioned earlier, Medical Prioritisation Dispatch System codes are placed in either the Red, Amber 1, Amber 2 or Green category a consequence of which is that some codes are more likely to be clustered within incidents

having the quickest response times. Taking average outcomes for each code, we can calculate expected average outcomes for each response time,\* and then calculate outcome ratios by dividing the actual average outcomes with their associated expected average outcomes, at each response time point. **Figures 26–28** are expressed as these adjusted ratios, with the 100% line representing an outcome which is in line with what would have been expected given the mix of codes.

The proxy outcomes we used for patients waiting for an ambulance in the community.

- a. First presenting National Early Warning Score Ratio
- b. Conveyance Ratio
- c. Admission Ratio
- d. Cardiac Arrest Report Form (CARF)
- e. Recognition of Life Extinct (ROLE)

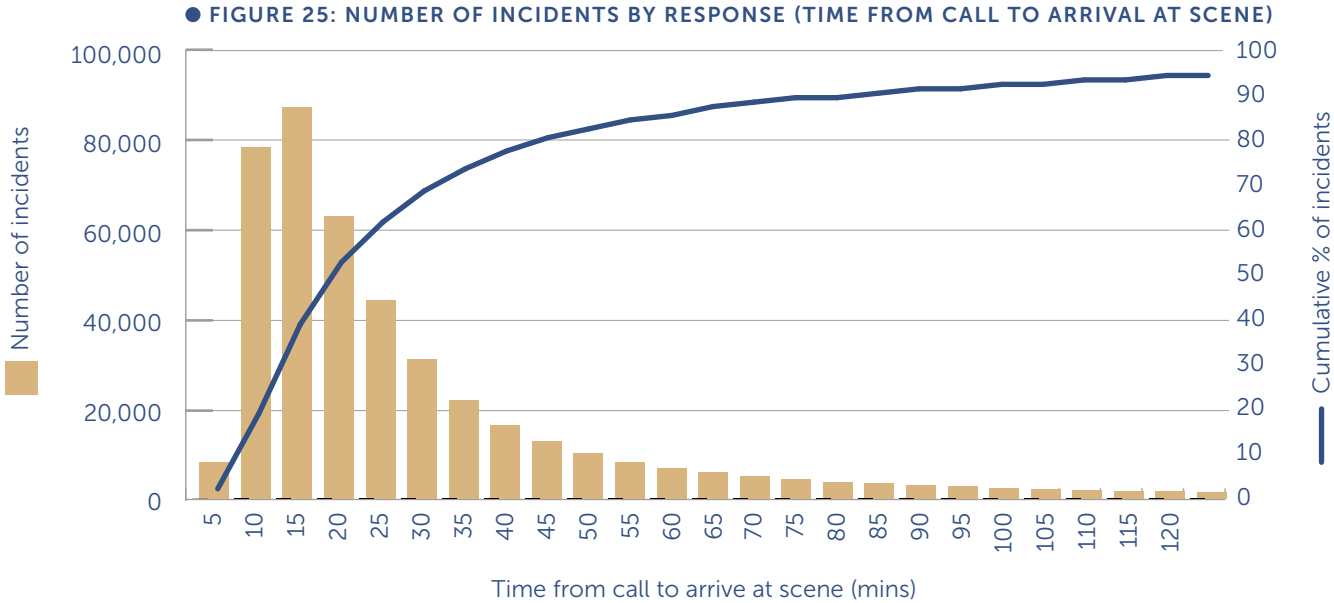
\*The expected average is a weighted average of the individual MPDS code outcomes, with weights based on the relative frequencies of those MPDS codes.



31.1.1  
Total incidents by Response Time

For context **Figure 25** shows the distribution of response times for all Amber calls, and it is clear that the majority of these calls are attended to within an hour, and care therefore needs to

be taken when assessing the significance of outcomes beyond this time which are likely to be subjected to a large degree of statistical error.

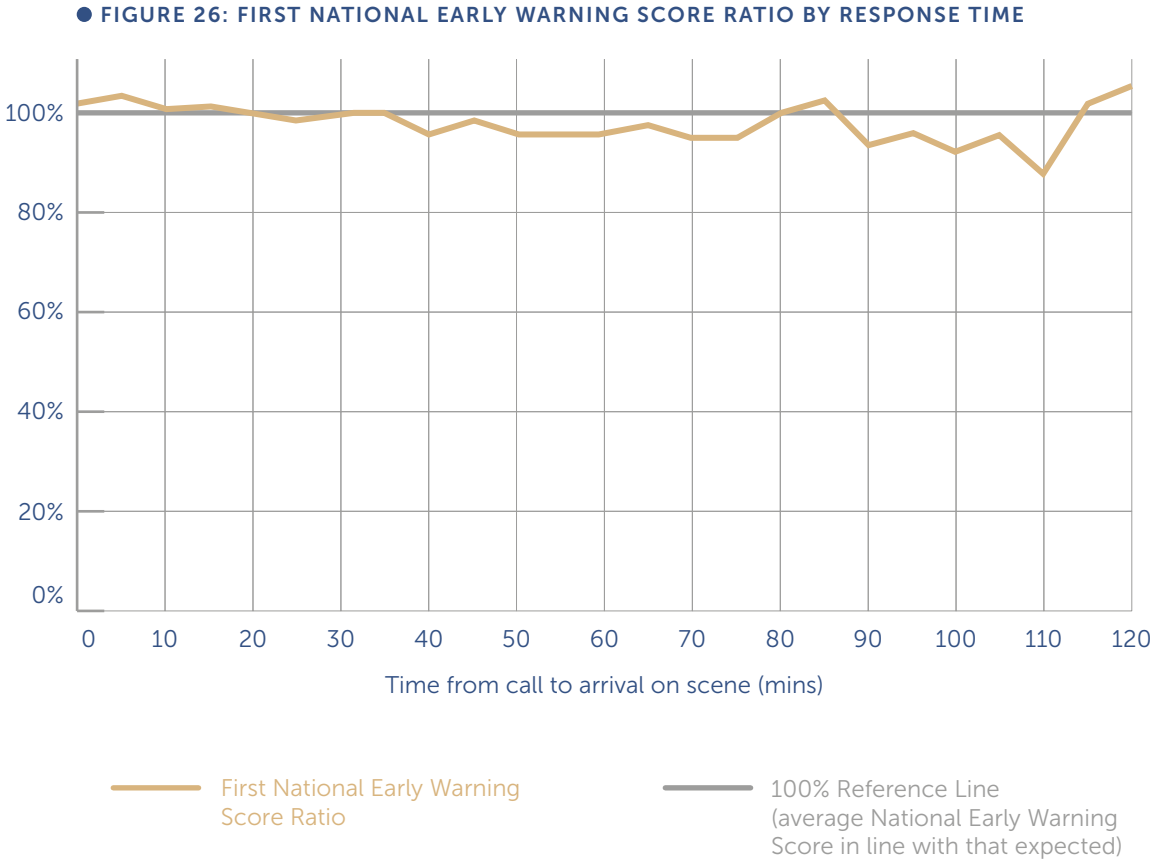


31.1.2  
First presenting National Early Warning Score Ratio

National Early Warning Score is used across the Ambulance Service and secondary care in Wales. It enables clinicians to calculate and articulate the level of risk of a patient’s physical condition deteriorating in a standardised way.

**Figure 26** demonstrates that those responded to within 20 minutes seem to have a higher National Early Warning Score on average than

would have been expected, given the mix of Medical Prioritisation Dispatch System codes, but after 20 minutes, it is generally lower. This effect might be down to a combination of factors; contact centre clinicians may be applying clinical discretion over the deployment of the next ambulance, or it could be that for a significant number of patients, their condition improves while they wait for an ambulance.

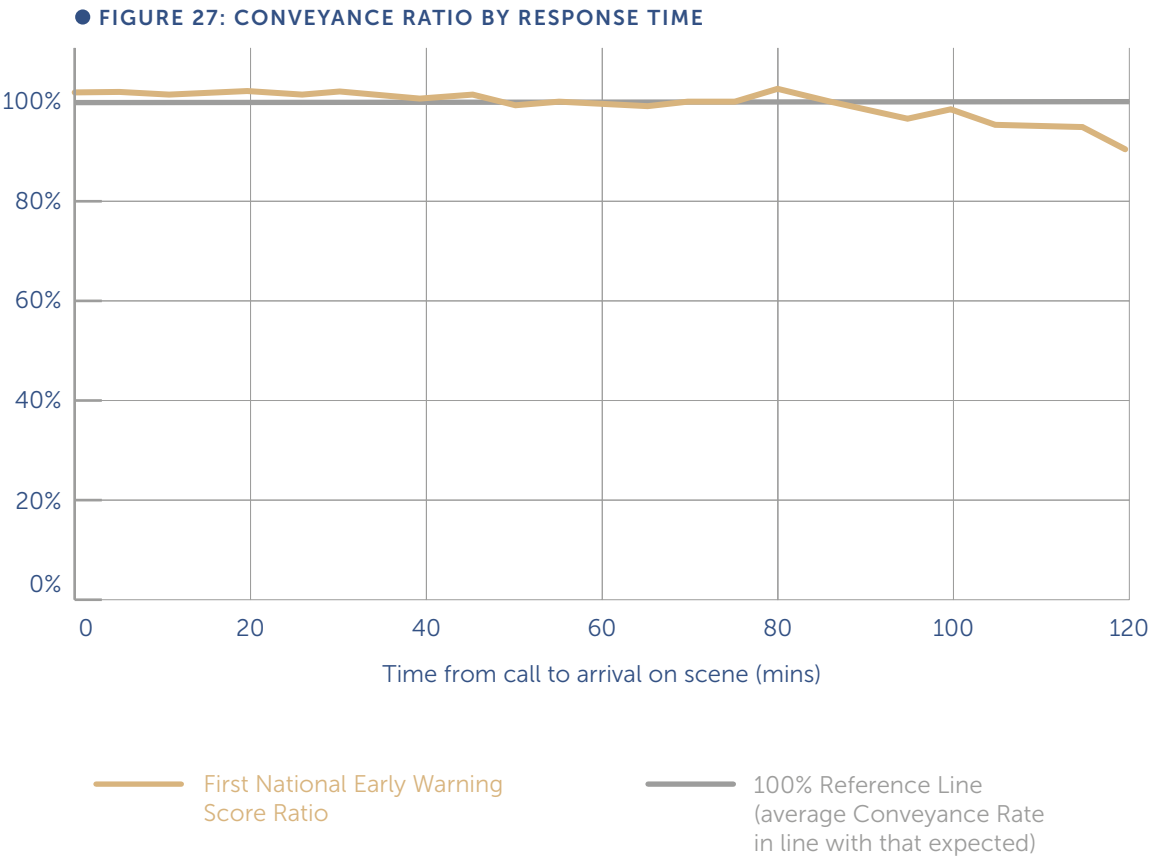


31.1.3  
Conveyance Ratio

Understanding the relationship between conveyance and length of response time may provide an insight into the appropriateness of ambulance prioritisation.

The conveyance ratios shown (**Figure 27**) are broadly in line with what would have been

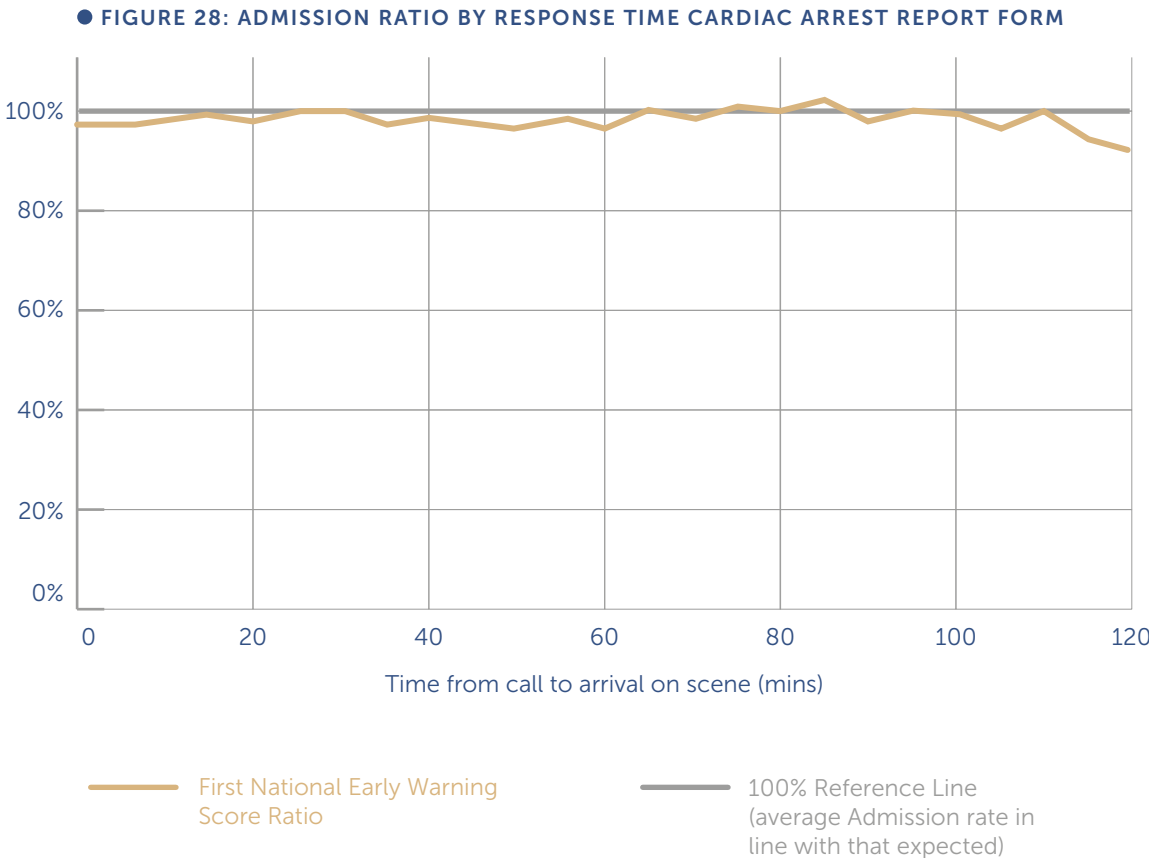
expected for response times up to around 80 minutes, but there is a noticeable drop-off beyond that point. However, care needs to be taken with regards to the interpretation of data points beyond this response time, due to the relatively small numbers involved.



31.1.4  
Admission Ratio

Understanding the relationship between response times and the rate of admission from Emergency Departments is a useful indicator of the clinical needs of a patient. Note that the ratio expressed is based on all incidents where an ambulance arrived at the scene, not just those where there was a conveyance to the Emergency Department.

**Figure 28** shows that the ratio of patients admitted into hospital is in line with that expected based on the mix of Medical Prioritisation Dispatch System codes, and there seems to be no evidence to show that longer response times have an effect on overall admission rates. However, this is not to say that there might have been individual instances in which a delayed response led to a poorer outcome, as stated earlier in this report.



31.1.5  
Cardiac Arrest Report Form

Understanding the link between response times and the need for cardiac arrest interventions is an important proxy measure of harm and accuracy of ambulance services prioritisation systems.

One of the ways we can measure this is to look at the number of patients in the Amber category where the ambulance crew document that they undertook an intervention as a result of the patient having a cardiac arrest. We looked at the time taken to respond to these patients compared to other patients.

Although it should be noted that the numbers are small in relation to the overall number of patients in the Amber category.

It is important to note that the cardiac arrest may occur at any point in time whilst the patient is with the ambulance crew.

Due to the very small numbers involved (0.3% of total Amber) it was not appropriate to calculate the adjusted ratios, and therefore, in **Figure 29** we compared the response time distributions for Amber patients having had a Cardiac Arrest intervention documented on the ‘Cardiac Arrest Report Form’ against those who did not.

**Figure 29** shows that those patients with an element of the Cardiac Arrest Report Form completed were attended to quicker than those without.

● FIGURE 29: COMPARISON OF RESPONSE TIME DISTRIBUTIONS FOR CARF V NOT CARF

	CARF	NOT CARF
Avg. response time (mins)	28.3	33.9
25th percentile response (mins)	7	8
Median response (mins)	13	16
75th percentile response (mins)	24.5	33
90th percentile response (mins)	51	74

31.1.6  
Recognition of Life Extinct

Understanding the link between response times and the Recognition of Life Extinct is an important proxy measure of harm and accuracy of ambulance services prioritisation systems.

**Figure 30**, due to the very small numbers (0.2% of total Amber), compares the response time distributions for Amber patients who are recognised as life extinct versus those who are not, and shows that the response times were slightly shorter in the Recognition of Life Extinct group.

● FIGURE 30: COMPARISON OF RESPONSE TIME DISTRIBUTIONS FOR RECOGNITION OF LIFE EXTINCT VERSES NON RECOGNITION OF LIFE EXTINCT

	CARF	NOT CARF
Avg. response time (mins)	33	33.9
25th percentile response (mins)	8	8
Median response (mins)	14	16
75th percentile response (mins)	27	33
90th percentile response (mins)	65	74

31.1.7  
Summary of Outcome Cluster for Waiting for an Ambulance

● FIGURE 31: WAITING FOR AN AMBULANCE OUTCOME SUMMARY

INDICATOR	FINDING
First presenting National Early Warning Score Ratio	Those responded to within 20 minutes have a higher National Early Warning Score than those responded to after 20 minutes
Conveyance Ratio	Conveyance ratios are in line with what would have been expected
Admission Ratio	No evidence that longer response times have an effect on admission ratios
Cardiac Arrest Report Form	Those patients with an element of the Cardiac Arrest Report Form completed were attended to quicker than those without
Recognition of Life Extinct	Response times for Recognition of Life Extinct patients were not dissimilar to non-Recognition of Life Extinct patients



31.2  
Waiting in an ambulance

It is difficult to gain a true understanding of the relationship between handover delays and patient outcomes, due to the fact that patients who wait in an ambulance are not representative of all patients conveyed to Emergency Departments.

The fact that these patients need to stay in an ambulance with crew members could indicate that their condition is such that they are not well enough to wait in the Emergency Department waiting room.

We focused on the observations taken during the patient’s time within the ambulance such:

- National Early Warning Score
- Pain scores

It should be noted that the numbers involved for this analysis are quite small, due to the current difficulties in identifying and analysing multiple observation records.

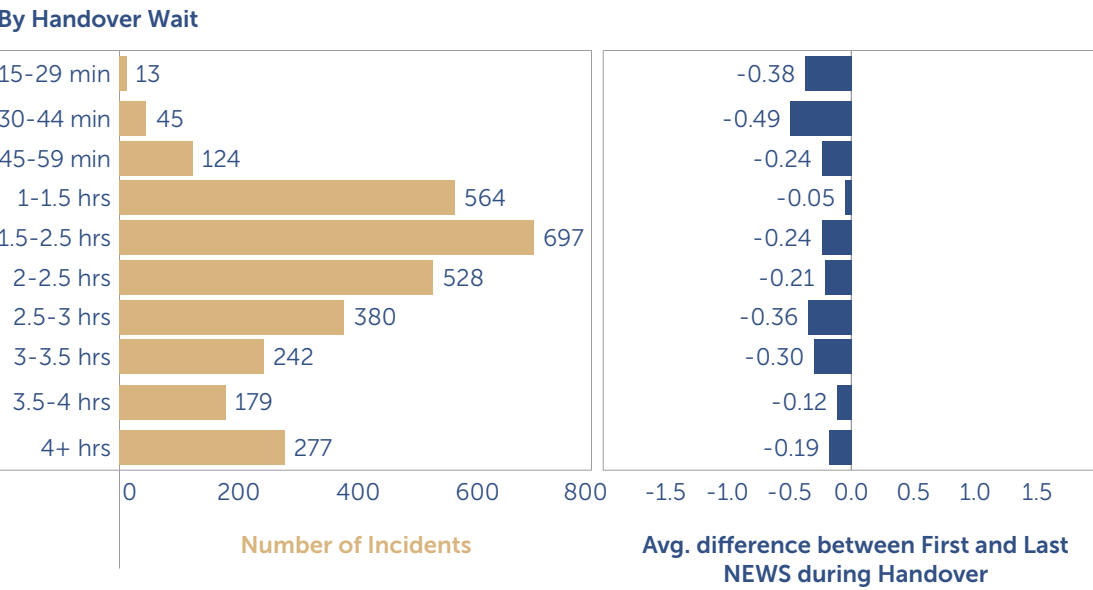
31.2.1  
Difference between the average First and Last National Early Warning Score during hospital handover delay

Measuring how a patient’s National Early Warning Score is affected during the wait outside a hospital prior to being handed over is important for understanding the impact of waiting on a patient’s clinical condition.

Figure 32 shows the differences between the average first and last National Early Warning

Score recorded by the ambulance crew during the handover delay, and for each of the handover wait time bands, the differences were less than zero, denoting that, on average, patients’ scores reduced slightly during their time in the ambulance, as we may expect when being cared for by skilled ambulance and emergency department staff.

● FIGURE 32: DIFFERENCE BETWEEN AVERAGE FIRST AND LAST NATIONAL EARLY WARNING SCORE DURING HOSPITAL HANDOVER DELAY



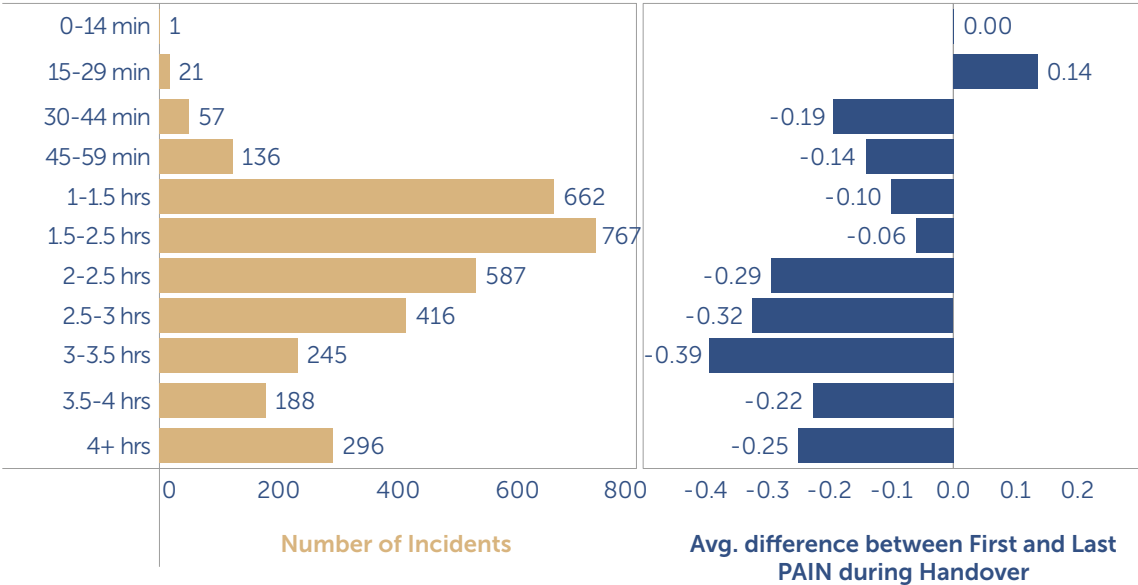
31.2.2  
Difference between the average First and Last Pain score during hospital handover delay

Measuring how a patient’s pain trend is affected during the wait outside a hospital prior to being handed over is important for understanding the impact of waiting on a patient’s clinical condition.

Figure 33 shows that the average pain scores reduced between the first set of observations outside the hospital and the last set of observations before the handover.

● FIGURE 33: DIFFERENCE BETWEEN FIRST AND LAST PAIN SCORES DURING HOSPITAL HANDOVER DELAY

By Handover Wait



31.2.3  
Summary of Outcome Cluster for Waiting in an Ambulance

● FIGURE 34: WAITING IN AN AMBULANCE OUTCOME SUMMARY

INDICATOR	FINDING
Difference between the average First and Last National Early Warning Score during hospital handover delay	On average patients’ National Early Warning Score reduced during their time in the ambulance, as we may expect when being cared for by skilled ambulance staff and ED
Difference between the average First and Last Pain score during hospital handover delay	On average pain scores reduced between the first set of observations outside the hospital and the last set of observations before the handover as we may expect when being cared for by skilled ambulance and ED staff

32 Do long waits cause harm? – Summary

It is possible that some patients may in the longer term exhibit poorer health outcomes due to their long wait for a response, however using the data available to us within the Integrated Information Environment there appears to be no *direct* relationship between long waits for an ambulance response and poorer outcomes for the majority of patients.

We believe that work should continue, in order to understand the relationship between harm and response times, especially for specific conditions, and that additional information is required to augment the Integrated Information Environment such as tissue viability assessments and emergency department interventions. ●



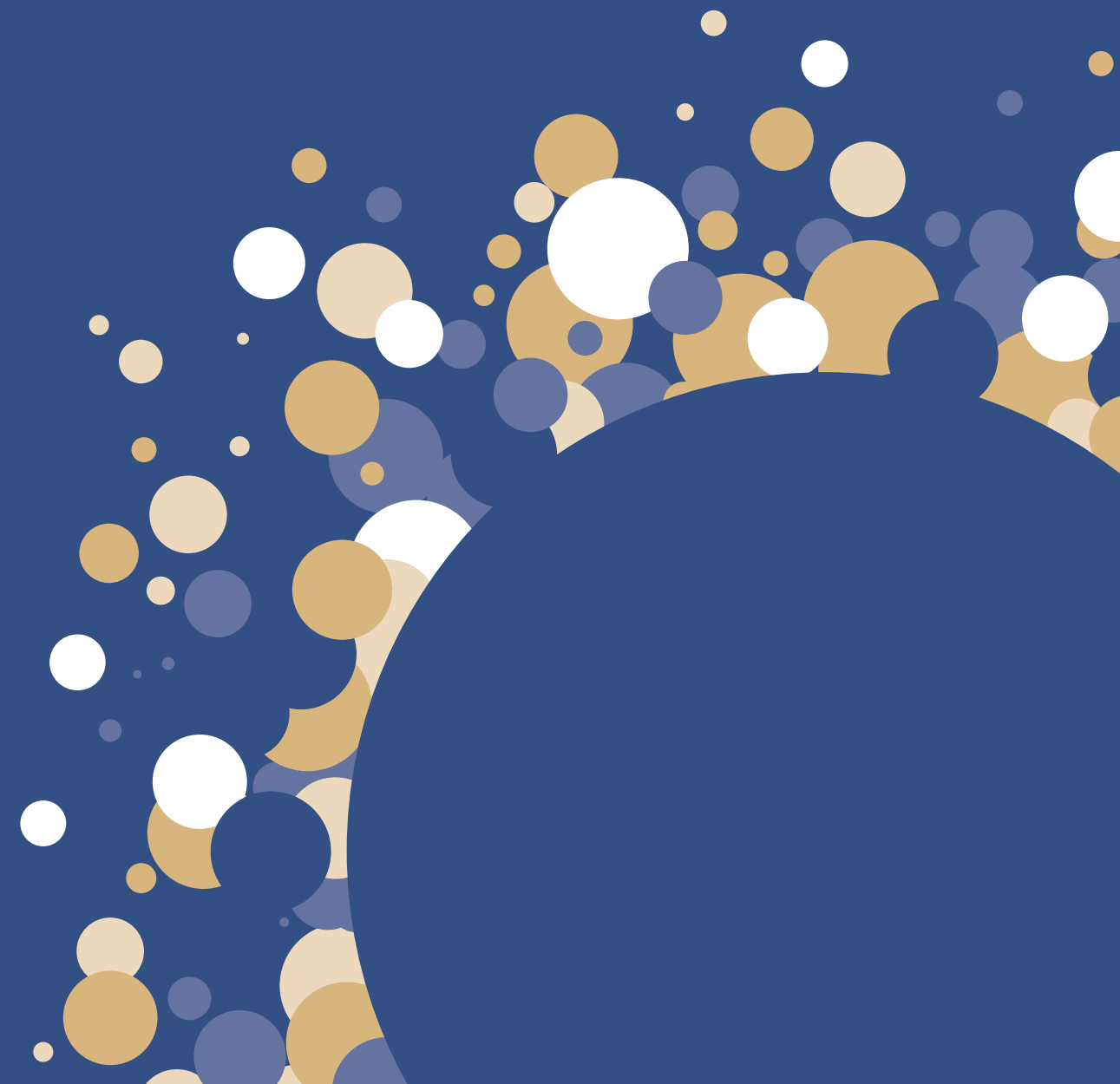
### 33 FINDINGS FOR DELIVERING AMBER

- Funding for ambulance services has increased
- The ambulance service does not always deliver sufficient resources to meet demand
- The time ambulances are waiting outside hospitals has increased
- Sickness levels remain high
- Emotional and psychological wellbeing of staff is important
- Call handlers should be supported, especially during periods of increased activity
- Resource availability is the foremost factor in providing an appropriate response
- A lack of resource availability can result in longer waits for some patients
- There has been an increase in the number of Serious Adverse Incidents reported
- The clinical response model is a valid and safe way of delivering ambulance services
- Members of the public support the principles of the clinical model
- The length of time you wait for an ambulance response in the Amber category, does not appear to correlate with worse outcomes

#### PART D

## Improving Amber

**This section considers the findings of the Amber Review and highlights opportunities for improvement.**



We have delivered in this Report a comprehensive assessment and narrative that describes the Amber category in detail. Overall we find that the principle of the clinical response model, of getting to the sickest patient first and getting the right response to the patient is supported by both the public and staff.

We have found instances of good practice as well as opportunities for improvement to the quality of care, public understanding or ambulance response for patients whose conditions have been categorised as amber.

The Welsh Ambulance Service is experiencing an increase in demand on its services, and the service is contributing in mitigating the impact of this demand on the wider health services.

There needs to be a better understanding of why demand is increasing, the role of other services in driving this demand and how the ambulance

service can further contribute to the management of this demand as part of the wider health system.

We have developed and used an innovative Integrated Information Environment to examine any possible correlation between response times, waiting outside a hospital and poorer outcome. We are reassured that this information demonstrated that the Welsh Ambulance Service is effectively prioritising patients and getting to the sickest patients first. We have shown that when patients are waiting outside of a hospital for admission they do not, on the whole, deteriorate or have worsening pain.

We believe that this Integrated Information Environment will provide stakeholders with a rich resource to enable a greater understanding of the key factors involved in pre-hospital unscheduled care and will enable more effective commissioning and delivery of services.

The link between Serious Adverse Incidents and Amber category is complex, and a clearer understanding of the root causes of these incidents need to be established.

**We have found that there are a number of patients in the amber category that are waiting too long to receive a response. The overriding factor in improving this is the availability of ambulance resources and not the categorisation of these patients as Amber.**

In order to avoid the combination of factors that were seen last winter, the ambulance service and the wider NHS must ensure that it takes every opportunity to maximise the availability and efficiency of resources in order that the patients of Wales receive the highest quality and timely ambulance response.



FINDINGS

The Review has found:

Explaining Amber

- The prioritisation of calls is complex
- There is a range of different responses depending on the patient’s condition.
- Ambulance staff felt frustrated by the restrictive nature of the prioritisation system
- The public felt that it was important to get the best response for their condition even if this was not the quickest

Exploring Amber

- There was increased demand in the Amber category
- Ambulance staff felt that expanding the numbers and roles of clinicians in the control room was essential
- Receiving a quick ambulance response but ensuring this is the right response for your condition is important to the public
- Further work is required to explore the relationship between cancellations and re-categorisations and ambulance response
- Further work is required to explore the relationship between hoax calls, refusals and ambulance response
- The Public support ambulance services doing at much as possible to avoid the need for them to go to hospital
- Staff require more information on alternative services
- Measures of quality is as important as response times
- Measurement of the ambulance service should be refined to reflect the whole patient journey
- Measures should be developed in partnership with patients
- Members of the public wish to be supported and be better informed when making a 999 call
- More patients in the Amber category are having their incident resolved or closed over the phone

RECOMMENDATIONS

Delivering Amber

- Funding for ambulance services has increased
- The ambulance service does not always deliver sufficient resources to meet demand
- The time ambulances are waiting outside hospitals has increased
- Sickness levels remain high
- Emotional and psychological wellbeing of staff is important
- Call handlers should be supported, especially during periods of increased activity
- Resource availability is the foremost factor in providing an appropriate response
- A lack of resource availability can result in longer waits for some patients
- There has been an increase in the number of Serious Adverse Incidents reported
- The clinical response model is a valid and safe way of delivering ambulance services
- Members of the public support the principles of the clinical model
- The length of time you wait for an ambulance response in the Amber category, does not appear to correlate with worse outcomes

In light of these findings the Review recommended the following:

- Measures of quality and response time should continue to be published although they need to reflect the patient’s whole episode of care
- Measures should be developed in collaboration with patients
- There should be a programme of engagement to ensure clarity on the role of emergency ambulance services and how calls are prioritised and categorised
- NHS services in Wales must improve and simplify their offering of alternative services
- There must be sufficient numbers of clinicians in the contact centres to ensure patients receive the most appropriate level of care
- The ambulance service must ensure that planned resources are sufficient to meet expected demand
- The ambulance service must deliver against it planned resource
- Health Boards must take appropriate actions to ensure that lost hours for ambulances outside hospitals reduce
- The longest waits for patients in the community must be reduced



It also recommends that further work is required as follows:

- Understand the change in activity and explore opportunities for improvement in:
  - number of calls
  - patient cancellations
  - re-categorisation
  - refusals of treatment and transportation
- The role of the clinical support desk within the wider unscheduled care system should be reviewed
- A review should be undertaken by the Chief Ambulance Services Commissioner to support the Welsh Ambulance Service to maximise front line staff availability
- There should be a review of the Serious Adverse Incidents reported and Regulation 28 notices received over the most recent winter to ensure lessons are learnt and shared
- A review should be undertaken by the Chief Ambulance Services Commissioner to support Health Boards to minimise lost hours to handover delay
- The Chief Ambulance Services Commissioner will develop and implement a long wait reduction programme

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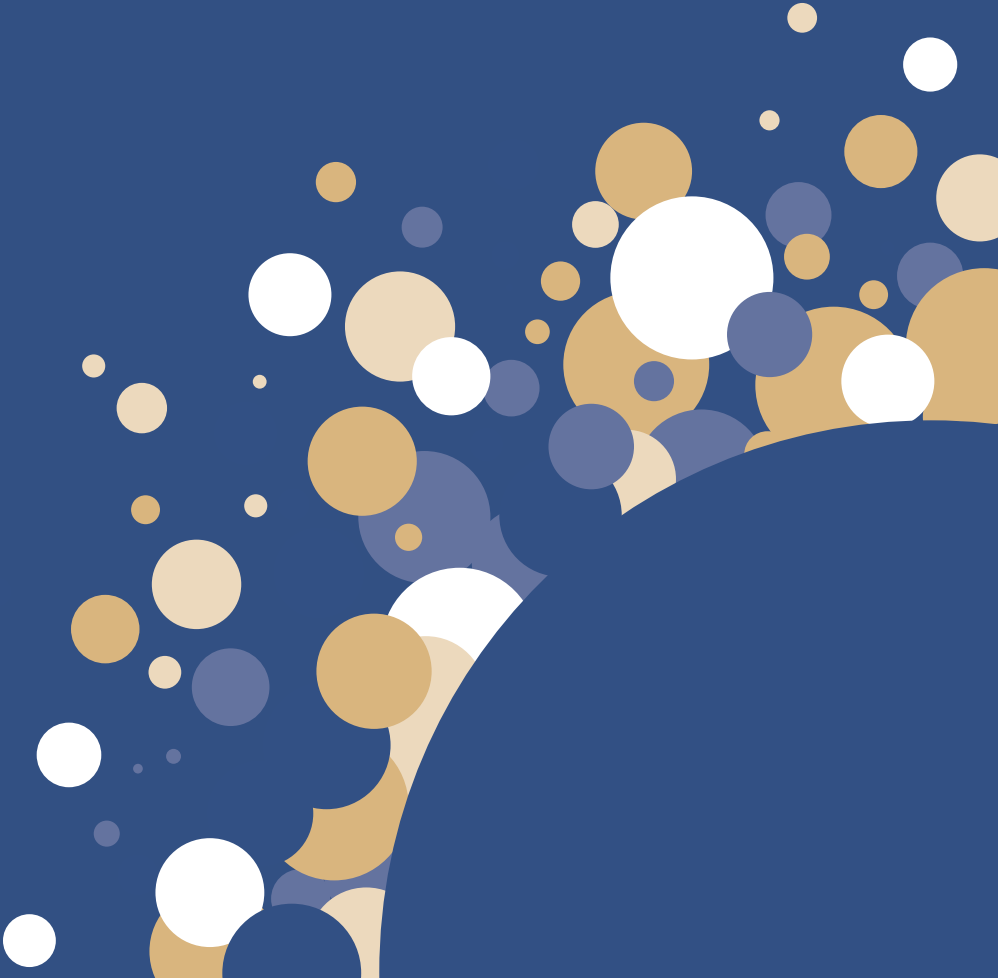
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# Appendix



Appendix I

Appendix I Introduction

The 2016/17 independent review of the clinical response model pilot, undertaken by the Public and Corporate Economic Consultants (PACEC), made a number of recommendations for further improvement to the clinical response model, including a recommendation to review the call categories outside of ‘Red’.

At the Emergency Ambulance Services Committee (EASC) of 28 March 2017, the committee members and Chief Ambulance Services Commissioner (CASC) endorsed the PACEC review and agreed to address the recommendations. A call category review was undertaken by the WAST Clinical Prioritisation Assessment Software Group in 2017/18 and ongoing review processes are in place.

However, it is recognised by the CASC, that the implementation of the clinical model is more nuanced than the allocation of clinical codes to response categories, and that there is significant interest across the political and public spectrum in the quality and safety of the ambulance response, particularly for patients whose clinical condition places them within the Amber category.

The 2018/19 EASC Integrated Medium Term Plan (IMTP) approved by the committee on the 27 March 2018, commits the CASC to undertake an ‘Amber review’ to consider these wider issues. The CASC has directed the EASC clinical team

to lead a review addressing the information, issues and concerns surrounding the Amber call category that will also consider patient expectation and experience, use of alternative responses and pathways, ambulance handover times and system risk.

Accountability and governance

The Chief Ambulance Services Commissioner will function as the reviews sponsoring officer. The review will be led by experienced clinicians, Mr Shane Mills, Director of Quality and Patient Experience and Mr Ross Whitehead, Assistant Chief Ambulance Services Commissioner. The review team will:

- Report formally to the Emergency Ambulance Services Committee on a quarterly basis.
- Bring to the Chief Ambulance Services Commissioners attention any significant matters, and seek decisions/guidance where necessary.

Scope

The review programme covers four general areas in respect of calls within the Amber category: In considering these questions the review team will ensure that the overarching aim of the clinical response model of ensuring that the sickest patients receive the quickest response and that the right response is sent the first time are used as the benchmark for assessing success.

Context – What is the Amber Category?

This question will explore:

- What conditions does it contain?
- How does it compare to similar categories elsewhere such as England, Scotland and internationally?
- How is this category prioritised?
- How is this category responded to?

Activity – What has been the workload in this Category over the last 2 years?

This question will explore:

- What has been the activity in this category for the last 2 years?
- How does this compare with similar activity elsewhere such as England, Scotland and internationally?

Performance/Outcomes – Is there a problem with the Amber Category?

This question will explore:

- What performance/outcomes have been achieved over the last 2 years?
- How does this compare to similar categories elsewhere?
- What is the relationship between the ambulance service performance and wider system pressures such as hospital handover delays? (including SAIs, Winter etc)
- How does the achieved performance compare with extant clinical guidelines?

Improvement – What can be done differently for this category?

This question will explore:

- Are the right conditions/patients in this category?
- Can we respond differently to parts or all of this category with existing or new services?
- Are we commissioning services to respond to this category effectively?

Guiding principles

In undertaking this review, the review team will be guided by the following principles. It will be guided by the principles of Prudent Healthcare and the ‘quadruple aim’:

- Improve population health and wellbeing.
- Improve the experience and quality of care of individuals and families.
- Enrich the wellbeing, capability and engagement of the workforce.
- Increase the value achieved from funding through improvement, innovation, use of best practice and eliminating waste.
- Encourage a whole system approach to the management of citizens in the Amber category, maintaining a focus on people, their outcomes and what matters to them.
- Ensure the clinical prioritisation of calls to emergency ambulance service is continued.

Stakeholders

The review will ensure wide engagement with relevant stakeholders, including:

- National Assembly Members
- Welsh Government
- Health Boards Executives and Clinical Leaders
- WAST Executives and Clinical Leaders
- Relevant voluntary agencies/groups (e.g. Stroke Association)
- Professional colleges (College of Paramedics, Royal College of Emergency Medicine, Royal College of General Practitioners)
- Staff representatives
- Clinical Networks

The review team are engaged with the Picker Institute to undertake staff and citizen engagement activities.

Support and dependencies

The Review team will be working at pace to address the Areas covered in section 3. The review team will in particular require dedicated support from:

- National Collaborative Commissioning Unit (for example Clinical Director of Unscheduled Care, administrative support)
- Subject area experts (for example WAST call takers, WAST clinicians, ED clinicians)
- Data and information specialists (for example NWIS, WAST, HBs)

The review team will be dependent on information providers for timely responses to information requests.

The review team will contact specific agencies outlining the required support week commencing 16 April 2018.

The review team will require access to funding, estimated at £72,000, to support research, engagement and communication activities.

Review

The review team will establish an expert reference group to provide independent peer review and oversight of the programme. A broad membership of experts will be drawn from across NHS Wales, academic and other institutions.

Appendix II

Methodology followed by the Amber Review

1 Methodology

The broad nature of this review required a mixed methods approach. The relevant methodology for each distinct area that the review covered is outlined below.

1.1 Context

This was a desk review that traced the history of the implementation of the clinical model in WAST and the background to the commencement of the commissioning of WAST and the establishment of EASC.

1.2 Comparisons with other countries

A desk review of library searches, public information searches and requested information to compare the model and activity in Wales with that of other countries.

1.3 Data sources and analysis

A two year time period for the 31 March 2016 to 1 April 2018 was agreed. The main data source for activity was provided by the Welsh Ambulance Services Informatics team based on the regular information provided to the Clinical Prioritisation Software Assessment Group. Performance information was derived from publicly available information from StatsWales, Ambulance Quality Indicators or Welsh Ambulance board reports. The Review Team also appointed a dedicated and experienced senior data analyst as the Amber Review data lead to ensure robust quantitative analysis.

1.3.1 Data Linking

A novel approach to using linked data across a patients unscheduled care journey was developed. The full methodology for the establishment of this data set is provided in Technical Appendix 1. A range of outcome cluster in dictators were developed to explore the impact of waiting on patients.

1.4 Management Engagement

Five individual interviews were undertaken by the Picker Institute with senior operational and clinical managers within the Welsh Ambulance Service. A topic guide was developed to frame the interview and a narrative summary of the discussions produced.

1.5 Staff engagement

Three focus groups were undertaken by the Picker Institute across Wales with a variety of operational staff. A topic guide was developed from the themes identified by the management interviews and a narrative summary of the discussions produced.

1.6 Public Engagement

A survey was developed by the Picker Institute to explore public perceptions and expectation of ambulance services for an urgent clinical condition. The survey was facilitated by YouGov and 1000 responses were received. Analysis of the findings and demographics of the respondents was then produced.

Appendix III

Expert Reference Group Invitees

**Stephen Clinton**  
Assistant Director of Operations  
(Clinical Contact Centers)  
Welsh Ambulance Services NHS Trust

**Shane Mills**  
Director of Quality and Patient Experience  
National Collaborative Commissioning Unit

**Ross Whitehead**  
Assistant Chief Ambulance Services Commissioner  
for The Emergency Ambulance Services Committee

**Chris White**  
Interim Chief Operating Officer  
ABM UHB

**Jonathan Whelan**  
Assistant Medical Director  
Welsh Ambulance Service NHS Trust

**Paresh Wankhade**  
Professor of Leadership and Management & Director  
of Research, Edge Hill University Business School

**Grayham Mclean**  
Unscheduled Care Lead , Executive Department,  
Welsh Ambulance Service NHS Trust

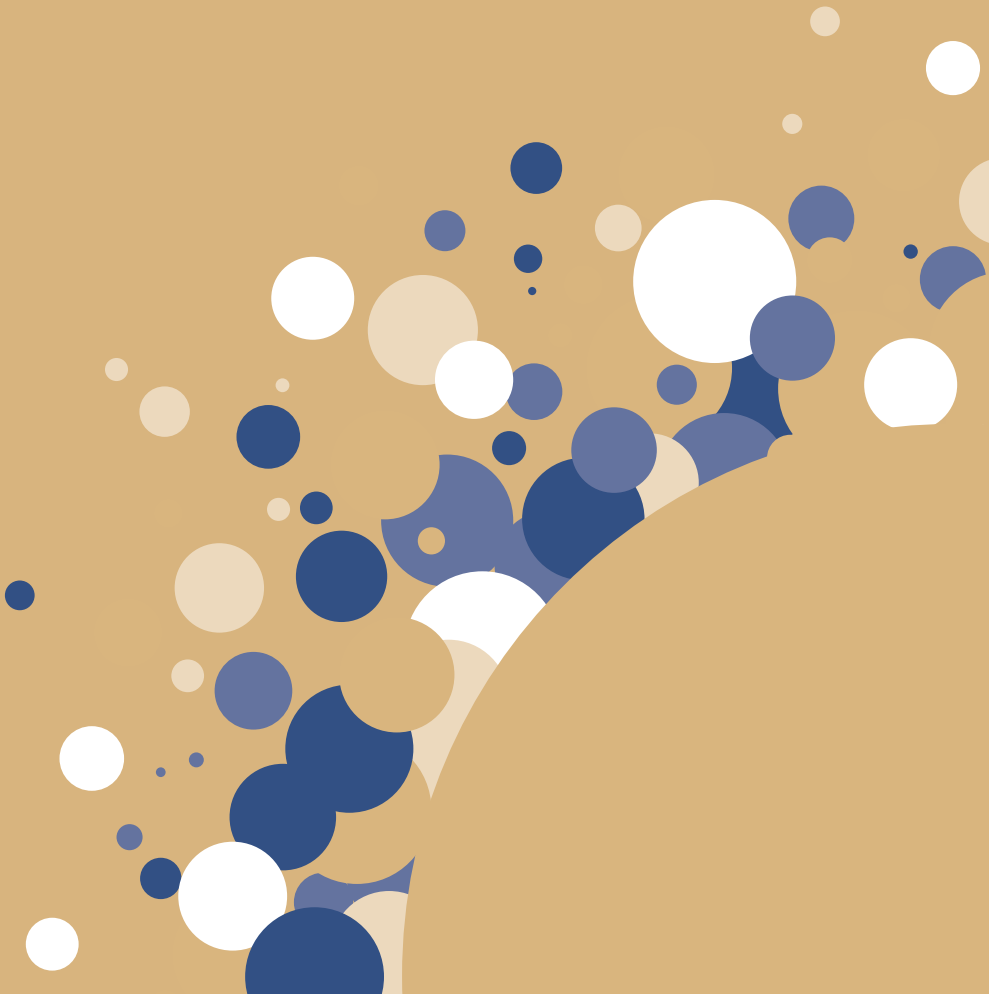
**Jan Thomas**  
Assistant Chief Operating Officer  
Corporate Services, ABM UHB

**Jo Mower**  
Clinical Director National Programme  
Unscheduled Care  
National Collaborative Commissioning Unit

**Andy Swinburn**  
Assistant Director of Paramedicine  
Welsh Ambulance Services NHS Trust ●

TA Technical Appendix

Supplementary information  
or supporting detail





# Technical Appendix: 1

## Methodology for linking Welsh Ambulance Services Trust data to Emergency Department data

**AUTHORED BY:**  
**Dr Gareth John**  
*NHS Wales Information Service*

### Data Sharing

A data-sharing agreement was signed by WAST and the NHS Wales Informatics Service (NWIS), allowing NWIS to access the ambulance Computer Aided Dispatch (CAD) and Patient Clinical Record (PCR) data. This agreement applied to data collected during the period 1st April 2016 to 31st March 2018, coinciding with the study period.

### Computer Aided Dispatch (CAD) data

Each ambulance incident can result in a dispatch of any number of vehicles, with associated CAD records being generated for each of these vehicle journeys. These records contain an incident identifier plus information about the nature of the incident and the MPDS dispatch code allocated to that incident (see below for details of MPDS), the type of vehicle dispatched, the location of

the incident, the key date/time points along the ambulance call cycle (e.g. time of call, time dispatch code established, time at scene, time left scene, time at hospital, time of handover), and the destination hospital.

In terms of person demographics, only the age and gender of the patient are recorded within the CAD record, although only one set of person demographics are provided per incident, regardless of the number of patients or conveyances involved in that incident. Therefore, within the record, it can appear that a 36 year old male was conveyed to hospital in a particular ambulance, whereas in fact it was a 30 year old female who was involved as part of the same incident, and the 36 year old male may have been separately conveyed to hospital in another vehicle, or may not have been conveyed at all.

Any vehicle can be “stood down” at any point in the journey, and these manifest themselves as “stop reasons” or “stood down” flags in the CAD dataset. In many cases, the vehicle which arrives first at the scene of an incident is not the one that subsequently conveys the patient to hospital. For example, a Rapid Response Vehicle (RRV) will often be the first vehicle on scene, but an Emergency Ambulance may subsequently convey the patient to hospital.

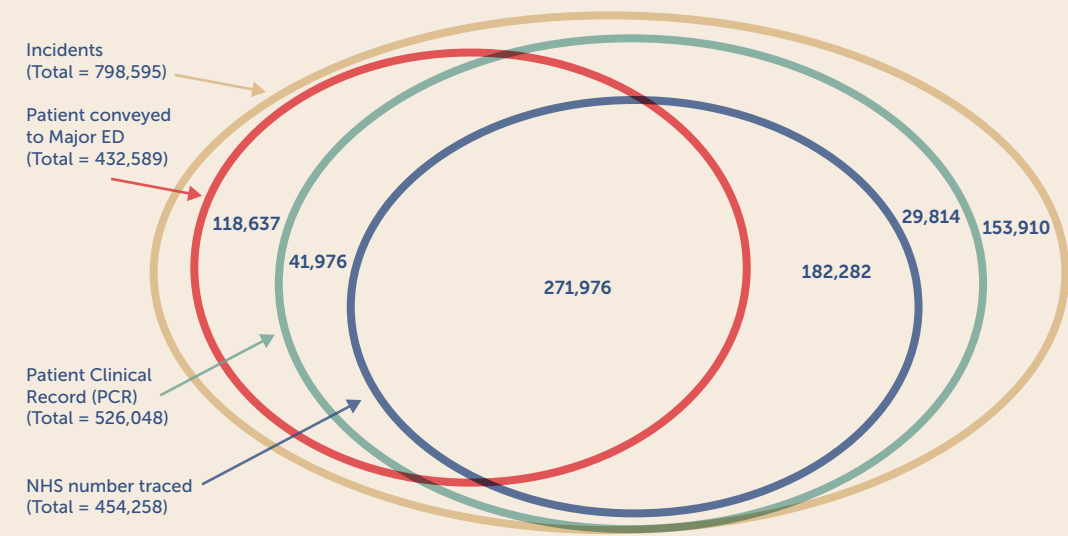
For the study period, the CAD data contained information relating to 798,595 distinct incidents, 432,589 (54.2%) of which involved the conveyance of at least one patient to one of the major EDs in Wales.

Patient Clinical Record (PCR)

The vehicle crew can complete any number of PCR forms for patients that they attend to, and these can be linked to the associated CAD records using unique PCR form identifiers. The PCR contains personally identifiable information (PII) such as forename, surname, date of birth, gender and postcode of residence, from which it is possible to derive NHS numbers using the standard NWIS/SAIL matching algorithm, which uses both exact and probabilistic matching. The derived NHS numbers can then be used facilitate the onward linkage of records to other health and mortality data, for both those sets of patients conveyed to hospital and for those treated at the scene or left at home.

The remainder of the PCR record is composed of detailed clinical information, including the six physiological findings and one observation that make up the National Early Warning Score (NEWS), which is used as a proxy measure for the level of acute illness. There are also pain scores and specific sections relating to the particular nature of that incident, e.g. Road Traffic Collisions and Cardiac Arrest. For the study period, PCRs were found for 526,048 incidents (67%), of which 454,258 were able to be traced to an NHS Number (86.3%). For those 432,589 incidents involving a conveyance to one of the major EDs in Wales, PCRs were found for 313,952 incidents (73%), and of these, NHS numbers were able to be traced for 271,976 (86.6%). A visual representation of the above numbers is shown in **Figure 35** below.

● **FIGURE 35:**



Linkage of conveyance ambulance incidents to ED records

Emergency Department (ED) data

The ED dataset contains demographic, administrative and clinical information relating to each attendance at an emergency department in Wales. The demographic fields include PII fields such as NHS number, forename, surname, date of birth, gender and postcode of residence, and the administrative data items include the name/code of the hospital, the patient’s mode of arrival, the ambulance incident number, key time points such as the administrative arrival date/time (the ED check-in time) and administrative end date/time, and the outcome of the attendance.

Due to considerations of data quality and availability, the scope of the linkage exercise was restricted to just the 13 major emergency departments in Wales (Minor Injury Units (MIU) excluded), and for the study period, there were 418,420 attendances reported at these EDs, where the reported mode of arrival was either ambulance or helicopter, or where an ambulance incident number was recorded.

The main focus for this work was the follow-up of those patients conveyed by ambulance to an ED, in order to determine a range of outcome information, based on events within the ED and beyond.

As previously mentioned, there were 432,589 distinct ambulance incidents in which at least one patient was conveyed to one of these major EDs, accounting for 450,462 ambulance journeys (and associated CAD records). However, with the ED datasets reporting a lower number of reported ED attendances (418,420), there was an immediate issue in terms of determining the true numbers of ambulance arrivals at the ED. One possible reason given for the higher numbers on the ambulance side was that certain patients might circumvent the ED, and be taken directly to specialist units (e.g. cardiac), although further work is required to fully understand these differences.

**Generating pairs of possible matches**  
The first stage of the matching algorithm was to extract pairs of records from the CAD and ED datasets which might be a possible match. Pairs of records where the hospital name (or code) matched and where the Administrative Arrival Date/Time (ED) was within 1 hour (±) of the Hospital Arrival Date/Time (CAD) were extracted into a table “Possible Matches”. This initial restriction placed on the number of pairs of records to consider for matching (known in matching parlance as “blocking rules”), would reduce the subsequent computational effort of the matching process. This first step generated

2,365,407 pairs of possibly matching records, with possible matches found for 449,303 (99.7%) of the CAD records and 416,535 (99.5%) of the ED records.

Linking CAD to ED records (deterministic matching)

For 276,036 of the incidents where at least one patient was conveyed to a major ED, an NHS number was able to be derived (as previously described under the PCR section), and therefore we defined our exact (deterministic) matches to be those “Possible Matches” pairs where the NHS numbers from the PCR/CAD matched the associated NHS number in the ED dataset, and also where this match was unique. This resulted in 222,677 of pairs of exact match records, which were loaded into the table “Highly Likely”, leaving 227,785 CAD and 195,743 ED records as still unmatched and needing to be run through a probabilistic matching algorithm.

Linking CAD to ED records (probabilistic)

For the remaining unmatched CAD and ED pairs in the “Possible matches” table, probabilistic matching was attempted, with matching scores based on an application of Bayes Theorem, with the prior log odds of a match combined with a set of independent Log Likelihood Ratios (LLRs) to create an overall match score for each possible pair.<sup>1a</sup>

<sup>1a</sup>e.g. if there were on average 20 attendances at Hospital A between 8am and 10am on a Thursday, there would likely to be (on average) 20 possible matching ED records for every CAD arrival (20 “Possible matches” pairs of records) at Hospital A between 8am-10am on a Thursday. However, only one (or possibly none) out of these possible pairs of records will be the correct matching pair and so the prior odds of us selecting the correct matching pair from the table (at random) would be 19:1.

<sup>1b</sup>This means that we would automatically be more confident that a pairs of records in our “possible matches” table would be a true match for the “Bronglais General Hospital between 06:00 and 07:59 on a Tuesday” pairing than the “University Hospital of Wales between 14:00 and 15:59 on a Monday” pairing.

POSTERIOR LOG ODDS OF A MATCH = PRIOR LOG ODDS<sub>0</sub> + Σ LLR<sub>i</sub> WHERE I RELATES TO EACH OF THE INDEPENDENT ATTRIBUTE COMPARISONS

For the prior log odds of a match in our case, we took into consideration the fact that arrival rates varied by hospital, the time of the day and the day of the week. Based on the previously mentioned blocking rules which were used to generate the “Possible matches” table, we would have expected to generate fewer pairs of “possibly matching” records for those patients arriving at an ED at 1am in a smaller ED, compared to 10am in a larger ED. Therefore, we based our prior log odds on the average number of pairs of records (from our “Possible Match” table) by hospital, the time of day of the arrival (2 hour periods) and the day of the week.\*

Figure 36 shows how the average numbers of ambulance arrivals at ED varies according to by the time of day & day of week (top table), and by individual ED (bottom table). The resulting prior log odds range from -2.28 for arrivals at the University Hospital of Wales between 14:00 and 15:59 on a Monday (the busiest period) to -0.41 for arrivals at Bronglais General Hospital between 06:00 and 07:59 on a Tuesday (the quietest period).\*\*

● FIGURE 36: AVERAGE AMBULANCE ARRIVALS PER HOUR AT EDS IN WALES

	MON	TUE	WED	THU	FRI	SAT	SUN
00:00 - 01:59	36.1	35.5	35.7	36.4	36.4	38.7	41.6
02:00 - 03:59	34.4	33.1	32.3	33.4	33.2	37.0	40.0
04:00 - 05:59	30.0	29.1	29.2	30.0	29.6	31.7	34.1
06:00 - 07:59	27.4	25.9	26.3	25.8	26.5	27.1	27.9
08:00 - 09:59	38.7	38.2	37.7	36.8	37.8	36.5	36.7
10:00 - 11:59	44.8	43.8	43.5	43.7	44.0	43.3	43.0
12:00 - 13:59	46.1	44.7	44.3	44.9	44.2	43.9	44.8
14:00 - 15:59	49.4	48.2	48.2	48.3	47.8	47.8	48.7
16:00 - 17:59	48.2	47.4	46.9	47.6	47.6	48.0	47.3
18:00 - 19:59	43.0	42.2	40.7	41.8	42.7	42.2	42.1
20:00 - 21:59	44.6	44.2	44.4	44.6	44.6	44.8	44.8
22:00 - 23:59	40.8	41.5	40.9	41.8	42.6	44.2	41.6

● AVERAGE AMBULANCE ARRIVALS PER ED PER WEEK

Bronglais General Hospital	158.1
Glangwili General Hospital	235.1
Morriston Hospital	341.1
Nevill Hall Hospital	218.1
Prince Charles Hospital	257.3
Princess of Wales Hospital	214.6
Royal Gwent Hospital	309.0
The Royal Glamorgan Hospital	244.0
University Hospital of Wales	367.5
Withybush General Hospital	188.9
Wrexham Maelor Hospital	267.5
Ysbyty Glan Clwyd	302.5
Ysbyty Gwynedd	253.4

In order to calculate the LLRs, comparisons were made between the CAD and ED records, with focus on those attributes that were either common to both records, or where attributes were in some way associated. The attributes compared were:

- Age of the patient (CAD vs ED)
- Gender of the patient (CAD vs ED)
- Incident location (CAD) vs patient’s place of residence (ED)
- Ambulance arrival time at the hospital (CAD) vs the administrative arrival time (or check-in time) at ED
- Ambulance incident number (CAD vs ED)

Labels were assigned to describe the comparison of each of the CAD/ED attribute pairings compared, as shown below.

a. Age of patient

Although age is a very obvious attribute to compare, as previously mentioned, only one set of demographics are assigned to an incident, regardless of the number of patients conveyed to hospital. This might be an issue in the case of a road traffic collision involving multiple casualties, but should be less of an issue in the case of medical emergencies. The labels use for age comparison are as follows:

- i. Same age
- ii. 1-year difference in age
- iii. 2-year difference in age
- iv. 3 or more year difference in age

b. Gender of patient

Gender is another obvious and direct comparison, although note that the same issues covered above for the age of patient, also apply to gender. The labels used are as follows:

- i. Same Gender
- ii. Different gender

c. Proximity of incident location to patient’s place of residence

A large proportion of ambulance incidents take place at or near a patient’s place of residence, and so for the matching process, different measures of proximity were defined. The first set were based on geographic area codes (e.g. postcodes, and census geographies), and the second set used the crow-fly distance between the two locations, which mitigated against some of the issues associated with geography-based measures, e.g. where the distance between two locations is less than 1km, but those two locations are on either side of a geographic border. The labels used are as follows:

- Geographic location of incident (CAD) compared to geographic area of residence of patient (ED)
  - i. Postcode match
  - ii. Census output area match
  - iii. Lower super output area match
  - iv. No match on geographic area

- Crow-fly difference between location of incident (CAD) and place of residence of patient (ED)
  - i. Within 1km
  - ii. 1 to 4km
  - iii. 4 to 9km
  - iv. 9 to 16km
  - v. Over 16km

d. Time difference between the ambulance arrival at the hospital and the ED check-in

The comparison between the time of arrival of the ambulance at the hospital (CAD) and the administrative arrival time or check-in time (ED) is already part of the blocking rule used to generate the list of possible matches, and as a result, the time of arrival contributes to the prior log odds of a match. However, this comparison is based on smaller time difference bands.

Note that although patients can wait in the back of an ambulance, this should not delay the time of check-in.

The labels used relate to the following time differences:

- Administrative arrival time (ED) between 1 and 4 minutes before Vehicle at Hospital time (CAD)
- Administrative arrival time (ED) = Vehicle at Hospital time (CAD)

- Administrative arrival time (ED) between 1 and 4 minutes after Vehicle at Hospital time (CAD)
- Administrative arrival time (ED) between 4 and 9 minutes after Vehicle at Hospital time (CAD)
- Administrative arrival time (ED) between 9 and 16 minutes after Vehicle at Hospital time (CAD)
- Administrative arrival time (ED) between 16 and 25 minutes after Vehicle at Hospital time (CAD)
- Administrative arrival time (ED) between 25 and 36 minutes after Vehicle at Hospital time (CAD)
- Administrative arrival time (ED) more than 4 minutes before or more than 36 minutes after Vehicle at Hospital time (CAD)

e. Ambulance Incident Number

Ambulance incident numbers are recorded in both the CAD and ED data sets, and for most of the study period, they comprised of a one letter prefix (C, N or P), followed by 7 digits. Subsequent changes to ambulance dispatching system removed the need for these prefixes, at least from the point of view of creating unique incident numbers, although this was not obviously reflected in either the ambulance or ED datasets provided. In general, the ambulance data received was consistent, in that it retained the original one letter prefix and 7-digit format throughout, but there was huge variation in the formatting and completeness of the ambulance incident number in the ED dataset of the study

period. Some of these formatting issues were easier to deal with than others, and these are reflected in the labels below, but there were other problems which were more difficult to overcome, for example where hospital systems started to truncate the rightmost 1 or 2 characters of the incident number.

The labelling of the different possible scenarios was as follows:

**i. Label A**  
Submitted Ambulance Incident Number (ED) formatted as Annnnnnnn  
AND  
Incident ID (CAD) = Ambulance Incident Number (ED)

**ii. Label B**  
Submitted Ambulance Incident Number (ED) formatted as nnnnnnnn  
AND  
Incident ID (CAD) with prefix removed = Ambulance Incident Number (ED)

**iii. Label C**  
Submitted Ambulance Incident Number (ED) formatted as oonnnnnnn  
AND  
Rightmost 6 characters of Incident ID (CAD) = Rightmost 6 characters of Ambulance Incident Number (ED)

**iv. Label D**  
Submitted Ambulance Incident Number (ED) formatted as nnnnnnnnn  
AND  
Rightmost 7 characters of Incident ID (CAD) = Rightmost 7 characters of Ambulance Incident Number (ED)

**v. Label E**  
Submitted Ambulance Incident Number (ED) formatted as Annnnnnnn  
AND  
Rightmost 7 characters of Incident ID (CAD) = Rightmost 7 characters of Ambulance Incident Number (ED)

**vi. Label F**  
Submitted Ambulance Incident Number (ED) formatted as Annnnnnnn OR nnnnnnnn OR nnnnnnnnn  
AND  
None of the above matching combinations are satisfied

Having assigned labels to each of these attribute comparisons, the next task is to assign associated log likelihood ratios (LLRs) to these labels. The formula for the LLR is as follows:

$$\text{LOG LIKELIHOOD RATIO} = \text{LOG}_e \frac{\text{PROB (LABEL | RECORDS ARE A TRUE MATCH)}}{\text{PROB (LABEL | RECORDS ARE NOT A TRUE MATCH)}}$$

In plain English, the numerator here represents the probability of a particular label, given that the pair of records were a true match. Using age of patient as an example, this could be the probability of the label “same age”, given that the pair of records were a true match. We would expect this probability to be very high (close to 1), but data is not always perfect, and so it could be that in the high pressure and often chaotic environment within which ambulance crews operate, they occasionally get the age wrong by one or two years (label = “1-year difference in age” or “2-year difference in age”). The key to probabilistic matching is that it does not necessarily rule out pairs of records with these differences. Instead, it tries to quantify the relative likelihood of these labels existing in true matches compared to non-matches. The denominator represents the distribution of labels in pairs of records deemed to be non-matches.

We can elicit the numerator probabilities by analysing pairs of records that we know to represent correct matches (from our “Highly Likely” table). We can also generate a table containing non-matching pairs of records, by taking those pairs of records from the “possible matches” table, which we subsequently know could not have been true matches because the true matching pair was one of our “highly likely” matches. We then elicited the denominator probabilities by analysing these pairs of records.

Figures 37 to 41 shows the distribution of labels for “highly likely” pairs of matches compared to

non-matching pairs, for age, gender, geography/crow-fly distance, and the time from ambulance arrival to ED check-in.

Due to the aforementioned complexities associated with the comparison of ambulance incident numbers, **Figure 42** shows the distributions of labels split by each of the 6 Health Boards (HBs) that have a major ED. These are Aneurin Bevan (AB), Abertawe Bro Morgannwg University (ABMU), Betsi Cadwaladr University (BCU), Cardiff & Vale (C&V), Cwm Taf (CT) and Hywel Dda (HD).

All the associated LLRs across each attribute and label are shown in **Figures 43 and 44**, with the latter showing the ambulance incident number labels by health board and hospital.

For the comparison of patient age, **Figure 37** shows that the label “same age” is much more prevalent in the “highly likely” pairs than the non-matching pairs (74.8% v 1.3%) which is reflected in a likelihood ratio of 55.4 and an associated log likelihood ratio (LLR) of 4.0, as shown in **Figure 43**. The “1-year age difference” label also scores positively (LLRs = 1.7) and even though the “2-year age difference” has a negative score (LLR = -0.4), the penalty is not as high as for the “3+ years age difference” label (LLR = -2.8).

In all cases, a positively-valued LLR increases our confidence in a match but a negatively-valued LLR decreases our confidence in a match.



Figures 38 and 43 show distributions and associated LLRs for patient gender with and LLR of 2.0 for “same gender” and ~ 0.0 for “different gender”, which is almost exactly as would be expected, given that we would only expect a very number of our “highly likely” matches to have a mismatch on gender, and we would expect our non-matches to be evenly split between males and females.

The distributions and associated LLRs for the comparison of the geographic areas are shown in Figures 39 and 43 respectively, with “same postcode” receiving an LLR of 6.6, and “census output area match” and “lower super output area match” also receiving high LLR scores of 4.3 and 2.8 respectively. Lower down the table, it can be seen that the label “no match on geographic area” earns a LLR of -1.35.

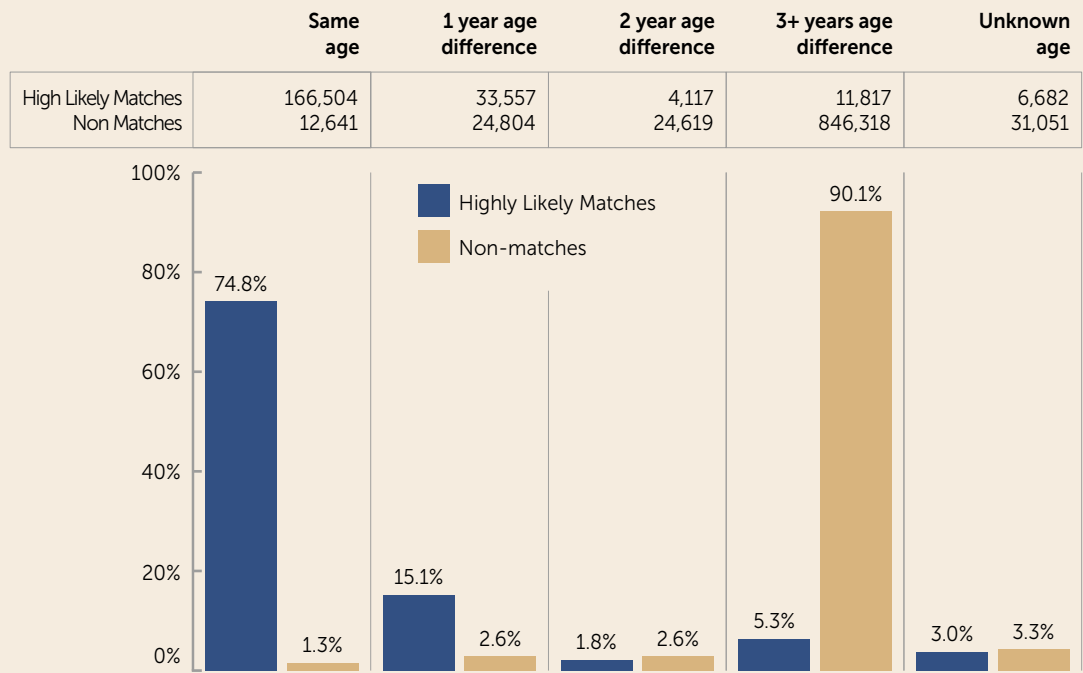
Figures 40 and 43 shows the information for crow-fly distances, and living within 1km of the incident location gains a LLR score of 3.5. However, all distances greater than 1km (including the 1-4km band) are more prevalent in the non-matches, which on first reading is surprising, but it should remembered that our earlier blocking rule stipulated that all possible pairs of CAD/ED matches had to have a match on the hospital, and therefore, it is more likely that the incident locations and places of resident are both relatively close to that hospital, thus reducing the expected range of our crow-fly distances.

Note that only one LLR should be used to cover both the proximity between the location of incident and the patient’s place of residence (due to the previously mentioned constraint of having independent LLRs, where possible), and so we simply choose the highest LLR from the geographic area and crow-fly distances.

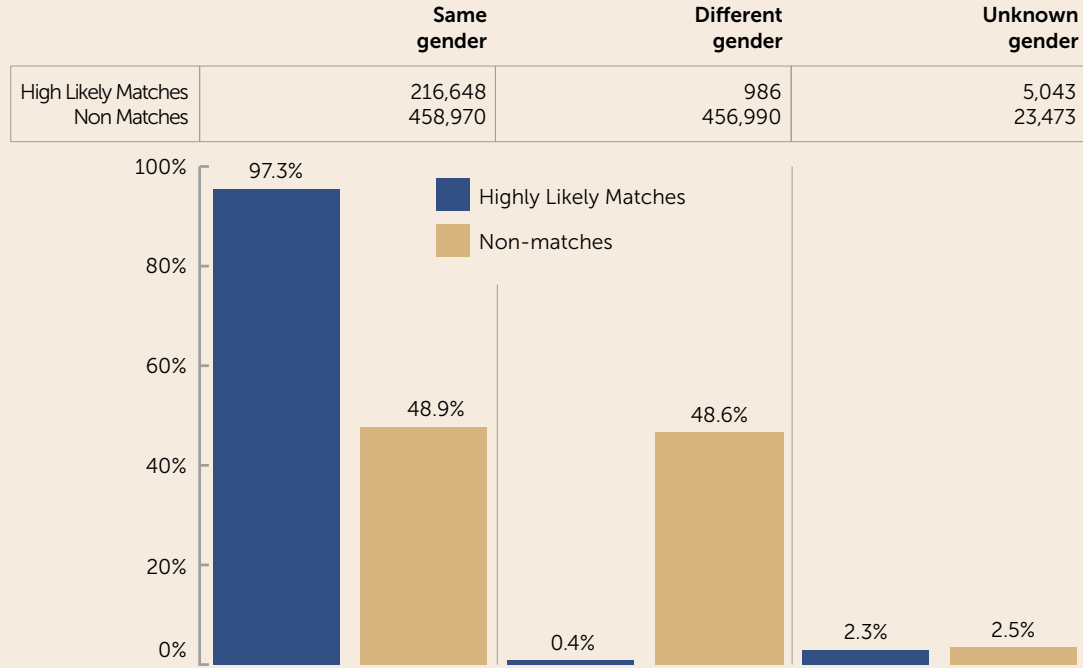
Figures 41 and 43 show that the time from ambulance arrival to ED check-in was most likely to be between 4 and 9 minutes for the “highly likely” matches (LLR = 2.4), with the time bands either side also scoring highly (LLR for 1-4 minutes = 2.1, LLR for 9-16 minutes = 1.5).

Finally, based on the information in Figures 42 and 44, it is clear that different hospitals “favour” different formats of ambulance incident number, and LLRs vary significantly between labels and hospitals. Label A scores highly across the board, which we would expect, given that it is the only label which indicates a match on a pair of correctly formatted ambulance incident numbers. Label B (same as label A but with the character prefix missing from the ED ambulance incident number) also scores highly for most hospitals. It is also noticeable how the level of confidence in match varies by hospital, even for the same label. For example, label D in Royal Gwent Hospital has a LLR of 5.9, compared with 2.5 for Withybush General Hospital. In fact, the LLRs for hospitals in the Hywel Dda health board (HD HB) are generally lower than for other health boards, with the right hand truncation of the ambulance incident numbers in the ED systems being a particular problem.

● FIGURE 37: DISTRIBUTION OF AGE OF PATIENT LABELS FOR “HIGHLY LIKELY” MATCHES VERSUS NON-MATCHES

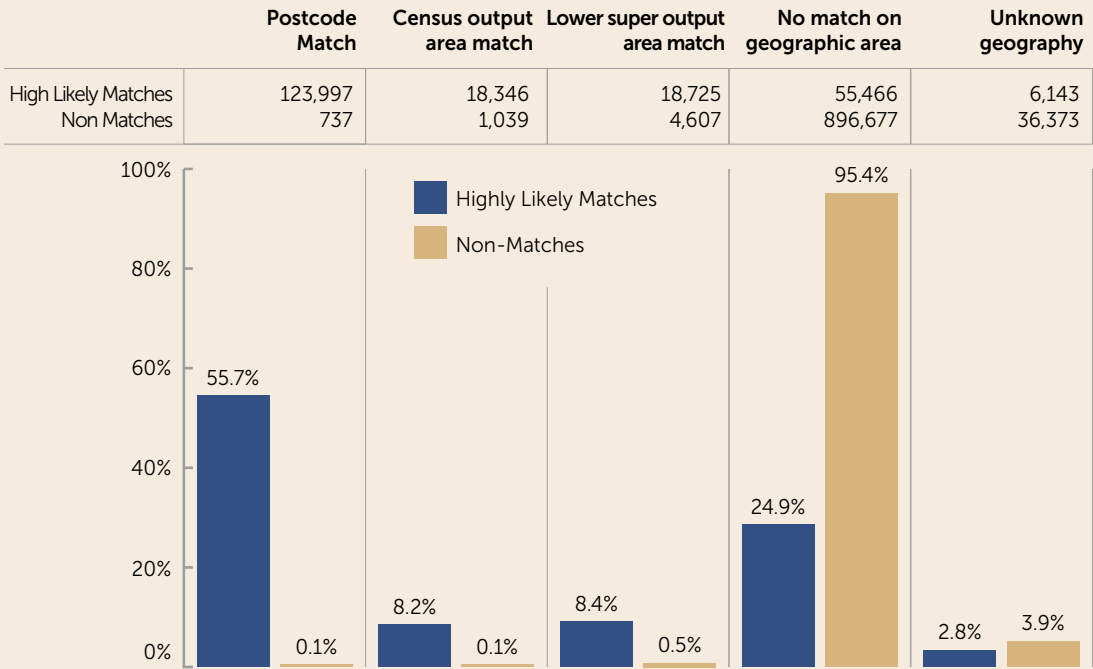


● FIGURE 38: DISTRIBUTION OF GENDER LABELS FOR “HIGHLY LIKELY” MATCHES VERSUS NON-MATCHES

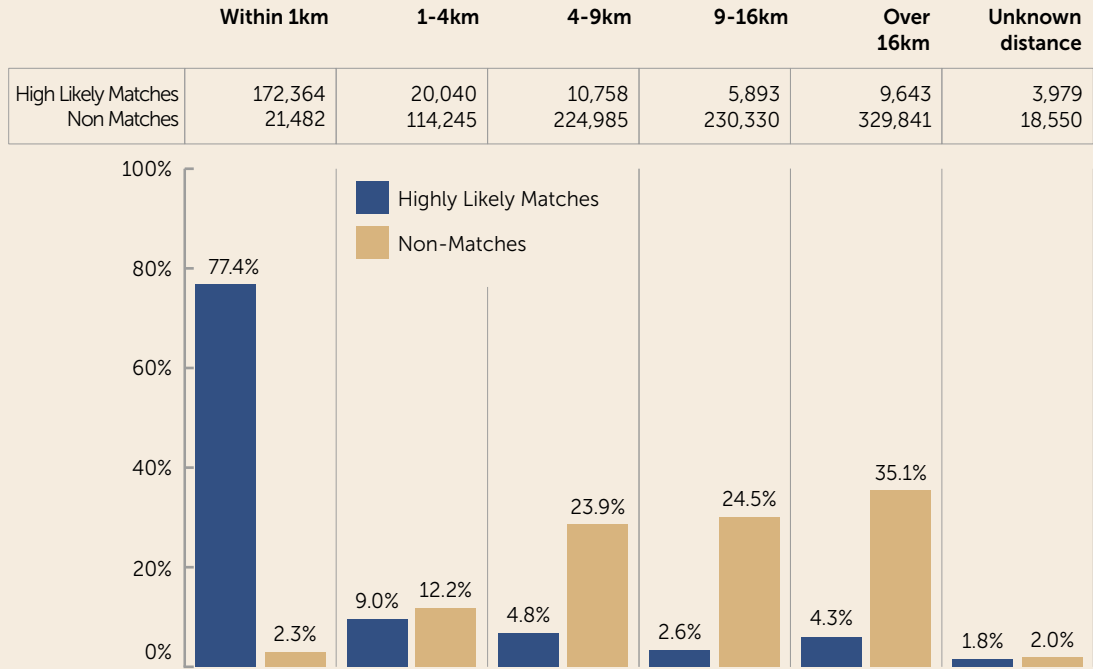




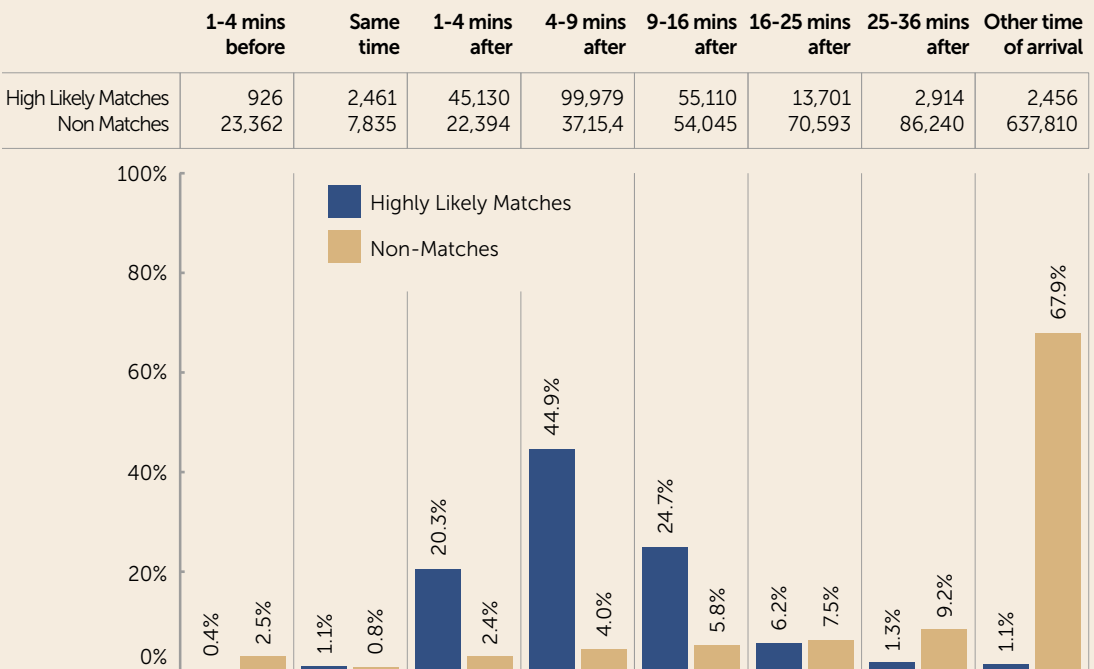
● FIGURE 39: DISTRIBUTION OF GEOGRAPHIC LABELS FOR “HIGHLY LIKELY” MATCHES VERSUS NON-MATCHES



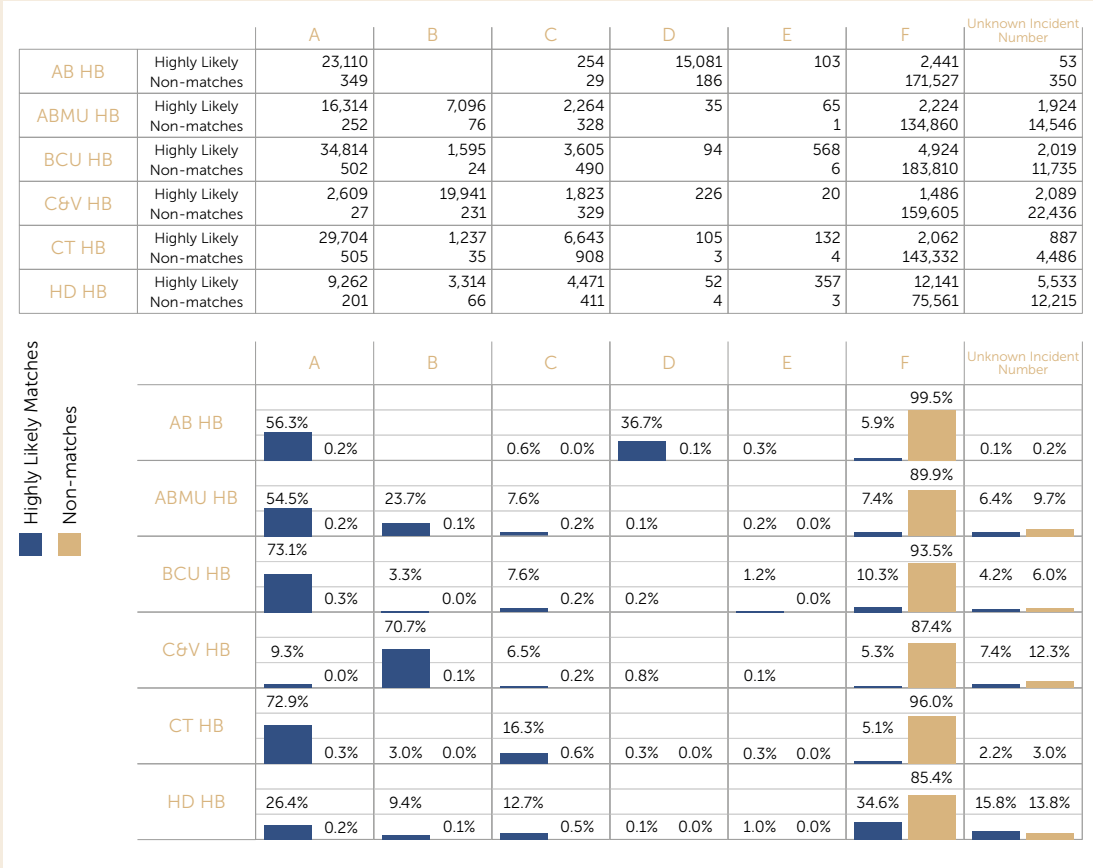
● FIGURE 40: DISTRIBUTION OF CROW-FLY DISTANCE LABELS FOR “HIGHLY LIKELY” MATCHES VERSUS NON-MATCHES



● FIGURE 41: DISTRIBUTION OF AMBULANCE ARRIVAL TO ED CHECK-IN TIME LABELS FOR “HIGHLY LIKELY” MATCHES VERSUS NON-MATCHES



● FIGURE 42: DISTRIBUTION OF AMBULANCE INCIDENT NUMBER LABELS FOR “HIGHLY LIKELY” MATCHES VERSUS NON-MATCHES (BY HEALTH BOARD OF MAJOR ED)



● FIGURE 43: LIKELIHOOD RATIOS (LR) AND LOG LIKELIHOOD RATIOS (LLR) FOR GEOGRAPHY, CROW-FLY DISTANCE, AGE, GENDER AND ARRIVAL TO CHECK-IN TIME LABELS

ATTRIBUTE	LABEL NAME	LR	LLR
Age	Same age	55.4	4.0
	1 year age difference	5.7	1.7
	2 year age difference	0.7	-0.4
	3+ years age difference	0.1	-2.8
Gender	Different gender	0.0	-4.7
	Same gender	2.0	0.7
Geography	Postcode match	701.7	6.6
	Census output area match	73.6	4.3
	Lower super output area match	16.9	2.8
	No match on geographic area	0.3	-1.4
Distance	Within 1km	33.8	3.5
	1-4km	0.7	-0.3
	4-9km	0.2	-1.6
	9-16km	0.1	-2.2
	Over 16km	0.1	-2.1
Arrival time	1-4 mins before	0.2	-1.8
	Same time	1.3	0.3
	1-4 mins after	8.5	2.1
	4-9 mins after	11.4	2.4
	9-16 mins after	4.3	1.5
	16-25 mins after	0.8	-0.2
	25-36 mins after	0.1	-1.9
	Other arrival time	0.0	-4.1

● FIGURE 44: LIKELIHOOD RATIOS (LR) AND LOG LIKELIHOOD RATIOS (LLR) FOR AMBULANCE INCIDENT NUMBER LABELS, BY HOSPITAL

HEALTH BOARD	HOSPITAL NAME	A		B		C		D		E		F	
		LR	LLR	LR	LLR	LR	LLR	LR	LLR	LR	LLR	LR	LLR
AB HB	Nevill Hall Hospital	217.7	5.4			26.6	3.3	307.4	5.7			0.1	-2.0
	Royal Gwent Hospital	293.2	5.7			42.4	3.7	374.8	5.9			0.1	-2.0
ABMU HB	Morrison Hospital	351.3	5.9	541.5	6.3	33.5	3.5			329.8	5.8	0.1	-2.0
	Prince of Wales Hospital	363.2	5.9	248.1	5.5	34.3	3.5					0.1	-2.0
BCU HB	Wrexham Maelor Hospital	209.4	5.3	229.4	5.4	28.4	3.3			267.7	5.6	0.1	-2.0
	Ysbyty Glan Clwyd	429.5	6.1	390.9	6.0	31.6	3.5					0.1	-2.0
	Ysbyty Gwynedd	260.3	5.6	230.5	5.4	31.6	3.5			164.4	5.1	0.1	-2.0
C&V HB	University Hospital of Wales	593.0	6.4	529.7	6.3	34.0	3.5					0.1	-2.0
CT HB	Prince Charles Hospital	192.3	5.3	193.1	5.3	26.2	3.3			111.7	4.7	0.1	-2.0
	The Royal Glamorgan Hospital	238.3	5.5	81.4	4.4	26.8	3.3	56.7	4.0			0.1	-2.0
HD HB	Bronglais General Hospital	112.1	4.7			36.1	3.6					0.4	-1.0
	Glangwili General Hospital	122.7	4.8	123.1	4.8	28.2	3.3	91.1	4.5			0.5	-0.7
	Withybush General Hospital	106.8	4.7	130.1	4.9	18.8	2.9	12.3	2.5	239.6	5.5	0.3	-1.1

CALCULATING THE OVERALL MATCH SCORE (POSTERIOR LOG ODDS SCORE)

Shown in **Figures 45** and **46** are two worked examples of how match scores (or the posterior log odds) are calculated. Note how only one out of the geographic area comparison and distance scores (the highest) contributes to the overall score, with

the five independent LLRs added to the prior odds to arrive at the posterior log odds. In **Figure 46**, also note that where any of the information is unknown or missing (e.g. the ambulance incident number in the ED record), a LLR score of 0 is awarded.

● FIGURE 45: CALCULATION OF MATCH SCORE FOR PAIR 1

ATTRIBUTE COMPARISON	AMBULANCE	ED	LABEL	LLR	LLR TO USE
Age comparison	73	73	Same age	4.0	4.0
Gender comparison	F	F	Same gender	0.7	0.7
Incident Location v Place of Residence					
Geographic area comparison					
Postcode	SA6 6NL	SA6 6RU			
Census Output Area	W00010084	W00004356		-1.4	
Lower Super Output Area	W01000816	W01000806			-0.3
Distance	1.3km		1-4km	-0.3	
Time from ambulance arrival to ED check in	03:57		1-4 minutes	2.1	2.1
Ambulance Incident Number	C1979447	1979447	Label B	6.3	6.3
<b>Prior Odds</b> for Arrivals at University Hospital of Wales at 02:24 on a Wednesday					-1.8
<b>Match score (Posterior log odds)</b>					<b>11.0</b>

● FIGURE 46 CALCULATION OF MATCH SCORE FOR PAIR 2

ATTRIBUTE COMPARISON	AMBULANCE	ED	LABEL	LLR	LLR TO USE
Age comparison	51	52	1 year age difference	1.7	1.7
Gender comparison	F	F	Same gender	0.7	0.7
Incident Location v Place of Residence					
Geographic area comparison					
Postcode	NP14 3QA	NP14 3QA			
Census Output Area	W00010012	W00010012	Postcode match	6.6	
Lower Super Output Area	W01000900	W01000900			6.6
Distance	0.0km		Within 1km	3.5	
Time from ambulance arrival to ED check in	05:12		4-9 minutes	2.1	2.4
Ambulance Incident Number	C1739173	Unknown	Unknown		0.0
<b>Prior Odds</b> for Arrivals at Royal Gwent Hospital at 16:30 on a Sunday					-2.1
<b>Match score (Posterior log odds)</b>					<b>9.3</b>

EXTRACTING THE “BEST” MATCHES

From the “possible matches” table, we removed those pairs of records already deemed to be an exact match, plus all associated pairs known to be non-matches, and calculated match scores for all remaining pairs of records.

In order to reduce the chance of false matches, we only considered those pairs of matches where the log odds score was the highest for that CAD record and also the highest for that ED record. We labelled these pairs of records as “best matches”.

What constitutes a good posterior log odds score?

In order to quantify how good a posterior log odds score is, there is a need to need to convert these scores to match probabilities. In order to do this, we carried out an independent probabilistic matching exercise for all those CAD records which already had a known “highly likely” ED match, verified previously using the NHS number, and then independently extracted “best matches” for these. We then calculated the proportion of times that the “best match” agreed with the “highly likely” match, for different ranges of posterior log odds scores.

Figure 47 shows how the % sensitivity (or % of records accepted as a match) decrease as our posterior log odds threshold values increase.

However, as the posterior log odds increases, our % confidence that those are true matches also increases. In this case, a posterior log odds of 0 equates to a match probability of around 91.4%, and using this value as the minimum threshold for the acceptance of a match, we result in a match rate (% sensitivity) of 98.8%. Indeed, for this threshold value of 0, the overall true match rate would be 98.3% (% specificity), as most of the posterior log odds are actually well in excess of 0.

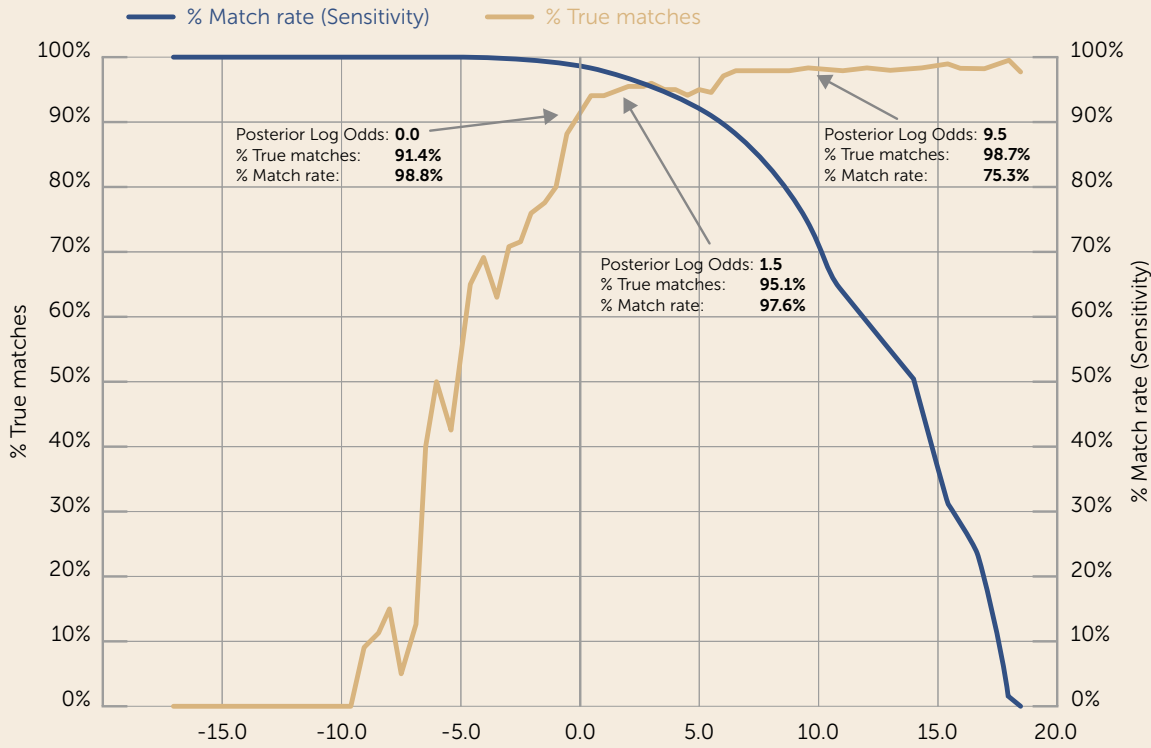
It should be noted that the sample of records used for this probability modelling are, by definition, a cleaner set than we would typically expect to deal with when carrying out probabilistic matching in practice; the fact that NHS numbers were able to be derived for these records would suggest that they were above average in terms of the completeness and accuracy of the fields contained within those records. In addition, the “highly likely” cohort deliberately excluded incidents where there were multiple patients conveyed, or where there were more than one ED attendances for the same patient in quick succession (possible duplicates). Therefore, when running the probabilistic matching in practice on less sanitised data, we would have expected to see significantly lower rates of sensitivity.

4 Match results for the study

Of the 432,589 ambulance incidents where there was at least one conveyance to a major ED, matches to associated ED records were found for 392,181 (a match rate of 90.7%). However, taken as a percentage of the slightly smaller number of ED records put forward for matching (418,420), a healthier match rate of 93.7% was achieved.

In terms of levels of confidence in the matches, 58.9% of the 392,181 were exact matches, 28.7% were probabilistic matches with match probabilities greater than 99%, 11.8% had match probabilities between 95% and 99% and 0.6% had match probabilities between 90% and 95%.

FIGURE 47



# Technical Appendix: 2

COMMISSIONING OF AMBULANCE SERVICES

## Emergency Ambulance Services Commissioning

The publication of the McClelland<sup>2a</sup> review of the Welsh Ambulance Service in April 2013, can be considered as a seminal point in the development of emergency ambulance services commissioning in Wales. Numerous<sup>3a</sup> other reviews had been conducted into the performance and quality of the ambulance service in Wales, in the six years prior to the publication of the review, however despite this level of scrutiny, ambulance response time performance was consistently the poorest in the UK.

The McClelland review made a series of recommendations on the future delivery of ambulance services in Wales, this included establishing the Emergency ambulance Services Committee (EASC) as a statutory body of health boards responsible for jointly planning and securing emergency ambulance services. Within the first year of being established EASC delivered a number of significant milestones, including the provision of additional £7.5m funding for 119 members of staff, a further recurrent £8m<sup>4a</sup>, and a commissioning quality and delivery framework that clearly set out the arrangements and expectations for the emergency ambulance service.

This progress acted as the catalyst to enable the delivery of the McClelland recommendation around the need to review ambulance service response targets and support the ambulance service to become a clinical service fully embedded in the wider unscheduled care system.

## Collaborative Commissioning Quality and Delivery Framework

Prior to the formation of EASC there were inadequate arrangements in place for the commissioning of emergency ambulance services between Health Boards and the Welsh Ambulance Services NHS Trust (WAST).

The EASC at its inaugural meeting in April 2014 sponsored the use of CAREMORE® for the creation of a Commissioning, Quality & Delivery Framework Agreement ('Framework Agreement') for Emergency Ambulance Services.

A Collaborative Commissioning Project Group was established to lead the production of the Framework Agreement, which consisted of representation, at executive director level, from all Health Boards and WAST, together with Welsh Government and Public Health Wales.

Collaborative Commissioning was the favoured methodology as it endorses the national 'once for Wales' approach to share and develop ideas in a non-competitive environment. This is the situation in which CAREMORE® has been successfully applied to develop the 'Framework Agreement'.

CAREMORE® is a commissioning method, focusing on Care standards, Activity, Resources Envelope, Model of care, Operational arrangements, Review of performance and Evaluation. It is a registered trademark belonging to Cwm Taf University Health Board UK2630477.

The Framework Agreement covers WAST's provision of emergency ambulance services, which includes:

- Responses to emergencies following '999' telephone calls;
- Urgent hospital admission requests from General Practitioners (and other Health Care Professionals);
- High dependency and inter-hospital transfers;
- Patient triage by telephone;
- NHS Direct Wales Services; and
- Major incident responses.

In addition, an innovative citizen centred perspective has been adopted in the creation of the Framework Agreement which is called the Ambulance Patient Care Pathway. This pathway describes a 5-step process for the supporting the delivery of emergency ambulance services within NHS Wales. The 5-steps are:

● FIGURE 48



The Ambulance Care Pathway is designed to ensure that ambulances are dispatched to calls where there is an immediate need to save life or provide treatment which requires an ambulance. For other less serious cases, alternative

treatments such as referrals to other parts of the NHS or telephone advice will be provided. The pathway is intended to ensure the ambulance service is providing the right response for a patient dependent on their clinical need.

# Technical Appendix: 3

## Call Categories

Call categories provide the ambulance service with a means to cohort the large number of MPDS codes into a manageable number of categories that require a similar response.

Within Wales and indeed across the UK there have been a number of iterations of call categories since the establishment of NHS ambulance services. The tables below provide an over view of the development of call categories in Wales over recent years.

● FIGURE 49 PRE-2011

CATEGORY	DESCRIPTION	TARGET / MEASURE
Category A	Immediately life-threatening condition/injury	65% of all Category A incidents across Wales must be responded to by a suitable responder within eight minutes of the chief complaint being verified by the call taker and a minimum level of 60% must be achieved in every LHB area
		95% of all Category A incidents must also be attended by a fully equipped emergency ambulance within a specified time of the start of the incident which is set at 14 minutes in Cardiff, 21 minutes in Powys, Ceredigion, Gwynedd and Anglesey and 18 minutes elsewhere in Wales
Category B	Serious but not life threatening condition/injury	95% of all Category B incidents must be attended by a fully equipped emergency ambulance within the 14/18/21 minute time period from the start of the incident
Urgent Journey	Neither life threatening or serious condition/injury	95% of all Urgent calls must be in hospital within 15 minutes of the time when the doctor specified that the patient should arrive

In December 2011, a number of changes took place to ambulance response time standards, from that point only the most serious calls,<sup>5a</sup> Category A (immediately life-threatening), were guaranteed an emergency blue light response. All other calls would receive an appropriate response, either face-to-face or telephone assessment, based on clinical need.

Category B was removed as a call category and the codes within there either upgraded to Category A (the codes considered most serious) or for the majority of Category B calls, included in a revised Category C. For the first time, Health Care professional Calls would be prioritised and classified as Category A or C in the same way as emergency 999 calls.

● FIGURE 50: 2011 – OCTOBER 2015

CATEGORY	DESCRIPTION	TARGET / MEASURE
Category A	Immediately life-threatening	A monthly all-Wales average performance of 65% of first responses to Category A calls arriving within 8 minutes
		A monthly minimum performance of 60% of first responses to Category A calls arriving within 8 minutes in each Unitary Authority area
Category C	Urgent and Planned	Planned face-to-face assessment - a monthly all-Wales average of 95% of first responses within 30 minutes
		Planned clinical telephone assessment - a monthly all-Wales average of 95% of calls receiving call back for clinical triage within 10 minutes



For operational purposes the ambulance service split Category A into Red 1 and Red 2. Red 1 calls are the most time critical and cover patients who have suffered a cardiac arrest or have stopped breathing; Red 2 calls are serious but less immediately time critical and cover all other potentially life-threatening conditions. A number of these Red 2 calls turn out after assessment or initial treatment to be suitable for referral to another agency such as primary care. From February 2015 information for RED 1 and RED 2 calls was published by Stats Wales.<sup>6a</sup>

Clinical Response Model

In early 2015, the increasing confidence in the commissioning arrangements for ambulance services, provided the Welsh Government with sufficient confidence to launch a clinical review of

ambulance targets in Wales, led by the ambulance services medical director, Dr Brendan Lloyd. The review found that the 8-minute response time target was introduced 41 years ago and was based on evidence which suggests it only improves outcomes for people who have suffered an out-of-hospital cardiac arrest.

The clinical review demonstrated that there was little evidence that an 8-minute response will make a difference to the vast majority of people’s outcomes following treatment – about 95% of people who access the Welsh Ambulance Service.<sup>7a</sup>

As such a radical pilot for ambulance response time targets in Wales was proposed that segregated patients into 3 categories:

● FIGURE 51: POST OCTOBER 2015

CATEGORY	DESCRIPTION	TARGET / MEASURE
Red	Immediately life-threatening	65% of emergency responses to arrive within 8 minutes
Amber	Serious but not immediately life threatening	No set targets / A range of measures contained within the Ambulance Quality Indicators
Green	Neither serious or life threatening	No set targets / A range of measures contained within the Ambulance Quality Indicators

Under the model, only the most serious calls, categorised as Red, are subject to a time-based target (65% of these calls to have a response time within 8 minutes).

All other calls receive a response, either face-to-face or by telephone, based on an assessment of clinical need. For operational purposes the Welsh Ambulance Service sub-divides the categories to allow control room staff to prioritise the next response.

● FIGURE 52

CATEGORY	SUB-DIVISION	TYPES OF CONDITIONS
Red	N/A	Cardiac arrest/major haemorrhage
Amber	Amber 1	Stroke within 4 hours/chest pain
	Amber 2	Stroke outside 4 hours/resolved fits
Green	Green 2	Expected deaths/not imminent labour
	Green 3	Sick person vomiting/eye injuries

The responsibility for the allocation of individual MPDS codes to each category rest with the Clinical Prioritisation Assessment Software (CPAS) Group within the Welsh Ambulance Service. This group is chaired by the Assistant Medical Director and senior representatives from across the operational, medical and quality directorate of the ambulance service.

During the establishment of the pilot model, the group established that the majority of Red 1 calls, would form the new Red Category (a small number of codes were re-categorised to Amber) whilst the majority of Red 2 calls would form the new Amber Category (a small number were re-categorised to Red).<sup>8a</sup>

# Technical Appendix: 4

## Independent Evaluation – Public and Corporate Economic Consultants (PACEC)

A 12 month pilot was enacted on 1st of October 2015, as part of the pilot an independent evaluation of the model was commissioned by EASC. Following a competitive tender process the Public and Corporate Economic Consultants in partnership with the Medical Care Research Unit at the University of Sheffield were appointed to undertake this evaluation.

In September 2016 the pilot was extended for a further 6 months to allow the independent evaluation to complete.

The final evaluation report was provided to EASC and published in January 2017.<sup>9a</sup> The evaluation found there to be a clear and universal acknowledgement, both from WAST and external stakeholders, that moving to the new clinical model was appropriate and beneficial and did not find evidence for reverting to the old model.

The report made a number of recommendations for improvement, which are outlined below:

- A need to review the call categories outside Red, in particular the Amber category. There is concern that the latter is too large and not sufficiently discriminatory in terms of prioritising patients with high acuity illness, and that for some calls this is resulting in unacceptably long waits.
- Investment in information systems which will provide opportunities to both enhance and make more seamless the call management and dispatch process and provide more robust information to support further development both internally and externally. The approved and planned replacement of the CAD system will be a key factor in supporting further development and improvement of the clinical model.

- Providing alternative response options is a multifactorial problem. Some factors lie within the emergency ambulance service, requiring identification of calls which might best be served by these options but also having the infrastructure, workforce profile and training to provide them at necessary scale. Others are outside the ambulance service and are concerned with the wider system provision of suitable alternative services, at the time they are needed and with clear agreed access and referral pathways that will allow ambulance service clinicians to safely transfer care.
- There is variation between health boards, indicating that wider system processes for managing calls that do not need transporting to an acute hospital are better in some areas than others. There is scope to increase hear and treat and see and treat if the right

pathways are in place that allow and support confident and safe clinical decision making by clinicians in the clinical hub or at scene with a patient.

The committee welcomed the report and accepted all of the recommendations. In February 2017, the Cabinet Secretary announced that on the basis of the report and the plan from EASC to deliver the recommendations that the clinical model would be implemented on a permanent basis.<sup>10a</sup>

# Technical Appendix: 5

## Welsh Ambulance Service Functions

### Call Cycle Process

When you call 999 a telephone operator will ask you which emergency service you need. In a medical emergency you will be connected with the Ambulance Service.

Welsh Ambulance Service operate a virtual call handling environment to ensure that all 999 calls are answered as quickly as possible. This means that whenever possible calls will be routed to the local clinical contact centre however if all call handlers are already dealing with 999 calls you will be routed to any available 999 call handler in Wales.

Once connected callers are asked about the consciousness and breathing status of the patient to ensure that immediately life-threatening emergencies are identified as soon as possible. Once this information is obtained the caller will be asked to describe what has happened.

This information is entered into our Computer Aided Dispatcher (CAD) system which integrates with an electronic version of the Medical Priority Dispatch System (MPDS). The EMD will then ask some additional questions including:

- the patient’s age, sex and medical history
- whether the patient is breathing, conscious, bleeding seriously or has had persistent chest pain
- the type of injury and how it happened

Asking these questions enables the EMD to offer advice and ensure the most appropriate assistance is provided. The answers to the questions provide a prioritisation code which informs the type of assistance provided.

### Computer Aided Dispatch System

The ambulance services in Wales, in common with other emergency services, uses a Computer Aided Dispatch System (CAD). These sophisticated systems are able to utilise and host a large range of systems such as mapping, telephony and radio’s and are able to track all of the incidents and resources available to the ambulance service.

In 2016 the Welsh Ambulance Services was supported with a significant financial investment to upgrade its CAD system to the latest technology. The Alert C3 system went live in Wales during November 2017 and whilst the initial project aimed to replicate the abilities of the previous CAD system, a rollout programme for additional functionality is now in place.

As part of initial implementation additional functionality was provided. Auto-Dispatch to Emergency calls prioritised as Red (Immediately Life-Threatening) allows the CAD system to allocate resources based on a set of pre-configured parameters. The system is able to allocate much quicker than manual dispatch and is quality checked by a dispatcher at the same time to ensure the decision is correct. The Clinical Support Desk function was also improved

through the implementation of a single dedicated queue of patients populated based on strict criteria. Previously the clinicians would spend time reading through existing calls to find the most appropriate patients which took time. The new functionality speeds up appropriate care for more patients and improves reporting of Clinical Support Desk operations.

### Types of Ambulance Service Emergency Response

The delivery of an emergency ambulance service system is complex and is dependent on a range of staff groups and vehicle to provide effective services. The following tables aim to provides a summary of roles, responses and capabilities that are available to the Welsh Ambulance Service.

● FIGURE 53: JOB ROLES

JOB TITLE	ROLE
Emergency Medical Dispatcher (Call Handler)	Receives and prioritises emergency, urgent and routine calls received in the Clinical Contact Centres
Allocator/Dispatcher	Reviews prioritised incidents requiring ambulance response and dispatches the most appropriate response based on guidelines provided in the Clinical Response Model
CCC Clinician	Reviews incidents suitable for Clinical Telephone Assessment or secondary triage to clinically assess the most appropriate response for patients
Paramedic	Paramedics respond to emergency calls and can provide Advanced Life Support, Trauma Care, Cardiac Care and treatment for a wide variety of acute and clinical conditions including invasive techniques and administer a variety of therapeutic drugs and medications
Emergency Medical Technician (EMT)	The Emergency Medical Technician (EMT) works alongside paramedics or form part of a double EMT crew. EMTs can provide emergency life support and administer certain therapeutic drugs and medications
Urgent Care Services	UCS primarily transfer patients from home to hospital or between hospitals but can also respond to a number of pre-determined emergencies as first responders prior to the arrival of an EMS vehicle. They monitor patients with in situ cannula and /or syringe drivers
Advanced Paramedic Practitioner	APPs have completed a relevant master’s degree and practice at advanced level, have the capability to make sound judgements in the absence of full information and to manage varying levels of risk when there is complex, competing or ambiguous information or uncertainty

● FIGURE 54: RESPONSE TYPES

RESPONSE TYPE	CAPABILITY
Emergency Ambulance	Respond to all types of emergency calls and undertake urgent and emergency transfers for medically unwell patients. Crewed by two clinicians and capable of conveying patients to a place of definitive care.
Rapid Response Vehicle	Respond to all types of emergency calls. Crewed by only one clinician, and unlike the emergency ambulance, have very limited ability to convey patients.
Urgent Care Vehicle	UCS supports the Emergency Medical Services (EMS) to provide safe transport for stable patients requiring urgent transport or transfer. UCS crews can undertake emergency transfers where a medical or nursing escort is travelling with the patient.
Hazardous Area Response Vehicles (HART)	HART provide a specialist response to incidents where their advanced Hazardous Area training is required. This includes fire, RTC, chemical, building collapse, water, height, difficult patient rescue etc. They are equipped with specialist equipment.
Emergency Medical Retrieval and Transfers Service (EMRTS)	EMRTS are an aeromedical response using rotary wing helicopters. The response and subsequent transport are rapid but dependent on landing zones and weather. Calls are selected by an EMRTS clinician as suitable.
Clinical Desk	Conducts 'Hear and Treat" consultations with patients accessing the 999 system to provide resolution of case, self-care advice, referral to alternative points of care or admission to hospital via alternative means.

● FIGURE 55: BACK UP REQUESTS

REQUEST TYPE	RESPONSE MODE	RESPONSE REQUIRED
Priority 1 (P1)	Blue Lights and Sirens	Nearest available responder to provide immediate support plus a conveying vehicle
Priority 2 (P2)	Blue Lights and Sirens	Nearest available conveying vehicle
Priority 3 (P3)	Normal Road Speed	Nearest appropriate conveying vehicle
Priority 4 (P4)	Normal Road Speed within 1-4 hours	Planned appropriate resource to meet the patients' needs

Ideal and Suitable Responses

In order to support dispatchers and allocators with the decision making process around which resource to send to each call based on the MPDS code, the Welsh Ambulance Service has developed a patients’ centred response matrix that aligns the most appropriate (ideal) response or next best response (suitable) to each individual MPDS code.

By using the matrix, dispatchers are able to make clinically appropriate decisions for the allocation of the next resource. As an example most MPDS codes related to stroke, have an Emergency Ambulance as the ideal resource, with the logic being that in order for these patients to receive the best level of care in the timeliest manner, they need a resource to attend with the capability of transporting them to hospital.

Rapid Response Vehicles are considered a suitable response to these calls, they are able to provide a level of clinical assessment and re-assurance, they have very limited patient transportation capabilities, as such their contribution to the patients care and clinical outcome is severely limited for patients with a stroke.

Clinical Desk

Over a number of years, Welsh Ambulance Service’s research and development resulted in the Clinical Support Desk being identified as a key element of the Clinical Response Model implemented in October 2015.

The Clinical Support Desk (CSD) staffed by clinicians, both nurses and paramedics who undertake a key role in providing quality care to service users by providing secondary triage to suitable callers within the 999 stream identifying alternative care pathways which may be more suitable than a trip by ambulance to the Emergency Department.

They clinicians can also assist Health Care Professional in managing appropriate transport for patient admissions and provide information from the local directory of services for operational staff and non-clinical CCC colleagues. Secondary triage is undertaken utilising the Manchester Triage System Telephone Triage and Advice (MTS TTA) model. This tool provides consistency in clinical decision making by guiding registered clinicians through a set of algorithms.

# Technical Appendix: 6

## Medical Prioritisation Dispatch System

To ensure that ambulance services appropriately respond to demand, they must use prioritisation systems that allow them to differentiate between patients conditions and decide which patient receives the next response.

The Welsh Ambulance Service uses the Medical Priority Dispatch System (MPDS) for this purpose. MPDS is used by approximately 3,000<sup>11a</sup> services across the globe. It is a system that allows ambulance control room staff to obtain vital information about the patient and the scene. This information can then be used to select the appropriate response and to provide immediate lifesaving advice over the phone.<sup>12a</sup>

In May 2018, the three clinical contact centres in Wales were awarded the International Academies of Emergency Dispatch Centre of Excellence

status.<sup>13a</sup> Only 250 services worldwide have achieved this status that recognises the delivery of the highest standards of compliance when using MPDS.

The MPDS system generates a specific dispatch code that is composed of three main pieces of information.<sup>14a</sup> A number of codes also have suffix letter as a 4th component, this suffix provides further detail about the incident such as environmental factors. The first component consists of a number from 1 to 37 that indicates the specific protocol card that has been selected following initial questions to the caller. Each protocol card contains a range of questions related to a patient’s condition.

The protocol cards are listed below:

1. Abdominal Pain/Problems

2. Allergies (Reactions)/ Envenomation (Stings, Bites)

3. Animal Bites/Attacks

4. Assault/Sexual

5. Back Pain (Non-Traumatic/Non-Recent)

6. Breathing Problems

7. Burns (Scalds)/Explosions

8. Carbon Monoxide/Inhalation/HAZMAT/CBRN

9. Cardiac or Respiratory Arrest/Death

10. Chest Pain

11. Choking

12. Convulsions/Seizures

13. Diabetic Problems

14. Drowning/Diving/SCUBA Accident

15. Electrocution/Lightning

16. Eye Problems/Injuries

17. Falls

18. Headache

19. Heart Problems/A.I.C.D.
20. Heat/Cold Exposure

21. Haemorrhage/Lacerations

22. Inaccessible Incident/Entrapments

23. Overdose/Poisoning (Ingestion)

24. Pregnancy/Childbirth/Miscarriage

25. Psychiatric/Suicide Attempt

26. Sick Person

27. Stab/Gunshot/Penetrating Trauma

28. Stroke (CVA)/Transient Ischemic Attack (TIA)

29. Traffic/Transportation Incidents

30. Traumatic Injuries

31. Unconscious/Fainting (Near)

32. Unknown Problem (Man Down)

33. Inter-Facility Transfer/Palliative Care

34. Automatic Crash Notification (A.C.N.)

35. HCP (Health-Care Practitioner) Referral (United Kingdom only)

36. Flu-Like Symptoms (Possible H1N1)

37. Inter-Facility Transfer specific to medically trained callers

N.B. Cards 33, 34, 36 and 37 are not currently in use by the Welsh Ambulance Service.

The second component is a letter from A to E and including the Greek letter Ω, this letter denotes the type of response that a patient may need for their condition based on the answers given by the caller.

The final component is a number. This number relates to further specific information about an individual patient’s condition.

# Technical Appendix: 7

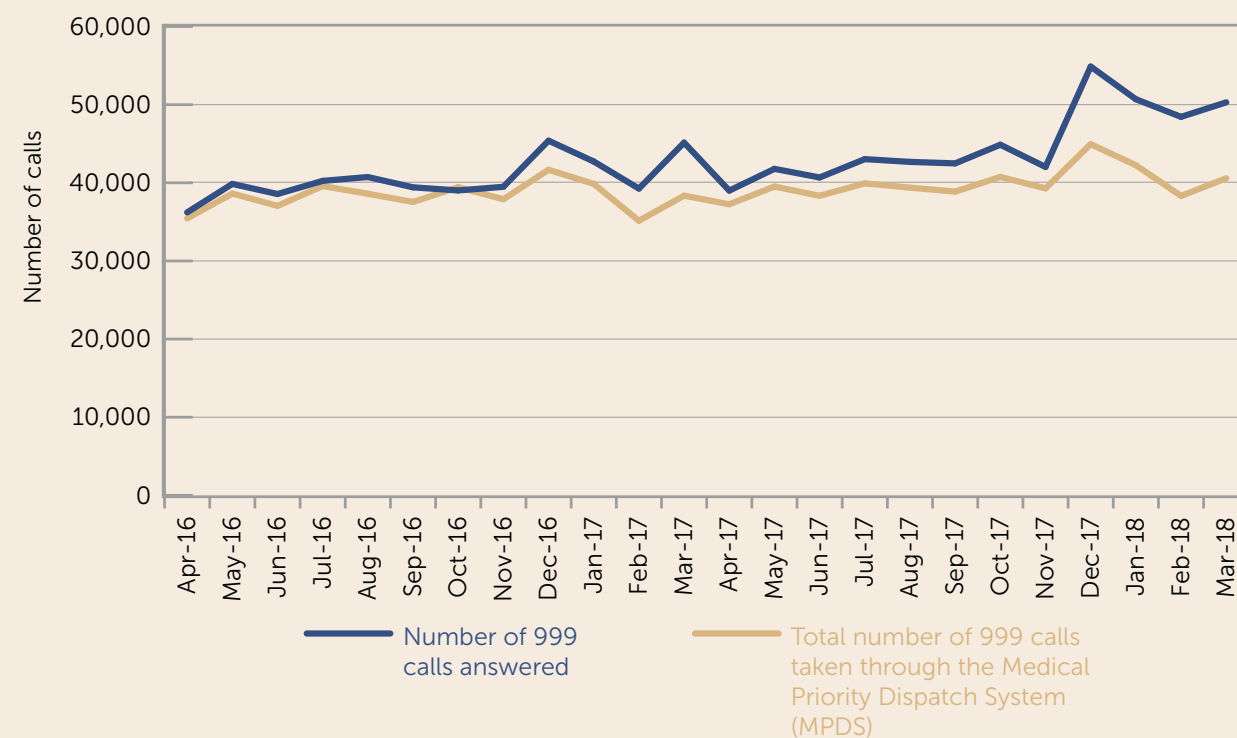
## Additional Activity Information and Analysis\*

### Step 2: Activity - Calls

**Figure 56** shows total number of 999 calls answered by the Welsh Ambulance Service Clinical Contact Centres against the total number of 999 calls prioritised through the Medical Priority Dispatch System for the period 1st April 2016 – 31st March 2018. This information excludes duplicate calls and calls that are passed to another ambulance service.

The lowest number of 999 calls answered was 36,216 in April 2016. The highest number of calls answered was 54,879 in December 17. The month by month variation in calls ranges from -13.6% to 30.6%. The largest month by month variation can be seen in November 2017 – December 2017. Calls increased by 12849 (30.6%).

● **FIGURE 56**



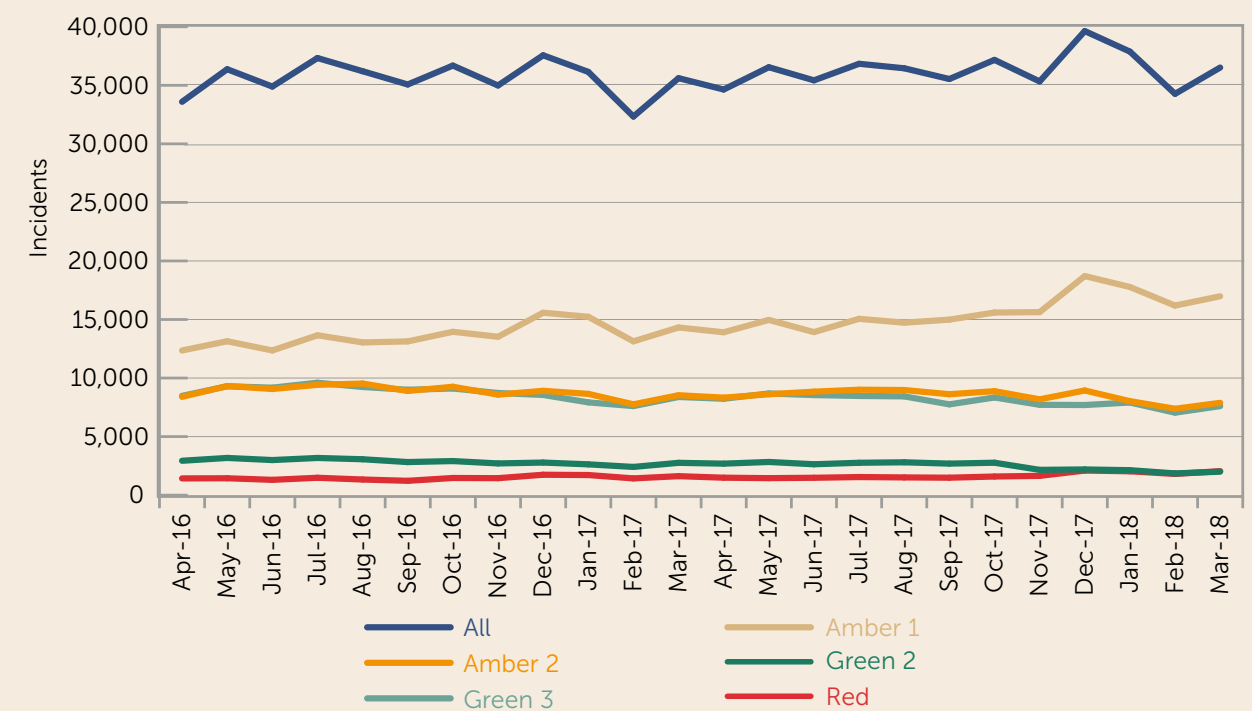
\*The impact of the implementation of a new Computer Aided Dispatch system and the resultant changes in operational practices in November 2017 cannot be fully quantified, but is a likely confounding factor in the apparent step change in activity for the November 2017 – December 2017 period.

### Step 3: Activity – Incidents

**Figure 57** shows total number of incidents generated in each of the ambulance service response categories following calls being prioritised through the Medical Priority Dispatch System for the period 1st April 2016 – 31st March 2018.

It includes all incidents recorded in the ambulance service computer aided dispatch system with a medical priority dispatch code.

● **FIGURE 57: TOTAL INCIDENT VOLUME AND BY CATEGORY**





For the total incident volume there is 2.2% increase in incident demand, equivalent to an additional 9456 incidents when comparing 2016/17 with 2017/18. The month by month variation in demand ranges from -11% to 12%.

For Red there is a 14.6% increase in incident demand, equivalent to an additional 2567 incidents when comparing 2016/17 with 2017/18. The month by month variation in demand ranges from -16.8% to 27.5%.

For Amber (Amber 1 and 2 combined) there is a 7.6% increase in incident demand, equivalent to an additional 20389 incidents when comparing 2016/17 with 2017/18. The month by month variation in demand ranges from -12.5% to 16.1%.

For Amber 1 there is a 15.3% increase in incident demand, equivalent to an additional 25,037 incidents when comparing 2016/17 with 2017/18.

The month by month variation in demand ranges from -13.8% to 19.7%.

For Amber 2 there is a 4.4% decrease in incident demand, equivalent to 4,648 decrease in incidents when comparing 2017/17 with 2017/18. The month by month variation in demand ranges from -10.3% to 11%.

For Green 2 there is a 14.1% decrease in incident demand equivalent to a 4,840 decrease in incidents when comparing 2016/17 with 2017/18. The month by month variation ranges from -22% to 14.5%.

For Green 3 there is an 8.2% decrease in incident demand equivalent to an 8,660 decrease in incidents when comparing 2016/17 with 2017/18. The month by month variation ranges from -11% to 10.2%.

Step 3: Activity – Incident by Condition 1

Figure 58 demonstrates each condition in the Amber category and the relative volume generated by each. Amber 1 is a significantly larger category than Amber 2.

● FIGURE 58:

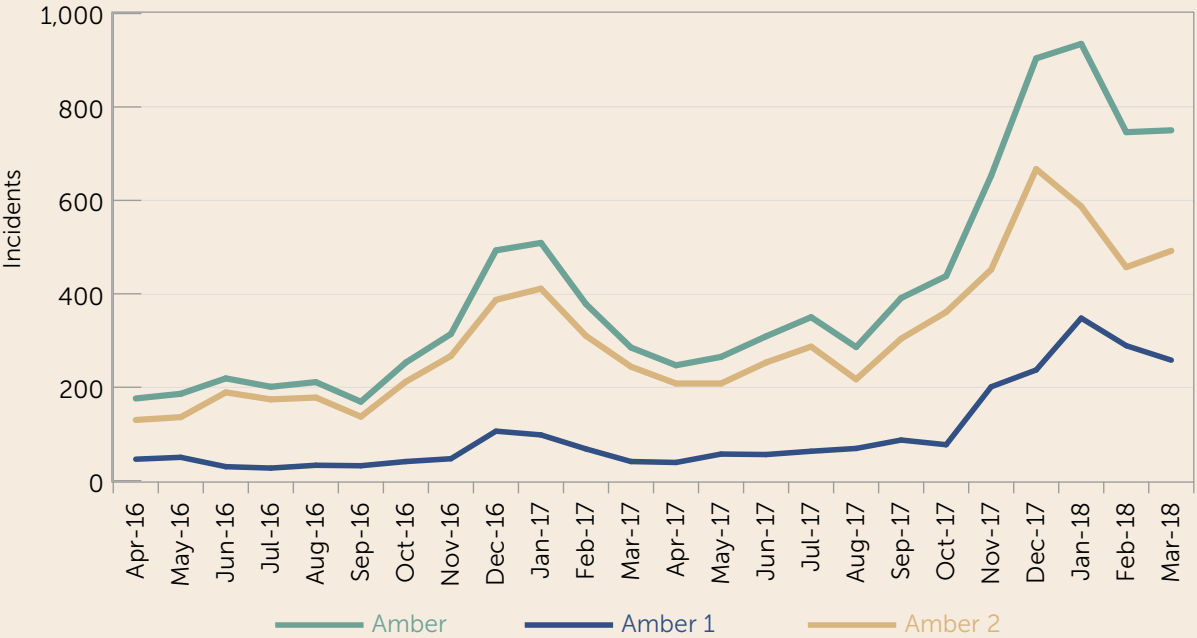
	AMBER 1	AMBER 2
ABDOMINAL PAIN/PROBLEMS	5,230	1,022
ALLERGIES(REACTIONS)/ENVENOMATIONS	2,053	500
ANIMAL BITES/ATTACKS	71	69
ASSAULT/SEXUAL ASSAULT	10	2,981
BACK PAIN (NON-TRAUMA/NON-RECENT)	2,169	1,209
BREATHING PROBLEMS	71,117	10,260
BURNS(SCALDS)/EXPLOSION	373	1,530
CARBON MONOXIDE/INHALATION/HAZCHEM	534	482
CARDIAC/RESPIRATORY ARREST/DEATH	10	2
CHEST PAIN	96,504	1
CHOKING	1,500	2
CONVULSIONS/FITTING	17,097	8,569
DIABETIC PROBLEMS	727	5,920
DROWNING(NEAR)/DIVING/SCUBA	259	114
ELECTROCUTION/LIGHTNING	72	--
EYE PROBLEMS/INJURIES	--	34
FALLS	28,309	50,423
HAEMORRHAGE/LACERATIONS	19,162	9,617
HEADACHE	914	1,380
HEALTH CARE PROFESSIONAL	4,679	3
HEART PROBLEMS/A.I.C.D	6,770	3,212
HEAT/COLD EXPOSURE	180	250
INACCESSIBLE INCIDENT/OTHER ENTRAP	136	88
INTERFACILITY EVALUATION/TRANSFER	--	2
OVERDOSE/POISONING (INGESTION)	678	18,718
PREGNANCY/CHILDBIRTH/MISCARRIAGE	2,111	1,954
PROQA COMPLETED ON CARDSET	1	--
PSYCH/ABNORMAL BEHAVIOUR/SUICIDE	451	24,130
SICK PERSON – SPECIFIC DIAGNOSIS	29,626	13,447
STAB/GUNSHOT/PENTRATING TRAUMA	6	208
STROKE – CVA	19,754	13,130
TRAFFIC/TRANSPORTATION ACCIDENTS	2,843	13,308
TRANSFER/INTERFACILITY/PALLIATIVE	--	3
TRAUMATIC INJURIES, SPECIFIC	5,631	11,369
UNCONSCIOUS/FAINTING(NEAR)	32,881	9,348
UNKNOWN PROBLEM – COLLAPSE-3RD PTY	5	4,671
TOTAL	351,863	207,956

Step 3:  
Activity – Incidents (Clinical Support Desk)

Figure 59 shows the volume of incidents dealt with Clinical Support Desk (CSD) for the period 1st April 2016 – 31st March

2018. A proportion of these incidents will still require transport to hospital, which may be by ambulance, taxi or their own transport.

FIGURE 59: AMBER 1 AND 2 INCIDENTS STOPPED BY THE CLINICAL SUPPORT DESK



For Amber (Amber 1 and 2 combined) there is an 84.9% increase in incidents stopped by the CSD, equivalent to an additional 2,880 incidents when comparing 2016/17 with 2017/18. The month by month variation in demand ranges from -25.7% to 57%.

For Amber 1 there is a 187.7% increase in incidents stopped by the CSD, equivalent to

an additional 1,162 incidents when comparing 2016/17 with 2017/18. The month by month variation in demand ranges from -40% to 161%.

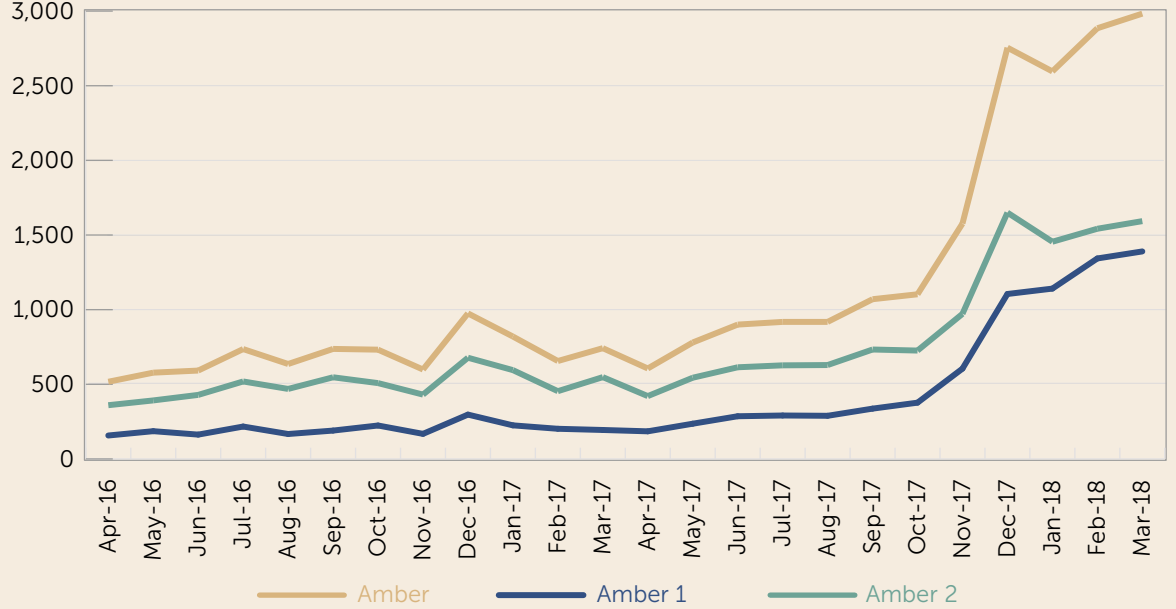
For Amber 2 there is a 61.9% increase in incidents stopped by the CSD, equivalent to an additional 1718 incidents when comparing 2016/17 with 2017/18. The month by month variation in demand ranges from -24.6% to 54.7%.

Step 3:  
Activity – Incidents (Cancelled)

Figure 60 demonstrates the number of incidents being cancelled by the caller prior to the

ambulance arriving at the scene for the period 1st April 2016 – 31st March 2018.

FIGURE 60: AMBER 1 AND 2 INCIDENTS CANCELLED PRE-ARRIVAL



For Amber (Amber 1 and 2 combined) there is a 129.5% increase in incidents cancelled pre arrival, equivalent to an additional 10771 incidents when comparing 2016/17 with 2017/18. The month by month variation in demand ranges from -20% to 74.7%.

For Amber 1 there is a 217.4% increase in incidents cancelled pre-arrival, equivalent to

an additional 5,195 incidents when comparing 2016/17 with 2017/18. The month by month variation in demand ranges from -25% to 82.6%.

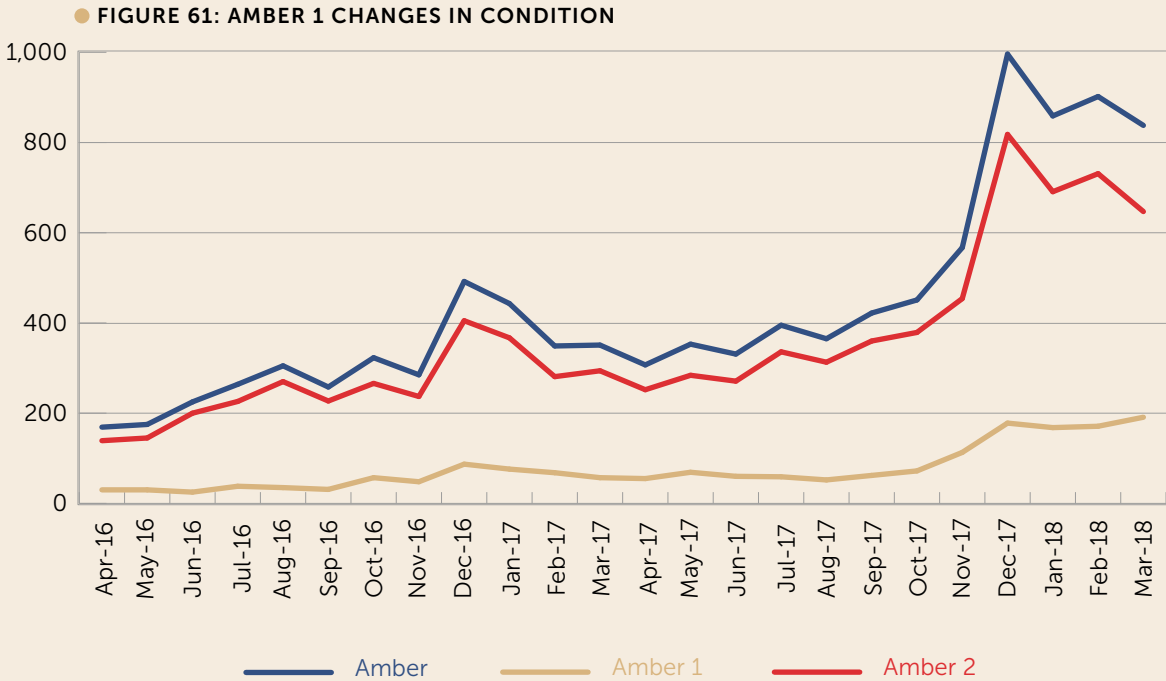
For Amber 2 there is a 94% increase in incidents cancelled pre-arrival, equivalent to an additional 5,576 incidents when comparing 2016/17 with 2017/18. The month by month variation in demand ranges from -23.7% to 69.8%.

Step 3:

Activity – Changes in prioritisation

Figure 61 show the numbers of incidents stopped in Amber 1 and Amber 2 due to the patient’s condition being re-prioritised for the period 1st April 2016 – 31st March 2018.

These instances occur when subsequent 999 calls are received for the same incident, but following re-prioritisation, a different category of response is required. In these instances the original incident will be closed and a new incident generated under the new priority.

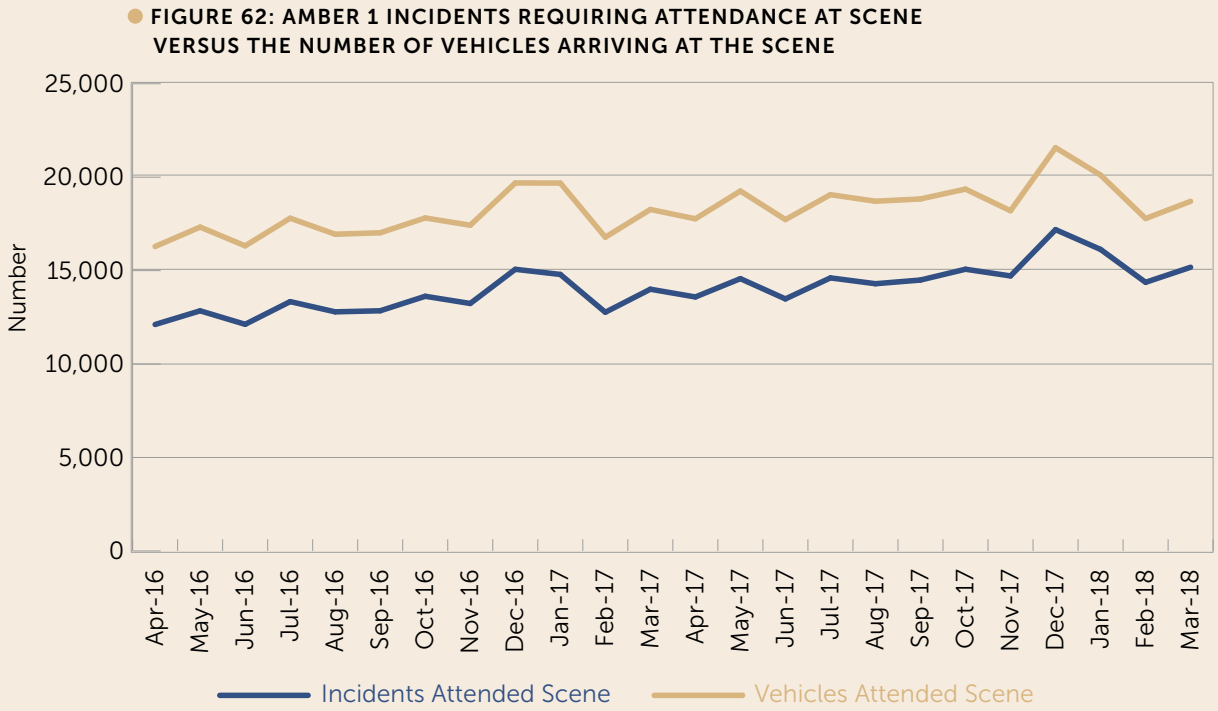


Step 4:

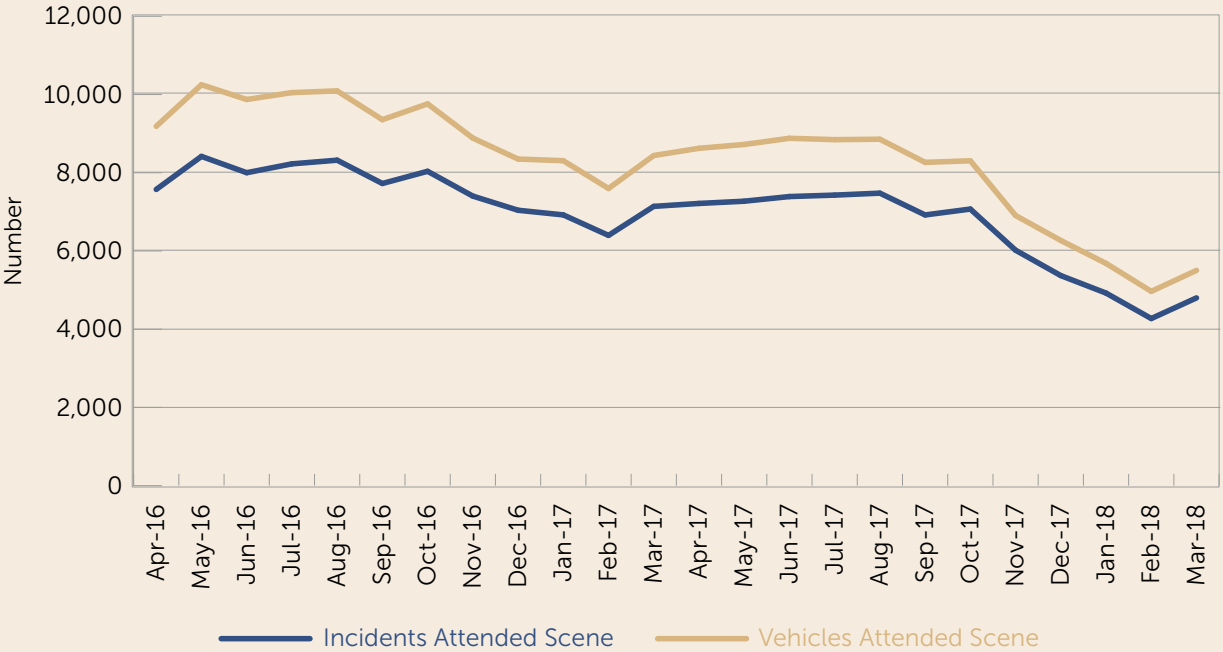
Activity – Attendance at Scene

Figure 62 and Figure 63 demonstrates the relationship between the numbers of incidents requiring an attendance at scene, against the number of vehicles that attended the scene for the period 1st April 2016 – 31st March 2018.

The clinical model is designed to minimise the number of multiple vehicle arrivals at scene for Amber incidents by sending the right resource the first time that is able to manage a patient’s condition. There are a number of Amber incidents where it is accepted that multiple resource may be appropriate (such as chest pain).



● FIGURE 63: AMBER 2 INCIDENTS REQUIRING ATTENDANCE AT SCENE VERSUS THE NUMBER OF VEHICLES ARRIVING AT THE SCENE



For Amber (Amber 1 and 2 combined) there is a 1.2% increase in incidents requiring attendance at scene equivalent to an additional 3,086 incidents when comparing 2016/17 with 2017/18. The month by month variation in demand ranges from -11.7% to 10.3%.

For Amber (Amber 1 and 2 combined) there is a 1.4% increase in the number of vehicles attending scene, equivalent to a decrease of 4,601 attendances when comparing 2016/17 with 2017/18. The month by month variation in demand ranges from -12.9 to 10.9%. For Amber 1 there is an 11.4% increase in incidents requiring attendance at scene, equivalent to an additional 18,132 incidents when comparing 2016/17 with 2017/18. The month by month variation in demand ranges from -13.7% to 16.8%.

For Amber 1 there is a 7.4% increase in the number of vehicles attending scene, equivalent to an additional 15,720 incidents when comparing

2016/17 with 2017/18. The month by month variation in demand ranges from -14.7% to 18.5%.

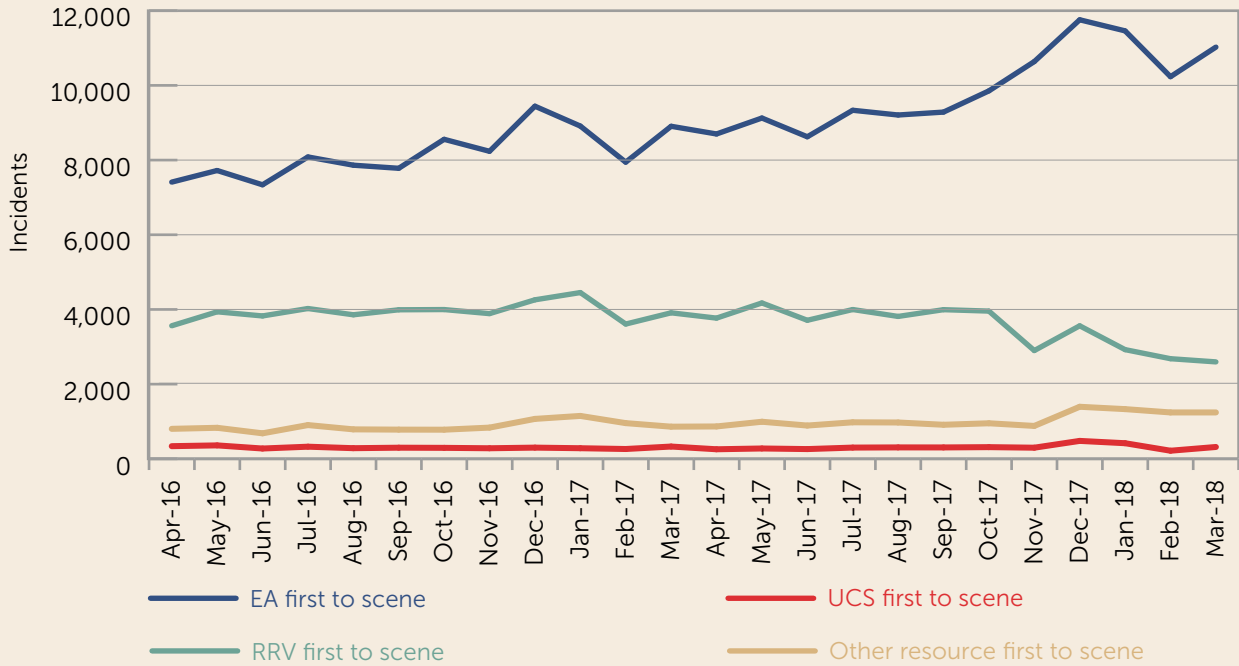
For Amber 2 there is a 16.5% decrease in incidents requiring attendance at scene, equivalent to a 15,046 decrease in incidents when comparing 2016/17 with 2017/18. The month by month variation in demand ranges from -14.9% to 12.4%.

For Amber 2 there is an 18.4% decrease in incidents requiring attendance at scene, equivalent to a 20,321 decrease in incidents when comparing 2016/17 with 2017/18. The month by month variation in demand ranges from -16.8% to 11.6%.

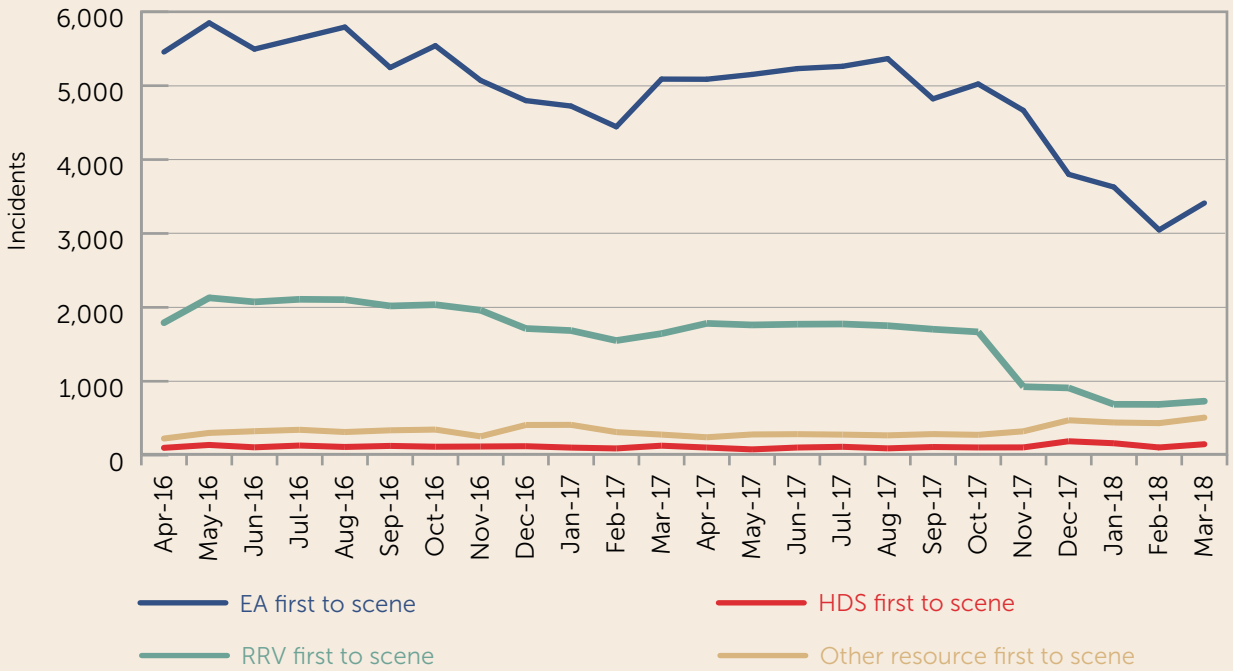
Step 4:  
Activity – First Vehicle to Scene

Figure 64 and Figure 65 demonstrate the type of vehicle arriving first at the scene of Amber 1 and 2 incidents over period 1st April 2016 and 2 incidents over period 1st April 2016 – 31st March 2018.

● FIGURE 64: AMBER 1 FIRST VEHICLE TO SCENE



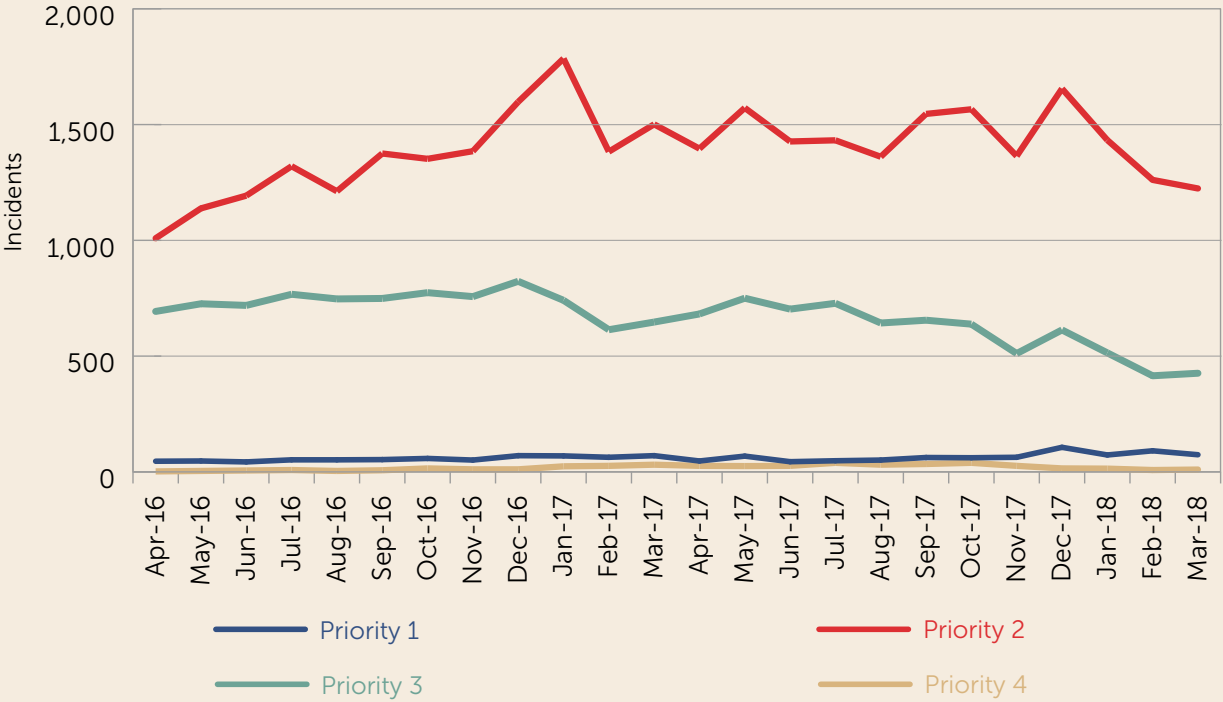
● FIGURE 65: AMBER 2 FIRST VEHICLE TO SCENE



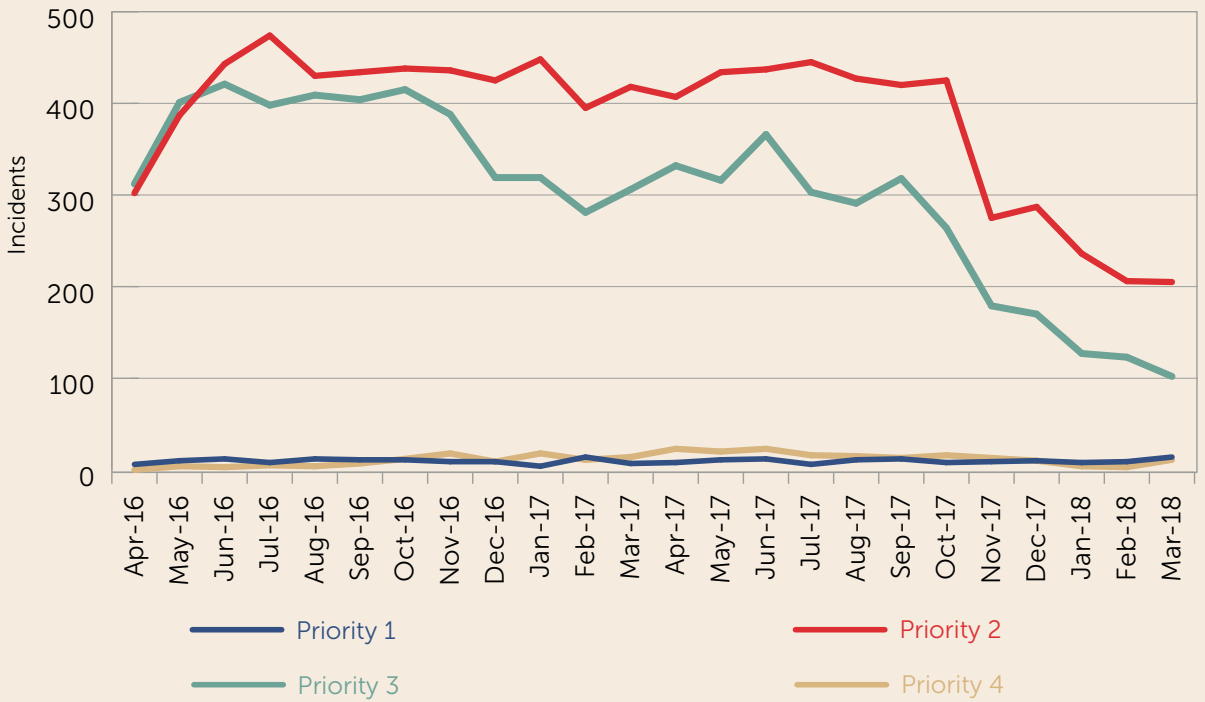
Step 4:  
Activity – Back Up Request

Figure 66 and Figure 67 demonstrate the volume and types of back up being requested by resources on scene for the period 1st April 2016 – 31st March 2018.

● FIGURE 66: AMBER 1 BACK UP REQUESTS



● FIGURE 67: AMBER 2 BACK UP REQUESTS

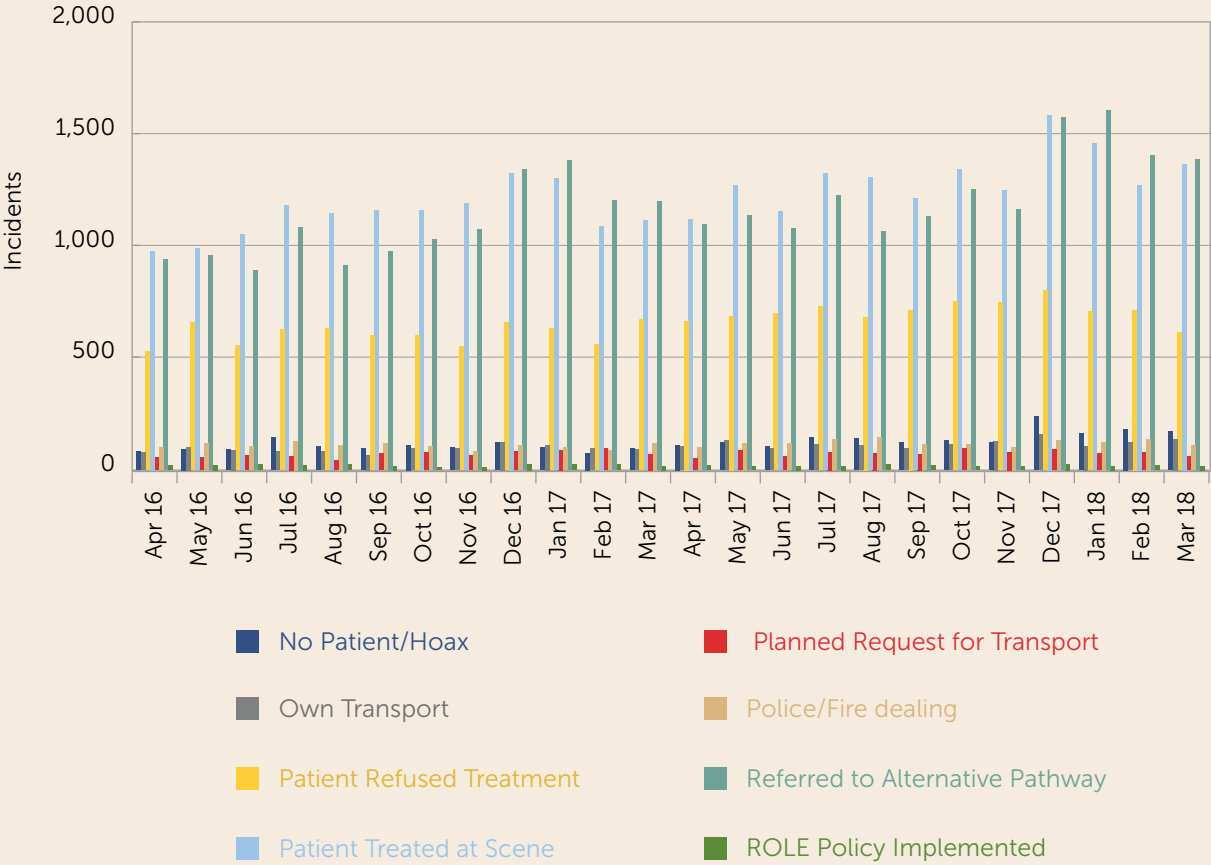




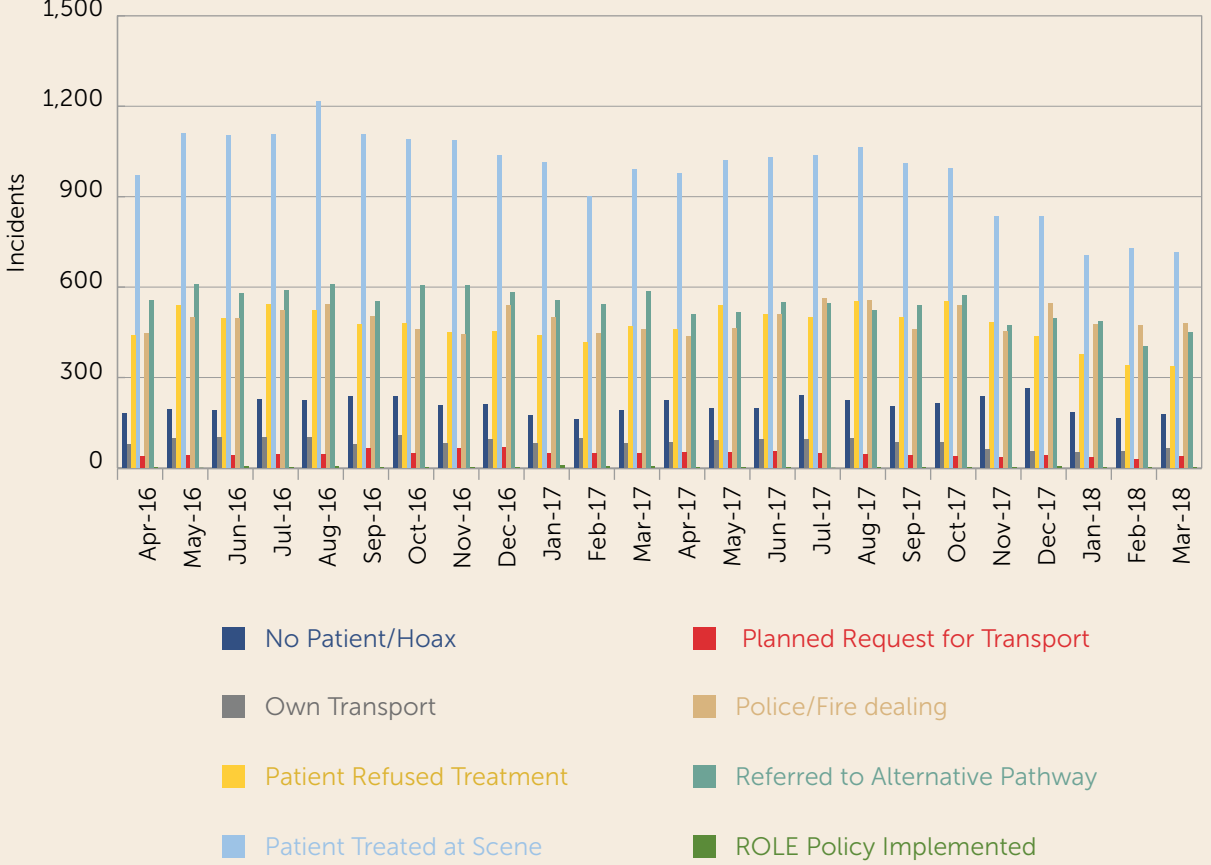
Step 4:  
Activity – Non-Conveyance

Figures 68 and Figure 69 demonstrate the numbers of incident resulting in a non-conveyance to hospital during the period 1st April 2016 – 31st March 2018.

● FIGURE 68: AMBER 1 NON-CONVEYANCE



● FIGURE 69: AMBER 2 NON-CONVEYANCE



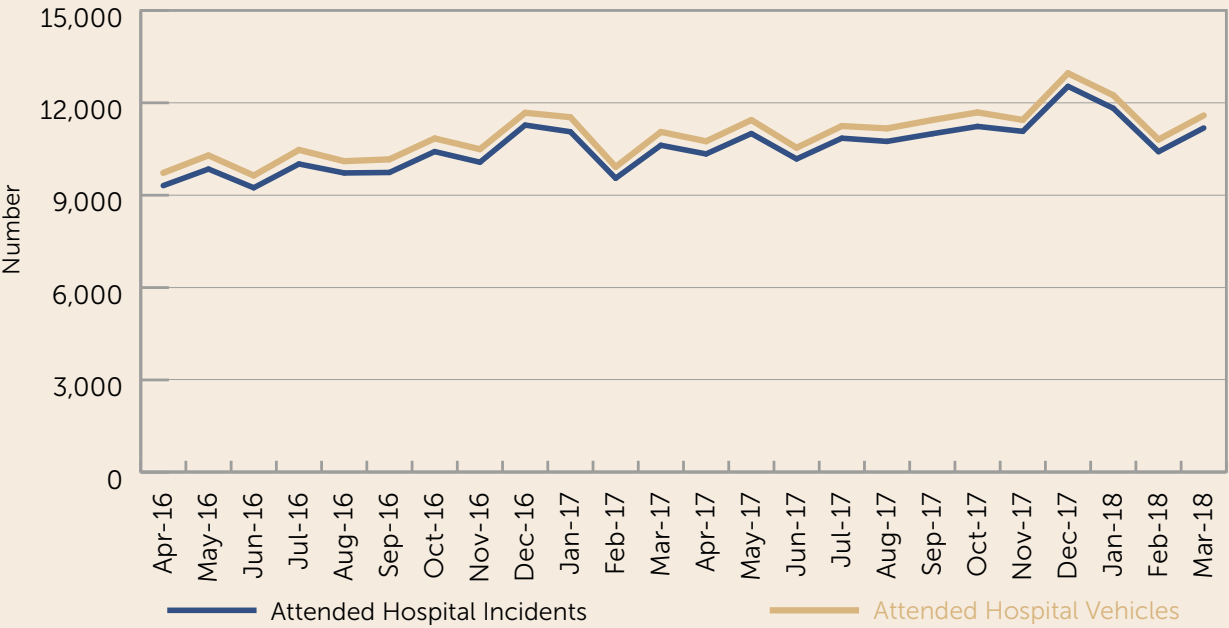
Step 5:  
Activity – Conveyance

Figure 70 and Figure 71 demonstrate the relationship between the numbers of incidents requiring transport to hospital from scene, against the number of vehicles that attended the hospital for the period 1st April 2016 – 31st March 2018. More than once vehicle may attend the hospital per incident if there are more than

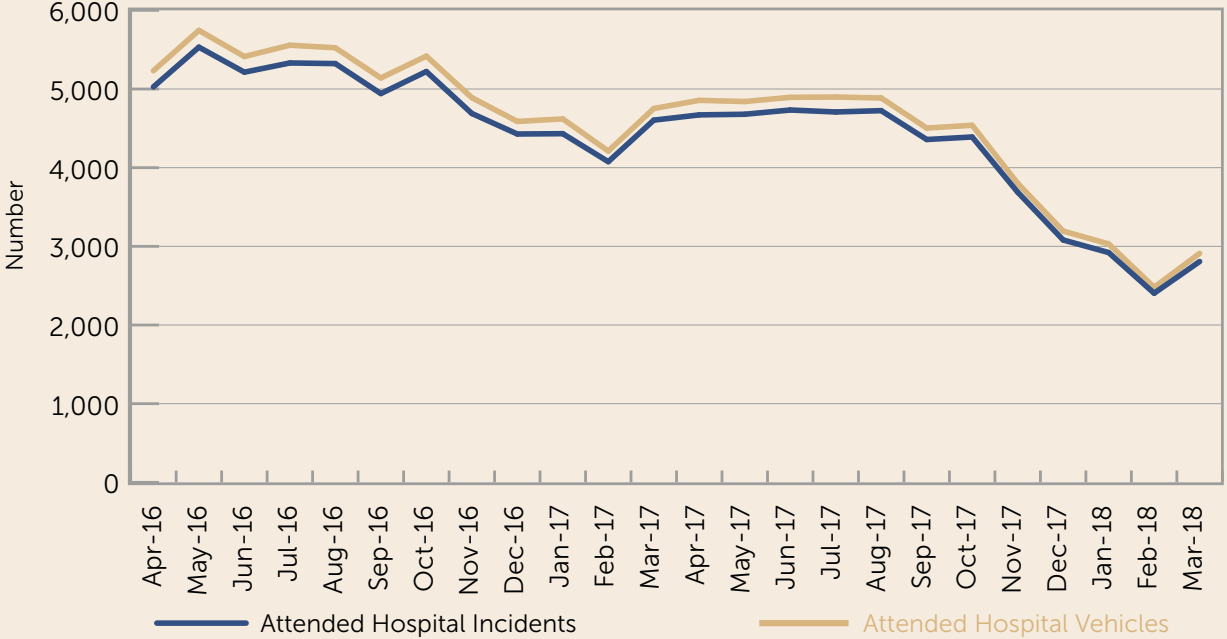
one patient, or if the patients being transported require a certain level of intervention or clinical skill set.

It should be noted that this metric relates to incidents only, the vehicle may be carrying one or more patients.

● FIGURE 70: AMBER 1 HOSPITAL ATTENDANCE



● FIGURE 71: AMBER 2 HOSPITAL ATTENDANCE



# Technical Appendix: 8

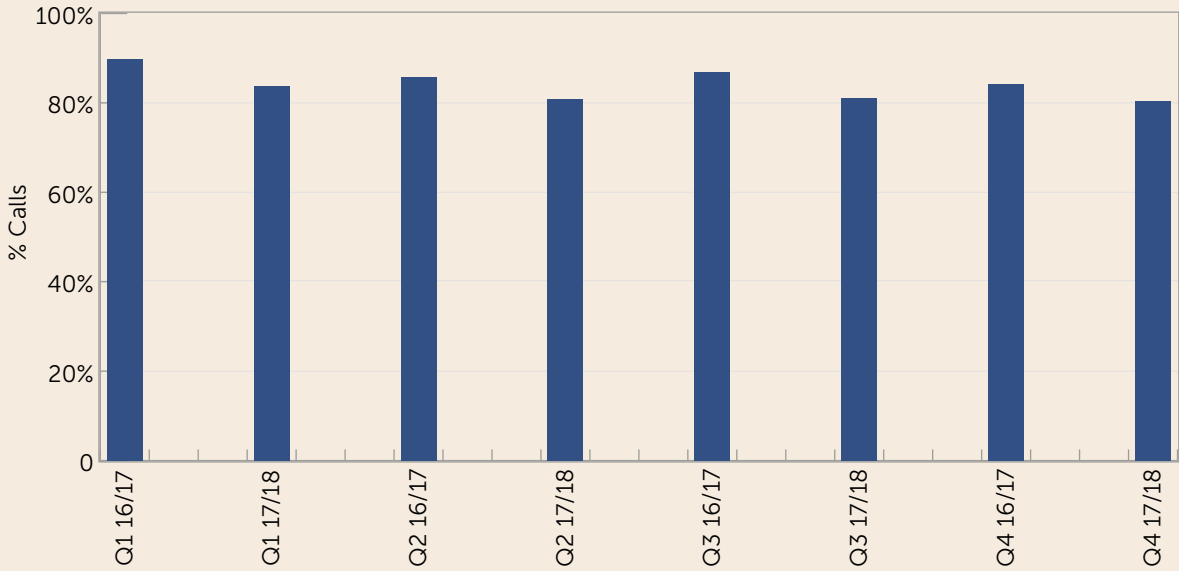
## Additional Performance Information and Analysis

### Step 2: Calls

Figure 72 shows quarterly comparisons of the average percentage of 999 calls answered within 6 seconds over each quarter during the period. There is a decrease in the average percentage of 999 calls answered within 6 seconds when comparing each quarter from 2016/17 with 2017/18. There was a 6% decrease

when comparing quarter 1 2016/17 with quarter 1 2017/18, a 5% decrease when comparing quarter 2 2016/17 with quarter 2 2017/18, a 5.9% decrease when comparing quarter 3 2016/17 with quarter 3 2017/18 and a 3.7% decrease when comparing quarter 4 2016/17 with quarter 4 2017/18.

● FIGURE 72: % CALLS ANSWERED IN 6 SECONDS AVERAGE QUARTERLY COMPARISONS



### Step 3:

#### Response Time

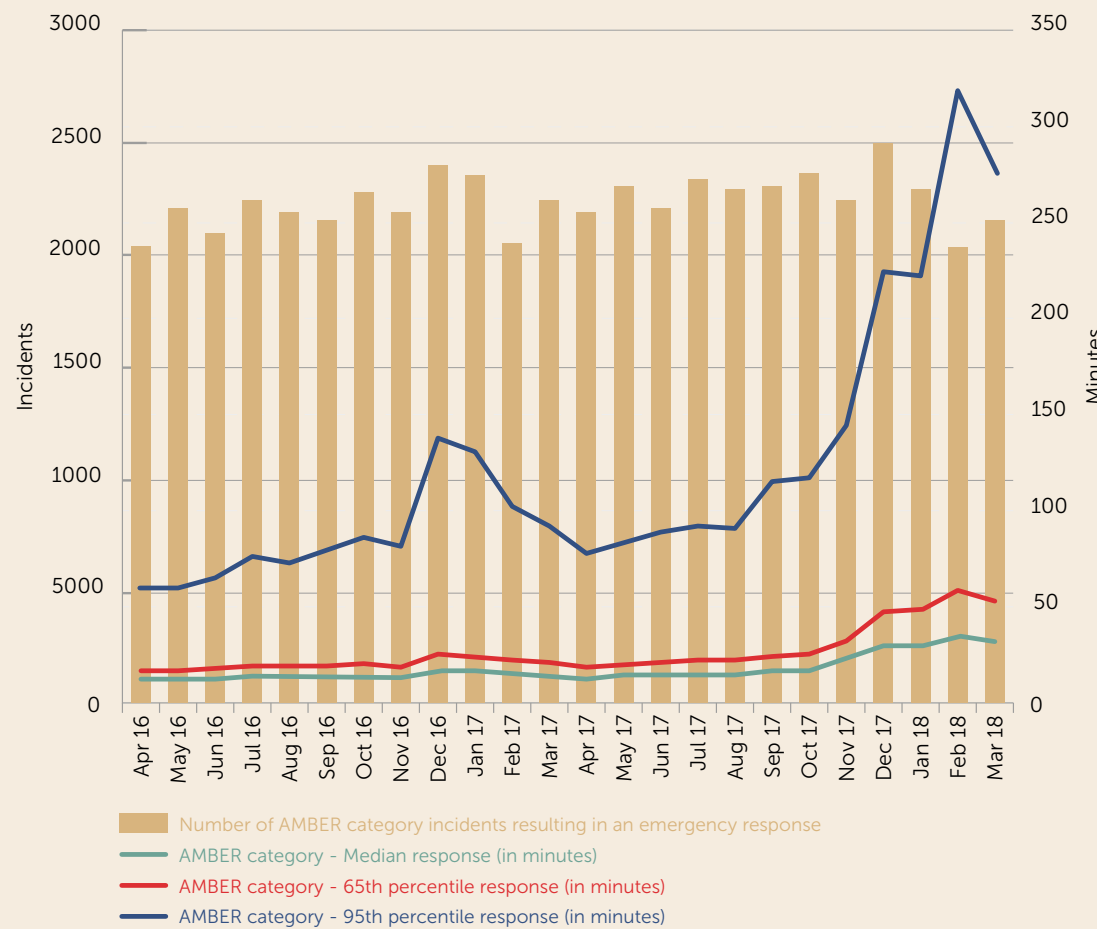
Figure 73 shows the relationship between Amber incident volume (where an incident requires attendance at scene) and the response time performance against median, 65th and 95th percentiles for the period 1st April 2016 – 31st March 2018.

**Median Response** – 53.1% increase (an average additional 7.32 minutes) when comparing 2016/17 with 2017/18. The month by month variation ranges from -6.9% to 36.7%.

**65th Percentile Response** – 65.17% increase (an average additional 12.94 minutes) when comparing 2016/17 with 2017/18. The month by month variation ranges from -9.6% to 45.7%.

**95th Percentile Response** – 76.63% increase (an average additional 66.97 minutes) when comparing 2016/17 with 2017/18. The month by month variation ranges from -21% to 67.68%.

● FIGURE 73: AMBER INCIDENT VOLUME VERSUS RESPONSE TIME PERCENTILE



Step 4:

Clinical Indicators

Figure 74 shows performance against the clinical indicators (excluding ROSC) the period 1st April 2016 – 31st March 2018.

Stroke patients

An average of 95.8% of patients during 2016/17 and 96.5% of patients during 2017/18 were documented as receiving the appropriate care bundle. The month by month variation ranges from 93.4% to 98.1%.

Older patients with suspected hip fracture

An average of 68% of patients during 2016/17 and 75.7% of patients during 2017/18 were documented as receiving the appropriate care bundle. The month by month variation ranges from 61.7% to 79.2%.

ST segment elevation myocardial infraction (STEMI) patients

An average of 65.8% of patients during 2016/17 and 68.8% of patients during 2017/18 were documented as receiving the appropriate care bundle. The month by month variation ranges from 52.4% to 77.5%.

Suspected sepsis patients

An average of 98.8% of patients during 2016/17 and 96.7% of patients during 2017/18 were documented as receiving the appropriate care bundle. The month by month variation ranges from 92.7% to 100%.

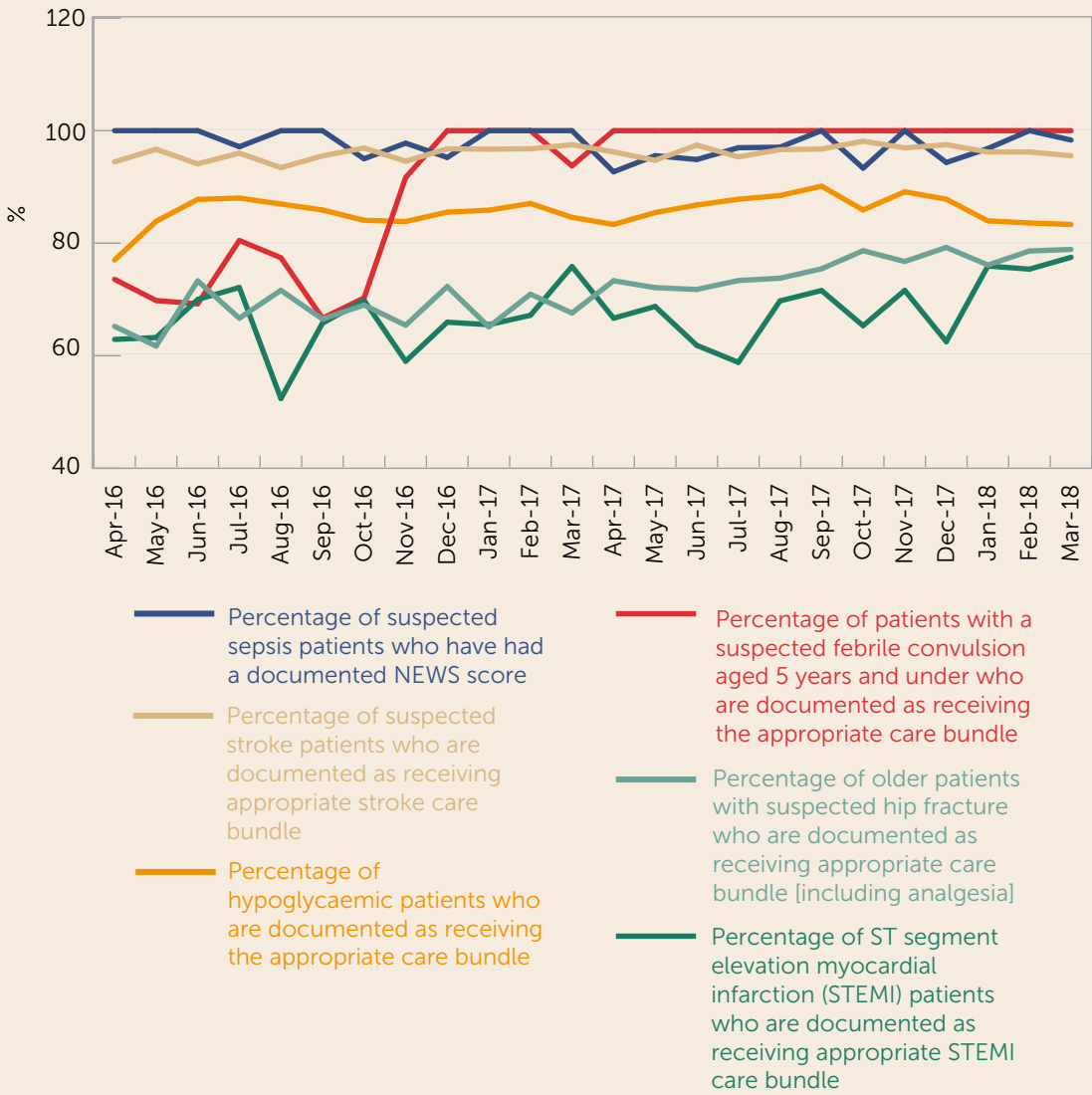
Patients with a suspected febrile convulsion aged 6 years and under

An average of 82.7% of patients during 2016/17 and 100% of patients during 2017/18 were documented as receiving the appropriate care bundle. The month by month variation ranges from 66.7% to 100%.

Hypoglycaemic patients

An average of 85% of patients during 2016/17 and 86.3% of patients during 2017/18 were documented as receiving the appropriate care bundle. The month by month variation ranges from 77% to 90.1%.

FIGURE 74: CLINICAL INDICATOR PERFORMANCE



# Technical Appendix Reference

1a Ronan A Lyons, Kerina H Jones, Gareth John, Caroline J Brooks, Jean-Philippe Verplancke, David V Ford, Ginevra Brown and Ken Leake; The SAIL databank: linking multiple health and social care datasets (2009) BMC Medical Informatics and Decision Making 2009, 9:3

2a A Strategic Review of Welsh Ambulance Services – Professor Siobhan McClelland – 2013

3a Welsh Ambulance Service NHS Trust – ORH Capacity Review- 2012

- Efficiency Review of The Welsh Ambulance Services NHS Trust – Lightfoot Solutions in association with Lis Nixon Associates And Baker Tilly on behalf of Health Commission Wales and The Welsh Ambulance Services NHS Trust – 2009
- Ministerial Review of Ambulance Services – 2008
- Wales Audit Office (WAO) follow up review of the Welsh Ambulance Service NHS Trust – 2008
- Morton Warner review of the Welsh Ambulance Modernisation Plan – 2008
- Welsh Audit Office review (2006) of the Welsh Ambulance Service NHS Trust (WAST) – 2006

4a [http://www.southwalesargus.co.uk/news/11749793.Ambulance\\_service\\_to\\_get\\_11m\\_boost/](http://www.southwalesargus.co.uk/news/11749793.Ambulance_service_to_get_11m_boost/)

5a <https://statswales.gov.wales/Download/File?fileId=241>

6a <https://gov.wales/docs/statistics/2015/150325-ambulance-services-february-2015-en.pdf>

7a <https://gov.wales/newsroom/health-and-social-services/2015/150729patients/?status=open&lang=en>

8a <https://gov.wales/docs/statistics/2017/170628-ambulance-services-2016-17-en.pdf>

9a <http://www.wales.nhs.uk/sitesplus/documents/1134/Final%20evaluation%20report.pdf>

10a <https://gov.wales/newsroom/health-and-social-services/2017/170227ambulance/?status=open&lang=en>

11a <http://www.emergencydispatch.org/AboutTheAcademy>

12a <http://www.emergencydispatch.org/articles/whatis.html>

13a <http://www.ambulance.wales.nhs.uk/Default.aspx?gcid=1545&pageId=2&lan=en>

14a <http://www.emergencydispatch.org/articles/princdocpullo3.pdf>

NATIONAL COLLABORATIVE  
COMMISSIONING UNIT

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## Quality, Safety & Experience (QSE) Committee

### Minutes of the Meeting Held in Public on 22.1.19 in The Boardroom, Carlton Court, St Asaph

#### Present:

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

#### In Attendance:

Mrs Deborah Carter	Associate Director Quality Assurance
Mrs Kate Dunn	Head of Corporate Affairs
Mrs Fiona Giraud (part meeting)	Director of Midwifery & Women's Services
Mr Mark Green (part meeting)	Director, Deloitte
Mrs Sue Green	Executive Director of Workforce & Organisational Development (OD)
Mrs Gill Harris	Executive Director of Nursing & Midwifery
Dr Melanie Maxwell	Senior Associate Medical Director
Dr Evan Moore	Executive Medical Director
Dr Jill Newman	Director of Performance
Miss Teresa Owen (part meeting)	Executive Director of Public Health
Prof Michael Rees	Chair of Healthcare Professionals Forum (HPF)
Mr Adrian Thomas	Executive Director of Therapies & Health Sciences

Agenda Item Discussed	Action By
<p><b>QS19/1 Chair's Opening Remarks</b></p> <p><b>QS19/1.1</b> The Chair welcomed everyone to the meeting. She referred to her correspondence to members of the 14.1.19 and reiterated the importance of reports being able to provide the Committee with clear assurances and noted that if this was not the case then this would be minuted as such and the paper resubmitted for future discussion. The Executive Medical Director welcomed this move but felt that clarity would be required as to how this message was translated across the organisation as there was a risk it could be perceived that the Board and Committees were only wishing to receive positive reports. The Executive Director of Nursing &amp; Midwifery added that on occasions the desired level of assurance simply wasn't in place. The Committee Chair accepted these points but felt there where assurance wasn't available this needed to be explicitly explained within the paper along with the reasons and action being taken. The Chair of the HPF added that where there were recommended actions to provide the necessary assurance, it needed to be accepted that resources would also be required. Executive colleagues felt that improvements to risk management systems would assist the organisation in making such choices more openly and transparently.</p>	

<p><b>QS19/2 Declarations of Interest</b></p> <p>None made.</p>	
<p><b>QS19/3 Apologies for Absence</b></p> <p>Apologies were received for Dr Chris Stockport and Mr Mark Thornton.</p>	
<p><b>QS19/4 Minutes of Previous Meeting held in public on 29.11.18 for Accuracy, Matters Arising and Review of Summary Action Log</b></p> <p><b>QS19/4.1</b> The minutes were agreed as an accurate record and updates to the summary action log were noted.</p> <p><b>QS19/4.2</b> A matter arising was raised by the Chair in that whilst a review of the cycle of business had been undertaken by herself and the Executive Director of Nursing &amp; Midwifery, comments would be welcomed from other members.</p>	
<p><b>QS19/5 Maternity Services in North Wales - Deloitte's Presentation and Final Update on the Commissioned Organisational Development (OD) Programme</b></p> <p><b>QS19/5.1</b> Mr Mark Green and Mrs Fiona Giraud joined the meeting. The Executive Director of Public Health introduced the item, confirming this was a key report for the Board following the conclusion of the OD work within maternity services. She noted that the Committee had received reports on the programme and she shared her view that the recent staffing and leadership appointments had made a real difference with a much improved culture of team work.</p> <p><b>QS19/5.2</b> Mr Green delivered a presentation in support of the narrative report which covered:</p> <ul style="list-style-type: none"> <li>• The core activities of the organisational development programme;</li> <li>• 10 proposed interventions to address clinical outcomes, effectiveness of the leadership team, culture and behaviour, outcomes for the North Wales Service;</li> <li>• Organisational effectiveness being central to vision, leadership, performance, clarity, culture and learning.</li> <li>• Workstreams being led by the Ysbyty Glan Clwyd (YGC) site team, North Wales clinical directors or the North Wales senior management team;</li> <li>• Recommendations for areas for continued improvement around 1) workforce establishment; 2) behaviours 3) developmental work plans; 4) coaching and mentoring; 5) handover and sustainability.</li> </ul> <p><b>QS19/5.3</b> The HPF Chair referred to a perception that historically women's services had not been fully integrated and that workforce issues could feel internalised within the service. The Executive Director of Public Health remarked that this was to some extent outside of the remit of the report and that latterly integration had much improved with good evidence of teams working together and with other services. In terms of the recent senior clinical appointments it was felt that they would need a consistent level of support from the Executive Team and that the Executive Director of Nursing &amp; Midwifery would follow up this conversation with Mr Green.</p>	GH

**QS19/5.4** A question was raised around sustainability of improvement and Mr Green confirmed that a robust handover and sustainability plan had been developed. He also assured the Committee that staff within the division were well aware of the OD work which would help the momentum to be sustained. Mrs Giraud added that the planned internal audit review would focus on the implementation of the quality improvement strategy into women's services. In response to a question regarding financial support and investment, the Executive Director of Public Health confirmed that this would be a prioritisation issue for the Board. It was suggested that the learning and methodologies from this whole piece of work could be beneficially applied elsewhere within the organisation. Finally the Chair noted that she had seen evidence of clear positivity within the team at YGC on a recent walkabout.

**QS19/5.5 It was resolved that** the Committee:

1. Note the update and progress to date and support the recommendations made by Deloitte.
2. Acknowledge that cultural change of the scale required in the Women's Directorate will need Corporate OD support and that the ongoing OD plan will need some financial support and investment to ensure that the early signs of positive change are embedded and sustained.
3. Support that the risk register entry as noted previously is not de-escalated until the findings of the Internal Audit of the service is considered in Q4.

## **QS19/6 Health & Safety Update**

**QS19/6.1** The Executive Director of Workforce & OD presented the paper which followed up on the report that had been submitted to the Health Board in November 2018, and drew members' attention to the areas of progress as set out on pages 5-6. She also highlighted that a copy of the internal audit report into health and safety had been appended to the report.

**QS19/6.2** The Independent Member (Trade Union) commented that she was aware that Trade Union and staff side colleagues were supportive of and welcomed the work that was being taken forward with regards to Health & Safety in the organisation. She enquired whether the Executives were content that structure as set out was sufficient to deliver the required agenda, and that the establishment of the Quality and Safety Group would be able to deliver improved compliance. The Executive Director of Workforce & OD outlined a range of positive developments in terms of the structure in that the two new Heads of Health & Safety had taken up post and were already making a difference in terms of leadership and visibility. She alluded to the need for a more integrated approach to the work of the Health & Safety and Occupational Health teams, and the refresh and realignment of various portfolios such as fire safety, security and violence & aggression. With regards to the post of Associate Director of Health, Safety and Equality there had been an excellent range of candidates and there was a high level of confidence in the ability to make a strong appointment at the interviews scheduled for the following week. This postholder would take a lead on bringing all the various Health and Safety professionals together. The Executive Director of Workforce & OD then confirmed that the new Health & Safety Group would be aligned to the Executive Team and would have responsibilities both in terms of ensuring the organisation met legislative requirements but also in strengthening the

shared agendas between occupational health, health and safety, and health & well-being. The HPF Chair made reference to discussions at the Local Negotiating Committee regarding occupational health and ensuring that recommendations made to support an individual off sick were followed up.

**QS19/6.3** In response to a question regarding reporting through the Committee structures, the Executive Director of Workforce & OD confirmed that update reports were now a standing item on Quality, Safety & Experience Committee agendas together with elements of performance monitoring to the Finance & Performance Committee. The Board would also receive a formal annual report. The Executive Director of Nursing & Midwifery added that discussions had been held at the Executive Team that a more risk based approach to health and safety needed to be established.

**QS19/6.4** It was resolved that the Committee note the position outlined in the report.

### **QS19/7 Health Protection Team (North Wales) 2018 Annual Report**

**QS19/7.1** The Executive Director of Public Health presented the annual report submitted by the Health Protection Team which detailed a range of activity and highlighted key challenges. She drew members' attention to the impact of seasonal flu which was an identified pressure point.

**QS19/7.2** A discussion ensued. Reference was made to the seemingly high rate of Cryptosporidiosis and it was explained that there was historically a higher incidence in rural parts of west Wales, and assurance was given that any untoward spike would be picked up and investigated. In terms of the statistics for mumps numbers it was confirmed there had been no actual outbreak identified but that there was a known challenge with vaccinating a certain population cohort, and there was work continuing with universities to address this.

**QS19/7.3** The Executive Director of Public Health welcomed feedback on the format of the report and the Committee Chair felt that the report contained an appropriate level of detail and information and was well-pitched for the Committee's use. **It was resolved that** the Committee note the contents of the report for information.

### **QS19/8 Integrated Quality & Performance Report**

**QS19/8.1** The Committee were informed that the Finance & Performance Committee had recently had a discussion around the content, quality, format and scope of this report. It was recognised that this was fundamental to ensuring the provision of an appropriate level of assurance but that the connectivity between ward and board still needed to improve to enable this. The Director of Performance confirmed that a suite of divisional reports were being developed to support the IQPR, and that this would change the culture and ownership of exception reporting. She advised that the IQPR would continue to lack some of the qualitative data that the Committee was looking for until such time as the 'building blocks' were in place. In addition there were inconsistencies in how the content for different divisions was presented, and some presentational and typographical aspects that needed to be standardised. The Chair raised the point of timeliness of data and the Director of Performance clarified that this

was an ongoing challenge as most month-end data wasn't available until the tenth working day of the following month which on occasions created pressures in providing validating data in time for Board and Committee deadlines. A general point was raised by the HPF Chair that there were instances where the narrative within the report did not align with the reported data, and examples of where the stated timescales for getting on track would seem too optimistic. The Director of Performance accepted there was room for improvement in terms of ensuring that there was evidence to support the stated timeframes. A discussion then ensued on the various chapters of the report:

#### **QS19/8.2 Chapter 1 Qualitative Reports**

- The Executive Director of Workforce & OD highlighted that in terms of advancing equality, BCUHB have become the best ranked Welsh health employer by lesbian, gay, bi and trans equality charity Stonewall in its Top 100 Employers list for 2019, having achieved 37<sup>th</sup> place.

#### **QS19/8.3 Chapter 1 Patient Safety Notices and Alerts**

- The Executive Medical Director wished to draw the Committee's attention to the fact that the organisation was compliant with all patient safety alerts for the very first time, and he extended thanks to Dr Melanie Maxwell and the wider team.

#### **QS19/8.4 Chapter 1 Concerns**

- A question was raised regarding an improvement plan for addressing the profile of concerns going beyond the 30 days response target and this would be provided as a briefing note alongside the trajectories that were being signed off. This would be presented at a future meeting.

#### **QS19/8.5 Chapter 1 Incidents**

- The Chair noted she had asked for further detail on incidents and that this would be provided reports currently being developed by the quality assurance team.

#### **QS19/8.6 Chapter 1 Mortality**

- The Senior Associate Medical Director provided reassurance that sepsis performance had improved in November as a result of the work of the collaborative and that improvements were being seen in terms of processes on sites. She anticipated that a rapid improvement would be noted once remaining data issues were resolved.

#### **QS19/8.7 Chapter 2 Infection Control**

- There was continued concern at the level of pressure ulcers and the Associate Director of Quality Assurance indicated that it was known that on occasions the same incident was being reported two or three times into Datix. Work was actively being taken forward to ensure staff were fully aware of how to properly report a pressure ulcer and also to make it easier for them to do so. It was also noted that there were inconsistencies in reporting across Welsh organisations and that the Welsh Government were shortly to amend the reporting requirements, and that as a general point when promoting a learning culture and encouraging reporting by staff, this did mean that the statistics look to worsen. The Committee were also reminded that the Board continued to work closely with the Wales Ambulance Services NHS Trust in terms of reducing the risks of pressure ulcers resulting from long waits inside ambulances.

DC

- The Executive Director of Nursing & Midwifery reminded members that the initial 90 day plan for infection prevention and control stemmed from the review by Janice Stevens, and she reported that Ms Stevens had been invited back in March 2019 to assess the Board's progress in terms of delivery against her recommendations. The outcome report of this further review would need to be scheduled into the Committee and/or Board cycles of business in due course.
- Reference was made to the statement within the report of the "nurses right to challenge antibiotic prescribing" and whether this should be wider than nurses. The Associate Director of Quality Assurance accepted that there were many other opportunities for health care professionals to provide challenge but that predominantly it was a nurse at the point of administration, and that this particular narrative arose from a specific piece of work in Ysbyty Glan Clwyd.
- With regards to flu vaccinations it was noted with concern that the performance against target for staff vaccinations would be lower than the previous year. The Executive Director of Public Health felt there remained a significant cultural issue with myths and concerns that discouraged staff from taking up the offer of the vaccination. She added that other Board were in a similar position and that improvements had been noted where incentives were utilised. On a more positive note she was pleased to report that uptake in the over 65s category was the best in Wales, although still not achieving the target. The Committee were also informed that this year's vaccine was a good match for the strain of flu that was currently circulating.

KD

#### **QS19/8.8 Chapter 4 Mental Health**

- A comment was made regarding Child Adolescent Mental Health (CAMHS) in that the two recent 'deep dive' sessions had been very helpful in improving the understanding between the Division and the Board.
- In terms of the assessment/therapy target of 28 days it was noted there was variation across the areas but an improved understanding of the data.
- The Director of Performance flagged an anticipated drop in performance for care and treatment plans following significant validation work.
- In terms of the 28 day assessment and therapy target for adults, the Chair enquired as to the background for senior management time having been diverted to support Primary Care in West & East. The Director of Performance indicated that management support was being focused within teams where there was most scope for making a significant different. There was also variation across teams and that meetings were ongoing with informatics colleagues regarding the future use of Sharepoint and other community tools.
- The Chair also queried the statement that longest waiters were seen first and the Director of Performance assured the Committee that all long waiters were risk assessed and scheduled appropriately.

**QS19/8.9 It was resolved that** the Committee note the report.

#### **QS19/9 Policies , Procedures or Other Written Control Documents for Approval**

##### **QS19/9.1 Policy for Section 5(2) for use in General and Community Hospitals**

**QS19/9.1.1** The Executive Director of Workforce noted that some of the terminology required updating as the policy still referred to "SHOs", and that she would wish to see



<p>a cross-reference to patient restraint and absconding policies/procedures. The Chair requested that Section 16 on training be amended to reflect that a range of levels of training was available to <u>all</u> staff.</p> <p><b>QS19/9.1.2 It was resolved that</b> the Committee approve the policy for implementation pending the amendments set out above.</p>	
<p><b>QS19/9.2 Covert Administration of Medication Clinical Policy</b></p> <p>The Committee were not happy to approve a policy without sight of an appropriate Equality Impact Assessment (EQIA). It was also noted that any references to protected characteristics must be consistent with terminology agreed within legislation. A point was raised regarding mental capacity and whether the policy potentially applied to patients outside of a mental health setting but it was agreed this was sufficiently explicit within the policy. A range of specific amendments were noted by the Associate Director of Quality Assurance who would feedback to the policy author.</p> <p><b>It was resolved that the Committee:</b></p> <ol style="list-style-type: none"> <li>1. request an amended policy to be circulated via email with appropriate EQIA;</li> <li>2. agree that Chair's Action then be taken to approve the Covert Administration of Medication Clinical Policy for use within BCUHB</li> </ol>	<p>DC</p> <p>DC</p>
<p><b>QS19/9.3 BCUHB Restricted Antimicrobial Policy</b></p> <p><b>QS19/9.3.1 It was resolved that</b> the Committee approve the policy for implementation in BCUHB.</p>	
<p><b>QS19/10 Quality Safety Group Assurance Report - Meetings Held 13.12.18 and 9.1.19</b></p> <p><b>QS19/10.1</b> The Executive Director of Nursing &amp; Midwifery presented the report and highlighted issues pertaining to:</p> <ul style="list-style-type: none"> <li>• Risks which could potentially impact on key clinical services at the Wrexham Maelor Hospital relating to risks of failure within domestic hot water &amp; heating pipes. Work was ongoing to mitigate these risks. This was to include a heat map identifying highest risk areas</li> <li>• An ongoing debate around safe storage of medicines which was now being taken forward by a subgroup of QSG.</li> <li>• A lack of assurance around point of care testing. QSG had requested further work and a report back in February.</li> <li>• The need to re-establish groups to respond appropriately to audits on ward kitchen and environments.</li> </ul> <p><b>QS19/10.2</b> A discussion ensued. The Executive Director of Workforce &amp; OD suggested that the recommendations around centralising ward kitchen food systems should be linked across to staff food systems also. She also asked whether the heatmap for the Wrexham site would incorporate other known estates risks and the</p>	

Executive Director of Nursing & Midwifery that prioritisation and mitigation would be brought together with estates and health & safety colleagues. The Chair of the HPF noted the planned review group to address delays in ophthalmology out-patient appointments and requested that both ophthalmology and optometry teams be involved. The Chair enquired whether there were any specific types of point of care testing that were of particular concern, and the example of pregnancy testing was given and that a different methodology was required.

**QS19/10.3 It was resolved that** the Committee note the report.

*[Miss T Owen and Cllr C Carlisle left the meeting]*

### **QS19/11 Improvement Group (HASCAS & Ockenden) Chair's Assurance Report**

**QS19/11.1** The Executive Director of Nursing & Midwifery presented the report and provided additional context in that the report had been prepared with the dual purpose of a submission to the Public Accounts Committee and she acknowledged therefore that the content may not be as focused as the Committee would have wished. She also reminded members that recommendations had been aligned where there was overlap between HASCAS and Ockenden. The Executive Director of Nursing & Midwifery went on to highlight that an appointment had been made to the post of consultant nurse in dementia. In addition it was reported that some members of the Stakeholder Group (particularly those representing families) had identified a range of task & finish groups that they would wish to individually become involved with. The Executive Director of Nursing & Midwifery concluded by saying that the pathway work did require additional support and investment, potentially through a Project Management Office approach, and also that a multi-agency meeting was planned for March to map out the approach to older people's services.

**QS19/11.2** A discussion ensued. A delay with the work around responding to the HASCAS recommendation around clinical records was noted. The Executive Medical Director set out challenges in terms of responding to the national infected blood inquiry which required the organisation to cease destroying clinical records which meant there was a need to store approximately an additional 50,000 records per month. The Committee were advised that this was being seen as a driver and opportunity to progress the work around single electronic patient records and to develop a business case hopefully by the end of 2019. The Chair suggested that whilst the level of background and context within the paper was helpful, she found it difficult to clearly map the progress made against each of the recommendations and requested that this be addressed in future reports. The Executive Director of Nursing & Midwifery confirmed that there was a wealth of detail available from other sources and assured the Committee that a 'confirm and challenge' culture was in place at the meetings of the Improvement Group. The Chair also fed back that she felt there were some general statements within the paper which could undermine the amount of actual progress made, and she queried whether learning could be taken from how audit recommendations were reported to the Audit Committee. The Associate Director of Quality Assurance responded that it was often difficult to match an action back to a specific recommendation as some of them were quite vague. The Chair explained that the report needed to provide a clear audit trail from the original recommendations to the action/progress taken in order to provide the Committee with assurance that improvements were being made. A way forward was suggested that

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<p>consideration could be given to inviting the lead officer to the Committee if members wished to undertake a deep dive into a certain area where progress appeared to be slow, or where the Committee wished to test the level of assurance that was being reported in the narrative document. Finally, a comment was raised regarding service user representatives on the Stakeholder Group and it was confirmed that these includes individuals with more recent experiences of using BCUHB services.</p> <p><b>QS19/11.3 It was resolved that</b> the Committee note the progress of the HASCAS &amp; Ockenden recommendations and the format of the report would be reviewed.</p>	
<p><b>QS19/12 Tissue and Organ Donation Report : Mr Adrian Thomas</b></p> <p><b>QS19/12.1</b> The Executive Director of Therapies &amp; Health Sciences presented a summary activity report for BCUHB for NHS Blood &amp; Transplant services for 2017-18 together with a summary of key achievements and priorities for the coming year. He highlighted the well-attended and valuable memorial service event held in St Asaph Cathedral.</p> <p><b>QS19/12.2</b> A discussion ensued. A member recalled that previous reports had set out where donation had not been possible due to the unavailability of intensive care beds for example. The Executive Director of Therapies &amp; Health Sciences confirmed the structure of reporting had altered but he would ascertain if this information was available. The question was asked whether there were any live donations reported; it was confirmed there weren't currently but that there should be increased awareness around this organ donation option. In response to a question around ongoing support to organ recipients it was confirmed this would be picked up by the transplant centre.</p> <p><b>QS19/12.3</b> It was resolved that the Committee note the activities of the BCU/NHS-BT Organ Donation Committee and to highlight the report to the Health Board through the Chair's report.</p>	AT
<p><b>QS19/13 Issues Discussed in Previous In Committee Session</b></p> <p><b>QS19/13.1 It was resolved that</b> the Committee note the information in public.</p>	
<p><b>QS19/14 Documents Circulated to Members</b></p> <p><b>QS19/14.1</b> The Committee noted that the following information had been provided to members:</p> <p>10.1.19 Briefing note regarding care commissioned from a Gwynedd nursing home  14.1.19 Arrangements for future meetings and agendas  15.1.19 Quality Safety Group notes 10.10.18</p>	
<p><b>QS19/15 Issues of Significance to inform the Chair's Assurance Report</b></p> <p>To be agreed with Chair.</p>	

<b>QS19/16 Date of Next Meeting</b>	
Tuesday 19.3.19 @ 9.30am in Carlton Court	
<b>QS19/17 Exclusion of Press and Public</b>	
It was resolved that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960.'	

BCUHB QUALITY, SAFETY& EXPERIENCE SUB COMMITTEE - Summary Action Log Public Version				
Officer/s	Minute Reference and summary of action agreed	Original Timescale	Latest Update Position	Revised Timescale
<b>29<sup>th</sup> November 2018</b>				
E Moore	<b>QS18/172.3</b> Arrange for IMs to receive further details including financial implications of proposals regarding primary coronary intervention.	December	Verbal update to be provided at January meeting. 22.1.19 The Executive Medical Director sought clarity on what financial details the IMs were seeking. Discussion took place and that the role of the QSE Committee was more around quality or safety risks not business cases. The Committee Chair accepted that any additional significant quality issues would be flagged by the Executives and was therefore happy to close the action.	January  Closed
G Harris	<b>QS18/174.1</b> Circulate details of actions that had been taken in relation to the public interest report regarding complaints handling as detailed within the PSOW annual letter	<del>December</del>  March	Briefing note sent to Committee Chair 15.1.19.  22.1.19 Committee Chair indicated she was not happy to close the action as the briefing note wasn't specific to the public interest report in question. It was agreed that the Executive Director of Nursing & Midwifery would follow this up.  12.2.19 Update received from Assistant Director Service User Experience as follows. The review of this case found that whilst an investigation had been completed in line with PTR, an SIR report had not been produced but instead the findings of the investigation had been captured in a PTR response letter. The briefing note previously	


			sent described the improvements made/being made that would address this.	
G Harris	<b>QS18/185.3</b> Work to establish an appropriate mechanism to share with the Committee the key elements of QSG discussions around individual action plans for never events.	January	Ongoing discussions to ensure that a report is provided. 22.1.19 will be captured within QSG notes 11.2.19 Director of Performance confirmed that data relating to SUI closure times had been received. Data would be reviewed and included in IQPR for March. In addition the Associate Director of Quality Assurance met with the Committee Chair to discuss the format of the quality report to include Never Events. There was an understanding of the issues to be represented within future reports and a revised report will be presented to the QSE in May.	March  May
J Newman D Carter	<b>QS18/185.3</b> Arrange for exception report within IQPR on the backlog for sign-off of incidents	January	22.1.19 Not included within IQPR but will be worked upon for the March meeting.	March
J Newman	<b>QS18/185.3</b> With regards to closing of concerns within 30 days ensure that future IQPR reports provide an indication of how far past the 30 days cases were.	January	22.1.19 Not included within IQPR but will be worked upon for the March meeting.	March
M Denwood	<b>QS18/184.2</b> Reflect on format of future safeguarding reports and how best to include appropriate level of detail around HASCAS and Ockenden recommendations.	January	Ongoing conversations between the Associate Director of Safeguarding and Associate Director of Quality Assurance, and Executive Director of Nursing & Midwifery.	
A Roach	<b>QS18/178.1</b>	December	22.1.19 Committee noted that this action remained outstanding. To be followed up urgently with Director of MHLDS	

12/03/2019 17:50



	Provide a briefing note on email to explain the recommendation to decrease the corporate risk register score (CRR13)		6.2.19 Briefing note circulated on behalf of Director of Nursing MHLDS.	Closed
G Harris	<b>QS18/178.2</b> Flag with Exec Team colleagues the committee's query regarding how potential risk around pharmaceutical supplies post-Brexit were being managed.	December	Discussed with Exec Team. Matter being managed and reported through a newly formed group with a report being presented to the February Quality Safety Group. 12.3.19 Radioisotope issue being managed through the EU Exit Contingency Group.	March
G Harris	<b>QS18/182.2</b> Set up small task group to review and refresh the listening and learning report format in light of Committee discussion.	January	Meeting held. Refreshed report on March agenda.	Closed
L Reid	<b>QS18/183.2</b> Write to the QSG to express concern at shared lack of assurance around the HIW inspection report and the need for clear evidence to allow actions to be closed down.	December	Circulated on 21.1.19	Closed
<b>22<sup>nd</sup> January 2019</b>				
G Harris	<b>QS19/5.3</b> Follow up with Mark Green (Deloitte) the conversation re ongoing support to the recent senior clinical appointments within women's services.	March	Meeting held between GH and Mr Green on 7.2.19	Closed
D Carter	<b>QS19/8.4</b> Provide briefing note on the improvement plan and trajectories relating to concerns 30 day target (including explanation of how far over the 30 days the breaches are)	February		

K Dunn	<b>QS19/8.7</b> Ensure that outcome of further Jan Stevens review of IPC is scheduled into Committee and/or Board cycles of business	February	6.2.19 Visit confirmed as 7/8 March. Report anticipated in time for May QSE Committee. Added to cycle of business forward plan.	Closed
D Carter	<b>QS19/9.2</b> Feedback to Ann Jones (clinical pharmacist) that the covert administration of medication policy was not approved and requires the EQIA and agreed amendments to be completed for circulation to QSE Committee members on email with option of then taking Chair's action to approve.	February	Feedback has been provided. Amended policy awaited for circulation with the associated EQIA.	
G Harris	<b>QS19/11.2</b> Consider further format of HASCAS and Ockenden reports to ensure QSE receive more of a summary of progress that can, where possible, be clearly aligned to a recommendation. Also consider use of deep dive sessions.	March	Refreshed report on March agenda.	Closed
A Thomas	<b>QS19/12.2</b> In terms of the Tissue and Organ Donation report, look to see if data available on cases where transplants were not carried out – eg due to unavailability of ICU beds. Members recalled this had been included in previous years' reports.	February	19.2.19 The Executive Director of Therapies & Health Sciences confirms that this has been raised with the specialist nurses for organ donation across the three main sites, and they confirmed that this has not been an issue of concern for a number of years.	Closed

<b>Quality, Safety &amp; Experience Committee</b>  <b>19.03.19</b>	 <b>GIG CYMRU NHS WALES</b>   Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board  <b>To improve health and provide excellent care</b>
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<b>Report Title:</b>	<b>Integrated Quality &amp; Performance Report</b>
<b>Report Author:</b>	<b>Ed Williams, Head of Performance Assurance</b>
<b>Responsible Director:</b>	<b>Mark Wilkinson, Executive Director of Performance and Planning</b>
<b>Public or In Committee</b>	<i>Public</i>
<b>Purpose of Report:</b>	This report provides the Committee with a summary of key quality and performance indicators.
<b>Approval / Scrutiny Route Prior to Presentation:</b>	This paper has been scrutinised, approved and signed off by the Executive Director of Planning and Performance.
<b>Governance issues / risks:</b>	<p>The report outlines the key performance and quality issues that are delegated to the Quality, Safety &amp; Experience Committee.</p> <p>This month sees the third presentation of the report in the new format with all measures presented in Chapter form as per the Health Board version.</p> <p>The Summary of the report is now included as an Executive Summary within the report itself.</p>
<b>Financial Implications:</b>	<i>N/A</i>
<b>Recommendation:</b>	The Quality, Safety and Experience Committee is asked to note the report.

<b>Health Board's Well-being Objectives</b> <i>(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)</i>	√	<b>WFGA Sustainable Development Principle</b> <i>(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.)</i>	√
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			
<b>Special Measures Improvement Framework Theme/Expectation addressed by this paper</b> 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. It also addresses key indicators for mental health and primary care.			
<b>Equality Impact Assessment</b> The Health Board's Performance Team are establishing a rolling programme to evaluate the impact of targets across the Equality & Diversity agenda.			

*Disclosure:*

*Betsi Cadwaladr University Health Board is the operational name of Betsi Cadwaladr University Local Health Board*



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Betsi Cadwaladr  
University Health Board



## February 2019

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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.

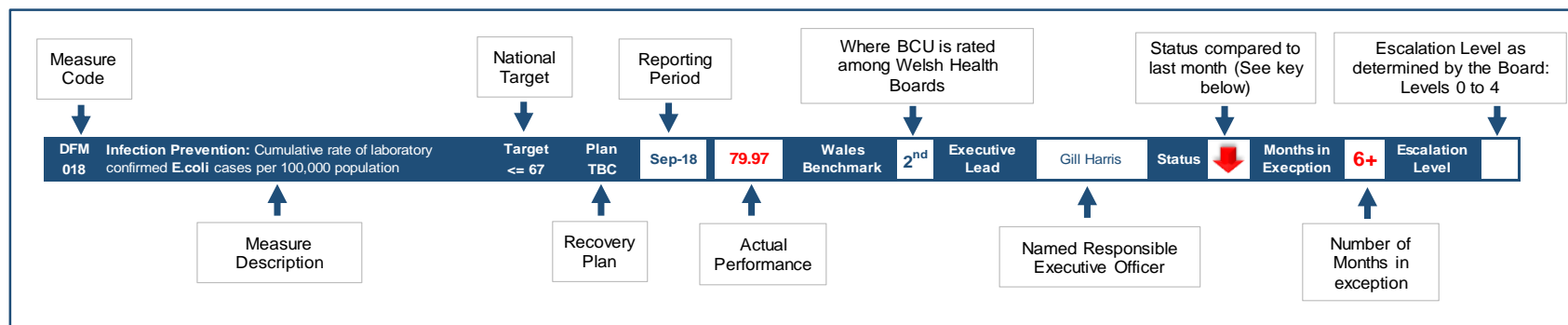
## Escalated Exception Reports

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 Achieved but Improved		Not Achieved Worse	

Of the 50 Measures reported under the remit of the Quality, Safety & Experience (QSE) Committee, performance has improved against 29, remains static for 6 and is worse for 15 in comparison to the last report.

**Quality:** The Health Board has improved performance against 16 of the 25 measures within the Quality chapter. Improvements include a significant improvement in the number of Concerns replied to within 30 days, continued improvement in Clinical Coding and the achievement of all targets regarding research. However improvements are required with regards the number of incidents assured within agreed timeframes and in reducing the number of Healthcare Acquired Pressure Ulcers (HAPU).

Chapter	Better	Worse	Same
Quality	16	7	2
Infection control	3	3	2
Immunisation	6	1	1
Mental Health	3	3	1
Primary Care	1	1	0
<b>Total</b>	<b>29</b>	<b>15</b>	<b>6</b>

**Infection Control:** The Health Board is the best performing in Wales with regards reducing S.Aureus infections, and 2<sup>nd</sup> best for reducing E.Coli infections. However, at 4<sup>th</sup> in Wales in terms of C.Difficile, there is still room for improvement.

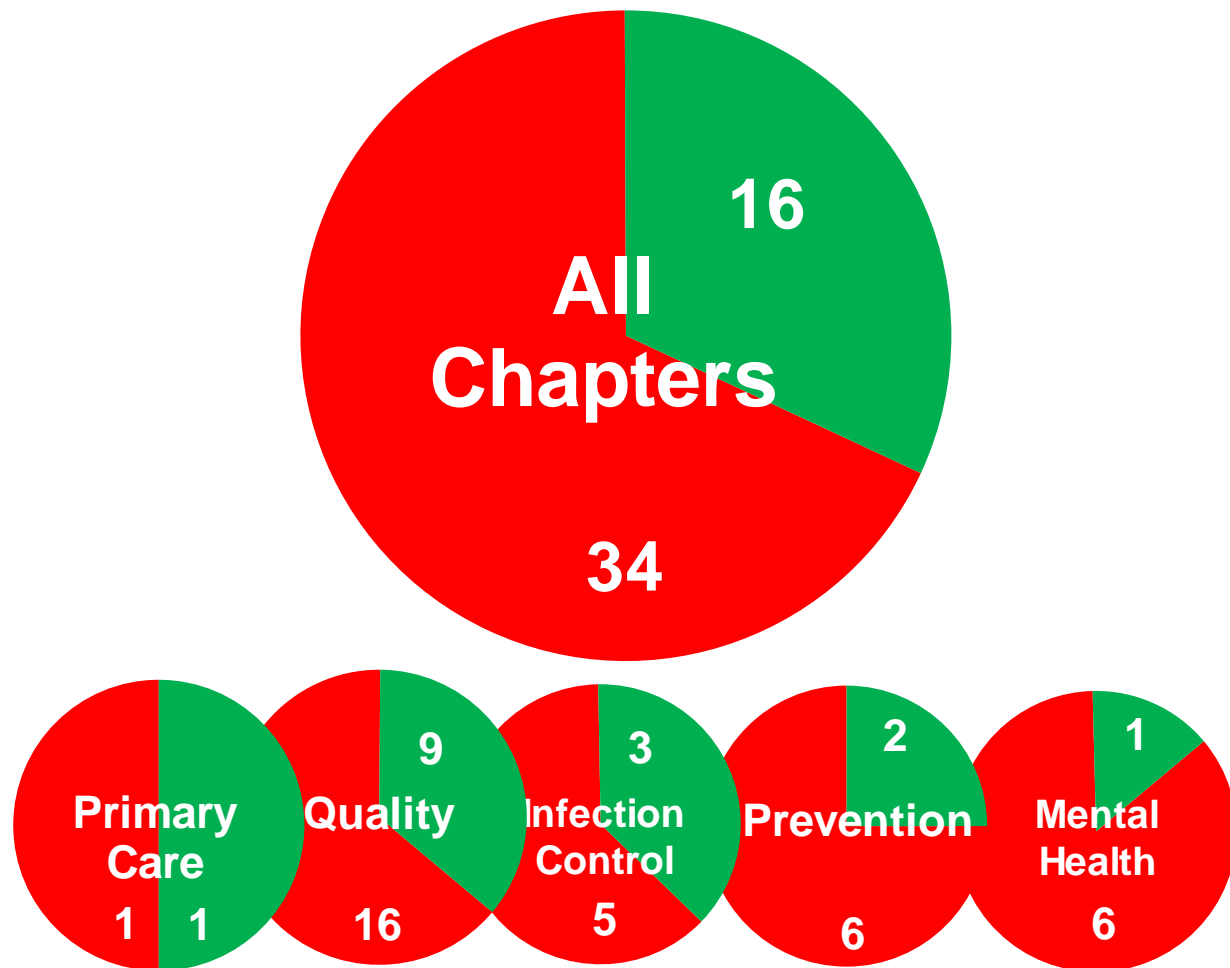
**Prevention:** The Health Board is the best in Wales with regards Children's Immunisations, being the only Health Board to achieve the 95% rate for Hexavalent 6 in 1 measure, and achieved the highest rate of MMR vaccines. Furthermore, the Betsi Cadwaladr is the best performing Health Board in Wales in terms of Flu Vaccinations for Over 65's, Under 65's at risk groups and for pregnant women.

**Mental Health:** Performance against the Assessment and Treatment within 28 Days Measures in both Adult Mental Health and Child & Adolescent Mental Health Services is worse in January 2019 with particular concern regarding patients beginning treatment within 28 days at 56.80% and 24.50% respectively.

#### Primary Care:

Performance against the Number of GP Practices open core hours has significantly improved. And Although the rate of GP practices open in the evenings has fallen, the Health Board is no longer in Special Measures regarding these measures.

# Summary Dashboard



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

## Headlines

5

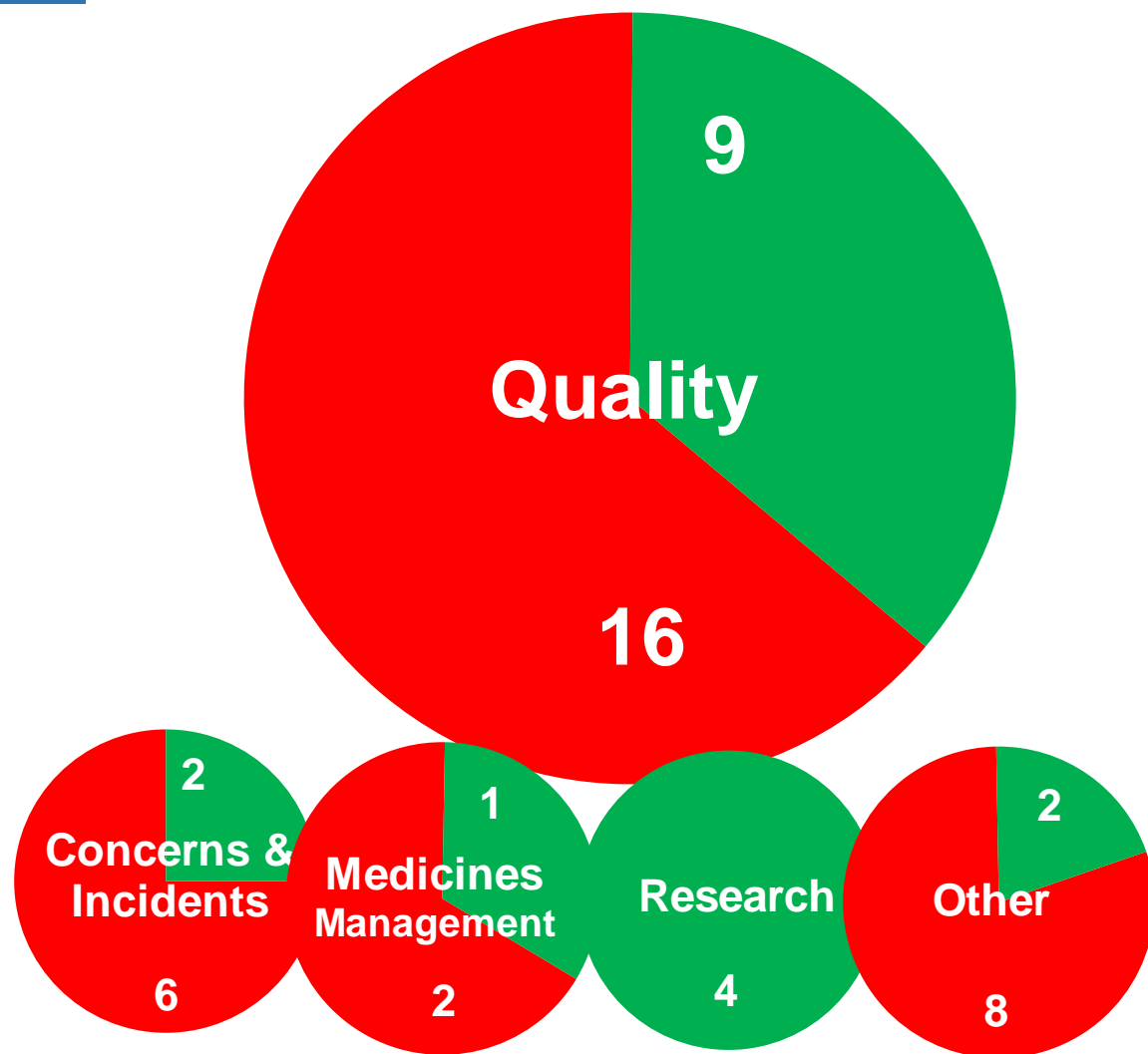
### Most Improved

Measure	Status	(Target)
Clinical Coding Accuracy	89.60% ↑	Improve
New Never Events	0 ↑	0
GP Open Core Hours	92.45% ↑	>= 91%
Universal Mortality Reviews	90.70% ↑	>= 95%
Concerns: % Replies within 30 days	74.90% ↑	>= 75%

### Of Most Concern

Measure	Status	(Target)
Infection Prevention: MSSA	15 ↓	<= 11
Incidents: % Assured within agreed timescales	37.00% ↑	>= 90%
Healthcare Acquired Pressure Ulcers (HAPU)	42 ↑	<= 21
Sepsis Six Bundle: Emergency Department	48.15% ↓	Improve
Mental Health: Therapy within 28 Days CAMHS	24.50% ↓	>= 80%

February 2019



Due to space constraints, the summary of measures in this chapter is on the following page (No 7).

Compared to the last report, Performance improved on 17 of the Measures whilst it decreased on 4 and remained static on 2.

# Chapter 1 – Summary

## Quality

7

Measure	Status	(Target)	Measure	Status	(Target)
Qualitative Reports x 4 (April to September 2018)	Submitted	Submit	Healthcare Acquired Pressure Ulcers (Reported as Serious Incidents)	42	<= 21
New Never Events	0	0	Medication Errors (Reported as Serious Incidents)	2	0
Incidents: % Assured within agreed timescales	37.00%	>= 90%	Falls Prevention (Reported as Serious Incidents)	11	<= 11
Concerns: % Replies within 30 days	74.90%	>= 75%	Antibacterial items per 1000 STAR PUs	274.72	Reduce
Patient Safety Notices: Number Not Assured	5	1	Total Antibacterial Items Prescribed	9.41%	Reduce
Patient Safety Alerts: Number Not Assured	1	0	NSAIDS per 1000 STAR PUs	1,149	Reduce
Ward Staffing Levels	87.00%	100%	Information Governance Training	80%	>= 85%
Ward Staffing Skill Mix	55.0%	60%	Episodes Clinically Coded within 1 month	90.40%	>= 95%
ITU Delayed Transfers of Care: % Hours Lost	7.81%	<= 5%	Clinical Coding Accuracy	89.60%	Improve
ITU Delayed Transfers of Care: % Within 4 Hrs	49.10%	>= 95%	Number of H&CRW Studies*	213	>= 40 (Q2)
Mortality: Crude Under 75 yoa	0.74%	<= 0.70%	Number of Commercially Sponsored Studies	10	>= 6 (Q2)
Mortality: Universal Mortality Reviews	94.40%	>= 95%	Number recruited to H&CRW studies*	1,247	>= 1000 (Q2)
			Number recruited to Commercial studies	71	>= 50 (Q2)

\*H&CRW = Health and Care Research Wales

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

February 2019

<b>DFM 077</b>	Evidence of advancing Equality throughout the organisation	Target Submit QRT	Plan Submit QRT	Apr-Sep 18	Yes	Wales Benchmark	N/A	Executive Lead	Sue Green	Status	➔	Months in Exception	N/A	Escalation Level	
<b>DFM 078</b>	Qualitative report detailing progress against the 5 standards that enable the health and wellbeing of homeless and vulnerable groups to be identified and targeted	Target Submit QRT	Plan Submit QRT	Apr-Sep 18	Yes	Wales Benchmark	N/A	Executive Lead	Gill Harris	Status	➔	Months in Exception	N/A	Escalation Level	
<b>DFM 079</b>	Qualitative report detailing the achievements made towards implementation of the Wales standard for accessible communication and information for people with sensory loss	Target Submit QRT	Plan Submit QRT	Apr-Sep 18	Yes	Wales Benchmark	N/A	Executive Lead	Gill Harris	Status	➔	Months in Exception	N/A	Escalation Level	
<b>DFM 080</b>	Evidence of promoting and using the Welsh Language throughout the organisation as per the 'More Than Words' document.	Target Submit QRT	Plan Submit QRT	Apr-Sep 18	Yes	Wales Benchmark	N/A	Executive Lead	Sue Green	Status	➔	Months in Exception	N/A	Escalation Level	

The Committee received an update on these qualitative measures in October 2018 after submission of the bi-annual reports. The next update will be after the March 2019 submissions, unless the Committee requests an update beforehand.

*QRT = Qualitative Report Template*



<b>DFM 023</b>	Of the serious incidents due for assurance, the percentage which were assured within the agreed timescales	<b>Target</b> 90.0%	<b>Plan</b> 90%	<b>Feb-19</b>	<b>37.00%</b>	<b>Wales Benchmark</b>	<b>7th</b>	<b>Executive Lead</b> Gill Harris	<b>Status</b> ↑	<b>Months in Exception</b> 6+	<b>Escalation Level</b>
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## Actions

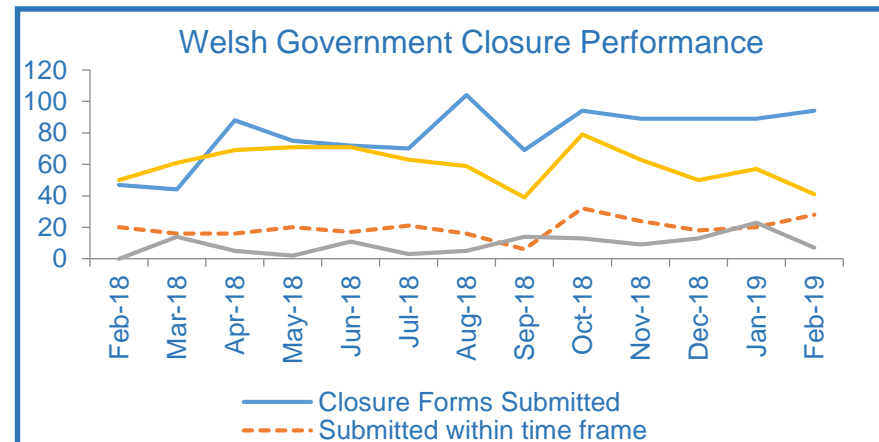
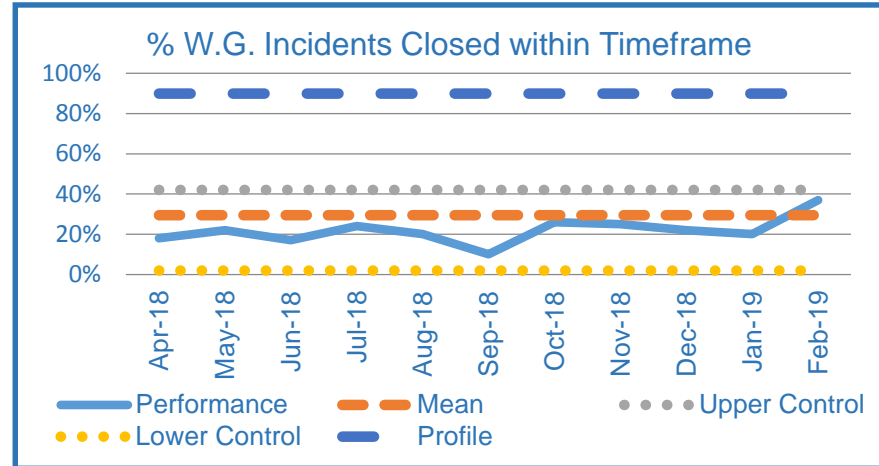
- Weekly Incident Review Meeting in place which is ensuring a more focused approach to managing major and catastrophic incidents. Also focusing on over due incidents which have been reported to Welsh Government
- Review of model for corporate and governance teams to allow greater support to the wider incident management

## Outcomes

- Reduction in the number of incidents significantly overdue for closure
- Reduction in the number of major/catastrophic incidents
- Improvement in the total number of overdue Welsh Government Incidents
- Improvements in the standard/quality of closure forms being submitted
- Single senior lead for incidents management across BCUHB

## Timeline for improvement:

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



<b>DFM 046</b>	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	<b>Target</b> ≥ 75%	<b>Plan</b> ≥ 75%	<b>Dec-18</b>	<b>30.00%</b>	<b>Wales Benchmark</b>	<b>7th</b>	<b>Executive Lead</b>	Gill Harris	<b>Status</b> 	<b>Months in Exception</b>	<b>6+</b>	<b>Escalation Level</b>	
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## Actions:

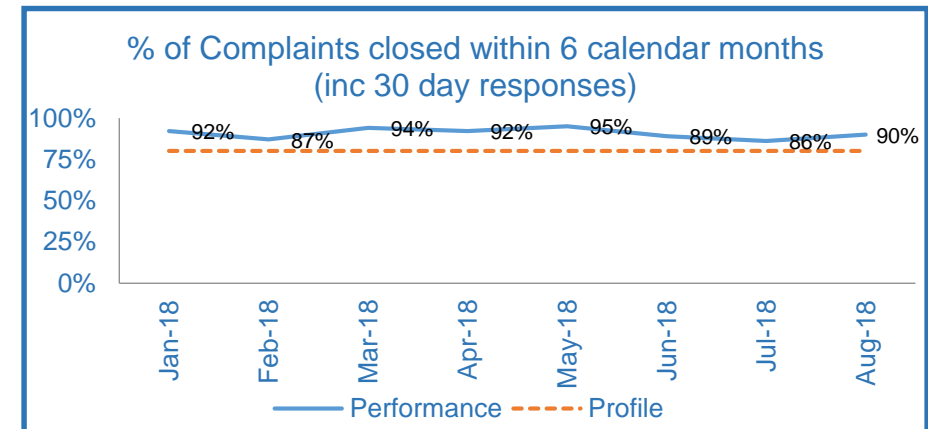
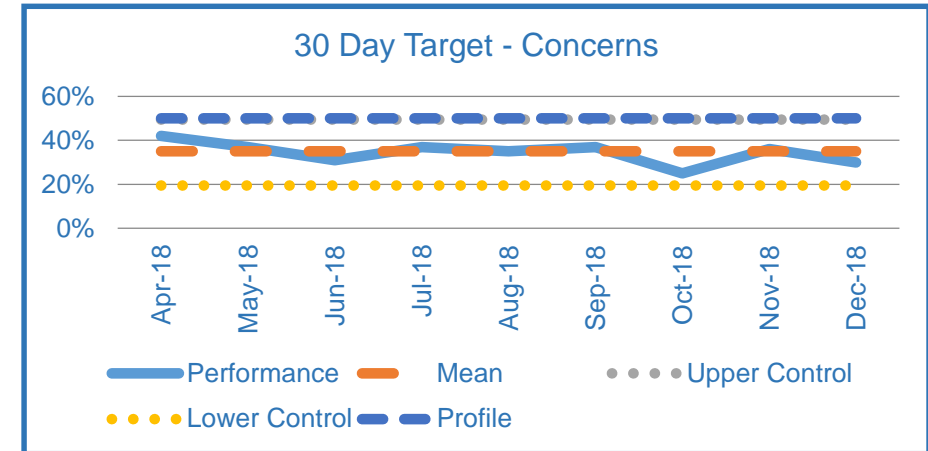
- All complaint responses over overdue complaints discussed weekly with the Director of Quality Assurance
- Daily, weekly and monthly monitor of performance in place
- Review of model for corporate and governance teams to allow greater support to the wider complaints management.

## 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

## Timelines

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



DFM 022	Number of Patient Safety Solutions Wales Alerts that were not assured within the agreed timescale	Target 0	Plan 0	Feb-19	1	Wales Benchmark	7th	Executive Lead	Evan Moore	Status	↓	Months in Exception	6+	Escalation Level	
LM 22B	Number of Patient Safety Solutions Wales Notices that were not assured within the agreed timescale	Target 0	Plan 0	Feb-19	5	Wales Benchmark	N/A	Executive Lead	Evan Moore	Status	↓	Months in Exception	6+	Escalation Level	

As of 28th February 2019, the Health Board is 92% compliant with the 9 Patient Safety Alerts issued by the Welsh Government (WG).

**PSA009** Wrong selection of orthopaedic fracture fixation plates – compliance due 15/05/2019. Identified as relevant to Secondary Care, information distributed and requested to identify lead to provide compliance assurance.

To date 48 Patient Safety Notices have been issued by the WG and the BCUHB are 88% compliant with 42 alerts complete, 6 remain open, details as follows:-

**PSN030** The safe storage of medicines: Cupboards - compliance due 26/08/2018. There is recognition nationally of the difficulties complying with this notice and advice is awaited from the MARRS group. Nevertheless, BCU have made significant progress mitigating risks, through ward automation; the YGC refurbishment project; and the work of a medicines management collaborative. To comply with this notice the following actions remain outstanding a) Installation of doors to medicine treatment rooms with swipe card access- this programme is progressing though the completion date is now March/April 2019. b) Temperature control within the medicine treatment rooms – Agreed thermometers will be placed in all treatment rooms.

**PSN034** Supporting the introduction of the National Safety Standards for Invasive Procedures (NatSIPs) – compliance due 28/09/2017. Relevant procedures identified on all sites, with 83 published to date and the remainder by April 2019. Secondary care have a short-term plan and have a long term solution for human factors training, and moving to see this in place by end April. It is anticipated this Notice can be closed following the Secondary QSE in May.

**PSN043** Supporting the introduction of the Tracheostomy Guidelines for Wales – compliance due 03/10/2018. Assured Long Term Ventilation services are compliant, final sign-off requires confirmation from secondary care. Dependent on completion of training in April, its anticipated closure will follow Secondary Care QSE in May.

**PSN046** Resources to support safer bowel care for patients at risk of autonomic dysreflexia – Compliance due 29/03/2019. Information distributed to relevant services/divisions and confirmation of compliance required.

**PSN047** Management of life threatening bleeds from arteriovenous fistulae and grafts – Compliance due 26/05/2019. Notified to Secondary Care on 12/12/18, Response received from Vascular CD- “All LTBs currently are referred to the consultant at each site (YG, YGC and Wrexham) between 0800 and 1600 and to the on call consultant for the network after 1600. If the consultant for each site is not available between 0800 and 1600 then the network consultant on call would be contacted. We are currently in the process of writing the pathways including the fistula pathways for the network after the centralisation which will include management of bleeding fistula”

**PSN048** Risk of harm from inappropriate placement of pulse oximeter probes – Compliance due 29/03/2019. Information distributed to Divisions/Services and Medical Gases Group with request that they lead on confirming compliance.

DFM 026	Number of Grade 3, 4 & Unstageable healthcare (hospital or community) acquired pressure ulcers (HAPU) reported as Serious Incidents	Target Reduce	Plan 35	Jan-19	42	Wales Benchmark 7th	Executive Lead Gill Harris	Status	Months in Exception 6+	Escalation Level
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### Actions

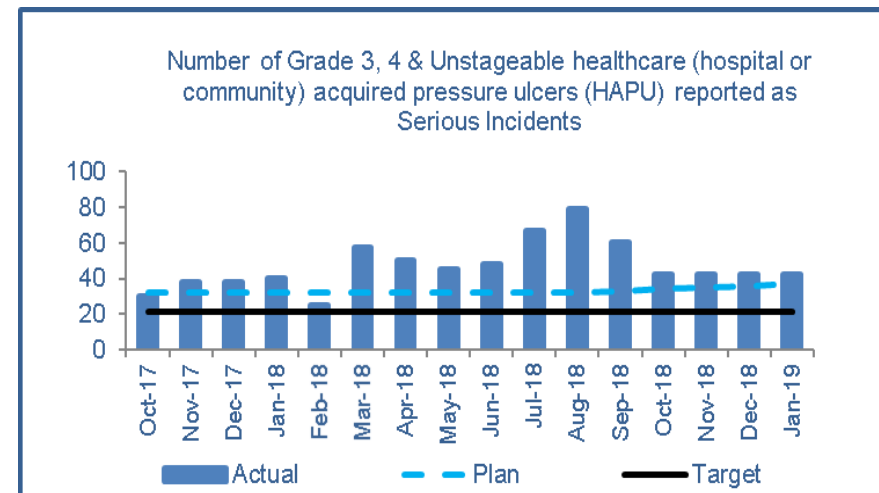
- HAPU collaborative commenced November 2018 with the aim to reduce the incidence of HAPU for inpatients only. 14 wards identified and currently testing interventions with the aim being to provide a Health Board Standard for identification of patients at risk, prevention and management of pressure ulcers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



<b>WG 201</b>	Ward nurse staffing fill rate (%)	Target 100%	Plan	Feb-19	87.00%	Wales Benchmark	N/A	Executive Lead	Gill Harris	Status	↓	Months in Exception	6+	Escalation Level	
<b>WG 202</b>	Ward nurse staffing skill mix ratio (% Registered)	Target >= 60%	Plan	Feb-19	55.00%	Wales Benchmark	N/A	Executive Lead	Gill Harris	Status	↑	Months in Exception	6+	Escalation Level	

## Actions

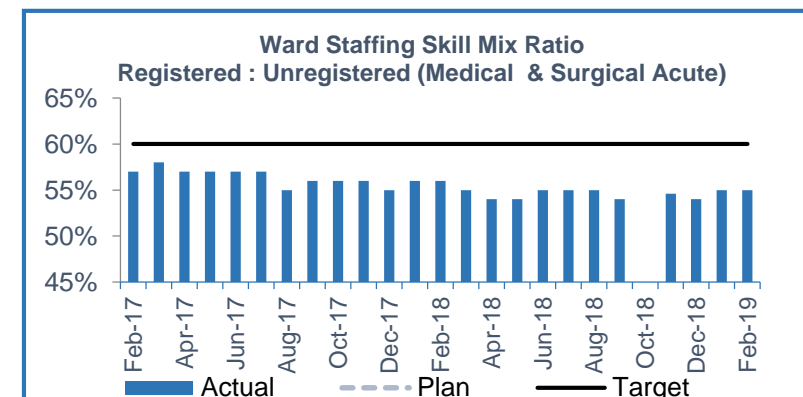
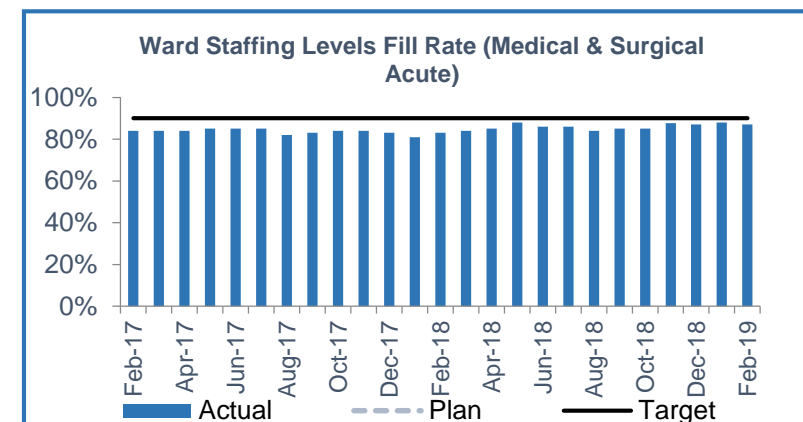
- BCUHB attendance at RCNi Manchester in February. Advert closed 10/03/2019
- Priority Wards Campaign commenced in Wrexham Maelor and Ysbyty Glan Clwyd sites
- Focussed support from recruitment team to support Ward Managers
- New Graduate weekend recruitment event scheduled for March 16<sup>th</sup> & 17<sup>th</sup>. 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.



LM 131A	Delayed Transfers of Care (DToC): Critical Care - % hours lost due to ITU DToC	Target ≤ 5%	Plan ≤ 5%	Jan-19	7.81%	Wales Benchmark	N/A	Executive Lead	Gill Harris	Status	Months in Exception	6+	Escalation Level	
LM 131B	Delayed Transfers of Care (DToC): Critical Care - % Discharged within 4 Hours of patient being ready	Target ≥ 95%	Plan	Jan-19	49.10%	Wales Benchmark	N/A	Executive Lead	Gill Harris	Status	Months in Exception	6+	Escalation Level	

## Actions

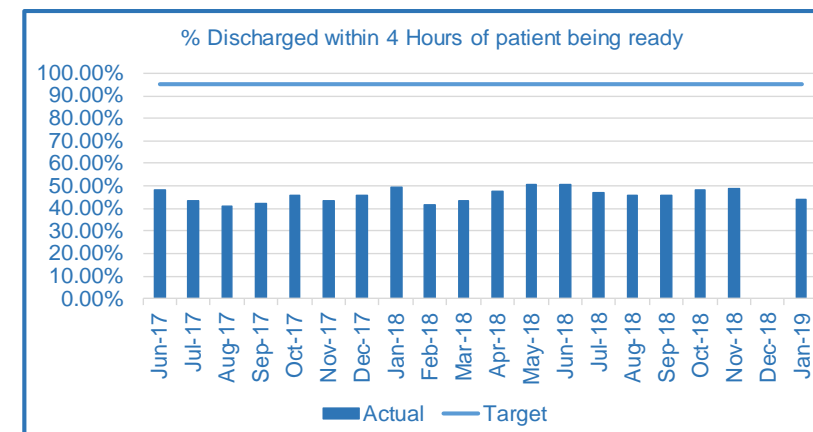
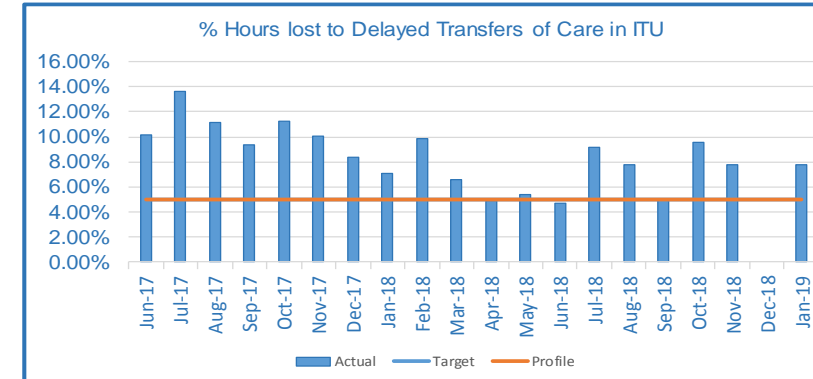
- Performance shared at each site Safety Huddle.
- 3 DToCs prioritised to ensure ICU “emergency bed” available.
- Unscheduled care workstreams ongoing across all 3 sites to improve overall site patient flow.

## 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.





<b>DFM 032</b>	Percentage of universal mortality reviews (UMRs) undertaken within 28 days of a death	<b>Target</b> ≥ 95%	<b>Plan</b> ≥ 95%	<b>Feb-19</b>	<b>94.40%</b>	<b>Wales Benchmark</b>	<b>3rd</b>	<b>Executive Lead</b>	Evan Moore	<b>Status</b> 	<b>Months in Exception</b>	<b>6+</b>	<b>Escalation Level</b>	
<b>DFM 033</b>	Crude mortality rate of patients under 75 years of age	<b>Target</b> Reduce	<b>Plan</b> < 0.70%	<b>Feb-19</b>	<b>0.74%</b>	<b>Wales Benchmark</b>	<b>2nd</b>	<b>Executive Lead</b>	Evan Moore	<b>Status</b> 	<b>Months in Exception</b>	<b>6+</b>	<b>Escalation Level</b>	

## 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

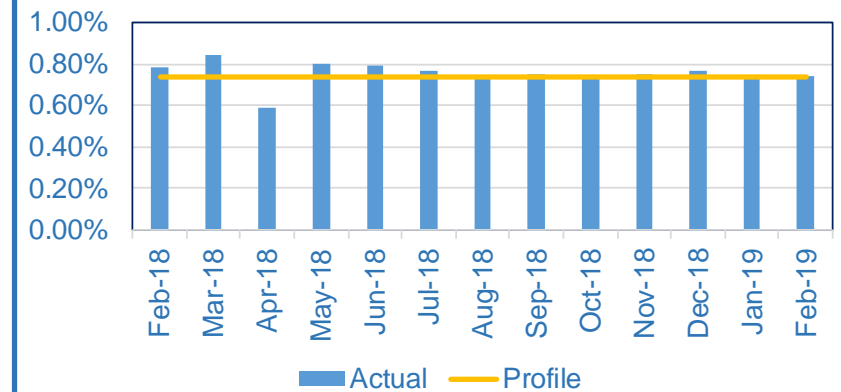
## Outcomes

- 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.

Crude mortality rate of patients under 75 years of age



<b>DFM 035</b>	Percentage episodes clinically coded within 1 month of the episode end date	Target ≥ 95%	Plan ≥ 95%	Feb-19	90.40%	Wales Benchmark	5th	Executive Lead	Evan Moore	Status	↑	Months in Exception	6+	Escalation Level	
<b>DFM 036</b>	Percentage of clinical coding accuracy attained in the NWIS national clinical coding accuracy audit programme	Target Improve	Plan TBC	17/18	84.20%	Wales Benchmark	7th	Executive Lead	Evan Moore	Status	↓	Months in Exception	6+	Escalation Level	

## Actions:

Band 2 coding support vacancy appointed at East, start date TBC. Vacancies at other site to be approved through vacancy control.

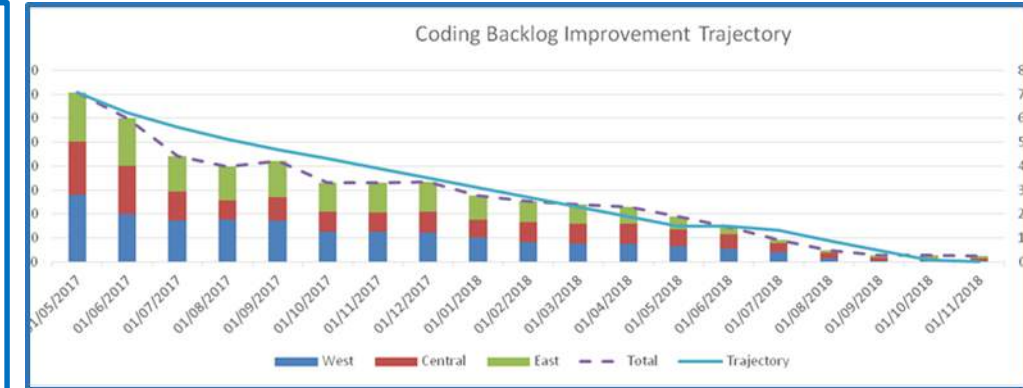
## Outcomes:

DFM 035 – February 2019 percentage episode coded within 1 month 91.7%. January 2019 percentage 91.5%.

DFM 036 – 2018/19 audit result 89.6% accuracy attained, this is a 5.4% improvement from 2017/18

## Timelines:

Originally it was expected to achieve the 95% rate by the end of Quarter 3, 2018/19. However, due to various issues affecting capacity this wasn't achieved in the original timeframe and it is now expected that the Health Board will reach the 95% target rate by the end of Quarter 1 of 2019/20.



<b>DFM 038</b>	Number of Health & Care Research Wales clinical research portfolio studies (quarterly Year-To-Date figure)	<b>Target</b> ≥ 89	<b>Plan</b> ≥ 23	<b>Qtr3 18/19</b> 213	<b>Wales Benchmark</b> 3rd	<b>Executive Lead</b> Evan Moore	<b>Status</b> ↑	<b>Months in Exception</b> 6+	<b>Escalation Level</b> 
<b>DFM 039</b>	Number of commercially sponsored studies (rolling 4 quarter sum)	<b>Target</b> ≥ 11	<b>Plan</b> ≥ 3	<b>Qtr3 18/19</b> 10	<b>Wales Benchmark</b> 3rd	<b>Executive Lead</b> Evan Moore	<b>Status</b> ↑	<b>Months in Exception</b> 6+	<b>Escalation Level</b> 
<b>DFM 040</b>	Number of patients recruited into Health & Care Research Wales clinical research portfolio studies (quarterly Year-To-Date figure)	<b>Target</b> ≥ 2,016	<b>Plan</b> ≥ 505	<b>Qtr3 18/19</b> 1,247	<b>Wales Benchmark</b> 5th	<b>Executive Lead</b> Evan Moore	<b>Status</b> ↑	<b>Months in Exception</b> 6+	<b>Escalation Level</b> 
<b>DFM 041</b>	Number of patients recruited into commercially sponsored studies (rolling 4 quarter sum)	<b>Target</b> ≥ 92	<b>Plan</b> ≥ 24	<b>Qtr3 18/19</b> 71	<b>Wales Benchmark</b> 1st	<b>Executive Lead</b> Evan Moore	<b>Status</b> ↑	<b>Months in Exception</b> 6+	<b>Escalation Level</b> 

## Actions:

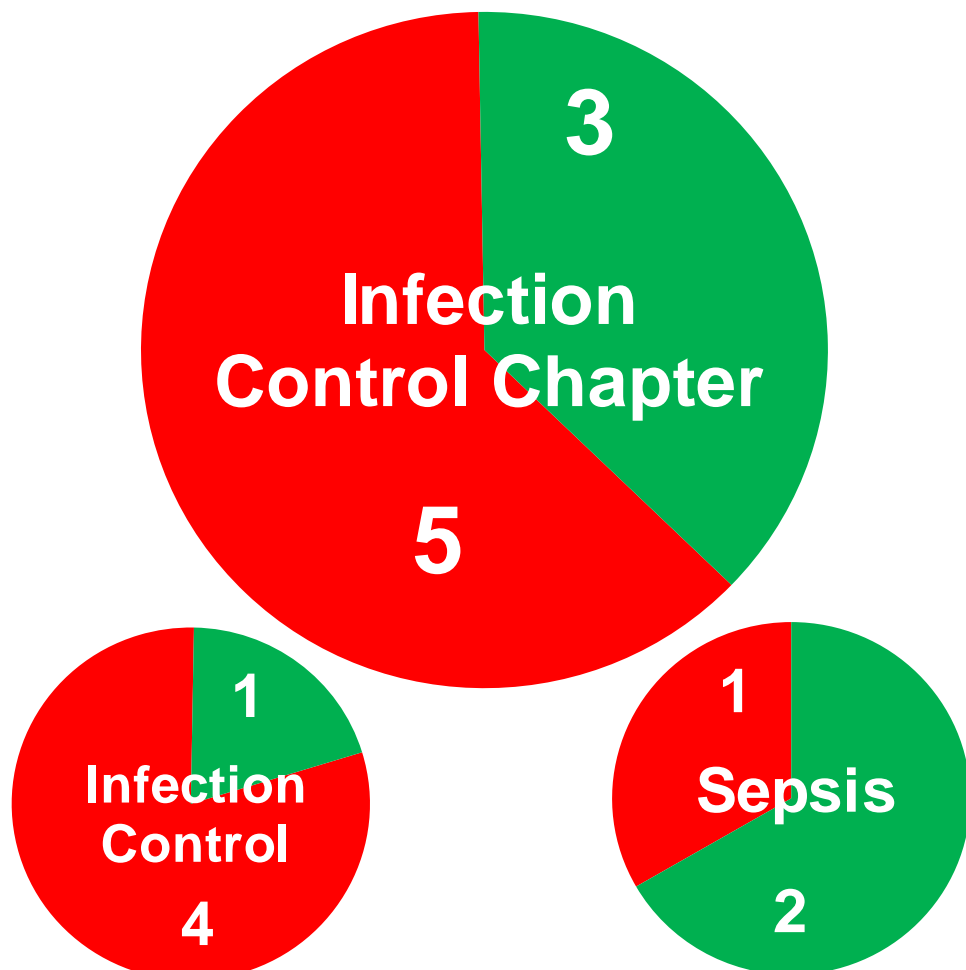
- Weekly performance meetings and reviews take place to ensure we are actively seeking out studies
- Streamlining our expression of interest process to ensure we open appropriate studies
- Regular communications with all staff regarding performance to target.
- Bank research delivery staff are now in place with the specific role of recruiting into studies.
- Strategies in place to improve performance and identify and prioritise studies.

## Outcomes:

We expect to meet 3 of the 4 Key performance Indicators this year.

## Timelines:

Initiatives in place to ensure all KPIs met in 19/20 and performance trajectory quarterly is expected to reflect this.



Measure	Status	(Target)
Infection Prevention: E.Coli	84.24	<= 67
Infection Prevention: C.Difficile	24.64	<= 26.00
Infection Prevention: S.Aureus	24.01	<= 20.00
Infection Prevention: MRSA	1	0
Infection Prevention: MSSA	15	<= 11
Sepsis Six Bundle - Emergency Departments	48.15%	100%
Sepsis Six Bundle- Inpatients	100%	100%
Preventable Hospital Acquired Thrombosis (HAT)	0	0

DFM 018	The cumulative rate of laboratory confirmed E.coli bacteraemias cases per 100,000 population	Target ≥ 67	Plan ≥ 67	Feb-19	84.70	Wales Benchmark	2nd	Executive Lead	Gill Harris	Status	↓	Months in Exception	6+	Escalation Level	
DFM 020	The cumulative rate of laboratory confirmed C.difficile cases per 100,000 of the population	Target ≤ 26	Plan ≤ 26	Feb-19	26.66	Wales Benchmark	4th	Executive Lead	Gill Harris	Status	↑	Months in Exception	6+	Escalation Level	
DFM 019	The cumulative rate of laboratory confirmed S. Aureus Bacteraemia (MRSA and MSSA) cases per 100,000 of the population	Target ≤ 20	Plan ≤ 20	Feb-19	22.79	Wales Benchmark	1st	Executive Lead	Gill Harris	Status	↓	Months in Exception	6+	Escalation Level	

## Actions:

- Infection Prevention & Control (IPC) Team monitor all Health Care Acquired Infection (HCAI) groups via ICnet on a daily (M-F) basis.
- Typing takes place for any infections considered to be cross infection or outbreaks.
- Post infection reviews are carried out for all CDI and MRSA blood stream infections (BSI).
- All C. difficile infections (CDI) are followed up for 4/52 following completion of treatment or discharge.
- All antimicrobial prescribing is monitored by the pharmacy team with an emphasis on Start Smart then Focus (SSTF) related to stepping down Intravenous to oral treatment.
- Monitor population sizes and demographics in relation to infection rates and trajectories.
- Dedicated IPC resource for community and Mental health services.

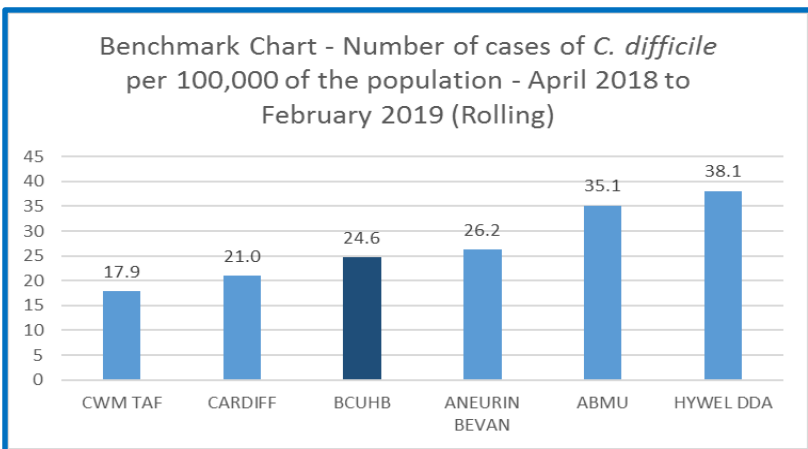
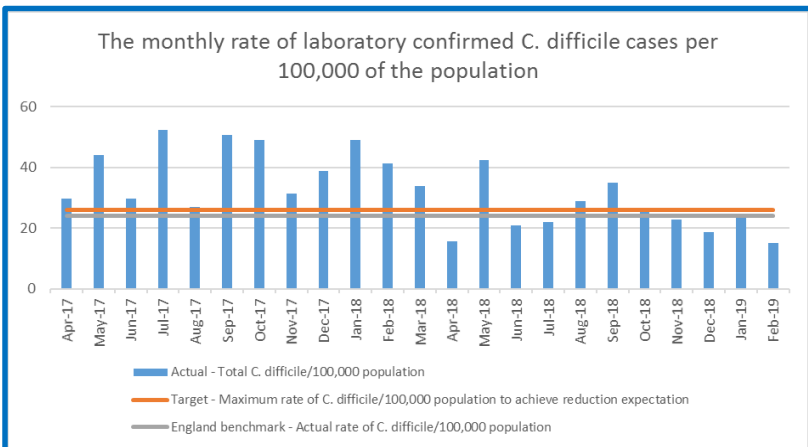
## Outcomes:

- Increased awareness of trends and prevalence of infection rates in Primary, Secondary & Community Care.
- Sharing of knowledge across the health economy.
- Patients remain on a seamless follow up for CDI.
- Reduction in unnecessary antibiotic prescribing and related resistance.
- A more robust outcome in relation to avoidable and unavoidable infections.
- Focus on those infections or harm which is deemed avoidable.
- Reduction in the use of invasive devices and risk of infection.
- Scrutiny and learning from focused HCAI executive review.

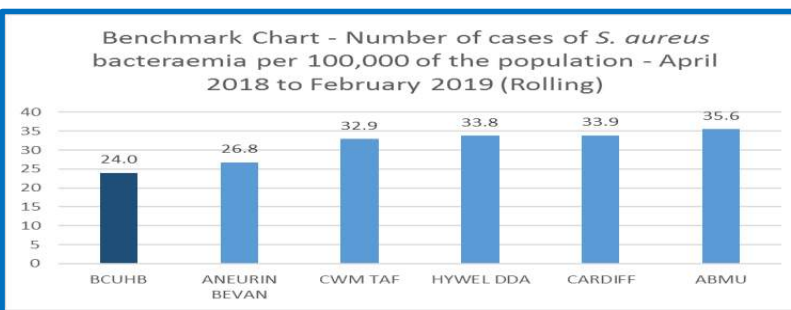
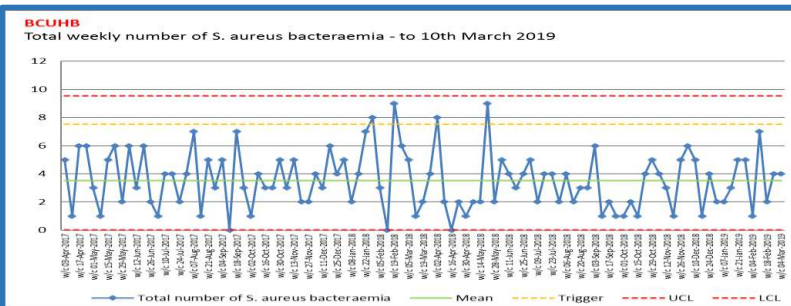
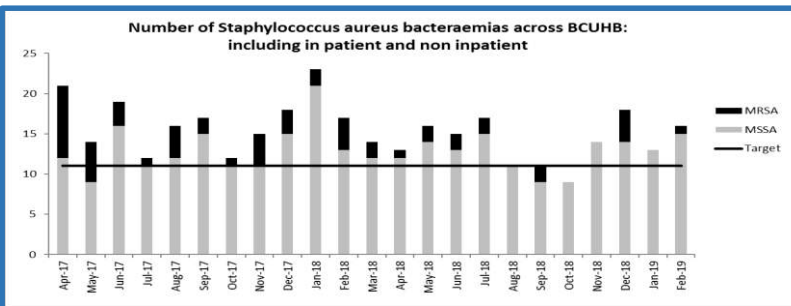
## Timelines:

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

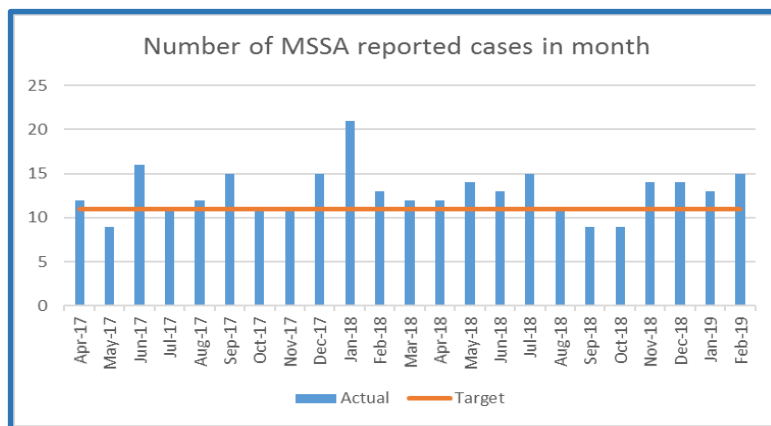
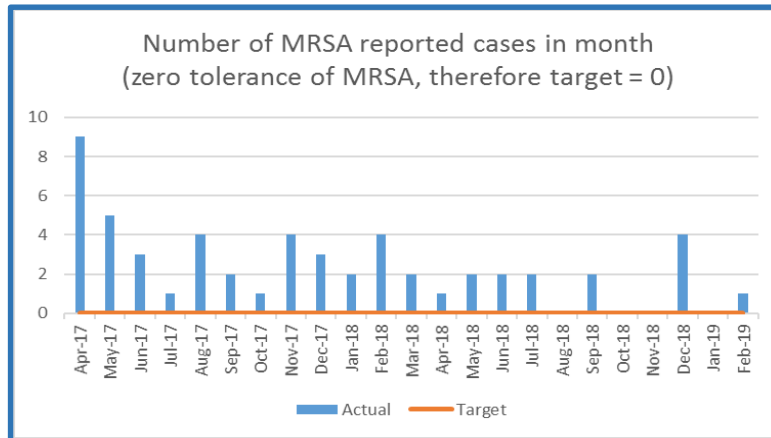
## Clostridium Difficile



## Staphylococcus Aureus (S.Aureus)



## S.Aureus split: MRSA and MSSA





DFM 013	Percentage of in-patients with a positive sepsis screening who have received all elements of the " Sepsis Six" first hour care bundle within one hour of positive screening	Target Improve	Plan TBC	Feb-19	100%	Wales Benchmark 1st	Executive Lead	Evan Moore	Status	Months in Exception	N/A	Escalation Level	N/A
DFM 014	Percentage of patients who presented to the Emergency Department with a positive sepsis screening who have received all elements of the 'Sepsis Six' first hour care bundle within one hour of positive screening	Target Improve	Plan TBC	Feb-19	48.15%	Wales Benchmark 2nd	Executive Lead	Evan Moore	Status	Months in Exception	6+	Escalation Level	

## Actions

Sepsis collaborative in progress, specific focus is on the emergency departments (ED) and the introduction of DRIPS. Next collaborative is April 5th 2019

Sepsis e-form developed along with dashboard to enable staff on front line to enter data and review in timelier manner.

## Outcomes

DRIPS meetings in place in all Emergency departments

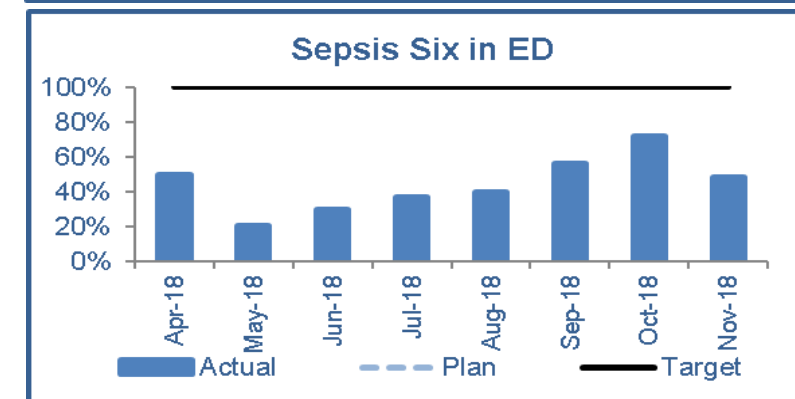
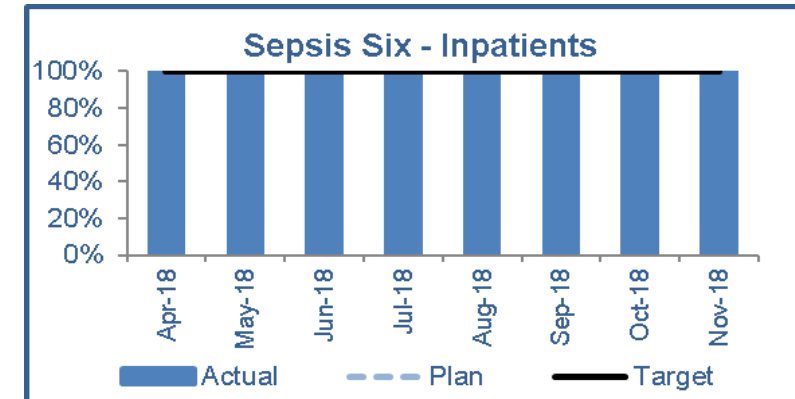
Compliance in ED with sepsis 6 bundle is improving.

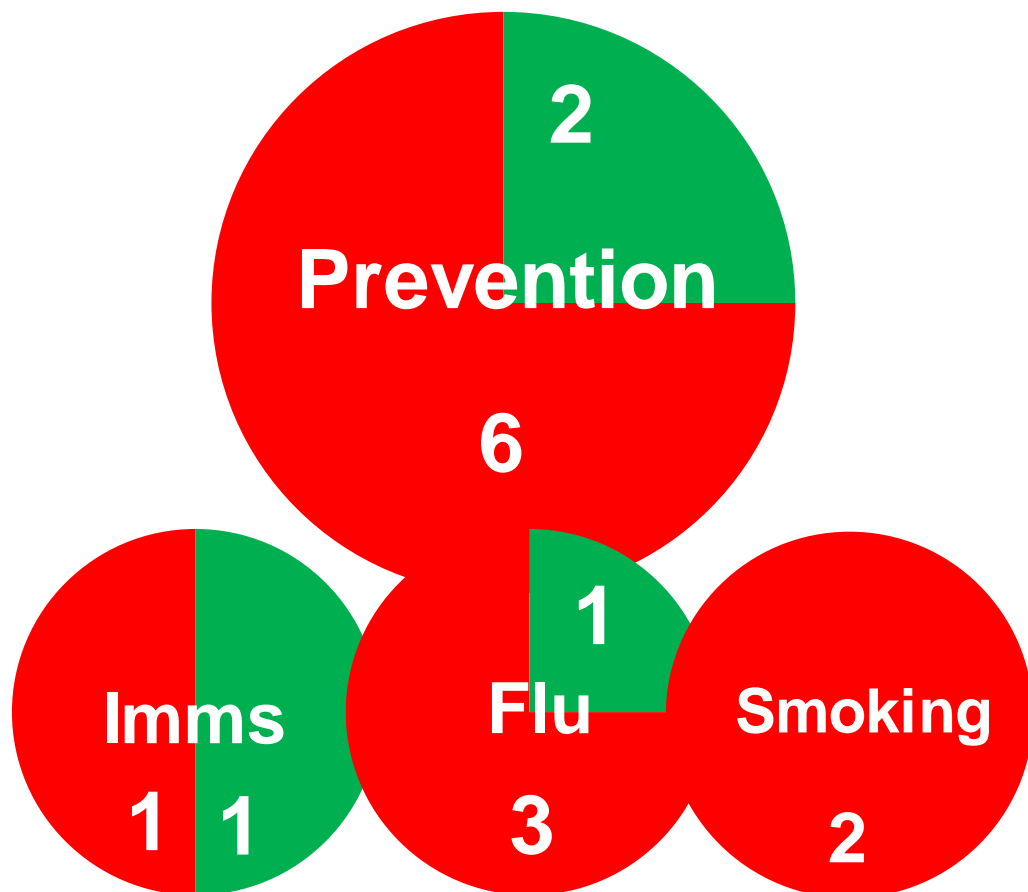
## Timelines

Work will continue with sites on sepsis post collaborative and will feed in to the BCUHB RRAILS group BCUHB RRAILS group continue to meet monthly and will also focus on delivery of the recommendations from the all Wales peer review for the deteriorating patient

\*A DRIPS meeting is a multidisciplinary meeting to help gather data, engage frontline staff with sepsis identification and process, and to create a sustainable organisational culture. The acronym is made up as follows:-

1. Discuss Data and results from the previous week
2. Review all sepsis forms.
3. Develop an action plan around issues requiring Improvement
4. Plot the dots: plot results on a run chart to be displayed in public areas
5. Share and celebrate: share the success of the work staff have undertaken and acknowledge improvement.





Measure	Status	(Target)
Immunisation: 3 doses of 6 in 1	96.60%	↑ ≥ 95%
Immunisation: 2 doses of MMR	91.70%	↑ ≥ 95%
Flu Vaccination: Under 65's at Risk Group	47.60%	↑ ≥ 55%
Flu Vaccination: Over 65's	70.90%	↑ ≥ 75%
Flu Vaccination: Pregnancy	75%	→ ≥ 75%
Flu Vaccination: Healthcare Workforce	50.90%	↑ ≥ 60%
Smoking Cessation: % Service Use	3.63%	↑ ≥ 5%
Smoking Cessation: Validated as Quit	38.80%	↓ ≥ 40%

DFM 002	Percentage of children who received 3 doses of the hexavalent '6 in 1' vaccine by age 1	Target 95.0%	Plan 95.00%	Qtr2 18/19	95.00%	Wales Benchmark	4th	Executive Lead	Teresa Owen	Status	Months in Exception	6+	Escalation Level	
DFM 003	Percentage of children who received 2 doses of the MMR vaccine by age 5	Target 95.0%	Plan 95.00%	Qtr2 18/19	90.70%	Wales Benchmark	2nd	Executive Lead	Teresa Owen	Status	Months in Exception	6+	Escalation Level	

## Actions

Childhood Immunisation Action plan is in place to address a range of issues but specifically to follow up children who miss appointments.  
An initiative is underway to improve form filling and reduce treatment queues at some GP practices  
Awareness raised on all immunisation training of current uptake and top tips for increasing uptake  
Strategic Immunisation plan is nearing completion  
MMR Action plan will be reviewed and updated to factor in recently published new guidance

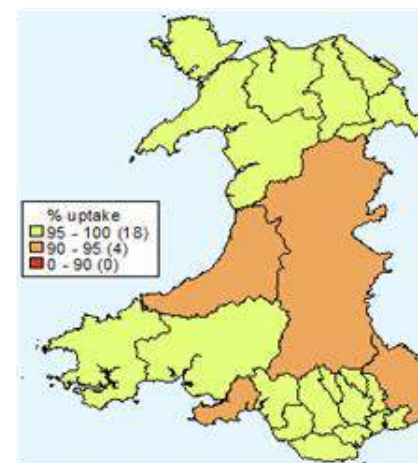
## Outcomes

Uptake should increase due to:  
Improved attendance at appointments  
Treatment queues will decrease significantly or disappear  
Child health staff will be able to process the forms more efficiently  
The Health Board will have a more consolidated oversight for all immunisation programmes and their uptake

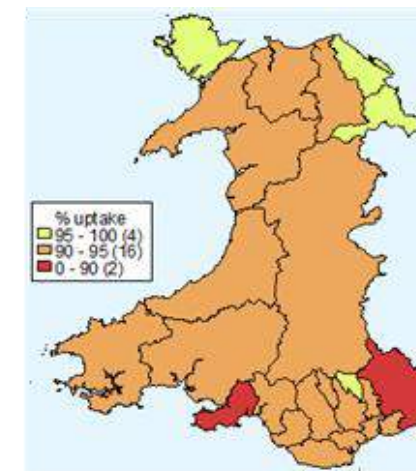
## Timelines

With a continued focus on the actions in the Childhood Immunisation Action plan it is expected to sustain the current achievement and also make small increases in more areas over the next two quarters during 2019.

Uptake of 6 in 1 at 1<sup>st</sup> birthday



Uptake of 2<sup>nd</sup> MMR at 5<sup>th</sup> birthday



## To note: 2<sup>nd</sup> MMR at 5<sup>th</sup> birthday

- BCUHB is the only Health Board to exceed 95% target for 2<sup>nd</sup> MMR at 5 years, 3 N Wales Local Authorities missed the target by only 8 children.
- BCUHB has not reached this specific target since Q2 in 2015

DFM 005a	% uptake of influenza vaccine in Under 65's at risk	Target ≥ 55%	Plan ≥ 53%	Feb-19	43.80%	Wales Benchmark	N/A	Executive Lead	Teresa Owen	Status	↑	Months in Exception	6+	Escalation Level	
DFM 005b	% Uptake of influenza vaccine in Over 65's	Target ≥ 75%	Plan ≥ 72%	Feb-19	68.00%	Wales Benchmark	1st	Executive Lead	Teresa Owen	Status	↑	Months in Exception	6+	Escalation Level	
DFM 005c	% uptake of the influenza vaccine in pregnant women	Target ≥ 75%	Plan ≥ 75%	Feb-19	N/A	Wales Benchmark	N/A	Executive Lead	Teresa Owen	Status	N/A	Months in Exception	N/A	Escalation Level	N/A

The flu vaccination activity will cease at the end of the campaign on 31<sup>st</sup> March 2019.

## Actions:

- Scrutiny of the flu vaccines recorded on GP practice systems is currently taking place
- Uptake on pregnant women will be available in April following a Point of Delivery Audit conducted in January
- A Flu Debrief has taken place to evaluate the current campaign which adopted a whole system approach this year to maximise uptake
- The new scheme of midwives vaccinating pregnant women is to be evaluated
- Vaccination uptake data is being circulated to the Areas and Clusters for discussion locally

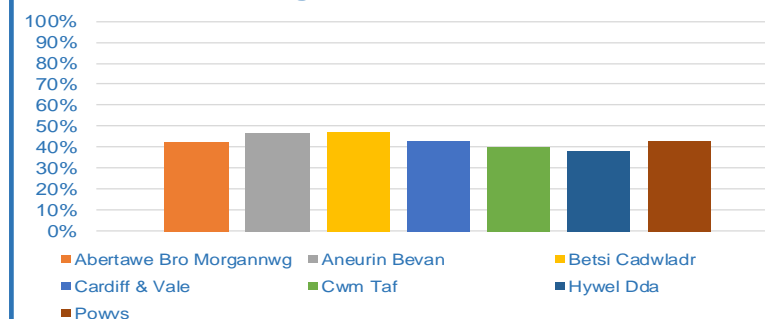
## Outcomes

- Ensure the data being submitted for national reporting is accurate and captures all vaccination activity
- 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
- Identify improvement opportunities for the next campaign in 4 specific areas
- ◀ 65 years+ ◀ at risk patients under 65 years ◀ 2&3 year olds ◀ NHS staff

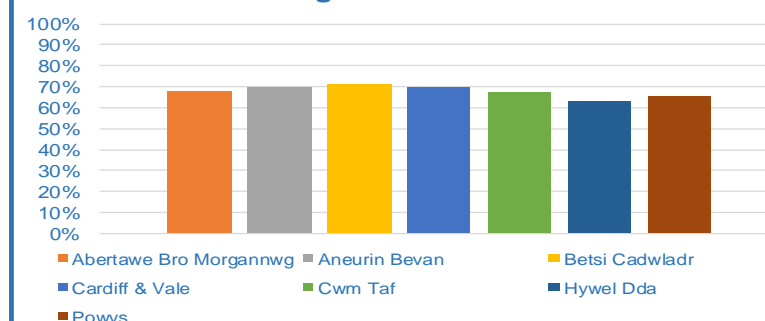
**Timelines :** These final actions of the current campaign 2018-19 will ensure accurate data is reported

- The Seasonal Influenza Flu annual report for 2018-19 is due to be published in June 2019
- Local early planning for the 2019-20 campaign will generate more targeted activities to improve performance.

% aged under 65 at risk



% aged 65 and older



DFM 005d	Uptake of influenza vaccination among: Health care workers	Target ≥ 60%	Plan ≥ 60%	Feb-19	50.90%	Wales Benchmark	4th	Executive Lead	Teresa Owen	Status	↑	Months in Exception	6+	Escalation Level	
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## Actions

- 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 local flu vaccinators to deliver flu campaign
- Target communication messages to identified low performing areas outlined in flu report
- Evaluate effectiveness of flu campaign model for 2018 / 19

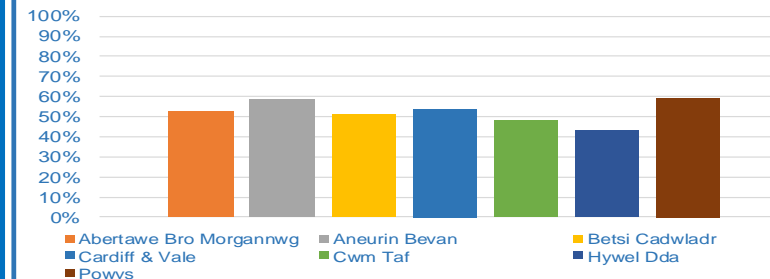
## Outcomes

- After 157 days of the flu campaign starting we are at a 51.12% uptake (n9089). We need to provide a further 1578 flu vaccinations to reach target
- We are 308 doses lower (2.72%) when compared to this time last 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. Currently 40 (17.46%) have given more than 50 flu vaccines.
- Weekly flu bulletins and up-dates provided to organisation and weekly performance data to flu co-ordinators / local teams for review and action

## Timelines

- Will continue to provide flu vaccinations up until 31st of March 2019
- Continue to provide key targeted messages on flu to organisation to support flu peak weeks
- Review and evaluate the effectiveness of the flu campaign model for 2018 / 19
- Begin to design and draft the flu campaign model for 2019 / 20

% Health Care Workers



	2017	22.02.19	Variance	% to target
Area East	59.98%	55.08%	-4.90%	4.92%
Area Central	55.63%	53.56%	-2.07%	6.44%
Area West	54.55%	51.11%	-3.44%	8.89%
Secondary Care East	57.57%	55.09%	-2.48%	4.91%
Secondary Care Central	51.42%	48.53%	-2.89%	11.47%
Secondary Care West	57.32%	52.90%	-4.42%	7.10%
Women's	58.45%	61.71%	3.26%	-1.71%
MHLD	44.19%	44.25%	0.06%	15.75%
Estates & Facilities	47.02%	42.24%	-4.78%	17.76%

DFM 028	Number of patient falls reported as Serious incidents	Target Reduce	Plan ≤ 11	Feb-19	11	Wales Benchmark	7th	Executive Lead	Gill Harris	Status 	Months in Exception	N/A	Escalation Level	N/A
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## Actions

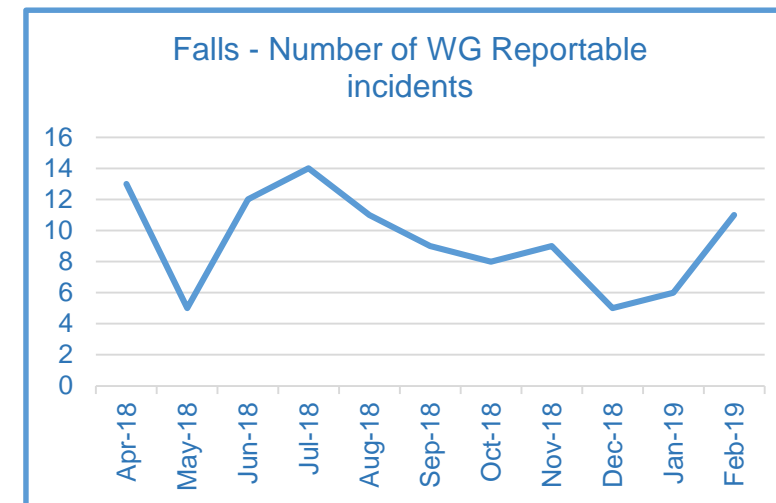
- Each site are required to undertake an RCA/desktop review with MDT involvement for all falls with Harm that are WG reportable e.g. fall resulting in fractures, severe head injury lessons learned shared with local quality and safety meetings
- Falls collaborative planned to commence in April 2019 using the HAPU collaborative methodology with one cohort of wards. The aim is to develop the Health Board standard that will support the reduction in harm from falls for inpatients (over 65 years of age and/or patients presenting with co morbidities) by assessment and implementation of an individualised care plan.
- Refresh the strategic falls group
- Development of falls faculty to support the collaborative

## Outcomes

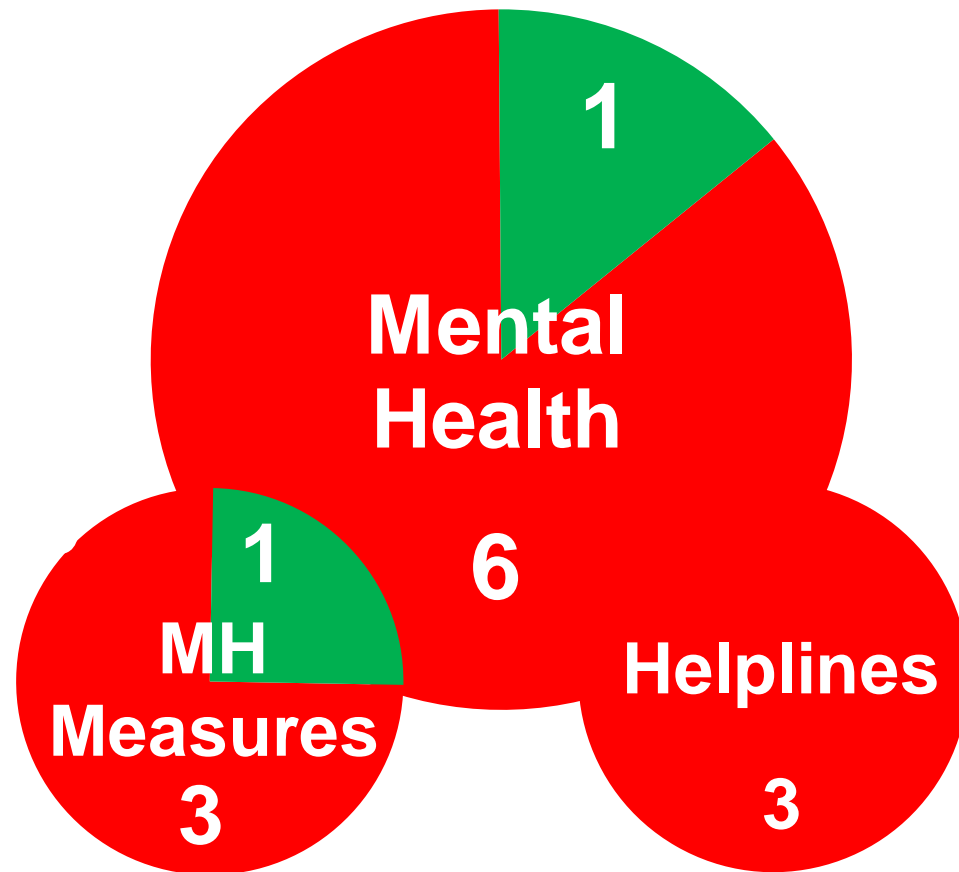
It is anticipated that there will be a reduction in falls with Harm during the work of the collaborative for the selected wards and then as Health Board.

## Timelines

Falls collaborative planned to commence April 2019 with a Health Board standard for implementation December 2019.







Measure	Status	(Target)
MHM1a - Assessments within 28 Days	65.20% ↓	>= 80%
MHM1b - Therapy within 28 Days	48.80% ↓	>= 80%
MHM2 - Care Treatment Plans (CTP)	89.90% ↑	>= 95%
MHM3 - Copy of Agreed plan within 10 Days	100% →	100%
Helplines: CALL	230.5 ↑	Improve
Helplines: DAN	7.0 ↓	Improve
Helplines: Dementia	61.0 ↑	Improve

LM 074A	% of assessment by the LPMHSS undertaken within 28 days of the date of referral: Adult	Target $\geq 80\%$	Plan	Jan-19	64.80%	Wales Benchmark	N/A	Executive Lead	Andy Roach	Status	↓	Months in Exception	6+	Escalation Level	
LM 075A	% of therapeutic interventions started within 28 days following an assessment by LPMHSS: Adult	Target $\geq 80\%$	Plan	Jan-19	56.80%	Wales Benchmark	N/A	Executive Lead	Andy Roach	Status	↓	Months in Exception	6+	Escalation Level	

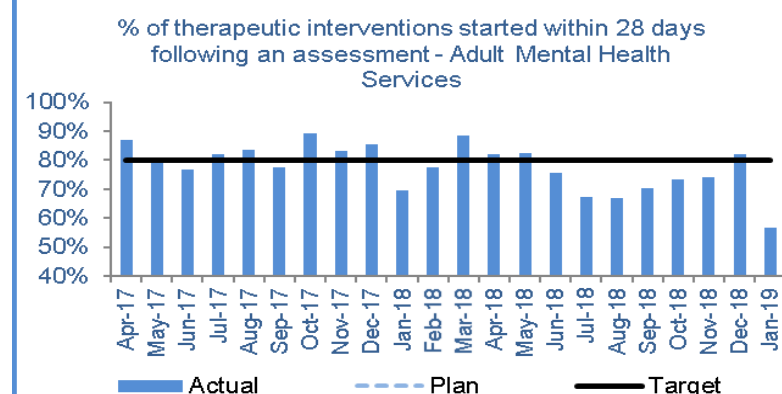
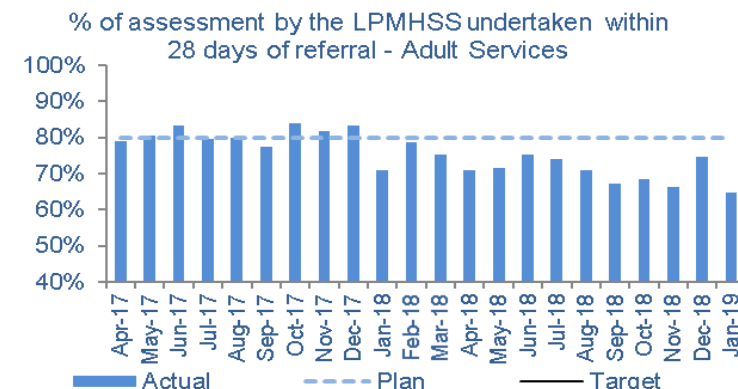
**Actions:** Patients are treated in turn has been widely adopted which has impacted on performance and is clinically the right action for patients

- 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
- 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.



LM 074B	% of assessment by the LPMHSS undertaken within 28 days of the date of referral: CAMHS	Target >= 80%	Plan	Jan-19	68.50%	Wales Benchmark	N/A	Executive Lead	Andy Roach	Status	↓	Months in Exception	6+	Escalation Level	
LM 075B	% of therapeutic interventions started within 28 days following an assessment by LPMHSS: CAMHS	Target >= 80%	Plan	Jan-19	24.50%	Wales Benchmark	N/A	Executive Lead	Andy Roach	Status	↓	Months in Exception	6+	Escalation Level	

West – Assessments: 20 within 28 days (91%), Therapy: 5 within 28 days (22%)  
 Conwy – Assessments: 3 within 28 days (19%), Therapy: 7 within 28 days (64%)  
 Denbighshire Assessments: 2 within 28 days (20%), Therapy: 8 within 28 days (47%)  
 Flintshire – Assessments: 17 within 28 days (81%), Therapy: 1 within 28 days (3%)  
 Wrexham – Assessments 32 within 28 days (82%) Therapy: 6 within 28 days (21%)

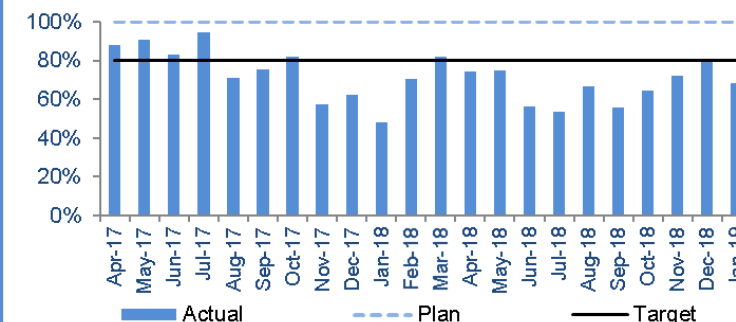
### Actions:

- Weekly demand and capacity meetings being held.
- All urgent referrals are assessed within 12 – 24 hours, target is 48 hours.
- Recruitment to vacancies including reconfiguring the workforce with WOD support to create different posts
- Management of long term sickness due to serious illness in central area
- Trajectories produced for each team
- Non-recurrent funding secured with agency staff appointed across the teams
- Funding secured as part of Local Authority Crisis bid
- Recurrent Psychological Therapies funding secured – training being arranged
- Refresh of Crisis bid to be undertaken and submitted to Welsh Government for 2019/20 funding

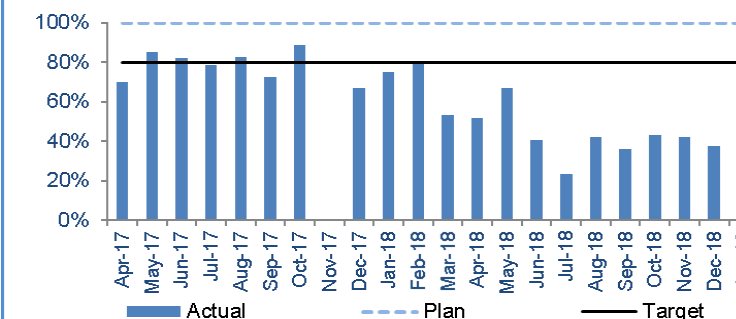
Timelines Based on current demand and current/known capacity:

- 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.

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



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



DFM 085	% of LHB residents (all ages) to have a valid CTP completed at the end of each month	Target ≥ 90%	Plan 89.7%	Jan-19	89.90%	Wales Benchmark	5th	Executive Lead	Andy Roach	Status	↑	Months in Exception	6+	Escalation Level	
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## Actions:

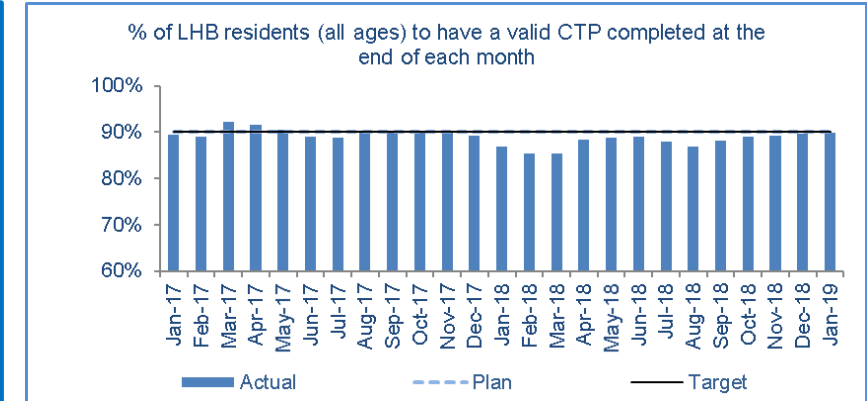
Detailed & timely reports disseminated to teams and individual care coordinators.  
 The Mental Health Measure Leads are aligned to local areas to improve performance and overall quality of services to patients.  
 Regular data cleansing & caseload validation  
 Close and regular monitoring of activity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

## Outcomes

Further education  
 Correct & validated information  
 Teams informed and engaged

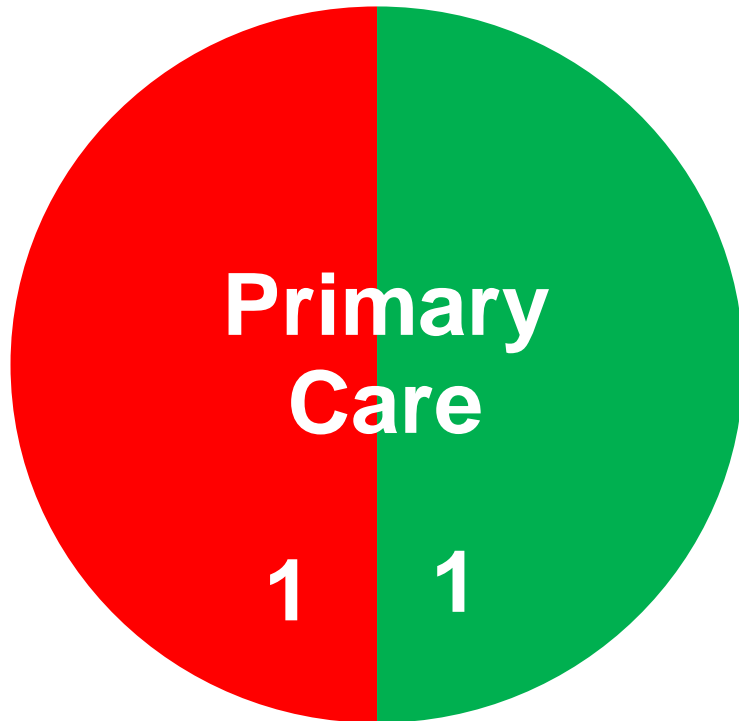
## Timelines

With sustained focus, the Division expects to be back on track Q1.



DFM 082	Number of mental health calls to the 'CALL' helpline	Target Improve	Plan Improve	Qtr3 18/19	230.50	Wales Benchmark	2nd	Executive Lead	Andy Roach	Status	↑	Months in Exception	6+	Escalation Level	
DFM 083	Number of calls relating to dementia to the 'Dementia' helpline	Target Improve	Plan Improve	Qtr3 18/19	61.00	Wales Benchmark	1st	Executive Lead	Andy Roach	Status	↑	Months in Exception	6+	Escalation Level	
DFM 084	Number of calls relating to drugs and alcohol to the 'DAN 24/7' helpline	Target Improve	Plan Improve	Qtr3 18/19	7.00	Wales Benchmark	1st	Executive Lead	Andy Roach	Status	↓	Months in Exception	6+	Escalation Level	

A variety of Promotional events have occurred during Q3 to increase the usage of the helplines. This has included attendance at Health awareness events, use of social media, working with Capital FM radio and Filming with ITV Wales in a barber shop (LL19 Barbers) about their work with men and mental health and the ICAN work. A new shift manager has also been appointed, so more events can be attended thus increasing awareness of all the helplines and the DAN mobile van, which has a digital advertisement of the DAN & C.A.L.L. Helplines travels throughout various locations in Wales to promote the helpline services



Measure	Status	(Target)
% GP practices open during daily core hours	92.45%	↑ ≥ 91%
% GP practices open between 17:00 and 18:30	66.04%	↓ ≥ 99%

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

DFM 053	% GP practices open during daily core hours or within 1 hour of daily core hours	Target Improvement	Plan 91.0%	Qtr2 18/19	87.9%	Wales Benchmark	Executive Lead	Chris Stockport	Status ↑	Months in Exception	Escalation Level
DFM 054	% GP practices offering appts between 17:00 and 18:30 at least two days a week	Target Improvement	Plan 99.0%	Qtr2 18/19	95.40%	Wales Benchmark	Executive Lead	Chris Stockport	Status ↑	Months in Exception	Escalation Level



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](http://www.pbc.cymru.nhs.uk)
- Stats Wales [www.bcu.wales.nhs.uk](http://www.bcu.wales.nhs.uk)  
[www.statswales.wales.gov.uk](http://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>

<b>Quality, Safety &amp; Experience Committee</b>	 <b>GIG CYMRU NHS WALES</b>   Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board
<b>19.3.19</b>	<i>To improve health and provide excellent care</i>

<b>Report Title:</b>	Update on Infection Prevention and Control (IPC) across BCUHB
<b>Report Author:</b>	Ms Amanda Miskell, Advanced Nurse Specialist – Infection Prevention and Control
<b>Responsible Director:</b>	Mrs Gill Harris, Executive Director of Nursing & Midwifery
<b>Public or In Committee</b>	Public
<b>Purpose of Report:</b>	The need for all Health Boards to reduce avoidable infections remains a high priority across Wales, and the Board of BCUHB continues with close scrutiny of this important quality and safety issue.
<b>Approval / Scrutiny Route Prior to Presentation:</b>	The issues reported are all considered through the Infection Prevention Sub-Group, which includes representation from the Community Health Council.
<b>Governance issues / risks:</b>	<p>Healthcare-associated infection, incorporating decontamination, cleanliness and antimicrobial resistance, remains on the corporate risk register. This has been reviewed by the corporate nursing team and remains with a combined risk score of 20. (Likelihood = 4, Impact = 5). A wide range of mitigating actions and control measures are in place, including the actions described in this report, and measures described in previous reports to the Quality, Safety &amp; Experience (QSE) Committee and the Board. These actions include implementation of the Safe Clean Care Campaign.</p> <p>Key issues highlighted in the report include:</p> <ul style="list-style-type: none"> <li>• A brief summary of infection performance data for key infections targets, including benchmarking against other Welsh Health Boards.</li> <li>• An update on the Safe, Clean, Care (SCC) campaign.</li> <li>• Update on the Welsh Government review of the decontamination of medical devices across BCUHB.</li> <li>• Update on improvements to environmental cleanliness across BCUHB.</li> </ul>
<b>Financial Implications:</b>	On average hospital in-patients who develop healthcare-associated infections incur costs 2.9 times higher than those who do not develop an infection.
<b>Recommendation:</b>	The Committee is asked to:

	<ol style="list-style-type: none"> <li>1. Note current performance in relation to key infections, and how BCUHB benchmarks with other Welsh Health Boards.</li> <li>2. Note recent progress with key elements of the Safe Clean Care Campaign.</li> <li>3. Request any further information needed to provide assurance.</li> </ol>
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<b>Health Board's Well-being Objectives</b> <i>(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)</i>	✓	<b>WFGA Sustainable Development Principle</b> <i>(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.)</i>	✓
1.To improve physical, emotional and mental health and well-being for all	x	1.Balancing short term need with long term planning for the future	
2.To target our resources to those with the greatest needs and reduce inequalities	x	2.Working together with other partners to deliver objectives	x
3.To support children to have the best start in life		3. Involving those with an interest and seeking their views	
4.To work in partnership to support people – individuals, families, carers, communities - to achieve their own well-being		4.Putting resources into preventing problems occurring or getting worse	x
5.To improve the safety and quality of all services	x	5.Considering impact on all well-being goals together and on other bodies	
6.To respect people and their dignity	x		
7.To listen to people and learn from their experiences	x		
<b>Special Measures Improvement Framework Theme/Expectation addressed by this paper</b>			
Patient safety through leadership and governance			
<b>Equality Impact Assessment</b>			
Preventing infection helps prevent inequalities that arise as a result of those infections.			

**Disclosure:**

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

Board/Committee Coversheet v10.0

**Executive Summary**

Performance to end January 2019

Indicator	Clostridium difficile	Staphylococcus aureus Bacteraemia	E Coli Bacteraemia	Klebsiella species Bacteraemia	Pseudomonas aeruginosa Bacteraemia
Performance to Date	149	137	484	96	27
Target to Date	150	116	388	86	23
Number above target	0	21	96	10	4

The Health Board will not achieve year 2018/19 trajectories for all alert organisms, however we may still come under trajectory for *Clostridium difficile*. It should be noted that although the Health Board is not yet fully achieving the Public Health Wales (PHW) trajectories, BCUHB 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.

BCUHB also has the third best rate per 100,000 population for *E. coli* bacteraemia and *C. difficile*. As of January 2019 the Health Board is below target for *C. difficile* infection with a rate of 25.53 per 100,000 population compared with a target of 26.00.

#### Key issues highlighted in the report include:

- A summary of the most recent infection performance data for key infections targets, including benchmarking against other Welsh Health Boards, and the all-England mean.
- An update on the Safe, Clean, Care campaign and some of the recent highlights.
- A report on the outcome of the 2018 Welsh Government review of the decontamination of medical devices across BCUHB.
- An update on next steps to continue with improvements to environmental cleanliness across BCUHB.

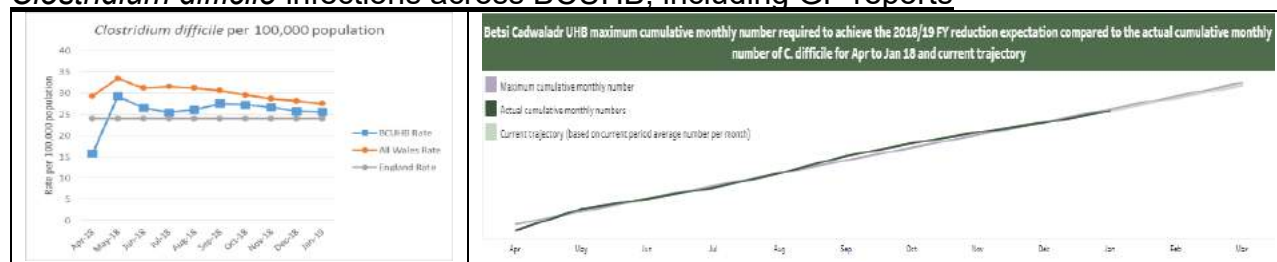
#### Highest Scoring Risks

The IPC risk of Health Care Acquired Infection (HCAI) and Antimicrobial Resistance (AMR) are on the corporate risk register with a risk score of 20 (CRR2). The risk register is reviewed regularly by the Infection Prevention Sub-Group (IPSG) of QSE and is now a standing item. During Q4 of the year all IPC, AMR and Decontamination risks were reviewed collaboratively and updated and some removed where appropriate. The highest scoring risks 16 and greater are discussed and escalated from IPSG to QSE.

#### Performance Exception Report: Health Care Associated Infection (HCAI) Targets

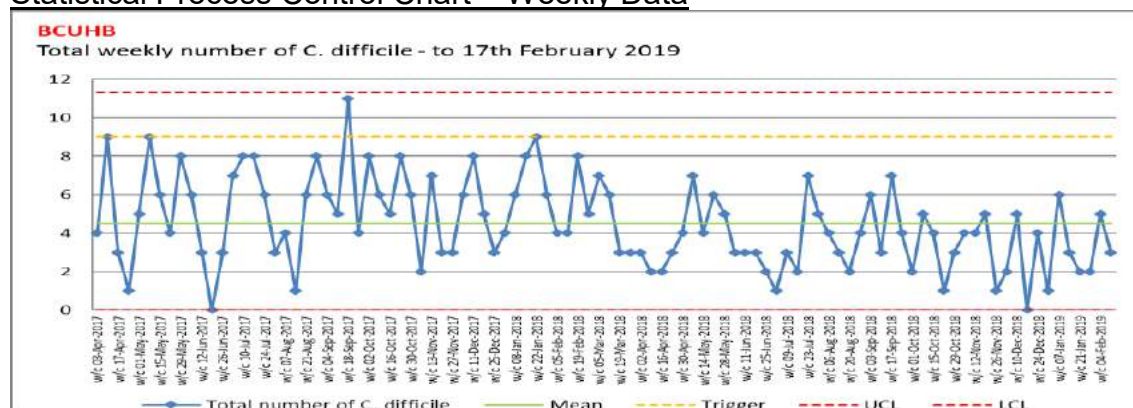
##### *Clostridium difficile* Infection

### Clostridium difficile infections across BCUHB; including GP reports



- Our 2018/19 maximum target number of *C. difficile* infections to achieve the reduction expectation set by Welsh Government is 180.
- As of the end January 2019 the number of people across North Wales diagnosed is 149 vs 150 trajectory to date.

### Statistical Process Control Chart – Weekly Data

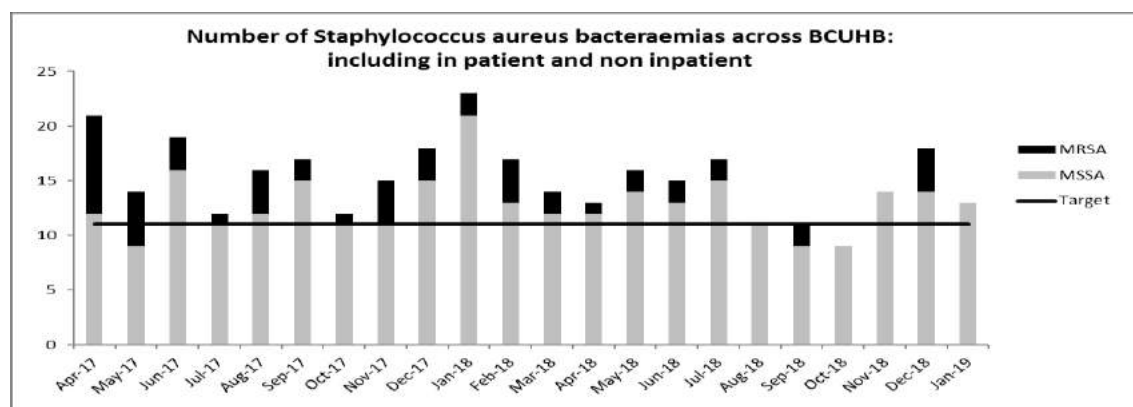


The chart above shows common cause variation in our *C. difficile*, with signs of improvement over the previous months. This means that we have to embed the work that we have been doing and continue to raise the profile in order to show sustained improvement. Since February 2019 the IPC team have commenced Post Infection Review (PIR) on all *C. difficile* Toxin Positive Infections including community cases. This coincides with a follow up of all *C. difficile* Toxin Positive Infections for a period of 4 weeks after completion of treatment or discharge. This will enable the team to review patients, trends, prevent relapses and consider if these infections were avoidable or not. In patient PIRs to date have indicated learning which may be transferable to community health care provision where applicable.

- Inappropriate antimicrobial prescribing
- Rapid detection and treatment
- Delayed isolation and advice for patients with diarrhoea
- Poor compliance with bare below the elbows
- Sustainability of environmental and cleanliness standards

Actions in the IPC and Safe Clean Care (SCC) improvement plans are continuing to focus on these issues and have made significant impact which has meant that these features are reduced and along with them the reduction in overall infection rates.

## Staphylococcus aureus Bacteraemia

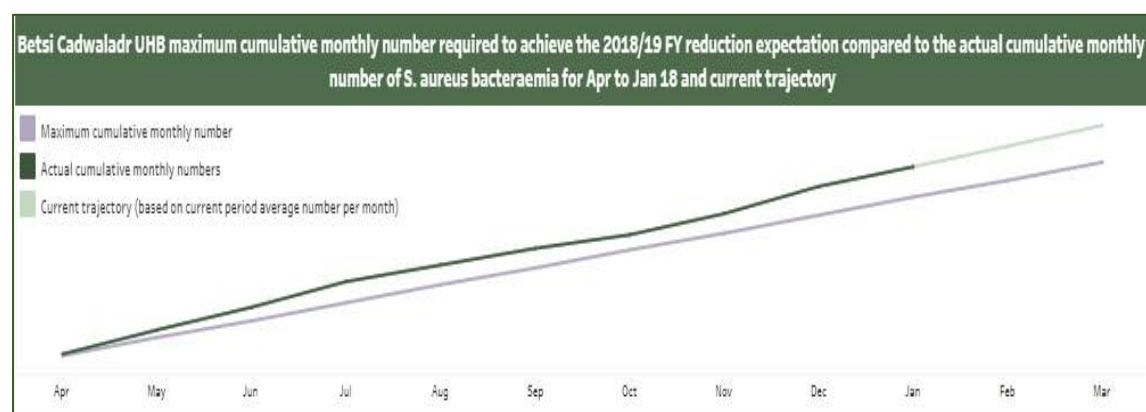


### Staphylococcus aureus bacteraemia across BCUHB

MRSA = Meticillin-resistant *Staphylococcus aureus*

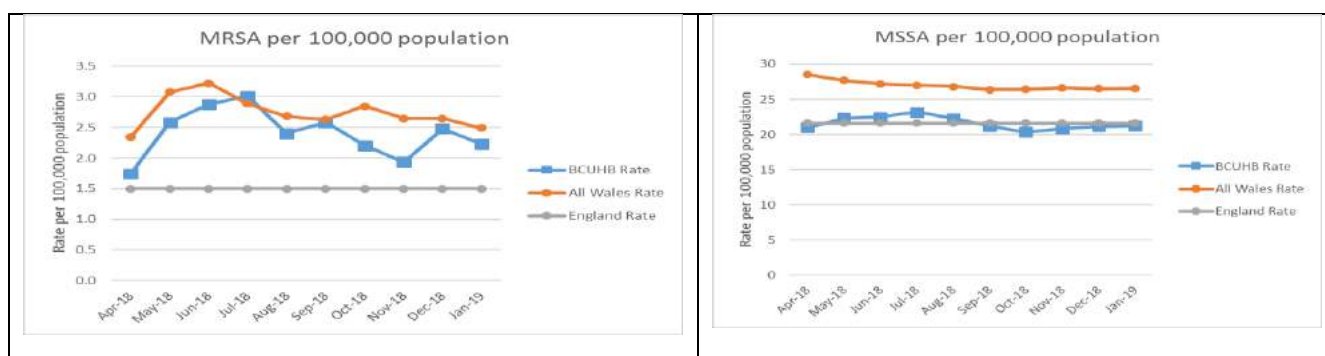
MSSA = Meticillin-sensitive *Staphylococcus aureus*

### Performance against target

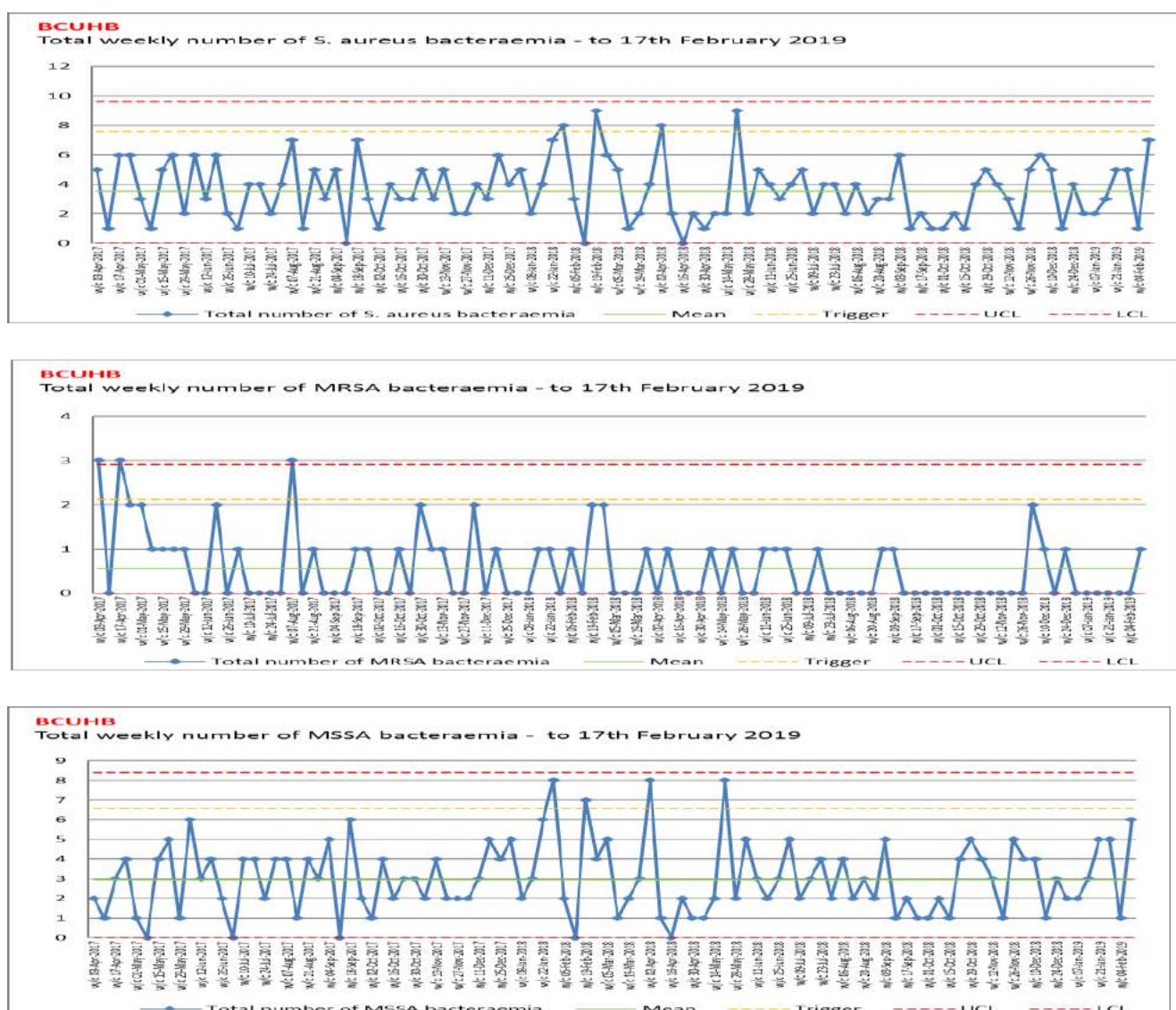


- The chart above shows the cumulative numbers of MRSA and MSSA combined.
- Our 2018/19 *St. aureus* bacteraemia target set by Welsh Government is less than 140.
- BCUHB is not presently on target to achieve this reduction expectation. However there has been a reduction in the number of infections when compared to 2017-18. By January 2018 there had been 167 people affected by *St. aureus* bacteraemia, which is 30 more people than by the same time frame in 2018-19.





### Statistical Process Control Chart – Weekly Data

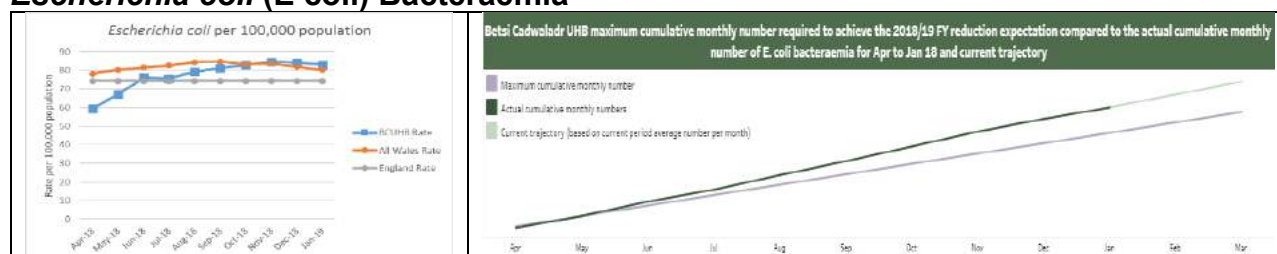


From April 2018 to January 2019 the Health Board has had 13 people with a MRSA bacteraemia, compared with 34 people with MRSA bacteraemia in April 2017 to January 2018.

BCUHB continues to have the lowest rate of MSSA bacteraemia in Wales and during the 5 months from September 2018 to January 2019 has returned to benchmarking better than the all-England rate.

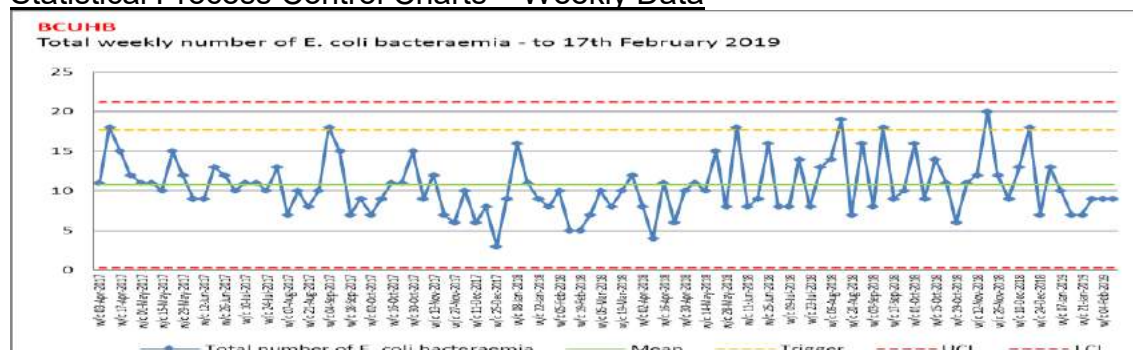
However further focus is required to reduce the number of these infections. Themes from PIRs of MSSA Blood Stream Infections (BSIs) include skin and soft tissue infections in the community leading to bacteraemia, and in hospital poor cannula care and contaminated blood cultures. The programme of work to reduce these includes improving cannula care and blood culture technique through the use of aseptic non-touch technique (ANTT) by medical and nursing staff. Actions continue in the Safe Clean Care Programme to improve practice on these issues. From March 2019 there will be an increased effort as part of SCC and the IPC team to review all invasive devices on a daily basis with emphasis on vascular lines. In addition increased focus will be provided on intravenous antibiotics using the Start Smart Then Focus methodology, and for urinary catheters, the HOUDINI approach whereby nurses can make the decision to review and remove urinary catheters (not supra pubic devices).

### ***Escherichia coli* (E coli) Bacteraemia**



Between April 2018 and January 2019 484 patients have been diagnosed with an *E coli* bacteraemia, which is 96 more than trajectory to date. The prevalence of origin for these infections alongside other gram negative infections is across the whole health economy with more community cases than inpatient, 382/137 respectively, although it is likely that some of the diagnosed inpatient infections were in fact attributable to community. The E coli collaborative work continues, with work in place to further increase focus on key drivers of these infections (primary care urinary tract infections and their management, urinary catheters and hydration). This will require a multi-faceted approach across all sectors of the health economy working collaboratively with Public Health Wales et al.

### **Statistical Process Control Charts – Weekly Data**



### **Deaths related to *Clostridium difficile* infection**

The number of deaths in patients who have *Clostridium difficile* infection (CDI) continues to be very closely monitored. Deaths related to *Clostridium difficile* infection are recorded on either part 1 of the patient's death certificate (a direct cause), or on part 2 of the certificate (a contributory cause). All cases are reported as serious incidents and post-infection review performed, with lessons learned shared.

#### Deaths with *Clostridium difficile* Infection cited on Death Certificate

Year	Total number of people
2013-14	24
2014-15	19
2015-16	12
2016-17	9
2017-18	19

2018-19	Part 1	Part 2	Total number of people
Quarter 1	1	0	1
Quarter 2	1	0	1
Quarter 3	0	0	0
Quarter 4			
<b>Total</b>	<b>2</b>	<b>0</b>	<b>2</b>

#### Safe Clean Care Campaign and 90-Day Plans

A range of activities has continued to take place in the latest improvement cycle and work continues with the IPC team and hospital/community leads to focus on improved accountability, and local plans to ensure sustainability of practice improvements in the longer-term. The programme of aseptic non-touch technique (ANTT) e learning continues with further review of the Training Needs Analysis to concentrate on key staff groups including the review of e learning uptake.

The SCC Programme Board is overseeing the programme to utilise the capital funding of approximately £1M allocated in 2018-19 to address infection risks associated with the environment. A commitment has been given to provide this in the next financial year and bids have already been submitted.

The Ward Accreditation Programme commenced in October 2018, using validated methodology. The monitoring tools and assessment criteria have been reviewed with input from the IPC Team to ensure they align with evidence-based standards required, and support the Safe Clean Care Programme. From March 2019 the IPC team will be joining the ward accreditation visits and the audit and assurance visits.

The Health Board continues to actively participate in the all-Wales 1000 Lives HCAI Improvement Programme, and the national programme officer is participating in the BCUHB E coli collaborative to support this work.

## Environmental Cleanliness

Recent feedback from patient representatives has confirmed their view that the programme in place is continuing to improve the visual cleanliness of our wards and departments, despite our cleaning audit scores not yet reflecting that improvement.

The increase to risk-based monthly auditing will further support improvement. The identified cost-pressures required to fully meet national audit frequency will be considered as part of the 2019-20 budget setting process, along with any other cost-pressures subsequently identified.

The launch of the Matrons Walk round tool and the Ward Accreditation will harmonise with the cleaning work as they also consider a number of the themes within the C4C programme, this will also support more consistency of our approach.

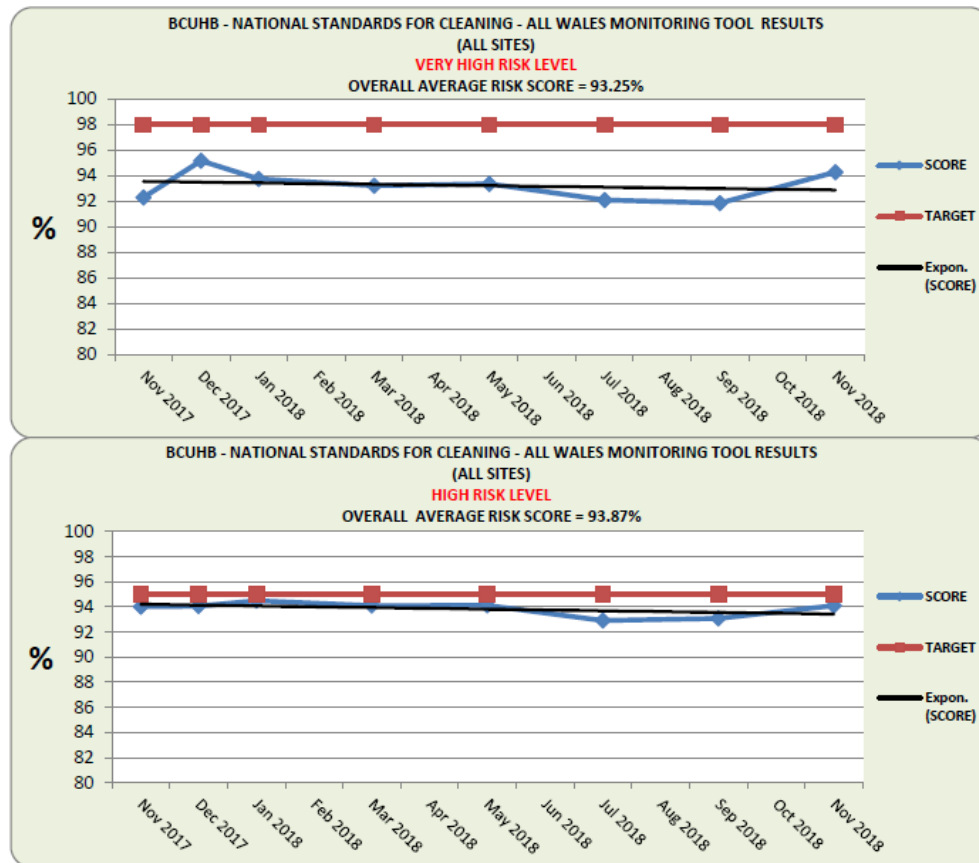
The IPC team continues to work with senior facilities and estates staff to review the trail of cleaning processes and products. A further trail will take place combining products and processes and a decision to move to a standardised, effective and simplistic schedule will be fully established by summer 2019. This will require an extension of laundering facilities across community areas which has been considered and agreed for 2019/2020.

Excerpt from BCUHB Cleanliness Report November 2018 (this is the most recent report available):

### 1.2 Very High Risk and High Risk Average Risk Scores

Site	Risk Level / Target Score	
	Very High Risk (98%)	High Risk (95%)
<b>Acute Sites</b>		
Wrexham Maelor Hospital	89.65 ↓	92.80 ↑
Ysbyty Glan Clwyd	94.79 ↑	95.41 ↑
Ysbyty Gwynedd	93.53 ↑	91.75 ↑
<b>Community Areas</b>		
East Area	96.00 ↑	95.61 ↓
Central Area	93.94 ↓	94.10 ↓
West Area	97.70 ↑	94.90 ↓
<b>Overall Average Risk Score</b>	<b>94.27 ↑</b>	<b>94.10 ↑</b>

KEY				
Risk Level	Minimum Target Score to achieve National Cleaning Standards for Cleaning / Nursing & Estates	Green	Amber	Red
Very High	98% minimum	98% & Above	88% to 98%	Below 88%
High	95% minimum	95% & Above	85% to 95%	Below 85%
Significant	85% minimum	85% & Above	75% to 85%	Below 75%
Low	75% minimum	75% & Above	65% to 75%	Below 65%



### Decontamination of Medical Devices

Welsh Government performed their annual peer survey of decontamination across BCUHB on 15-18 October 2018. The headline message was that the survey team were delighted to see the great deal of progress that was evident across BCUHB. A further visit will take place during spring 2019. Many of the decontamination risks have been closed or reduced due to a focus on the overarching IPC review of the current risk register.

### MRSA Screening

MRSA screening of certain groups of patients on admission is required in line with the evidence-base, national requirements and BCUHB protocol. This includes universal screening of 100% patients in key risk groups including intensive care and orthopaedics. From reviews the IPC team have recognised that although compliance around screening is high, screening of other sites and devices is sometimes missed. February's monthly IPC learning focused on this and support for screening patients at risk will continue with a review of the MRSA policy.

### Conclusion

QSE are asked to note the content of the report and support the continued programme of work.



**Quality, Safety & Experience  
Committee**
**19.3.19**

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University Health Board

***To improve health and provide excellent care***

<b>Report Title:</b>	Health and Safety Update
<b>Report Author:</b>	Stephen Roscoe, Head of Health and Safety Centre/West Gary Monaghan, Head of Health and Safety, East
<b>Responsible Director:</b>	Mrs Sue Green, Executive Director of Workforce and Organisational Development
<b>Public or In Committee</b>	Public
<b>Purpose of Report:</b>	This report provides an update on the actions approved by the Health Board at its meeting on 1 <sup>st</sup> November 2018.
<b>Approval / Scrutiny Route Prior to Presentation:</b>	N/A
<b>Governance issues / risks:</b>	<p>The lack of a visible functioning system and structure for the effective management of health and safety is a significant risk to the organisation in people; financial and governance terms.</p> <p>The continued lack of stability and clarity of accountability, roles and responsibilities together with a lack of capacity and capability will further compound this risk if not addressed in a systematic way.</p>
<b>Financial Implications:</b>	There are no direct financial implications from this report
<b>Recommendation:</b>	The Committee is asked to: 1. Note the position outlined in the report.

<b>Health Board's Well-being Objectives</b> <i>(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)</i>		<b>WFGA Sustainable Development Principle</b> <i>(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.)</i>	
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	√		
<b>Special Measures Improvement Framework Theme/Expectation addressed by this paper</b>			
Engagement			
<b>Equality Impact Assessment</b>			
Update paper – none required.			

*Disclosure:*

*Betsi Cadwaladr University Health Board is the operational name of Betsi Cadwaladr University Local Health Board*

## Health and Safety Update Report

### 1. Purpose of report

This report provides an update on the actions approved by the Health Board at its meeting in November 2018.

### 2. Background and Progress

#### 2.1 Capacity and Capability

As reported to the last meeting, the new Heads of Health and Safety have been appointed and the scope of leadership responsibilities for each role has now been identified, agreed and implemented. In addition to the responsibility for a geographical “patch”, a number of key organisation wide responsibilities have been agreed e.g. Compliance; Relationship Management with external bodies; Essential Training and learning culture development; Security etc.

The role of Associate Director of Health, Safety and Equality has been appointed to with the individual commencing on 13<sup>th</sup> May 2019. He is an experienced senior manager with extensive knowledge and experience across health settings and as such there is confidence that we will have a robust professional Health and Safety service moving forward.

This role of Associate Director of Health, Safety and Equality will be responsible for the management and delivery of the following, both on a workforce and service provider/public basis:

- Health and Safety
- Occupational Health
- Equality and Human Rights

One of the many opportunities to be exploited as part of developing the structure outlined previously is the maximisation of synergies between services previously managed separately.

Progress has been made in two priority areas:

- Agreement has been reached to transfer the current Moving and Handling team from Organisational Development into the Health and Safety team. This will enable greater application of the skills of the team and will improve the capacity of team by sharing knowledge and identifying hot spots of areas of concern and areas of good practice and in doing so develop a critical mass of health and safety/moving and handling practitioners across the Health Board. These practitioners will be auditing, training and giving information using the same methodology and templates. Musculoskeletal injury/absence is a key priority under the Attendance Improvement Plan and as such an updated set of Key Performance Targets are being set for 2019/20 as one of the methods to evaluate impact.

- Accountability for Security i.e. having the correct systems in place to manage security as well managing the contract for security services in secondary care has moved to the Health and Safety Team.

The Head of Health and Safety (Centre/West) has commenced a scoping of the current security provision across the whole Health Board. At this juncture a review of current security arrangements including Security Strategy and Procedures has been conducted with the intent to confirm an appropriate framework is in place to meet the requirements of the Security Management Framework for NHS Trusts in Wales (2005).

A number of significant gaps have been highlighted as part of this initial review e.g. CCTV and crime prevention. However these will be addressed in the short/medium term working with the Violence and Aggression Case Manager and the advisor in place from North Wales Police.

In the meantime, following the decision to procure the provision of security services for the 3 Emergency Departments and the awarding of the contract to Samson Security with effect from 1<sup>st</sup> April 2019, the Head of H&S has taken handover from the previous lead and has established himself as the conduit to Samson Security to work collaboratively to establish those elements that are currently not in existence are put in place, where reasonable and practicable, prior to contract commencement.

Additionally he will monitor the incoming contractor and develop appropriate arrangements and measures with the contractor, until a Security Manager is identified and, to inform the wider Review of Security identified as a key priority in the plan for 2019/20.

The purpose of this Review is to develop appropriate recommendations for the improvement and potential consolidation of existing security provisions to provide a better service and reduce costs.

## **2.2 Governance and Management System/Plan and Progress**

Since the last report determined efforts have been to scope out gaps in the current Health and Safety Management System (HSMS) for the organisation. This has included

- Mapping the current state in relation to divisional governance processes for Health and Safety and identified Health and Safety Leads in each area.
- Analysis of data to inform the HSMS where the highest need for resources i.e. prioritisation
- Revising internal processes for departmental self-assessment and corporate Health and safety advisors health and safety review.

Additionally, concerns have been noted in relation to the process for reporting and management of accidents/incidents reportable to the Health and Safety Executive under the RIDDOR - Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013

The Regulations apply to both non clinical accidents and clinical incidents meeting the criteria set. There have been a number of issues previously including failure to meet reporting standards and in some instances, disagreement between clinical teams and the Health and Safety Advisors regarding the appropriateness of reporting of patient related incidents.

An interim process for the management of RIDDOR reporting has been implemented to ensure:

- Central decision making and reporting to HSE through the Health and Safety team;
- Joint review of clinical RIDDORS between H&S and Quality team to ensure consistency of decision making and identification of themes;
- Proper/timely investigation and learning from incidents is undertaken.

To date this process has been effective in ensuring the Health Board's responsibilities are met in terms of timeliness of reporting. It has also been helpful in highlighting themes to be addressed across the Health Board.

Between 1<sup>st</sup> January 2019 and 28<sup>th</sup> February 2019 there have been:

- 11 staff safety reports. Of these 10 have been reported (including 2 slip incidents , 2 V&A, 2 incidents relating to staff unable to commence usual duties, 2x chemical exposure, 2 moving and handling);
- 6 patient safety reports. All reports were as a result of a fall and all were in inpatients areas. 5 of these incidents were reported to HSE. The 6<sup>th</sup> incident was not reported following a joint view that there was no evidence of a management failure.

Evaluation of the process will be undertaken and a Procedure will be drafted for approval through Health and Safety Group in May 2019 (following commencement of the new Associate Director). In addition, agreement will need to be reached in relation to the reporting of these incidents moving forward as this will move from the Terms of Reference for the Quality and Safety Group (QSG) to Health and Safety Group (HSG) from 1<sup>st</sup> April 2019.

As a result of the chemical exposure incidents the HSE has indicated that they will be visiting the Health Board to investigate this matter. It is not clear at this stage whether the HSE are investigating this case or reviewing the wider system for COSHH/Hazardous substances. The Health and Safety Team will be managing the preparation and arrangements for the visit.

The need for a systematic approach to managing Health and Safety will be documented in a 3 year Improvement Plan in line with the Workforce Strategy. The Draft key themes for this plan include:

- Improving on the current and developing a robust HSMS system
- Improved Management of RIDDORS including support/investigation/learning/preventing and reducing time lost
- Improving the Managing of Exposure to Hazardous Substances
- Achieving a Reduction in Slip, Trip and Falls
- Improvement in the prevention and management of Stress and Wellbeing
- Improved management of MSK/moving and handling across the Health Board including ensuring interventions are appropriate for the setting/role
- Improved compliance with Safer Sharp Regulations and reduction in the number of avoidable incidents
- Improvements in Health and Safety Training and impact.
- Improvements in Management of Security and reduction in violence and aggression incidents/response/time lost
- Improvements in management of contractors and third parties

#### **4. Assessment of risk and key impacts**

The lack of a visible functioning system and structure for the effective management of health and safety was previously noted as a significant risk to the organisation in people; financial and governance terms.

The current entry (text below) on the Risk Register has been reviewed and updated from an initial risk score of 20 (L4xC5) 31/03/2016 to a risk score of 15(L3xC5) 28/01/2019.

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

#### **5. Conclusions / Next Steps**

As acknowledged by the Board in November 2018, there is a need for a systematic approach to improving the management of health and safety across the Health Board. Good progress is being made against the actions set out to the Board and there is confidence that taking a more structured approach will result in an improvement in our position in terms of Health and Safety and the associated HSMS.

In delivering against the actions outlined above, we will also be delivering the recommendations set out within the Internal Audit Report of 2018.

#### **6. Recommendations**

The Committee is asked to note the position outlined in this report.

**Quality, Safety & Experience  
Committee**
**19.3.19**

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*To improve health and provide excellent care*

<b>Report Title:</b>	Annual Quality Statement 2018/2019 – DRAFT
<b>Report Author:</b>	Mrs Deborah Carter, Associate Director of Quality and Governance Mrs Diane Read, Quality Improvement Team Mr Andrew Rogers, Head of Communications
<b>Responsible Director:</b>	Mrs Gill Harris, Executive Director of Nursing and Midwifery
<b>Public or In Committee</b>	Public
<b>Purpose of Report:</b>	<p>The attached draft Annual Quality Statement (AQS) is presented to the Committee for comments / feedback on content.</p> <p>The aim of the AQS is to provide the citizens of North Wales with an easy to read and easily accessible document, which will provide an overview that will engage all age groups and will be a valued resource by the public. The AQS will complement and direct the reader to the Health Board reports such as the Annual Report which include detailed data.</p> <p>The AQS provides an open and honest overview in terms of the quality agenda of our services, the Health Boards progress against the previous year's priorities; outline other areas of development and achievements for the past year. It will also provide an overview of areas for focused improvement for the coming year.</p> <p>Data contained within the AQS will be for year end quality measures that will have been presented to the Committee prior to the AQS inclusion. To support the easy access approach as required for the AQS the data will be presented where appropriate as an infographic (as used in the early pages in the draft AQS document).</p> <p>The AQS has been developed following submissions from across the Health Board this is a working draft document. Formatting will take place during the final stages and following feedback from all the groups/committee.</p>
<b>Approval / Scrutiny Route Prior to Presentation:</b>	The AQS will be presented to other groups for further feedback during the draft phase.
<b>Governance issues / risks:</b>	The AQS document highlights good practice that has taken place across the organisation and identifies areas where further improvement work is required.



<b>Financial Implications:</b>	None identified at the point in time
<b>Recommendation:</b>	The Committee are asked to provide feedback on the content of the AQS and to note this is a current working draft document

<b>Health Board's Well-being Objectives</b> <i>(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)</i>	√	<b>WFGA Sustainable Development Principle</b> <i>(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.)</i>	√
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	√		
<b>Special Measures Improvement Framework Theme/Expectation addressed by this paper</b>			
Leadership and Governance			
<b>Equality Impact Assessment</b>			
The AQS will be subject to Equalities Impact Assessment.			

*Disclosure:*

*Betsi Cadwaladr University Health Board is the operational name of Betsi Cadwaladr University Local Health Board*

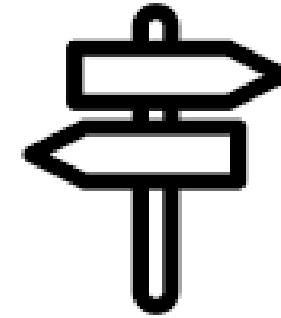


# Annual Quality Statement

1<sup>st</sup> April 2018 – 31<sup>st</sup> March 2019

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Where is the information you want to know?

“The different colours represent the 7 areas of the Health Care Standards.”



## About this report

The Annual Quality Statement is an opportunity for us to share what we have been doing to improve the quality of our services over the last year. This report follows the format of the Health and Care Standards<sup>1</sup> themes:

**Staying Healthy** - you are well informed and supported to manage your own physical and mental health.

**Safe Care** - you are protected from harm and protect yourself from known harm.

**Effective Care** - you receive the right care and support as locally as possible and contribute to making that care successful.

**Dignified Care** - you are treated with dignity and respect and treat others the same.

**Individual Care** - you are treated as an individual with your own needs and responsibilities.

**Staffing and Resources** - we have enough staff with the right knowledge and skills available at the right time to meet your need.

Thank you for taking the time to read this report.

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<sup>1</sup> Published by the Welsh Government on the 1<sup>st</sup> April 2015. For further information about the standards please use the following link:  
[http://www.wales.nhs.uk/sitesplus/documents/1064/24729\\_Health%20Standards%20Framework\\_2015\\_E1.pdf](http://www.wales.nhs.uk/sitesplus/documents/1064/24729_Health%20Standards%20Framework_2015_E1.pdf)

## Introduction and Welcome

The purpose of our Board is to govern the organisation effectively. We aim to build confidence in the quality and safety of the care that we provide. For more information about BCIHB Board Members, please find us on our Website [www.bcu.wales.nhs.uk](http://www.bcu.wales.nhs.uk)



**Statement from Mr Gary Doherty, Chief Executive & Mr Mark Pollin, Chairman**

**Statement from Mrs Lucy Reid, Chair of Quality and Safety Committee & Mrs Gill Harris, Executive Director of Nursing & Midwifery**

## Betsi Cadwaladr University Health Board (BCUHB)

The purpose of the Board is to govern the organisation effectively. We aim to build confidence in the quality and safety of care that we provide. For more information about Board members, please use the following link:

<http://www.wales.nhs.uk/sitesplus/861/page/40836>

This document forms part of our annual reporting. In addition to this report, our Annual Report and Annual Governance Statement can be found at the following link:

[www.wales.nhs.uk/sitesplus/861/page/40903](http://www.wales.nhs.uk/sitesplus/861/page/40903).

This report and supporting documents can be made available in other languages or formats on request from the Corporate Communications Team:

Email: [bcuhbpressdesk@wales.nhs.uk](mailto:bcuhbpressdesk@wales.nhs.uk)

Telephone: 01248 384776

Address: Communications Team  
Block 5  
Carlton Court  
St. Asaph Business Park  
St. Asaph  
LL17 0JG

**There are many opportunities to get involved and share your ideas about how we can improve health in North Wales.**

We are keen to hear from you, whether as a member of the public, patient or carer, or if you have a compliment or a suggestion.

**It is your local health services.  
Help us to help you!**

You can also sign up to our involvement scheme. By registering, (please use the link below) you will get our newsletter, hear about how you can share your views and ideas and get updates on activities and events. We want to involve everyone irrespective of age, disability, gender, gender identity, race, religion or belief or sexual orientation.

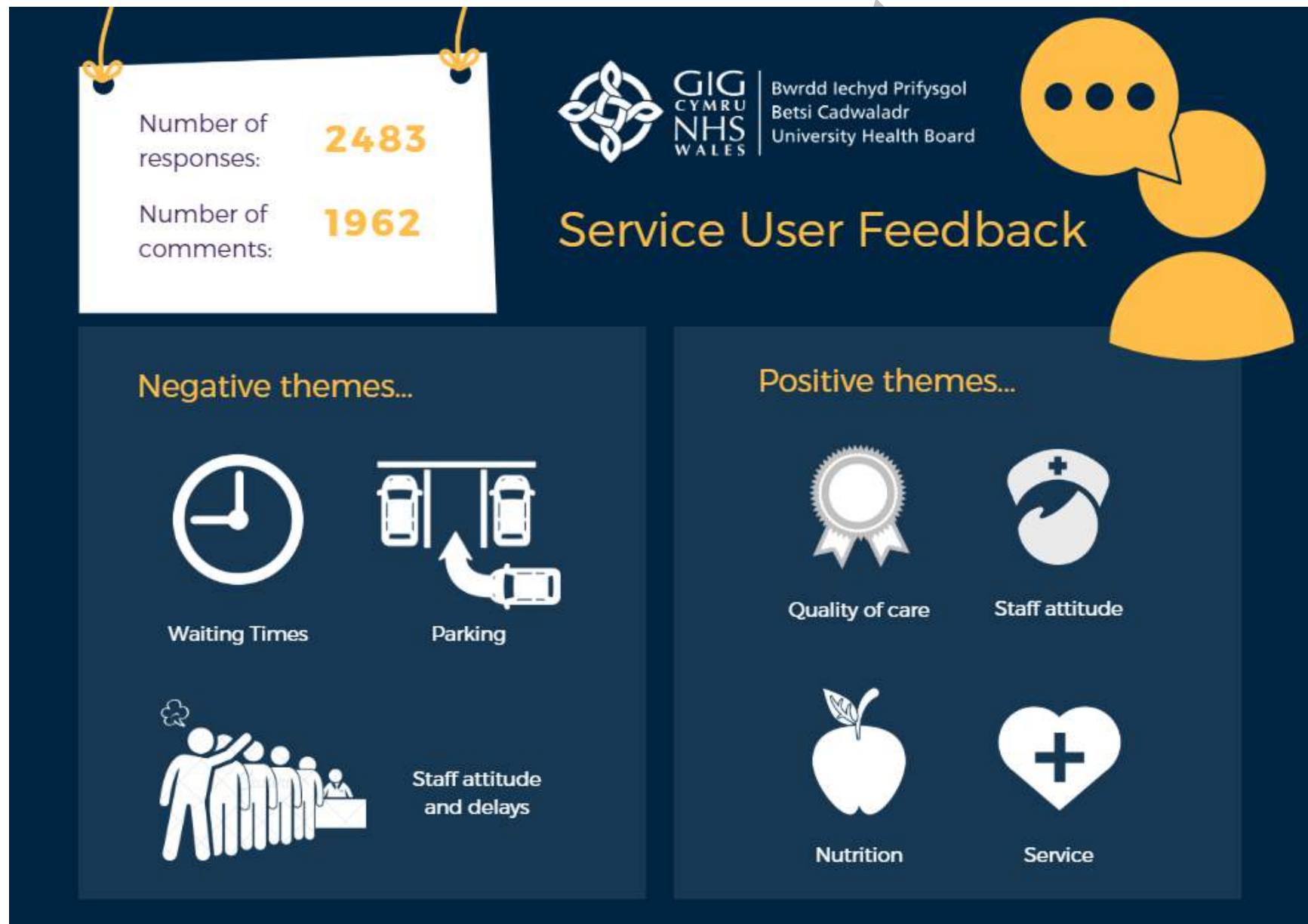
<http://www.bcugetinvolved.wales/register>



## About BCUHB



## Your Comments about BCUHB over the last year



## Progress since last year

What we said last year...	What we did ...	What we will do this year (2019/2020)...
<p>Avoidable Deaths - by reducing our mortality rate and using mortality reviews to focus areas for learning and improvement.</p> <ul style="list-style-type: none"> <li>We will implement the Learning from Death's Policy across the Health Board.</li> </ul>		
<p>Harm Free Care - by delivering care in the right place, by the right member of staff at the right time.</p> <ul style="list-style-type: none"> <li>Continued development of the ward level dashboard to increase staff access to accurate information for improvement.</li> <li>To continue to focus on the aim of harm free care for the coming year by taking Health Board wide action on reducing: Healthcare Acquired Pressure Ulcers and inpatient Falls</li> <li>We will implement the improvements across the Health Board for Hospital Acquired Thrombosis.</li> </ul>		

What we said last year...	What we did ...	What we will do this year (2019/2020)...
<p>Achieve the highest level of reliability in clinical care by Strengthening our clinical pathways.</p> <ul style="list-style-type: none"> <li>• Continue to focus on clinical pathways in line with national guidance, results of national audits and findings from mortality reviews.</li> <li>• Continue to develop a ward accreditation programme and implement across the Health Board in the coming year.</li> </ul>		
<p>Deliver “What Matters” work in partnership with patients, carers and families to meet their needs and actively improve their health - by moving towards open visiting times and act on results from patient feedback in real time. Include patients, carers and families in the delivery of care.</p> <ul style="list-style-type: none"> <li>• Patient feedback via Viewpoint to be evaluated and used locally for improvement. Viewpoint data displayed on ward information Boards outside ward entrances</li> <li>• Introduce a Patient Advisory and Support Service to manage (in a timely manner) local resolutions</li> </ul>		

What we said last year...	What we did ...	What we will do this year (2019/2020)...
<p>Deliver innovative and integrated care closer to home which supports and improves health, wellbeing and independent living - Track performance through the development of a Business Intelligence Community Dashboard.</p> <ul style="list-style-type: none"><li>• Continue to promote the use of information for improvements and develop the Community dashboard further.</li></ul>		

## Staying Healthy

### Nursery Nurses

Thanks to the efforts of our Nursery Nurses, more mums across North Wales have started breast-feeding. Our Nursery Nurses carry out antenatal visits and provide advice about breast-feeding and give parents opportunities to ask questions.



### Getting immunisation off to a flying start

The Flying Start Programme has helped to give Anglesey some of the best child immunisation rates in Wales in 2018. The programme is aimed at giving disadvantaged children the best start in life when it comes to health and other services. It includes more regular contact with health visitors and more support for parents.

### Protecting our children

Our childhood vaccination programme is one of the most significant and cost effective ways in which we protect the health of children and young people against infections which can lead to serious complications and even death. Our vaccination rates are among the highest in Wales at age 4, although they remain below the 95% target levels. More recent uptake of childhood vaccines among children at age 1 and age 2 suggests steady improvement with target levels achieved in a number of our local authority areas. After a number of years steady increase in vaccination rates, in common with the rest of Wales, rates now appear to have plateaued. Concerted efforts are now needed to maximise uptake to levels at which the whole population is protected.



## Safe Care

### Point of care testing

We have started to rollout the national Point Of Care Testing (POCT) system. When this goes live, it will connect to all suitable POCT devices, and allow remote management, a full audit trail, electronic storage of all tests and an interface to the Welsh Clinical Portal so that test results can be viewed. As part of this work we have already started to use connected Glucose Meters across North Wales, which greatly improves patient safety.



### Improving our estate

The removal of asbestos from the original Radiology Department in Ysbyty Glan Clwyd is complete. This has taken a number of years to do and involved the temporary relocation and closure of x-ray and scanning rooms, offices and corridors. Our staff, however, have worked both creatively and tirelessly to ensure service users experienced as little disruption as possible.

### Providing high quality, critical care

Our new £18m neonatal unit to care for premature and sick newborn babies from across North Wales is now complete. The SuRNICC will provide a range of new facilities and increased capacity to care for newborn babies with significant care needs. The completion of the work means the unit now has its full complement of cots. In total, the unit has five intensive care cots, five high dependency cots, one stabilisation cot and nine special care cots. The service is supported by a dedicated neonatal transport service. The completed unit also has a dedicated parent's area with facilities for families of babies on the unit, including a play area for young children, and additional accommodation to allow parents to stay on the unit with their sick babies if needed.



## Effective Care

## Supporting mental health and wellbeing

ICAN centres have been introduced at each of our district general hospitals to provide emotional support and signpost appropriate support services for people who do not need to be treated at an Emergency Department or by a Mental Health Practitioner. They are available to people over the age of 18 who are experiencing emotional distress and form part of an ambitious plan to improve mental health support in North Wales. We are working closely with our partners, including North Wales Police, local authorities, Welsh Ambulance Service and mental health charities to establish a seamless integrated urgent care



## Leading the field

Our Cellular Pathology Department continues to lead the field by adopting the very latest in technology to improve service delivery. It is currently the only laboratory in Wales to use digital slide scanning for clinical diagnosis and is currently working on the development of pioneering improvements in rapid reports for tissue diagnosis. The department has also expanded its repertoire of diagnostic procedures with the adoption of the very latest specialised cancer tests to improve treatment for patients with breast cancer.

## Peer review

We have been able to verify the accuracy of our x-ray reports thanks to a regular and consistent peer review system established our Reporting Radiographers. The review sample of 5% is consistent with Royal College guidelines and the results for the last 12 months has consistently been more than 99%. This, together with the reporting model, is considered exemplar practice and provides measurable assurance for our patients and staff.

## Dignified Care

### Supporting

In February, we opened a new Comprehensive Assessment Unit (CAU) at Ysbyty Glan Clwyd. This is a 12-bedded acute frailty unit to provide Comprehensive Geriatric Assessment (CGA) in older, frail patients. The aim is to optimise medical diagnosis and treatment and provide active rehabilitation and reablement with a view to reduce length of stay, reduce inappropriate community hospital transfers and achieve better utilisation of community resources.



### Improving our environment

There has been positive feedback about the improvements we have made to the Paediatric Area in Ysbyty Glan Clwyd's Emergency Department (some of the new artwork can be seen on the right). One of our patients said: ***"Think the rooms are great! Love the decoration."***

We have also worked closely with the design team supporting the project to remove asbestos from the Radiology Department at Ysbyty Glan Clwyd. There has been a particular focus on privacy, dignity and safe care with the development of the Interventional Radiology facility. For example, it has been built to theatre standards and equipped with imaging equipment to enable patients to have procedures there instead of having to go to theatre.



### Reviewing the way we work

Our Anglesey Health Visiting Service has completed a pilot enquiry into Adverse Childhood Experiences (ACEs) with service users and practitioners. The pilot was reviewed by Public Health Wales who found the enquiry improved practitioners understanding of families and informed their assessment procedures. Service users said their relationship with their Health Visitor improved with some families having 4 ACEs or more saying it was the first time that they had had the opportunity to discuss these with a professional. This pilot has now been extended to four other areas in Wales to test its transferability.

## Timely Care

### Cancer diagnosis cellular pathology

Waiting times for histology diagnosis have significantly reduced over the last 12 months. This is due to the dedication of the laboratory team and the recruitment of additional expert Pathologists to North Wales. The Pathologists say they join the team at BCU, because the department encourages pioneering work in Cellular Pathology service delivery.



### Improving emergency access for children

We have carried out a lot of work to make sure people are getting the most appropriate care in as timely a way as possible when they come to our Emergency Departments. Part of this work has involved having a Paediatrician working in our EDs to make sure children are assessed as quickly as possible before being treated or referred to the most appropriate service. This work supports admission avoidance, the flow of patients through our hospitals and the experience our patients receive, particularly younger people.

### Child and Adolescent Learning Disability Service

Thanks to a successful bid for support through the Welsh Government Integrated Care Fund our Child and Adolescent Learning Disability Service (CALDS) has been able to recruit additional qualified nurses, health care support workers and a psychology assistant. This has allowed the team to provide a timely service to a larger number of young people without accruing a waiting list. Historically the CALDS team offered a service to those aged between 8 and 18, but as of January 2019 it has increased the age range to those between 5 and 18 years to provide earlier intervention. Other benefits of the enhanced service have included being able to provide more support for young people at home and running accessible music workshops.





## Individual Care

### Working together

The Bringing Agencies Together initiative has been helping to support patients to look after their mental health once they are ready leave hospital. The partnership approach between Ablett Unit staff and North Wales Mental Health Development agency, Unllais, helps patients to identify activities and support services in their local community. They are encouraged to link in with these support services after leaving hospital in order to help them to continue to look after their mental health and wellbeing.



### Improving communication

Our Language Choice Scheme, where 'Speaking Welsh' magnets are placed over patients' beds, has been rolled out to community hospitals, allowing wards to plan their workforce so that Welsh speaking staff are paired with Welsh speaking patients. This has also ensured wider planning, allowing multi-disciplinary teams to plan their care when attending to patients.

We have also further developed our Welsh Language Training Programme with more than 600 members of staff accessing language training at various levels. Our Welsh Language Tutor has tailor-made courses in line with service needs, such as specialised CAMHS professionals and staff groups involved with dementia care.



### Breaking down language barriers

Wrexham Maelor Hospital has become the first site in the Welsh NHS to gain Makaton-friendly status. This was a great achievement for staff on the Children's and COPD wards. Courses have been running for staff and Makaton boards are in place in both areas, as well as the availability of resources like Makaton stories, activity sheets and DVD's.

## Staffing and Resources

### Empowering our staff

Our Quality Improvement hub launched in September 2018 with one of the aims being to support all staff with the opportunities to improve capability through Silver IQT training. This training provides learners with the knowledge and skills to make improvements in the workplace. A new website has been launched to provide staff with information and resources to support the quality improvement program.



### Strengthening staff engagement

The latest NHS Wales Staff Survey results have shown that a wide range of initiatives being used to strengthen staff engagement have had a positive impact on culture. These include the monthly Seren Betsi recognition award, developing Listening Leads to improve two-way communication, using the 3D model as a listening methodology and establishing 'Proud Of' groups to celebrate success and share best practice. We have also launched a new Staff App to help share information and updates across the organisation with staff who do not or cannot access email or the intranet. This platform also allows our staff to post their own news and share information within their own communities.

### Celebrating success



More than 500 people packed in to Venue Cymru for this year's Staff Achievement Awards. The event recognised and celebrated some of the great work carried out by our staff every day across North Wales. The winners were picked from hundreds of nominations, which came from patients, staff and members of the public. Among this year's winners was Leyla Ustay (pictured right receiving her award) who picked up the 'New Ways of Working' Award for developing a system to review patient medications so that when they are discharged from hospital, patients quickly receive the right medicine in the right quantities.





## Wales for Africa

The Health Board is a signatory to the Charter for IHP in Wales, which signals its commitment to helping others as part of promoting global health and sustainable development. As well as benefitting people in poorer countries who have fewer resources and less developed healthcare systems, involvement in humanitarian overseas work also benefits our staff in a number of ways. These include improving their teaching skills, building leadership confidence, generating ideas for health service delivery within limited resources, learning about the delivery of healthcare to people from different cultures and also gaining direct experience of global diseases that may pose a risk to the population of Wales. This enhanced skill and knowledge can then be used by our colleagues when they return from overseas, for the benefit of patients in North Wales. Teams of local nurses, doctors, midwives, public health specialists, pharmacists, IT experts, researchers and others are involved in our international health links work, most notably as part of the Wales for Africa Programme.

In North Wales, there are active links to healthcare in the Quthing district of Lesotho, hospital care in Hossana Hospital, Ethiopia and primary care and eye care in Hawassa, Ethiopia. Over the past year, the Health Board has supported the work of the links by hosting the International Health Group (IHG), developing national guidance, awareness-raising, and by enabling staff to participate in reciprocal visits involving Wales for Africa partners.

Members of the IHG have made a number of overseas visits – including those to Lesotho and Uganda as part of the International Learning Opportunities (ILO) scheme; to Ethiopia to provide hospital informatics support as well as ophthalmology, cardiology and basic emergency department training; to Lesotho to provide mental health and HIV anti-stigma training; and to Kenya on a fact-finding visit as part of plans to establish a new link. The Health Board holds a list of 150 individuals who are either actively undertaking international work, involved in supporting this work, or who have expressed an interest in becoming involved in volunteering.

## Special Measures

The Health Board has been in special measures since June 2015. Work has been ongoing to make improvements in line with the expectations of the Special Measures Improvement Framework issued by Welsh Government. The Framework covers four themes: leadership & governance, strategic & service planning, mental health and primary care including GP out of hours services.

Over the past year, quality improvements under special measures have included the implementation of the Mental Health Quality Improvement Plan, focusing on improving dementia care, stopping inappropriate out of area patient placements and taking action to address findings from the reports published about failings in care on Tawel Fan ward.

Initiatives to improve patient safety during special measures include the roll out of patient safety 'huddles' (meetings designed to enable teams to focus on patients most at risk), use of technology to reduce avoidable harm through the 'Harms dashboard' electronic system, use of the 'SAFER bundle' (a method promoting best practice in patient care), and having better systems in place to support learning from concerns, incidents and claims.

The work undertaken has led to a variety of improvements to the patient journey, such as patients being seen more quickly when they arrive at hospital by ambulance, a reduction in the MRSA and c.difficile infection rates, and fewer delays for patients who are ready to go home from hospital. In February 2019, GP out of hours services were deemed to have improved to the extent that it was removed from special measures.

Working towards the achievement of all special measures expectations, in particular improving the Health Board's challenging financial and performance position, will continue to be a priority. Further quality improvements will continue to be made on an ongoing basis, with progress overseen locally by the Special Measures Task & Finish Group, and reported to the Health Board.

## Looking Forward. 2019-2020

Draft

<b>Quality, Safety &amp; Experience Committee</b>		<b>GIG CYMRU NHS WALES</b>	Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board
<b>19.3.19</b>	To improve health and provide excellent care		

<b>Report Title:</b>	Committee Annual Report 2018-19
<b>Report Author:</b>	Mrs Kate Dunn, Head of Corporate Affairs
<b>Responsible Director:</b>	Mrs Gill Harris, Executive Director of Nursing & Midwifery
<b>Public or In Committee</b>	Public
<b>Purpose of Report:</b>	<p>To seek Committee input to the annual report for 2018-19 which has been prepared on a BCU-wide template which was amended following Audit Committee consideration of the previous year's annual reports.</p> <p>The report will require further amendment to incorporate themes from the March Committee meeting and will be submitted to a workshop of the Audit Committee on the 14<sup>th</sup> May 2019.</p>
<b>Approval / Scrutiny Route Prior to Presentation:</b>	An early draft was discussed with the Committee Chair and Lead Executive with their comments being incorporated into the attached draft.
<b>Governance issues / risks:</b>	None identified
<b>Financial Implications:</b>	None identified
<b>Recommendation:</b>	<p>The Committee is asked to:</p> <ol style="list-style-type: none"> <li>1. Review the draft Annual Report for 2018-19</li> <li>2. Provide comments and feedback as necessary</li> <li>3. Approve that Chair's Action can be taken to agree the final version for submitting to Audit Committee</li> </ol>

<b>Health Board's Well-being Objectives</b> (indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)	✓	<b>WFGA Sustainable Development Principle</b> (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	✓		
<b>Special Measures Improvement Framework Theme/Expectation addressed by this paper</b>			
Governance			
<b>Equality Impact Assessment</b>			
Equality impact assessment is not considered necessary for this paper.			

*Disclosure:*

*Betsi Cadwaladr University Health Board is the operational name of Betsi Cadwaladr University Local Health Board*



## Committee Annual Report 2018/19

### 1. Title

Quality, Safety & Experience Committee

### 2. Name and role of person submitting this report:

Mrs Gill Harris, Executive Director of Nursing & Midwifery

### 3. Dates covered by this report:

01/04/2018-31/03/2019

### 4. Number of times the Committee met during this period:

The Committee was routinely scheduled to meet 12 times plus an annual joint meeting with the Audit Committee (and otherwise as the Chair deemed necessary) however the frequency of meetings was amended in-year from monthly to bimonthly. During the reporting period therefore it met on 10 occasions including 1 extraordinary in-committee meeting. Attendance at meetings is detailed within the table below:

INDEPENDENT MEMBERS	24.4.18	22.5.18	26.6.18	24.7.18	25.9.18	6.11.18 (Joint with Audit)	29.11.18	22.1.19	28.2.19 (extraordinary)	19.3.19
Cheryl Carlisle	A	√*	√	√	√	√	A	√*	√	
Margaret Hanson (Chair)	√	√	◆	◆	◆	◆	◆	◆	◆	◆
Peter Higson (Interim Chair)	◆	◆	√	◆	◆	◆	◆	◆	◆	◆
Jackie Hughes	◆	◆	√	√	√	√	√	√	√	
Lyn Meadows (Chair July-Sept)	√	√*	√	√	√	√	A	√*	√	
Lucy Reid (Chair Sept-March)	◆	◆	◆	◆	√*	√	√	√	√	



Directors and Officers in Attendance	24.4.18	22.5.18	26.6.18	24.7.18	25.9.18	6.11.18 (Joint with Audit)	29.11.18	22.1.19 (extra ordinary)	28.2.19	19.3.19
Sue Green Executive Director of Workforce & OD	◆	◆	◆	◆	◆	√	A	√	√	
Gill Harris Executive Director of Nursing & Midwifery	√	√	A	√	√	√	√*	√	√	
Evan Moore Executive Medical Director	√	√	A	√	√	√	√*	√	A	
Morag Olsen Chief Operating Officer	A	A	A	◆	◆	◆	◆	◆	◆	◆
Teresa Owen Executive Director of Public Health	√	√	√	√	√*	√	√*	√*	√	
Michael Rees Chair of Healthcare Professionals Forum	A	√*	A	A	√	A	A	√	A	
Chris Stockport Executive Director of Primary & Community Services	◆	◆	◆	◆	◆	◆	◆	A	√*	
Adrian Thomas Executive Director of Therapies & Health Sciences	√	√	√	√	√	√	√	√	√	
<p><b>Key:</b>  √ Present  √* Part meeting  A Apologies/Absent  ◆ Not a member of the Committee at this time.</p> <p>In addition to the above core membership, other Directors and Officers from the Health Board regularly attend meetings of the Committee. These include the Associate Director of Quality Assurance, Staffside Chair, Senior Associate Medical Director, Director of Performance and the Community Health Council Vice-Chair/Chair. For a full list of attendance, please see the detailed Minutes which can be accessed on the Health Board's website via the following link:-  <a href="http://www.wales.nhs.uk/sitesplus/861/page/88168">http://www.wales.nhs.uk/sitesplus/861/page/88168</a></p>										

## 5. Assurances the Committee is designed to provide:

The Committee is designed to provide assurance to the Board on the following key areas as set out in its Terms of Reference as follows:-

- Ensure that arrangements for the quality and safety of patient care are in accordance with its corporate goals, stated priorities within the Quality Improvement Strategy and the principle of continuous quality improvement including organisational learning.
- Ensure the adequacy of safeguarding and infection, prevention and control arrangements.
- Provide assurance in relation to improving the experience of patients, citizens and all those who come into contact with the Health Board's services, as well as those provided by other organisations or as part of a partnership arrangement.
- Seek assurance on the robustness and appropriateness of Health and Safety arrangements across the Health Board including aspects impacting on patient care, quality and safety and experience.
- Ensure that all reasonable steps are taken to prevent, detect and rectify irregularities or deficiencies in the quality and safety of care provided and in particular that:
  - Sources of internal assurance (including clinical audit) are reliable
  - Recommendations made by internal and external reviewers are considered and acted upon on a timely basis
  - Appropriate review is carried out and corrective action is taken arising from incidents, complaints and claims known collectively as 'Concerns'.
- Review achievement against the Health and Care Standards including accessible health care to inform the Annual Quality and Annual Governance Statements.
- Seek assurance on the quality and safety of services commissioned from external providers (including care homes) and others who provide a commissioning role on behalf of the Health Board e.g. Welsh Health Specialised Services Committee (WHSSC); Emergency Ambulance Services Committee (EASC).
- Review and seek assurance on the appropriateness of the quality indicators defined within the Integrated Quality and Performance Report (IQPR) and scrutinize the quality dimensions contained within the IQPR.
- Review the sustainability of service provision across the Health Board in terms of quality of service, patient experience and model of care provided.
- Provide advice and assurance to the Board regarding the quality impact assessment of strategic plans as appropriate.
- Receive periodic updates in respect of the workforce flu vaccination<sup>1</sup>.

During the period that this Annual Report covers, the Committee operated in accordance with its terms of reference V4.0 which were operative from March 2018 to January 2019 and V5.0 operative from February 2019. The terms of reference are appended at Appendices 1 and 2.

<sup>1</sup> Added to terms of reference from February 2019 onwards

An integral part of the process is the requirement for the Committee to undertake a self-assessment. This year the Health Board has adopted a different approach as recommended by Wales Audit Office with quarterly reviews of Committee performance being undertaken collectively by the Committee Business Management

Group (CBMG) who perform a more integrated governance role in this respect. Modifications to the overall Committee structure have been undertaken in year.

Insert individual comments from Committee in terms of whether there are any further issues to be highlighted/reviewed by CBMG at the end of the Calendar year.

At a workshop of the Audit Committee held on the 15<sup>th</sup> May 2018 members reviewed each of the Committee and Advisory Group's annual reports for 2017-18 with the aim of providing evidence on the scope and effectiveness of Committees and of their evaluation of the sources of assurance available to them. At the system of Board Assurance continued to be refined, Audit Committee members made the following comments specific to the QSE Committee:-

That QSE should monitor clinical audit outcomes in-year on a more regular basis	Reflected within cycle of business
Future reports would benefit from the inclusion of examples of learning from concerns.	Meeting held between Committee Chair, Community Health Council Chair and report authors to scope and inform future Listening & Learning Reports.
Ensure that future Annual Reports include a specific explanatory comment if no assurance was received by the Committee	Completed for 2018-19
Ensure that future Annual Reports include detailed narrative of actions being taken against any red or amber levels of assurance	Completed for 2018-19
Encourage improvement to both IM and Executive attendance levels	2017-18 IM attendance was 77% Exec attendance was 72%  2018-19 IM attendance was Exec attendance was

In addition, Audit Committee members made the following generic comments pertaining to the Committee and Advisory Group Annual Reporting process:-

Recurring themes around the need for training for members in respect of specific Committee responsibilities, and concerns around the volume of work some Committees were dealing with.	A full review and refresh of the cycle of business has been undertaken with the Committee Chair and Lead Executive. Meeting duration has been extended to allow for full discussion of items. Committee members have also increased their skillset through the wider Board Development and Workshop programme. Other specific training has also been provided eg risk
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	management, equality, safeguarding and continuing health care.
Externally commissioned/produced reports e.g. Deanery/Royal Colleges should be centrally logged.	Central logging now in place within Office of the Board Secretary.
Chairs assurance reports to in future confirm actions being taken to address key risks identified.	Template amended in July 2018
Template for future Committee Annual reports to be amended to detail "focus for the year ahead" at the end of the report.	Completed (see section 9)
Any difficulties in identifying sources of assurance to be included as a key focus for the year ahead.	Completed (see section 9)
In respect of internal or external audit reports individual committees are asked to review and provide commentary within their annual report on whether the implementations of the recommendations arising from audits relevant to their remit have led to overall qualitative improvements.	Committee to consider 19.3.19
Ensure new assurance map addresses quality of primary care and quality of commissioned services.	Completed as part of ongoing development of Board Assurance Framework
Sources of assurance document to be updated as follows:- <ul style="list-style-type: none"> <li>• Outcome findings of local clinical audit work to be included (ACS 21A)</li> <li>• Systems of internal control to be included (ACS 11A)</li> <li>• Team Central Tracker aligned to Audit Committee to be included (ACS66).</li> <li>• Delete RAG colour coding from document.</li> </ul>	Completed as part of ongoing development of Board Assurance Framework

## 6. Overall **\*\*RAG** status against Committee's annual objectives / plan: Amber

The summary below reflects the Committee's assessment of the degree to which it has met these objectives. The supporting narrative included alongside the assessment below describes this in more detail.

Objective as set out in Terms of Reference	Was sufficient assurance provided?	Was the assurance positive?	Supporting narrative (Please provide detail for all actions showing amber or red assurance levels in terms of actions being taken to address these issues).
	RAG	RAG	
Ensure that arrangements for the quality and safety of patient care are in accordance with its corporate goals, stated priorities within the Quality Improvement Strategy and the principle of continuous quality improvement including organisational learning.	Green	Amber	Clinical Audit and Organisational Learning to be strengthened and prioritised within committee business.
Ensure the adequacy of safeguarding arrangements.	Green	Amber	Gaps in assurance have been articulated in the reports provided.
Ensure the adequacy of infection prevention and control arrangements.	Green	Green	
Provide assurance in relation to improving the experience of patients, citizens and all those who come into contact with the Health Board's services, as well as those provided by other organisations or as part of a partnership arrangement.	Amber	Amber	The development of a range of Stakeholder Groups. Strengthening of patient stories. Embedding revised arrangements for patient experience. Refresh the approach to Listening & Learning reports. Rollout of PAS to Wrexham.
Seek assurance on the robustness and appropriateness of Health and Safety arrangements across the Health Board including aspects impacting on patient care, quality and safety and experience.	Amber	Red	Externally commissioned report. Escalation to corporate risk register. Amended executive portfolios.

			Establish H&S Committee.
Ensure that all reasonable steps are taken to prevent, detect and rectify irregularities or deficiencies in the quality and safety of care provided and in particular that: <ul style="list-style-type: none"> <li>Sources of internal assurance (including clinical audit) are reliable</li> <li>Recommendations made by internal and external reviewers are considered and acted upon on a timely basis</li> <li>Appropriate review is carried out and corrective action is taken arising from incidents, complaints and claims known collectively as 'Concerns'.</li> </ul>	Amber	Amber	Paper on clinical audit due March 2019. Clinical Audit plan was not received in-year. Improvements to be made on organisational learning.
Review achievement against the Health and Care Standards including accessible health care to inform the Annual Quality and Annual Governance Statements.	Green	Amber	Committee input into AQS development
Seek assurance on the quality and safety of services commissioned from external providers (including care homes) and others who provide a commissioning role on behalf of the Health Board e.g. Welsh Health Specialised Services Committee (WHSSC); Emergency Ambulance Services Committee (EASC).	Green	Amber	HIW report due 19.3.19
Review and seek assurance on the appropriateness of the quality indicators defined within the Integrated Quality and Performance Report (IQPR) and scrutinize the quality dimensions contained within the IQPR.	Green	Green	
Review the sustainability of service provision across the Health Board in terms of quality of service, patient experience and model of care provided.	Amber	Amber	Committee sighted on concerns around endoscopy, ophthalmology and children's services
Provide advice and assurance to the Board regarding the quality impact assessment of strategic plans as appropriate.	Red	Red	Reflect QIA in ongoing development of the Three Year Plan.
Receive periodic updates in respect of the workforce flu vaccination.	Green	Green	



## **7. Main tasks completed / evidence considered by the Committee during this reporting period:**

### **Need to add in items from 19<sup>th</sup> March**

#### Standing Items

- Chair's assurance report from the Quality Safety Group
- Integrated Quality Performance Reports
- Policies for approval
- Chair's assurance report from HASCAS & Ockenden Improvement Group (from Sept 2018 onwards)

#### Regular Items

- Infection Prevention and Control / Safe Clean Care Updates
- Listening and Learning from Patient Experience reports
- Committee Risks from Corporate Risk and Assurance Framework
- Mortality updates
- Accessible Healthcare Standards annual report
- Putting Things Right annual report
- Service development reports from Mental Health Learning & Disabilities Division
- Continuing Health Care assurance reports
- Equalities annual report
- Health and Safety reports
- Annual Quality Statement
- Quality Assurance reports (evolving into CLIC – Complaints, Litigation, Incidents and Coroner) reports
- Integrated Resilience (Winter) Plan
- Flu vaccination uptake reports
- Shared patient experience discussions with Wales Ambulance Services NHS Trust
- Updates against quality Improvement Strategy
- Prison health updates
- Healthcare Inspectorate Wales inspection updates
- Public Services Ombudsman Wales annual letter
- Safeguarding reports
- Health Protection Team annual report
- Tissue and Organ Donation annual report

#### Ad-Hoc

- Feedback from Chief Dental Officer on the BCUHB Update against National Oral Health Plan
- Presentation from Cemlyn Ward, Cefni Hospital on good practice examples / psychology programme
- Presentation on child health
- Briefing on Older People's Commissioner review into care homes
- Reports of the Organisational Development project into Women's Services
- Stroke services update
- Update on Pressure Ulcer collaborative

- Review of special measures expectations

#### Governance Items

- Review of minutes and actions
- Committee annual report
- Radiation Protection sub-group annual report
- Minutes and briefings from Welsh Health Specialised Services Committee's Quality & Patient Safety Committee
- Review and refresh of Committee terms of reference

Full details of the issues considered and discussed by the Committee are documented within the agenda and minutes which are available on the Health Board's website and can be accessed from the following link:-

<http://www.wales.nhs.uk/sitesplus/861/page/88168>

#### **8. Key risks and concerns identified by this Committee in-year which have been highlighted and addressed as part of the Chair's reports to the Board:**

<b>Meeting Date</b>	<b>Key risks including mitigating actions and milestones</b>
24.4.18	<ul style="list-style-type: none"> <li>• Correlation between nurse staffing levels and incidents of harm such as patient falls and hospital acquired pressure ulcers. <u>Controls/Actions</u> - monitoring through IQPR, development of dashboards</li> <li>• Delays in responding to the Public Accounts Committee (PAC) hospital catering and patient nutrition action plan. <u>Control/Actions</u> – taken forward through Quality Safety Group</li> </ul>
22.5.18	<ul style="list-style-type: none"> <li>• Challenges in meeting the target for smoking cessation with pregnant women. <u>Controls/Actions</u> – continued monitoring through IQPR.</li> <li>• Concerns regarding nurse staffing levels. <u>Controls/Actions</u> - monitoring through IQPR, development of dashboards.</li> <li>• The Committee was keen that the seasonal/winter plans for 2018-19 be drawn up much earlier than in previous years. <u>Controls/Actions</u> – highlighted to Board and relevant officers.</li> </ul>
26.6.18	<ul style="list-style-type: none"> <li>• Lack of organisational accountability for performance in relation to compliance with Accessible Healthcare Standards (AHCS). <u>Controls/Actions</u> – resulting action plans from audits to be acted upon and incorporated into PADRs; extension of audits into primary care; completion of “easy wins” by all operational areas; incorporation into ward accreditation programme; re-establish the AHCS Steering Group.</li> <li>• Low levels of participation in training, development and awareness of AHCS. <u>Controls/Actions</u> – mandatory completion of sensory loss e-learning for all staff; rollout toolkit to all operational areas.</li> <li>• Sensory loss fields within primary care systems not being completed. <u>Controls/Actions</u> – ensure that all managed practices record communication needs within practice management systems; encourage patients and third sector representatives to request their GP to record communication needs; develop agreed reference values within WPAS; ensure communications needs are checked and entered into WPAS for each contact with BCU.</li> </ul>

	<ul style="list-style-type: none"> <li>• More transparent RAG rating better supported by trend data within performance reports. <u>Controls/Actions</u> - Director of Performance led on refresh of IQPR in-year.</li> <li>• Ward staffing levels. <u>Controls/Actions</u> - Associate Director of Quality Assurance to look at an enhanced reporting functionality for a future report.</li> <li>• Numbers of catastrophic adverse incidents noted within the Putting Things Right report. <u>Controls/Actions</u> – the Deputy Director of Contractor Services would provide a refreshed coversheet for submission to the July Health Board.</li> <li>• The implications of Gosport investigation. <u>Controls/Actions</u> - exception assurance report to be provided to September meeting.</li> <li>• Corporate safeguarding support to the MHLDS. <u>Controls/Actions</u> – the next planned safeguarding report to clearly set out assurances and actions.</li> <li>• Health &amp; Safety Annual Report. <u>Controls/Actions</u> – report to be to developed report further and resubmitted to a subsequent Health Board meeting.</li> </ul>
24.7.18	No risks identified
25.9.18	<ul style="list-style-type: none"> <li>• Potential adverse implication of an amended process for influenza vaccine distribution to primary care. <u>Controls/Actions</u> – ongoing monitoring.</li> <li>• Deteriorating position in respect of pressure ulcers. <u>Controls/Actions</u> - improvement collaborative established with update report due to next meeting.</li> <li>• Deteriorating position in terms of delayed transfers of care (specifically Gwynedd and Wrexham. <u>Controls/Actions</u> - Chief Executive wrote to the respective Local Authority Chief Executives; launch of amended process in terms of care home of choice.</li> <li>• Timeframe for addressing issues with 24 hour on-call services for Section 136 (Child Adolescent Mental Health Services). <u>Controls/Actions</u> - interim measure to be implemented ahead of longer solution of service redesign.</li> <li>• Paediatric middle grade cover in the West. <u>Controls/Actions</u> - Executive Medical Director to provide an update on mitigating actions in November and the Executive Director of Primary Care &amp; Community Services to provide a paper early in 2019 on governance and escalation processes for this service.</li> <li>• The need for risks within HMP Berwyn report to be rated or scored. <u>Controls/Actions</u> – Executive Director of Primary Care &amp; Community Services to take forward with the HMP Berwyn team.</li> </ul>
29.11.18	<ul style="list-style-type: none"> <li>• Rate of closure for incidents. <u>Controls/Actions</u> - an exception report to the next meeting.</li> <li>• Child Adolescent Mental Health Services (CAMHS) performance. <u>Controls/Actions</u> - prioritisation of longest waiting patients; internal deep dive ahead of a national review; use of external funding to address backlog.</li> <li>• Initial risk scores and risk appetite for a range of corporate risks. <u>Controls/Actions</u> - to be followed up at the Board Workshop 20.12.18.</li> <li>• Lack of evidence to explain the proposed reduction in risk score for CRR13 (mental health). <u>Controls/Actions</u>- Director of MHLDS to provide briefing note.</li> <li>• Format and content of Listening and Learning from Experience reports to the Committee. <u>Controls/Actions</u> - small task group to be established.</li> </ul>

	<ul style="list-style-type: none"> <li>Lack of assurance around how the Quality Safety Group reported the closing down of Healthcare Inspectorate Wales actions. <u>Controls/Actions</u> - Committee Chair to write formally to the QSG.</li> </ul>
22.1.19	<ul style="list-style-type: none"> <li>Continued concern at the level of pressure ulcers. <u>Controls/Actions</u> – measures to ensure staff were aware of correct reporting processes; work closely with the Ambulance Trust to reduce the risk of pressure ulcers resulting from long waits in ambulances.</li> <li>Format of the assurance report for HASCAS &amp; Ockenden. <u>Controls/Actions</u> - continue to refine format to more clearly map progress made against each of the recommendations.</li> </ul>
19.3.19	

## 9. Focus for the year ahead:

The primary focus of the Committee over the next twelve months will be:

- Organisational learning
- Responding to HASCAS / Ockenden
- Impact of systems and processes on patient experience
- Clinical audit
- Children's services

The Committee has established a Cycle of Business for the year ahead covering the breadth of its work, and primarily focussing on its key areas of risk, as defined in the Board's Corporate Risk and Assurance Framework. This is attached **as Appendix 3.**

### **\*\*Key:**

<b>Red</b>	= not on target to achieve all actions, and may not achieve these actions by the next quarter
<b>Amber</b>	= not on target to achieve all actions, but has plans in place to see these actions achieved by the next quarter
<b>Green</b>	= on target to achieve all actions

**Betsi Cadwaladr University Health Board****Terms of Reference and Operating Arrangements****QUALITY, SAFETY AND EXPERIENCE COMMITTEE****1 INTRODUCTION**

1.1 The Board shall establish a committee to be known as the **Quality, Safety and Experience Committee (QS&E)**. The detailed terms of reference and operating arrangements in respect of this Committee are set out below.

**2 PURPOSE**

2.1 The purpose of the Committee is to provide advice and assurance to the Board in discharging its functions and meeting its responsibilities with regard to quality, safety, patients and service user experience of health services.

**3 DELEGATED POWERS**

3.1 The Committee, in respect of its provision of advice and assurance will and is authorised by the Board to:-

3.1.1 ensure that arrangements for the quality and safety of patient care are in accordance with its corporate goals, stated priorities within the Quality Improvement Strategy and the principle of continuous quality improvement including organisational learning;

3.1.2 ensure the adequacy of safeguarding and infection, prevention and control arrangements;

3.1.3 provide assurance in relation to improving the experience of patients, citizens and all those who come into contact with the Health Board's services, as well as those provided by other organisations' or as part of a partnership arrangement;

3.1.4 seek assurance on the robustness and appropriateness of Health and Safety arrangements across the Health Board including aspects impacting on patient care, quality and safety and experience;

3.1.5 ensure that all reasonable steps are taken to prevent, detect and rectify irregularities or deficiencies in the quality and safety of care provided and in particular that:

- Sources of internal assurance (including clinical audit) are reliable
- Recommendations made by internal and external reviewers are considered and acted upon on a timely basis

- Appropriate review is carried out and corrective action is taken arising from incidents, complaints and claims known collectively as 'Concerns'.

3.1.6 Review achievement against the Health and Care Standards including accessible health care to inform the Annual Quality and Annual Governance Statements;

3.1.7 Seek assurance on the quality and safety of services commissioned from external providers (including care homes) and others who provide a commissioning role on behalf of the Health Board e.g. Welsh Health Specialised Services Committee (WHSSC); Emergency Ambulance Services Committee (EASC).

3.1.8 Review and seek assurance on the appropriateness of the quality indicators defined within the Integrated Quality and Performance Report (IQPR) and scrutinize the quality dimensions contained within the IQPR;

3.1.9 Review the sustainability of service provision across the Health Board in terms of quality of service, patient experience and model of care provided.

3.1.10 provide advice and assurance to the Board regarding the quality impact assessment of strategic plans as appropriate;

#### **4 AUTHORITY**

4.1 The Committee may investigate or have investigated any activity (clinical and non-clinical) within its terms of reference. It may seek relevant information from any:

- employee - and all employees are directed to cooperate with any legitimate request made by the Committee; and
- other committee, sub-committee or group set up by the Board to assist it in the delivery of its functions.

4.2 It may also obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements;

4.3 It may consider and where appropriate, approve on behalf of the Board any policy within the remit of the Committee's business concerning Quality, Safety and Patient Experience matters.

4.4 It will review risks from the Corporate Risk Register that are assigned to the Committee by the Board and advise the Board on the appropriateness of the scoring and mitigating actions in place;

#### **5 SUB-COMMITTEES**



5.1 The Committee may, subject to the approval of the Health Board, establish sub-committees or task and finish groups to carry out on its behalf specific aspects of Committee Business.

## **6 MEMBERSHIP**

### **6.1 Members**

Four Independent Members of the Board.

### **6.2 In attendance**

Executive Director of Nursing and Midwifery (Lead Executive)  
 Executive Medical Director  
 Executive Director of Therapies and Health Sciences  
 Chief Operating Officer  
 Executive Director of Public Health  
 Associate Director of Quality Assurance  
 Senior Associate Medical Director / 1000 Lives Clinical Lead  
 Chair of Healthcare Professionals Forum -Associate Board Member  
 Representative of Community Health Council  
 Staff Side Representative

6.2.1 Other Directors/Officers will attend as required by the Committee Chair, as well as any others from within or outside the organisation who the Committee considers should attend, taking into account the matters under consideration at each meeting. The Mental Health & Learning Disabilities Division will attend as per scheduled items on the cycle of business.

### **6.3 Member Appointments**

- 6.3.1 The membership of the Committee shall be determined by the Chairman of the Board taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government. This includes the appointment of the Chair and Vice-Chair of the Committee who shall be Independent Members.
- 6.3.2 Appointed Independent Members shall hold office on the Committee for a period of up to 4 years. Tenure of appointments will be staggered to ensure business continuity. A member may resign or be removed by the Chairman of the Board. Independent Members may be reappointed up to a maximum period of 8 years.

### **6.4 Secretariat**

6.4.1 Secretary: as determined by the Board Secretary.

### **6.5 Support to Committee Members**

6.5.1 The Board Secretary, on behalf of the Committee Chair, shall:

- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and
- Ensure the provision of a programme of development for Committee members as part of the overall Board Development programme.

## **7 COMMITTEE MEETINGS**

### **7.1 Quorum**

7.1.1 At least two Independent Members must be present to ensure the quorum of the Committee, one of whom should be the Committee Chair or Vice-Chair. In the interests of effective governance, it is expected that a minimum of two Executive Directors will also be in attendance.

### **7.2 Frequency of Meetings**

7.2.1 Meetings shall be routinely be held on a monthly basis.

### **7.3 Withdrawal of individuals in attendance**

7.3.1 The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

## **8 RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS**

**8.1** Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of the organisation.

**8.2** The Committee is directly accountable to the Board for its performance in exercising the functions set out in these Terms of Reference,

**8.3** The Committee, through its Chair and members, shall work closely with the Board's other Committees including joint committees/Advisory Groups to provide advice and assurance to the Board through the:

- 8.3.1 joint planning and co-ordination of Board and Committee business; and
- 8.3.2 sharing of information

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.

- 8.4** The Committee shall embed the corporate goals and priorities through the conduct of its business, and in doing and transacting its business shall seek assurance that adequate consideration has been given to the sustainable development principle and in meeting the requirements of the Well-Being of Future Generations Act.
- 8.5** Receive assurance and exception reports from the Quality and Safety Group (QSG)

## **9. REPORTING AND ASSURANCE ARRANGEMENTS**

- 9.1** The Committee Chair shall:
- 9.1.1 report formally, regularly and on a timely basis to the Board on the Committee's activities via the Chair's assurance report as well as the presentation of an annual report;
  - 9.1.2 ensure appropriate escalation arrangements are in place to alert the Health Board Chair, Chief Executive or Chairs of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.
- 9.2** The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation. In doing so account will be taken of the requirements set out in the NHS Wales Quality and Safety Committee Handbook.

## **10. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS**

- 10.1** The requirements for the conduct of business as set out in the Standing Orders are equally applicable to the operation of the Committee, except in the following areas:
- Quorum

## **11. REVIEW**

- 11.1** These terms of reference and operating arrangements shall be reviewed annually by the Committee and any changes recommended to the Board for approval.

### **Date of approval:**

Audit Committee 9.2.18

Health Board 5.4.18

**Betsi Cadwaladr University Health Board**  
**Terms of Reference and Operating Arrangements**

**QUALITY, SAFETY AND EXPERIENCE COMMITTEE**

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3.1.9 Review the sustainability of service provision across the Health Board in terms of quality of service, patient experience and model of care provided.

3.1.10 provide advice and assurance to the Board regarding the quality impact assessment of strategic plans as appropriate;

3.1.11 to receive periodic updates in respect of the workforce flu vaccination.

## **4 AUTHORITY**

4.1 The Committee may investigate or have investigated any activity (clinical and non-clinical) within its terms of reference. It may seek relevant information from any:

- employee - and all employees are directed to cooperate with any legitimate request made by the Committee; and
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## **6 MEMBERSHIP**

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 Executive Medical Director  
 Executive Director of Therapies and Health Sciences  
 Executive Director of Primary Care & Community Services  
 Director of Performance  
 Executive Director of Workforce & Organisational Development  
 Executive Director of Public Health  
 Associate Director of Quality Assurance  
 Senior Associate Medical Director / 1000 Lives Clinical Lead  
 Chair of Healthcare Professionals Forum -Associate Board Member  
 Representative of Community Health Council  
 Trade Union Partners

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7.1.1 At least two Independent Members must be present to ensure the quorum of the Committee, one of whom should be the Committee Chair or Vice-Chair. In the interests of effective governance, it is expected that a minimum of two Executive Directors will also be in attendance.

## **7.2 Frequency of Meetings**

7.2.1 Meetings shall be routinely be held on a bi-monthly basis.

## **7.3 Withdrawal of individuals in attendance**

7.3.1 The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

# **8 RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS**

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8.2 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these Terms of Reference,

8.3 The Committee, through its Chair and members, shall work closely with the Board's other Committees including joint committees/Advisory Groups to provide advice and assurance to the Board through the:

8.3.1 joint planning and co-ordination of Board and Committee business; and

### 8.3.2 sharing of information

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.

- 8.4** The Committee shall embed the corporate goals and priorities through the conduct of its business, and in doing and transacting its business shall seek assurance that adequate consideration has been given to the sustainable development principle and in meeting the requirements of the Well-Being of Future Generations Act.
- 8.5** Receive assurance and exception reports from the Quality and Safety Group (QSG)

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## 10. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

- 10.1** The requirements for the conduct of business as set out in the Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

### Quorum 11. REVIEW

- 11.1** These terms of reference and operating arrangements shall be reviewed annually by the Committee and any changes recommended to the Board for approval.

#### **Date of approval:**

QSE Committee 29.11.18

Board 24.1.19

V5.0

**QSE CYCLE OF ANNUAL BUSINESS AND FORWARD PLANNER last updated 12/03/2019 16:42**

**Part 1 – Annual Recurring Business**

<b>Agenda Items</b>	<b>Officer Contact</b>	<b>Jan</b>	<b>Mar</b>	<b>May</b>	<b>Jul</b>	<b>Sep</b>	<b>Nov</b>
Accessible Healthcare Standards Annual Report	<i>Peter Morris</i>			X			
Annual Quality Statement	<i>Ali White</i>		X draft	X final			
Children's Services	<i>Teresa Owen</i>			X			X
CLIC / Quality Report to include section on progress against HIW recommendations; quality aspects of Welsh Risk Pool reports (the value aspect goes to Audit); PSOW?	<i>Shan Kennedy Barbara Jackson</i>	X		X		X	
Clinical Audit – monitoring of outcomes from clinical audit plan	<i>Adrian Thomas</i>		X				Via JAQS meeting
Committee Annual Report (inc Review of Terms of Reference and Approval of Cycle of Business)	<i>Kate Dunn</i>		X final				
Community Health Council joint priorities				X			
Continuing Health Care Assurance Report (for information)	<i>Marianne Whalmsley</i>	X		X		X	
Corporate Risk Assurance Framework (QSE Risks)	<i>Peter Barry</i>			X			X
Dashboard (hams/quality) exception report as required and/or through Associate DQA reports		X	X	X	X	X	X
Equality Annual Report (for info)	<i>Sally Thomas</i>			X			
Executive Quality & Safety Updates <b>In Committee</b> (To sight the Committee on current issues around complex complaints, never events, key risks, Regulation 28s and any significant quality & safety issues)	<i>All Execs</i>	X	X	X	X	X	X

**QSE CYCLE OF ANNUAL BUSINESS AND FORWARD PLANNER last updated 12/03/2019 16:42**

<b>Agenda Items</b>	<b>Officer Contact</b>	<b>Jan</b>	<b>Mar</b>	<b>May</b>	<b>Jul</b>	<b>Sep</b>	<b>Nov</b>
Healthcare Inspectorate Wales Annual Report				X			
Health & Safety (including Corporate Health at Work updates – agreed at CBMG 10.1.19)	<i>Sue Green</i>	X	X	X ann rep	X	X	X
Health Protection (PHW Report)	<i>Teresa Owen</i>	X					
Improvement Group (HASCAS & Ockenden) Chair's Assurance Report	<i>Gill Harris</i>	X	X	X	X	X	X
Infection Prevention & Control	<i>Tracey Cooper</i>	90 day plan update	Full report	90 day plan update	Full report	90 day plan update	Full report
Integrated Quality Performance Report	<i>Ed Williams Jill Newman</i>	X	X	X	X	X	X
Listening & Learning Report (focusing on patient experience and what has changed or is planned as a result of their feedback)	<i>Peter Morris Barbara Jackson</i>		X		X		X
Medicines Management	<i>Berwyn Owen</i>		X ann rep			X key risks	
Mental Health Service Development (CBMG 10.1.19 advised that papers to QSE need to focus on quality improvement aspects, with updates against the strategy going to SPPH)	<i>Steve Forsythe</i>		X		X		X
Mortality & Morbidity (inc lessons learnt from casenote reviews) Frequency to be determined	<i>Melanie Maxwell</i>						
Nurse Staffing Report (as required by Wales Act 2016)	<i>Trevor Hubbard</i>		X			X	
Patient Stories		X	X	X	X	X	X

**QSE CYCLE OF ANNUAL BUSINESS AND FORWARD PLANNER** last updated 12/03/2019 16:42

Agenda Items	Officer Contact	Jan	Mar	May	Jul	Sep	Nov
Policies for Review (as required)	<i>Varies</i>	X	X	X	X	X	X
Primary Care Quality Assurance Report	<i>Chris Stockport</i>		X			X	
Prison Health	<i>Chris Stockport</i>		X			X	
PSOW Annual Letter	<i>PSOW</i>						X
Putting Things Right Annual Report (inc link to PSOW Annual Report)	<i>Barbara Jackson</i>			X			
Quality Improvement Strategy 2017-2020	<i>Deborah Carter</i>				X update		
Quality Safety Group – assurance report	<i>Deborah Carter Caroline Williams</i>	X	X	X	X	X	X
Radiation Protection – Annual Report of Sub Group <i>Scheduling tba</i>	<i>Peter Hiles Helen Hughes Adrian Thomas</i>						
Safeguarding	<i>Michelle Denwood</i>		X		X Ann Rep		X
Standing Items – Opening Business (apologies, declarations of interest, minutes)		X	X	X	X	X	X
Standing Items – Closing Business (items discussed in committee, documents circulated, issues of significance, any other business, date of next meeting)		X	X	X	X	X	X
Tissue & Organ Donation Annual Report	<i>David Southern</i>	X					
Wales Interpretation & Translation Service (WITS) Annual Report	<i>Eleri Hughes Teresa Owen</i>					X	
Welsh Health Specialised Services Committee – Quality & Patient Safety Committee Minutes and/or Chair’s Reports (held in public) <i>obtained from WHSCC website</i>	<i>Cathie Steele WHSCC</i>	X	X	X	X	X	X

**QSE CYCLE OF ANNUAL BUSINESS AND FORWARD PLANNER** last updated 12/03/2019 16:42

<b>Agenda Items</b>	<b>Officer Contact</b>	<b>Jan</b>	<b>Mar</b>	<b>May</b>	<b>Jul</b>	<b>Sep</b>	<b>Nov</b>
Welsh Risk Pool Services and Legal & Risk Services Annual Review	<i>Barbara Jackson</i>		X				

<b>Quality, Safety &amp; Experience Committee</b>  <b>19.3.19</b>	 <b>GIG Cymru NHS Wales</b> Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board  <i>To improve health and provide excellent care</i>
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<b>Report Title:</b>	Pharmacy & Medicines Management Annual Quality and Safety Report 2018-19
<b>Report Author:</b>	Louise Howard-Baker, Assistant Area Director for Pharmacy & Medicines Management (East) Medicines Safety Officer
<b>Responsible Director:</b>	Dr Evan Moore, Executive Medical Director
<b>Public or In Committee</b>	Public
<b>Purpose of Report:</b>	To provide an annual statement to the Committee on Pharmacy & Medicines Management's Quality and Safety using the Health & Care Standards Framework.
<b>Approval / Scrutiny Route Prior to Presentation:</b>	Via Chief Pharmacist (Dr Berwyn Owen) and Executive Medical Director (Dr Evan Moore)
<b>Governance issues / risks:</b>	The risks highlighted in the report cover: <ul style="list-style-type: none"> <li>• Pharmacy support to Mental Health Division;</li> <li>• The replacement of the pharmacy robots in Ysbyty Gwynedd and Wrexham Maelor;</li> <li>• Medicines shortages;</li> <li>• Pharmacy support to cancer services in Bangor and Wrexham;</li> <li>• Recruitment;</li> </ul>
<b>Financial Implications:</b>	None
<b>Recommendation:</b>	The Committee is asked to note the report.

<b>Health Board's Well-being Objectives</b> <i>(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)</i>	√	<b>WFGA Sustainable Development Principle</b> <i>(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.)</i>	√
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	✓

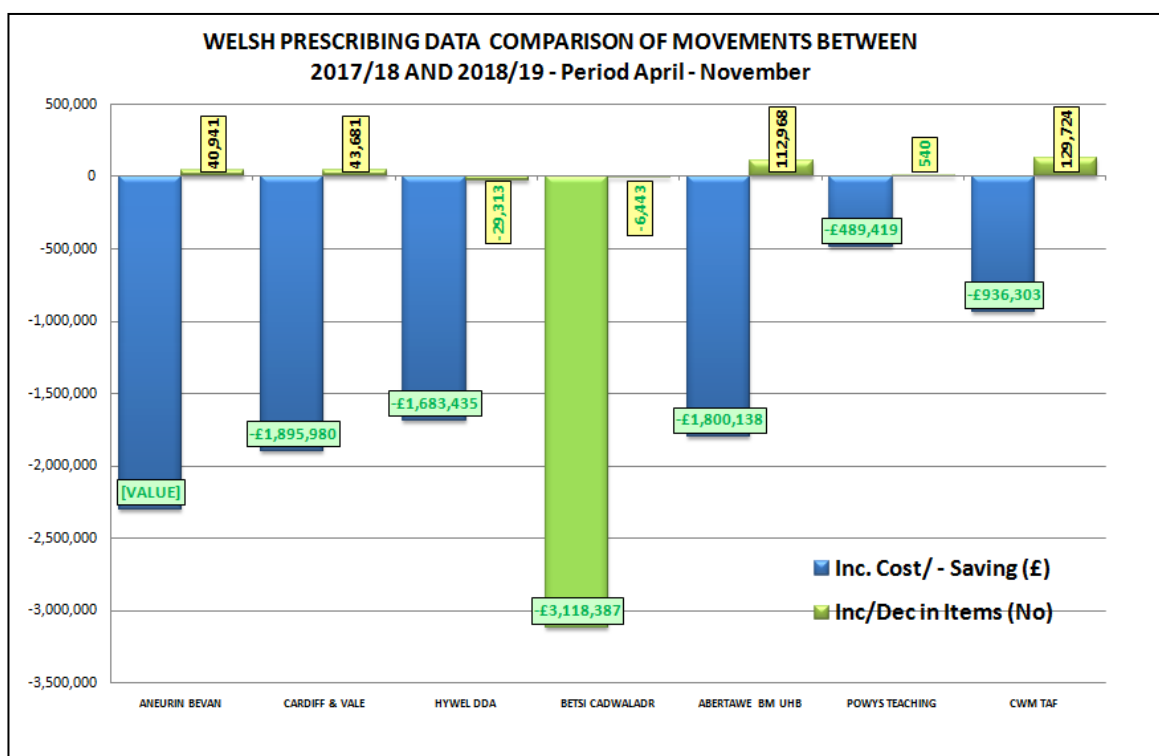


3.To support children to have the best start in life		3. Involving those with an interest and seeking their views	✓
4.To work in partnership to support people – individuals, families, carers, communities - to achieve their own well-being	✓	4.Putting resources into preventing problems occurring or getting 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	✓		
<b>Special Measures Improvement Framework Theme/Expectation addressed by this paper</b>			
Leadership and Governance			
<b>Equality Impact Assessment</b>			
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 sites in Wales for a Sore Throat Test and Treat service.

There are several milestones set by the 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.

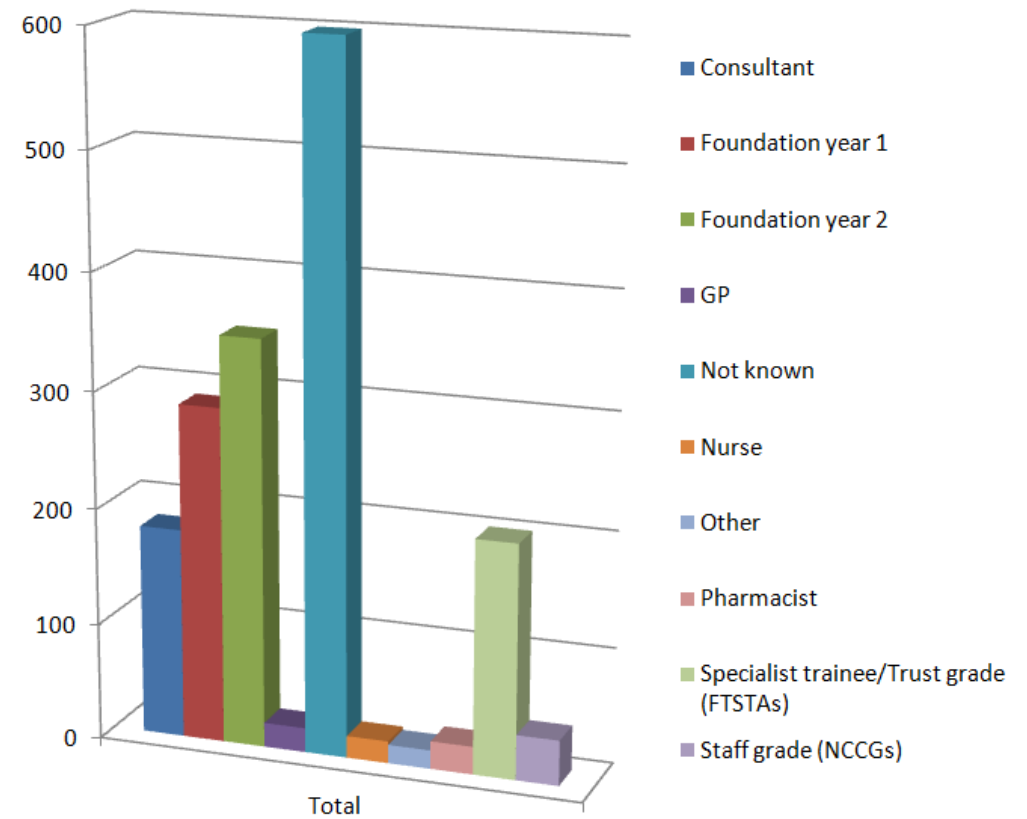
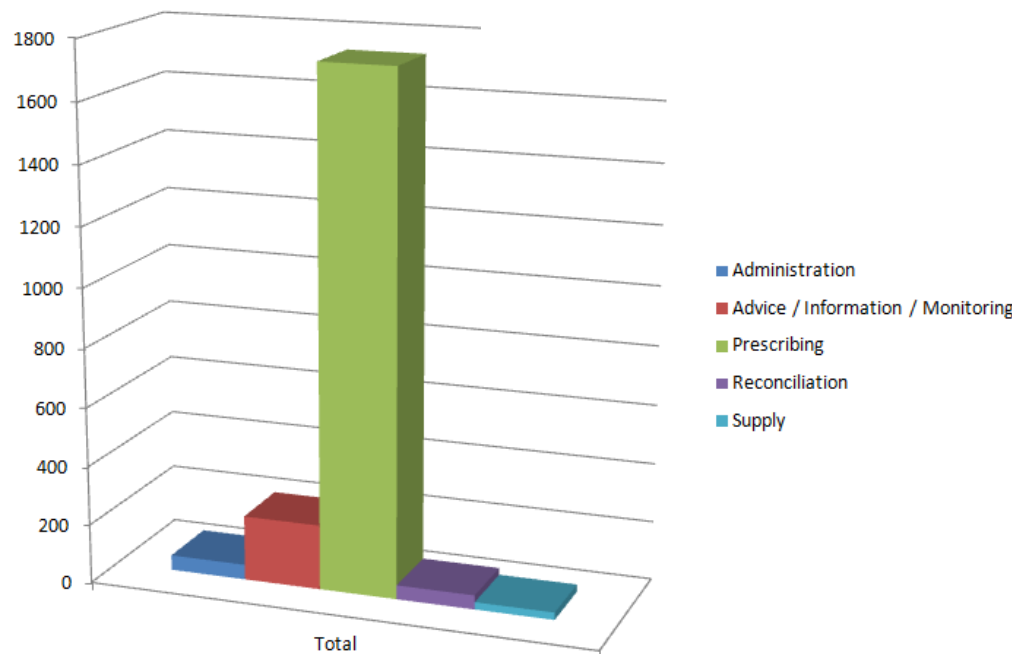
## Interventions

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%





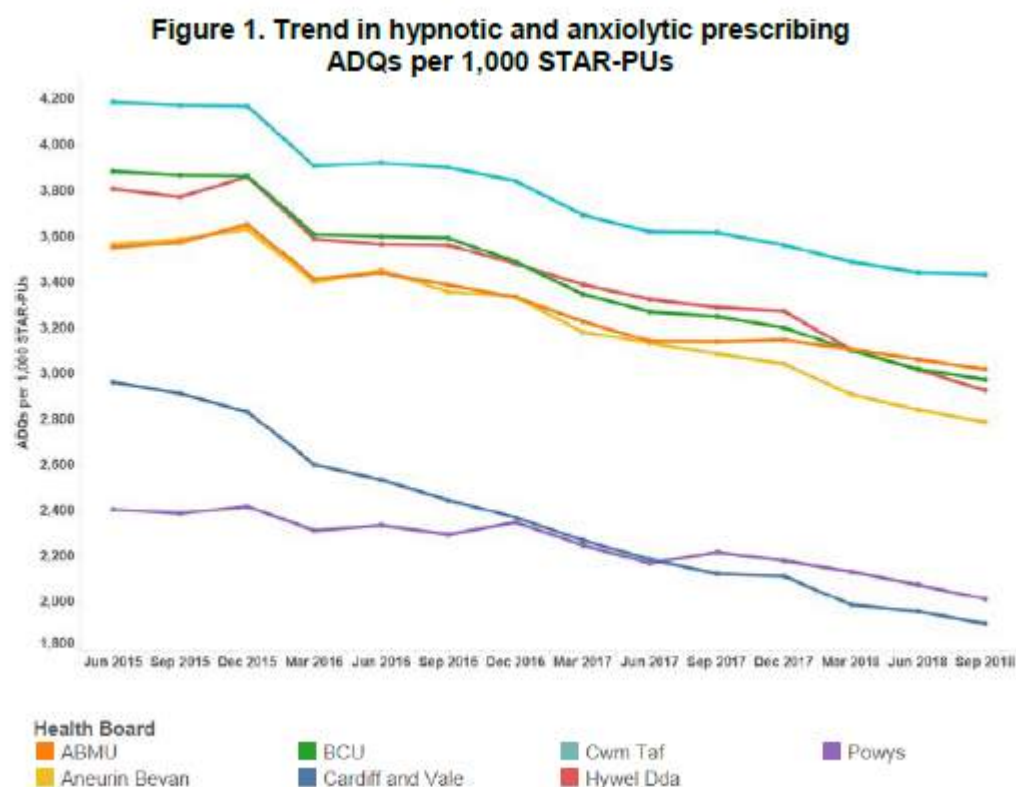
## 2.3 Falls

Pharmacy and Medicines Management is a member of the strategic falls group. At Ysbyty Glan Clwyd (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 5<sup>th</sup> best in Wales.

The Primary Care Pharmacy and Medicines Management 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.



## 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



Fridge Temperature Monitoring											
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### 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 1<sup>st</sup> 2018-Jan 31<sup>st</sup> 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

### 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.
- Hydrocortisone 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
- Hypercholesterolaemia 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 AWMMSG 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.

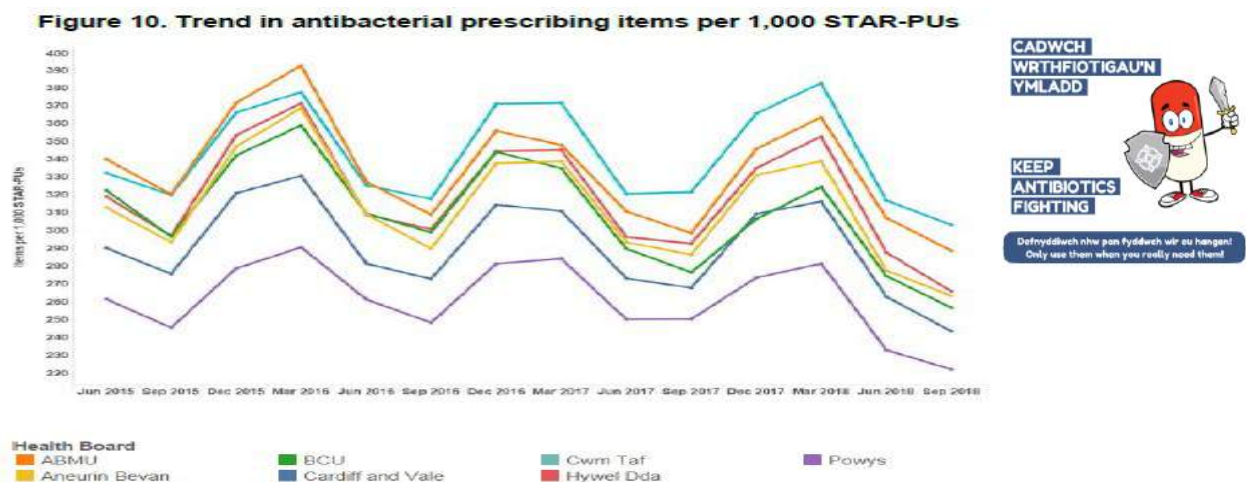
In addition, there are four specific safety indicators comparing the prescribing of sleeping tablets (hypnotics and anxiolytics – see Section 2.3 *Falls Prevention*) and analgesics as there is widespread concern about the appropriate use and review of these medicines, together with the potential for 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 indicators 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 3<sup>rd</sup> best in Wales.



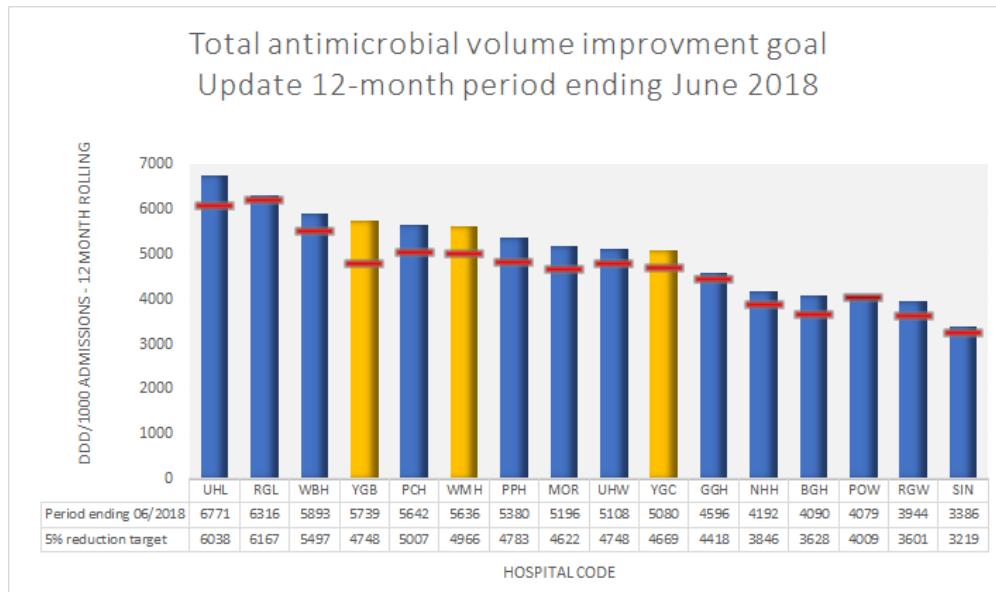
Some of the interventions that have been undertaken to achieve this reduction include:

- **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.

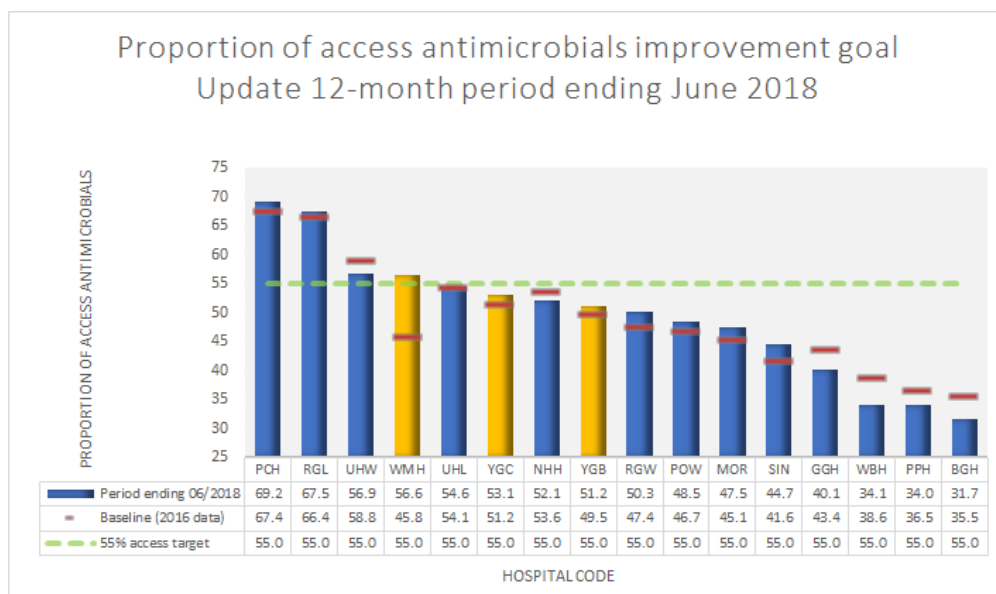
Future work includes:

- 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.



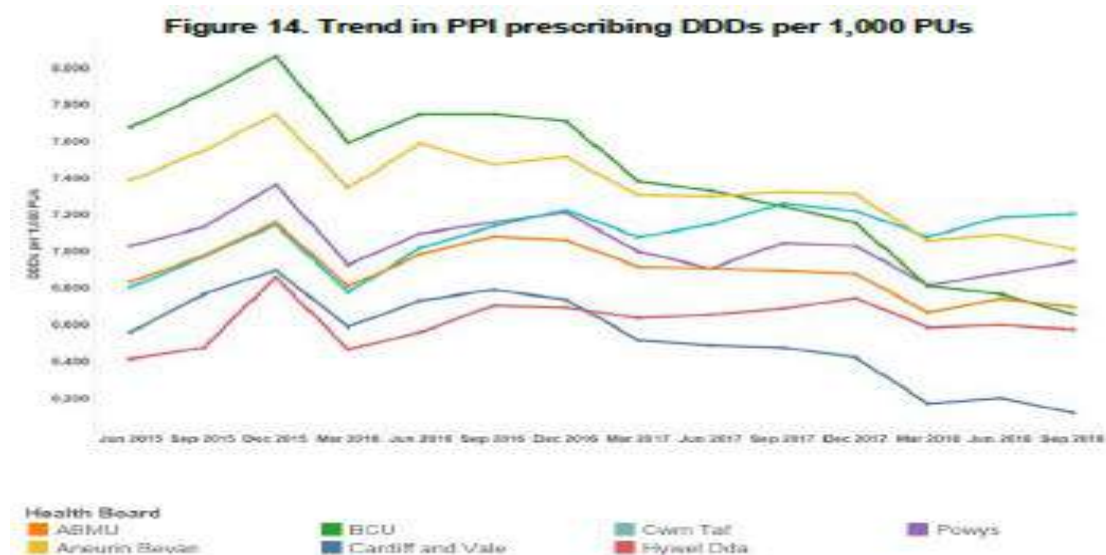
However the antimicrobial pharmacists have set about to restrict access to certain antibiotics (World Health Organisation Access Antimicrobials) by removing ward stocks and as a result, all three acute hospitals have improved, with Wrexham surpassing the target for this indicator. An Antimicrobial Restriction Policy has been



produced to support this agenda.

### 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 1,000 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 3<sup>rd</sup> best in Wales.



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°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.

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 if 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:

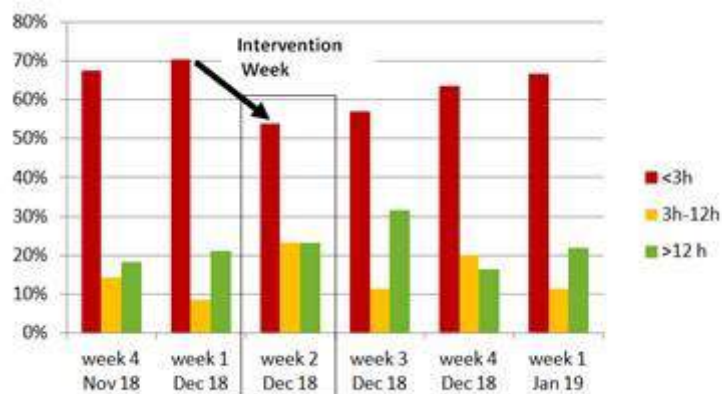
- Area
- Specialty
- Discharge Destination
- Ward
- Consultant
- e.g. home, hospital

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 form. 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 allow 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.

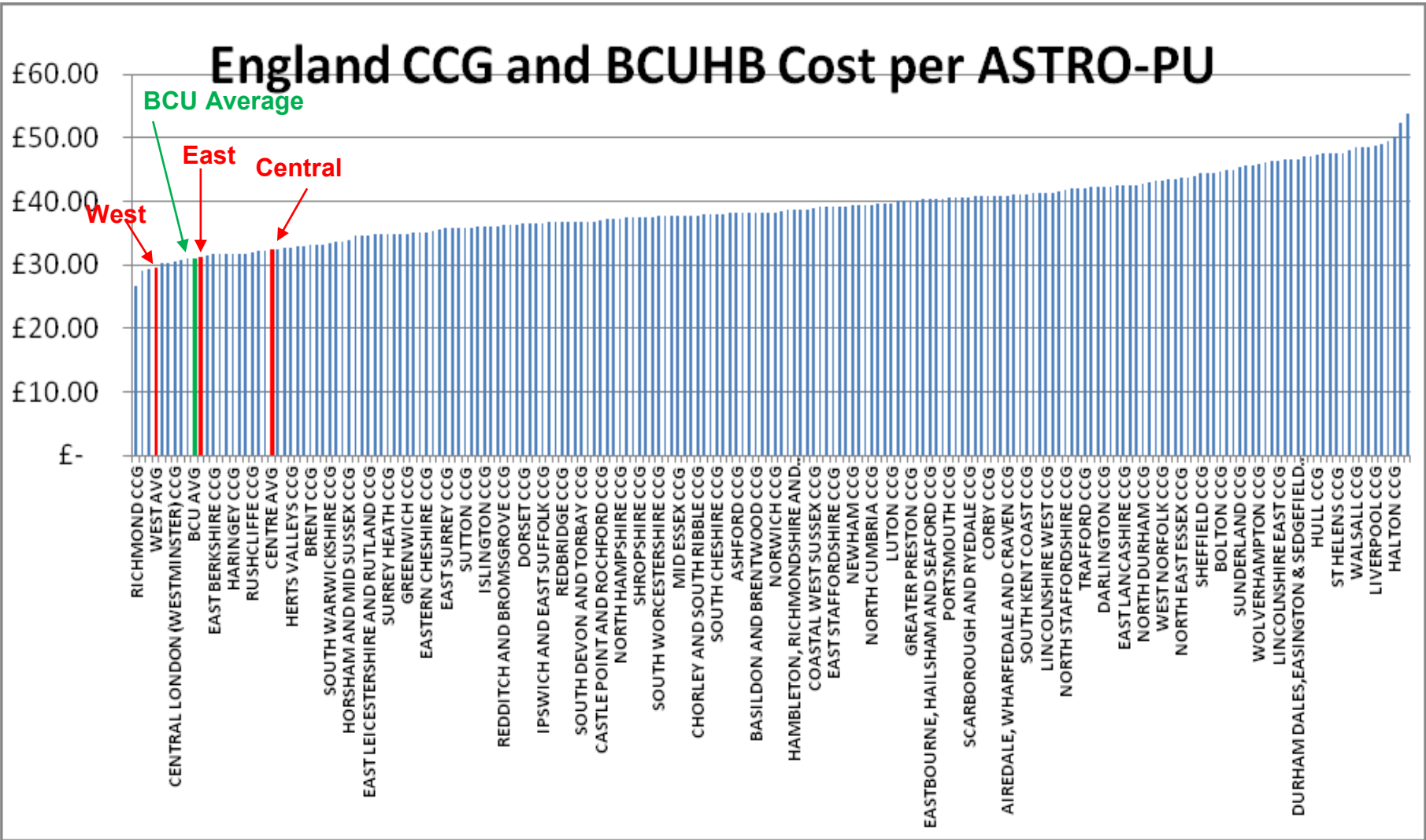
### Workforce Performance

	Target/ comparator	BCU	Central	East	West	Exception report
PADRs (M9)	85%	67.6%	60.8%	88.4%	54.4%	Central: action plan in place, improved from 35% in July 2018 West: action plan in development
Mandatory training (M9)	85%	87%	82%	89%	93%	
Sickness absence (M9)	4.55%	3.04%	2.19%	1.64%	5.64%	
Maternity rate (YTD)	BCU average		4.57%	3.01%	4.47%	
Staff turnover rate (YTD)	7-9.5% 6-6.9% OR 9.6-10.5% <6% OR >10.5%		16.0%	8.5%	9.5%	

### Key Risks

The key risks are relating to medicines management in BCUHB taken from the risk register are:

- 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



**Quality, Safety & Experience  
Committee**

**GIG  
CYMRU  
NHS  
WALES**

 Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board

19.3.19

*To improve health and provide excellent care*

<b>Report Title:</b>	Mental Health & Learning Disabilities (MHLD) Division Update on Quality Improvement Governance Plan (QIGP)
<b>Report Author:</b>	Mr Steve Forsyth, Director of Nursing, MHLD Division
<b>Responsible Director:</b>	Mr Andy Roach, Director of MHLD
<b>Public or In Committee</b>	Public
<b>Purpose of Report:</b>	<p>This report provides an update to the Health Board on the Special Measures Improvement Framework (SMIF) and specifically updates on the Quality Improvement &amp; Governance Plan that draws together a series of improvement themes in response to the Special Measures Improvement Framework.</p> <p>Key achievements to note within the report include:</p> <ul style="list-style-type: none"> <li>• Improvements to pathways particularly Older People's Mental Health (OPMH)</li> <li>• Staff engagement initiatives and communication</li> <li>• Improvements to the environment</li> <li>• Clinical governance arrangements</li> <li>• Proposed changes to the workforce</li> </ul> <p>The report also highlights the direction of travel and key actions for delivery over the next 90 days will be:</p> <ul style="list-style-type: none"> <li>• Production of a Division wide action plan that engages with each of the area teams</li> <li>• Development of the quality improvement strategy to articulate what good looks like for sustained improvement</li> </ul>
<b>Approval / Scrutiny Route Prior to Presentation:</b>	Detail has been discussed within SMIF updates MHLD Divisional Directors
<b>Governance issues / risks:</b>	Details relating to Welsh Government (WG) Serious Incidents (SIs) articulated in the report, a paper detailing this has been presented to the BCUHB Quality Safety Group (QSG).
<b>Financial Implications:</b>	None of significance to currently note. Funding received from Welsh Government.
<b>Recommendation:</b>	The Committee is asked to note the contents of the report setting out the improvements to date through Special Measures, detail the Quality Improvement & Governance Plan, Appendix 1 being the updated Implementation Plan, Appendix 2 being the driver diagram for the 10

key themes and Appendix 3 the prepared report for Executives attending Public Accounts Committee (PAC) on 4 <sup>th</sup> March 2019			
<b>Health Board's Well-being Objectives</b> <i>(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)</i>	√	<b>WFGA Sustainable Development Principle</b> <i>(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.)</i>	√
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	√		
<b>Special Measures Improvement Framework Theme/Expectation addressed by this paper</b>			
Mental Health			
<b>Equality Impact Assessment</b>			
Not required for an update paper of this nature.			

*Disclosure:*

*Betsi Cadwaladr University Health Board is the operational name of Betsi Cadwaladr University Local Health Board*

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## 1. INTRODUCTION

This paper provides an update to the Health Board on the Special Measures Improvement Framework (SMIF) in place with Welsh Government. The paper will provide a progress report against the actions listed in the MHL Division's Quality Improvement & Governance Plan (QIGP).

## 2. BACKGROUND

Previous reports have provided updates to the Board about improvements required under the SMIF, which have been achieved within the MHL Division, the latest report provided in November 2018.

## 3. QUALITY IMPROVEMENT GOVERNANCE PLAN

The QIGP is articulated as a series of actions and these are provided in Appendix 1. In this quarter of the reporting cycle there have been phenomenal changes and developments which have been instrumental on the progress made against the QIGP. Improvements and service developments have occurred division wide as well as more localised changes, which are specific and relevant to our population we serve.

Notable success has occurred with our partner organisations working alongside BCUHB to achieve shared visions and goals as well as meeting the needs of the community through consultation and engagement in co-production initiatives.

The QIGP is guided by 10 broad improvement themes (Appendix 2). A number of initiatives, projects and improvements have been made. The scope of these improvements have been far reaching and varying in size.

Using the TODAY ICAN methodology MHL 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.

## ACHIEVEMENTS AGAINST 10 KEY THEMES

### Care Pathways

#### **Barbers initiative** ✓ **Care pathways**

As part of the Mental Health strategy, Barbers across North Wales received training to identify signs of mental health problems in customers and provided skills in how to listen, give advice and signpost to support services. BCUHB's CALL helpline is widely advertised within the initiative raising its profile as an accessible and confidential helpline for people in North Wales.

This ICAN initiative was launched on Monday 19<sup>th</sup> November on International Men's day with a view to raise awareness of male suicide and end the stigma associated with men's mental health.

The evolution of the initiative came from the West Local Implementation Team (LIT). The chair of the West LIT identified that *"The training was the first step towards building resilient communities which are empowered to take ownership and responsibility towards making changes to improve people's lives."* The project has been so successful and so popular that the LITs are considering other customer facing services that would like to be involved.



**It's OK not to be OK**



#barbers4mentalhealth #Internationalmensday

**End of life care framework for older person's mental health (OPMH) ✓ Care pathways, ✓ Patient and carer experience, ✓ older person's dementia care, ✓ Environment**

Through co-production an end of life pathway has been developed for older persons on dementia wards. There has also been an emphasis on developing and delivering new staff training which equips staff to understand the complexities of caring for patients who are near to end of life and deliver high quality care.

As part of this work stream, an OPMH ward in the Heddfan Unit has recently opened a new suite which has been refurbished to provide a dignified setting for people with dementia to receive end of life care. Alongside this refurbishment there are facilities to ensure that family can stay close to their loved one.



### **ICAN centres ✓ Care pathways**

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 (ED) 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.

All I CAN centres are run by 3rd sector organisations who have extensive experience of working with people who are in crisis or require support when in emotional distress. Below captures teams in Ysbyty Glan Clwyd and visitors from Welsh Government



### **Environment**

#### **Refurbishment of Tegid ward ✓ Environment**

The refurbishment of Tegid ward has now been completed. A number of areas were addressed. The ward has been re-decorated to make it more aesthetically pleasing for patients, visitors and staff. The reception was previously located in a place that prevented clear observation. The re location of the reception has created an open-

plan space making the environment feel more spacious and light. All areas have had anti-ligature work completed where appropriate.

### **Refurbishment - Gwanwyn Ward ✓ Environment**

The refurbishment of Gwanwyn OPMH ward is currently underway. A number of works have been completed. A room which was not being used for patient care has been turned into a quiet room for patients. Staff approached Coleg Cambria art department and invited a team of students in to decorate the room. The artwork has provided a calming and serene backdrop for patients.



### **Patient Carer Experience**

#### **TODAY We Talked - Tryweryn Ward ✓ Patient and Carer Experience ✓ Culture**

This initiative evolved from the TODAY ICAN methodology. The ward manager wanted to save staff and patient time. Recognising that when patients were having periods of extreme distress, the situation would often escalate, with an increase in restraints being noted.

The consequences of restraining a person can be significant, impacting on therapeutic relationships, trust, recovery, heightening the risk of injury to staff/patient but also creates an unsettled atmosphere. By using de-escalation techniques and activities to distract the patient, there has been notable reduction in time used for restraining and follow up actions.

The initiative is an extremely good example of TODAY ICAN. The manager and his team have been invited to present at the next TODAY ICAN conference as an example of how to apply the methodology that impacts on patient care.

#### **Sensory Boxes ✓ Patient and Carer Experience**

In the PICU in Heddfan, a mental health staff member used the TODAY ICAN methodology to create a sensory box which contains visual and tactile props. The box serves the purpose of helping focus, distract and stimulate patients.



## **Safeguarding and Public Protection**

### **Sexual safety initiative ✓ Safeguarding and Public Protection ✓ Patient and Carer Experience ✓ Communication**

MHLD services are working alongside CANIAD with a user led project. Surveys were completed by service users and staff to define a shared definition of sexual safety and identify barriers to achieving it. This has now been accepted as a co-produced paper for academic publication. In partnership with Bangor University and Caniad, the next stage of this initiative is running appreciative inquiry (AI) workshops. The aim of the AI workshops is to inform the development of practice guidelines, appropriate and current staff training packages as well as patient information leaflets.

## **Older Persons Dementia Care**

### **Dementia Friendly name badges ✓ Older Persons Dementia Care ✓ Patient and Carer Experience**

Following a unique collaboration between staff from Bangor University and BCUHB, new approaches have been developed to improve staff and patient relationships as patients with dementia were struggling to read name badges or remember staff names.

Bangor University students used Applied Behaviour Analysis (ABA). ABA uses an attentive observation of the person with dementia and their behaviours and the meticulous collection and analysis of data. This is then used to design interventions that will address that person's individual needs.

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. When patients and their families know the names of staff, it makes it easier to build a positive and therapeutic relationship.







progress in relation to the complaints process and addressing complaints and concerns in a timely manner. The Division has no concerns over three months, and there is a downward trend in the number of formal complaints, and an upward trend in the number of One the Spot (OTS) concerns being addressed and resolved locally.

The Governance Team have developed new methods for capturing actions that arise from complaints and SI's and have a robust system in place in order to review actions on a regular basis. New methods of shared learning approaches are being harnessed to ensure that there is cross-divisional learning. These come in the format of visual and concise notifications. There will be support from the communications team to ensure this is a successful learning exchange across the division.

### **Our Workforce**

#### **Mental Health Nurses Day ✓ Workforce ✓ Communications ✓ Culture**

On 21<sup>st</sup> February BCUHB celebrated Mental Health Nurses Day to thank and recognise the hard work and commitment of our MHLN nurses. This attracted significant media attention and captured amazing feedback from people within our communities reflecting on their positive experiences of MHLN services from individuals.



The event was supported by BCUHB's own Chief Executive, Directors as well as a special visit from the Chief Nursing Officer Professor Jean White.

#### **Happy Birthday Learning Disability Nurses ✓ Workforce ✓ Communications ✓ Culture**

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.





**Come and celebrate 100 years of Learning Disability Nursing**  
**Villa 16 Bryn Y Neuadd Hospital from 10 am – 3pm**  
**on St David's day Friday March 1<sup>st</sup> 2019**

There will be cake and refreshments – of course, patient's art work, softolls, photographs, awards display, chat with the fabia from "Today I can" and through a PowerPoint loop of positive achievements of learning disability nurses over time, make a pledge and take time to meet and network through the day. It will be an informal celebration of some of the wonderful things that LD Nurses do... and for those who would like it, a Books beyond Words workshop at the end of the day! See you all there! Why not bring your photos? and if there's something special you would like to do then email me [jackie@brynyneuadd.nhs.uk](mailto:jackie@brynyneuadd.nhs.uk) and I can ask our student nurses there to help you arrange it.



### **Healthcare support worker (HCSW) forums** ✓ **Culture** ✓ **Workforce** ✓ **Communications**

Recognising the dedicated and committed teams of HCSW's in MHL D is essential for the contribution they make to patient care. In February 2019 the first cohort of LD HCSWs attended and participated in a dedicated HCSW forum. The forum provided much needed protected time for HCSWs to receive news, updates and a chance to reflect on the importance of their role in delivering quality patient care. Equally, it was an opportunity for the Director of Nursing for MHL D to thank the HCSWs for their hard work and commitment.

### **Staff engagement** ✓ **Workforce** ✓ **Communications**

Trained Listening Leads act as the link co-ordinator between the staff group and senior managers. The Director of MHL D meets with Listening Leads across the division to discuss the concerns and issues of the staff with whom they represent. The last Listening leads meeting took place on 26<sup>th</sup> 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.



### **Be Proud ✓ Workforce ✓ Communications ✓ Culture**

To further improve staff engagement, the “Be Proud Pioneer Programme” is now being rolled out. 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. The MHL service have gained 6 places on the very first cohort which is due to start in March 2019.

## **4. HIW Inspections**

In January 2019 the Ablett unit located in Ysbyty Glan Clwyd had an unannounced HIW inspection. Feedback was shared from the recent HIW inspection that took place. A summary was given including:

Team observed as being close knit with good level of communication ✓ **Communication**

There was compassion between staff and patients ✓ **Culture**

Patient experience on all units was very positive. Patients stated that they received excellent care ✓ **Patient and Carer experience**

Infection prevention was a high standard ✓ **Clinical Governance** ✓ **Culture**

Increase in staff morale through investment of training, development reviews and supervision ✓ **Culture** ✓ **Clinical Governance** ✓ **Workforce**

Acute care meetings well attended ✓ **Culture** ✓ **Care Pathways**

Care plans very patient centred ✓ **Care Pathways**

The impact of this feedback and the external validation has confirmed the progress made and also encouraged our shared understanding of “what good looks like”. These will form part of our Quality Improvement Strategy to be reported on in September 2019.

## **5. TODAY ICAN**

**TODAY ICAN Conference** ✓ **Culture** ✓ **Workforce** ✓ **Communications**

On 20<sup>th</sup> December 2018 the formal launch of TODAY ICAN took place with a division wide TODAY ICAN conference. The event was over-subscribed and 130 delegates attended.

Guest speakers Professor Brian Dolan OBE and Lynda Holt introduced the TODAY ICAN change methodology to the delegates in an interactive and thought provoking style. Senior managers within the MHLD division shared their personal stories of the impact of TODAY ICAN in their work.

Some comments received about the event:

***“Brilliant conference today, emotional at times, hilarious at others and interesting from beginning to end. Lots of new ideas to take back to the ward.”*** Leanne @Lilith1411

***“The day was thoroughly enjoyable and all speakers were truly inspiring! I’m already inspired and know that this initiative CAN make a big difference within my team and ultimately for patients.”*** Joanne Jeffreys – Business Support Manager

***“Feeling privileged to be part of a fantastic and empowering conference today. Let’s all get on board and spread the word #TODAY ICAN”*** Laura Richards

The success of the conference has had a dramatic impact on the enthusiasm and inquisitive nature of staff. The intended output of the conference is to set the tone for staff to question their own narratives, which can stimulate a positive environment for change to occur. The sessions are contagious and invigorating, which encourages staff to leave the session with tools and confidence to make changes.

The next TODAY ICAN event is due to take place on 3<sup>rd</sup> April 2019 and with 4 weeks to go it is already oversubscribed. To meet demand, the event has now been moved to a larger venue with a capacity of 220.

### **Commencement of TODAY ICAN team ✓ Workforce ✓ Communications ✓ Culture**

At the beginning of the New Year the Improvement Lead Programme Manager and three TODAY ICAN Change Facilitators commenced in their roles. The fourth facilitator is due to start in April 2019. On the 14th January 2019 the team received “Train the Trainer –TODAY ICAN”. This has enabled them to spread, embed and deliver localised training.



The team have been actively supporting staff in promoting changes that they are making and also in the development of ideas. The enthusiasm and appetite that staff

have to make small but significant changes has been overwhelming. Some instant changes that staff have been empowered to make are:

- Replacing kettle in patient kitchen area with a safer alternative
- Appropriate utensils sourced and provided to improve safety and meet the needs of people who are admitted to our inpatient wards
- Removing old children's sensory toys from dementia ward to replace with age appropriate sensory equipment.

Other ongoing initiatives that the team are supporting include:

- Undertaking a service redesign of substance misuse services (SMS) in Central to reduce the frequency of people who do not attend appointment (DNA) and encourage clients on treatment to engage with psychosocial interventions
- Procuring and rolling out an electronic prescribing service to reduce the number of prescribing errors in SMS services and also to reduce staff time in handwriting prescriptions.
- Establishing funding to enable MHL D staff to undertake a Certificate of Mental Health and Deafness qualification in order to better communicate and support MHL D patients who have a hearing impairment
- Developing forums for staff to share best practice and peer support
- Using TODAY ICAN to support BCUHB staff engagement initiatives within MHL D
- Sexual Safety appreciative inquiry workshops in order to scope out the development of practice guidelines, user information books and shared training.
- Developing Activities Co-ordinator training for staff working with patients with Dementia
- Securing the loan of a portable ECG machine to allow MHL D staff to do ECGs for patients who are on anti-psychotic medication but unable to attend appointments to improve medicines management and patient safety and reduce DNA's

The Improvement Lead has also been nominated to undertake the "1000 Lives Improvement Advisor" programme. This exciting programme is in high demand and has very limited places available. Completion of the programme will not only benefit the MHL D but wider BCUHB by becoming one of the few Improvement Advisors within the organisation.

### **TODAY ICAN QIGP 90 cycle review**

TODAY ICAN (TIC) team, triumvirates and TODAY ICAN change champions came together to review the 10 key areas of the QIGP (Appendix 2).

The TIC team facilitated an interactive and stimulating session to capture work that has been completed under the QIGP and actions to prioritise for the next 90-day cycle.

A Division wide work plan approach has been agreed and will be co-ordinated by the TIC team. This will engage each of the 4 area teams in Division wide changes and will be presented to the Board May 2019.



### **Quality and Workforce Groups – A new approach**

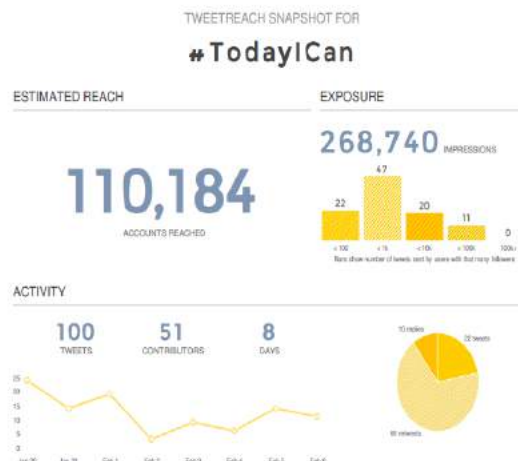
Never one to do things in the same old way, the Director of Partnerships enlisted the support from the TIC team to co-facilitate and develop an interactive, accelerated learning event for the 7 Quality and Workforce (Q&W) groups.

### **TODAY ICAN and social media ✓Communication**

#TODAYICAN on twitter has become a regularly used hashtag by MHL D staff on twitter when they have used their initiative and overcome problems or set their mind to achieve something in the workplace.

In November 2018 the #TODAY ICAN reached 54,415 accounts and made 89,561 impressions. At the beginning of February 2019, it has reached 110,184 accounts and made 268,740 impressions.





TODAY ICAN has a place in BCUHB's Staff connect smart app. Good news stories and events become part of a showcase as well as the BCUHB Diary promoting attendance at our TODAY ICAN training.

## 6. CNO Annual Conference

Following calls for submissions of abstracts for oral and poster presentations at the 2019 CNO Conference, MHL D leaders submitted an abstract to share and celebrate the innovative approach of TODAY ICAN to improve patient care. In our first online survey, previous attendees were asked if they felt empowered to make small changes 8 weeks after the event. 100% of respondents answered yes. When asked whether attendees had made a small change to improve patient care; 96% responded yes.

## 7. Next steps

### Quality Improvement Strategy

As part of the QIGP, the MHL D have pledged a commitment to produce and launch a Quality Improvement Strategy. The strategy will be developed in consultation with staff, partners and people with lived experience of using our services. Whilst the division have made significant changes, it is important to maintain a focus on the future and hold ourselves to account. 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. We will be including clear statements on what good looks like (through quality indicators), how we will know when we have got there, how we get from good to great and importantly having a section on Always Events which will be co-produced.

With a commitment to launch the strategy in July 2019, the working group are set to form and establish the TOR in March 2019.

### Local Delivery Plans

In order to avoid the risks and complications of a multitude of action plans, the TODAY ICAN team are in the process of capturing local objectives and improvements from the different areas and bringing them under the umbrella of the 10 key themes referenced in the driver diagram (Appendix 2). The TODAY ICAN team will work with the 4 area

management teams to ensure that actions are reviewed and completions are evidenced accordingly.

### **Staff Engagement**

The first cohort of the Be Proud Pioneer Programme are due to commence their training in March 2019 and will receive regular mentoring and support from Organisational Development representatives. Feedback from the cultural diagnostic tools will influence the way that staff engagement is approached. Future teams will be identified from MHL D to participate in Be Proud and will be placed on cohorts 2, 3 and 4.

Following the results of the staff survey, further staff engagement sessions are to take place to look and resolve key issues for MHL D staff. The engagement approaches will be multi-faceted to reach a large audience and overcome the geographical, IT and availability obstacles that are often a barrier.

### **Workforce restructuring**

Two significant workforce developments have been approved and just commenced in the consultation stage. These include an inpatient establishment review that will lead to a more stable staffing structure. The tier 5 and 6 staffing structures include changing of roles, removing of certain roles and creation of additional posts that reflect meeting the needs and demands within the services.

### **Environment**

Work has just commenced on refurbishing the S136 suite in Wrexham which was in need of updating and making it fit for purpose. The work is set to take six weeks and in the mean-time a temporary S136 suite has been located in Heddfan until works have been successfully completed.

### **Ward accreditation**

A lead for MHL D has been identified to continue driving forward the Ward accreditation initiative. Additional assessors will be identified and relevant Ward Accreditation boards will be designed for MHL D services.

### **Medicines Management**

The TIC Improvement Lead will be presenting to the Medicines Management Group to identify priority actions and establish key individuals to take responsibility in addressing further areas in the Medicines Management improvements.

### **Acute Care Pathways**

As a priority the TIC team will be working closely with Triumvirates to establish a working party to address key concerns in the Acute Care Pathway.






## **MHLD Division**






### **Quality Improvement & Governance Implementation Plan (QIGP)**

 Completed
  Underway
  Overdue

ACTION	TIMESCALE	LEAD PERSON	PROGRESS REPORT	FURTHER ACTION
1) Launch of the QIGP within area triumvirate: <ul style="list-style-type: none"> <li>▪ Celebration of progress to date.</li> <li>▪ Fusion of I CAN and TODAY = TODAY ICAN.</li> <li>▪ Inform of change methodology.</li> <li>▪ Introduction to the format and template of Local Delivery Plan tool (LDP).</li> <li>▪ Collaboration on the governance structure to ensure robust scrutiny and implementation of the LDP.</li> <li>▪ Review of QIGP, internal and external reviews and reports that identify the themes and trends to develop LDP</li> </ul>	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	

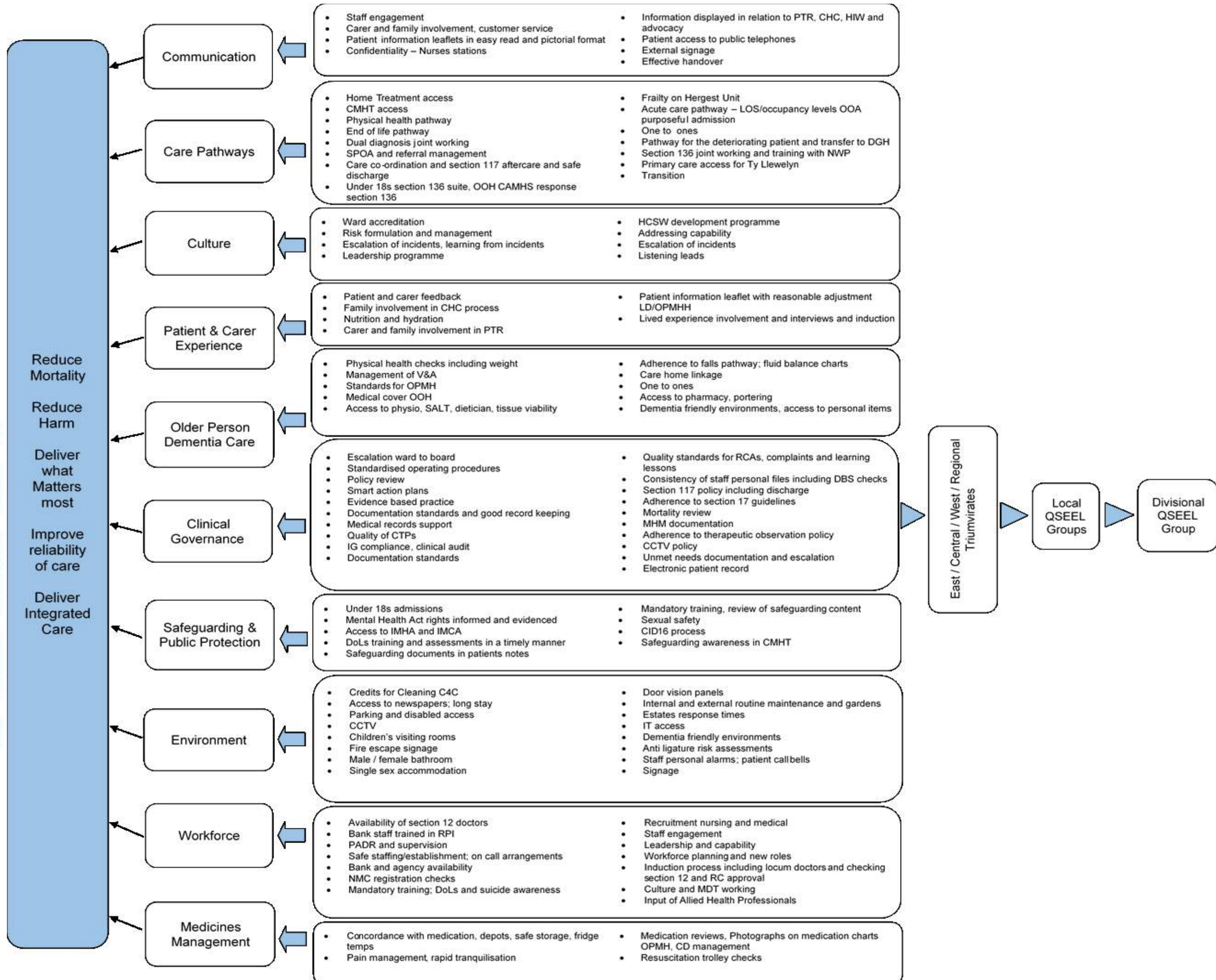
2) Advertisement and recruitment of 1.0 WTE band 8a Change Agent Lead and 4.0 WTE band 5 Change Champion Support Managers	July 2018 for advertisement	Director of Nursing MHL D	Action complete Recruitment complete with the West Service Improvement Facilitator commencing in April 2019	✓
3) Intake of first Change Lead agents cohort – TODAY: <ul style="list-style-type: none"> <li>▪ Triumvirates (HOP, HON, CD's)</li> <li>▪ Safeguarding</li> <li>▪ Nurse Consultant</li> <li>▪ Academic Lead</li> <li>▪ Head of Governance</li> <li>▪ Investigating team officers.</li> </ul>	September 2018	Director of Nursing MHL D	<u>Action complete</u> Training event has taken place in October	✓
4) Intake of first Change champion agents – TODAY: Operational staff	September 2018	Director of Nursing MHL D	<u>Action complete</u> This training has taken place in December 2018	✓
5) 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: <ul style="list-style-type: none"> <li>• Safe</li> <li>• Experience</li> <li>• Effectiveness</li> </ul> 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	✓
6) Benchmark survey on how the MHL D 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.	✓

7) 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 MHL D, Director of Operations, Director of Partnerships, Director of Transformation, Medical Director	<u>Action Complete</u> Change agent training completed December 2018	✓
8) 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	✓
9) 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	✓
10) 2/52ly TODAY Lead change agents accountability meetings with Brian Dolan and DoN MHL D	December 2018	Director of Nursing MHL D	The Improvement Lead for TIC meets every 6 weeks with Healthcare 360 for support and progress reviews	✓
11) 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	✓

12)LDP action plans to identify achievements, leads, plans to progress, support required, options appraisals, prioritisation, risk mitigation to support delivery, outcomes of completion	December 2018	Heads of Nursing, Clinical Director, Head of Operations	<u>Action Complete</u> Guided by an overall plan which is progressed through the 4 area teams progress is monitored and tracked by the TIC team using a 90 day cycle	
13)Implementation of MHL D ward accreditation.	February 2019	Heads of Nursing	Designated Lead will continue with the implementation of the Ward Accreditation and design MHL D appropriate Boards. There are still wards which require ward accreditation visits	
14)Presentation of LDP to area Quality and Safety Group	February 2019	Heads of Nursing, Clinical Director, Head of Operations	This is being developed by the TIC team to track progress against the 10 themes of improvement	
15)LDPs presented to MHL D QSE	February 2019	Heads of Nursing	This is being progressed by providing updates from the TIC team who tracks progress against the driver diagram in appendix 2	
16)Sign off of LDP at Divisional Director meeting	March 2019	Director of Nursing MHL D	Regular updates are provided to Divisional Directors on progress of the actions relating to 10 key themes	
17)Implementation of LDP through a 6 month improvement trajectory	April 2019	Heads of Nursing Clinical Director Head of Operations	Triumvirates will work alongside the TIC team using the overall work plan and achieve completions in 90 day cycles	

18)Monitoring of LDPs as a continuous cycle of quality improvement via Quality & Safety groups	May 2019 and monthly review	Heads of Nursing, Clinical Directors, Head of Operations	Local QSEEL meetings take place with a set agenda to review	
19)Monitoring of LDP's through QSE & Divisional Directors	May 2019 & monthly review	Director of Nursing MHL D, 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 in appendix 2	
20)Establish steering group to develop MHL D 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 MHL D Quality strategy	July 2019	Director of Nursing, MHL D	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, MHL D	To be finalised nearer the date.	





**Mental Health Learning Disability Division (MHLDD)**

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## 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 (MHLDD) Strategy and Quality Improvement and Governance Plan (QIGP), which is a specific requirement of the Special Measures Improvement Framework (SMIF).

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 achieved within BCUHB to date and sets out the intended methodology and implementation time scales to progress the MHLDD Division from good to great.

## 2. INTRODUCTION

**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.**

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.

### 3. BACKGROUND

The mental health strategy was developed in 2016 at a time when the BCUHB MHL 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.

### 4. 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.

#### 4.1 Developing integrated care closer to home

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 (LITs), 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.

The overall implementation architecture will therefore default to six LITs, one for each of the six local authorities in North Wales. These LITs have lead responsibility for implementation of the Mental Health Strategy for North Wales in their area.

Specifically, each LIT will:

1. Identify initial priorities, knowledge known and required, and future areas of work to be taken forward to meet strategic expectations locally.
2. Share 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 Delivery Group is aware of progress against the implementation of agreed actions, and the associated risks to delivery, and of any mitigation taken.
4. Consider and agree the accountability and scrutiny processes for delivery of the actions, including those areas which may require local scrutiny through existing mechanisms.
5. Capture, celebrate and share positive practice and learning to spread innovation around all aspects of mental health.
6. Identify and commission 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).

## **4.2 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.

## **5. 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 special measures objectives are detailed below:

### **5.1 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 training 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.
- 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 [Charlotte Jones](#), which have all been widely covered by the local, regional and national media.

- There is now a mental health training programme aimed at giving non-mental health professionals the skills and confidence to respond positively and appropriately to people in distress. This was launched on International Men's Day and was initially targeted at [North Wales Barbers in a bid to tackle male suicide](#). Again, key health messages were disseminated in a press release which was widely covered by the 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.

## **5.2 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 HTT activity to prevent admission

## **5.3 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.

## **5.4 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 in early 2019.

- 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

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

- Model for crisis cafes due to be trialled across 3 district general hospital sites over the winter pressures period to provide proof of concept for model to be rolled out across community settings.
- 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.

#### **5.6 Objective - The development of a clear plan for the future of our mental health services 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 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.

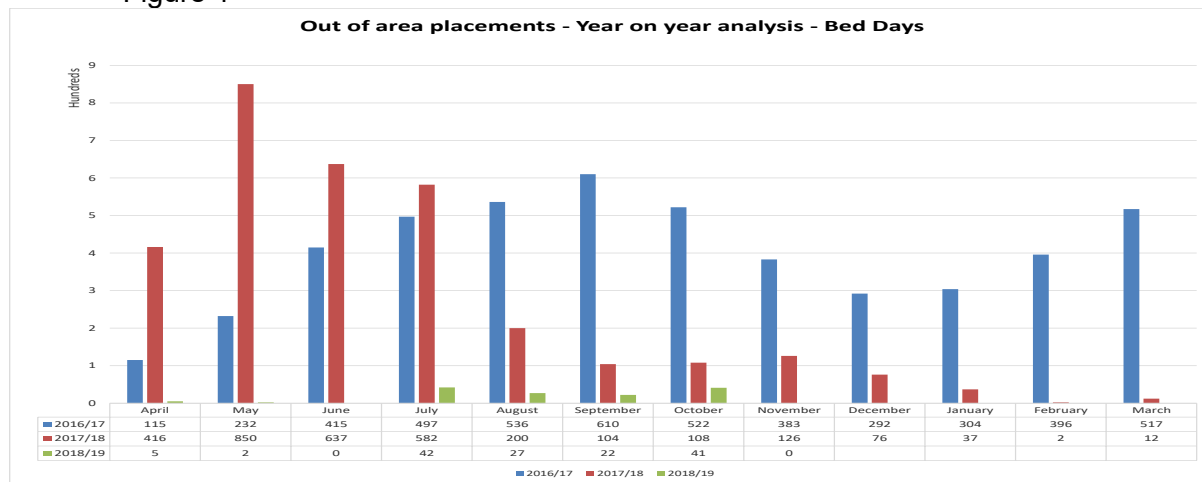
#### **5.7 Objective – Reduce the number of detentions of people under s.136 of the mental health act**

- 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.
- Currently s.136 detentions have not reduced as initiatives are not fully embedded.

## 5.8 Objective – To reduce the number of placements of local people outside 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.

Figure 1



## 6. 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 MHL D 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 quadruple aim of Safe, Experience, Effective and Leadership themes, also known as the Quality SEEL.

BCUHB is driving forward change through a unique exercise that incorporates a clear brand of the 'TODAY ICAN' approach (**Figure 2**) which sees the bridging of the ICAN MHL D 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 MHL D Division, each of the local and regional triumvirates have control over their delivery of TODAY ICAN. The Health Board has appointed dedicated project management support to enable the triumvirates to engage with the Quality Improvement Governance Plan and produce Local Delivery Plans (LDP) for review by Divisional Directors. LDP's 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 2**



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**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 #EndPJPParalysis 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 TODAY ICAN.

December the 20<sup>th</sup> 2018 was the BCUHB MHL D official launch of the TODAY ICAN 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 MHL D Division workforce.

***"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

## 6.1 Engaging staff and communicating the message

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 TODAY ICAN 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 TODAY ICAN approach is gaining traction with staff from across the MHLD Division. The webpages have been visited more than 1,000 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 TODAY ICAN in every local meeting with the aim of it becoming embedded in our everyday language;
- Introducing TODAY ICAN 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 TODAY ICAN 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.

## 6.2 Some initiatives inspired by TODAY ICAN have been covered by the local, regional and national media.

Our [training drive to help barbers support customers who may be experiencing mental health difficulties](#) has been widely covered by the national media. Based on the principles of TODAY ICAN, the training 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.



TODAY ICAN 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 TODAY ICAN in their everyday work.

# Nurse nears end of run fundraiser

**By Suzanne Kendrick**  
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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 therapeutic activities, provided



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

## 7. 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	<ul style="list-style-type: none"> <li>• All staff met by the inspection team were engaging with the inspection process</li> <li>• The inspection team noted the motivated, enthusiastic and caring approach of staff on the wards and observed a good rapport between staff and patients</li> <li>• Management at ward level were keen to develop the service with positive outcomes for patients firmly in mind.</li> <li>• The team noted that the acute care meeting process in place is a very good example of effective communication and aided with planning the patient pathway.</li> <li>• The team found that the patient care documentation being trialled on the ward, which has been designed to reduce the volume of paperwork staff needed to navigate, appeared to be working well</li> <li>• The team felt that staff should be commended for the redecoration and personalisation of the ward.</li> </ul>
Bryn Hesketh 2017	<ul style="list-style-type: none"> <li>• Leadership at Bryn Hesketh was strong</li> <li>• Staff were dedicated to maximising the patient experience</li> <li>• Refurbishment had improved the dementia friendliness of the hospital</li> <li>• Legal documentation under the Mental Health Act and Deprivation of Liberty Safeguards was compliant with the relevant legislation.</li> </ul>
East CMHT 2017/8	<ul style="list-style-type: none"> <li>• We found the quality of patient care and engagement to be good and service users spoke positively about the support they received.</li> <li>• Good engagement with service users and families</li> <li>• Person centred approach with service users involvement in some aspects of the planning and delivery of care</li> <li>• Staff committed to providing a good service</li> <li>• Good team working</li> <li>• Good access to social, employment and educational services</li> <li>• The service users we spoke with during our inspection were positive about the services they received. They described good accessibility of all</li> </ul>

	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:	<ul style="list-style-type: none"> <li>• Patients that we spoke to were complimentary of the care received</li> <li>• Staff interacted and engaged with patients respectfully</li> <li>• Established governance arrangements that assisted staff in the provision safe and clinically effective care.</li> <li>• 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.</li> </ul>

In addition to this, in 2017 all three memory assessment services in the Health Board have received accreditation through Royal College of Psychiatrists. These were the first services to be accredited in Wales and we remain the only Health Board in Wales with fully accredited memory services. The process of seeking Accreditation of In-patient Mental Health Services (AIMS) began in 2015 and all three successfully re-accredited during 2017.

## 8. 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.

TODAY ICAN 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;



TODAY ICAN 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

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.

<b>9.</b>	<b>CONCLUSION</b>
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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.

## **10. BCUB BE PROUD - Key Achievements 2016 - 2019**

### **10.1 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>

### **10.2 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>

### **10.3 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>



## **10.4 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.

## **10.5 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>

## **10.6 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.

## **10.7 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.

### **10.8 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>

### **10.9 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>

### **10.10 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>

### 10.11 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>

### 10.12 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>

### 10.13 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>

#### **10.14 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 from 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>

#### **10.15 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>

#### **10.16 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>

### **10.17 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>

### **10.18 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.

### **10.19 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>

## **10.20 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.

## **10.21 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.

## **10.22 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>

## **10.23 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.



**Quality, Safety & Experience  
(QSE) Committee**
**19.3.19**

**GIG  
CYMRU  
NHS  
WALES**

 Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board

*To improve health and provide excellent care*

<b>Report Title:</b>	Quality & Safety in Primary Care
<b>Report Author:</b>	Clare Darlington, Wyn Thomas & Janet Ellis - Assistant Area Directors of Primary Care Mike Buckle – Assistant Director Dental Services Rory Wilkinson - Area Head of Pharmacy, Primary Care & Community Services Lynne Joannou, Assistant Director Primary Care Contracting
<b>Responsible Director:</b>	Dr Chris Stockport, Executive Director Primary & Community Care
<b>Public or In Committee</b>	Public
<b>Purpose of Report:</b>	To provide an overview of the arrangements in place in relation to the quality and safety of primary care services.
<b>Approval / Scrutiny Route Prior to Presentation:</b>	This report will be shared with all relevant Area Quality and Safety groups as an overview. As an overview paper no approval was required prior to presentation to the Committee
<b>Governance issues / risks:</b>	Demand for services across the NHS and care services is increasing; in addition there is a strategic direction to care for patients closer to home where safe to do so.  Across primary care there are also challenges in ensuring that the clinical multi-professional workforce is available to meet this demand. The Health Board will continue to support recruitment campaigns, along with the development of training and primary care services, to ensure the sustainability and quality of provision.
<b>Financial Implications:</b>	There are no financial implications associated with this report
<b>Recommendation:</b>	It is recommended that the Committee:  1. Notes the arrangements in place in relation to Quality and Safety in Primary Care 2. Notes the priorities for Primary Care Quality & Safety in 2019/20 3. Notes the development of future primary care reports to the QSE Committee

<b>Health Board's Well-being Objectives</b> <i>(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)</i>	√	<b>WFGA Sustainable Development Principle</b> <i>(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.)</i>	√
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	√		
<b>Special Measures Improvement Framework Theme/Expectation addressed by this paper</b>			
Evidence of strengthened resilience and sustainability in primary care services			
<b>Equality Impact Assessment</b>			
As this is an overview paper an EqlA is not required. Equality is, however, an integral part of the Quality Improvement agenda and as such individual EqlA assessments will be required when undertaking an associated initiatives.			

*Disclosure:*

*Betsi Cadwaladr University Health Board is the operational name of Betsi Cadwaladr University Local Health Board*

## Quality & Safety in Primary Care

### 1. Purpose of report

This report has been prepared to provide an overview of the arrangements in place in relation to the quality and safety of primary care services.

### 2. Introduction

Betsi Cadwaladr Health Board is responsible for ensuring the availability of primary care services for the total population of North Wales.

Primary care services are provided by GP practices, general dental practices, optometrists and community pharmacies. In the main, these services are provided by independent contractors and commissioned under nationally negotiated contracts. In recent years, however, a number of GP practices have become managed by the Health Board when contractors have retired or resigned their contracts. As at 1<sup>st</sup> April 2019, the Health Board will be managing 16 out of 105 GP Practices across North Wales.

As commissioners and providers of primary care, the Health Board must ensure that these services are safe, whilst continually striving for quality improvement.

The three Area teams are responsible for primary care services. The Assistant Area Directors for Primary Care (AADPC) and recently appointed Assistant Director Dental Services (ADDS) work very closely with the Assistant Director Primary Care Contracting (ADPCC), to provide and commission services, and coordinate the processes in order to address their quality and safety.

### 3. Quality & Safety Assurance Infrastructure

#### **3.1 Area Primary Care Quality & Safety Groups**

Each Area has a Primary Care Quality & Safety (Q&S) group as part of the assurance frameworks agreed across these divisions.

The Assistant Area Directors for Primary Care chair the groups, supported by the Area Medical Directors and Quality teams at an Area level.

The main duties of the Primary Care Q&S groups are:

- To provide evidence based and timely advice to the Area Leadership Teams with regard to quality, safety, and patients and service users experience of the primary care health services they are responsible for;
- To provide assurance to the Area Leadership Teams in relation to the arrangements for improving the quality and safety of primary care services, in accordance with the standards determined by NHS Wales
- To provide assurance to the Area Leadership Teams in relation to improving the experience of patients and all those that come into contact with primary care services.

- To provide assurance to the Area Leadership Teams that it is discharging its functions, and meeting its responsibilities, with regard to information governance in primary care

These groups report to the Area Q&S groups and Area Leadership Teams.

Clinical governance reports are presented to the Q&S groups for consideration, these include:

- Incidents; total number reported and number by type of primary care provider, severity reported (including details of major and catastrophic incidents, category of incidents (including any trends), emerging trends and lessons learnt from incidents reported.
- Concerns; total number reported and number by type of primary care provider, severity reported (including details of major and catastrophic concerns, category of concerns (including any trends), lessons learnt from concerns received.
- Focused reports on Health Board managed practices.
- Overview of any Health Inspectorate Wales visits and reports
- Summary from Concerns Review Group - this group reviews the management and closure of incidents and is attended by Assistant Medical Directors (AMDs), Clinical Governance, Medicines Management and Nursing representatives.

### **3.2 Regional Primary Care Quality & Safety Group**

In addition to the Area primary care Q&S groups, a regional primary care Q&S group has been formed to ensure consistency of approach and develop and agree management processes in relation to Q&S across North Wales. This brings together all aspects of Q&S, enforces a common understanding of issues requiring consideration and provides a forum to share lessons learnt.

The purpose of the Regional Primary Care Quality and Safety Group, (Q&S Group) is to:

- Ensure consistent appropriate systems are in place for the quality assurance (clinical governance) of primary care contractors and services (General Practitioners, Dental, Community Pharmacy and Optometrists) across the Health Board;
- Ensure best practice and learning is shared across primary care services in North Wales;
- Assure that there are effective management processes in place for overseeing and dealing with individual clinician and practice performance concerns;
- Provide evidence based and timely advice to the Assistant Directors of Primary Care in relation to risks associated with the provision of primary care, to assist them in discharging their functions and meeting their responsibilities with regard to the quality and safety of healthcare

The group has standing agenda items including Area Primary Care risk registers, HIW reports, Area Primary Care Q&S reports with shared lessons learnt.

This regional Q&S Group reports urgent identified risks and/or significant issues to the appropriate Area Director or Executive Director. Issues raised are also reported back to the Area Primary Care Q&S Groups for action as appropriate.

### **3.3 National Primary Care Contracts and quality**

#### GMS Contracts

The national GMS contract provides opportunities to monitor and improve the quality of services provided by GP practices.

The Quality and Outcomes Framework (QOF) was introduced as part of the new GMS contract in 2004 and rewards practices for the provision of 'quality care' as well as helping to standardise improvements in the delivery of clinical care. Practice participation in QOF is voluntary but most practices on General Medical Services (GMS) contracts, take part in QOF.

QOF is widely recognised as having introduced improvement in the quality of data recording in general practice and the routine call and recall of patients for the management of chronic conditions. More recently, it has also included the activity required in relation to GP cluster working.

All GP practices are encouraged to participate in the QOF. The monitoring and processing of claims is undertaken by the Primary Care Contracting department, with medical and clinical governance input from Area teams where required.

In addition, as part of the core GMS contract, GP practices are required to demonstrate their clinical governance assurance processes. The majority of practices opt to do this by utilising the Clinical Governance Practice Self Assessment Tool (CGPSAT), hosted by Public Health Wales. The CGPSAT is primarily designed to help practices assess their own systems to ensure safe practice and improve quality of care provision.

The CGPSAT includes 47 domains covering aspects such as Equality, Diversity \& Human Rights, Patient Information & Consent, Dignity & Respect, Safeguarding Children & vulnerable adults, infection prevention, control & Decontamination, records management.

#### Dental Contracts

As in previous years, dental contractors will be required to complete their Quality Assurance Self-Assessment (QAS) returns for 2019 online as part of the Health Board's ongoing clinical governance process.

BCU Health Board contract monitoring priorities are:

- Reduce contract under delivery
- Maintain safety and quality of service provision
- Manage financial risk to the Health Board
- Identify and understand treatment pattern anomalies
- Increase patient access to NHS dental services

Contract activity monitoring will occur at the following levels:

- Monthly monitoring – via NHSBSA data reports and contact with individual contractors
- Mid-year review – cumulative activity to the end September below 30% of annual contracted level will trigger a mid-year review and require the contractor to submit an action plan detailing how delivery levels will be increased during the second half of the year. Performance between 30%-40% may lead the Health Board to seek reassurance that the full year's activity is achievable. Where the Health Board is not sufficiently reassured that full delivery is achievable it may request a contract variation or withhold contract payments or a combination of the two.
- End of Year review – contractors will receive an annual contract review. The review process is intended to cover aspects of access, quality and governance as well as activity delivered during the year.
  - Contractors achieving less than 95% contracted activity will have to repay the value of the under delivery and should expect to discuss with the HB the relevant level of contracted activity for the coming year along with the contractor's plans to achieve it.

A breach of contract or remedial notice will be issued to contractors where a contract breach has arisen. Most contract breaches are easily remedied within the notice period. Where the breach is sufficient to warrant consideration of further sanctions the issue will be referred to Assistant Director Dental Services for deliberation.

The above is taken from the department's Principles and Processes for Dental Contract Management for 2019/20 submitted to the Primary Care Dental Contract Management Group Thursday 17<sup>th</sup> January 2019 for noting.

### Community Pharmacy Contracts

All Community Pharmacy Contractors in Wales are required to complete a compulsory annual online Clinical Governance Self-Assessment (CGSA) and Information Services Management Systems Self-Assessment. They are also asked to complete a voluntary Controlled Drug Self-Assessment. The collation of the completed submissions is managed by NHSSSP on behalf of the LHB. The returns are reviewed and used to inform the agenda of the LHB led Quality Assurance Visit Programme.

All community pharmacy services are claimed for and paid via NHS Wales Shared Services Partnership (NWSSP). Historically, claims have been submitted on a paper form with records of service delivery retained in the Pharmacy. The seven LHBs in Wales have been working with Welsh Government, Community Pharmacy Wales and NWSSP to develop electronic claim systems. This means that a greater level of data relating to pharmacy services activity and outcomes is now available. NWSSP are currently developing a dashboard which will allow pharmacy outcomes to be compared at pharmacy, Cluster and LHB level.

There is an agreed programme of post payment verification visits undertaken on a rolling basis. These visits review the payments claims made for advanced services,

these are undertaken by NHWSSP on behalf of the LHBs and a post visit report is submitted for each visit.

### **3.4 GP Managed Practices and Quality**

The overall responsibility for GP managed practices rests with the Assistant Area Directors of Primary Care.

A pan-BCULHB group has been established to work through a common set of policies and procedures for managed practices, including a project workbook to support the transfer process from independent to managed status.

The Group has developed a business continuity framework document to be used in each managed practice, a core set of performance and quality indicators to be used to report on managed practice performance and a Governance Framework for nurses and pharmacists working in managed practices.

Update reports considered by the Regional Primary Care Q&S group are highlighted and discussed at this managed practice group to ensure that the Health Board practices are appropriately addressing quality and safety issues.

<b>4.</b>	<b>Quality Priorities 2019/20</b>
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#### **4.1 Quality Assurance Visiting Programme 2019/20**

A Quality Assurance Visiting Programme (QAVP) is in place across GP Practices, Dental Practices and Community Pharmacies which serves to seek assurances that providers have adequate clinical governance frameworks in place. QAVP visits are also aimed at ensuring contractors and the Health Board have the opportunity to discuss and understand factors relevant to the delivery of a quality service in a safe clinical environment.

The content and arrangements for this programme have been separately developed for each type of primary care contractor. The visits are on a rolling programme and cover provider groups in turn, with the intention of visiting each practice at least once every 3 years. The visiting programme commenced in 2014 with GP Practice visits, then moved to dental practices and latterly the focus has been on community pharmacy visits. The 3 year cycle was disturbed during the period of internal reorganisation, however, all GP Practices, Dental Practices (86) and Community Pharmacies (153) which are contracted to provide services by BCULHB have now received a visit.

Over the last 6 months the regional Primary Care Q&S group tasked the Primary Care Clinical Governance Managers with reviewing and revising the QAVP approach for GP practices, in preparation for the new round of visits to commence in April 2019. This was done by reviewing the matrices of the Clinical Governance Practice Self Assessment Toolkit (CGPSAT) and looking for trends, which then identified several areas where practices have scored themselves low. By using the CGPSAT data in this way, the Area teams can work to support practices to improve their processes and ultimately improve their CGPSAT score. There is no intention of



performance managing practices by using the toolkit, but rather ensuring the Health Board has adequate assurances and can support and assist practices with their clinical governance requirements.

It is proposed that all GP practices have a QA visit in 2019/20, which will also cover their branch surgeries. Should a practice be deemed to benefit from greater assistance, a further visit from a wider multi disciplinary team will be arranged.

Reporting outcomes from the QAVP will be undertaken at the Area Primary Care Q&S meetings with a pan North Wales overview at the Regional Primary Care Q&S group.

## **4.2 Quality Improvement (QI)**

Further work will be undertaken to ensure that primary care services are an integral part of the Quality Improvement developments and projects within the Health Board. This will include sharing information on the QI Hub and ensuring full engagement with the QI Conference at the end of April 2019.

## **5. Conclusions and Next Steps**

The infrastructure and governance arrangements in place with regards to primary care quality and safety have been developed to support Area responsibilities but also allow a regional approach to developing Q&S assurance processes, and sharing lessons learnt.

This paper provides a high level overview of these arrangements. Future reports will be further developed under the direction of the QSE Committee to provide more specific detail and information as requested. This could include trend and themed reports in relation to concerns, incidents, contract breaches, patient stories and lessons learnt, as well as quality improvement initiatives.

## **6. Recommendations**

It is recommended that the Q&S Committee:

1. Notes the arrangements in place in relation to Quality and Safety in Primary Care
2. Notes the priorities for Primary Care Q&S in 2019/20
3. Notes the development of future primary care reports to the QSE Committee

**Quality, Safety and  
Experience Committee**


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University Health Board

**19.3.19**
***To improve health and provide excellent care***

<b>Report Title:</b>	Clinical Audit Report
<b>Report Authors:</b>	Dr M Maxwell - Senior Associate Medical Director/1000 lives Clinical Lead Mr Trevor Smith – Head of Clinical audit and Effectiveness Mr Adrian Thomas, Executive Director Of Therapies & Health Sciences
<b>Responsible Director:</b>	Mr Adrian Thomas, Executive Director Of Therapies & Health Sciences
<b>Public or In Committee</b>	Public
<b>Purpose of Report:</b>	The Joint Audit Quality and Safety (JAQS) meeting in October 2018 raised a number of concerns in relation to the level of assurance of the effectiveness of Clinical Audit. This paper has been prepared to address the issues raised.
<b>Approval / Scrutiny Route Prior to Presentation:</b>	The report has been to the Executive Team Meeting and is scheduled for the Health Board Quality and Safety Group meeting on the 13 <sup>th</sup> March.
<b>Governance issues / risks:</b>	Clinical audit should provide assurance that service delivery is safe and support improved service delivery both within and beyond professional, departmental and organisational boundaries.  This paper recommends changes that will deliver improved assurance at all levels.
<b>Financial Implications:</b>	None indicated at this time.
<b>Recommendation:</b>	The Committee is asked to approve the Report and Recommendations.

<b>Health Board's Well-being Objectives</b> <i>(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)</i>		<b>WFGA Sustainable Development Principle</b> <i>(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.)</i>	
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	√		
<b>Special Measures Improvement Framework Theme/Expectation addressed by this paper</b>  Due to the scope and breadth of the topics included in Clinical Audit all the themes are of relevance. This is due to the wide reach of Divisional / Specialty services involved in the audit cycle. Patient and carer feedback is sought for some projects ('Engagement'); 'Strategic & Service Planning' influenced by findings; 'Governance' structures that support and are influenced by this activity; Local service and Corporate 'Leadership' required to support engagement with the projects and resultant improvement activity.			
<b>Equality Impact Assessment</b>  N/A			

*Disclosure:*

*Betsi Cadwaladr University Health Board is the operational name of Betsi Cadwaladr University Local Health Board*

## **Clinical Audit Proposal: Governance Processes and Assurance**

### **Situation**

This paper has been prepared to address the issues raised by the Joint Audit Quality and Safety (JAQS) meeting in October 2018 in relation to improving assurance of the effectiveness of clinical audit.

The Wales Audit Office structured assessment 2017 recommended that the Health Board's programme of clinical audit needed to align with the priorities and risks identified in the Health Board's Quality Strategy, be more explicit in regards to patient/quality outcomes to understand the added value of clinical audit. This recommendation was repeated in the structured assessment 2018 as the expected progress had not been made within the timeframe. The Health Board has agreed that there will be a structured process for planning clinical audit based on the analysis of clinical risk and aligned to the Health Board's Quality Improvement Strategy by September 2019.

### **Background**

Clinical audit is one of a number of tools used to support quality improvement. It helps to determine whether a service is delivering best practice by measuring practice against defined evidence based standards that should deliver good patient outcomes.

Within the Health Board there are three levels of Clinical Audit:

**Tier 1 – National:** These are nationally mandated by the Welsh Government's National Clinical Audit and Outcome Review Advisory Committee and are drawn from the UK National Clinical Audit and Patient Outcomes Panel (NCAPOP) under the auspices of the Health Quality Improvement Partnership (HQIP) and mainly administered by the Royal College's. These audits usually measure our services against a national standard or are performed to allow national provision of a service to be understood and benchmarked. The Welsh Government specify an annual list of the projects mandated for all Health Boards within the National Clinical Audit and Outcome Review Plan (NCAORP).

**Tier 2 – Corporate:** These are the BCUHB wide audits that the organisation has made the decision to undertake to support its service improvement plans and/or agreed priorities. These clinical audits should be aligned to the priorities set out within the Health Board's Quality Improvement Strategy. The Quality Safety and Experience Committee are responsible for approving the clinical audit plan identified at this level to support risk management and service improvement.

**Tier 3 – Divisional:** These are clinical audits that should form part of a prioritised programme at a local level; whether this be Divisional, individual department or specialty level. Often, these cover topics that clinicians have chosen to support a local specialist service or personal interest aligned to further education. These audits may be more important in some specialist areas where there are no mandated national audits or there is a key risk. Clinical audit should be used as a key part of professional

development recognising that this may cover a wider clinical network for example Dermatology.

HQIP has developed 10 'simple rules' for NHS Boards that support mature governance arrangements and effective clinical audit<sup>1</sup>:

1. Strategic alignment of audit to the Board's agenda
2. Ensuring audit is one of a range of quality improvement tools
3. Ensuring that there is a mix of both national and local priorities
4. Audit should be sufficiently resourced to deliver the programme
5. There is a rolling programme with an underpinning plan that ensures resources are effectively deployed.
6. The assurance needs to be set against the benchmark of national guidance and /or benchmarked against similar organisations; with an agreed understanding of acceptable variation.
7. Where possible audit should cross boundaries and encompass the whole patient pathway.
8. Audit results should be publically available and reports patient friendly, with patients and stakeholder engaged throughout the audit process.
9. Audit should be published alongside outcome data and evaluations.
10. Underpinning education and training is available to staff to generate capacity

### *Corporate Clinical Audit Team*

A review has been undertaken of the current structure and configuration of the Corporate Clinical Audit Team. The team is managed by the Executive Director of Therapies and Health Sciences.

### **Corporate Clinical Audit Team**

<b>Role</b>	<b>Banding</b>	<b>WTE</b>	<b>Remit</b>
Head of Clinical Audit and Effectiveness (CA&E)	8a	1.0	HB
Administration Assistant: CA&E	3	1.0	HB
Clinical Audit & Effectiveness Manager	7	(1.0) Vacant	HB
Clinical Effectiveness Facilitator: NICE &AWMSG	5	1.0	HB
Integrated Care Pathway Lead	6	0.8	HB
Integrated Care Pathway Assistant	3	0.8	HB
CA&E Facilitators	5	1.8	WM/HB
CA&E Facilitators	5	2.0	YGC/HB
CA&E Facilitators	5	2.0	YG/HB

In 2017 it was determined that the Clinical Audit Team would be deployed primarily to support Tier 1 and Tier 2 clinical audits. Tier 3 clinical audits would only be supported if any capacity remained or if topics were demonstrated to link to Tier 1/2.

Key issues identified include

- The Head of Clinical Audit and Effectiveness (CA&E) is the only member of the department with a clinical background.
- Staff work predominantly within acute services.
- Primary care receive limited support for Tier 1 audits by staff from within the Area Team Governance Structure.
- Administrative posts within the acute hospital sites also support clinical audit with data capture and entry e.g. Myocardial Infarction National Audit Programme and the Trauma Audit Research Network. This resource is variable between sites and is not managed by the Corporate Clinical Audit Team.

There is a central repository for all Tier 1 and Tier 2 clinical audits, with an associated work plan. It is the role of the CA&E facilitators to liaise with the clinical leads regarding the submission of data. The subsequent report is sent to the relevant clinical lead for action; they receive an action plan and updates on the audit progress, although there can be some inconsistency in this. Following earlier discussion with the clinical executives, there is a focus upon Tier 1 and 2 activity and the engagement with Tier 3 is restricted to registration on the database. Responsibility for design and supervision is with the local supervisor and/or local audit lead. Whilst Tier 3 audits are registered there is little evidence recorded of the audit cycle being completed and the benefits being realised.

The review has identified variation in roles and responsibilities which need to be re-aligned to better meet the needs of the organisation and its key strategic priorities and risks.

### *Current Governance Arrangements*

What is in place currently?

There is information on the Health Board's website which provides contact information for the Clinical Audit Team, clinical audit registration forms, links to the national audit annual plan, the latest corporate clinical audits and an on line e-learning package.

There is an electronic repository with the latest Tier 1 audit reports and action plans and a separate repository for the Tier 2 clinical audits which have been supported by the corporate clinical audit team. For example, consent, discharge letters and case note review).

Each national audit has a designated Health Board Clinical Lead supported by a Clinical Lead from the relevant speciality on each site or area. There are a variety of ways in which this work is overseen. This is aligned to the nature of the clinical audit being undertaken. For example specialty forum (Renal Network), topic-specific BCUHB groups (such as Diabetes at the Diabetes Programme Delivery Group), departmental meetings (e.g. National Hip Fracture Database).

The governance and oversight arrangements at a divisional or service level are variable and whilst some are mature and effective, others appear to be still evolving and require strengthening. For example, maternity services have robust arrangements in place and their audit plan is monitored within the Division; the lead maintains a

database of audits and ensures they are presented at the departmental meetings with SBAR development and follow up including re-audit. HMP Berwyn also has a quarterly Health and Well Being Clinical Governance Meeting attended by a member of the corporate audit team.

However, a review of the arrangements at hospital site and area team level have identified variability in clinical engagement, follow through of actions and alignment with corporate priorities.

The BCU-wide Clinical Effectiveness and Audit Sub Group (CEASG) Chaired by the Executive Director of Therapies and Health Sciences supports the Executive led Quality and Safety Group in discharging its responsibilities for clinical effectiveness. This includes clinical audits, receiving site and/or area reports. It also ensures the NCAORP assurance reporting forms have been returned to Welsh Government; CEASG meets bimonthly.

In September 2017 the Audit Committee approved a framework in relation to the function of clinical audit within the Health Board, the framework sets out the specific role of the Audit Committee alongside that of the Quality, Safety and Experience Committee in relation to clinical audit so that their roles and responsibilities were clear. In summary, QSE Committee are required to ensure there is an effective function in place and Audit Committee are required to provide assurance to the Board that the function is effective. The paper also confirmed that the Quality and Safety Group are responsible for determining the content of the Corporate Clinical Audit Plan, taking into account the priorities set out in the Quality Improvement Strategy reflecting on complaints and concerns and other patient feedback.

The review of the current governance structure has identified that

- The internal governance structure could be simplified as it is overly complex potentially leading to confusion and duplication about reporting lines.
- Hospital and Area arrangements require review and realignment to reflect changes in organisational structure.
- The Secondary Care Quality and Safety Group and CEASG need to develop a reporting arrangement so that there is sufficient oversight of clinical audit.
- The content and nature of reporting to QSE and Audit Committee needs to better reflect the outcomes as well as the activity of clinical audit and demonstrate alignment with organisational priorities and risks.

## **Assessment**

There is a wide variation in the management of clinical audit, and whilst some parts of the governance and reporting arrangements are robust, this is not consistent. Therefore the assurance that audit is an effective tool for improving services could be improved.

There is no overarching procedure setting out the Health Board expectations around clinical audit including the risk assessment process to determine Tier 2 audits. Corporate resources are supporting Tier 1 and 2 audits, the majority of which are positioned within secondary care; this means Area Teams and Primary Care are



largely unsupported. The Health Board needs to be assured that clinical audit is being used effectively across the whole organisation.

The Board and its Committees are not yet receiving full assurance that there are robust systems in place to ensure the audit cycle is being followed. There needs to be more robust evidence of improvement and where necessary, risk assessment and mitigation associated with the audit findings.

The current clinical audit plan has limited strategic alignment, with a predominantly externally driven agenda (Tier 1 audits) and it is not evident that all Tier 2 clinical audits are aligned with the corporate risks and priorities.

## Recommendations

Recommendation	Lead	Planned Outcome	Deadline	Progress Update 7.3.19
Review corporate Clinical Audit Team structure	Adrian Thomas	Ensure team have the capacity and capability to deliver the agreed work programme across the whole organisation including primary care	September 2019	Baseline review completed and this will form part of the exercise to align quality improvement activity across the Health Board.
Develop a BCU wide clinical audit procedure	Head of Clinical Audit	Support staff with a clear governance framework for clinical audit	July 2019	Initial review of similar procedures from other NHS organisations completed
Embed clinical audit within BCU Quality Improvement activities	Adrian Thomas / Exec Team	Drive improvement in areas of key risk	July 2019	A review and realignment of all quality improvement activity has been commenced by Executive Team
Review and revise the governance and reporting arrangements for clinical audit (from ward to Board)	Adrian Thomas/ Clinical Execs	Strengthen accountability and address gaps and omissions and reduce duplication	June 2019	Baseline review completed options for revised structure drafted for consideration initially by QSG in March 2019. A common reporting template will also be considered once finalised a consistent terms of reference will be shared for adoption across operational sites
Improve tracking of Improvement plans.	Adrian Thomas	Improve tracking, reporting and trajectory planning against improvement plans for Clinical Audits.	September 2019	Discussion with Mr D Harries, Internal Audit, indicated that using Team Tracker to track Tier 1 Clinical Audit was not feasible. It was suggested that the system could be used for Tier 2. However as this would require a separate instance the cost needs to be investigated and comparison against other systems made.

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**Quality, Safety &  
Experience Committee**
**19.3.19**

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*To improve health and provide excellent care*

<b>Report Title:</b>	Special Measures: Review of expectations allocated to the Quality, Safety & Experience (QSE) Committee
<b>Report Author:</b>	Mrs Liz Jones, Assistant Director
<b>Responsible Director:</b>	Mrs Grace Lewis-Parry, Board Secretary
<b>Public or In Committee</b>	Public
<b>Purpose of Report:</b>	<p>The Special Measures Improvement Framework Task &amp; Finish (SMIF T&amp;F) Group previously agreed that special measures expectations would be allocated to the most relevant committee for review, with a view to the committee providing updates where necessary and assurance on progress to the SMIF T&amp;F Group.</p> <p>Work on the October 2018 – March 2019 section of the Framework has included a session held by the Executive Team in January 2019, dedicated to examining special measures progress in detail. As a result, it was deemed that several of the expectations had been satisfactorily addressed and could be closed for monitoring purposes. The SMIF T&amp;F confirmed the decisions at its February 2019 meeting.</p> <p>All 'open' SMIF monitoring log expectations allocated to the QSE Committee from the section of the Framework ending March 2019 are presented for comment.</p>
<b>Approval / Scrutiny Route Prior to Presentation:</b>	The special measures progress monitoring log is overseen by the SMIF T&F Group. The log was last reviewed by the Group on 25.2.19,
<b>Governance issues / risks:</b>	There is a risk that recommendations will not be fully met unless driven forward at sufficient pace.
<b>Financial Implications:</b>	No additional funding currently required in respect of this paper.
<b>Recommendation:</b>	<p>The Committee is asked to:</p> <ol style="list-style-type: none"> <li>1. Review the updated information provided</li> <li>2. Include within its Chair's Assurance Report a summary of the Committee's discussion regarding the extracts, and a comment on the level of assurance on progress towards meeting the recommendations' requirements</li> <li>3. Share the Chair's Assurance Report with the Office of the Board Secretary, for submission of relevant information to the SMIF Task &amp; Finish Group.</li> </ol>

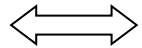
<b>Health Board's Well-being Objectives</b> <i>(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)</i>	√	<b>WFGA Sustainable Development Principle</b> <i>(Indicate how the paper/proposal has embedded and prioritised the sustainable development principle in its development. Describe how within the main body of the report or if not indicate the reasons for this.)</i>	√
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	√		
<b>Special Measures Improvement Framework Theme/Expectation addressed by this paper</b>			
Audit Committee related expectations – leadership and governance.			
<b>Equality Impact Assessment</b>			
An Equality Impact Assessment is not considered necessary for a paper of this type.			

*Disclosure:*

*Betsi Cadwaladr University Health Board is the operational name of Betsi Cadwaladr University Local Health Board*

# QSE MARCH 2019 EXTRACT of Betsi Cadwaladr University Health Board: **Special Measures Monitoring Log** for the second Improvement Framework May 2018-Sept 2019 (incorporating Deloitte Financial Governance Review recommendations and WAO Structured Assessment 2017)

No Change since last update:



Improvement since last update:




Deterioration since last update:





\*See previous monitoring log: This monitoring log builds upon actions and progress during phases 1-3 of the initial Special Measures Improvement Framework. The headings of the log have been adjusted to reflect a greater focus on measurable outcomes and to capture definitive evidence of success.

Line Ref	Theme	IM / Director (+Operational) & Committee Lead	Expectation	Action: What needs to be done and why are we doing it?	By When	Progress	Outcomes and impacts: what difference are the actions making?	RAG Status	Evidence (see iBabs and shared drive folder)
<b>Leadership &amp; Governance</b>									
<b>October 2018 – March 2019</b>									
34	Leadership & Governance	Marian Wyn Jones / Executive Director of Nursing & Midwifery (Deputy Director for Concerns)  QSE Committee	Continued improvement and engagement to enable shared learning from concerns, complaints, incidents and claims	Revise processes to identify and act on early learning by Jan 19	<del>Jan 19</del> May 19	Update 25.2.19 – cannot be closed until the new report in consolidated format is received by the QSE Committee (May). There is evidence of improvement but not sufficient sharing.	Better services for patients.	Green  	
<b>Strategic &amp; Service Planning</b>									
<b>May 2018 – September 2018: (carried over)</b>									
41	Strategic and Service Planning	Chair of F&P Committee/ Executive Director of Planning & Performance/ Executive Director of Nursing & Midwifery (Director of Performance / Deputy Director for Concerns)  F&P / QSE Committee	An operational plan for 2018/19 will have been agreed by the Board and Welsh Government and delivery against the first 6 months is on schedule. This to include improvements in areas of quality, unscheduled care and planned care, noting that final targets for year are currently subject of		<del>Sept 2018</del> March 2019	Update 25.2.19 – this cannot be closed due to current performance issues. There have been some improvements, particularly when compared to last year, though not in all areas. See 54.	- The Board has committed to achieving no patients waiting over 36 weeks by end March 2019 (except for orthopaedics, where there will be no waits over 52 weeks.). See response to action 26 above for the improvement at year end 2018/19, albeit that the final position fell short of the agreed target. - The Board has achieved improvements	Amber  	

Line Ref	Theme	IM / Director (+Operational) & Committee Lead	Expectation	Action: What needs to be done and why are we doing it?	By When	Progress	Outcomes and impacts: what difference are the actions making?	RAG Status	Evidence (see iBabs and shared drive folder)
			<p>continuing discussion:</p> <ul style="list-style-type: none"> <li>-Improvement in the numbers of patients waiting over 36 weeks;</li> <li>-Improvements in the % of patients to receive ambulance handover in less than an hour, patients spending less than 4 hours in all major and minor emergency units, and a reduction in the number of patients spending more than 12 hours;</li> <li>-Demonstration of timely and organisation-wide learning from the concerns, complaints, incident and claims processes to further improve and meet quality standards and full engagement in the all-Wales arrangements in place to enable and ensure consistent shared/system learning.</li> </ul>				<p>in the ambulance handover time as at June 2018 and is developing actions to deliver consistent improvements in the 4 hour and 12 hour waiting time targets for major and minor emergency units.</p> <p>Harms dashboard will contain indicators on number of falls, HAPUs etc</p>		
47	Strategic and Service Planning	<p>Chair of QSE Committee / Executive Director of Nursing &amp; Midwifery</p> <p>QSE Committee</p>	Progress on delivery of the principles of the SAFER patient flow bundle	Deliver SAFER to improve the patient journey	<del>Sept 2018</del> March 2019	Update 25.2.19 – this can be closed once SAFER is demonstrated to be embedded across the organisation.	Improved performance – reduction in delayed transfers of care (DTocS)	<p>Amber</p> 	
Mental Health									
October 2018 to March 2019:									



Line Ref	Theme	IM / Director (+Operational) & Committee Lead	Expectation	Action: What needs to be done and why are we doing it?	By When	Progress	Outcomes and impacts: what difference are the actions making?	RAG Status	Evidence (see iBabs and shared drive folder)
65	Mental Health	Chair of QSE Committee / Director of MHL  QSE Committee	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		March 2019	Update 25.2.19 – the outstanding element is embedding - paper to be submitted to QSE Committee and consideration to be given to what constitutes evidence of embedding.		Amber 	QSE progress report paper Jan 2019
66	Mental Health	Chair of QSE Committee / Director of MHL  QSE Committee	Continued progress demonstrated in delivering on the Mental Health Strategy		March 2019	Update 25.2.19 - Progress made. Key milestones for 2019/20 have been agreed with the chair of each Quality and Workforce Groups, further work to develop detailed plans for 2019/20 will be completed by the end of March 2019. There were five key objectives identified for delivering in the first year of the strategy they were:  Working to prevent mental health crises by focussing 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 Significant progress has been made against all the		Amber 	E-mail evidence from S Ingham 16.1.19

Line Ref	Theme	IM / Director (+Operational) & Committee Lead	Expectation	Action: What needs to be done and why are we doing it?	By When	Progress	Outcomes and impacts: what difference are the actions making?	RAG Status	Evidence (see iBabs and shared drive folder)
						objectives with evidence of impact available.			

EXTRACT V24.0 updated 25.2.19 Stored in:\Boards and Committees\governance \Special Measures\Improvement Framework inc PROGRESS ACTION MONITORING LOG\NEW ACTION PROGRESS MONITORING LOG JUNE 18

**Quality, Safety & Experience  
Committee**
**19.3.18**

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*To improve health and provide excellent care*

<b>Report Title:</b>	Pressure Ulcer Collaborative (Hospital Acquired Pressure Ulcers/HAPU) Update
<b>Report Author:</b>	Mrs Deborah Carter, Associate Director Of Quality Assurance Mrs Diane Read, Head of Quality Improvement Team (Corporate Nursing)
<b>Responsible Director:</b>	Mrs Gill Harris, Executive Director of Nursing & Midwifery
<b>Public or In Committee</b>	Public
<b>Purpose of Report:</b>	<p>The report provides an update of progress to date of the first Health Board Pressure Ulcer Collaborative. The purpose of the Pressure Ulcer collaborative (Commenced November 6<sup>th</sup>) is to develop a Health Board standard approach to care with the aim of reducing tissue damage and pressure ulcers for patients whilst in our care as an inpatient.</p> <p>The Pressure area care standard/bundle of interventions will be a Health Board 'Always event' for all inpatients screened as been at risk of developing skin damage/pressure ulcers.</p> <p>The report will highlight lessons learned, benefits and challenges whilst facilitating a collaborative across the Health Board in preparation for Health Board wide implementation of the standard and will provide valuable lessons in preparation for the Falls collaborative planned to commence April 2019.</p>
<b>Approval / Scrutiny Route Prior to Presentation:</b>	No prior scrutiny
<b>Governance issues / risks:</b>	There will (and has been) an increase in the number of incidents being reported for HAPU due to increased staff knowledge, improved surveillance and focus on transparent reporting for all grades of pressure damage.
<b>Financial Implications:</b>	Testing of interventions so far has highlighted inappropriate seating for patients with reduced mobility and has required that chairs be condemned which will require replacing with more suitable alternatives.
<b>Recommendation:</b>	<p>The Committee are asked to:</p> <ol style="list-style-type: none"> <li>1. Continue its support for the collaborative approach adopted by the Health Board for future collaboratives.</li> <li>2. Acknowledge the potential of an increase in HAPU reported initially during the roll out phase.</li> </ol>

<b>Health Board's Well-being Objectives</b> <i>(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)</i>	√	<b>WFGA Sustainable Development Principle</b> <i>(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.)</i>	√
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	√		
<b>Special Measures Improvement Framework Theme/Expectation addressed by this paper</b>			
Leadership and Governance			
<b>Equality Impact Assessment</b>			

## Disclosure:

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

Board/Committee Coversheet v10.0



## Pressure Ulcer Collaborative Update – February 2019

## 1.0 Introduction:

The Pressure Ulcer collaborative commenced in November 2018 and provides an opportunity for the selected wards from across the Health Board to share current practice and explore the interventions/improvements in order to provide optimal pressure area care for inpatients.

The aim of the collaborative (using a supportive approach of Quality Improvement methodology) is to develop an agreed Health Board standard of care for pressure areas, with the primary aim being to reduce the incidence of, and levels of harm due to Health care Acquired Pressure Ulcers.

The collaborative wards are creating the *always event* or the standard that will be implemented for each patient across the Health Board. This standard will include standardised risk assessment, standardised preventive care interventions and standardised management of patients if tissue damage occurs in order to provide optimal care.

## 2.0 Methodology:

Following the presentation of the briefing paper to the Committee in November 2018 the two cohorts of wards (both Acute and Community sites) have attended classroom sessions for quality improvement training that includes reviewing their own data and then undertaking tests of interventions following engagement with their teams with support by a member of the expert faculty.

The faculty for the collaborative includes all Tissue Viability team members and the Corporate Nursing Quality Improvement team who have, and will continue to support each of the wards within the collaborative.

The cohort wards meet at key points within the collaborative to network, share learning and plan their next test of change which will be subject to further testing with other wards within the collaborative. At all times close monitoring of the data is maintained as the collaborative progresses. The cohorts are testing interventions under the following key drivers

- Measuring and monitoring;
- Identification of risk;
- Prevention and proactive care based on risk;
- Prompt identification and treatment of Pressure Ulcers;
- Innovations for complex problems.

This method of testing interventions and peer testing of the same interventions will provide a robust set of interventions that will be the Health Board standard or the *always events* for pressure area care.

## 3.0 Wards and tests of change:

The participating wards were selected following a review of the data available via the Datix incident reporting as wards that had a higher record of reporting Pressure Ulcers incidents.

The data highlighted a mix of both acute and community inpatient wards from across the Health Board. As the wards are undertaking tests of change the faculty have commenced improvement projects that include review, refreshing and revitalising of the tissue viability resources that include guidance, pathways, care plans and training resources associated with pressure area care available for our staff and patients.

**Table1:**

Cohort 1 Wards	Cohort 2 Wards
<ul style="list-style-type: none"> <li>• Ward 19 Ystbty Glan Clwyd</li> <li>• Bersham Stroke unit , Wrexham</li> <li>• Pantomime, Wrexham</li> <li>• Glaslyn, Ystbty Gwynedd</li> <li>• Moelwyn, Ystbty Gwynedd</li> </ul>	<ul style="list-style-type: none"> <li>• Ogwen, Ystbty Gwynedd</li> <li>• Aberconwy, Llandudno</li> <li>• Morris, Wrexham</li> <li>• Ward 11 Ystbty Glan Clwyd</li> <li>• Ward 1 Ystbty Glan Clwyd</li> <li>• Wards 1 &amp; 2, Colwyn Bay</li> <li>• Ceiorg ward, Chirk</li> </ul>

### 3.1 Interventions currently being tested:

Below is an overview by theme of the interventions currently being tested by the cohort wards:

- Improved quality and accuracy of reporting of incidents using Datix system;
- Rapid identification of patients at risk and early interventions for prevention;
- Improving staff knowledge of management, assessment of our patients;
- Staff knowledge of positioning of patients and use of equipment.

Each ward is actively testing and cross ward testing, i.e. where an intervention has been successfully tested in one ward area this intervention is then retested with another ward/s to check transferability and usability of the intervention between the varying ward profiles and settings. For example the alert or flagging system currently being tested in the acute and community setting to identify a patient's level of risk of tissue damage once assessed means the Multi-Disciplinary Team (MDT) are aware and can ensure early intervention to help prevent pressure ulcers occurring.

### 3.2 Benefits and Challenges to date:

**Table 2:**

Benefits	Challenges
<ul style="list-style-type: none"> <li>• All wards have engaged in the collaborative approach;</li> <li>• Opportunity for the teams to fully engage with their data;</li> <li>• Increased knowledge and experience of the use of data and QI methodologies;</li> <li>• Datix data collected accurate and improved quality for further QI;</li> </ul>	<ul style="list-style-type: none"> <li>• Capacity of the ward teams;</li> <li>• Motivation of the teams as incidents have increased initially;</li> <li>• Unstable Leadership during the tests of change at ward level;</li> <li>• All Wales Datix system.</li> </ul>

<ul style="list-style-type: none"> <li>• MDT engagement;</li> <li>• Networking and sharing with colleagues from across the Health Board.</li> </ul>	
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#### 4.0 Outcomes to date:

The collaborative is still in progress but early indications are that the cohorts have established a set of standards that can be shared across the Health Board which will impact positively on the Health Board aim for pressure area care.

The collaborative phase is due to be completed with a presentation and celebration event at the end of March. However, the faculty will continue to monitor and support the cohort wards by reviewing their data and offer QI support until the launch across the Health Board. They will then continue to provide support and guidance post the launch to new areas until the standards are fully embedded in everyday practice.

The collaborative has provided a standard or base for which future collaborative can be based upon.

**\*Please note** as all the cohort wards when reviewing their data highlighted that some HAPU's within the Datix reporting system were incorrectly categorised at the time of reporting which has led to inaccurate reporting of incidents. For example duplicate reporting, as patients moved from ward to ward, under reporting, as patients may have more than 1 area pressure damage etc.

All cohort wards are currently testing the interventions that have been developed to improve the accuracy and quality of reporting at ward level which has led to increase in the number being reported. Based on this it would be reasonable to conclude that once the standards are spread across the Health Board there will be an increase in HAPU incidents initially.

#### 5.0 Recommendations:

The Committee are asked to continue its support for the collaborative approach adopted by the Health Board for future collaboratives.

The Committee are asked to acknowledge the potential of an increase in HAPU reported initially during the roll out phase.

#### 6.0 Next Steps:

Once testing of the interventions by the cohort wards is complete, and the standard agreed the Health Board wide implementation plan will commence. The communication and implementation plan is currently being developed following feedback at celebration events.

The plan will include the briefing of senior colleagues, a Health Board launch across various sites, followed by workshops, QI clinics, road shows and continued support by



the faculty. The cohort wards will act as buddies for new wards or champions to share their experience.

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19.3.19

*To improve health and provide excellent care*

<b>Report Title:</b>	Ward Accreditation Update
<b>Report Author:</b>	Mrs Deborah Carter, Associate Director of Quality and Governance Mrs Diane Read, Head of Quality Improvement Team (Corporate Nursing) Mrs Alison White, Quality Improvement Team (Corporate Nursing)
<b>Responsible Director:</b>	Mrs Gill Harris, Executive Director of Nursing & Midwifery
<b>Public or In Committee</b>	Public
<b>Purpose of Report:</b>	This report provides the Quality, Safety and Experience Committee with an overview of the Ward Accreditation programme and an update of implementation, initial themes and initial feedback of the Ward Accreditation programme across the Health Board.
<b>Approval / Scrutiny Route Prior to Presentation:</b>	Quality and Safety group
<b>Governance issues / risks:</b>	The Ward Accreditation process highlights / flag any areas of concern, issues or risks that are shared with the ward team and senior team immediately or as part of the validation process depending upon the level of risk.
<b>Financial Implications:</b>	The Ward Accreditation process has highlighted areas requiring financial support and may highlight areas that require further financial support to improve upon as part of patient and staff safety and as the overall quality agenda. These areas may differ from one ward to another but the quality Improvement team are monitoring these areas.
<b>Recommendation:</b>	The Quality, Safety and Experience Committee are requested to continue to support through their Leadership of the Ward Accreditation process and maintain a strong commitment to being a part of the Ward Accreditation process.

<b>Health Board's Well-being Objectives</b> <i>(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)</i>	√	<b>WFGA Sustainable Development Principle</b> <i>(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.)</i>	√
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	√		
<b>Special Measures Improvement Framework Theme/Expectation addressed by this paper</b>			
Leadership and Governance			
<b>Equality Impact Assessment</b>			

*Disclosure:*

*Betsi Cadwaladr University Health Board is the operational name of Betsi Cadwaladr University Local Health Board*

## Ward Accreditation Update

### **1.0 Introduction:**

The Ward Accreditation Programme commenced mid October 2018 and provides an opportunity for the Health Board to embed the principles of Safe Clean Care by the implementation of a set of standards to frame our quality, safety and patient care agenda. The programme maintains the momentum for Health Board wide improvement by use of a common language. The accreditation programme provides a framework for quality assurance from ward to board and provides a 360 degree review of the ward.

The key benefits to the ward accreditation programme are:

- Provide opportunity for sharing of good practice;
- Reduces avoidable harm;
- Improve the patient experience;
- Improve staff experience;
- Standardisation of language and basic quality improvement;
- Visible standards;
- Standard ward quality metrics to focus improvements from ward to board;
- Increases Board level awareness and assurance from Ward to Board.

### **2.0 Methodology:**

The approach is a process very similar to Health Inspectorate Wales (HIW) unannounced inspections to our clinical areas.

The Ward Accreditation visit by a team of 3 senior nursing leaders are unannounced. The visit team observe care delivery review documents and speak with staff, patients and relatives during the visit which typically last 4 to 5 hours. The visit team will provide brief feedback areas of good practice to celebrate and areas for improvement to the Ward Manager before leaving the ward. If any areas require immediate improvement this will be highlighted in the feedback with a time limit of 7 to 10 days before an unannounced spot check by a member of the visit team.

Following the visit, a report is produced which will include an indicative score for each topic within the Ward Accreditation process and an overall score for the ward as their Ward Accreditation score.

Approximately 1 to 2 weeks later the visit the team lead will be required to attend a validation panel whereby the ward will be presented to other senior nursing colleagues who are also visit team leads. The purpose of the validation meeting is to undertake a QA of the visits, to discuss themes, opportunities for improvement, celebrate good practice and to confirm results.

Once an overall score is agreed at the validation meeting, the results are shared with the ward team followed by a more in-depth feedback and presentation of a certificate dependent upon overall score.

### 3.0 Ward Accreditation Visit Process:

The accreditation team will be notified of BCUHB site 24 hrs before the visit, the team are currently 2 senior nurse leaders plus a member of the Corporate Nursing Quality Improvement Team. These visits are standardised to ensure a systematic and consistent approach across the Health Board.

On arrival on a ward and following introductions, the visit team will review the prepared data pack of information before undertaking observations of care, reviewing of patient documents and discussions with the Multi- disciplinary Team (MDT), ward team, Ward manager and patients and relatives.

**Table 1** -Areas reviewed during the visit by the Ward Accreditation team are as follows:



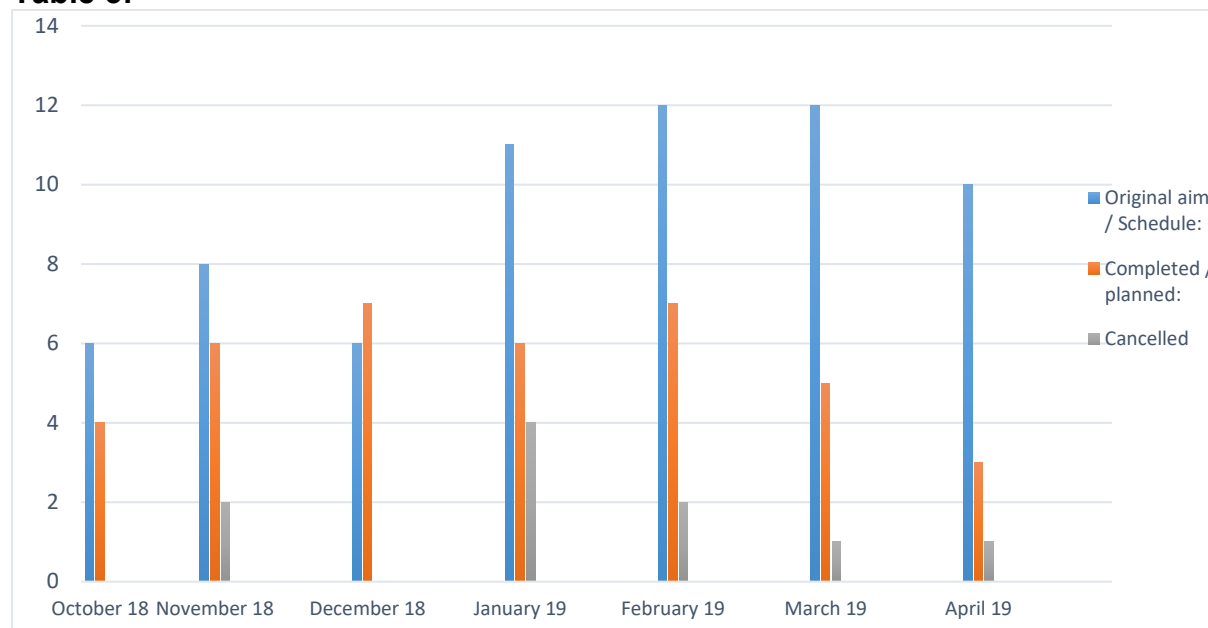
**Table 2** -Scoring definition / standard used as part of the Ward Accreditation for each topic within the Ward Accreditation and for an overall score are defined below:

Awarded Status	Definition
GOLD	Achieved excellent standards and have clear evidence of sustaining this success in data over at least 6 months
SILVER	Achieved very good standards and have some data over time to evidence this
BRONZE	Achieved good standards as expected by the Trust but have no evidence of sustaining this over time or have fallen below expected standards but are completing appropriate actions to address this
WHITE	Have not achieved the Trust minimum standards in at least one area and are not completing appropriate actions to address this issue – some additional support is required
FLAGGED	Serious concerns have been identified in relation to safety or quality that require weekly monitoring and significant support

Please note, if a ward is scored white in any topic the wards overall score will be white which will initiate a support plan for the area (depending upon areas defined as requiring support). Please see appendix 1.

All Ward Managers and / or Deputy Ward Managers were invited to attend a Ward Accreditation Masterclass in September 2018 prior to starting the programme (a total of 130 from across the Health Board attended).

To facilitate the visits, the Quality Improvement Team maintain and coordinate the Ward Accreditation visit rota (please see **Table 3** bar chart below) which highlights the number of visits planned, completed and cancelled:

**Table 3:**

#### 4.0 Ward Accreditation Results to date:

**22** wards across the Health Board have had an unannounced Ward Accreditation visit.

**19** of the 23 wards have had a confirmed Ward Accreditation result following validation as follows:

- **13** wards confirmed as **SILVER**;
- **6** wards confirmed as **BRONZE**,
- **4** wards confirmed as **WHITE**.



#### 5.0 Recurrent Themes requiring Immediate Improvements:

Below are the common themes requiring an immediate improvement plan by the ward manager and the team, and are subject to an unannounced spot check by visit team member:

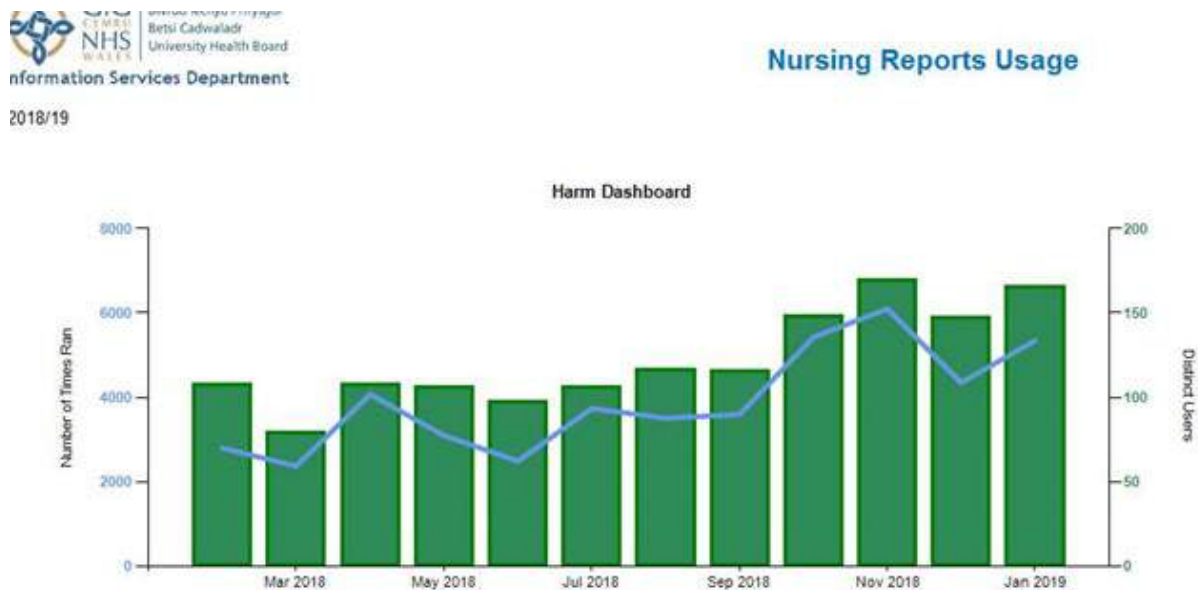
- Mental Capacity Act (MCA)/Deprivation of Liberty (DoLs) awareness and documentation completion;
- Record keeping;
- Recording of medication and food fridge temperature in line with Health Board standards;
- Security of medication trolleys and cupboards;
- Security of CoSHH products;
- Information Governance- access to patient notes;
- Celebrating of success;
- Mandatory training.



### Opportunity to Celebrate Success:

Below are the areas of success that are not routinely shared or recognised by the clinical teams:

- Quality Improvement (QI) projects in progress include Falls and HAPU;
- Board rounds;
- Patient and relative feedback extremely positive but not always captured;
- Members of the MDT feedback very positive;
- Record keeping;
- Ward Leadership;
- Harms dashboard usage increased:



### Staff feedback:

Ward staff have embraced the Ward Accreditation programme and have given extremely positive feedback. Quotes from Ward managers below:

*"A lot of work but worth it in the end we are going for Gold."*

*"We Welcome setting of standards to help to implement change."*

*"A really good idea to standardise."*

*"At last we know what we need to be doing."*

*"Will this standardisation stop us being creative."*

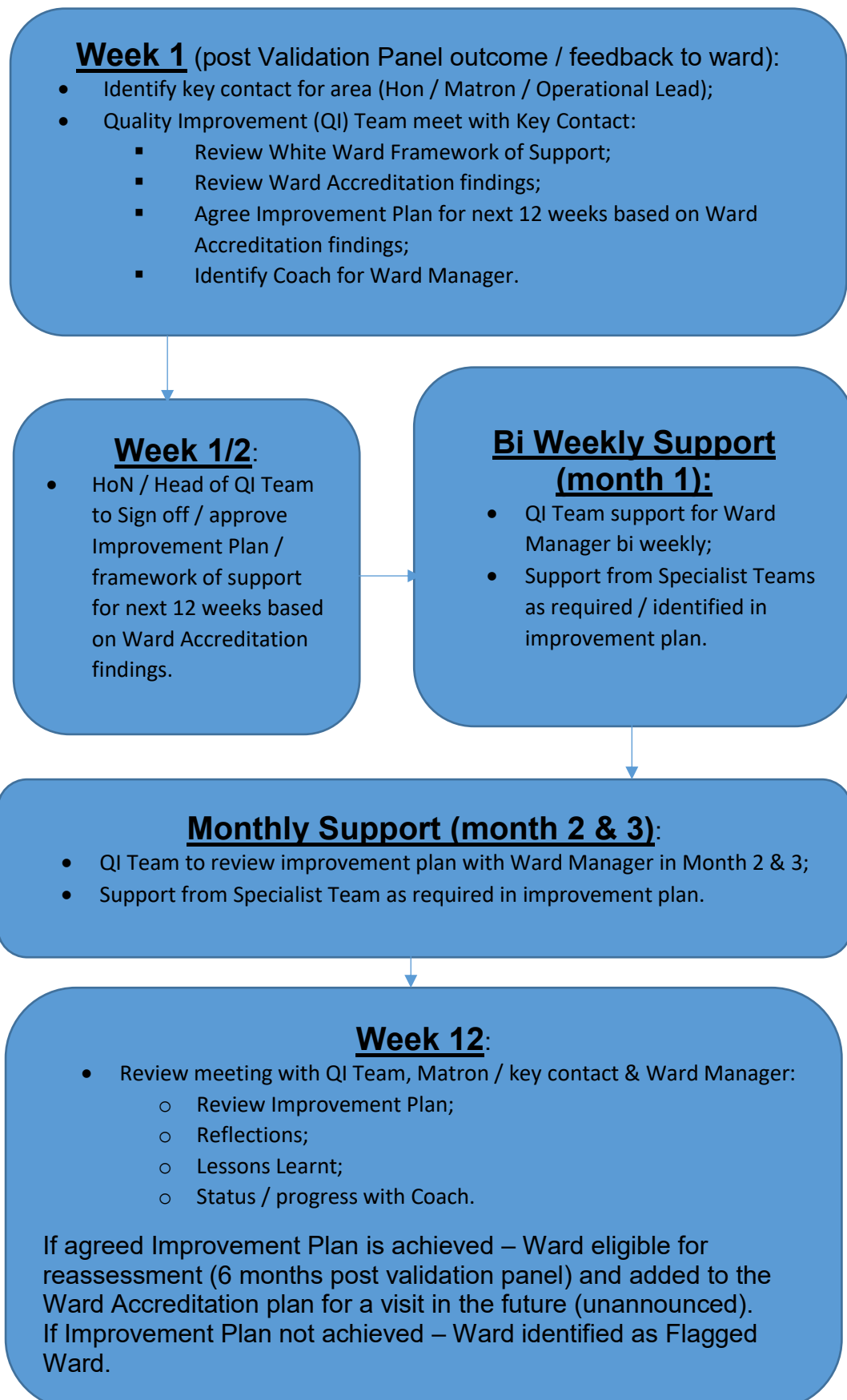
*"Even though I am new in post as a Ward Manager it has given me a good baseline to start from with a direction."*

**Next Steps:**

- Continue with the agreed process to visit all wards in the Health Board before implementing into bespoke areas such as day units, theatres etc;
- Planned review of the supporting documentation such the E handbooks, Ward Accreditation visit prompt questions August 2019;
- Introduction of new ward monthly quality metrics linked to Ward Accreditation;
- Implementation of a buddying system of wards for support following ward accreditation.

## Appendix 1

### Framework of Support: White Wards (following Ward Accreditation)



**Quality, Safety &  
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**19.3.19**
***To improve health and provide excellent care***

<b>Report Title:</b>	Stroke Services
<b>Report Author:</b>	Mrs Judith Rees, Directorate General Manager, Medicine East
<b>Responsible Director:</b>	Dr Evan Moore, Executive Medical Director
<b>Public or In Committee</b>	Public
<b>Purpose of Report:</b>	To update the Committee on progress within Stroke Services on the implementation of the 2017 Royal College of Physicians (RCP) Peer Review report and compliance with Standards and Guidelines
<b>Approval / Scrutiny Route Prior to Presentation:</b>	No prior scrutiny has been undertaken
<b>Governance issues / risks:</b>	The report is for information and advises the Committee on the progress within governance arrangements post the Peer Review and ongoing challenges to Stroke performance against the Welsh Government targets and associated patient safety risks
<b>Financial Implications:</b>	The report does not have any financial implications but advises the Committee of the further work being undertaken in Stroke services which will identify the significant investment needed to improve the service to required performance and patient safety standards
<b>Recommendation:</b>	The Committee is asked to receive the report and note the improvements that have been made within existing resources.

<b>Health Board's Well-being Objectives</b> <i>(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)</i>	✓	<b>WFGA Sustainable Development Principle</b> <i>(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.)</i>	✓
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		4.Putting resources into preventing problems occurring or getting worse	

achieve their own well-being			
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			
<b>Special Measures Improvement Framework Theme/Expectation addressed by this paper</b>			
Strategic and service planning			
<b>Equality Impact Assessment</b>			

*Disclosure:*

*Betsi Cadwaladr University Health Board is the operational name of Betsi Cadwaladr University Local Health Board*

## BETSI CADWALADR UNIVERSITY HEALTH BOARD

### STROKE SERVICES

#### 1. PURPOSE OF THE REPORT

The purpose of this paper is to update the QSE on progress with implementation of the recommendations from the Royal College of Physicians (RCP) Peer Review of Stroke Services in the Health Board in 2017. An initial progress report was submitted to the Quality Safety & Experience Committee in September 2018 and this paper will outline further progress to date. Additionally it will also provide an update on progress of plans for improvement of the Government (WG) performance targets known as Quality Improvement Measures (QIMs).

#### 2. INTRODUCTION

In January 2017 following a request from the Health Board, the RCP undertook a Peer Review of the Stroke Pathway in North Wales. Concerns had been raised in 2016 following Delivery Unit (DU) intervention regarding poor compliance with the WG QIMs and performance against the Stroke Sentinel National Audit Programme (SSNAP) standards. Particular concerns had been raised about the variation in the number of patients who received Thrombolysis Treatment intervention between the three District General Hospitals (DGHs) and Governance arrangements.

There were a number of commendations for all three Sites but this report focuses on the recommendations for improvement that were made.

RECOMMENDATION	ACTIONS	OUTCOME	RISK/ ISSUE	LEAD	TIMESCALE
Requirement for improved Board Level Leadership and Clinical Governance arrangements to be strengthened	Area Director East appointed as Stroke Management Lead	Senior Leadership across BCU  Focus on Planning and Strategy via Collaborative group Chaired by Area Director  Focus on shared Learning and cross site	Lack of attendance from all areas and professions is an ongoing issue. Terms of Reference (TOR) redrafted Feb 19 and Area Director to send communication to relevant parties for requirement for improved attendance	Area Director East	Achieved

		and Area working across BCU Accountability of monthly Local Quality and Safety (Q&S) groups for performance improvement which are all established			
All patients should be transferred to the Access to the Acute Stroke Unit (ASU) with 4 hours of diagnosis	Ring fenced bed protected on all 3 sites	Improved compliance with target and patients receiving appropriate care sooner in the Pathway	Risk that Site Unscheduled care (USC) pressures prevent ring fencing of bed, particularly a risk out of hours (OOH). This is an ongoing risk with the BCU performance since the last report showing marginal improvement however, Wrexham has seen a marked improvement with deterioration in YG and YGC. Each Site has been asked to improve focus and compliance via bed meeting and Safety Huddles.	Hospital Director	Continuous
	Medical Clerking undertaken post transfer to the ASU	Improved compliance with target and patients receiving appropriate care sooner in the Pathway	Only followed in Wrexham at present and fails OOH sometimes. To be rolled out in YG and YGC once tested fully in Wrexham	DGMs	February 2019 and ongoing
	Fast Bleep alerts of FAST positive patients on arrival to ED	Treatment for patients started earlier in the pathway and bed available to facilitate timely transfer to ASU	Not fully operational in YG and YGC. Protocol being amended March 2019	DGMs	Achieved in Wrexham. March 2019 for YG and YGC
	Pre Alert of potential Thrombolysis	Earlier intervention for patients and improved compliance with target	Current model of alert from WAST Control desk to ED adds risk of inadequate information being	Locality Manager WAST	March 2019



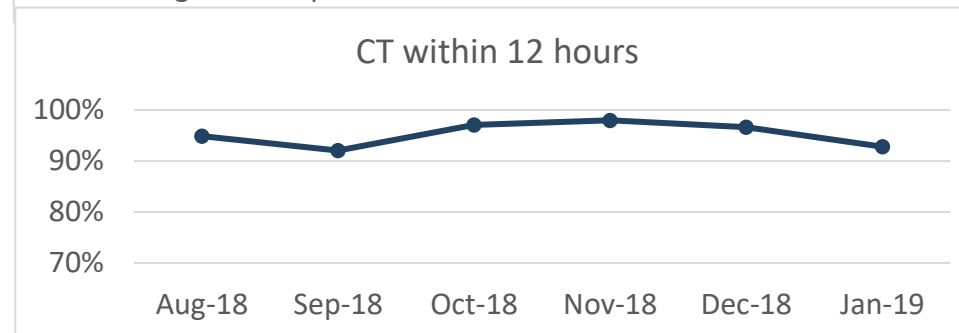
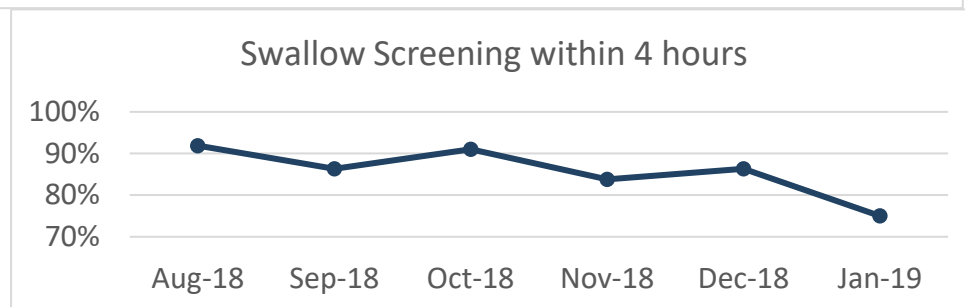
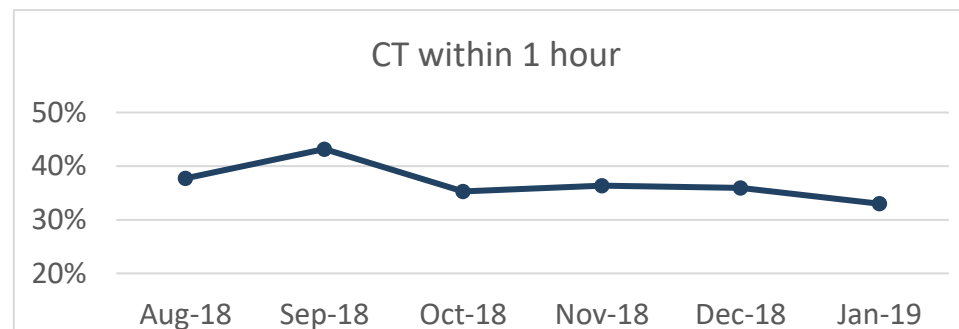
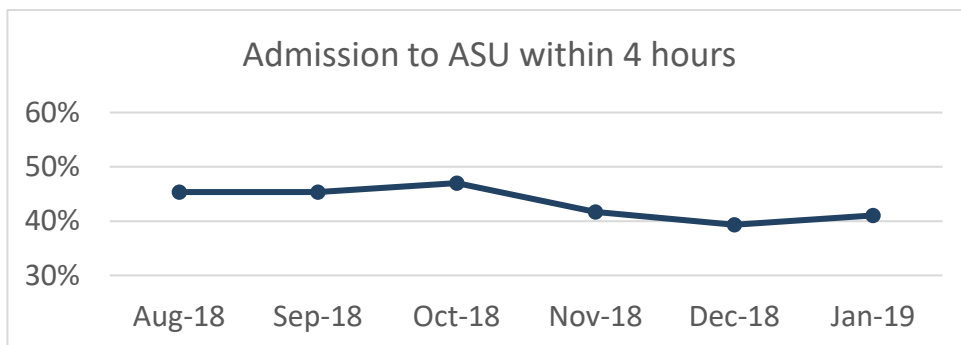
	patients from WAST		available at point of contact and reduces opportunity for Clinician to Clinician contact. Direct contact from WAST crews being explored with WAST as protocol already in place in other parts of Wales	(East)	
	Raise awareness of Stroke being an Emergency with medical and nursing staff	Patients prioritised for earlier intervention by Medical staff and improved access to ASU and better compliance of all targets	Lack of time for Clinical staff to attend training sessions	Clinical Lead/Consultants/Stroke Nurses	January 2019 and ongoing
	Stroke Nurses to become ANPs	Patients clerked earlier in the pathway supporting medical staffing delays and gaps. Able to prescribe and support full pathway improvement	Only being progressed in Wrexham this year. YG Senior Stroke Nurse already ANP	Head of Nursing East	Commenced September 2018
Reduce variance across BCU in % of patients Thrombolysed and improve Door to Needle (DTN) times in line with the performance target of 50% within 30 mins and 90% within 45 mins	Review BCU wide Thrombolysis protocol	Standardised approach to Thrombolysis and reduced variance  CNSs to be approved as Non Medical Referrers for CT requesting which will speed up pathway  Rapid CT pathway implemented which will improve 1 hr CT compliance		Clinical Lead  Matrons  Clinical Lead	Achieved December 2018  Achieved February 2019  Achieved February 2019 in Wrexham

		<p>Review Job Plans and Service impact for Consultants to improve OOH Service</p> <p>Roll out Access to Imaging from home for Consultants to reduce travel time and improve compliance with target</p> <p>Greater understanding of variance. Action plan for improvement and opportunity for greater standardisation and shared learning</p>	<p>Risk to General Internal Medicine (GIM) rota across BCU. Risk Consultants will not want to reduce GIM commitments. Financial risk of increased sessions.</p> <p>Broad width not available for all Consultants. Financial risk of ongoing revenue costs</p>	<p>Asst Area Directors and DGM East</p> <p>Clinical Lead and DGMs</p> <p>Director of Improvement &amp; performance</p>	<p>and rolling out to YG and YGC March 2019</p> <p>Initial discussions held February 2019 with option appraisal May 2019</p> <p>Feedback received February 2019, plan to be developed March 2019</p> <p>Discussion commenced 2018 but no Service change agreed</p>
Establishment of Hyper Acute Unit including Early Supported Discharge Service and Stroke inpatient Rehabilitation Services	Business Case to be concluded and Board to consider recommendations	<p>Phased implementation with ESD and Rehabilitation a priority for years one and two</p> <p>Workforce modelling Capacity and demand</p>	Risk of not supported by Health Board. Financial risk as significant investment needed. Risk of unable to be able to recruit	Area Director (East)	Updated version of Business case submitted February 2019. Await

		completed and has informed Business Case			consideration by Board
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### 3. PERFORMANCE

Performance of the key targets in the last 6 months is as below **(Please note the axis are not from 0 - 100 %)**. It is pleasing to note that initial indications for the February performance show an ongoing improving performance.



### 4. CONCLUSIONS

There has been some progress with the implementation of the recommendations from the Peer Review in 2017;

Access to the ASU within 4 hours remains a challenge with the ongoing USC pressures on each site but actions outside of retaining the ring fenced beds have been progressed to support improved performance.

Reduced variance in the in hours and OOH Thrombolysis rates has seen limited improvement and will not improve significantly without a change in the Job plans of the Consultants and a solution to the impact this will have on the GIM rota. Discussions are progressing on this. Investment in the telemedicine from Consultants home will support some improvement. The review by the DU will enable

further understanding of the variances of the Thrombolysis rates and action plans to be developed and improved further outside of the Consultant Job Plan changes required.

The Board are required to support the recommendations of the HASU Business Case to make any significant improvements in the Stroke pathway overall.

## 5. **RECOMMENDATIONS**

The Committee is asked to receive the report and note the improvements that have been made within existing resources.

**Quality, Safety &  
Experience Committee**
**19.3.19**

**GIG  
CYMRU  
NHS  
WALES**

 Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board

***To improve health and provide excellent care***

<b>Report Title:</b>	Care Inspectorate Wales Inspection into Older Adult Services in Wrexham County Borough Council
<b>Report Author:</b>	Mrs Andrea Hughes, Area Nurse Director (East)
<b>Responsible Director:</b>	Mrs Gill Harris, Executive Director of Nursing & Midwifery
<b>Public or In Committee</b>	Public
<b>Purpose of Report:</b>	To update the Committee on the recent Healthcare Inspectorate Wales (HIW) and Care Inspectorate Wales (CIW) joint inspection of Older Persons Services in Wrexham Local Authority
<b>Approval / Scrutiny Route Prior to Presentation:</b>	This paper has been scrutinised by the East Area Director and approved by the Office of Executive Director of Nursing
<b>Governance issues / risks:</b>	No governance or risk issues identified in this paper
<b>Financial Implications:</b>	No specific Financial implications detailed in this paper.
<b>Recommendation:</b>	<p>The Committee is asked to note:</p> <ol style="list-style-type: none"> <li>1. the implementation of a new framework of inspection by CIW with HIW</li> <li>2. the overview of the inspection process of Wrexham County Borough Council as the first in North Wales of the National Inspection into Prevention and promotion of independence for older adults living in the community</li> <li>3. the initial feedback of Inspectors the partnership working of the WCBC and BCUHB</li> </ol>

<b>Health Board's Well-being Objectives</b> <i>(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)</i>	✓	<b>WFGA Sustainable Development Principle</b> <i>(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.)</i>	✓
1.To improve physical, emotional and mental health and well-being for all	<input checked="" type="checkbox"/>	1.Balancing short term need with long term planning for the future	<input checked="" type="checkbox"/>

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	✓		
<b>Special Measures Improvement Framework Theme/Expectation addressed by this paper</b>			
Leadership and governance			
<b>Equality Impact Assessment</b>			
Not required for update paper of this nature			

*Disclosure:*

*Betsi Cadwaladr University Health Board is the operational name of Betsi Cadwaladr University Local Health Board*



## **Care Inspectorate Wales Inspection into Older Adult Services in Wrexham County Borough Council**

### **Situation**

Wrexham County Borough Council have been the first council in North Wales to be the subject of Care Inspectorate Wales (CIW) National programme of inspection into Older Adult services. This inspection is the first of a new inspection framework where Healthcare Inspectorate Wales (HIW) will work alongside CIW.

The purpose of these new framework of inspections is to explore how well local authorities and local Health Boards are promoting independence and preventing escalating needs of older adults. The inspections will identify those factors that drive good outcomes for people as well as the barriers to progress.

The inspection focused upon the experience of older adults as they come into contact with and move through social care services up until the time they enter residential or nursing care. The inspection took place in the weeks commencing 7<sup>th</sup> January 2019 and 21<sup>st</sup> January 2019.

### **Background**

The CIW inspection methodology is underpinned by the four principles of the Social Services and Wellbeing act (Wales) 2014. The key questions the inspection will explore the areas of:

- Well-being
- People – voice and control
- Partnership and Integration
- Prevention

The inspection explores how well local authorities and local health boards are promoting independence and preventing escalating needs of older adults. The focus is on people being supported to remain living at home and does not include people living in care homes.

People who primarily receive support from Community Mental Health Teams were also not included in this inspection.

### **Assessment**

In the first week CIW assessed a sample of cases. Which included interviewing the allocated caseworker, their manager and partner agencies. In addition, the views of service users, families and carers were sought.

During the second week CIW explored themes arising from week 1. A number of individual interviews and focus groups with elected members, staff, managers, partners and service providers were undertaken.

CIW took the opportunity to observe practice and visited some of our integrated and partnership work such as the discharge hub at the Maelor Hospital.

A feedback meeting was attended by the Area Director at which the following provisional findings were presented;

- There were no significant issues or problems raised that related to BCUHB services.
- The combined Community Resource Team (CRT) model with Wrexham Social Services was complemented
- Partnership working was identified as good.

Areas identified for improvement included:

- Further work on developing alternative pathways of care; an example was provided where a patient was referred to a Urologist and waited for review when he could have been looked after by the CRT
- Waiting time in hospital – patients wait a long time in the Ysbyty Maelor
- Lack of professional challenge- Staff in the Health board and LA work well together but may be accepting each other's' difficulties in circumstances where more challenge may be appropriate.

In addition the Inspectors commented positively on the Values demonstrated by CRT staff

Individual reports for each authority will be published in line with CIW practice guidance.

A report of the findings will be published on the CIW website and provided to the Minister for Health and Social Services along with a media statement.

A national overview report will be produced once all inspections have been completed towards end of 2019 or early 2020.

### **Recommendation**

That the Committee discuss and note

- the implementation of a new framework of inspection by CIW with HIW
- the overview of the inspection process of Wrexham County Borough Council as the first in North Wales of the National Inspection into Prevention and promotion of independence for older adults living in the community
- the initial feedback of Inspectors the partnership working of the WCBC and BCUHB

<b>Quality Safety &amp; Experience Committee</b>	 <b>GIG CYMRU NHS WALES</b> Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board
<b>19.3.19</b>	<b>To improve health and provide excellent care</b>

<b>Report Title:</b>	Medicines Management Policy MM01 (Updated)
<b>Report Author:</b>	Judith Green, Lead Pharmacist Medicine (East) / Acting Governance Pharmacist
<b>Responsible Director:</b>	Dr Berwyn Owen, Director of the Pharmacy & Medicines Management Division
<b>Public or In Committee</b>	Public
<b>Purpose of Report:</b>	Approval of the Policy.
<b>Approval / Scrutiny Route Prior to Presentation:</b>	Professional Advisory Group 9.11.18 Pharmacy Professional Advisory Group 21.11.18 Secondary Care QSG 21.11.18 Medicines Policies and Procedures Subgroup 26.11.18 Drugs and Therapeutics Group 5.12.18 Consultation via email on 31.10.18 to the following groups: Area and secondary care QSGs for each site All BCU Consultants, Speciality Doctors, Junior Doctors, Matrons, Drugs and Therapeutics Group members, Divisional and Local Medical and Nursing Directors, Clinical Governance Lead Nurses, Pharmacy staff. Consultation to Mental Health, Paediatrics and HMP Berwyn, Primary Care via Pharmacy Leads. Quality Safety Group 9.1.19
<b>Governance issues / risks:</b>	Update of existing policy – none identified.
<b>Financial Implications:</b>	Update of existing policy – none identified
<b>Recommendation:</b>	The Committee is asked to approve the Medicines Policy MM01 for use within BCUHB

<b>Health Board's Well-being Objectives</b> <i>(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)</i>	√	<b>WFGA Sustainable Development Principle</b> <i>(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.)</i>	√
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			
<b>Special Measures Improvement Framework Theme/Expectation addressed by this paper</b>			
Leadership and Governance			
<b>Equality Impact Assessment</b>			
See attached			

*Disclosure:*

*Betsi Cadwaladr University Health Board is the operational name of Betsi Cadwaladr University Local Health Board*

## MEDICINES POLICY

<b>Author &amp; Title</b>	<b>BCUHB MEDICINES POLICY</b> Medicines Policy Task and Finish Group Editorial Group Medicines Governance Lead Pharmacist Medicines Management Nurses Associate Director of Nursing (Chapter 8 HCSWS)
<b>Responsible dept / director:</b>	Pharmacy & Medicines Management Clinical Division Dr Berwyn Owen, Chief Pharmacist
<b>Approved by:</b>	Medicines Policies and Procedures Subgroup 26.11.18 Drugs and Therapeutics Group 5.12.18 QSG 9.1.19
<b>Date approved:</b>	XX
<b>Date activated (live):</b>	XX
<b>Documents to be read alongside this document:</b>	<b>BCU Medicines Management Policies</b> <ul style="list-style-type: none"> <li>• MM 03 Non-Medical Prescribing Protocol for Supplementary and Independent Prescribers Policy</li> <li>• MM05 Intrathecal chemotherapy policy</li> <li>• MM08 BCUHB Code of Practice for BCUHB staff with pharmaceutical companies (also providing guidance for General Practitioners and other independent health contractors)</li> <li>• MM11 Guidance for Nurse Independent Practitioner (INP) V100 /V150 prescribers</li> <li>• MM 12 Procedure for the Management of Medication Administration Incidents and Near Misses including Management of Nursing / Midwifery Staff, or other Registered Healthcare Professionals</li> <li>• MM 15 Guidance for Administration and use of Emergency and Non-Emergency Oxygen in Adults In Acute and Community Hospitals</li> <li>• MM16 BCUHB Written Control Document for Guidance on the Transcription of Medicines</li> <li>• MM 21 BCUHB self administration guideline</li> <li>• MM31 BCUHB Policy for the prescribing, supply and administration of methotrexate for hospital inpatients</li> <li>• MM33 Guidelines for Community Staff on the removal of unwanted medication from a patient's home</li> <li>• MM PGD 01 Patient Group Directions -Procedure and Guidance for Authors and Users</li> <li>• Injectable Medicines Policy – awaiting ratification</li> <li>• Unlicensed Medicines Policy – awaiting ratification</li> </ul>



	<ul style="list-style-type: none"> <li>Covert Administration of Medicines Clinical Protocol</li> </ul> <p><b>Standard Operating Procedures</b></p> <ul style="list-style-type: none"> <li>Pharmacy Department's Clinical Trial Standard Operating Procedures PCT01</li> <li>Guidelines</li> <li>Standard Operating Procedure BCUHB Safe discharge of all patients taking warfarin</li> <li>BCUHB Critical Medicines Guide</li> <li>SOP for destruction of CDs for authorised witnesses</li> </ul> <p><b>BCU Documents (non medicines management)</b></p> <ul style="list-style-type: none"> <li>F03 BCUHB Local Anti Fraud, bribery and corruption Policy</li> <li>WP6 BCUHB Code of Conduct ( Disciplinary rules and standards of behaviour</li> <li>NU01 Discharge Protocol</li> <li>IMMS 04 Storage and handling of Vaccines Written Control Document</li> <li>RES 03 BCUHB Cardiopulmonary Resuscitation (CPR) Policy</li> <li>CSPM 01 Guidance for ensuring Safety and Quality of Chemotherapy Services</li> <li>MD 17 Interventions not normally undertaken (INNU)</li> <li>BCUHB Guideline for the in-patient management of adult patients addicted to opioids</li> <li>ES 03 Waste Management Policy</li> </ul> <p><b>National Policies or Documents</b></p> <ul style="list-style-type: none"> <li>All Wales Pharmacist Enabling Therapeutic Switch (PETS) Policy</li> <li>AWMSG All Wales Multidisciplinary Medicines Reconciliation Policy</li> <li>Codes of Conduct for Regulatory Bodies of all health professional</li> <li>MARRS All Wales Policy for Medicines Administration, Recording, Review, Storage and Disposal (2015)</li> <li>PSN 15 'The storage of medicines: Refrigerators 2015</li> <li>PSN 030, The safe storage of medicines: Cupboards 2016</li> </ul>
<b>Date of next review:</b>	XXXX
<b>Date EqlA completed:</b>	Nov 2018

First operational:	12/2015 Replaces MM02– Medicines Code				
Previously reviewed:	12/ 2015	09/2018			
Changes made yes/no:	YES (MM02)	YES (MM01)			

N.B. Staff should be discouraged from printing this document. This is to avoid the risk of out of date printed versions of the document. The Intranet should be referred to for the current version of the document.



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## **Chapter 1 Introduction to the BCUHB Medicines Policy**

### **1.1 Introduction**

Betsi Cadwaladr University Health Board (BCUHB) is committed to the safe and secure handling of medicines to protect its patients, staff and visitors and its financial resources.

This Medicines Policy updates and replaces the previous Medicines Code used in North Wales Hospitals incorporating Community based services e.g. GP Out of Hours (GPOOH) and BCUHB managed primary care services. It also includes the health services provide to HMP Berwyn. A BCUHB Medicines Policy Task and Finish Group revised the Medicines Policy which was then editorially corrected by a small editorial group. Following broad consultation the Policy was subsequently approved by the BCUHB Medicines Policy, Procedures and PGD sub group, and then endorsed by the BCUHB Drugs and Therapeutics Group (DTG). The BCUHB Quality and Safety Committee and Quality, Safety and Experience Committee gave final approval to the document, as required by BCUHB OBS1 Policy.

### **1.2 Purpose of the Medicines Policy**

The purpose of this Medicines Policy is to set out a clinical and corporate governance framework to promote the safe and secure systems for controlling and handling of medicinal products in all aspects of clinical services operated and delivered by the BCUHB .

Guidance on safe and appropriate prescribing will be considered and disseminated by the BCUHB DTG Group. In general, medicines need to satisfy tests of clinical and cost effectiveness and should be justifiable on grounds of safety, given the alternative therapies available and the circumstances of the patient.

In addition to this Medicines Policy, healthcare professionals must comply with the current version of their relevant professional bodies' policies and policies of practice. If any circumstances arise such that this Policy cannot be applied, then the prime consideration will be the safe and effective treatment of any patient concerned. However, those staff involved must document all alternative measures taken in the appropriate records and inform senior professional staff of their actions outside of procedure.

### **1.3 Scope**

This Medicines Policy ,with the underpinning principles of legal, quality and safe practice, applies to all registered health care professionals and their support staff, across hospital and community settings within BCUHB including acute and community hospitals (including mental health and paediatric services) ,GP Out of Hours Services, Community Nursing services BCUHB managed primary care services, and those health services provided by BCUHB at HMP Berwyn. It includes all staff involved in the ordering, supply, storage, prescribing, administration and disposal of medicines. Medicines include Prescription Only Medicines (POM), Pharmacy Medicines (P), General Sales List Medicines (GSL) and Controlled Drugs (CD). The Policy includes complementary and herbal medicines, pharmaceuticals (non-therapeutic items) which include certain medical devices traditionally held in hospital pharmacy departments.

## 1.4 Standard Operating Procedures (SOP)

Each Clinical Division or service will develop and implement standard operating procedures (SOPs) describing safe working practice for aspects of work conducted within their clinical area. If an SOP/Written Control Document involves medicines or aspects of medicine usage across a multi-professional area, then the document is to be approved by the Clinical Division and then reviewed and/or approved by the BCUHB Medicines Policy, Procedures and PGD sub group.

## 1.5 Classification of medicines

Medicines are considered as two main sub-groups, Controlled Drugs and Medicines.

- **Controlled Drugs**  
Controlled Drugs are those drugs classified under the 'Misuse of Drugs Act 1971', and its associated regulations.
- **Medicines**  
Medicines will be taken to be all substances defined under the Medicines Act as being medicinal products. These include those restricted to supply on prescription (POM), those that can only be sold from a Pharmacy (P), and those that can be sold at any establishment, General Sales List medicines (GSL). Unlicensed medicines do not have a United Kingdom Product Licence.
- **Complementary and herbal medicines**  
The principles adopted for the use of medicines will also be followed for complementary and herbal medicines.
- **Pharmaceuticals**  
The term "pharmaceuticals" will be used to describe those non-therapeutic items covered by the policy (e.g. disinfecting and sterilising agents). It will also include certain devices carrying a CE mark traditionally stocked by pharmacy.
- **Black triangle medicines** are newly introduced medicines, subject to intensive monitoring for potential side effects by the Commission on Human Medicines (CHM) and Medicines and Healthcare Products Regulatory Agency (MHRA) (identified by ▼ in the British National Formulary).
- Unlicensed medicines used outside product licence are medicines used in a manner, indications, dosage or in patient types, which are outside the Summary of Product Characteristics (SmPC).
- Specials are medicines that do not have a product licence and are usually commissioned from a licensed manufacturing unit at the request of a prescriber, or by a pharmacist acting on behalf of that prescriber.

## 1.6 Corporate responsibilities

- **Chief Executive**  
The Chief Executive has overall responsibility for the medicines' management in BCUHB.
- **Medical Director**  
The above responsibility is delegated to the Board's Medical Director, supported by the BCUHB Drug & Therapeutics Group.
- **Chief Pharmacist for Medicines Management**  
The Chief Pharmacist Medicines Management is responsible for organising, monitoring and reporting on medicines' management, its systems and procedures

### **Revision Medicines Policy Editorial Group**

Alan Hughes, Medicines Governance Lead Pharmacist

Judith Green, Lead Pharmacist Medicine (East)

Dr Stuart Robertson, Consultant Nephrologists (East)

Julie Smith, Associate Director of Nursing, deputised by the following;

- Eiriann Turner, Medicines Management Specialist Nurse Primary & Community (West)
- Katherine White, Specialist Nurse Medicines Management (East)
- Val Bamber, Specialist Nurse Medicines Management

Rory Wilkinson, Lead Locality Pharmacist (Central)/ Sarah Kingman Deputy Head of Pharmacy for Primary Care and Community Services (West)

Elizabeth Bond, Lead Mental Health Pharmacist

Jacqui Liddle, Lead Operations Pharmacist (West)

Janet Thomas, Patient Safety Pharmacist (East)

### **Revision Medicines Policy Task and Finish Group (2017/8)**

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Janet Thomas, Patient Safety Pharmacist (East)

William Duffield, Patient Safety Lead (Central)

Richard Wynne, Medication Safety Pharmacist (Central)

Alison Jones, Patient Safety Lead (West)

## **Chapter 2 Operational Responsibilities for All Professional Staff**

### **2.1 Responsibility of the Executive Director of Nursing & Midwifery, Deputy Director of Nursing & Midwifery, Area Directors Clinical Services, Secondary Care Nurse Director and Assistant Directors of Nursing**

The Executive Director of Nursing Services, in conjunction with the Deputy Director of Nursing & Midwifery, Area Directors Clinical Services, Secondary Care Nurse

Director and Assistant Directors of Nursing, is responsible for ensuring that there are appropriate systems in place within wards, departmental clinics, HMP Berwyn Health and Wellbeing service and community settings for the following:

- The ordering of medicines and pharmaceuticals.
- The storage (physical and environmental conditions of medicines and pharmaceuticals).
- The administration of medicines including patients' own medicines other than those administered by a Doctor
- The recording of administration of medicines
- The security of medicines and prescription forms
- The supply and administration of medicines to patients in accordance with Patient Group Directions (PGDs)
- The reporting of medicines related incidents and errors via Datix, the incident reporting system
- The safe and proper disposal of unused/unwanted medicines and pharmaceuticals
- The retention of documents relating to the ordering, storage and administration and supply of medicines
- The induction of new staff with respect to the BCUHB Medicines Policy
- The education and training required to enable nurses to comply with the BCUHB Medicines Policy and for ensuring that a copy is readily available to staff.

## **2.2 Responsibility of the manager of the clinical area**

The manager of the clinical area will have joint responsibility with the BCUHB managed pharmacy for the ordering system where there is a pharmacy provided led stock control service.

The manager of the clinical area is responsible for ensuring that there are appropriate systems in place for the following:

- The investigation and reporting of medicine-related incidents and errors via Datix incident reporting system.
- The auditing of compliance with the Medicines Policy and the implementation of remedial action.

## **2.3 Responsibility of nurses, midwives and health visitors**

Each nurse, midwife and health visitor is responsible for:

- Reading and understanding this Medicines Policy
- Complying with this Medicines Policy
- Complying with Nursing Midwifery Council (NMC) 2015 The Code Professional standards of practice and behaviour for nurses and midwives.
- Complying with the NMC Standards for Medicines Management.
- Not undertaking tasks beyond their qualifications, competency or authorisation
- When undertaking tasks considered as an extended role, they must undertake approved training and evidence their competence in this new role

## **2.4 Responsibility of doctors and dentists employed by BCUHB**

The Medical Director will devolve the operational management responsibility to consultants, and directly employed medical staff, who will ensure that BCUHB employed doctors/ dentists are aware of and comply with the Medicines Policy. The



Medicines Policy is applicable to all BCUHB staff employed within BCUHB managed GP practices and to those BCUHB staff employed in HMP Berwyn.

## **2.5 Primary Care contractor services with independent health professionals**

should use the BCUHB Medicines Policy as a model for good practice. This will include General Practitioners, Dental Contractors, Community Pharmacists, Opticians, Practice Nurses and others

## **2.6 Responsibility of other Health and Care professionals** (including operating department practitioners (ODPs), physiotherapists, radiographers, chiropodist/podiatrists, orthoptists, clinical physiologists, pharmacy technicians)

Each practitioner is responsible for:

- Reading and understanding the Medicines Policy
- Complying with this Medicines Policy and the Health & Care Professions Council Standards and the Profession's code of practice where applicable
- Not undertaking tasks beyond their qualifications, competency and authorisation
- When undertaking tasks considered as an extended role, they must undertake approved training and display competence in this new role

## **2.7 Responsibility of Non-Medical Prescribers**

Non-medical Prescribers will practice in accordance with MM 03 Non-medical Prescribing Protocol for Supplementary and Independent Prescribers Policy or MM11 Guidance for Nurse Independent Practitioner (INP) V100 /V150 prescribers and will comply with their respective professional Codes of Practice.

## **2.8 Chief Pharmacist Medicines Management**

The Chief Pharmacist Medicines Management is responsible for ensuring that there are sufficient systems in place for the following:

- Providing a safe, effective, efficient and secure system for medicine stocks held within pharmacy.
- Providing a safe, effective, efficient and secure system for medicine distribution.
- Providing a system for monitoring medicine usage and advising on appropriate stock range and stock holding levels
- Providing advice on medicines and Controlled Drug security
- Providing advice on appropriate, environmental storage conditions
- Providing advice on safe and proper means of disposal of unused/unwanted medicines
- Providing advice on safe and effective systems and arrangements for medicine administration. This includes commenting and advising on medicine administration errors and near misses reported via the Datix incident reporting system
- Providing advice on transport of medicines and other pharmaceuticals
- Providing a system, when the pharmacy is closed, of access to emergency medicine stocks and the availability of a pharmacist for emergency duties
- Where a pharmacy led stock control service is provided there will be a shared responsibility between the manager of the clinical area and the Local Assistant Director of Pharmacy

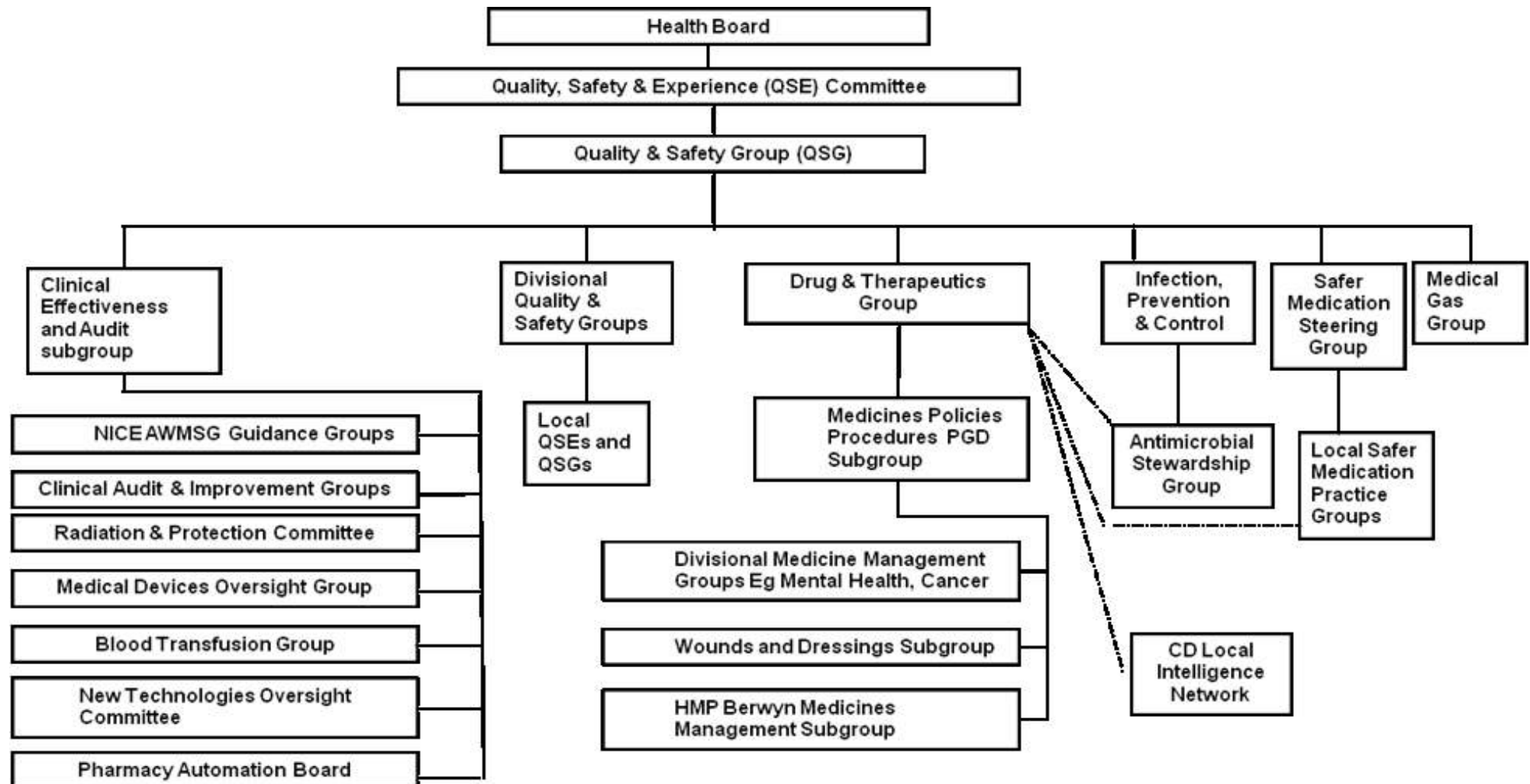
- Providing advice on clinical pharmacy services and ensuring that there is consistency of approach such that prescriptions are monitored, and appropriate action taken to ensure patient safety and effective use of resources
- Ensuring that there are adequate mechanisms in place to monitor and report on the usage on medicines throughout BCUHB and to devise strategies to promote cost effective prescribing
- Ensuring that there are systems in place to reduce the risk associated with the use of medicines throughout BCUHB
- Ensuring appropriate stock levels of medicines are held to meet the need of hospitalised patients and immediate response to civilian emergency
- Ensuring pharmacy representation on local medical devices committees to ensure safe usage of infusion systems and devices within BCUHB

Each Clinical Division will have an assigned lead clinical pharmacist who has a delegated responsibility for routine implementation of the above.

In community services a locality lead pharmacist is responsible for the community arm of the pharmacy services.



## 2.9 Medicines Management Governance Structure



## **Chapter 3 Medicines Audit, Suspected Fraud and Theft, Tampering of Medicines, Control of Medicines in Clinical Areas**

### **3.1 Monitoring and audit**

As part of the responsibility of delivery of the medicines' management process, the Chief Pharmacist Medicines Management will ensure that the following explicit, written, quality standards are prepared and regularly audited as part of the BCUHB audit cycle:

- The process of prescribing of medicines in BCUHB
- The appropriateness of medicines prescribed for individual patients including licence status and adherence to agreed therapeutic guidelines.
- The preparation of parenteral medicines. This will include all BCUHB hospital clinical areas as well as the main pharmacy department.
- The pharmacy reviewing of prescriptions and of dispensing medicines.
- The administration of medicines to patients.
- The supplying of medicines to take home and the counselling of patients about those medicines.
- The reporting of medication errors.
- Medicines administered for clinical research and clinical trials.

### **3.2 Risk management and patient safety initiatives**

- The Chief Pharmacist Medicines Management or a senior member of the Pharmacy Management Team will be a member of the BCUHB Quality and Safety Group.
- The Chief Pharmacist Medicines Management or a senior member of the Pharmacy Management Team will actively participate in patient safety initiatives e.g. 1000 Lives Plus or subsequent campaigns.
- The Chief Pharmacist Medicines Management or a senior member of the Pharmacy Management Team will hold responsibility for communication and liaison with the Welsh Risk Pool, and Patient Safety (Wales) on Medicines Safety and Risk Issues
- The risks inherent in medicines management and the effectiveness of risk control measures must be monitored and reviewed on a continual basis.
- Senior Management, both within Pharmacy and BCUHB, must be informed of any significant risks and risk control measures.
- All healthcare staff involved with medicines should undertake continued professional development (CPD) that is aligned with Clinical Governance and the requirements of the health professional's regulatory body, in order to keep up to date with the changes in medicine's management.
- Medication incidents should be regularly monitored, and issues of significance reported to the BCUHB Quality and Safety Group via the Safer Medication Practice Group.

### **3.3 Anti fraud and theft culture**

BCUHB has a zero tolerance anti fraud and theft culture and is committed to the principle that the NHS resource of medicines is always put towards the patient in

need of that prescribed medicine. BCUHB will seek to reduce medicine losses from fraud and theft to an absolute minimum by sanctions against those determined to steal or defraud the NHS. Possible sanctions may include criminal, civil or disciplinary proceedings, and BCUHB will seek to recover the cost of stolen or defrauded medicines.

### **3.4 Suspected fraud or theft allegations response plan**

#### **3.4.1 Discrepancy or misappropriation of medicines**

Each BCUHB employee must maintain their own record of any incident they have been involved with and their subsequent action. The manager of the clinical area will make initial enquiries to establish if any suspected theft or suspected fraud may have occurred.

#### **3.4.2 Suspected theft of medicines**

Incidents involving members of staff and/or patients that are suspected to have stolen BCUHB medicines or prescription forms or prescription pads, should be reported through the Datix system which automatically informs the line manager and a senior pharmacist, who should inform the local Security Manager, and where deemed necessary the Counter Fraud Officer.

The line manager and/or senior pharmacist may conduct initial enquiries and then should matters proceed to an investigation, the local Security Manager will then take responsibility for any subsequent investigation of alleged theft. The Security Manager will liaise with North Wales Police and the Human Resources Manager as appropriate.

#### **3.4.3 Suspected fraud in respect of medicines**

Some examples of NHS medicine and prescription frauds are as follows:

- Falsified medicine stock records
- Falsified orders for medicines
- Prescription fraud e.g. forged signatures and/or false representation by the patient for medicine not prescribed by an authorised NHS prescriber
- Self prescribing
- Prescribing for family members or friends

Prescribing for those who are not entitled to be prescribed NHS medicines e.g. foreign nationals who are not entitled to NHS treatment

This list is not exhaustive and those determined to commit fraud may develop new and sophisticated methods to avoid detection.

If an alleged theft involves suspected fraud, the Senior Pharmacist of the local hospital pharmacy and/or the Security Manager will refer the incident to the Local Counter Fraud Specialist of BCUHB. Any subsequent investigation will be conducted in line with the BCUHB Local Anti Fraud, bribery and Corruption Policy. (F03)

([http://howis.wales.nhs.uk/sitesplus/documents/861/F03\\_local\\_anti-fraud\\_bribery\\_corruption\\_policy.pdf](http://howis.wales.nhs.uk/sitesplus/documents/861/F03_local_anti-fraud_bribery_corruption_policy.pdf))

#### **3.4.4 Suspected Tampering of Medicines**

Incidents have occurred across the NHS where it is suspected that medicines have been tampered with. Examples of this may include the introduction of a contaminant into a fluid or other infusion, injection or other medicine dose form. The motive for such action may well be unclear but could include deliberate harm to others. If such an incident is suspected the nurse manager and senior



GIG  
CYMRU  
NHS  
WALES

Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board

pharmacist must be immediately informed and if suspicion of tampering is evident the Police must be immediately informed. Each suspected item must be retained in a separate plastic bag and labelled so to preserve the chain of evidence.

### **3.5 Control of Medicines in Clinical Areas**

#### **3.5.1 Security of medicines in BCUHB pharmacies**

The safe custody of medicines within the pharmacy, pharmacy keys and pharmacy entry swipe cards are the responsibility of the local Assistant Director for Medicines Management.

#### **3.5.2 Security of medicines in clinical areas**

All cupboards containing medicines must be lockable, either with a key or an electronic locking system. Electronic locking systems can be used for medicine cupboards with the exception of control drugs cupboards, which use either radio frequency identification (RFID), barcode, fob or finger print security. The use of standard key pads, where the number is shared with a number of users are not considered secure and hence are not recommended. Master key copies are permitted on a clinical area but a risk assessment must be carried out by the manager and pharmacy staff, to ensure the appropriate number of key copies are available. See section 3.5.4 for custody of keys. See section 9.6.1 for storage requirements for controlled drugs.

#### **3.5.3 Custody of keys and electronic locking systems**

The nursing manager or clinical lead of the area is responsible for the overall safe custody of medicines within the clinical area ie by ensuring safe custody of keys or by restriction of swipe card or finger print access only to authorised persons. The manager can delegate responsibility for possession of the keys for medicines cupboards, refrigerators, freezers and trolleys. Controlled drug cupboard keys must be kept separate from the stock medicine cupboard keys. Unauthorised persons must not be permitted access to medicines and keys within BCUHB premises.

All medicine storage keys must be passed to the next manager on duty at shift handover, keys must not leave the clinical area except in exceptional circumstances. It is the responsibility of staff using the keys to ensure they do not take them home at the end of their shift. For areas not open seven days a week, there must be a designated safe place to store keys. If there is a second set of keys, they should be kept in a secure place accessible to a senior staff member or manager.

A master key or electronic device must be held by each clinical area. Lost keys or electronic devices must be reported to the manager of the clinical area and a Datix incident form completed.

#### **3.5.4 Loss of keys from a clinical area**

If medicine storage keys and controlled drug cupboard keys cannot be found, urgent efforts should be made to retrieve the keys as soon as possible eg by contacting staff who have just gone off duty. Loss of keys must be reported to the manager of the clinical area following a thorough search. If spares are available they may be accessed. A Datix incident form must be submitted, pharmacy contacted and locks changed if considered a security risk (liaise with the site security manager).

### **3.6 Samples of medicines left by pharmaceutical representatives**

It is imperative that BCUHB must know what products are being used within its boundaries. Samples of medicines must not be left in clinical areas or issued to individual healthcare staff by pharmaceutical representatives for use within BCUHB. Representatives wishing to discuss supply of samples for use for evaluation of a medicinal product must be referred to the local hospital pharmacy. See Code of Practice for BCUHB Staff with Pharmaceutical Companies.

## Chapter 4 Prescribing Medicines

### 4.1 Process for Prescribing Medicines

All prescribing must be on BCUHB approved prescription stationery before supply or administration to a patient may occur. Electronic prescribing systems are in place within BCUHB, for example in HMP Berwyn, emergency departments at acute hospitals.

BCUHB approval has been given to the model of service for specialised paediatric oncology as set in 4.2.6.

#### 4.1.1 Persons authorised to prescribe medicines

Only those employed by BCUHB or working under a service level agreement (or contractual arrangement e.g. a model of service for specialised oncology) and are legally authorised to prescribe medicinal products for patients and service users of BCUHB, ie;

- Doctor
- Dentist, within area of competence
- Registered non-medical prescribers, see MM 03 Non-medical prescribing protocol for supplementary and independent prescribers policy.
- Registered Nurses Practitioners (Community) see MM11 Guidance for Nurse Independent Practitioner (INP) V100 /V150 prescribers. INP who have an annotation as Community Practitioner Nurse prescriber' on the NMC register, confirms that they are qualified to prescribe drugs, medicines and appliances from the Nurse Prescribers' Formulary (NPF) in the current edition of the British National Formulary. The majority of nurses who have undertaken this course are district nurses/ community nurses, health visitors and school nurses.

Provisionally registered doctors (FY1s) may only prescribe in connection with their contracted employment with BCUHB and cannot prescribe for out-patients.

Medical students cannot prescribe, but may write prescriptions to acquire and demonstrate competency. This must be under direct supervision of an authorised prescriber, with the prescription being countersigned immediately by the same authorised prescriber.

Medical assistants cannot prescribe, and are not permitted to prepare prescriptions or in patient medication records for countersigning by authorised prescribers.

Pharmacists who have demonstrated competency, may transcribe medication onto the in-patient chart/medication administration record from various corroborative sources as part of the medicines reconciliation process when a patient is admitted to an acute hospital. This is transcribing, not prescribing as set out in the All Wales Pharmacist Enabling Therapeutic Switch (PETS) Policy. The nurse can administer these transcribed medicines without a medical prescriber's signature.



In exceptional circumstances a nurse working in a community hospital may transcribe an in-patient prescription chart using the framework set out in the MM16 Nurse Transcribing Policy.

#### **4.1.2 Prescriber Responsibility**

Prescribers have a responsibility to monitor and ensure that the medicines they have prescribed have been reviewed. Prescribers should refer to the patient's existing prescriptions/supplementary charts and the patient's available records (eg IHR, secondary care records) before prescribing or amending a prescription. Changes to prescribed medicines must be recorded and communicated within the patient's medical record along with the indication for treatment or reason for stopping treatment (e.g. ineffective / side effects). The discharge letter must include medication changes with reasons.

The prescriber should provide counselling for the patient about important side effects and precautions, including any need for ongoing monitoring, which if needed should be agreed between primary and secondary care clinicians.

#### **4.1.3 Prescribing competence**

##### **4.1.3.1 Medical Prescribers**

All authorised prescribers must ensure they have appropriate knowledge and experience to prescribe competently in their area of practice. Knowledge of the "Guidance on Prescribing" sections in the current British National Formulary and any local guidance is essential for all prescribers. [Good Practice in Prescribing and Managing Medicines and Devices \(2013\)](#) guidance issued by the General Medical Council (GMC) also gives comprehensive advice for doctors.

##### **4.1.3.2 Non-medical Prescribers**

See [MM 03](#) Non-medical prescribing protocol for supplementary and independent prescribers policy for V300 and [MM11](#) Guidance for Nurse Independent Practitioner (INP) V100 /V150 prescribers.

#### **4.1.4 Prescription Stationery**

The type of prescription form used depends upon the prescriber and where the prescription will be dispensed e.g. hospital or primary care sector.

##### **4.1.4.1 Hand written prescriptions**

Each prescription must be legal, legible, unambiguous and written in indelible ink that can be photocopied. Upper or lower case may be consistently used.

A simple test for legibility is for another person who is unfamiliar with the prescriber's handwriting to read it without difficulty. Unused space on a hand written prescription should be cancelled by drawing a line or a large 'Z' through it to prevent additions to the prescription by unauthorised persons.

##### **4.1.4.2 Computer generated prescriptions**

The planning, development and implementation of electronic prescribing systems must be approved by the BCUHB Drugs and Therapeutics Group or delegated to the BCUHB Medicines Policy, Procedures and PGD sub group.

Different electronic prescribing systems exist within BCUHB. Electronic prescribing is limited to prescribers trained in use of that particular system. Access must be





password controlled with password issue only after training. Prescribers must adhere to the BCUHB IT policies.

#### **4.1.4.3 WP10 Prescriptions**

Prescription forms and pads are Controlled Stationery and their storage and issue is in accord to the BCUHB Standing Financial Instructions. See SOP for the Secure Management of WP10 HP/HIPs for guidance.

- WP10 HP and WHP10 HIP prescriptions (Hospital use).  
See MM 03 Non-medical Prescribing Protocol for Supplementary and Independent Prescribers Policy.
- WP10 IP/SP for V300 nurses working in primary care see MM 03
- WP10 CN for V100/150 INP Registered Nurse Practitioners. See MM11.  
Guidance for Nurse Independent Practitioner (INP) V100 /V150 prescribers

#### **4.1.4.4 In-patient medication administration record (prescription chart)**

The All Wales In-Patient Medication Administration Record is to be completed including any relevant risk assessments. Additional All Wales and BCUHB approved medication administration records are in use e.g.

- Long stay All Wales In-Patient Medication Administration Record
- Mental Health All Wales In-Patient Medication Administration Record
- Paediatric All Wales In-Patient Medication Administration Record
- BCUHB Critical Care Administration Record
- Supplementary infusion chart
- Syringe driver chart
- Anticoagulant chart

Medicine - specific charts e.g. chlorthalidone, vancomycin, unfractionated heparin, iloprost, methotrexate.

Care must be taken to avoid duplication or omission of treatment particularly where more than one prescribing document is in use for a particular patient. If an additional specialist chart is in use, it must be clearly indicated on the main chart.

#### **4.1.4.5 Care pathways and the use of pre printed prescriptions and/or pre printed labels**

Certain patient pathways include pre-printed prescription details and/or pre printed labels that are used where there is a need for clarity when prescribing complex regimens, or to provide a safe and complete package of care. Examples are insulin regimens where there is dosage titration dependent upon blood glucose results, also under the model of service for specialised paediatric oncology as set out in 4.2.6 and in post operative pain relief for parenteral or epidural opioid analgesia.

Before use in BCUHB, all pre-printed prescription details or labels must be approved by the BCUHB Drug and Therapeutics Group.

The prescriber has the responsibility to check that the correct pre-printed prescription or pre-printed label has been selected for the individual patient and must sign and date the prescription order to authorise its use. No medication should be administered until there is an authorised prescriber's signature present.

#### 4.1.5 Prescription writing standards

See British National Formulary prescription writing guidance

The following patient details must be entered:

- Name
- Confirmed Address
- Unit number and NHS number when practicable
- Date of birth
- Ward name (where applicable)
- Name of consultant (where applicable)
- Actual weight (as soon as practical)
- Medicine sensitivity to include date of reaction and severity

A pre-printed addressograph label should be used whenever possible and attached to the prescription chart or form before other details are added.

If more than one medicine chart is in use, “1 of 2, 2 of 2” etc. should be written on each chart.

The recommended International Non-Proprietary Name (rINN) (i.e. the approved / generic name) of the medicine should be used wherever possible.

Proprietary names (i.e. brand names) should be used for;

- Multi-ingredient preparations with no approved name
- Products whose proprietary name defines a specific formulation (e.g. combination inhalers and combination product topical preparations)
- Safety reasons to avoid miss selection of product (e.g. Shortec® and Longtec®, insulin - see section 4.2.11)
- Differences in bioavailability between brands of the same medicine, particularly if the medicine has a narrow therapeutic index eg lithium, ciclosporin.

Further information can be found in [https://www.sps.nhs.uk/wp-content/uploads/2017/12/UKMi\\_QA\\_Brand-name\\_prescribing\\_Update\\_Nov2017.pdf](https://www.sps.nhs.uk/wp-content/uploads/2017/12/UKMi_QA_Brand-name_prescribing_Update_Nov2017.pdf)

Each prescribed medicine must comply with the following:

- Route of administration must be stated
- Dose and frequency of administration
- Where a medication is to be administered via a device, the device must be specified eg spacer for inhalers
- Medicine names should not be abbreviated e.g. MTX, MMS, ISMN, FeSO4 are not acceptable. GTN is the only abbreviation that is considered acceptable.
- The date on which the treatment is to commence must be entered on the prescription. Short courses of antibiotics must include the stop date.
- If rewritten, the *original* start date on the in-patient medication chart must be used, not the date of the rewrite.

- The current weight of the patient must be entered for all paediatric patients and for patients where medicine dose adjustments by weight will be made.

#### **4.1.5.2 Dosing units**

- Doses must be expressed in the International System of Units (SI) units for single drugs. For preparations with a known strength, the total dose must be specified eg paracetamol 1g (not paracetamol 2 tablets). Where the preparation has no known strength, the dose should be expressed in number of tablets eg multivitamin tablets 1 tablet.
- Dose may be expressed as number of tablets for combination products
- e.g. co-codamol 30/500 “1-2 tablets 4-6 hourly p.r.n.”
- Roman numerals “II” or expression “ii” should be avoided
- Liquid preparations should be prescribed as volume e.g. 10mL.
- Liquid medicines available as different concentrations should be expressed as quantity (weight, units, mmol) and not simply as volume. For example “amoxicillin 500mg” or “amoxicillin 250mg in 5mL, 10mL” is acceptable, but amoxicillin 10mL is not acceptable.
- The terms ‘microgram’ and ‘nanogram’ must not be abbreviated but must be written in full.
- Quantities less than 1 gram must be written in milligrams.
- Quantities less than 1 mg must be written as micrograms (and where used, nanogram)
- Avoid decimal points. For example, 500 mg not 0.5 g. If a decimal point is used, e.g. 2.5mg, legibility is essential to avoid misreading as 25mg
- Avoid using trailing zeros i.e. use 1 mg and not 1.0mg, to avoid misreading as 10mg
- “Units” must be written in full. See section 4.2.11.

#### **4.1.5.3 Recording allergy status on in-patient medication chart**

The clerking health professional must complete the medicine allergy section on admission, including detail of the name of the medicine, nature of the reaction and where possible, when the reaction occurred. An allergy record in medical clerking notes is not sufficient. The medicine(s) in question must be specified and the type of allergy noted or the ‘none known’ box signed and dated. If it has been confirmed that the patient has no known allergies, this should be similarly documented.

It is not acceptable to prescribe any medicine without checking the patient’s allergy status. Should a patient be unconscious and this information is unable to be determined on admission, the patient notes should record this and flag the need to revisit the allergy status once the patient or relative can confirm.

A doctor, nurse, pharmacist or a pharmacy medicines management technician can complete the allergy section at a later stage if an allergy is subsequently discovered or the detail is initially incomplete. This applies also if a new adverse drug reaction occurs during the hospital visit. The GP should be informed of the reaction and the medicine involved.

#### **4.1.5.4 Variable routes**



Medicines for administration by variable routes can be prescribed on the prescription chart indicating the routes e.g. PO/IV, only when the doses by each route are the same e.g. metoclopramide. The person administering the medication must record the route by which the prescribed medication was administered and the time of administration to avoid duplicated doses being administered (see section 7.8.4). When the doses by each route are different e.g. prochlorperazine, each route required must be prescribed individually and endorsed with 'either / or' to avoid duplication.

#### **4.1.5.5 Approved abbreviations for routes of administration:**

IM for intramuscular

INH for inhalation

IV for intravenous

NEB for nebulisation using compression or oxygen

PO /O for oral

PR for rectal

PV for vaginal

SC for sub-cutaneous

S/L for sub-lingual

Top for topical

NG for nasogastric

PEG for percutaneous endoscopic gastrostomy

Other routes of administration should be written in full.

#### **4.1.5.6 Dose frequency**

For regular medication the prescriber should preferentially use the pre-set medicine round times to indicate administration time on the in-patient medication chart. The 24-hour clock should be used when specific timings are needed e.g. for antibiotics to space doses evenly through 24 hours, or for frequent dosage regimen used in Parkinson's Disease. Avoid prescribing doses at 12 midnight as this can lead to confusion.

The following abbreviations are standard means of indicating a dose regime:

od            Once a day

om            Each morning

on            Each night

bd            Twice daily

tds           Three times daily

qds           Four times daily

mane        Morning

nocte        At bedtime

see chart    As per dosing/additional chart

prn           As required (with indication interval/maximum dose stated)

Stat           Immediately

All other dose regimens and abbreviations such as 4<sup>o</sup> should not be used and must be written in full, for example, 4 hourly.

#### **4.1.5.7 'Once only' doses (stat doses)**



Stat doses are valid for a maximum of 24 hours. They are prescribed with the intention that it is needed to be given immediately. It is imperative that the prescriber communicate with a registered nurse to minimise delay in the patient receiving the dose. If not given within that timeframe nursing staff should ensure that stat doses should be discontinued by the prescriber and re-prescribed if necessary.

#### 4.1.5.8 As required (prn) prescriptions

For “as required” medicines, where a maximum frequency exists, it must be stated as well as the maximum dose in 24 hours. Where relevant the times for administration must be written by the prescriber e.g. hypnotics should be prescribed at night. It may not be easy to define a maximum 24 hour dose (e.g. for salbutamol). In these situations the **frequency** of dosing must be prescribed but the time may be determined locally, in accordance with an agreed protocol or procedure.

#### 4.1.5.9 Discontinued medicines on handwritten prescriptions

When a prescribed medicine is discontinued, the cancellation must be obvious and amendment signed and dated. This can be done by one of the following options:

A diagonal line drawn through the prescription

A large ‘Z’ or ‘X’ drawn through the prescription

Use of a ‘Cancelled stamp’

The original record must still be readable although it must be clear that no further doses must be administered from the date the order was cancelled.

It is good practice to record the reason for the discontinuation on the chart, unless discontinuation was completion of a course of treatment.

#### 4.1.5.10 Prescribing non-daily medication

There are a number of medicines which are not administered on a daily basis, for example bisphosphonates, hormone replacement therapy patches, and opioid analgesic patches. When these medicines are prescribed, it should be made clear on which days the medicines should be administered. On the All-Wales in-patient administration prescription chart, this should be indicated by drawing a box around the appropriate administration day and time. On the days on which medicines should not be administered, an “x” should be placed in the box to indicate a dose should not be given. On discharge the last date of administration should be specified eg fentanyl 25 microg patch apply every 3 days, last patch applied on 2.11.18.

The following illustration uses the example of fentanyl patch which should be administered every three days.

PATIENT'S NAME A. PATIENT HEALTH RECORD NUMBER 123456

MORNING (around 0800); MIDDAY (between 1200 & 1400); EVENING (around 1800); BEDTIME (around 2200)

ENTER DOSE AGAINST TIME REQUIRED. USE ONE ROUTE ONLY. FOR EACH ENTRY		REGULAR MEDICINES		MONTH	YEAR	DISCHARGE PRESCRIPTION											
DATE →	22/10/18	22	23	24	25	26	27	28	29	30	31	1/11	2/11	3/11	4/11		
ROUTE →	TOP	FENTANYL		EVERY 72 HOURS		PRESCRIBER'S SIGNATURE		PHARMACIST SIGNATURE		SUPPLY		To be reviewed by GP		Continued			
SPECIFY TIME IF REQUIRED ↓		PATCH		Medicines Reconciliation (click)		A. Prescriber		P. Haymer		1234							
				Started		Continued		Dose Changed									
Morning	✓ 12 micrograms	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	Limited Duration
Midday																	days
Evening																	Other instructions
Bedtime																	





PATIENT'S NAME **A. PATIENT** HEALTH RECORD NUMBER **123456**

MORNING (around 0800); MIDDAY (between 1200 & 1400); EVENING (around 1800); BEDTIME (around 2200)

ENTER DOSE AGAINST TIME REQUIRED. USE ONE ROUTE ONLY FOR EACH ENTRY		REGULAR MEDICINES		MONTH		YEAR		DISCHARGE PRESCRIPTION									
				OCTOBER		2018											
DATE	DOSE	SIGN	DOSE CHANGE	22	23	24	25	26	27	28	29	30	31	1/11			
ROUTE →	PO			MEDICINE (Approved Name)		SPECIAL INSTRUCTIONS		PRESCRIBER'S SIGNATURE		PHARMACIST SUPPLY		DISCHARGE PRESCRIPTION					
SPECIFY TIME IF REQUIRED ↓				ALENDRONIC ACID		WEEKLY - TUES		A. Prescriber		P. Harcourt							
						Medicine Reconciliation (date)		Sleep No. 1234									
						Start		Continue		Date changed							
Morning	06:00	70mg		X		X		X	X	X	X	X	X	X	X	X	
Midday																	
Evening																	
Bedtime																	
																Other instructions	

See MM31 - Policy for the prescribing, supply and administration of methotrexate for hospital inpatients for specific guidance on prescribing methotrexate.

#### 4.1.5.11 Rewriting of All-Wales in-patient administration charts

The authority to administer a prescribed medicine on a medicines record chart is valid until stopped by prescriber, or a defined stop date. When administration section is nearly full the prescriber should review and rewrite the medicine record chart. A new medicines record must be written if patient is readmitted. Rewriting charts is the routine responsibility of the prescribing team.

As set out in the All Wales Pharmacist Enabling Therapeutic Switch (PETS) Policy, pharmacists may rewrite prescription charts. The nurse can administer these transcribed medicines without a prescriber's signature. Any rewrite should include a review of the medicines prescribed, with any proposed changes discussed with the prescribing team.

In exceptional circumstances a nurse working in a community hospital may rewrite an in-patient prescription chart. It must be countersigned by an authorised prescriber as set out in the BCUHB MM16 Nurse Transcribing Policy.

Non-medical independent prescribers may rewrite medicines records in areas that they are competent to prescribe. See MM 03 Non-medical prescribing protocol for supplementary and independent prescribers policy.

#### 4.1.5.12 Validity of prescriptions

Only in-patient charts originating within the BCUHB are valid within BCUHB except when patients are transferred directly into a Community Hospital from an acute service provider outside of BCUHB. In this case the external Trust/Health Board medication record can be used until the next weekday, which will usually be within 72 hours. It could however be longer over public holidays or for clinical areas that do not have daily visits from clinicians. In these circumstances, the chart can be used until a local review can be undertaken by an approved prescriber of BCUHB. Transfers from a BCUHB acute hospital to a BCUHB community hospital (*and vice versa*) may continue using the original chart provided treatment was reviewed before transfer. The date of transfer must be marked on the chart.

In paediatric acute services, in-patient charts are reviewed and rewritten when patients are transferred between acute sites.



Out-patient prescriptions are valid for dispensing for a maximum of six months from the date they were signed. Prescriptions for schedule 2 and 3 controlled drugs are valid for 28 days from either the date of prescribing or a 'valid from' date specified by the prescriber on the prescription. See section 4.5 for further guidance on out-patient prescribing.

#### **4.1.5.13 Prescribing for relatives and visitors of in-patients**

Relatives and visitors of in-patients may occasionally stay overnight locally or within the hospital. They are responsible for supplying their own medication. When they have not brought their own medication to the hospital and their health may suffer as a consequence they should obtain an emergency supply from a community pharmacy, or if not local to the area, a local GP practice may be willing to prescribe as a temporary resident. The GP Out of Hours Service provider can issue a prescription to a temporary resident and in certain circumstances attendance for treatment at the Emergency Department is appropriate. If relatives cannot leave the hospital, and the consultant team treating the patient agree to take prescribing responsibility, the hospital pharmacy may agree to dispense a prescription written by the hospital team treating the in-patient. The hospital pharmacy may issue an emergency supply in exceptional circumstances.

#### **4.1.5.14 Verbal prescriptions to nursing staff - prescribing by telephone**

Telephoned prescriptions are permitted only in exceptional circumstances when, in the nurse's professional judgement, patient safety or care would otherwise be compromised by not accepting verbal instructions. It is emphasised that verbal orders are only appropriate in exceptional circumstances and are expected to be minimal in numbers. Exceptional circumstances will mainly be for areas such as community settings, where there are no doctors on site, e.g. Community Hospitals, Minor Injuries Units, and when treatment is needed to urgently relieve symptoms. Telephoned prescriptions can amend, delete or add a prescription item. Controlled Drugs must not be prescribed via a verbal order. Any refusal by a nurse to accept a verbal prescription must be documented by the nurse.

The prescriber must determine other medicines currently prescribed for that patient and confirm the patient's allergy status. A verbal order must be received by a nurse and confirmed ideally by a second nurse or suitably competent other (except in circumstances detailed in paragraph below).

The prescriber must state the:

- Identity of the patient
- Prescriber's identity
- Name of the medicine to be administered (spelt to avoid confusion)
- Dose to be administered
- Route and time to be administered

This information must be given to the first nurse to transcribe onto the in-patient medication record or emergency department card and then repeated back to the prescriber by the second nurse. The nurse taking the verbal message should be familiar with the medicinal product. See MM16 written control document for guidance on the transcription of medicines.





The prescriber should confirm the verbal instruction by fax or electronic means, which is then printed by the recipient of the verbal order and attached to the in-patient medication record or emergency department card. Where a nurse or other exempted person has had occasion to administer parenteral medication utilising those medicines set out in Chapter 16, they should make a record of those medicines administered as soon as is reasonably possible after administration.

When it is not possible for two registered nurses to be present to receive the verbal order, a second healthcare professional, who can be qualified or non-qualified, should be present. Both members of staff involved must sign and date the entry.

In exceptional circumstances;

- When a community health professional is working alone and is unable to receive a fax or electronically transferred instruction, the health professional may accept a verbal order from a prescriber to administer an urgent single dose of a medicine until such time as a fax or electronically transferred instruction can be made.
- Where medication has been previously prescribed and the prescriber is unable to issue a new prescription, but where changes to the dose are considered necessary, the use of information technology (such as fax, text message or email) may be used but must confirm any change to the original prescription (NMC 2010)

The prescriber must sign the form as soon as possible after giving the order. In the acute hospital, where doctors are on site, all telephone / verbal orders must be signed as soon as possible and in any event within the prescriber's shift. In areas where doctors are not on site, the telephone / verbal order for prescription only medicine must be signed as soon as possible, ie the next working day. This will usually be within 72 hours (though it could be longer over public holidays) or when a local review can be undertaken by an approved prescriber of BCUHB. Where a GP Out of Hours service is in operation, the prescriber giving verbal instructions can arrange for a second prescriber to countersign the verbal order. In areas where doctors are not on site doses may be administered for up to 72 hours without the doctor's signature until the verbal instructions are signed by a prescriber.

#### **4.1.5.15 Verbal prescriptions to pharmacists – corrections by telephone**

Verbal orders can be given by a prescriber to a pharmacist to amend delete or add a prescription item. This need often results from a pharmacist initiated query.

The pharmacist must confirm the following details:

- The patient's identify
- The medicine name, form, dose and frequency
- The name of the prescriber contacted

The pharmacist must also have access to sufficient information to assure themselves of the appropriateness of the medicine and dose. The pharmacist must read the alteration or addition back to the prescriber who must then affirm the original instructions.

The pharmacist will then amend the in-patient medication record, out-patient prescription or discharge prescription and record the name of the prescriber, who has been contacted, then sign and date the amendment.

If the alteration is to formulation, frequency or timings of dose, then that part of the prescription may be crossed out, altered and dated to ensure that the alteration is clear.

If the alteration involves any other changes e.g. new medicine, change in dose, then the whole prescription for that item must be written out by the pharmacist as a new entry on the in-patient medication record, outpatient prescription or discharge prescription.

Pharmacists should refer to the Royal Pharmaceutical Society publication: Medicines, Ethics and Practice for further guidance.

#### **4.1.5.16 Prescribing for medical staff who are unwell at work**

All routine medicines for doctors, their families and other hospital staff should be obtained through the General Practitioner Services. Prescriptions are subject to routine and random audit and exceptions to this protocol will be escalated to the Medical Director.

Medical staff that are unwell must follow the BCUHB Sickness Absence Policy which applies to all staff. The GMC Good Practice in prescribing and managing medicines and devices discourages prescribers wherever possible to self prescribe or to prescribe for anyone with whom the prescriber has a close personal relationship.

In order to standardise practice for medical staff that are unwell at work and to ensure compliance with the Welsh counter fraud initiative and the principles of clinical governance, it is acceptable for doctors to prescribe limited quantities of medicines for a medical colleague who is employed by BCUHB in **exceptional circumstances**, using the following principles:

- The prescriber must be a fully registered practitioner and hold the post of Consultant, Staff Grade Doctor, Specialist or Specialist Registrar.
- The prescriber's decision to prescribe is taken to support the attendance of his/her medical colleague in the workplace.
- A maximum of one week's treatment (or one original pack where appropriate) will be supplied.
- If a prescription levy is currently in force the appropriate prescription charge(s) must be paid.
- WP 10 (HP) forms must not be used for this purpose.

Prescribers should note that data from prescription forms WP 10(HP) dispensed by community pharmacies, are returned to BCUHB for audit purpose and are subject to regular scrutiny.

Prescriptions outside this guidance will be treated as a private transaction, and the full cost of the medication will be charged to the patient in accordance with the private prescription and signed order charge arrangements within the local hospital. The local hospital pharmacy will not dispense any prescription for any

medicines that significantly affect performance, mood altering medicines or Controlled Drugs under this protocol.

## **4.2 Prescribing**

### **4.2.1 Formulary and non-formulary medicines**

All newly initiated medicines should be prescribed from the approved BCUHB Formulary list. Formulary medicines are categorised using a colour code which indicates the place of therapy known as the BCUHB BRAG list. Advice on formulary dressings can be found in the BCUHB wound care and dressings formulary BCUHB wound care and dressings formulary.

Patients prescribed non-formulary medicines initiated historically will be continued on these medicines where appropriate. However in certain situations substitution with an alternative formulary item may happen in accordance with a local procedure approved by the BCUHB Drugs and Therapeutics Group.

### **4.2.2 Initiation and Continuation of Medication at the request of a Tertiary Centre outside of BCUHB**

New therapy for non-formulary/hospital only (Red Drugs) medicines recommended by tertiary centres outside of BCUHB must be approved by the NHS Wales/BCUHB Individual Patient Funding Request (IPFR) commissioning process and then can be prescribed once approved by BCUHB.

### **4.2.3 Shared Care Arrangements**

Certain formulary medicines are designated within the BCUHB Medicines Formulary as Amber, meaning that a shared care arrangement process is in place. Prescribers should be aware of the formulary status of the medicines they prescribe. Shared care agreements are listed within the BCUHB Prescribing Matters web pages BCUHB Share Care Arrangements

### **4.2.4 Unlicensed medicines**

See unlicensed medicines policy

### **4.2.5 Off License / Off Label medicines**

See unlicensed medicines policy

### **4.2.6 Anti cancer medicines**

The prescribing of cancer medication is limited to authorised prescribers set out in CSPM 01 Guidance for ensuring Safety and Quality of Chemotherapy Services. Paediatric oncology medication is only prescribed by limited authorised prescribers from the Merseyside and Cheshire Children and Young People's Cancer Network under a model of service and governance utilising Paediatric Oncology Shared Care Units (POSCU) MDTs which include Level 1 Services including IV bolus chemotherapy. Non-authorised prescribers must not prescribe cancer medication within this specialised area.

See MM05 Intrathecal chemotherapy policy for guidance on prescribing intrathecal chemotherapy.

### **4.2.7 Controlled Drugs**

See Medicines Policy Chapter 9.

For specific advice on prescribing for controlled drug dependent patients, registered drug dependent patients admitted to hospital on methadone or

buprenorphine, and non registered drug dependent patients admitted to hospital using illegal supplies see chapter 9.

#### 4.2.8 Intravenous and parenteral medication

See Injectable Medicines Policy

#### 4.2.9 Dietetic products and borderline substances

Whilst dietetic products are not medicines, dieticians can initiate formulary dietetic products by writing them on the patient's in-patient prescription chart or where used, a BCUHB approved nutrition chart. Consideration must be given to medicine-food interactions and feed breaks, contact pharmacy for advice if necessary. Restrictions upon prescribing of borderline substances within the community are set out within the BNF and the current edition of the Drug Tariff. Certain borderline nutritional products may be supplied from a local hospital pharmacy.

#### 4.2.10 Complementary and herbal medicines

See MD 17 Interventions not normally undertaken (INNU) for guidance.

As part of the admission and pre operative assessment procedures any complementary and herbal medication will be reviewed and stopped where a known interaction is identified. A record of previous complementary and herbal medicines should be made within the patient record. The patient's own supply can be administered during the in-patient stay but the hospital pharmacy will not make a new supply.

#### 4.2.11 Oxygen

See MM15 Guidance for Administration and use of Emergency and Non-Emergency Oxygen in Adults for guidance.

#### 4.2.12 Insulin (NEW SECTION)

In addition to all the usual prescribing standards, the following must also be clearly identified on the prescription:

- Brand
- Source of the insulin if not human eg. porcine.
- Strength of the insulin ie 100 units/mL, 300 units/mL
- Type of insulin device i.e. 10ml vial, 3ml cartridge or 3ml disposable pen
- Date and time / frequency that insulin should be administered
- Dose or dose-range, and route of administration
- Dose ranges must be expressed with the word "to". e.g. "6 to 8 units" and not "6-8 units" as this has been misinterpreted as 68 units. The word 'units' must be written above the dose to avoid misinterpretation of the 'u' as a zero. An example of an in-patient prescription chart can be found below:

DATE →		2/1/17		MEDICINE (Approved Name)		SPECIAL INSTRUCTIONS		PRESCRIBER'S SIGNATURE		PHARMACIST	
ROUTE →		SC		NOVORAPID		WITH MEALS		A. DOCKER		SUPPLY	
SPECIFY TIME IF REQUIRED ↓		DOSE		SIGN		Medicines Reconciliation (circle)		Bleep No. 1234			
		↓		↓		Started Continued Dose Changed					
		UNITS									
Morning		6									
Midday		6									
Evening		8									
Bedtime											
DATE →		2/1/17		MEDICINE (Approved Name)		SPECIAL INSTRUCTIONS		PRESCRIBER'S SIGNATURE		PHARMACIST	
ROUTE →		SC		LANTUS				A. DOCKER		SUPPLY	
SPECIFY TIME IF REQUIRED ↓		DOSE		SIGN		Medicines Reconciliation (circle)		Bleep No. 1234			
		↓		↓		Started Continued Dose Changed					
		UNITS									
Morning											
Midday											
Evening											
Bedtime		18									

#### 4.2.13 Oral anticoagulants

When prescribing warfarin or phenindione for in-patients, the additional anticoagulant chart must be completed and cross referenced to the All Wales inpatient administration chart. The oral anticoagulant chart must be used to prescribe the individual daily doses of anticoagulant and for recording the INR results as appropriate. The drug name and dosing schedule must be added to the All Wales inpatient administration chart but the dose must not be specified. The words 'see chart' must be added, to direct medical and nursing staff to the separate additional oral anticoagulant chart.

In addition to all the usual prescribing standards, all sections of the additional oral anticoagulant chart (warfarin or phenindione) should be completed as directed. These include:

- Date and time for administration of anticoagulant
- Record of the baseline INR
- The approved name of the drug and the indication for use
- Target INR for the patient and an indication of whether the anticoagulant is newly commenced or continuation therapy or whether the anticoagulant should be given at its usual maintenance dose
- INR on the specified date and the dose of anticoagulant to be administered on that date
- Where doses of anticoagulants are to be omitted, this should be indicated on the prescription chart and signed against.

When discharging patients on warfarin and phenindione, the Standard Operating Procedure BCUHB Safe discharge of all patients taking warfarin must be followed.

NOACs must be prescribed on the All Wales inpatient administration chart. The Oral anticoagulation initiation form and dosing calculator also must be completed when initiating a patient on a NOAC. It is the prescriber's responsibility to complete the form. Two copies must be printed, one copy to be filed in the patient's notes and the other copy sent to the GP along with the discharge summary. It is good practice to attach the completed checklist to the prescription so that pharmacy staff are aware it has been completed when issuing the medication. Prescribing advice on initiating a NOAC (ie. edoxaban, apixaban, rivaroxaban, dabigatran) can be found within Prescribing Matters on the intranet. The NOAC initiation form can be used to risk assess ongoing treatment for patients admitted to hospital.

#### 4.2.14 Prescribing for patients with naso-gastric or gastrostomy tubing (Dosage form changing)

Some patients are unable to take medication in solid oral dosage forms. A stepwise approach should be taken to choose a suitable alternative:



Where possible, use a licensed medicine in a suitable formulation to meet the patient's needs (e.g. a dispersible tablet or licensed liquid medicine).

If there is no suitable licensed formulation, consider using a licensed medicine in an unlicensed manner (ie off label use), for example by crushing tablets or opening capsules

In order to use a licensed medicine, consider switching to a different therapeutic agent in the same class, or to a different route of administration. In most cases a suitable licensed preparation will be available to meet the patient's needs.

In the few situations where the patient's needs cannot be met by licensed medicines, the use of special-order products ('specials') may be considered.

Prescribers should be aware that many medicines are not available in a form that can be administered via naso-gastric or gastrostomy tubing. The crushing of a tablet or opening of a capsule changes its licensed status. If a tablet requires crushing or a capsule requires opening to facilitate their administration, the prescriber should indicate this on the patient's medicine record after consulting the pharmacist for advice. Specialist information can be obtained from the BCUHB Medicines Information service and the ['NEWT Guidelines'](#), which can be accessed via the intranet.

Alterations that change the licensed status of a medicine must be brought to the prescriber's attention and recorded in writing. The patient should be informed of the licence status of their prescribed medicine. See Unlicensed Medicines Policy

#### 4.2.15 Critical Medicines

Critical medicines are medicines that must not be delayed or omitted without a clinical reason that has been discussed with a prescriber. Examples of groups of critical medicines are:

- Anti-infectives
- Anticoagulants
- Anti-epileptics
- Insulin
- Parkinson's medicines

The BCUHB Critical Medicines Guide is not exhaustive, but gives examples of medicines that must not be delayed or omitted. Omitting critical medicines may result in serious harm or death and therefore must be reported as a patient safety incident via the Datix incident reporting system.

#### 4.2.16 High Risk Medicines

High risk medicines are those medicines that **have a high risk of causing significant patient harm or death when used in error**, eg methotrexate.

Although errors may or may not be more common than with other medicines, the consequences of errors with these medicines can be more devastating. A high risk medicine may also be a critical medicine i.e. administration is time critical.

Examples of classes of high risk medicines that are also critical medicines are:

- Anticoagulants (oral and parenteral)
- Insulins
- High dose opioids

- High risk injectable medicines e.g. chemotherapy, parenteral nutrition (see injectable medicines policy, [HYPERLINK](#))

#### **4.2.17 Prescribing medicines which carry a black triangle symbol in the BNF**

The black triangle symbol ▼ identifies those preparations in the BNF that are monitored intensively by the Medicines and Healthcare Products Regulatory Agency (MHRA). Prescribers are urged caution when prescribing these preparations and should report adverse drug reactions to the MHRA via the Yellow Card Reporting System.

#### **4.2.18 Prescribing medicines for which Patient Safety (Wales) has issued safety concerns**

Where Patient Safety (Wales) has identified certain medicines as having particular risks associated when they are prescribed, the risk is highlighted through the National Reporting and Learning System (NRLS) and [Patient Safety \(Wales\)](#) by issue of patient safety alerts and notices.

#### **4.2.19 Prescribing for patients detained under ‘The Mental Health Act 1983’**

Circumstances arise where a patient is detained under The Mental Health Act and will need medication prescribed either by consent or against the patient's wishes. The prescribing team must ensure that any prescribing will be in accordance with the current legislation set out under the Mental Health Act (1983).

#### **4.2.20 Patient Group Directions (PGDs)**

See MM PGD 01 Patient Group Directions -Procedure and Guidance for Authors and Users . A record of approved PGDs is displayed on the BCUHB intranet. When the review date for a PGD arrives each Division will be responsible for reviewing and updating the PGD.

### **4.3 Medicines Reconciliation and Prescribing on Admission**

Medicines reconciliation is the process to ensure that medicines prescribed on admission correspond to those the patient was taking prior to admission and to ensure any changes, deletions or omissions are documented. This process must be started by the healthcare professional clerking the patient. Every effort should be made by the clerking healthcare professional to obtain an accurate medicine history at the time of admission. If the information cannot be obtained at the time of admission, further consolidation of the medicines reconciliation can be undertaken by the admitting doctor, a nurse or member of pharmacy staff (pharmacy technician or pharmacist). A pharmacist must always verify (clinically check) the medicines reconciliation at the earliest opportunity.

See [All Wales Multidisciplinary Medicines Reconciliation Policy](#) for further guidance.

### **4.4 Prescribing for Discharge - To Take Out (TTOs)**

See NU01 Discharge Protocol for advice on discharging adult patients.

#### **4.4.1 Discharge prescribing in acute hospitals**

Discharge prescriptions should be written as early as possible as part of the discharge procedure. TTO prescriptions for adult patients should ideally be written



at least 24 hours prior to discharge to avoid delays in dispensing. It is not practical to prescribe TTO prescriptions for paediatric patients in advance.

Access to a minimum of 7 days' supply of medicines on discharge will be ensured. Exceptions to this are medicines which are only available from hospital (see BCUHB BRAG list). If a prescription is required for a longer duration, pharmacy must be contacted before the prescription is issued. There are some exceptions e.g. tapering courses of steroids and other drugs to ensure the full course is completed.

TTO prescriptions should be written by an authorised prescriber from the responsible consultant team, by other medical prescribers covering shifts or by a non-medical prescriber. For the GP's information, all current medication at discharge should be included on the discharge prescription. The discharge letter must also include details of any medicines that have been stopped or started and the reasons why.

A pharmacist should clinically check all discharge prescriptions to ensure they are safe and appropriate. It is acceptable for the issue of over labelled packs direct from a clinical area to be second checked by a registered healthcare professional, as set in chapter 14. Ward stock medicines **must never** be issued to patients on discharge. Where practical a pharmacist should clinically check the TTO within the clinical area. Where this is not possible, a TTO prescription sent to the hospital pharmacy or satellite pharmacy for dispensing must be accompanied by the medication administration record or if not practical a photocopy or scanned image of the medicines administration record. Any patients' own medicines and medicines individually dispensed for the patient should also be sent to pharmacy if available and practical. Faxed or scanned TTO prescriptions are not permitted within acute hospitals, the original TTO prescription must be sent to the pharmacy before the dispensed medication is released.

Discharge prescriptions for patients who have been admitted for less than 24 hours to a high turnover clinical area (e.g. acute medical and surgical admission areas) are the exception. If the medicines for these patients have not been changed, it is sufficient to note that no medicines have changed on the discharge letter and they do not need to be prescribed. If any medicine, dosage or frequency has changed, a complete new TTO must be generated.

#### **4.4.2 Discharge prescribing in community hospitals and off site mental health inpatient and rehabilitation units**

Supply of discharge medication may be obtained from the local hospital pharmacy or by use of the patients own drugs (PODs) or from a local community pharmacy if a BCUHB approved procedure is in place. Where a patients' own drug (POD) medicines management system is not in operation, discharge prescription supply is usually obtained by sending or scanning the original discharge prescription to the local hospital pharmacy for dispensing.

Each faxed/scanned TTO prescription must be accompanied by a copy of the in-patient medication record. Controlled Drugs cannot be dispensed from faxed/scanned TTO prescriptions, but may be dispensed and supplied only when the original TTO prescription is received and checked against fax copy.



#### **4.4.3 Pharmacist transcribing discharge prescriptions**

Pharmacists that have had their competency assessed, may transcribe medication written on the patient medication record onto a discharge prescription once the discharge medication is confirmed with the medical team. The accuracy of transcription must be checked by a second pharmacist, a pharmacy technician or another healthcare professional.

Changes in medication from admission will be highlighted for the benefit of the GP with reasons why.

#### **4.4.4 Pharmacy technician transcribing for discharge (TTOs)**

Pharmacy technicians must be trained and assessed as competent in transcription, in accordance with BCUHB approved guidance on pharmacy technician transcribing. This would usually be a recognised medicines management training programme. Competent Pharmacy technicians may transcribe current medication from the medication administration record onto a discharge prescription once the discharge medication is confirmed with the prescriber. The pharmacy technician transcription must be checked by a pharmacist who will authorise the TTO.

#### **4.4.5 Leave medication for patients on mental health wards**

Short term leave medication should be planned in advanced and ordered from the hospital pharmacy. The leave medication can be dispensed from the All Wales inpatient mental health chart using the leave section, and a photocopy will be retained in the pharmacy. Controlled drugs must be prescribed on an outpatient prescription and sent to pharmacy with the drug chart where the original copy will be retained in pharmacy. Medication dispensed and labelled by pharmacy for leave can be supplied to cover the period of time until the patient returns to hospital. Nurses **must not** dispense medication from ward stock to facilitate supply of leave medication as this is a contravention of Regulations under the Medicines Act. If medication is required out of hours the emergency duty pharmacist must be contacted for advice.

#### **4.4.6 Discharge prescribing for patients at risk of self harm**

Patients deemed to be at risk of self-harm, will be supplied, for example, with a maximum of two weeks medication, on discharge from a clinical area. A decision around the exact quantity to supply should be made following an assessment of the patient and their individual circumstances.

### **4.5 Prescribing for Out-Patients**

When medicines are to be prescribed for administration in the out-patient clinic, they should be written and recorded within the patient's notes or written on a prescription chart to allow nurse administration to be recorded.

Out-patient prescribing should be minimal, limited to hospital only products or when an urgent clinical need exists. The internal hospital out-patient prescription form HMR 112 (W) can only be dispensed from the hospital pharmacy.

Routine and non urgent amendments to medication can be made by the use of a GP prescribing referral form. An 'Outpatient Department GP Medication review' pink form is available to facilitate this process – only medical teams and registered prescribers / Non- Medical Prescribers may complete either of these forms. It must

be remembered that GP prescription turnaround time is usually a minimum of 3 days. The request to prescribe must be accompanied by clinical information to inform the prescriber of why the prescription is necessary and whether there have been any other medicine or dose changes.

The WP10 (HP) or Non-Medical Prescriber (NMP) equivalent prescription form WP 10 (HIP) may only be used in pre agreed circumstances. The local hospital pharmacy should be contacted to obtain supplies. This form can be dispensed from community pharmacies. There may be local agreements where WP 10(HP) prescriptions are used for routine prescribing eg CAMHS services. It is normal practice for a maximum of 28 days to be dispensed at a time, although there may be specific services or situations where it is acceptable to prescribe for longer durations at the discretion of the prescriber.

The WP10 (HP) or WP10 (HIP) must not be used to circumvent any hospital prescribing procedure e.g. non formulary medicine. Prescribers need to be aware that data from WP10 (HP) WP10 (HIP) prescriptions are audited for compliance. The prescriber must clearly print their name and contact number when using a WP10 (HP) or WP10 (HIP), to enable contact should a query arise from the dispensing community pharmacy. The doctor or NMP should ensure that the prescription is appropriate, including carrying out any tests required to ensure safety.

Communication of prescribing recommendations from out-patient clinics to patients and their GPs is a complex area where patient safety can be compromised. All communications should be in writing with the responsible doctor or NMP identified. Where communications are sent via the patient, there should be clear instructions to the patient regarding the time scale for completion of the prescription, this should be in addition to and not instead of a formal communication.

Handover of responsibility has to be a joint consensual decision between hospital team and GP. If the GP hasn't accepted that role, the person requesting the prescribing must retain responsibility. The [GMC Good Practice in prescribing and managing medicines and devices](#) is clear that the legal responsibility for prescribing lies with the prescriber who signs the prescription. Where a GP feels that a prescription recommendation is inappropriate, the secondary care clinician should be informed. Primary care prescribers are responsible for informing secondary care doctors caring for a patient when a recommended treatment has had to be stopped or changed. That responsibility can only be delegated to someone else if they accept by prior agreement.

#### **4.5.1 Repeat Prescribing for Hospital Out-Patients**

- A repeat prescription written on an internal hospital out-patient prescription form HMR 112 (W), is valid for a period of 12 months from the date of writing after which they will be filed.
- A repeat prescription must state the exact number of repeats that a prescription is valid for in terms of frequency and quantity. A repeat prescription that states "Repeat as necessary" or "rolling prescription" will not be valid and the prescriber will be contacted by

pharmacy to confirm the frequency and number of repeats that may be required.

- The first dispensing must be made within 3 months from the prescription being written. Patients presenting prescriptions after this period will be referred back to clinic.
- Repeat or instalment prescriptions for schedule 2 and 3 Controlled Drugs (CDs) are not allowed.
- The total / cumulative supply made to a patient against one prescription will not exceed either the stated duration or a maximum 12 month's supply of that particular product.
- In the event of a breakage or loss of medication, a new prescription is required. A record of this should be endorsed on the repeat prescription.

## **4.6 Commissioned health care**

### **4.6.1 Commissioned private healthcare**

Any such commissioned service will be to a standard of NHS Wales and those commissioned healthcare professionals to a standard of their regulatory body and set out in a service specification for the commissioned service. Medicines will be handled in accordance with the regulations of the Care Act.

### **4.6.2 Cancer Services at Home**

Systemic anti-cancer therapy (SACT) will be routinely commenced on the three chemotherapy units within BCUHB. There are some scenarios whereby a patient's treatment will be continued at home:

- Patients prescribed continuous fluorouracil pumps will continue to receive their chemotherapy at home for 2-5 days. Once finished, the pump will be disconnected from the peripherally inserted central catheter (PICC) by an appropriately trained nurse.
- A small cohort of patients are offered the option to receive their cancer treatment at home via a homecare service.
- Oral targeted treatments are increasingly becoming mainstay treatment for cancer patients. These treatments will be prescribed by their cancer clinicians and will, in the main, be dispensed by the local hospital. These tablets/capsules will be taken by the patient in their own home. Patients will be made aware that further supplies will be prescribed by their cancer clinician only.

### **4.6.3 Palliative Care in adults**

The specialist Palliative Care team will be involved with some palliative patients in conjunction with the primary care team. They may advise and support the community teams. Some medication will be commenced by the General Practitioner and others by Consultants in the Acute Hospitals, Community Hospitals or Hospices.

A palliative care medical advice helpline for BCUHB is available 24hrs a day, 7 days a week via Nightingale House Hospice 01978 316800 and Clinical Nurse Specialists are available 9am-5pm, 7days per week via switchboard in each area.

### **4.6.4 Registered Nursing and Residential Care Homes**



Care Homes are registered and regulated by the Care Inspectorate Wales (CIW) and medicines should be handled in those settings in accordance with the Care Homes (Wales) Regulations (2002). Where a BCUHB employee (usually a registered nurse) is called to administer a particular medicine within a care setting then they must ensure that they have written authorisation from a prescriber to administer that medicine, which may be in the form of a dispensed medicine in that service user's name and a clear dose is specified. A record of administration will be made on the appropriate District Nurse medication administration record. See MM16 for guidance on the transcription of medicines by registered nurses in exceptional circumstances.



## Chapter 5 Ordering and Receipt of Medicines

Categories of medicines include::

- Stock medicines ie an agreed list of medicines that are used regularly within the clinical area
- Non –stock medicines ie medicines for use by individual patients

Options for ordering are set out below.

### 5.1 General principles for ordering medicines for clinical areas

The process of ordering and receiving medication from pharmacy must include the following:

- a clear audit trail to maintain safety and security of medicine use
- maintenance of safety for staff and patients
- clearly defined staff responsibility for each stage of the process
- regular monitoring of medicines liable to diversion or misuse
- the use of “controlled stationery” to order medicines. and as such order books must be stored safely when not in use. Access to ordering books must be restricted to authorised staff. Electronic ordering systems must be limited to staff with authorisation attached to their individual user name and password. All paper and electronic orders must be kept for 2 years as a record of the transaction for audit purposes, see [chapter 12](#) for further guidance.

#### 5.1.1 Ordering stock medicines in clinical areas

Ordering stock medicines will depend upon the storage system in use ie electronic or paper. In areas where the automated storage cabinets exist, the cabinets are programmed to send an electronic order to pharmacy when stock reaches an agreed minimum level. All clinical areas will have an agreed restocking cycle. Stock medicines can also be ordered on an ad-hoc basis if necessary but will not be routinely supplied at weekends/out of hours except in clinical emergencies.

#### 5.1.2 Responsibility/control of stock medicines in clinical areas

The manager has responsibility for all medicines on that ward or unit. This overall responsibility cannot be transferred to anyone else since it covers the strategic elements of medication handling in the clinical area which ensures that day to day practice is in line with current legislation, local and national policies/guidance. The stock levels should be agreed between the pharmacy department and the manager of the clinical area and this should be reviewed on a regular basis (at least twice a year).

The pharmacy will agree and arrange which system of regular top-ups/stock control is best suited for that clinical area and the frequency with which these will take place. Clinical areas not receiving pharmacy stock control must arrange with their supplying pharmacy for regular stock medicines checks.

Order assembly and the transfer back to the clinical area will be the responsibility of the pharmacy department. The pharmacy will highlight medicines needing special storage or temperature conditions, to ensure the security and stability of the medicines until they are delivered to the clinical area.



## 5.2 Ordering of non stock medicines in hospitals

Where a patient is prescribed a medicine that is not held as ward stock, a supply can be obtained from pharmacy. Medicines brought into the hospital by the patient can be used without need to order further supplies, as long as the medicine is suitable for re-use. If a supply is needed the order may be generated by either the ward based pharmacy technician or pharmacist for that ward as part of the regular pharmacy service or alternatively, by a registered nurse.

A registered nurse can generate a non stock medicine order using the approved order documentation and send to the hospital pharmacy. The order must be accompanied by the original patient administration record or photocopy or scanned image so that a clinical check can be made by the pharmacist in the pharmacy to ensure patient safety. This applies to both acute wards/departments and community hospitals.

## 5.3 Non-availability of medicines

In the event of lack of availability, the following should be considered:

- Category of medicine, ie whether the medicine is a stock or non-stock medicine.
- For stock items place an ad hoc order.
- For non-stock medicines, either order from Pharmacy, check if the patient has brought in their own supply or ask if the relatives/ carers could bring in a supply from home.
- For patients transferred from another clinical area, contact the previous clinical area to check if the medicine is still there.
- Check whether the Pharmacy delivery bag or box been emptied.

### 5.3.2 Non availability when pharmacy is closed

When a medicine is unavailable the registered nurse must consider the urgency and necessity of the patient receiving the medication. If a decision is made that the medication is required to be given before pharmacy reopens every effort must be made to find an alternative way of obtaining it. See BCUHB Critical Medicines Guide for guidance on medication that must never be omitted.

In the event of lack of availability out of hours, the followed should be considered: Where available, remotely search from the BCUHB intranet home page for the availability of medicines in clinical areas, or through the automated medicine storage cabinet linked system.

Check the hospital's emergency room/cupboard stock list on the BCUHB intranet and follow the local procedure for access to this supply e.g. contact clinical site manager (CSM). If a supply is located, only full packs are be taken, do not remove doses from the original and make a record what has been taken.

If a supply still cannot be obtained, contact the local CSM for permission to contact the emergency duty pharmacist in accordance with local procedures. The emergency duty pharmacist may recommend an alternative, or make a supply, whichever is clinically appropriate.

For Controlled Drugs Record see chapter 9.

### 5.3.3 Borrowing of Medicines

There should be no reason for clinical areas to borrow medicines from other clinical areas when the local hospital pharmacy is open. When borrowing is unavoidable, the identity of the nursing staff, midwife or ODP requesting the medicine must be checked and recorded before the transfer takes place. The



appropriateness of the request must be considered in terms of the medicine requested and the risk of diversion.

## **5.4 Receipt of medicines in the clinical area**

### **5.4.1 Receipt of stock medicines**

When medicines have been delivered to the clinical area the recipient should check the medicines received against the delivery note issued with the medication. If all the items are correct then the recipient shall sign and date the delivery note and then put away the medicines in their designated locked cupboards in that clinical area. The signed delivery note must be kept for 4 weeks for audit purpose. The checking and putting away should take place as soon as possible after delivery has taken place. The delivery must be checked for those items that need special storage e.g. fridge items and these must be unpacked immediately and refrigerated.

### **5.4.2 Receipt of individual patient medicines in hospitals**

When individual patient medicines have been delivered to a clinical area the recipient should identify which patient the medicines have been dispensed for and transfer to the appropriate bedside locker. The locker should only contain medicines for that patient, it should be emptied each time a patient is discharged from the bed space.

The delivery must be checked for those items that need special storage e.g. fridge items and these must be unpacked immediately and refrigerated. Should the patient have been transferred to another ward then the recipient must take steps to transfer the medicines to the new ward. See section 6.3.3 for further details. Only registered healthcare professionals are permitted to place medicines in the patient's bedside locker as defined in [MARRS](#) All Wales Policy for Medicines Administration, Recording, Review, Storage and Disposal (2015).

## Chapter 6 Storage of Medicines in Clinical Areas

Well designed and appropriate storage of medicines can reduce waste, incorrect medicine selection and missed doses. The Patient Safety Notices [PSN 030](#), The safe storage of medicines: Cupboards 2016, [PSN 15](#) 'The storage of medicines: Refrigerators 2015', and the [All Wales Policy for Administration, Recording, Review, Storage and Disposal, November 2015](#) set out the legal standards, best practice and patient safety recommendations that apply to the safe and secure storage of medicines. [The Nursing and Midwifery Council Code \(2015\)](#) dictates that a registrant takes all steps to ensure medicines are stored securely.

### 6.1 Responsibility

The nursing manager or clinical lead of the area is responsible for the safe custody, storage and documentation of all medicines within a clinical area. They may delegate some duties involved in the storage of medicines but cannot delegate responsibility.

### 6.2 Storage of Medicines in Clinical Areas

In all clinical areas, medicines must be stored in an area or room which:

- Is clean, well ordered and not be freely accessible to patients. In areas without a 24 hour staff presence, the room must be lockable
- Accessible only to authorised staff
- Has running water and a sink
- Has an adequate lighting level
- Medicines must be locked within a medicines cupboards at all times unless for the immediate administration to a patient. In this case they must be in the possession of a person to administer and not left unattended at any time.
- Sufficient space should be provided to allow the safe preparation of medicines within hospital in-patient areas. Work surfaces must be clean and not cluttered. PSN 30 requires a minimum worktop area of 2m<sup>2</sup> for medicine preparation on a 24 bedded in patient ward area.

Where pneumatic air tubes are in use to transport medicines to and from pharmacy, the receiving cupboard must be locked and checked regularly especially at the end of each shift.

Medicines must not be stored near sources of direct heat such as radiators or direct sunlight near a window.

Medicines must be kept in their original containers.

#### 6.2.1 Stock medicines

Clinical areas must have distinct, storage facilities for medicines to reduce the risk of medicine mis-selection. External medicines and medicated dressings can be stored in trays and baskets. All other medicines and diagnostic testing reagents (including urine testing) must be stored in separate lockable cupboards or in separate compartments of an automated storage system. See chapter 9 for storage of controlled drugs. Each clinical area must also have designated separate lockable cupboards to store medicines 'to take home' and 'returns to pharmacy'.

Where medicines have similar names and appearance measures to separate the medicines to avoid mis-selection should be employed. Contact Pharmacy for further advice.

### **6.2.2 Epidural Infusions (where permitted)**

Epidural bags must be stored separately from intravenous infusion bags. Compound epidural bags containing controlled drugs must be stored in a locked CD cupboard. This cupboard must **not** be used to store other intravenous or any parenteral medication.

### **6.2.3 Intrathecal infusions (where permitted)**

See MM05 Intrathecal Chemotherapy Policy for further details

### **6.2.4 Intravenous fluids**

Intravenous fluid containers must not be transferred from their original box where possible. If a small number of infusion bags cannot be stored in original boxes, the bags must be segregated in a clearly labelled area so that they cannot be mis-selected.

Intravenous fluids must be stored on shelves and not on the floor. They must not be mixed with peritoneal solutions or large volume sterile irrigations.

### **6.2.5 Medical gases**

For storage of medical gas cylinders see Guidance for Administration and use of Emergency and Non-Emergency Oxygen in Adults in Acute and Community Hospitals [MM 15](#).

### **6.2.6 Flammable medicines including flammable topical products**

Flammable medicines should be stored in lockable metal cupboards if quantities greater than 5L are to be stored. Small volumes can be stored in medicine cupboards. Contact Pharmacy to undertake a risk assessment to ascertain whether a fire resisting metal cabinet is required, which will take in to account the quantity and flammability of the medicines.

A list of paraffin based skin products that are at risk of fire can be found within the medication safety alert.

### **6.2.7 Patients' Own drugs (PODs)**

'Patient's Own Drugs' (PODs) refers to medicines that have been brought into the clinical area by the patient having been previously dispensed for that patient. It also includes over the counter (OTC) medication purchased by a patient. PODs medicines are not BCUHB property but to ensure safe use and control for an individual patient their medicines must be stored and handled as set out in 6.3.3.

### **6.2.8 Emergency boxes, anaphylaxis kits and hypoboxes**

All clinical areas and community based setting should have access to immediate life saving treatment i.e. emergency box, anaphylaxis kit and hypo box. These should not be stored in locked cupboards but be kept in a safe location in the clinical area so as to be readily available when needed. This must be balanced against the need for medicine security. A [risk assessment](#) should be undertaken by the manager of the clinical area or community based setting or staff to establish the requirements for staff to obtain and carry medicines relevant to their practice.

Wherever possible these boxes should be stored out of direct view of the public. Each emergency box and anaphylaxis kit has a tamper evident seal and expiry date, and once the seal is broken or the box expires it should be replaced via the

pharmacy department as soon as possible. Hypoboxes once used, should be topped up from ward stock.

No medicines may be stored on resuscitation trolleys except the emergency sealed box and a bag of 0.9% sodium chloride intravenous infusion 500mL.

All in-patient clinical areas stocking opioids must ensure they have access to injectable naloxone. All in-patient clinical areas stocking injectable benzodiazepines must ensure they have access to injectable flumazenil.

### **6.3 Medicine Cupboards**

Medicine cupboards must comply with the current British Standard – BS2881 (1989). Either metal lockable cupboards or automated medicine storage systems must be used.

In the hospital inpatient setting, it should be ensured that the medicines cannot be taken from the back of the cupboard. Medicine cupboards within ground floor clinical areas should be located so that they are not visible from an outside window. Visibility from outside windows can be minimised by fixing opaque sheets to ground level windows. Contact the Estates department for further advice.

If different arrangements are required, the Chief Pharmacist should be consulted and approve storage arrangements for the following areas storing medicines:

#### **6.3.1 Medicines Trolleys**

Where in use, the contents of medicines trolleys should be restricted to the minimum requirements to meet the needs of the medicine round. When the trolley is being used, it must not be left unattended unless locked. Trolleys must not be placed next to radiators or in direct sunlight. When the trolley is not in use, it must be locked and secured to a main wall or floor by a chain, padlock or security system. Medicines, including nutritional supplements and thickening agents must not be left on top or beneath the trolley (see section 6.2.1). Controlled drugs must not be stored in a medicines trolley.

#### **6.3.2 Medicines Refrigerators and Freezers**

Medicines requiring storage at temperatures between +2°C and +8 °C must be stored in a locked medicines refrigerator. Refrigerators must only be used to store medicines and nutritional supplements. Advice can be obtained from pharmacy regarding what products can be stored in the medicines refrigerator.

For storage of vaccines, refer to [IMMS 04](#) 'Storage and handling of Vaccines Written Control Document'.

Refrigerators must be locked or under the control of an automated medicine storage system when not in use and must not be over loaded. There should be sufficient space for air to circulate around the internal space. Medicines must not be in contact with the sides or back of the refrigerator. Medicines no longer needed should be returned to pharmacy.

Freezers (where used) must also be locked and the temperature maintained at -18°C to -23°C.

See section 6.5 for temperature monitoring guidance.

#### **6.3.3 Bedside medicine cupboards in hospital**

Storing medicines in bedside cupboards reduces the risk of selection error. Where in use, individual lockable cupboards are used to store patients' own medicines and medicines which have been individually dispensed for that patient. Stock medicines can also be stored in the patients' medicine cupboard if the medicine is prescribed for that patient.

Each medicine cupboard must have a unique suited key within that clinical area, with a master key for the suite required for nursing staff and pharmacy. Electronic locking systems e.g. swipe card or fob are permitted for locking medicines cupboards.

Patients should have access to either the key or electronic locking device to facilitate self administration. See MM 21 self administration guideline for further details. When a patient is transferred or discharged, the cupboard must be emptied.

Medicines must be locked away in the medicines cupboard. Only a registered healthcare professional can place medicines into the patient's medicine cupboard, as defined by [MARRS](#) All Wales Policy for Medicines Administration, Recording, Review, Storage and Disposal (2015). It is however permissible to leave out specific medicines required on an 'as needed' basis e.g. reliever inhalers, glyceryl trinitrate spray and topical preparations. This practice may be unsafe in certain clinical areas and should be risk assessed by the manager of the clinical area. If a patient requires access to any other medicines, they should be assessed for self administration. Refer to MM 21 as above.

#### **6.3.4 Storage of medicines in operating theatres**

Within theatre areas it is essential that there is rapid access to medicines in the event of an emergency. Therefore the medicines cupboards within recovery and anaesthetic rooms may remain unlocked while theatres are in use as long the area has staff present. Where installed, controlled access to theatre areas must be utilised. When the operating list is complete and staff are no longer present, the cupboards must be locked and the unit locked.

Where possible local anaesthetics must be stored separately to other intravenous medication.

It is not acceptable practice to store prepared injectable medicines (i.e. medicines drawn up in syringes) in any medicine cupboard. If syringes are not used they should be discarded appropriately. When the patient is transferred from the anaesthetic room to the theatre, any medication prepared in syringes should be labelled and transferred with them, or disposed of appropriately if no longer required.

#### **6.3.5 Storage and transport of medicines by community nurses**

Where community staff need to carry medicines to a patient's home or elsewhere, they must ensure that all medicines are securely stored i.e. in a suitable lockable container or medical bag. These must be concealed in the boot of a vehicle but not in view of the general public for the minimum time needed. If possible they should not be left unattended until use or return to the originating storage cupboard at base. This includes anaphylaxis kits and hypo boxes. Medicines must be returned to secure storage at clinic/hospital base at the end of the nurse's shift.



Storage must be in line with the medicines manufacturer's recommended temperature. If the medicine requires cold storage the medicine must be carried in appropriate packaging to maintain the 'cold chain' (See section 6.3.2). It is acknowledged that issues of personal safety and security for individual employees in certain circumstances may require medicines to be carried in a fashion that does not draw attention either to the individual or to the medicines being transported. A [risk assessment](#) should be undertaken by the manager of the clinical area or community based setting.

Enhanced care teams may be required to carry a limited stock of medication to undertake an initial clinical assessment or/ and where the client requires an immediate prescription, administration and supply of medication. This may be necessary to avoid undue delay in commencing a course of essential and urgent medication. The team must have the stock requirements agreed with, and closely monitored by, the Pharmacy Department. Medication from this stock must only be administered against a valid written prescription or under operation of a patient group direction (PGD).

Designated community staff should possess an authenticated identification card which must be carried at all times. Staff who are not registered nurses may deliver medication for self-administration by the client. For removal of unwanted medication from patients home, refer to MM33 Guidelines for Community Staff.

## **6.4 Transport of medicines**

When medicines are being transported from the pharmacy to a clinical area, it shall be in such a manner that ensures they reach their destination safely, undamaged and have been kept under the correct storage conditions.

### **6.4.1 Transport of medicines from hospitals to clinical areas**

Each hospital pharmacy will put in place a system for recording despatch and delivery of medicines from the originating pharmacy. If it is found that the storage conditions are inappropriate, the manager of the clinical area or community setting must be informed. In a situation of a continuing problem the pharmacist will notify in writing the clinical manager responsible for the clinical area.

### **6.4.2 Transport of medical gases in community**

Patients in the community needing oxygen will have a commissioned service provided by a medical gas contractor or in certain circumstances, an oxygen concentrator. Where BCUHB staff have a need to carry medical gases in their own transport they must ensure that the manufacturers recommendations for storage and use are followed and that their vehicle insurance includes provision for carriage of medical gases.

### **6.4.3 Storage conditions in transport**

Whenever medication is to be transported from one area to another, the recommended storage conditions e.g. Controlled Drugs, temperature or humidity must be considered and the method of transfer must take these storage conditions into account. When sending out items with highly sensitive temperature conditions e.g. vaccines, it is good practice to notify the receiving unit of the day/date of transportation to maintain the cold chain as described in the National Reporting and Learning system (NRLS) Rapid Response directive (RRR008 Cold Storage). Refer to 'Storage and handling of Vaccines Written Control Document (IMMS 04) using the link IMMS 04

#### **6.4.4 Packaging for transportation**

When transporting any medicine due regard must be taken of the fragility of the item being despatched. Those items known to be fragile e.g. items already packed in a glass container, or items which are known to have a COSHH hazard must be packed carefully (these may require extra padding around the container) in order to remain intact throughout the transport process. It is essential that when the item reaches its destination it is still intact and can be used for a patient. Pharmacy must be notified immediately of any damaged receipts.

#### **6.4.5 Transport documentation**

Medication should only be transferred from pharmacy to a clinical area on the same site by hospital staff. In most cases this will be hospital porters. Other staff e.g. pharmacy, nursing or health care workers can also transport medication, but only if they can be identified by their employer identification badge. For any transfer that is going off site to another health premises, then the person carrying out the delivery must sign a pharmacy transport note on pickup within pharmacy. In addition they must also ensure the receiving staff signs for receipt of the medication to ensure a complete audit trail. The carriers in this case will be signing for the outer transport bag or box and not for the individual contents. The record of receipt will be returned to the supplying pharmacy as soon as possible. If voluntary transport arrangements are in use then a badge or similar identification system must be in place.

### **6.5 Temperature monitoring**

A minimum and maximum calibrated thermometer must be used to monitor minimum and maximum temperatures of all rooms storing medicines, refrigerators and freezers. Thermometers need to be replaced every 12 months as calibration is only valid for this period. Thermometers can be obtained via contacting the local Medicines Management Nurse. Batteries must be replaced immediately if the readings become erratic or the display clarity fades. The thermometers use 2 AAA batteries, which can be obtained from stores. Some refrigerators have with in-built temperature monitoring and SD card readers which automatically log temperatures and alarm visually and audibly if a fault is detected. Such refrigerators must be calibrated on an annual basis.

#### **6.5.1 Refrigerator and freezer temperature monitoring**

Both refrigerator and freezer temperatures must be recorded on a daily basis. It is good practice to monitor temperatures for refrigerators storing vaccines on a twice daily basis.

See Appendix 1 for guidance and Appendix 2 for monitoring forms.

#### **6.5.2 Room temperature monitoring**

The room temperature of areas holding medicines must be checked on a daily basis to ensure appropriate storage temperatures are maintained. The temperature range would be expected to be between 15°C to 25°C for most medicines although some medicines can be stored at up to 30°C. If the room temperature rises above 25°C for 2 days or more, the Pharmacy team must be informed so that specific advice can be provided where necessary. Staff working in the clinical area should take remedial action to reduce the temperature in the clinical rooms as quickly as possible and document, e.g. windows opened, portable air conditioning unit installed, drugs relocated, etc.

See Appendix 2 for monitoring forms.



## Chapter 7 Administration of Medicines

### 7.1 Persons authorised to administer medicines

All healthcare employees set out below and evidenced as competent to administer medicines can administer medicines on the authorisation of a medical practitioner, dental officer, and non-medical prescriber. Any doubts in relation to the safety, accuracy or clarity of a prescription must always be checked with the prescriber or a pharmacist before administration.

#### 7.1.1 Nurses/Midwives

The following groups of nursing staff can administer medicines:

- All BCUHB employed nurses and midwives with a current registration with the NMC, including Bank nurses. All newly qualified nurses must have completed the BCUHB Medicines Management Assessment Workbook and Competencies before they can carry out single nurse administration.
- Agency workers who are registered with the NMC, provided BCUHB has received written assurance from the agency that there are no performance issues concerning medicines management. See SOP for BCUHB Nurse Bank and Agency Nurses/Operating Department Practitioners (OPD) workers to be able to administer medication including intravenous (IV) medication for guidance.
- Registered nurses (Level 2) with a current registration with the NMC undertaking a conversion course whilst allocated to their own speciality area, except Paediatrics.

Registered midwives may, in the course of their professional practice administer, on their own initiative, any of the substances specified in medicines legislation under midwives exemptions. When medicines are administered or supplied by a midwife in these circumstances a record should be made in the patient notes or midwifery record see [midwives exemptions 2018](#).

All staff involved in medicines administration must receive medicines management education/training as part of their induction to the BCUHB and update their knowledge of Medication Administration, Recording, Review & Storage (MARRS) practices every three years by completing the All Wales MARRS e-learning via ESR or face to face 'back to basics in Medicine Management'. A practitioner's medicines practice must also form part of the individual's annual review process, giving both the reviewer and practitioner opportunity to identify any learning needs and actions required in the intervening years, between undertaking the required learning programme every third year.

#### 7.1.2 Non-nursing/midwifery employees

The following groups can administer medicines:

- Registered Medical Practitioners and Dentists
- Registered Operating Department Practitioners (ODPs) only with the appropriate training and assessment of competence
- After appropriate training and competence assessment specific medicines may be given by registered health professionals. e.g. Radiographers,

Podiatrists, Orthoptists, Clinical Physiologists, Physiotherapists, BCUHB employed paramedics

- By delegation of a registered nurse, Pharmacists and Pharmacy Technicians who have completed the accredited QCF Level 3 Unit 29 Administering Medication to Individuals (QCFW, 2006) or equivalent training.
- By delegation of a registered nurse, BCUHB care staff who have undergone specific training and assessment of competence in medicine administration when delivering personal care or domiciliary care in the community (see [Chapter 8](#)).

## 7.2 Independent second check and witnessed administration

An independent second check describes the process by which two competent persons separately check that the correct medicine has been selected and prepared. The independent second check must not be led or influenced by any other person. The independent second check must check that the:

- Patient has been positively identified and the correct prescription has been selected
- Medicine selected matches the prescription
- Correct strength, dose and form has been selected
- Calculations are correct
- Medicine is fit for use and has not expired
- Patient is not allergic to the particular medicine, medicine class or any ingredient contained therein.

Accountability for the preparation of medication remains with both the administrator and the competent person providing the independent second check.

The second checking of medicines does not apply in areas of anaesthesia and resuscitation where the doctor, dentist or ALS provider can administer medicines alone.

The second checking of medicines does not apply in community practice e.g. at a patient's home.

Witnessed administration describes the process in which two competent persons witness the **complete** procedure ie from the patient identification and allergy check, product selection against prescription and preparation through to the administration of the medicine to the patient for whom it is prescribed.

The following can undertake an independent second check and witness administration:

- Registered nurses, midwives and ODPs
- Bank/agency registered nurses/midwives, once they can evidence competence (e.g. copy of competence document)
- Student nurses, student midwives and student ODPs under **direct supervision from two** separate registered nurse/midwife/ODP.
- Whilst in placement training, student nurses/midwives/ODPs must be given practical training in the clinical area in the skills necessary for the administration of medicines but they must have **direct supervision from two** separate registered nurses/midwives/ODPs.



- Healthcare Support Workers (HSCW) can second check CDs, see [Chapter 8](#) for full details
- Pharmacy technicians and pharmacists who have completed BCUHB second checking competency assessments. This includes second checking of CD medicines, if approval has been given by the Executive Director of Nursing.

### **7.2.1 Medication requiring an independent second check and witnessed administration**

An independent second check must be obtained and administration witnessed for the following types of medicines :

- All medicines administered to a child under 16 years of age
- Controlled Drugs (see chapter 9)
- The selection and mixing of medicines in syringes or infusion bags
- The administration of all intravenous, epidural injections and infusions
- Administration of insulin injections in the in-patient setting
- Any medicine with which the primary administrator is unfamiliar or working outside area of routine clinical practice, in particular those medicines that are to be administered parenterally
- Any complex calculations
- The reconstitution of sterile dry powders into a solution for injection/or for oral administration e.g. antibiotic liquids
- Titrated doses require a second check at every dose change, although it will not always be applicable for both professionals to sign, depending on regime being administered. Risk assessments should be undertaken in these cases.

Injectable bolus doses have to be checked at the patient's bedside, but the second checker is not required to stay throughout the administration, administration does have to be witnessed.

Medicines designated by divisions as needing two person administration must be communicated to any new or external nurses/ midwives.

### **7.3 Selecting medication**

The medicine selected must match the administration record for the correct dose, strength, route and form and be in date. Care must be taken when selecting medicines with similar names and packaging.

All medicines supplied from the hospital local pharmacies will be labelled by the original manufacturer or by the pharmacy in a manner that will allow identification of the medicine contents against the patient's prescription.

If the pharmacy repackages an original manufacturer pack, the pharmacy label will then identify the contents of the dispensed container. If the container is a box containing a strip of tablets, it is good practice to confirm identity marked on the label with the tablet/capsule name and strength printed on the strip. This is necessary to ensure that a wrong strip has not been returned to another container box at a previous administration time. If the name and strength of a medicine is not clearly printed on a medicine strip, or a label seek advice from another health practitioner. If there is any ambiguity it is advisable to check with the local pharmacy to confirm identity of the tablet/capsule.

If a part dose (e.g. half a tablet) is required, the remaining half should be disposed of.

Monitored dosage systems (also referred to as blister packs, compliance packs and 'pouches on a roll') are **not** to be used except where a missed dose will cause harm to the patient and a supply cannot be obtained from the local hospital pharmacy. Out of hours, every effort should be made to obtain a supply eg by using the emergency cupboard or checking available stock from other clinical areas. If the following criteria are met in addition to those set out in section 6.2.7, the pack can be used if:

- The medicine is a critical medicine (See BCUHB Critical Medicines Guide)
- The dispensing date on the pack is within the last four weeks
- The blister pack only contains one medicine, is labelled and the dispensing date is within the last four weeks.
- The medicines can be identified by either description or by appearance, or the patient can reliably identify them
- The blister pack has not been obviously modified ie remains a sealed pack as supplied by the community pharmacy or dispensing doctor

The nurse must be sure of the identity of the medication prior to administration.

Pill organiser boxes (also referred to as 'Dosset<sup>®</sup>' boxes) are boxes that are filled by the patient, relative or carer and therefore are not filled or labelled by a pharmacy or dispensing doctor. Medicines must never be administered from these boxes; a supply from hospital pharmacy must be obtained.

#### **7.4 Administration of medicines**

When administering medicines the 5 rights must be followed;

- Right medicine
- Right dose
- Right route
- Right time
- Right patient

The administrator must be familiar with the therapeutic uses of the medicine to be administered, the usual dosage, frequency, adverse effects, precautions and contra-indications. If there are any uncertainties, the BNF, senior nurse, pharmacist or doctor should be consulted.

When administering medicines the following must be followed:

- Check the prescription carefully, clarifying any ambiguities in relation to the legibility or ability to understand with the prescriber or pharmacy
- Where electronic prescribing is used, ensure that the correct patient is selected. Where handwritten prescription charts are being used, ensure the correct prescription has been selected particularly where multiple charts are in use.
- Ensure that the date and time is correct, the dose, frequency and route are clearly documented and the prescription has been signed by the prescriber
- Confirm the patient's identity with the patient by asking them their name/ date of birth/ hospital, if the patient is able to. Check the patient's wristband or photo-identity card for the hospital number/NHS number and name in conjunction with the medication record.

- Check that the prescribed dose has not already been given or taken by the patient (check manual or computerised records)
- Check that the patient is not allergic to the medicine before administering (check wristband, look for medical alerts, ask the patient). If the allergy section is incomplete this section must be completed with information provided by the patient and the medical records checked.
- Where a medicine is prescribed for administration by variable routes e.g. oral/IV the record must show the actual route by which the medicine is administered.
- Medication intentionally withheld or refused by the patient must be clearly documented on the medication chart and in the patient's care plan.
- In paediatrics, both nurses involved in the medicine administration process make this record.
- Medicines to be administered via different routes must be prepared separately and administered at different times to avoid serious administration errors. Medicines must be prepared and administered for one patient at a time. Batching of medicines is not permitted.
- Medicines to be administered with a variable dose should have the actual dose administered recorded on the administration chart.

It is the responsibility of the administrator to contact a prescriber without delay where:

- contraindications to the prescribed medicine are discovered
- the patient develops a reaction to the medicine
- assessment of the patient indicates that the medicine is no longer suitable
- a critical medicine has been omitted

Administration must be witnessed by the administrator, medication must never be left unattended or left in medicine pots at the patient's bedside. The administrator may delegate observing the patient to a HCSW, to ensure they have taken the medicines. The HCSW must remain present with that patient until the observation is complete.

#### **7.4.1 Administration of medicines without prescription authorisation**

In the following strictly defined situations, medicines can be administered without prescription authorisation:

- Via a Patient Group Direction
- Via the discretionary medicine list ([see chapter 15](#))
- A verbal order (see chapter 4)
- Via midwives exemptions (see 7.1.1)
- The use of specified parenteral medicines for the purpose of saving life in an emergency (see [chapter 16](#))

### **7.5 Administering cytotoxic medication**

See CSPM 01 Guidance for ensuring Safety and Quality of Chemotherapy Services. The administration of cancer medication in Paediatric oncology must only be within a model of service and governance utilising Paediatric Oncology Shared Care Units (POSCU).

See MM05 Intrathecal chemotherapy policy for guidance on administering intrathecal chemotherapy.



## 7.6 Depot Injections

Care is needed to ensure:

- The correct formulation is selected for example certain antipsychotic medicines are available in both depot and acute onset formulations.
- The correct dose is administered to the patient

## 7.7 Implants

Injectable medicine implants must be prescribed by an authorised prescriber and include product name, dose and route. The healthcare professional administering the medicine implant must demonstrate competence in administration of that particular medicine implant. The prescriber is responsible for ensuring arrangements are in place to remove the implant should a problem arise. The expiry date of the product must be sufficiently long to cover the implant treatment period.

## 7.8 Administration via the parenteral route

Refer BCUHB Injectable Medicines Policy

## 7.9 Recording of administration, independent second check and witnessed administration

A clear, accurate and immediate record of all medicines administered must be made by the healthcare professional administration. The healthcare professional must witness the patient taking the medicine before recording their signature. If the medicine or fluid is given as an intermittent or continuous infusion, the administration chart should be signed immediately after the infusion has commenced.

If an independent second check or witnessed administration is required (see section [7.2](#)), the checker must also sign the prescription chart once all the checks have taken place.

## 7.10 Administration of liquid medicines

Medicines via enteral tubes (including PEG, JEJ and NG) must be administered using an enteral syringe (ENFit®). Medicines must be drawn up into the syringe using an appropriate adapter (e.g. bottle adapter, ENFit® medicines straw, ENFit® fill/filter needle). Medicines must never be drawn up into an enteral (ENFit®) syringe without the use of an adapter.

Oral syringes (clearly labelled 'oral' and/or 'enteral') with coloured syringes must be used for the preparation and administration of all medication to be administered by the oral/enteral route, where a 5mL spoon or graduated measuring cup cannot be used.

All oral / enteral syringes containing liquid medicines must be labelled with the name and strength of the medicine, the patient's name, and the date and time it was prepared by the person who has prepared the syringe, unless preparation and administration is one uninterrupted process and the unlabelled syringe does not leave the hands of the person who has prepared it. Only one unlabelled syringe should be handled at any one time.

Parenteral syringes must never be used for administering liquid medications due to the risk of inadvertent intravenous administration of liquid medications intended for

enteral or oral administration. Enfit® syringes must not be used to administer oral meds other than by an enteral tube. This is due to the risk of inadvertent overdose that can occur due to filling of the moat at the tip of the syringe.

### **7.11 Covert administration**

Refer to the Covert Administration of Medicines Guideline

### **7.12 Self administration and administration by carers providing supported administration**

See Guidelines for supported or self –administration of medicines by hospital patients in BCUHB MM 21.

### **7.13 Omission of prescribed medicines**

Patients have a right to receive their medicines at the time they are intended. Delays and omissions can lead to serious adverse effects for patients. Healthcare professionals should only omit medicines when there are clear grounds.

Inappropriate omission of a medicine is a serious professional matter and may result in disciplinary / capability actions.

Critical medicines are those where the omission or delay is likely to cause harm. See BCUHB Critical Medicines Guide. If a critical medicine cannot be administered, medical guidance should be sought and this should be documented in the patient's medical records, with the reason for omission.

If a dose of any medicine is omitted, the registered healthcare professional must record this on the administration chart and record the reason for the omission. On the All Wales inpatient administration chart, the code number for the omission must be recorded and the entry signed. The reason for the omitted medicine must be considered and appropriate action taken recorded. If a patient refuses a medicine or the route is unavailable, medical or pharmacy advice must be sought and an explanation documented in the patient's medical record. Pharmacy is available for advice.

### **7.14 Non-availability of medicines in hospitals**

#### **7.14.1 Non availability when pharmacy is closed**

See chapter 5

#### **7.14.2 Borrowing of Medicines**

See chapter 5

### **7.15 Administration Incidents**

See Procedure for the management of medication administration incidents and near misses including management if nursing/midwifery staff, or other registered healthcare professionals MM 12, for specific guidance on medicine administration incidents.

### **7.16 Administration of medicines under a Patient Group Direction**

Patient group directions only authorise those named registered health professionals within the PGD to administer that particular medicine. See MM PGD 01 Patient Group Directions -Procedure and Guidance for Authors and Users . A record of approved PGDs is displayed on the BCUHB intranet.



## **7.17 Delegation of administration of medicines to Health Care Support Workers by Healthcare employees**

See [chapter 8](#).

## Chapter 8 Health Care Support Workers (HCSW) NEW CHAPTER

For the purpose of this chapter a Health Care Support Worker (HCSW) includes the terms used for; Health Care Assistants, Unregistered Practitioners, Nursing Auxiliaries and Band 4 HCAs (Assistant Practitioners).

Nursing teams have developed over the last few years; in addition, patients have become more complex. The practice undertaken by HCSW must be in accordance with locally agreed written protocols and procedures for designated settings where the Health Board has a responsibility for providing care. It is therefore the responsibility of the Health Board to identify such areas. Though delegation of the task will be from a registered nurse or midwife, in line with NMC (2015) and the BCUHB Medicines Policy, the HCSW may be carrying out duties without direct supervision of a registered nurse or midwife; i.e. the registrant need not be in the same room/building as the HCSW when the delegated task takes place. The Health Board will accept responsibility for all agreed tasks undertaken by the HCSW, as long as they are competent and compliant with agreed local written protocols and procedures.

Delegation of medicines administration to HCSWs must only be undertaken where it can be evidenced that it will benefit the individual receiving the support. This may be in community settings, HMP Berwyn or specific acute inpatients areas identified by the Health Board.

The scope does not affect the ability of community nurse prescribers to delegate specific tasks, which may include application of items they have prescribed, e.g. skin or wound care products, to specific patients. Where this is practised, directions for administration will be documented in the patient's care plan, and the administration or application of such items will be recorded in the home file. This practice is not transferable and any other medicines support required by the patient must be practiced in accordance with this policy.

This chapter is specifically for use by registered nurses who delegate duties to Health care support workers (HCSWs) employed by the Health Board and by HCSWs who assist, prompt and administer medicines under direct or indirect supervision of the registered nurse. This chapter will also be applicable to registered nurses who delegate medicines management tasks to agency and bank HCSW working within Health Board, including Domiciliary care workers (e.g. district nurses asking for carers to give medicines via PEG).

This section aims to:

- Recognise the opportunities and boundaries of HCSWs within BCUHB
- Standardise the involvement of the HCSW in the processes involved in medicines management and to ensure that only appropriately trained HCSWs, with the right knowledge and skills, can provide support with medication and its related tasks.
- Promote the safety and well-being of the patients
- Address and simplify a wide range of issues likely to be encountered on a day-to-day basis, providing clear, unambiguous procedures for staff to follow

- Define educational requirements

HCSWs across the Health Board perform a variety of roles, and it is not possible to reflect all them all within this chapter.

It is important that any medicine-related task *delegated by a registrant*:

- Has a written protocol / procedure
- Is discussed and agreed with the employer who will detail expectations
- Is recognised by an employee; including the right not to perform any role for which they are neither trained nor competent.

### 8.1 Levels of Medication Support / Roles and Responsibilities

Prior to providing any level of medication support needed by an individual, it must be assessed. It is the responsibility of the registrant to assess the level of support needed.

There are 3 levels of support, which are fully explored below. These levels A, B and C should be considered as a continuum, accepting that patients may move up and down the levels depending on their health status and/or functional ability at the time. These make up the standard levels of support.

In addition, individuals with complex needs will be categorised as requiring **enhanced support**. Timely review is essential to ensure that any support provided is appropriate to the patient's ability and needs. Furthermore, the patient may need support with medicines administration procedures which might require registered nursing input.

- Level A  
Level A supports individuals who take full responsibility for their own medicines and require no assistance with medication from the HCSW.
- Level B  
Only appropriately trained HCSW who have undertaken the accredited QCF level 2 -Unit 28 *Assist in the Administration of Medicines*, may be permitted to undertake Level B.  
Level B supports individuals who are aware of, and understand their medicines regime, retain responsibility for their medicines, but may have difficulties with undertaking the task.

Assistance with self-administering may be given as follows:

- Reminder  
The patient may require a simple reminder to initiate the task but is then able to self-administer without physical assistance. This is not appropriate for patients with significant cognitive/memory difficulties
- Physical assistance  
The patient manages their own medicines but has difficulty with dexterity and/or mobility and may ask the HCSW to help carry out certain tasks. It is the responsibility of the patient to direct which package/bottle/topical medication they require assistance with (e.g. opened/closed/placed in mouth/stored) and such tasks must be completed within sight of the patient at all times.

**N.B. In level B: The patient, NOT the HCSW, retains sole responsibility for their medicines management and administration. In line with agreed written protocols, the exact assistance given on each visit will be documented by the HCSW.**

- **Level C**

Only appropriately trained (Level 3 or above QCFW, 2006) HCSW's may be permitted to undertake Level C. This must include the accredited QCF Level 3 Unit 29 *Administer Medication to Individuals and Monitor the Effects* or above (QCFW, 2006).

Level C supports individuals who are unable to self-administer, due to difficulties around distinguishing which/when medicines are to be taken, often associated with impaired memory, cognition, or visual impairment. This level of support is not approved within the acute care settings. In providing Level C support the HCSW is responsible for the task of administering prescribed medication to the patient as delegated by the registrant. This is the level of support required to patients at HMP Berwyn.

HCSWs will carry out the administration of medicines using Health Board approved documentation for administration in accordance with agreed local written protocols and procedures. This includes oral, topical, inhaled medicines, buccal and transdermal patches, with special local consideration to CDs.

In line with agreed written policies and procedures, all medicines administered at each visit will be documented.

### **Enhanced Support**

Enhanced support is defined as a task for which specific training is necessary and assessment of competencies must be undertaken (e.g. administering rectal medicines), in addition to having the accredited QCF level 3 Unit 29 *Administer Medication to Individuals and Monitor the Effects* or above QCFW, (2006).

Enhanced support tasks will locally be deemed as patient-specific depending on the task, and are strictly limited to those approved by the Health Board. The routes and forms of medicines that HCSWs generally can or cannot administer are described later in this chapter.

Enhanced support for adults and children may only be given through delegation by a registered nurse/midwife, supported by risk assessment and individualised care plans that have been constructed in conjunction with the patient, or via the best interest process for adults that lack mental capacity, and children with complex needs. This would include children, who are developmentally delayed, do not have capacity or dexterity and who are represented by a consenting parent/carer with parental responsibility. Where a need is identified for a medicines administration task to be undertaken by HCSWs that is not currently included on the approved list, a risk assessment must be undertaken and agreement sought from the Executive Director of Nursing.

## **8.2 Education levels**

To enable HCSWs to assist, prompt and administer medicines under direct or indirect supervision of the registrant, the HCSW should complete (including assessment of competence), the Health Board compulsory accredited QCF level of

education in Units 28 level 2 *Assist in the Administration of Medicines* and Unit 29 level 3 *Administer Medication to Individuals and Monitor the Effects* depending on the level of the support being undertaken.

The completion of these units will support the broad education and knowledge needed to be able to safely be involved in supporting patients to receive medicines. However, in addition, Divisions will need to provide local speciality specific competency frameworks where HCSW are involved in administering medication where specific training (enhanced support tasks) is required:

The HCSW providing enhanced support should undertake annual task specific medicines management updates provided by the team the practitioner works with, if they are providing administration of medications for enhanced support.

All other HCSWs involved in medication support must receive three yearly updates provided by the education team.

It will be appropriate to outline responsibilities of the HCSW concerning appropriate documentation relating to the administration of medicines. All Wales Guidance for Health Care Support Workers



All Wales Guidance  
for Health Boards and

No HCSW should be involved in checking or administering medication if they have not been assessed as competent and have the underpinning knowledge to support the task.

### **8.3 Responsibilities**

#### **8.3.1 Registered Nurse Responsible for Delegating**

It is the responsibility of the Registered Nurse to provide the HCSW with specific written procedures for the tasks required, ensuring that appropriate record keeping and training needs are met.

The Registered Nurse must ensure that appropriate training and an assessment of competence has been completed prior to the HCSW undertaking the tasks, and that the HCSW agrees that competence and confidence has been achieved.

#### **8.3.2 Line Manager**

The Division should provide updates to a centrally held HCSW register that shows staff who undertake assisting, prompting and administration of medication as delegated by the registered nurse.

An annual declaration must be submitted by the Division on an annual basis to enable the HCSW register to be updated. This declaration will identify specific areas of practice, evidence of updated competences, date of last PADR, profiles of agreed medication and any risk assessments are reviewed.

For audit purposes a record must also be maintained by the Line Manager of the signatures/initials of all HCSWs.

The role must be described in the HCSW job description

#### **8.3.3 HCSW**



The HCSW:

- must be assessed as competent by their Line manager in the activities they undertake around medicines.
- Know which medicines each person requires and should keep a complete account of all medicine support provided
- Ensure that medicines are stored safely and in accordance with legislation, manufacturer's instructions and this Medicines Policy (e.g. refrigerated if needed). See Chapter 6
- Ensure that medicines are administered safely, correctly and only via an authorised written direction
- Complete an annual declaration

#### **8.4 Tasks associated with medicines management that may be delegated to HCSWs in BCUHB.**

Following relevant training and competency assessment, HCSW may undertake the following tasks as delegated by a registrant (who may be the manager of a department, unit or team) education framework.



Task	Setting Acute (A) Community Nursing (CN) Community Hospital (CH) HMP Berwyn (HMP)	Procedure - local/BCU	Education level plus QCF Unit 28
Ordering of ward stock medication via approved ordering system (excluding CD's)	CH HMP	Refer to Chapter 5 of this Policy  SOP HCA Patient Specific Medication O	2
Ordering of patient specific medication at request of registered practitioner	Not to be done by HCSW. MUST be a Registrant		
Storage of medication in automated cupboard (Mediwell/Omniceil) / stock cupboard	A CH HMP	Refer to Chapter 6 of this Policy	2
Place patient specific medication into patient's POD locker	Not to be done by HCSW. MUST be a Registrant In line with All Wales MARRS Standards		
Second checker for Controlled Drugs stock check with a registered practitioner	CN CH HMP	 SOP HCA 2nd Check CD stocks.docx	2 Plus Completion of independent second checker competency and competence assessment

### 8.5 Routes of administration of medications by HCSW giving level C or Enhanced Support





Where undertaking any other medication task (usually called 'specialised techniques'), a HCSW will need additional enhanced training.









The specialised technique is carried out **only by staff** specifically trained and assessed as competent in the identified technique for a specified patient. Any change in circumstances with the patient. E.g. a change in medication would trigger a review, further education and training and competency assessment. Where complex patients are cared for in their own homes, compulsory regular review of patient medication and provision of an updated medication administration record,




should either be integrated with a community pharmacy local enhanced service, or should be reviewed by a BCUHB practice pharmacist. The registered nurse and HCSW should be part of the discussion following the MUR on a yearly basis. The administration of permitted Schedules 3, 4 and 5 CD medication (designated controlled drugs see Glossary, Administration of Schedule 2 controlled drugs is not permitted, Schedule 1 controlled drugs are not used medicinally) can be administered all governance arrangements are satisfied as identified above with the approval of the Executive Nurse Director, Executive Medical Director and Chief Pharmacist. This should only be endorsed for stable complex/long term conditions, on a named patient basis, as part of a nursing caseload within the community setting (excluding community hospitals) The HCSW and the caseload manager must also satisfy all of the governance arrangements outlined in this Policy. Parenteral administration of any CD is not permitted. Non-Medical Prescribers employed by the Health Board MUST not provide verbal instructions to a HCSW for any changes to prescribed medication

### Specialised Techniques/Patients receiving Enhanced Care

Task	Setting Acute (A) Community Nursing (CN) Community Hospital (CH)	Procedure - Local/BCU	Education level 3 Required- Unit 29
Administration of subcutaneous low molecular weight Heparin (Clexane® /Fragmin®) to patients specified by registered practitioner	CN CH	 SOP LMWH Admin 2017.doc	Level 3 or above on the QCFW (2006), in addition to the specific skills. Completed competence assessment
Administration of Microlax® & Phosphate enemas to patients as delegated by registered practitioner	CN	 SOP HCA Rectal Meds (Microlax Enem	Level 3 or above on the QCFW (2006), in addition to the specific skills. Completed competence assessment
Administration of insulin to named patients (community domiciliary settings only)	CN (only)	 Insulin HCAs.doc	Level 3 or above on the QCFW (2006), in addition to the specific skills. Completed competence assessment
Application of creams/ointments to patients delegated by registered practitioner	A CN CH	 SOP HCA Applic Cream Ointment.doc	Level 3 or above on the QCFW (2006), in addition to the specific skills. Completed competence assessment

Instillation of eye/ear/nose drops (or spray) to patients specified by registered practitioner	CN or Ophthalmology departments	 SOP HCA Admin eye drops.doc  SOP HCA Nose Drops Admin.doc  SOP HCA Admin ear drops.doc	Level 3 or above on the QCFW (2006), in addition to the specific skills. Completed competence assessment
Removal and disposal of transdermal patches to patients specified by registered practitioner	CN (only)	 SOP HCA Admin Transdermal Patch.doc	Level 3 or above on the QCFW (2006), in addition to the specific skills. Completed competence assessment
Administration of medicines by mouth, in liquid or solid dosage form (tablets including sub-lingual and capsules) only to patients specified by registered practitioner	CN (only)	 SOP HCA Oral Meds Admin.doc	Level 3 or above on the QCFW (2006), in addition to the specific skills. Completed competence assessment
Administration of medication via inhalers, spacers device specified by registered practitioner	CN (only)	 SOP HCA Inhalers & MDI.doc	Level 3 or above on the QCFW (2006), in addition to the specific skills. Completed competence assessment
Assist individuals to use nebulised medication safely and effectively	CH CN A	MM15  SOP Admin Nebulizers.doc	Level 3 or above on the QCFW (2006), in addition to the specific skills. Completed competence assessment
Assist individuals to use oxygen safely and effectively	CH CN A	MM15	Level 3 or above on the QCFW (2006), in addition to the specific skills. Completed competence assessment
Administration of	CN (only)		Level 3 or above




specified medicines via Enteral tube route (NG, PEG) only to patients specified by registered practitioner.			on the QCFW (2006), in addition to the specific skills. Completed competence assessment
Discontinue infusions delivered subcutaneously and remove syringe driver or infusion device	CH CN	 SOPHCSWSubcutrem ovalNov18.docx	

### 8.6. Independent second check and witnessed administration.

Accountability for the preparation and administration remains with both the healthcare professional administering the medicine and the independent second checker.

Witnessed administration by definition is by two persons who must witness the whole procedure from the identification of the medicine until it is administered to the patient for whom it is prescribed.

Task	Setting Acute (A) Community Nursing (CN) Community Hospital (CH) HMP Berwyn (HMP)	Procedure - local/BCU	Education level / required
2 <sup>nd</sup> Checker for administration of Controlled Drug (oral) to a patient by a registered professional	CN CH (Individually designated areas where no second registered nurse is available, following risk assessment Director of Nursing must approve) HMP	 SOP HCA 2nd Check for administration of	Level 3 or equivalent or above on the CQFW (2006). In addition, completion of independent second check competency Completed competence assessment
2 <sup>nd</sup> Checker for administration of insulin to a patient by a registered professional	CH HMP		Level 3 or equivalent or above on the CQFW (2006). In addition, completion of independent second check competency Completed competence assessment
2 <sup>nd</sup> checker for administration of subcutaneous fluids (no additives) to a patient by a registered professional	CH CN HMP		Level 3 or equivalent or above on the CQFW (2006). In addition completion of independent second check competency Completed competence assessment

## Chapter 9 Controlled Drugs

### 9.1 Accountability

The BCUHB Accountable Officer (AO) is responsible for all aspects of the safe and secure management of Controlled Drugs (CDs). This is to ensure that safe systems are in place for the management and use of CDs, monitoring and auditing of management systems and investigation of concerns and incidents related to CDs. It is the responsibility of each Clinical Division to ensure that staff are trained to carry out the tasks required of them in the management of CDs, and that staff follow Policies and Standard Operating Procedures (SOPs) of BCUHB and the Clinical Division and comply with their professional standards for medicines management.

Each acute hospital pharmacy shall maintain a record of those persons and their signatures, of those who are authorised to order CDs e.g. doctors, dentists, nurses and paramedics.

### 9.2 Classification of Controlled drugs

Under the Misuse of Drugs Regulations, CDs are divided into five schedules each of which have specific requirements with respect to supply, prescribing, storage and record keeping. (For full details refer to the 'Controlled drugs and drug dependence' section in the British National Formulary). Compliance with these specifications is mandatory but the AO or a person delegated by the AO may require additional precautionary controls to be followed for certain drugs where there is concern about the risk to patients or potential for abuse linked to that drug.

All senior staff have a responsibility to ensure that they and their teams are aware of the issues and restrictions related to all schedules of CDs and that the special requirements on handling them are adhered to.

### 9.3 Prescribing Schedule 2 Controlled Drugs

#### 9.3.1 Prescribing for administration during admission

Schedule 2 CDs can only be prescribed by authorised prescribers employed by BCUHB. Doctors who have not achieved full registration with the GMC are permitted to prescribe CDs (and other prescription only medicines) for inpatient use (and hence discharge prescriptions). They are not permitted to prescribe for outpatients without being fully registered. Non-medical prescribers may only prescribe CDs in accordance with the Non-medical prescribing protocol for supplementary and independent prescribers policy MM 03 .

Prescribed items must be on the appropriate in-patient medication administration record (electronic or paper) or other approved prescribing stationery. The prescription must be indelible, clearly written, signed by the prescriber and dated. The dosage and frequency of administration must be stated. See chapter 4 for general prescribing principles.

#### 9.3.2 Prescribing for supply of a CD to an outpatient, or on discharge, or in Primary care

Prescriptions for the supply of CDs to leave the BCUHB premises are subject to specific legal prescription requirements to enable lawful supply. The prescription must:

- Be written in indelible ink and signature of the prescriber in their own handwriting. Prescriptions for CDs may legally be computer generated but a handwritten signature is still required. It is good practice for the prescriber's pager or contact number to be specified and the prescriber's name printed for recording in the CD register
- Include the date
- Specify the name and address of the patient
- State the name, form (e.g. tablet, capsule, liquid) and strength of the CD, even if only one form exists
- Specify the total quantity of the medicine to be supplied in words and figures. For liquids, state the total volume in millilitres (in both words and figures) of the preparation to be supplied. For dosage units (tablets, capsules, ampoules), state the total number (in both words and figures) of dosage units to be supplied e.g. 10, ten tablets (of 10 mg) rather than 100 mg total quantity.
- State the prescribed dose and frequency of administration. It is not acceptable to use 'as directed' or 'when required' unless a dose is specified. E.g. 5mg when required is not acceptable, whereas 5mg up to four hourly when required is acceptable.
- The dosing instructions must be clear and unambiguous on the prescription. The corresponding medicine label must also include clear dosing instructions, including the individual unit dose and maximum total daily dose ([NICE NG 46 controlled drugs - safe use and management](#).)

### **9.3.3 Prescribing for controlled drug dependent patient during admission**

If a newly admitted patient reports to be prescribed medication for their addiction, the following information must be obtained from a third party (i.e. not the patient) and documented in the patient's medical notes:

- Name of drug service provider or supplying community pharmacy, and the person with whom the dose was confirmed.
- Dose, formulation and frequency of drug to which patient is dependent upon.
- Other medicines prescribed by the drug service
- Collection days
- Date last collected and quantity
- Other relevant information (e.g. supervised administration)

The third party must be a member of the staff from the Substance Misuse Service (SMS), the patient's GP or community pharmacist.

See BCUHB Guideline for the in-patient management of adult patients addicted to opioids for further guidance.

Only prescribers who hold a special licence issued by the Home Secretary may prescribe, administer or supply diamorphine, dipipanone or cocaine in the treatment of drug addiction. Other practitioners must refer any service user who requires these drugs to the substance misuse service. See current British National Formulary (BNF) . Whilst an inpatient an alternative substitution will be given under the advice of the treating SMS. This does not restrict practitioners prescribing these particular CDs for treating organic disease or injury.



The prescriber treating the person's drug addiction SMS and community pharmacy that supplies their medication must also be informed of their admission to hospital by the ward healthcare professional, so that they are aware not to dispense any more medication until informed by the hospital of the patient's impending discharge.

Initiation of methadone, buprenorphine or Suboxone® (Buprenorphine /naloxone combination) as a substitute for heroin must only be prescribed with involvement of the local SMS. This is to ensure supply can be continued upon discharge. When a patient under the care of the substance misuse service is admitted to a hospital their pain symptoms should be managed according to the SMS Guidance for the management of pain [BCUHB Guideline for the in-patient management of adult patients addicted to opioids](#) .

No take home medications should be issued without prior agreement from SMS as most often substitute medication is provided on a daily supervised basis in the community and as such the risks may be deemed too high to provide any take home medication. Provision for ongoing prescription in the community post discharge can be arranged with the relevant SMS. Adequate notice is required to ensure ongoing prescription (contact numbers below). Locality SMS contact details are listed below (for in hours only). The local hospital bronze on-call can be contacted out of hours:

Anglesey	03000 853355
Caernarfon	03000 853333
Colwyn Bay	01492 523681
Rhyl	03000 856828
Deeside	01244 831798
The Elms Wrexham	03000 859444

The SMS has set out procedures for prescribing and supplying medicines to patients of that service. Patients in the community who are receiving treatment from SMS will obtain their medicines from an agreed regular pharmacy. Any variations in usual arrangements must involve the SMS team.

## 9.4 Ordering Controlled Drugs

### 9.4.1 Ordering Controlled Drugs for clinical areas

Controlled drugs order books are regarded as controlled stationery. The CD order book must be stored securely in a clinical area. CDs for stock in a clinical area must be ordered on an approved CD requisition by registered nurse/midwife/ODP. A pharmacist or pharmacy technician can also order CDs for a clinical area but the order must be countersigned by a registered nurse.

The requisition must include:

- The clinical area being supplied
- The name and strength of the CD preparation including the dose form (e.g. injection, tablet, capsule etc.)
- The total quantity to be supplied (e.g. manufacturer's outer pack size)



- Signature of the registered nurse/midwife/designated healthcare professional followed by the name in print

For those areas where CD stock lists are used, they are ordered as stock. If an additional CD is needed, an order can be placed using the CD requisition book. Where practicable, Controlled Drugs are only to be ordered for clinical areas in unit numbers of the outer packaging of the manufacturer's product.

#### **9.4.2 Ordering Controlled Drugs in community hospitals and including mental health premises/facilities without a pharmacy**

The nurse in charge must order CDs for stock from the pharmacy in the ward CD order book. Since there may be delay in the order arriving at the pharmacy and the timing of the next scheduled delivery, nursing staff must reorder stock items in a timely manner to maintain continuity of supply.

#### **9.4.3 Ordering Controlled Drugs for operating theatres**

If theatres have more than one CD cupboard, there should be a separate CD order book and register for each CD cupboard. Only authorised registered nurses or Operating Department Practitioners (ODPs) can order CDs for theatre stock. Registered ODPs may deal with the ordering and receipt of CDs in theatre provided that authority is delegated by the registered nurse/ODP in charge.

#### **9.4.4 Ordering Controlled Drugs by ambulance paramedics**

The Welsh Ambulance Services NHS Trust (WAST) will provide each BCUHB pharmacy with a list of Ambulance Clinical Team Leaders, authorised to order morphine 10mg Injection for storage within the clinical area based electronic medicine storage cabinet. Clinical Team Leaders requisitioning morphine must be in BCUHB uniform, have a valid Trust identity badge and have a copy of their signature available for inspection at the hospital pharmacy. Clinical Team Leaders are responsible for maintaining morphine stocks in the cabinets. All WAST clinicians have access to medicines via biometric (fingerprint) security. Morphine withdrawals can only be completed by WAST paramedics registered on the system and require a second witness fingerprint to complete the transaction. The electronic medicine cabinet records the paramedic making the request, the vehicle it is being requested for and the witness ID. The paramedic is then responsible for signing the morphine into the vehicle CD register, in line with existing WAST CD procedures.

### **9.5 Collection of Controlled Drugs**

#### **9.5.1 Collection from the pharmacy by clinical areas**

CDs may be collected from the pharmacy by a person nominated for the task by the nurse/midwife in charge of the ward or department. Health board identification must be shown before CDs can be collected. Further details can be found within the Pharmacy CD SOPs at each hospital.

#### **9.5.2 Collection of an out-patient CD by a patient or proxy for the patient**

It is a legal requirement for pharmacy staff to request identity of the person collecting the CD. This can be provided by means of a driving licence or other forms of identification. A record of the person supplied with the CD must be made within a designated register for collection of CDs.

#### **9.5.3 Collection of discharge CDs (TTO CDs)**

It is a legal requirement for pharmacy staff to request identity of the person collecting the TTO CDs. This can be provided by a BCUHB staff identify badge or equivalent by the staff member collecting the CDs. A record of the person supplied with the CD must be made within the CD register.

#### **9.5.4 Collection of CDs by paramedics or other non BCUHB health professionals**

It is a legal requirement for pharmacy staff to request identity of the person collecting the CD. This can be provided by a name badge or equivalent. A record of the person supplied with the CD must be made within the CD register.

### **9.6 Delivery of Controlled Drugs**

#### **9.6.1 Delivery within acute hospitals**

At the acute hospitals with a pharmacy department, arrangements are in place for CDs to be delivered by a pharmacy courier or hospital porter. The porter will make the necessary checks before signing for receipt of CDs. Since the delivery arrangement is for multiple destinations the porter must use a designated CD trolley or equivalent approved arrangement for delivery of all CDs. A despatch sheet (transit record) will set out the CD delivery schedule for the porter. The porter must return a copy of the signed transit record to the originating pharmacy. See section [9.7](#) for guidance on receipt of CDs in the clinical area.

#### **9.6.2 Delivery of Controlled Drugs to community hospitals, mental health units or other sites without a pharmacy**

Delivery of CDs to community hospitals or other site premises is permitted by employees of WAST, porters and transport drivers, who each will take upon the responsibility set out in 9.5.4. They must make the necessary checks when signing for receipt of CDs, by checking the despatch details of the sealed numbered package for transit. During transit the CD must be stored securely at all times. The person making the delivery must obtain a signature from the nurse/midwife accepting the CD delivery. The pharmacy must retain the top copy of the signed receipt to enable completion of the pharmacy CD register and the despatch details will be retained in the pharmacy for audit purpose. The person delivering the CD must return a copy of the signed transit record to the originating pharmacy.

#### **9.6.3 Transfer of patient's own CDs between clinical areas**

Patient's own CDs brought into hospital should be transferred with the patient if they move to a different clinical area. Registered nurses, pharmacists or pharmacy technicians can sign the CDs out of the ward CD register with a witness and then transport the CDs to the new ward where they are responsible for recording the CDs in the CD record book with another witness.

### **9.7 Receipt of Controlled Drugs in clinical areas**

Upon receipt of CDs from the messenger, the nurse, midwife or ODP must immediately check the CDs:

- Sign the receipt section of the CD order in the CD order book
- Enter the details of the CDs received on the appropriate page of the ward or department CD register
- Record the date that the CD is received

- Enter the requisition number in the appropriate column, and update the running balance to include the new and previous stock
- Check that the ward stock balance tallies with the quantity physically present
- The receipt of a CD should be witnessed by another member of staff and the CD record book signed by both staff members
- Lock the newly received CDs in the appropriate section of the CD cupboard.

#### **9.7.1 Receipt of Controlled Drugs at community hospitals, mental health units**

The registered nurse who receives the sealed package must:

- Examine the package/s to verify that the transit seal/s is/are intact.
- Sign for receipt of an intact package on the messengers “sealed package sheet” (transit record.)
- If the seal is broken the nurse must not sign the sheet. The pharmacy must be informed immediately so that an investigation can be undertaken.
- After signing for the sealed package the registered nurse must check the contents and sign the CD order book for receipt of the CDs
- A record of receipt must be entered and witnessed in the ward CD Register (record book).

#### **9.8 Retaining of Controlled Drug records**

Ward and department CD order books and ward CD record books must be kept in the clinical area for two years after the last entry and may then be destroyed.

#### **9.9 Storage of Controlled Drugs**

Storage requirements will depend on the schedule of the CD and any special Accountable Officer approved increased security/vigilance requirements which may be in place.

##### **9.9.1 Storage of Schedule 2 Controlled Drugs in clinical areas**

In clinical areas all CDs under control of the Misuse of Drugs Act (1971) and labelled as CD by pharmacy must be stored in a dedicated CD cupboard that conforms to the current legislation for storage of CDs in hospitals and NHS premises. CDs that have been designated as ‘high strength’ by BCUHB must be stored apart from standard strength preparations in a designated high strength storage area within the CD cupboard. This may be a separate shelf, a separate part of the cupboard, or a separation box within the CD cupboard.

High strength CDs are:

- Diamorphine, morphine or oxycodone injections at strengths of 30mg or more
- Alfentanil 5mg/mL injection
- Morphine 20mg/mL oral solution
- Oxycodone 10mg/mL oral solution
- Methadone oral solution, concentrations above 10mg/mL
- Morphine MR 100mg oral capsules/ tablets

Clinical areas that hold CDs must have access to reversal agents e.g. naloxone and flumazenil.

If a discharge prescription includes a CD, it should be stored within the ward CD cupboard until such time as the patient is discharged. Any CDs labelled for discharge should be segregated from ward stock.

Refrigerated CDs require storage in a separate locked refrigerator dedicated for CDs only and the key must be kept with the main CD cupboard key.

CD cupboards must be kept locked when not in use and all CDs must be locked in the cupboard when not in use. Only CDs are to be stored in the CD cupboard unless, following a risk assessment and approval by the Accountable Officer, it is decided other items need to be stored in the cupboard for security reasons.

Storage of CDs in automated medicines cabinets is permitted in certain circumstances, once a risk assessment has been undertaken by the Controlled Drug and Chemical Liaison Officer and a senior pharmacist. Additional security measures are put into place to ensure the CDs are stored securely within the automated cabinet e.g double finger prints are required to access the unit. The CD register and controlled drug order book must be stored a locked cupboard or drawer.

#### **9.9.2 Patient's own Controlled Drugs brought into the hospital**

After medicine reconciliation if it is necessary to retain patient's own CDs on the ward, the nurse in charge should make a record of the receipt in the designated Patient's Own CD register and be witnessed by a registered nurse.

A nurse may administer Patient's Own CDs whilst that patient is an in-patient. A record of administration of Patient's Own CDs must be kept as if the medication were ward stock. If the CD is still clinically indicated at discharge, these medicines may be returned to the patient with a witnessed record of the return being made in the relevant CD Record Book.

#### **9.9.3 Self administration of Controlled Drugs**

Situations may arise when an in-patient may wish to self administer their own CDs. In exceptional circumstances and where an individual patient risk assessment is made, the patient may self administer in accordance with BCUHB guidance for supported or self –administration of medicines by hospital patients MM21 . If the patient assessed as suitable for self administration, the patient's own CDs can be stored either in the patient's POD cabinet or in the CD cupboard. If stored in the POD cabinet then it is still necessary to record a running balance in the CD Register (Ward or Patient's Own).

#### **9.9.4 Temazepam, midazolam and tramadol**

Temazepam, midazolam, and tramadol are ordered in the same way as schedule 2 CDs. Temazepam and Tramadol must be stored and recorded in the same way as for schedule 2 CDs. A record of receipt and administration must be made for temazepam and tramadol within the Controlled Drug Register.

Midazolam, need not to be stored in a CD cupboard, but must be stored with other Prescription Only Medicines. There is no requirement to maintain a record of receipt or administration of midazolam within the Controlled Drug Register. See Table 1 below.

Buccal midazolam preparations are prescribed to provide immediate treatment for status epilepticus or febrile convulsions. In hospital it would usually be stored with other prescription only medicines, but can be stored in a more accessible place when set out in a BCUHB Cardiopulmonary Resuscitation (CPR) Policy RES 03 . In the community buccal midazolam need not be kept in a locked place excepting those premises registered under the Care Homes (Wales) Regulations (2002) where it should be stored in accordance with those regulations.

Within the prisons setting, tramadol is handled under the national guidance for secure health and justice settings.

**Table 1: storage requirements for temazepam, midazolam and tramadol**

	CD Order	CD Storage	CD Records	Administration
Temazepam	YES	YES	YES	Two nurses
Midazolam	YES	NO	NO	* Single nurse for buccal route and when nurse is familiar with the medication (Two nurses for IV route)
Tramadol	YES	YES (this may be a specially designated Schedule 3 cupboard)	YES	* Single nurse for IM or oral route and when nurse is familiar with the medication (Two nurses for IV route)

## 9.10 Control of Controlled Drugs in clinical areas

The nurse/midwife with continuing responsibility of a clinical area must ensure that all regulations concerning the control and recording of CDs are complied with. In the absence of the nurse/midwife with continuing responsibility, a designated deputy who must be a registered nurse or Operating Department Practitioner (ODP) will take responsibility for controlling access to CDs.

The nurse with continuing responsibility will agree a list and quantity of CDs held as stock on the clinical area. If there is need for CDs outside of this list to be used on the ward they can be ordered for administration to a patient. The keys for the clinical area's CD cupboard must be kept on the person of the nurse/midwife in charge and separate from other clinical area keys.

### 9.10.1 Recording of administration of Schedule 2 Controlled Drugs in clinical areas

The controlled drugs register, which is regarded as controlled stationary must be stored securely. It is to be used for all schedule 2 CDs and 'designated' drugs from other schedules, such as Tramadol, as described in 9.9.4.



The CD Register contains legal and patient information and therefore must be kept in safe custody within data protection and information governance rules.

The nurse/midwife or ODP with continuing responsibility for a clinical area will ensure that a CD Register is maintained for all CDs received and administered in the clinical area. The Register should have an index page indicating the corresponding page number for that CD. The page number does not need to correspond with the serial requisition number of the CD order book. There should be one preparation per page. A record of CD administration must be made each time a CD is administered. The record is made on the page for that CD and must include the name and dose of the CD, the name of the patient, the date and the time. The stock balance must then be updated. The record must be signed by the nurse/midwife/theatre practitioner administering the CD and signed by a second registered practitioner who witnessed the administration. In Community hospitals a trained competent Health Care Support worker can act as a second checker. See [chapter 8](#) for specific guidance on second checking of medication by HCSWs.

If a part dose is given from an ampoule or vial, then the registrant must record the amount given and the amount wasted e.g. if the patient is prescribed diamorphine 2.5mg and this dose is given from a 5mg ampoule, the record must show 2.5mg given and 2.5mg wasted.

If a part tablet (e.g. half a tablet) is required then the registrant must record the amount given and the amount wasted e.g. half tablet given, half tablet wasted. The remaining part dose must be disposed of in accordance to section 9.9.1 Table1.

Once the page is filled, the stock should be transferred to the next available page and the new page number documented in the index and at the bottom of the completed page. If a mistake is made in the CD Register, brackets should be made around the error in such a way that the original entry is clearly legible. A correction should be made immediately the error is found and witnessed by a second person preferably a registrant. The use of correction fluid is forbidden.

### **9.10.2 Checking of Controlled Drug stock balances**

All clinical areas holding stock of CDs must perform a regular stock check balance for each CD held in stock. Wards should perform this check daily, but each ward or department may determine that this check is made more or less frequently in consultation with the local pharmacy safety lead. Clinical areas that are not providing continuous patient care should perform the checks on the days of opening and upon opening and closing the clinical area.

This check is to be made by two registered practitioners (nurse, midwife, ODP, pharmacist or pharmacy technician). A student nurse, student midwife or student operating department practitioner may be the second checker provided they have the necessary knowledge and competence for this task and a supervising checker is also present. In Community hospitals a trained competent Health Care Support worker can act as a second checker. See [chapter 8](#) for specific guidance on second checking of medication by HCSWs.

Checking of CDs involves checking of entries in the CD record book against the contents of the CD cupboard, not the reverse, to ensure all entries are checked. It

is not necessary to open packs with intact tamper-evident seals when checking stock.

Stock balances of liquid medicines may be checked by visual inspection and must not be poured into a measure and returned to the original container. Any discrepancy discovered whilst the bottle is in use or completed should be reported to the nurse/midwife/theatre practitioner in charge. Should the discrepancy remain unresolved the pharmacy department must be informed as above. A record indicating that the CD check has been carried out and stocks have been confirmed as correct must be kept in a separate record book, known as the BCUHB Controlled Drug Daily Check Register.

The pharmacist or pharmacy technician for the clinical area are responsible for ensuring that a reconciliation of Controlled Drugs stocks and register is undertaken at least every 6 months and this check is recorded in the CD register. For theatres this task may be delegated to the nurse manager in collaboration with the pharmacist responsible for the theatre.

### **9.10.3 Control of Controlled Drugs in operating theatres**

The nurse or theatre practitioner in charge of theatres is responsible for the control and storage of CDs in the designated areas. A designated deputy (who must be a nurse or theatre practitioner) may take responsibility for controlling access to CDs, whilst the responsibility for all medicines remains with the nurse/theatre practitioner in charge. In theatres, the nurse/theatre practitioner with continuing responsibility may delegate the task of carrying out daily CD checks to other theatre practitioners. A record of the mandatory checks must be kept as set out above for wards and departments. Good practice would recommend that these are done before and after each list but must be carried out as a minimum on a daily basis.

During normal working hours, the nurse in charge/theatre practitioner or designated deputy will hold the keys for the CD cupboard within the designated area (under their personal control within the theatre area). Out of hours, the nurse in charge/theatre practitioner of recovery or deputy will hold the CD cupboard keys (take responsibility for the entire theatre CD keys). If all theatres are closed the nurse in charge/theatre practitioner will take personal control of all theatre CD keys to ensure that CD stocks remain intact.

Where an operating theatre runs a system of signing out CDs to a particular anaesthetist, all movements of CDs must be recorded in the theatre CD register.

The nurse in charge/theatre practitioner is responsible for ensuring that an auditable system is put into place for:

Recording the amount issued to the anaesthetist and recalculating the stock balance.

Returning unused ampoules to stock and amending the balance.

The anaesthetist is responsible for:

- Signing the register for the amount of ampoules received
- Recording the amount of CD administration on the anaesthetic and operation record of the patient.



- Returning any unopened ampoules to the nurse and signing the CD register.
- Personally disposing of, as shown in Table 2 (section 9.12.1) any unused CD in an open ampoule or in a syringe in accordance with theatre procedures.

### **9.11 Administration of Controlled Drugs during a period of care**

CDs must be administered by two persons who must witness the whole procedure from the identification of the medicine and its preparation until it is administered to the patient. Of the two persons who administer, check and witness the procedure, one shall be a registered nurse, midwife or ODP and the other shall be a doctor, registered nurse, midwife, ODP, or a competent pharmacist, pharmacy technician who must act as a witness following planned formal preparation for the task. See [chapter 8](#) Health Care Support Workers (HCSW) for specific guidance administration and second checking of medication by HCSWs.

Whilst in placement training, student nurse/student ODP must be given practical training on the ward in the skills necessary for ordering, receipt, checking and administration of CDs. Once trained in these tasks student nurses/student ODPs may act as lead or second checker in the above processes but they must be continually supervised and witnessed by a registered nurse, midwife or ODP.

Midwives can possess, supply and administer specified CDs provided that it is in the course of their professional midwifery practice and in line with local guidance.

#### **9.11.1 Exceptional circumstances for administration of a CD to a patient on another clinical area**

A nurse in charge of a clinical area is only permitted to hold a stock of CDs for administration to patients under his/her care. This means that a nurse/midwife/ODP is not empowered by law to make a supply to another practitioner, whether this request comes from another ward or is a request from a doctor.

In exceptional circumstances, a single dose of a CD can be administered to another patient on another ward/theatre when the pharmacy is closed. The nurse/midwife/ODP from where the CD is stock must supervise and be part of the whole administration process. A record of administration is to be made in the originating ward/theatre CD record book and the record must be made or witnessed by the registered Nurse/ODP in the original ward/theatre who must accompany the CD to its place of administration. Further supply of CDs must be obtained from the local hospital pharmacy when next open or in an emergency contact the emergency duty pharmacist for advice or supply.

### **9.12 Return, disposal and destruction of Controlled Drugs**

For GP managed practices see SOP for destruction of CDs for authorised witnesses.

In the interests of security, safety and containment of environmental pollution, CDs which include unwanted or expired stock, unwanted patient's own medication and unused discharge medication should **not** be destroyed on the ward/clinical

area. As far as is practicable it should be returned to the pharmacy for safe denaturing and disposal.

The nurse/midwife in charge or registered nurse with delegated responsibility must inform the ward pharmacist or ward technician of any unwanted or excess CDs in a timely fashion.

Destruction of any CD whether patient's own or expired stock in NHS Community hospitals/clinics/HMP Berwyn should be destroyed on site. If this is not possible and for stock CDs no longer required, items may be returned to the local hospital Pharmacy, on obtaining permission to do so and with adherence with hospital pharmacy standard operating procedures. For removal of unwanted medication from patients home, refer to MM33 Guidelines for Community Staff.

### **9.12.1 Disposal and Destruction of Controlled Drugs**

See Table 2 for guidance on destruction and disposal of CDs.

All liquid oral and parenteral formulations must be poured onto an absorbent paper towel and put in a sharps container if a denaturing kit is not available. For powder-containing ampoules, water must be added to dissolve the powder inside, poured on an absorbent towel and disposed of in a sharps bin if a denaturing kit is not available.

Solid dose formulations must be ground or crushed to ensure the whole tablet or capsule is not retrievable and then added to water. The resulting mixture is then be poured onto an absorbent paper towel and added to a sharps container if a denaturing kit is not available.

The backing of an unused patch should be removed, the patch folded over on itself and disposed on in a sharps container.



**Table 2:** Guidance on destruction and disposal of CDs for clinical areas where there is a pharmacy on site

Type of CD	Location of destruction	Person to destroy CD and method	Person to witness destruction	Register entry	Notes
<b>PATIENTS'S OWN CDs</b>					
Sent from clinical area	Pharmacy	Pharmacist or registered pharmacy technician <b>Denaturing Kit</b>	Pharmacist or registered technician	Pharmacy CD Destruction Register	The patient must consent to the destruction
Handed in directly to Pharmacy e.g. outpatients	Pharmacy	Pharmacist or registered pharmacy technician <b>Denaturing Kit</b>	Pharmacist or registered technician	Pharmacy CD Destruction Register	The patient must consent to the destruction
Patient deceased	Pharmacy	Pharmacist or registered pharmacy technician <b>Denaturing Kit</b>	Pharmacist or registered technician	Pharmacy CD Destruction Register	Can be destroyed without the consent of patient's estate (or relatives)
<b>WARD STOCK CDs</b>					
Excess/unwanted or expired	Pharmacy	Pharmacist or registered pharmacy technician <b>Denaturing Kit</b>	Pharmacist or registered technician	Clinical area: CD Register Pharmacy: CD destruction Register	
<b>WASTAGE</b>					
Part doses drawn up on <b>ward</b> for individual patient e.g. when 5mg dose from 10mg ampoule	Clinical area	Registered nurse or midwife <b>Empty into sharps bin</b>	Registered nurse, midwife, doctor or pharmacist	Clinical area CD register	Record details of dose wastage e.g. 5mg given/ 5mg wasted and name of patient in CD register
Part doses drawn up in <b>theatre</b> for individual patient eg. 5mg dose from 10mg ampoule	Theatre	Registered: nurse, midwife or ODP <b>Empty into sharps bin</b>	Registered nurse, midwife, doctor or pharmacist	Theatre CD register	Record details of dose wastage e.g. 5mg given/ 5mg wasted and name of patient in Theatre CD register



Type of CD	Location of destruction	Person to destroy CD and method	Person to witness destruction	Register entry	Notes
<b>WASTAGE</b>					
Dose drawn up in a clinical area for individual patient but not given	In the clinical area	Registered nurse or midwife <b>Empty into sharps bin</b>	Registered nurse, midwife, doctor or pharmacist	Clinical area CD register	Record name of patient and reason for non-administration in CD register
Dose drawn up in theatre for individual patient but not given	In theatre	Registered nurse, midwife, ODP or anaesthetist <b>Empty into sharps bin</b>	Registered nurse, midwife, ODP, doctor or pharmacist	Theatre CD register	Record name of patient and reason for non-administration in theatre CD register
Wastage from discontinued parenteral dose in infusion bag or syringe	In the clinical area	Registered nurse or midwife <b>Empty into sharps bin</b>	Registered nurse, midwife, doctor or pharmacist	Clinical area CD register	Details of amount discarded should show name of patient and reason for non-administration
<b>PHARMACY</b>					
Pharmacy stock unfit for use (schedule 1 or 2)	Pharmacy	Pharmacist or Registered pharmacy technician	Authorised person* Denaturing Kit	Pharmacy CD register	
Part doses drawn up in pharmacy e.g. during extemporaneous dispensing	Pharmacy	Pharmacist or staff member dispensing the preparation Denaturing Kit	Pharmacist or registered technician	Pharmacy extemp prep worksheet and Pharmacy CD register	Record details of amount issued, BN of extemp prep & name of patient in CD register

\*Further details can be found within the Pharmacy CD SOPs at each hospital.

If a CD is prepared for administration (i.e. removed from its original container in a way that it cannot be replaced) but is not administered, it must be disposed of in accordance with guidance in Table 2. If not administered the dose must not be returned to stock, with the exception of whole ampoules or vials. Oral tablets or capsules removed from blister packaging must be destroyed and placed in a sharps bin and an entry made in the CD register.

### 9.12.2 Disposal or Return of CDs from clinical areas without a pharmacy on site

Any excess or expired CD stock or patient's own CDs that are no longer needed must be disposed of onsite unless there is an agreement authorised by the Accountable Officer (AO), or a person to whom the AO has delegated the decision that the CDs can be returned to the pharmacy. Patient's own CDs should be returned to the patient on discharge provided that the patient is still prescribed the medicine and at the same dose and frequency.

If authorisation has been given for the CDs to be returned to the pharmacy, this must be carried out in accordance with the BCUHB SOP for the Return of Controlled Drugs (CD's) from Community Hospitals to the Acute Site Pharmacy Department with Transport. In this circumstance, follow the guidance in Table 2 for the method of destruction.

### **9.12.3 Expired Controlled Drugs held by paramedics**

Expired CDs held as stock by WAST must be returned, as set out in the WAST procedures, to the local hospital pharmacy for destruction. The ambulance paramedic will make arrangement for a convenient time to come to the hospital pharmacy.

The pharmacy will accept and dispose of expired CDs in accordance with the pharmacy department procedure for disposal of CDs.

### **9.12.4 Expired Controlled Drugs temporarily held by primary care practitioners/GP Out of Hours Service**

There are occasions where Primary Care Practitioners (PCPs) and GP Out of Hours Service Practitioners may have previously dispensed CDs returned to them, from the family of a patient who has recently deceased. The family should be advised to return the no longer needed CD to the dispensing pharmacy. If the family wishes for the CD to be taken away immediately by the PCP, it should be accepted on the understanding that the PCP takes full responsibility for the safe destruction of the CD in accordance with the practice guidance for destruction of CDs. In certain circumstances it may be practical to surrender the CD to the local hospital pharmacy. In each of the above situations the PCP must document and record the CD, strength, dose form and quantity so that a full auditable trail for the CD from patient to destruction is made. For further guidance see MM33 Guidelines for Community Staff on the removal of unwanted medication from a patient's home

### **9.13 Discrepancies and irregularities relating to Controlled Drugs**

Any discrepancy or irregularity relating to a CD is a serious matter and upon discovering such an event it is the duty of the registrant to inform a senior line manager. During normal pharmacy working hours, the discrepancy must be reported to the senior nurse/midwife/theatre practitioner or clinical manager on duty and to the clinical area pharmacist. A Datix incident report must be completed as soon as possible after the discrepancy has been discovered. Sometimes the discrepancy is resolved through double checking of all records of receipt and administration and by reconciliation of all clinical area's CDs with the actual stock and the CD record balance in the register. Additionally medicines administration record charts can be checked against administration records held in the ward CD book.

If the discrepancy remains unresolved, the Clinical Division Senior Nurse must be informed by the nurse/midwife/theatre practitioner in charge and a written report submitted. The Clinical Division Senior Nurse will then inform the Assistant Director of Nursing and the Local Assistant Director of Pharmacy. If initial enquiries lead to suspicion of fraud or theft, follow the procedure set out in chapter 3.4.2 and 3.4.3. Outside of normal pharmacy working hours, the nurse/midwife/theatre practitioner in charge will inform the senior nurse/midwife/theatre practitioner on duty and Bleep 100 holder/Site Facilitator/Clinical Site Manager. A Datix incident report must



be completed as soon as possible after the discrepancy has been discovered. Pharmacy should be informed as soon as practical during the next opening hours.

#### **9.14 Lost or missing Controlled Drug cupboard keys**

If keys to Controlled Drug cupboards cannot be found then urgent efforts should be made to retrieve the keys as soon as possible e.g. the keys may have been inadvertently taken home by a member of staff going off duty. If the keys are missing, the Clinical Division Senior Nurse, the Local Assistant Director of Pharmacy and Security must be informed. The Accountable Officer (Chief Pharmacist for BCUHB) will also be informed. If a potential risk to the security of CDs exists the ward/theatre CD cupboards must have replacement locks, as a minimum action, or the cupboards entirely replaced. Advice can be sought from the pharmacy team. A Datix incident report must be completed.

#### **9.15 Administration of Controlled Drugs in patients' homes**

There must be written instructions by a medical practitioner for the individual patient. These written instructions are normally printed on the dispensed medicine label by the dispensing pharmacy. A designated nurse will be responsible for the administration of the CD.

It is advisable that the nurse is accompanied by a second person for the purpose of stock control of the CD (witnessing the administration of the CD as described in 7.3). In the absence of a second person the medication (CD) may be administered by one person provided that it is a first level registered nurse/midwife.

#### **9.16 Suspicious substances**

Occasions will arise when a patient must surrender certain medicines or materials that are considered to be 'Suspicious Substances'. Items that may be considered under this category include brown resinous material, white crystalline powder and suspicious tablet pressings, but the variety of illicit presentations may include more sophisticated formulations.

Unless a person holds formal authorisation from the Home Office, it is an offence to possess Schedule 1 Controlled Drugs. A health professional may take possession of a suspicious substance for purpose of preventing harm to patient under their care or other persons and be able to justify their action on these grounds. If a health professional has to take possession of a suspicious substance in these circumstances they must immediately notify the local hospital pharmacy in hours or securely store in the CD cupboard and inform pharmacy the following day. The pharmacist will arrange collection of the suspicious substance, recording their receipt of the material in the clinical area's CD register. The pharmacist will then ensure safe custody of the suspicious substance within the pharmacy CD storage area and record receipt of the material within the pharmacy CD register. At locally agreed periodic intervals, the Controlled Drug and Chemical Liaison Officer will arrange for safe disposal of the materials. If there is suspicion of a crime being or attempted to be committed (for example possession with intent to supply, trafficking) the product must be retained so it can be handed over to the Police.



## **Chapter 10 Return, Disposal and Destruction of Medicines**

### **10.1 Return of excess or unwanted medicines**

#### **10.1.1 Returns from clinical areas**

All unwanted CDs are to be returned in accordance with the Chapter 9 of the Medicines Policy. All other excess or unwanted medicines (ward stock, individually dispensed or patient's own medicines ) must be held within a clinical area until arrangements have been made for their return to pharmacy for disposal. Patient's own medicines can be removed if consent has been obtained or when it is in the patient's best interests.

Arrangements should be made for the return of these excess or unwanted medicines to pharmacy during normal pharmacy opening hours.

Wards receiving stock control by pharmacy staff must not make returns without prior agreement with the pharmacy. Pharmacy staff will return stock to pharmacy at the time of stock control. Wards who order their own stock should notify pharmacy of any excess or unwanted medicines.

#### **10.1.2 Returns by Community Staff**

See MM33 Guidelines for Community Staff on the removal of unwanted medication from a patient's home.

### **10.2 Disposal of cytotoxic medicines**

See CP5M01 Guidance for Ensuring Safety and Quality of Chemotherapy Services.

### **10.3 Disposal of Controlled Drugs**

Excess or unwanted CDs must be returned and disposed of in accordance with the Chapter 9.

### **10.4 Disposal of part used syringes and injections**

Syringes that are not fully discharged and partly used infusion bags containing prescription only medicines (POMs) should be disposed using a 'sharps' container. They must not be returned to pharmacy. See ES 03 Waste Management Policy for further guidance.

### **10.5 Disposal of medicines by the BCUHB managed pharmacy**

All disposal and destruction of medicines within the BCUHB managed pharmacy must be in accordance with departmental procedures and in line with ES 03 Waste Management Policy and guidelines from the Professional Regulatory body for pharmacy.



## Chapter 11 Defects, Hazards, Adverse Reactions and Incidents Involving Medicines

### 11.1 Losses and discrepancies

#### 11.1.1 Apparent loss of medicines in a clinical area

The manager in charge of the clinical area must assess the significance of the loss of the medicine and complete a Datix incident report. All losses involving CDs must be referred as soon as possible to the senior clinical manager who will contact the local hospital Pharmacy Operations Manager as necessary. The procedure set out in the chapter 9 must be followed.

If theft or fraud is suspected follow the guidance set out in sections [see section 3.3](#) and [3.4](#).

#### 11.1.2 Apparent loss within the pharmacy

Any apparent loss of medicines within the pharmacy must be reported immediately to the senior pharmacist on duty and a Datix incident report completed. The senior pharmacist and the person reporting the loss should examine the records against the physical stock to confirm the apparent loss. If no satisfactory explanation is forthcoming the Operations Pharmacist will inform the local Assistant Director for Medicines Management, after having checked the stock records against physical stock. Should the apparent loss remain unexplained, the Assistant Director for Medicines Management will inform the Security Manager and depending of the severity of the loss Chief Pharmacist Medicines Management and security officer in consultation with him/her may report the incident to the Police and ask for an independent investigation.

### 11.2 Management of medication errors

In order to prevent medication errors, it is in the individual responsibility of all Practitioners to adhere to their professions Code of Practice and to the BCUHB Medicines Policy at all times.

A medication error can be defined as a preventable error that may cause or lead to inappropriate medication use or patient harm while medication is in control of the health care professional or patient. Such events may be related to professional practice, health care products, procedures and systems including prescribing; order communication, product labelling, packaging and nomenclature; compounding; dispensing; administration; counselling and monitoring. Health practitioners should learn from any medication error, near miss or adverse outcome in order to prevent repetition. A balanced approach is required to protect patients and staff alike. Staff must be given adequate support by their line manager as applicable to the circumstances specific to the medication error. The over-riding concern is to protect patient care and the immediate clinical action that may be required to reverse or negate any adverse clinical consequences.

Through analysis of incidents, NHS Wales have developed [Patient Safety Solutions](#) which are nationally issued and hence implemented across BCUHB.

#### 11.2.1 Immediate action to be taken in event of medication error

Following any medication error:

- Patient safety must be maintained and a member of the medical team informed.
- The patient must be reviewed medically and a medical action plan put in place which is specific to the nature of the medication error.

The manager of the clinical area must be informed. In the event of a dispensing error that has led to inappropriate medication administration, a senior member of the pharmacy staff must be informed.

For administration incidents see 'Procedure for the Management of Medication Administration Incidents and Near Misses including Management of Nursing/Midwifery Staff, or other Registered healthcare Professionals' MM 12, for specific guidance on medicine administration incidents.

### **11.2.2 Reporting a medication error**

All incidents involving medicines that have led to a medication error or inappropriate medication administration must be reported using the Datix incident reporting system and the BCUHB procedure set out in MM 12 followed.

### **11.2.3 Dispensing errors discovered in a clinical area**

When an apparent dispensing error is discovered in a clinical area, the manager in charge must contact the BCUHB managed pharmacy as soon as it practical in order to confirm the status of the medication and ensure that where necessary a new supply is made available to the patient. The staff member identifying the error should complete a Datix incident report detailing the error or provide information to the local hospital pharmacy or community pharmacy for completion. Dispensing errors are considered 'must report incidents' within the BCUHB policy for clinical incident reporting.

If a patient has wrongly received any medicine, the most senior doctor in charge or GP of that patient will be informed of the incident so that any clinical action needed can be taken and that the patient and/or relatives can be informed. See MM 12 for further details as above.

### **11.2.3 Serious medication errors**

A serious medication error occurs when a patient is harmed or harm is anticipated. In the event of a serious error the consultant must be informed as soon as possible. If this is outside normal working hours, the hospital co-ordinator must be contacted via switchboard. In turn, the on call manager / consultant as must be contacted, as appropriate.

The Executive Medical Director, the Director of Nursing, Chief Pharmacist Medicines Management and the Risk Management Department must be informed of the error and the relevant circumstances at the earliest opportunity. Serious incidents may be deemed notifiable to the North Wales Regional Officer (WAG) and this is required within 24 hours of the incident or the next working day. In the event of a serious medication error, the Risk and Clinical Governance Co-ordinator will co-ordinate the preliminary investigation with the Clinical Governance Facilitators under the guidance of the Executive Medical Director and Director of Governance and Communication.

All serious medication errors along with patient related incidents will be reported to the Patient Safety Wales via the Risk and Clinical Governance Co-ordinator. Error analysis and recommendations will be conducted in accordance with local procedures.

A never event is defined as a serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented. The Never Event List is updated annually by Patient Safety Wales.

### **11.3 Near misses**

Any event that would have led to an error but did not actually happen due to last minute intervention should be reported as a 'near miss'. In clinical risk management terms, reporting a near miss is just as important as reporting an actual error. Medication errors are rarely the 'fault' of individual practitioners and are commonly the result of poor processes/systems. The collation of information on near misses can provide valuable data that may indicate poor system design.

### **11.4 Pharmacists' interventions**

By the very nature of their work, pharmacy staff provide a significant safety net system in the prevention of medication errors by identifying prescribing errors. Pharmacists record their interventions as part of the patient's medical record and utilise a separate database for such purposes. Due to the limited availability of staff, many interventions are retrospective and the prescribing error may have already led to a medication error. In these circumstances, a Datix incident report must be completed as above.

### **11.5 Reporting, recording adverse drug reactions and defective medicinal products**

#### **11.5.1 Adverse drug reactions**

All suspected and confirmed adverse reactions to medicines including contrast media should be reported to the Commission on Human Medicines (CHM) using the "yellow card system". These can be found in the back of each copy of the British National Formulary, BNF-online (<https://www.medicinescomplete.com/mc/bnf/current/>) or MHRA Yellow Card Scheme online (<https://yellowcard.mhra.gov.uk/>)

The nature of the adverse reactions and the medicine involved should be accurately recorded in the patients' case notes. A clearly visible statement to the effect that the patient has suffered an actual or suspected adverse reaction to a given medicine should be permanently imprinted inside the front of the case notes and/or the electronic patient record and also on the in-patient chart, out-patient or discharge prescriptions, either in large lettering or using specially prepared label. If this has led to the hospital admission, documentation must be clear in the notes for the Clinical Coding dept to clinically code this for NHS Wales data collection purposes.

#### **11.5.2 Defective medicinal products**

The Medicines and Healthcare products Regulatory Agency (MHRA) investigates all reports of defective medicines. Where the results of investigations have implications for other patients or users, the MHRA will issue a [Hazard or Medicines Alert](#), which advises of hazardous products or unsafe practices.

Healthcare staff must report their concerns to a pharmacist or emergency duty pharmacist via the clinical site manager (if out of normal working hours) if a defective or potentially defective medicine is suspected. Examples of defective medicines include defective products themselves, wrong products contained in outer packaging, poor or incorrect product labelling, poor or incorrect instructions for use. The BCUHB managed pharmacy department is responsible for informing the MHRA of defective or potentially defective products and will follow the pharmacy standard operating procedure for MHRA and manufacturer drug alerts.



## Chapter 12 Storage of Records Relating to Medicines

### 12.1 Delivery notes accompanying clinical area stock deliveries

Once items delivered have been checked against the delivery note, and there are no apparent discrepancies by way of delivery error or costing error, the delivery note is to be kept on the receiving ward for 3 months and then may be destroyed.

### 12.2 Controlled Drug order books

These are to be kept on the ward/department for 2 years after the date of the last order entry in the book. The CD order book can then be destroyed.

### 12.3 Controlled Drug record books

These are to be kept on the ward/department for 2 years after the date of the last entry of receipt or administration, whichever is the later. The CD record book can then be destroyed.

If the CD Controlled Drug Record Book contains a record of destruction it must be retained for 7 years.

### 12.4 Medicines transit records

Upon completion of signature of the receipt, the delivery driver/ porter must return the record of receipt to the despatching pharmacy as soon as possible. The delivery record will be kept for 3 months and then may be destroyed.

### 12.5 Pharmacy records

The pharmacy will retain records of orders, receipt and supply as set out in WHC (2000)/71 which details document retention as follows:

- 3 months:** Picking records/ delivery notes to wards & departments
- 1 year:** Stock-take reports plus current year  
Worksheets for resuscitation boxes (one year after expiry of longest dated item)
- 2 years:** Orders/requisitions for medicinal products supplied by the pharmacy including all dispensing  
Pharmacy copy of Discharge Prescription (TTO)  
Controlled Drug Registers and Requisitions (2 years after last date of entry)  
Hazard Warnings
- 5 years:** Unlicensed medication requests and issues  
Worksheets for chemotherapy, aseptic and total parenteral nutrition  
Repackaging  
Certificates of analysis  
Recall Documentation  
Clinical trials records (5 years after end of trial)
- 6 years:** Orders  
Financial records including invoices  
Disposal of waste records
- 7 years:** Records of Controlled Drug destruction (Hospital stock or patient's own)
- 8 years:** Medicines Information questions and answers  
(25 years in case of child or obstetrics & gynaecology)
- 13 years:** Production records including extemporaneous Controlled Drug products and radio pharmacy



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For further information refer to

<https://www.sps.nhs.uk/articles/retention-of-pharmacy-records/>

In order to comply with GDPR requirements, BCUHB must demonstrate that it is processing (recording and retaining) information for a lawful purpose. For further information on GDPR see <https://ico.org.uk/for-organisations/guide-to-the-general-data-protection-regulation-gdpr/lawful-basis-for-processing/#ib3> .

## **Chapter 13 Medicines in Clinical Trials**

### **13.1 Research Ethics Committee approval**

All clinical study protocols must be approved by a Research Ethics Committee before commencement. Any study involving a medicine as an intervention must obtain approval from a Research Ethics Committee flagged to approve such a study. Local Site Specific Assessment approval will be needed from the Local Research Governance Committee/Internal Review Panel in such cases. All clinical trials involving medicines need pharmacy assessment prior to approval by local Clinical Research Governance Committee.

### **13.2 Clinical trial storage, prescribing and supply**

All clinical trial medicines must be stored and supplied through the pharmacy unless the particular protocol of the study is such that the medicine needs administering in an acute situation and the pharmacy assessment concludes that a safe alternative method of storage and supply can be made without direct involvement of the pharmacy.

The arrangement of the supply through the pharmacy must be in accordance with the clinical trial protocol and the Pharmacy Department's Clinical Trial Standard Operating Procedures PCT01.

A prescription for a clinical trial medicine must be written and signed by an approved prescriber and member of the investigation team on a standard hospital prescription form unless the trial protocol or the pharmacy assessment has led to an agreed alternative prescription form. The clinical trial prescription will be retained in the pharmacy.

### **13.3 Randomisation codes**

A copy of the clinical trial protocol and randomisation codes (when applicable) must be lodged in the Pharmacy before the clinical trial is commenced. Records must be retained for five years after the trial has been completed.

### **13.4 Disposal or return of clinical trial medicines**

Any unwanted clinical trial study medication must be returned to the hospital pharmacy. Returned clinical trial study medication must be recorded by the pharmacy and stored as set out in the clinical trial protocol. Returned clinical trial medicines or any un-issued clinical trial medication must be returned to the sponsor or disposed of in accordance with the clinical trial protocol.

### **13.5 Patients admitted to hospital on clinical trial medication**

When patients taking an investigational medical product (IMP) as part of a clinical trial are admitted as an inpatient within the Health Board, the principal investigator (PI) and will be notified as soon as practical by the clinical team looking after the patient. Consideration will need to be given to whether:

- The IMP should be continued or discontinued
- The patient has been admitted with an adverse effect from the IMP
- A code break needs to happen to benefit the patient's treatment. This should only occur with the consent of either the patient's consultant or the PI

Where is appropriate to continue the IMP:

- The clinical trial medication should be prescribed on the prescription chart under the name of the clinical trial and endorsed as a clinical trial. Further





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information

such as

investigational product name and strength can be added to the special instructions as appropriate.

- Arrangements for continued supply should be noted on the prescription chart and in the patient's medical notes.

## Chapter 14 The Direct Supply of Medicines from a Clinical Area

### 14.1 The issue of over labelled medicines

Issuing medicines that do not have patient specific dosage directions and a pharmacy label on the original pack, are contrary to the Medicines Policy and would also be a Regulatory breach under the Medicines Act. A supply can only be made in accordance with a Patient Group Direction (PGD) or a prescription.

The local hospital pharmacies supply a number of clinical areas with pre-labelled medicines in accordance with agreed treatment pathways. Examples that are commonly used are analgesics and antibiotics. All medicines given to patients must be supplied by pharmacy and as a minimum, be labelled so that the patient's name and date of supply can be added at the point of issue. Ward stock must never be issued to patient.

Examples of approved labels are:

<p style="text-align: center;">Keep out of the reach of children</p> <p style="text-align: right;">MS 3593 I</p> <p style="text-align: center;"><b>CLARITHROMYCIN 250mg</b></p> <p style="text-align: center;"><b>ONE to be taken TWICE a day.</b></p> <p>Take at intervals of approximately 12 hours. Complete the course unless otherwise directed.</p> <p><b>BATCH NO. A03</b> <b>EXPIRY DATE 15 JUN 15</b></p> <p style="text-align: right;">Name: _____ Date: _____</p> <p style="text-align: center;">Pharmacy, Wrexham Maelor Hospital Tel: 01978 725959</p>	<p style="text-align: center;">Keep out of the reach of children</p> <p style="text-align: right;">MS 3593 I</p> <p style="text-align: center;"><b>AMOXICILLIN SYRUP 250mg/5ml</b></p> <p style="text-align: center;">Take ____ x 5ml spoonful(s) <b>THREE times a day for ____ days.</b></p> <p>Take at regular intervals. Complete the prescribed course unless otherwise directed.</p> <p>SHAKE THE BOTTLE. STORE IN A REFRIGERATOR. Discard any remaining solution once course is complete.</p> <p><b>BATCH NO. A03</b> <b>EXPIRY DATE 15 JUN 15</b></p> <p style="text-align: right;">Name: _____ Date: _____</p> <p style="text-align: center;">Pharmacy, Wrexham Maelor Hospital Tel: 01978 725959</p>
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KEEP OUT OF THE REACH AND SIGHT OF CHILDREN  
TAKE / USE AS DIRECTED

NAME
DATE ISSUED

FFERYLLFA / PHARMACY  
YSBYTY WREXHAM MAELOR HOSPITAL  
TEL: 01978 725959

Over labelled medicines with labels containing no specific directions are only available for over the counter medicines e.g. paracetamol or ibuprofen. The original manufacturer's pack contains directions of how to use the medicine. The patient's name and the date must be written in the spaces provided on the label. The procedure below must be followed when issuing over labelled medicines from a clinical area:

- Overlabelled packs must only be given to patients in accordance to a prescription or PGD. A prescription must be written for each item to be supplied. The same prescription form may be used for more than one item if required. (See chapter 4 for prescribing standards). If supply is made against a PGD, the correct PGD must be selected.

The over-labelled pre-pack may be retrieved from its storage area by any of the following staff groups:



- Nurse or
- Doctor
- Pharmacist or pharmacy technician
- Physiotherapist

midwife

The patient's name and the date must be written in the spaces provided on the label.

The directions printed on the discharge pre-packs must not be altered or manually amended under any circumstances apart from where there are pre-defined spaces for insertion of dose and frequency instructions.

For liquid medicines a 5mL spoon and/or oral syringe with instruction leaflet must be issued with the medicine. For doses which are not multiples of 5ml, an oral syringe must be supplied and the patient/carer advised on its use.

If the strength and dosing instructions (where pre-printed) are identical then the medicine can be supplied. If not the prescription must be dispensed by the pharmacy. The prescription or PGD must be second checked against the pre-labelled medicine by second qualified member of staff or doctor.

The prescription should be signed by the two registered members of staff making the supply. If the pack is being used for supply against a PGD this should be recorded appropriately.

If no items are required from Pharmacy, the prescription must be filed in the patient's notes for archiving. The duplicate copy should be sent to the GP. If additional items to the pre-packs / over-labelled items are required from Pharmacy, then the prescription should be filed in Pharmacy following the dispensing of the additional items.

## Chapter 15 Discretionary Medicines for Adult and Children In-patients

Normally a nurse shall not administer a medicine to an in-patient except on the written instructions of an authorised prescriber or under a Patient Group Direction (PGD.) The discretionary medicines listed below may be administered by a registered nurse within the constraints of this Policy.

- One may be administered within the schedule stated below (unless otherwise stated). If ongoing medication is required a prescription must be written before further doses are administered.
- Where discretionary medicines are administered, the doctor responsible for the day to day care of the patient must be notified as soon as is reasonably practicable and within 24 hours of the administration of the medicine.
- If administration of the discretionary medicine does not achieve the desired or expected effect in the anticipated time scale then the doctor should be called to assess the patient.
- All discretionary medicines administered to in-patients must be recorded on the prescription chart in the 'once only' section. In the case of administration of discretionary medicines to out-patients, this must be recorded in the patient's medical or care record.
- The provisions of this policy are intended to authorise administration of simple remedies for minor conditions. Where patients require medical assessment this must always be sought.
- The patient's allergy status must be checked before administration of medicines under this policy. Medicines to which the patient is known to be allergic must not be administered.
- Laxatives should not be given if the patient has abdominal pain of unknown cause .

Indication	Drug	Dose
<b>Adults</b>		
Fever	Paracetamol suppositories. 500mg	1-2 suppositories
Fever	Paracetamol tablets 500mg	1-2 tablets ( if patient under 50Kg in weight only give 1 tablet)
Constipation	Glycerine suppository	4g
Constipation	Bisacodyl 2.5mg	1-2 tablets
Constipation	Sodium citrate micro enema	1
Dyspepsia and reflux	Sodium alginate with calcium carbonate and sodium bicarbonate suspension	10-20mL
Cough	Simple linctus	5mL
<b>Procedures</b>		
For urinary catheter	Instillagel®	Once only prior to

insertion Flexible cystoscopy insertion (urology) Coil insertion (DSH)	(contains chlorhexidine check allergy status)	procedure
Local anaesthetic for topical application where there is no PGD in place	Ametop® / EMLA®	Once only prior to procedure
<b>Analgesia</b> If the patient has liver disease seek medical advice.  <b>Do not administer with other paracetamol containing products</b>		
Adult:	Paracetamol tablets 500mg	One or Two tablets
Adult:	Paracetamol liquid 250mg/5mL	Four 5mL spoonfuls (20mL)
Child 3 months-11 months:	Paracetamol Liquid	2.5 to 5mL (60 to 120mg) of 120mg/5mL
Child: 1 to 5 years:	Paracetamol liquid	5 to 10mL (120 to 240mg) of 120mg/5mL
Child: 6 to 12 years	Paracetamol liquid	5 to 10mL (250 to 500mg) of 250mg/5mL

A registered nurse, within their own competence of practice, may initiate and delegate the administration of:

- Selected barrier creams as set out in the BCUHB Wound care & Dressings Formulary 2018
- Selected non-proprietary emollient preparations and aqueous cream for simple dry skin and lips, as set out in the BCUHB formulary

The nurse has a duty of care to check the allergy status of patients to the ingredients of each barrier cream and must document the application. Referral to the Tissue Viability Specialist Nurse may be sought for complex cases.



## **Chapter 16 Administration of parenteral medicines for the purpose of saving a life in an emergency**

The following list of medicines can be administered by parenteral injection without prescription or written directions or patient specific direction when administered for the purpose of saving life in an emergency.

- Adrenaline 1 in 1000 intramuscular only
- Atropine sulphate injection
- Atropine sulphate and obidoxime chloride injection
- Atropine sulphate and pralidoxime chloride injection
- Atropine sulphate, pralidoxime mesilate and avizafone injection
- Chlorphenamine injection
- Dicobalt edetate injection
- Glucagon injection
- Glucose injection 50%
- Hydrocortisone injection
- Naloxone injection
- Pralidoxime chloride injection
- Pralidoxime mesilate injection
- Promethazine hydrochloride injection
- Snake venom antiserum
- Sodium nitrite injection
- Sodium thiosulphate injection
- Sterile pralidoxime

Taken from the Human Medicines Regulations 2012

<http://www.legislation.gov.uk/ukxi/2012/1916/contents/made>

## References (Updated)

- All Wales Medicines Strategy Group (AWMSG) medicines management resources <http://www.awmsg.org/>
- BNF online - <https://www.medicinescomplete.com/mc/bnf/current/>
- General Medical Council (GMC) <http://www.gmc-uk.org/>
- General Pharmaceutical Council (GPhC) <https://www.pharmacyregulation.org/>
- Medicines Act 1968
- Medicines, Ethics and Practice: A guide for Pharmacists. Royal Pharmaceutical Society of Great Britain 2018.
- Misuse of Drugs Act 1971
- Misuse of Drugs (amendment 2) regulations 2006
- **[Midwives Exemptions 2018](#)**
- NICE NG46 Controlled Drugs: Safe use and management, April 2016 <https://www.nice.org.uk/guidance/ng46>
- Nursing and Midwifery Council (NMC) <http://www.nmc.org.uk/>
- Patient Safety Wales <http://www.patientsafety.wales.nhs.uk/home>
- Royal Pharmaceutical Society of Great Britain. The safe and secure handling of medicines: a team approach. A revision of the [Duthie Report](#) (1988) led by the Hospital Pharmacists' Group of the Royal Pharmaceutical Society, March 2005.
- Shipman Inquiry 2005/6
- Summary of Product Characteristics (SmPC) for each medicine is produced by the manufacturer. <http://www.medicines.org.uk/emc/>
- Specialist information on medicines obtained from the local Medicines Information Centres based at Ysbyty Gwynedd, Ysbyty Glan Clwyd and Ysbyty Wrexham Maelor  
Ysbyty Glan Clwyd 01745 448788  
Ysbyty Gwynedd 01248 384141  
Ysbyty Wrexham Maelor 01978 726346
- Specialist Pharmacy Service <https://www.sps.nhs.uk/>



## Glossary (Updated)

**Administration:** Administer is 'to give a medicine either by introduction into the body, whether by direct contact with the body or not (e.g. orally or by injection) or by external application (e.g. application of an impregnated dressing).

**Controlled Drug:** A medicine included in the Schedules of The Misuse of Drugs Regulations (1971).

### **Schedule 1 (CD licence)**

Schedule 1 drugs include hallucinogenic drugs such as coca leaf, lysergide and mescaline. Production, possession and supply of drugs in this schedule are limited, in the public interest, to research or other special purposes. Most schedule 1 drugs have no therapeutic use and a licence is generally required for their production, possession or supply. Examples include hallucinogenic drugs (e.g. 'LSD'), ecstasy-type substances, raw opium and cannabis. Sativex® is a cannabinoid extract schedule 1 drug that does have a therapeutic use and has been exempted by the Home Office from licensing requirements.

### **Schedule 2 (CD POM)**

Schedule 2 includes more than 100 drugs such as the opioids, the major stimulants, secobarbital and amphetamine.

Safe custody – schedule 2 CDs (except secobarbital) are subject to safe custody requirements (under the Misuse of Drugs Safe Custody Regulations 1973 – see below). They must be stored in a locked receptacle, such as an appropriate CD cabinet or approved safe, which can only be opened by the person in lawful possession of the CD or a person authorised by them.

### **Schedule 3 (CD no register)**

Schedule 3 includes a small number of minor stimulant drugs and other drugs, which are less likely to be misused than drugs in schedule 2, or are less harmful if misused.

Safe custody – schedule 3 CDs are exempt from safe custody requirements.

Exceptions are flunitrazepam, temazepam, buprenorphine and diethylpropion, which must be stored in a locked CD receptacle within a secure environment.

### **Schedule 4 (CD benzodiazepines and CD anabolic steroids)**

Schedule 4 is split into two parts.

- Part 1 (CD benzodiazepines) contains most of the benzodiazepines, plus eight other substances including zolpidem, fencamfamin and mesocarb.
- Part 2 (CD anabolic steroids) contains most of the anabolic and androgenic steroids such as testosterone, together with clenbuterol (adrenoreceptor stimulant) and growth hormones (5 polypeptide hormones).

There is no restriction on the possession of a schedule 4 part 2 (CD anabolic steroids) drug when it is part of a medicinal product. However, possession of a drug from schedule 4 part 1 (CD benzodiazepines) is an offence without the authority of a prescription in the required form. Possession by practitioners and pharmacists acting in their professional capacities is authorised.

### **Schedule 5 (CD invoice)**

Schedule 5 contains preparations of certain CDs (for example, codeine, pholcodine, morphine), which are exempt from full control when present in medicinal products of low strengths, as their risk of misuse is reduced.

For more information refer to the current Misuse of Drugs Regulations.

## **Controlled**

stationery which could be used to obtain medicines fraudulently.

**Stationery:** All

**Critical Medicine:** Medicines that have the potential to cause harm if administration is omitted or delayed.

**Dentist:** A dentist holding registration with the General Dental Council.

**Dietician:** A dietician holding registration for practice as a dietician with the Health and Care Professions Council.

**Doctor:** A doctor holding both registration and licence to practice with the General Medical Council.

**Healthcare Support Worker (HCSW), Healthcare Assistant (HCA), Assistant Practitioner (AP):** A person working alongside, and assisting the work of a nurse or health professional under the guidance of a registered healthcare professional. The role can be varied depending upon the healthcare setting.

**High Risk Medicine:** Medicines that **have a high risk of causing significant patient harm or death when used in error.**

**Independent second checker:** A competent staff member authorised to administer medication.

**Medicine:** Medicinal products as defined in Section 130 of the Medicines Act, i.e. a substance administered by mouth, applied to the body or introduced into the body for a medicinal purpose.

A medicinal purpose may mean any one or more of the following:

- Treating or preventing disease
- Diagnosing disease or ascertaining the existence, degree or extent of a physiological condition
- Contraception
- Inducing anaesthesia
- Administration of products such as anti-D, albumin and immunoglobulins
- Otherwise preventing or interfering with the normal operation of a physiological function

## **Exclusions:**

- Items classified as medical devices e.g. Posiflush® (sodium chloride 0.9% pre-prepared flush)
- Reagents
- Sterile non-injectable water
- Non-medicated dressings, ligatures and sutures
- Blood components, including red cells, platelets, fresh frozen plasma (FFP) and cryoprecipitate
- Antiseptics used as cleansing agents for the skin and wounds and Barium Contrast media are exempted from the requirements of Sections 7 and 10 of this policy (i.e. prescribing and administration)

**Medicines Reconciliation:** Process of collecting information on medication history prior to admission using the most up to date recent and accurate sources, checking

this against the current prescribed medicines, ensuring any discrepancies are accounted for or actioned and communicating any changes, deletions or omissions to the patient's medication should be clearly documented.

**Midwife:** A midwife whose name is held on the Nursing and Midwifery Council register as a person who can meet specific standards to provide maternity care to patients,

**Non-Medical Prescriber:** A registered prescriber who is not registered as a doctor or dentist.

**Nurse:** A nurse whose name is held on the Nursing and Midwifery Council register as a person who can meet specific standards to provide care to patients.

**Operating Department Practitioner:** A person who is registered with the Health and Care Professions Council as an operating department practitioner.

**Parenteral Administration:** Administration of a medicine by means other than the alimentary canal e.g. IV, IM or S/C

**Patient Group Direction:** A written instruction for the supply and or administration of a licensed medicine in an identified clinical situation, signed by a doctor or dentist and a pharmacist. It applies to groups of patients who may not be individually identified before presenting for treatment.

**Patients Own Medicine/Patients Own Drugs:** Medicines brought into hospital having been dispensed for that patient outside of the hospital or purchased by the patient. It also includes over the counter (OTC) medicines, alternative remedies and other medicinal items purchased elsewhere eg internet.

**Pharmacist:** A pharmacist holding registration for practice with The General Pharmaceutical Council (GPhC).

**Pharmacy Technician:** A Pharmacy Technician holding registration for practice with the GPhC.

**Prescription:** Written instructions from a registered prescriber permitting a person so authorised to supply a prescription only medicine (POM) to the holder of the prescription.

**Transcription:** Copying of something written e.g. prescription, from one record to another.

**Unlicensed Medicine:** A medicine that does not have a product licence.

## APPENDIX 1 Monitoring and maintaining refrigerators and freezers

In order to maintain the medicine supply cold chain it is essential to keep a written record of the daily maximum and minimum temperatures of medication refrigerators. The BCUHB template for recording temperatures is included in Appendix 2 and is the only version of the monitoring form that should be in use. This will demonstrate that temperature sensitive medicines have been stored under correct conditions, and will therefore protect the interests of the patient and the nurse administering the medicine. Accurate temperature monitoring may contribute to waste reduction by identifying any deviance from ideal conditions quickly, thereby allowing medicines to be moved to another temperature controlled area before they deteriorate.

Readings must be taken **daily** using a maximum – minimum thermometer in accordance with the manufacturer's instructions. The reading must be recorded on the attached chart and the max/min thermometer must be reset after each time is has been read. A record should also be made of the date when the refrigerator is defrosted, which should be at **monthly** intervals unless it is clearly not required. A nurse, HCSW or housekeeper may undertake this task, providing they are suitably trained and they refer unusual results to a more senior member of staff if they are unable to take appropriate actions themselves. The manager of the clinical area should review the temperature record chart as part of their daily checks. Daily checks are not required for refrigerators with in-built temperature monitoring and SD card readers which automatically log temperatures and alarm visually and audibly if a fault is detected. Such refrigerators must be calibrated on an annual basis.

A freezer temperature must be kept between the range of  $-18^{\circ}\text{C}$  to  $-23^{\circ}\text{C}$ . The temperature of the refrigerator must be kept between the range of  **$+2^{\circ}\text{C}$  and  $+8^{\circ}\text{C}$** . Appropriate action should be taken to ensure that this range is maintained. A refrigerator containing medicines should not be used to store food (other than hospital issued nutritional supplements) and must be kept locked. There are two reasons for this:

- To minimise the risk of contamination
- Overfilling refrigerators increases the risk of changes in temperature. Medicines refrigerators must not be filled above 75% of their capacity and medicines no longer required must be removed. These may be destroyed or, if appropriate, immediately returned to pharmacy for recycling.

### Good practice points:

- Do not allow stock to come into contact with the refrigerator cooling plate or ice within the refrigerator
- Rotate stock to use short expiry stock first & where there is an opened vial (e.g. insulin) in use it should be marked with the date opened and placed at the front so it is used up first.
- Make sure it is clear which member of staff is responsible for monitoring temperatures of the refrigerator each day and that they know how to use and read the thermometer.
- Check the refrigerator has been monitored as part of the daily safety brief.
- The reset button must be pressed after every temperature recording in order to obtain a new baseline for the minimum and maximum temperatures.



- To avoid the refrigerator being switched off inadvertently, label the plug or electric socket accordingly.

### Trouble Shooting

- A minus reading indicates the refrigerator is or has been below freezing point. Check the readings again. Either the temperature has been read incorrectly or immediate action must be taken to remedy the adverse conditions within the refrigerator. Look at each medicine to see if it is frozen solid and check glass vials for evidence of any cracks. If stock has been allowed to freeze, many medicines will no longer be effective and advice from Pharmacy must be sought regarding the integrity of the product,
- The minimum temperature recorded is higher than the maximum temperature indicates that the thermometer has been read incorrectly.
- **The temperatures recorded are the same every day.** This is unlikely as variations in temperature occur when the refrigerator door is opened and closed and with changes in ambient room temperature. Often this is an indication that the thermometer has not been reset after each reading. Check that the individual responsible for the task understands how to use the thermometer and the importance of making accurate readings.
- **Regular readings below +2°C and above +8°C.** Review the training and competence of the member of staff reading the temperatures. Ensure the probe is in a suitable position. Defrost the refrigerator if this has not been done recently. Is your refrigerator working correctly and (where appropriate) is the temperature setting adjusted correctly? Follow flow chart attached:
- **Calibration:** Any concerns about calibration of the temperature recording devices in use should be referred to the Estates Department.

### Defrosting and Cleaning the Refrigerator

Refrigerators may have an auto defrost cycle function and may not require a scheduled defrost. For those that don't have this functionality:

- Move all stock from the refrigerator to another monitored medicine refrigerator.
- Defrost the refrigerator according to manufacturer's instructions then clean the interior and exterior.
- When the refrigerator thermometer indicates that the temperature is between +2°C and +8°C the medicines may be returned to the clean refrigerator
- Record the defrost and clean information on the refrigerator temperature record sheet.



## Actions to be taken if refrigerators fall outside temperature range

Recorded storage temperature of the refrigerator if outside the normal operating range of 2°C to 8°C



If single reading falls outside 2°C and 8°C, monitor closely. Some refrigerators may have an internal alarm system to alert when anomalies occur eg door left open  
If repeated and maximum and minimum readings are exactly the same – check the thermometer is being read and reset correctly  
If reading is below 1 degree, some medicines are likely to be damaged – contact Pharmacy for advice  
If repeated readings outside 2 and 8 degrees the following actions must be taken



Advice on stability of the individual medicines should be sought from the Medicines Information Department. You will need to know: The name, strength and manufacturer of all the products involved, the maximum and minimum temperature reading and how long the refrigerator may have been switched off/malfunctioning. If an answer is needed urgently make it clear when the drugs next need to be given.



While waiting for advice, quarantine and label all affected medicines – label **not to be used** and put the date, time and signature on the outside wrapping. Then store in correct storage conditions immediately (e.g. an alternative monitored refrigerator).

Any medicines that are not stable at the temperatures recorded must be destroyed. New supplies will need to be obtained from Pharmacy.  
Any medicines with a reduced expiry should be clearly labelled. All affected stock should be used as soon as possible and prior to any new stock.

Any stock that has a reduced expiry and is subsequently found to have been out of range again should be destroyed.



If the refrigerator is not operating correctly it should be labelled “NOT TO BE USED UNTIL FURTHER NOTICE”. Date, time and signature. The medicine refrigerator must be taken out of action, checked and/or repaired as necessary and not put back into use until fully functioning. Contact Estates to report the problem.



Incident should be reported to the Manager of the clinical area and a Datix incident report form completed

Medicine Information Helplines:

Ysbyty Glan Clwyd 01745 448788

Ysbyty Gwynedd 01248 384141

Ysbyty Wrexham Maelor 01978 726346

In an emergency, the emergency duty pharmacist can be contacted.

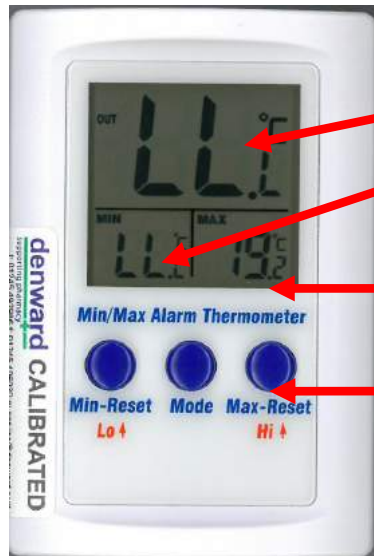




## APPENDIX 2 Temperature Monitoring Record

Ward: .....

Date started: .....



Current temperature

Minimum temperature since last

Maximum temperature since last

To reset - press the Max

Replace batteries immediately when the reading becomes erratic or the display clarity fades.

The device uses 2 \* AAA Batteries, available from Stores

### Temperature Monitoring

Monitoring of medication storage areas (fridge and medicines room) must take place daily.

Monitor and document: current displayed temperature, maximum and minimum temperature, then reset the thermometer by pressing the Max-Reset button

Action if temperature is outside of acceptable range

Reset the thermometer (as above) and re-check temperature in 30 mins (room/fridge)

If continues to be out of range – quarantine contents and contact medicines information on **YGC 01745 448788, YG 01248 384141**

**WMH 01978 726346**

Contact Estates to rectify technical problem.

### Responsibilities

Housekeeper/HCSW: Daily temperature check (fridge & room)

Staff Nurse/Sister in charge of Shift: Ensure daily temperature check (fridge & room) has been done.

Clinical area manager: Weekly temperature check

Area Matron: Three monthly temperature check (fridge & room)





## Daily Room/Fridge Temperature Monitoring Form

Ward/Unit: .....

Month: .....

Year.....

	Room Temperature Normal Range 15-25 °C				Fridge Temperature Normal Range 2-8 °C				Daily Check (Sign )	Comments / Actions Taken Record Actions, Issues, Cleaning And Defrosting In This Column And Sign	Ward Manager Weekly
Date	Current °C	Min °C	Max °C	Reset	Current °C	Min °C	Max °C	Reset			
1											Week 1
2											
3											
4											
5											
6											
7											Date
8											Sign
9											Week 2
10											
11											
12											
13											
14											
15											Date
16											Sign
17											Week 3
18											
19											
20											
21											
22											
23											Date
24											Sign
25											Week 4
26											
27											
28											
29											
30											
31											Date
											Sign

ONCE COMPLETE, STORE THIS RECORD LOCALLY FOR A PERIOD OF 1 YEAR



## Daily Freezer Temperature Monitoring Form

Ward/Unit: .....

Month: ..... Year.....

Freezer temperature Normal range -18 <sup>0</sup> c to -23 <sup>0</sup> c.					Daily Check (SIGN)	Comments/Action Taken Record actions, issues, cleaning and defrosting in this column and sign	Ward Manager Weekly
Date	Current °C	Min °C	Max °C	Reset			
1							Week 1
2							
3							
4							
5							
6							
7							Date
8							Sign
9							Week 2
10							
11							
12							
13							
14							
15							Date
16							Sign
17							Week 3
18							
19							
20							
21							
22							
23							Date
24							Sign
25							Week 4
26							
27							
28							
29							
30							Date
31							Sign

ONCE COMPLETE, STORE THIS RECORD LOCALLY FOR A PERIOD OF 1 YEAR

## EQUALITY IMPACT ASSESSMENT FORMS

### PARTS A and B: SCREENING AND OUTCOME REPORT

#### *Introduction:*

*These forms have been designed to enable you to record, and provide evidence of how you have considered the needs of all people (including service users, and their carers and our staff) who may be affected by what you are writing or proposing, whether this is:*

- *a policy, protocol, guideline or other written control document;*
- *a strategy or other planning document e.g. your annual operating plan;*
- *any change to the way we deliver services e.g. a service review;*
- a decision that is related to any of the above e.g. commissioning a new service or decommissioning an existing service.

**This is not optional:** Equality Impact Assessment is a specific legal requirement on public sector organisations under equalities legislation and failure to comply could result in a legal challenge to a decision or strategy. More importantly, equality impact assessment helps to inform better decision-making and policy development leading to improved services for patients. **This form should not be completed by an individual alone, but should form part of a working group approach.**

#### **The Forms:**

You must complete:

- **Part A** – this is the Initial Screening that is always undertaken and consists of Forms 1 to 3; these forms are designed to enable you to make an initial assessment of the potential impact of what you are doing, and decide whether or not you will need to proceed to a Full Impact Assessment (Part C);

**AND**

- **Part B** – this is the Outcome Report and Action Plan (Form 4) you will need to complete whether or not you proceed to a Full Impact Assessment;

Together, these forms will help to provide evidence of your Impact Assessment and how you have shown “due regard” to the duties.

You may also need to complete Part C (see separate Form) – if parts A and B indicate you need to undertake a Full Impact Assessment. This enables you to fully consider all the evidence that is available (including engagement with the people affected by your document or proposals) to

tell you whether your document or proposal will affect people differently. It also gives you the opportunity to consider what changes you may need to make to eliminate or mitigate any adverse or negative impact you have identified.

Remember that these forms may be subject to external scrutiny e.g. under a Freedom of Information request.

Once completed, the EqIA Forms should accompany your document or proposal when it is submitted to the appropriate body for approval.



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## Part A

### Form 1: Preparation

1.	What are you assessing i.e. what is the title of the document you are writing or the service review you are undertaking?	<b>Medicines Policy MM01</b>
2.	Provide a brief description, including the aims and objectives of what you are assessing.	<p>The purpose of the Medicines Policy is to set out a clinical governance framework to promote the safe and secure systems for controlling and handling of medicinal products in all aspects of clinical services operated and delivered by BCUHB.</p> <p>The policy applies to all areas within BCU where medicines are used, ie secondary care, community hospitals, managed practices, mental health and HMP Berwyn. Each area will have their own specific guidance to underpin the Policy but the necessary legal framework is set out within this Policy.</p> <p>The Policy supersedes the current Medicines Code.</p> <p>Policy Objective: To ensure the legal, safe and secure handling of medicines, including prescribing, ordering, dispensing, storage and administration.</p> <p>The Policy aims to:</p> <ul style="list-style-type: none"> <li>• Set out the operational responsibilities of all healthcare staff with regards to medicines management.</li> <li>• Describe the governance structure for medicines management</li> </ul>

		<ul style="list-style-type: none"> <li>• Provide guidance on the safe and secure use of medicines</li> </ul>
3.	Who is responsible for the document/work you are assessing – i.e. who has the authority to agree/approve any changes you identify are necessary?	As set out in OBS1, QSE Committee
4.	Is the Policy related to, or influenced by, other Policies/areas of work?	<p>Other policies referenced within the Policy are listed below:</p> <p><b>BCU Medicines Management Policies</b></p> <ul style="list-style-type: none"> <li>• <a href="#">MM 03</a> Non medical Prescribing Protocol for Supplementary and Independent Prescribers Policy</li> <li>• <a href="#">MM05</a> Intrathecal chemotherapy policy</li> <li>• <a href="#">MM08</a> BCUHB Code of Practice for BCUHB staff with pharmaceutical companies (also providing guidance for General Practitioners and other independent health contractors)</li> <li>• <a href="#">MM11</a> Guidance for Nurse Independent Practitioner (INP) V100 /V150 prescribers</li> <li>• <a href="#">MM 12</a> Procedure for the Management of Medication Administration Incidents and Near Misses including Management of Nursing / Midwifery Staff, or other Registered Healthcare Professionals</li> <li>• <a href="#">MM 15</a> Guidance for Administration and use of Emergency and Non-Emergency Oxygen in Adults In Acute and Community Hospitals</li> <li>• <a href="#">MM16</a> BCUHB Written Control Document for Guidance on the Transcription of Medicines</li> <li>• <a href="#">MM 21</a> BUCHB self administration guideline</li> <li>• <a href="#">MM31</a> BCUHB Policy for the prescribing, supply and administration of methotrexate for hospital inpatients</li> <li>• <a href="#">MM33</a> Guidelines for Community Staff on the removal of unwanted medication from a patient's home</li> <li>• <a href="#">MM PGD 01</a> Patient Group Directions -Procedure and Guidance for Authors and Users</li> <li>• Injectable Medicines Policy – currently a section in Medicines Code, has been removed as will become a stand alone Policy</li> <li>• Unlicensed Medicines Policy – awaiting ratification</li> <li>• <a href="#">Covert Administration of Medicines Clinical Protocol</a></li> </ul> <p><b>Standard Operating Procedures</b></p>

		<ul style="list-style-type: none"> <li>• Pharmacy Department's Clinical Trial Standard Operating Procedures <a href="#">PCT01</a></li> <li>• Guidelines</li> <li>• BCUHB <a href="#">Critical Medicines Guide</a></li> <li>• <a href="#">SOP for destruction of CDs for authorised witnesses</a></li> <li>• SOP for the Return of Controlled Drugs (CD's) from Community Hospitals to the Acute Site pharmacy department with transport</li> </ul> <p><b>BCU Documents (non medicines management)</b></p> <ul style="list-style-type: none"> <li>• <a href="#">F03</a> BCUHB Local Anti Fraud, bribery and corruption Policy</li> <li>• <a href="#">WP6</a> BCUHB Code of Conduct ( Disciplinary rules and standards of behaviour</li> <li>• <a href="#">NU01</a> Discharge Protocol</li> <li>• <a href="#">IMMS 04</a> Storage and handling of Vaccines Written Control Document</li> <li>• <a href="#">RES 03</a> BCUHB Cardiopulmonary Resuscitation (CPR) Policy</li> <li>• <a href="#">CSPM 01</a> Guidance for ensuring Safety and Quality of Chemotherapy Services</li> <li>• <a href="#">MD 17</a> Interventions not normally undertaken (INNU)</li> <li>• <a href="#">BCUHB Guideline for the in-patient management of adult patients addicted to opioids</a></li> <li>• <a href="#">ES 03</a> Waste Management Policy</li> </ul> <p>Healthcare professionals must comply with the current version of their relevant professional bodies' policies and Policies of Practice.</p>
5.	Who are the key Stakeholders i.e. who will be affected by your document or proposals?	<p>Registered and non registered healthcare staff involved in the safe and secure handling of medicines</p> <p>Whilst the policy is aimed at staff, the purpose is to ensure patients receive medication for the correct reason and receive the right medication, at the right dose and the right time as part of an overall medicines management process.</p>
6.	What might help/hinder the success of whatever you are doing, for example communication, training etc?	<p>Communication of Policy changes to all key stakeholders</p>

## Form 2: Considering the potential impact of your document, proposals etc in relation to equality and human rights

Characteristic or other factor to be considered	Potential Impact by Group. Is it:-		Please detail here, for each characteristic listed on the left:- (1) any Reports, Statistics, Websites, links etc. that are relevant to your document/proposal and have been used to inform your assessment; and/or (2) any information gained during engagement with service users or staff; and/or other information that has informed your assessment of Potential Impact.
	Positive (+) Negative (-) Neutral (N) No Impact/Not applicable (N/a)	High Medium or Low	
Age	N	N/A	The aim of the Policy is to ensure that people receive medication for the correct reason and receive the right medication, at the right dose and the right time. There is case law surrounding the administration of medicines in relation to age. BCUHB has a separate policy for the covert administration of medicines.
Disability	Neutral	N/A	BCU staff will ensure that patients with any disability are given/ carers given the appropriate support in order to facilitate medicines management.
Gender Reassignment	N	N/A	
Marriage & Civil Partnership	N	N/A	
Pregnancy & Maternity	Neutral	N/A	Staff returning from maternity leave must receive a local return to work induction to update them of any changes during their absence. Patients who are pregnant or who are breastfeeding are given appropriate support to facilitate medicines management.
Race / Ethnicity	N	N/A	
Religion or Belief	N	N/A	
Sex	N	N/A	
Sexual Orientation	N	N/A	
Welsh Language	Neutral	N/A	Where able information should be available in Welsh to facilitate medicines management. BCUHB is compliant with the Welsh Language standards.
Human Rights	N	N/A	



Guidance on completing Form 2: For each of the characteristics listed, and considering the aims and objectives you detailed in Q2 on Form 1, you need to consider whether your document or proposal likely to affect people differently, and if so, will this be in a positive or negative way? For example, you need to decide:

- will it affect men and women differently?
- will it affect disabled and non-disabled people differently?
- will it affect people in different age groups differently? - and so on covering all the protected characteristics.

Use your judgement to indicate the scale of any impact identified. The factors used to determine an overall assessment for each characteristic should include consideration of scale and proportionality as well as potential impact.

### Form 3: Assessing Impact Against the General Equality Duty

As a public sector organisation, we are bound by the three elements of the “General Duty”. This means that we need to consider whether (if relevant) the policy or proposal will affect our ability to:-	
<ul style="list-style-type: none"> <li>• Eliminate unlawful discrimination, harassment and victimisation;</li> <li>• Advance equality of opportunity; and</li> <li>• Foster good relations between different groups</li> </ul>	
1. Describe here (if relevant) how you are ensuring your policy or proposal does not unlawfully discriminate, harass or victimise	N/A as this Policy ensures there is a clinical governance framework in place to promote the safe and secure systems for controlling and handling of medicinal products within BCUHB
2. Describe here how your policy or proposal could better advance equality of opportunity (if relevant)	N/A
3. Describe here how your policy or proposal might be used to foster good relations between different groups (if relevant)	N/A

## Part B:

### Form 4 (i): Outcome Report

Organisation:	BETSI CADWALADR UNIVERSITY HEALTH BOARD
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1. What is being assessed? (Copy from Form 1)	<b>Medicines Policy MM01</b>
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2. Brief Aims and Objectives: (Copy from Form 1)	<p>The purpose of the Medicines Policy is to set out a clinical governance framework to promote the safe and secure systems for controlling and handling of medicinal products in all aspects of clinical services operated and delivered by BCUHB.</p> <p>The policy applies to all areas within BCU where medicines are used, ie secondary care, community hospitals, managed practices, mental health and HMP Berwyn. Each area will have their own specific guidance to underpin the Policy but the necessary legal framework is set out within this Policy.</p> <p>The Policy supersedes the current Medicines Code.</p> <p>The Policy aims to:</p> <ul style="list-style-type: none"> <li>• Set out the operational responsibilities of all healthcare staff with regards to medicines management.</li> <li>• Describe the governance structure for medicines management</li> <li>• Provide guidance on the safe and secure use of medicines</li> </ul>
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3a. Could the impact of your decision/policy be discriminatory under equality legislation?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
3b. Could any of the protected groups be negatively affected?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
3c. Is your decision or policy of high significance?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>

4. Did the decision scoring on Form 3, coupled with your answers to the 3 questions above indicate that you need to proceed to a Full Impact Assessment?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
	<p>Record here the reason(s) for your decision i.e. what did Forms 2 &amp; 3 indicate in terms of positive and negative impact for each characteristic?</p> <p>Overall there appears to be a neutral impact on the characteristics and health inequalities as a result of this Policy.</p>	
5. If you answered 'no' above, are there any issues to be addressed e.g. mitigating any identified minor negative impact?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
	<p>Record Details:</p> <p>This policy is relevant to patients across all equality groups and is not considered to negatively affect any of the protected groups. If any impact of disability, culture, or language arises on an individual basis, they will be met.</p>	
6. Are monitoring arrangements in place so that you can measure what actually happens after you implement your document or proposal?	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
	How is it being monitored?	Via the incident reporting system Datix.
	Who is responsible?	Division where incident occurred
	What information is being used?	E.g. will you be using existing reports/data or do you need to gather your own information? Existing incident reporting data
	When will the EqIA be reviewed? (Usually the same date the policy is reviewed)	In 3 years

7. Where will your decision or policy be forwarded for approval?	QSE
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8. Describe here what engagement you have undertaken with stakeholders including staff and service users to help inform the assessment	<p>The Policy content has undergone extensive consultation.</p> <p>Email Consultation to:</p> <ul style="list-style-type: none"> <li>• Doctors, (consultants, junior and speciality doctors)</li> <li>• All pharmacy staff</li> <li>• Matrons, Community Matrons</li> <li>• Medical and Nursing Directors</li> <li>• Theatres</li> <li>• Paediatrics</li> <li>• Mental Health</li> <li>• HMP Berwyn</li> <li>• Primary Care</li> <li>• Resus Committee</li> <li>• Estates</li> </ul> <p>The Policy has been presented to Nursing PAG, Secondary Care and Area Quality and Safety Groups in West, East and Central, QSG secondary care and QSE.</p>
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9. Names of all parties involved in undertaking this Equality Impact Assessment:	Name	Title/Role
	Judith Green	Lead Pharmacist Medicine (East)
	Alan Hughes	Lead Pharmacist Governance
	Katherine White	Medicines Management Nurse

	Janet Thomas	Medication Safety Pharmacist
	Eiriann Turner	Medicines Management Nurse
<b>Please Note: The Action Plan below forms an integral part of this Outcome Report</b>		

#### Form 4 (ii): Action Plan

This template details any actions that are planned following the completion of EqIA including those aimed at reducing or eliminating the effects of potential or actual negative impact identified.

	Proposed Actions	Who is responsible for this action?	When will this be done by?
1. If the assessment indicates significant potential negative impact such that you cannot proceed, please give reasons and any alternative action(s) agreed:			
2. What changes are you proposing to make to your document or proposal as a result of the EqIA?			
3a. Where negative impacts on certain groups have been identified, what actions are you taking or are proposed to mitigate these impacts? Are these already in place?			

	Proposed Actions	Who is responsible for this action?	When will this be done by?
3b. Where negative impacts on certain groups have been identified, and you are proceeding without mitigating them, describe here why you believe this is justified.			
4. Provide details of any actions taken or planned to advance equality of opportunity as a result of this assessment.			

<b>Quality Safety &amp; Experience Committee</b>	 <b>GIG Cymru NHS Wales</b> Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board
<b>19.3.19</b>	<b><i>To improve health and provide excellent care</i></b>

<b>Report Title:</b>	BCUHB Medical Gas Staff Responsibilities Policy
<b>Report Author:</b>	Andrew Merriman, Lead QA and Technical Services Pharmacist
<b>Responsible Director:</b>	Dr Berwyn Owen, Director of the Pharmacy & Medicines Management Division
<b>Public or In Committee</b>	Public
<b>Purpose of Report:</b>	Approval of the Policy
<b>Approval / Scrutiny Route Prior to Presentation:</b>	BCUHB Medical Gas Group May 2018 Updated in collaboration with: Richard Wynne - Medication Safety Pharmacist (Central) Patrick Hill – Deputy Director Medical Physics BCUHB Approved by: Medicines Policies and Procedures Subgroup 26.11.18 Drugs and Therapeutics Group 5.12.18 Quality Safety Group 9.1.19
<b>Governance issues / risks:</b>	Updated policy – none identified
<b>Financial Implications:</b>	Update of existing policy – none identified
<b>Recommendation:</b>	The Committee is asked to approve the Policy

<b>Health Board's Well-being Objectives</b> <i>(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)</i>	√	<b>WFGA Sustainable Development Principle</b> <i>(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.)</i>	√
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	√	4.Putting resources into preventing problems occurring or getting worse	√



achieve their own well-being			
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			
<b>Special Measures Improvement Framework Theme/Expectation addressed by this paper</b>			
Leadership and Governance			
<b>Equality Impact Assessment</b>			
See attached			

*Disclosure:*

*Betsi Cadwaladr University Health Board is the operational name of Betsi Cadwaladr University Local Health Board*

Version: 1.1



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University Health Board

**MMXX**

## Medical Gases: Staff Responsibilities across BCUHB

<b>Date to be reviewed:</b>	XXX	<b>No of pages:</b>	8
<b>Author(s):</b>	Richard Wynne  Updated by Andrew Merriman	<b>Author(s) title:</b>	Principal Safety Pharmacist (Central)  Lead Quality Assurance Pharmacist BCUHB
<b>Responsible dept / director:</b>	BCUHB Medical Gas Group		
<b>Approved by:</b>	Medicines Policies and Procedures Subgroup 26.11.18 Drugs and Therapeutics Group 5.12.18 QSG 9.1.19		
<b>Date approved:</b>	02/05/18 date Updated 27/11/18		
<b>Date activated (live):</b>	Date becomes live		
<b>Date EQIA completed:</b>	All policies must be Equality Impact Assessed – 27/11/18		
<b>Documents to be read alongside this policy:</b>	<ul style="list-style-type: none"><li>• Operational Policy and Procedures for the management of Medical Gas Pipeline Systems (as yet not approved)</li><li>• MM15 :- Guidance for the Administration and Use of Emergency and Non-Emergency Oxygen in Adults in Acute and Community Hospitals</li><li>• National Patient Safety Agency (NPSA) (2009/RRR006): Oxygen Safety in Hospitals.</li></ul>		
<b>Purpose of Issue/Description of current changes:</b> This is version 1 of this policy			

<b>First operational:</b>	Date the policy was first operational				
<b>Previously reviewed:</b>	date	date	date	date	date
<b>Changes made yes/no:</b>	Yes/no	Yes/no	Yes/no	Yes/no	Yes/no

PROPRIETARY INFORMATION



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## 1. Introduction

Under the Health and Safety at Work Act (1974) (HSWA), employers have a general duty of care to ensure, as far as possible the health, safety, and welfare at work of all their employees. Employers also have a duty under the Management of Health and Safety at Work Regulations (2002) to assess the risks to the health and safety of their employees. Employees are also required to take all reasonable care of themselves and others who might be affected by what they do, or do not do at work.

An alert issued by the National Patient Safety Agency (NPSA) (2009/RRR006) in September 2009 aims to improve the safety, storage, handling, prescribing and administration of oxygen within a hospital setting. Within that alert, the NPSA has given guidance on what an organisation should do to improve the safety of oxygen usage within its hospitals.

Oxygen has a designated status as a medicine and is given the legal classification of General Sales List (GSL). As such it can be administered without being prescribed, but best practice recommends that oxygen should be prescribed unless in an emergency, when oxygen can be administered first and the prescription written in a timely manner.

Fixed “Medical Gas Pipeline Systems” (MGPS) are also legislated for in the Pressure Safety Regulations (2000), and the Health Technical Memorandum (HTM) 02-01(2006) (NHS Estates guidance for medical gas pipeline systems) details best practice in the management of these pipelines.

## 2. Scope

The scope of this document is to ensure that staff understand their responsibilities in relation to the safe and effective storage, distribution, and use of medical gases (piped or cylinders) within Betsi Cadwaladr University Health Board (BCUHB). This document together with those which sit under it are intended to be used by all staff involved in the use, handling, storage and maintenance of medical gas pipes and cylinders.

## 3. Objectives / Purpose / Statement of intent

The purpose of this document and those linked to it is to ensure the correct and safe storage, handling, and use of medical gases through detailing the following:-

- Defining the roles and responsibilities of named staff dealing with medical gases as detailed in section 4 of this document
- Clearly detailing what is expected of staff who handle or use medical gases.

- Helping to prevent incidents involving medical gases and associated medical devices.
- Ensuring safe and secure facilities for storing medical gases.
- To review all incidents involving medical gases, and if deemed necessary act to prevent a similar incident reoccurring.

## 4. Roles and Responsibilities

### 4.1 BCUHB Board

In compliance with its legal duty under Health and Safety regulations BCUHB board will ensure that those staff named below carry out their responsibilities concerning medical gases. They must also ensure to resolve any medical gas issues thus ensuring that the storage, handling, and use of medical gases within BCUHB is both safe and effective for staff and patients, and is in line with current regulations and best practice. The BCUHB Board must ensure that there is a multi-disciplinary medical gas group in place for BCUHB.

### 4.2 Chief Executive

The Chief Executive Officer (CEO) has overall managerial responsibility for all matters relating to the management of medical gases. This responsibility includes ensuring that the management of Medical Gas matters is seen as an important priority for the Health Board, and is addressed through comprehensive policies and procedures that are effectively implemented. Day to day management of medical gases can be delegated to other named staff

### 4.3 Health & Safety Manager

Will ensure that there is sufficiently trained and experienced staff available to help and advise those managers and clinical staff who are required to carry out risk assessments on the storage, handling, and use of Medical Gases in their area of responsibility.

### 4.4 Fire Officer

Will check to ensure that all medical gases are stored in suitable locations that comply with fire regulations, and that suitable emergency procedures are in place for evacuation in the event of a fire.

### 4.5 Estates Senior Management (including Director of Estates and Facilities, Chief Engineer, and Director of Operational Estates)

Through clear managerial structures the senior management of the Estate Department must ensure that all Estates staff are fully aware and trained on the current policies, procedures and guidance surrounding MGPS. This includes the

appointment of sufficient qualified, trained, and approved Authorised Persons (see below) within their department to be able to carry out the day to day functions required to maintain these pipelines.

The senior management must also ensure that there is a formal agreement with an independent Authorising Engineer (see below).

#### 4.6 Authorising Engineer (MGPS)

The Authorising Engineer (MGPS) will oversee and audit the management by Estates of the MGPS, and the appointment of Authorised Persons (see below). This person will have specialist knowledge of MGPS, in particular the systems for which an Authorised Person (MGPS) will assume responsibility on appointment. They will act, and be employed independently of the organisation.

#### 4.7 Authorised Person (MGPS)

The Authorised Person (MGPS) is defined as that person designated by the Senior Estates management to be responsible for the day-to-day management of the MGPS at a particular site or sites. This includes the issue of permits in accordance with the Permit To Work Procedure. All Authorised Persons (MGPS) must be appointed in writing by the Senior Estates Management on the recommendation of an Authorising Engineer (MGPS). An individual assessment of the suitability of the potential Authorised Person (MGPS) will be required before such a recommendation can be made.

#### 4.8 Competent Person (MGPS)

The Competent Person (MGPS) is the person who carries out the installation and/or maintenance work on the MGPS, who has received appropriate training, and is on a list of Competent Persons (MGPS). In the case of directly employed labour, this list should be held by the Authorised Person (MGPS).

#### 4.9 Quality Controller (MGPS)

The Quality Controller (MGPS) is the person designated as the quality controller for the MGPS. They must be listed on the national (UK wide) register of medical gas Quality Controllers having completed all the required training and competency assessments. They are responsible for the quality control of the medical gases at the terminal units, and plant such as medical air compressors. This person has the professional responsibility for the last independent check of an MGPS which if faulty, could cause critical clinical consequences to patients.

#### 4.10 Designated Nursing Officer / Ward Manager



The Designated Nursing Officer (MGPS) is the person in each department with whom the Authorised Person (MGPS) liaises on any matters affecting the MGPS and who would give permission for a planned interruption to the supply. The Designated Nursing Officer (MGPS) acts as the focal point for communications related to the MGPS and advises on any special requirements for their department relating to MGPS, e.g. within the Health Board this role /functionality would be the most senior nurse or matron with responsibility for the ward/department at that time.

The nurse in charge of any clinical unit must ensure that all those staff under their management, who may have to deal with medical gases in any capacity, have received appropriate training to ensure they have the necessary knowledge, skills and competence to perform that role. These tasks will include

- The safe storage of medical gas cylinders in accordance with manufacturers' guidance.
- Frequent and regular checks of stored cylinders,
- Administration to patients,
- Monitoring of patients,
- Adjustment required due to monitoring
- Correct preparation for the transfer of patients requiring medical gases to another clinical unit.
- Ensure that ward staff accompanying a patient during transfer, and if staying with the patient in a department or unit e.g. radiology, are sufficiently trained and aware of their role and responsibility to that patient in relation to the use and monitoring of medical gas administration especially oxygen via a portable gas cylinder.

It is also their responsibility to ensure that all the tasks associated with medical gases undertaken by their staff have been, and will regularly be, risked assessed to ensure that all risks have been identified, highlighted, and if possible eliminated or at least reduced to an acceptable level. Any risks identified must be referred to or be added to the BCUHB risk register.

#### 4.11 Portering Manager

The Portering Manager has the responsibility to ensure that all portering staff have received the necessary training and have the required equipment to enable them to handle and transport compressed medical gas cylinders safely. This will include

- The ordering and receipt of cylinders from the supplier
- Storage, stock rotation, and expiry date checks of the cylinders
- Ensuring separation of unused and used cylinders
- Transfer of cylinders to clinical areas as required
- Attaching and removing from cylinders, medical equipment regulators and manifold tail-pipes
- Identification and replacement of faulty cylinders

It is also the Portering Manager's responsibility to ensure that all the tasks associated with medical gases undertaken by the portering staff have been and will be regularly risk assessed to ensure that all risks have been identified, highlighted, and if possible eliminated or at least reduced to an acceptable level. Any risks identified must be referred to or be added to the BCUHB risk register.

#### 4.12 Chief Pharmacist

As some medical gases are classed as medicines, the Chief Pharmacist has responsibility as to the quality and use of these gases in a similar manner as to their responsibility with any other medicine used within BCUHB.

It is also their responsibility to ensure that all the tasks dealing with medical gases undertaken by the pharmacy staff have been and will be regularly risk assessed to ensure that all risks have been identified, highlighted and if possible eliminated or at least reduced to an acceptable level. Any risks identified must be referred to or be added to the BCUHB risk register.

#### 4.13 Health Board employees

All employees need to be aware that BCUHB has developed guidelines concerning medical gases and their roles within these guidelines, if any. Clinical staff dealing with a patient who requires a medical gas must have been trained and deemed competent in the handling of that gas (irrespective of its method of supply i.e. MGPS or cylinder). This is especially true for clinical staff escorting a patient between clinical areas or to a clinical support department.

#### 4.14 BCUHB Medical Gas group

This BCU wide group meets regularly to oversee the policies, training, and all incidents involving medical gas and that they are in line with all current legislation, guidance and good practice

## References

British Thoracic Society (May 2017): Guidelines for emergency oxygen use in adult patients.

DH Estates and Facilities Division (2006) Health Technical Memorandum HTM 02-01 Medical Gas Pipeline Systems (MGPS)

Health and Safety Executive (HSE) Oxygen use in the workplace - Fire and explosion hazards INDG459 (2013)

Medicines and Healthcare products Regulatory Agency (MHRA). Oxygen cylinders and their regulators: tips on how to handle them (2013)

National Patient Safety Agency (NPSA) (2009/RRR006): Oxygen Safety in Hospitals

### Members of the Working Group:

Name	Title
Andrew Merriman	Lead Quality Assurance Pharmacist BCUHB
Richard Wynne	Medication Safety Pharmacist (Central)
Patrick Hill	Deputy Director Medical Physics BCUHB

### Engagement has taken place with:

Name	Date Consulted
BCUHB Medical Gas Group	May 2018



Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board

## EQUALITY IMPACT ASSESSMENT FORMS PARTS A and B: SCREENING AND OUTCOME REPORT

### Introduction:

These forms have been designed to enable you to record, and provide evidence of how you have considered the needs of all people (including service users, and their carers and our staff) who may be affected by what you are writing or proposing, whether this is:

- a policy, protocol, guideline or other written control document;
- a strategy or other planning document e.g. your annual operating plan;
- any change to the way we deliver services e.g. a service review;
- a decision that is related to any of the above e.g. commissioning a new service or decommissioning an existing service.

**This is not optional:** Equality Impact Assessment is a specific legal requirement on public sector organisations under equalities legislation and failure to comply could result in a legal challenge to a decision or strategy. More importantly, equality impact assessment helps to inform better decision-making and policy development leading to improved services for patients. **This form should not be completed by an individual alone, but should form part of a working group approach.**

### The Forms:

You must complete:

- **Part A** – this is the Initial Screening that is always undertaken and consists of Forms 1 to 3; these forms are designed to enable you to make an initial assessment of the potential impact of what you are doing, and decide whether or not you will need to proceed to a Full Impact Assessment (Part C);

AND

- **Part B** – this is the Outcome Report and Action Plan (Form 4) you will need to complete whether or not you proceed to a Full Impact Assessment;

Together, these forms will help to provide evidence of your Impact Assessment and how you have shown “due regard” to the duties.

You may also need to complete Part C (see separate Form) – if parts A and B indicate you need to undertake a Full Impact Assessment. This enables you to fully consider all the evidence that is available (including engagement with the people affected by your document or proposals) to tell you whether your document or proposal will affect people differently. It also gives you the opportunity to consider what changes you may need to make to eliminate or mitigate any adverse or negative impact you have identified.

Remember that these forms may be subject to external scrutiny e.g. under a Freedom of Information request.

Once completed, the EqlA Forms should accompany your document or proposal when it is submitted to the appropriate body for approval.



## Part A

### Form 1: Preparation

1.	What are you assessing i.e. what is the title of the document you are writing or the service review you are undertaking?	<b>Medical Gases – Policy for Staff Responsibilities across BCUHB</b>
2.	Provide a brief description, including the aims and objectives of what you are assessing.	<p>The purpose of this policy is to ensure that staff understand their responsibilities in relation to the safe and effective storage, distribution, and use of medical gases (piped or cylinders) within Betsi Cadwaladr University Health Board (BCULHB)</p> <p>Policy Objective: to define the roles and responsibilities of staff involved for the correct</p>

		storage, handling, and use of medical gases. The Policy aims to: Set out the operational responsibilities of all healthcare staff with regards to medical Gases management.
3.	Who is responsible for the document/work you are assessing – i.e. who has the authority to agree/approve any changes you identify are necessary?	As set out in OBS1, QSE Committee
4.	Is the Policy related to, or influenced by, other Policies/areas of work?	Other policies referenced within the Policy are listed below: <b>BCU Medicines Management Policies</b>  <b>Standard Operating Procedures</b> <b>CU Documents (non medicines management)</b>  Healthcare professionals must comply with the current version of their relevant professional bodies' policies and Policies of Practice.
5.	Who are the key Stakeholders i.e. who will be affected by your document or proposals?	Registered and non registered healthcare staff involved in the safe management of medical gases
6.	What might help/hinder the success of whatever you are doing, for example communication, training etc?	Communication of Policy changes to all key stakeholders

## Form 2: Considering the potential impact of your document, proposals etc in relation to equality and human rights

Characteristic or other factor to be considered	Potential Impact by Group. Is it:-		Please detail here, for each characteristic listed on the left:- (1) any Reports, Statistics, Websites, links etc. that are relevant to your document/proposal and have been used to inform your assessment; and/or (2) any information gained during engagement with service users or staff; and/or other information that has informed your assessment of Potential Impact.
	Positive (+) Negative (-) Neutral (N) No Impact/Not applicable (N/a)	High Medium or Low	
Age	N	N/A	
Disability	Neutral	N/A	
Gender Reassignment	N	N/A	
Marriage & Civil Partnership	N	N/A	
Pregnancy & Maternity	Neutral	N/A	
Race / Ethnicity	N	N/A	
Religion or Belief	N	N/A	
Sex	N	N/A	
Sexual Orientation	N	N/A	
Welsh Language	Neutral	N/A	
Human Rights	N	N/A	



Guidance on completing Form 2: For each of the characteristics listed, and considering the aims and objectives you detailed in Q2 on Form 1, you need to consider whether your document or proposal likely to affect people differently, and if so, will this be in a positive or negative way? For example, you need to decide:

- will it affect men and women differently?
- will it affect disabled and non-disabled people differently?
- will it affect people in different age groups differently? - and so on covering all the protected characteristics.

Use your judgement to indicate the scale of any impact identified. The factors used to determine an overall assessment for each characteristic should include consideration of scale and proportionality as well as potential impact.

### Form 3: Assessing Impact Against the General Equality Duty

As a public sector organisation, we are bound by the three elements of the “General Duty”. This means that we need to consider whether (if relevant) the policy or proposal will affect our ability to:- <ul style="list-style-type: none"> <li>• Eliminate unlawful discrimination, harassment and victimisation;</li> <li>• Advance equality of opportunity; and</li> <li>• Foster good relations between different groups</li> </ul>	
1. Describe here (if relevant) how you are ensuring your policy or proposal does not unlawfully discriminate, harass or victimise	N/A as this Policy ensures there is a clinical governance framework detailing staff responsibilities in relation to medical gases across BCUHB in place
2. Describe here how your policy or proposal could better advance equality of opportunity (if relevant)	N/A
3. Describe here how your policy or proposal might be used to foster good relations between different groups (if relevant)	N/A

## Part B:

### Form 4 (i): Outcome Report

Organisation:	BETSI CADWALADR UNIVERSITY HEALTH BOARD
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1. What is being assessed? (Copy from Form 1)	<b>Medical Gases – Policy for Staff Responsibilities across BCUHB</b>
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2. Brief Aims and Objectives: (Copy from Form 1)	<p>The purpose of this policy Policy is to set out the framework of staff responsibilities for the safe management of medical gases across BCUHB.</p> <p>This is a new policy applies to all areas within BCU where medical gases are used across BCUHB</p> <p>The Policy aims to:</p> <ul style="list-style-type: none"> <li>Set out the operational responsibilities of all healthcare staff with regards to medical gases</li> <li>Describe the governance structure for medicines management</li> <li>Provide guidance on the safe and secure use of medicines</li> </ul>
---	---

3a. Could the impact of your decision/policy be discriminatory under equality legislation?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
3b. Could any of the protected groups be negatively affected?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
3c. Is your decision or policy of high significance?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>

4. Did the decision scoring on Form 3, coupled with your answers to the 3 questions above indicate that you need to proceed to a Full Impact Assessment?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
	<p>Record here the reason(s) for your decision i.e. what did Forms 2 &amp; 3 indicate in terms of positive and negative impact for each characteristic?</p> <p>Overall there appears to be a neutral impact on the characteristics and health inequalities as a result of this Policy.</p>	
5. If you answered 'no' above, are there any issues to be addressed e.g. mitigating any identified minor negative impact?	Yes <input type="checkbox"/>	<input checked="" type="checkbox"/>
	<p>Record Details:</p> <p>This policy is relevant to patients across all equality groups and is not considered to negatively affect any of the protected groups. If any impact of disability, culture, or language arises on an individual basis, they will be met.</p>	
6. Are monitoring arrangements in place so that you can measure what actually happens after you implement your document or proposal?	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
	How is it being monitored?	Via the incident reporting system Datix.
	Who is responsible?	Division or department where incident occurred
	What information is being used?	
	When will the EqIA be reviewed? (Usually the same date the policy is reviewed)	In 3 years

7. Where will your decision or policy be forwarded for approval?

QSE

8. Describe here what engagement you have undertaken with stakeholders including staff and service users to help inform the assessment

The Policy content has undergone extensive consultation.

Consultation has taken place with:

BCU wide medical gas group which includes

- Pharmacy
- Estates
- Nursing
- Clinicians
- Health and Safety

9. Names of all parties involved in undertaking this Equality Impact Assessment:

Name

Title/Role

Andrew Merriman

Lead Quality Assurance Pharmacist BCUHB

<b>Please Note: The Action Plan below forms an integral part of this Outcome Report</b>		

**Form 4 (ii): Action Plan**

This template details any actions that are planned following the completion of EqIA including those aimed at reducing or eliminating the effects of potential or actual negative impact identified.

	Proposed Actions	Who is responsible for this action?	When will this be done by?
1. If the assessment indicates significant potential negative impact such that you cannot proceed, please give reasons and any alternative action(s) agreed:			
2. What changes are you proposing to make to your document or proposal as a result of the EqIA?			
3a. Where negative impacts on certain groups have been identified, what actions are you taking or are proposed to mitigate these impacts? Are these already in place?			

	Proposed Actions	Who is responsible for this action?	When will this be done by?
3b. Where negative impacts on certain groups have been identified, and you are proceeding without mitigating them, describe here why you believe this is justified.			
4. Provide details of any actions taken or planned to advance equality of opportunity as a result of this assessment.			

**Quality, Safety &  
Experience Committee**
**19.3.19**

**GIG  
CYMRU  
NHS  
WALES**

 Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board

***To improve health and provide excellent care***

<b>Report Title:</b>	RP02 Non-ionising radiation protection policy
<b>Report Author:</b>	Mr Peter A Hiles and Mr J A Saunders
<b>Responsible Director:</b>	Mr Adrian Thomas, Executive Director of Therapies and Health Sciences
<b>Public or In Committee</b>	Public
<b>Purpose of Report:</b>	This document aims to provide assurance to the Committee of the Health Board by stating clearly the organisation's policy on issues around the use on non-ionising radiation within BCUHB to ensure they are managed safely.
<b>Approval / Scrutiny Route Prior to Presentation:</b>	<p>This revised policy has passed through the Radiation Protection Committees (local and overarching), Clinical Audit and Effectiveness Sub-Group and the Quality and Safety Group.</p> <p>Since this policy applies across the whole of the Health Board and covers patients, staff and public, approval is required at Health Board level (delegated to the Quality, Safety &amp; Experience Committee).</p>
<b>Governance issues / risks:</b>	This policy provides the required assurance regarding the safe use of non-ionising radiations by the Health Board, with respect to patients, staff and the public
<b>Financial Implications:</b>	None
<b>Recommendation:</b>	The Committee is asked to endorse the policy.

<b>Health Board's Well-being Objectives</b> <i>(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)</i>	√	<b>WFGA Sustainable Development Principle</b> <i>(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.)</i>	√
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			
<b>Special Measures Improvement Framework Theme/Expectation addressed by this paper</b>			
Leadership and Governance			
<b>Equality Impact Assessment</b>			
Undertaken in June 2012 – see attached. A review of the EQIA has been undertaken in February 2019 and no changes are recommended.			

*Disclosure:*

*Betsi Cadwaladr University Health Board is the operational name of Betsi Cadwaladr University Local Health Board*



## NON-IONISING RADIATION PROTECTION POLICY

<b>Date to be reviewed:</b>	October 2021	<b>No of pages:</b>	18
<b>Author(s):</b>	Mr P Hiles Mr J Saunders	<b>Author(s) title:</b>	Head of Radiation Physics Laser Protection Adviser
<b>Responsible dept / director:</b>	Executive Director of Therapies and Health Sciences		
<b>Approved by:</b>	BCULHB Overarching Radiation Protection Committee / Clinical Effectiveness Sub-Group		
<b>Date approved:</b>	3 <sup>rd</sup> December 2018		
<b>Endorsement by:</b>	Quality, Safety and Experience Committee of the Health Board		
<b>Date endorsed:</b>	??		
<b>Date activated (live):</b>	??		

<b>Date EQIA completed:</b>	June 2012, reviewed February 2019 (no changes required)		
<b>Documents to be read alongside this policy:</b>	Health and safety policy HS01		
<b>Review</b>	<p><b>Purpose of Issue/Description of current changes:</b></p> <p>Issued to provide direction and arrangements for the safe management of non-ionising radiation within the BCULHB in compliance with Statutory Duties. Revised to take account of new regulations and guidance:</p> <ul style="list-style-type: none"> <li>• The Control of Electromagnetic Fields at Work Regulations 2016</li> <li>• MHRA Lasers, intense light source systems and LEDs – guidance for safe use in medical, surgical, dental and aesthetic practices.(September 2015)</li> </ul> <p>And new BCU organisation structures since removal of Clinical Programme Groups (CPGs).</p>		

<b>First operational:</b>	August 2012				
<b>Previously reviewed:</b>	Dec 2018	date	date	date	date
<b>Changes made yes/no:</b>	Yes	Yes/no	Yes/no	Yes/no	Yes/no

### PROPRIETARY INFORMATION

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# NON-IONISING RADIATION PROTECTION POLICY

## Contents

1. Introduction
2. Policy statement
3. Aims
4. Objectives
5. Organisation and responsibilities
6. Protection of staff and patients
7. General management of radiation sources
8. References

Appendix 1 Radiation protection organisation

Appendix 2 General guidance on entitlement

Appendix 3 Example non-ionising radiation equipment and uses in Health Board

## 1. Introduction

- 1.1 The main source of non-ionising radiation is electromagnetic radiation, which covers ultraviolet (UV), visible, infrared, microwave, radio frequency (RF) and laser radiation. Other sources include ultrasound (US), audio frequency sound (noise) and magnetism.
- 1.2 There are a number of different sources of non-ionising radiation used on Health Board premises (see Appendix 3). These produce a range of effects in the body, some of which are potentially hazardous to patients and staff in the clinical environment. Therefore protection measures may be needed to ensure that exposure is kept within acceptable levels.
- 1.3 The use of non-ionising radiation in health establishments in the UK is governed by statutory instruments and good practice guidance (refer to section 8). The legislation is enforced as health and safety regulations made under the Health and Safety at Work Act 1974. They cover general health and safety of staff and impose responsibilities on both the employer and employees.
- 1.4 This policy document sets out the Betsi Cadwaladr University Health Board (BCUHB) aims and objectives in connection with the use of non-ionising radiation on its premises. It also outlines the general arrangements in force within the Health Board for implementing the policy.
- 1.5 Under the authority of this policy, Departments using non-ionising radiation are required to produce their own operating procedures and local rules for implementing the policy within their area of responsibility.

- 1.6 The policy has been endorsed by the BCUHB Executive Board and forms part of the Health Board's Health and Safety Policy.

## **2. Policy Statement**

- 2.1 The BCUHB is committed to providing and maintaining a safe working environment for all its employees, patients and any other persons who may be affected by its activities involving non-ionising radiation.
- 2.2 The Board's commitment applies to all premises and activities involving non-ionising radiation within its control.
- 2.3 The Board is committed to establishing good communication between all those involved in the implementation of this policy.

## **3. Aims**

The purpose of this policy is to ensure that non-ionising radiation exposures of staff, patients and members of the public resulting from work carried out in the BCUHB are as low as reasonably practicable.

## **4. Objectives**

The Health Board, in pursuing this policy, is committed to the following key objectives for its use of non-ionising radiation:

- 4.1 To comply with all relevant statutory requirements and guidance documents (see section 8).
- 4.2 To identify radiation hazards, assess and control risks and prepare contingency plans;
- 4.3 To ensure that diagnostic procedures are performed in such a way that the non-ionising radiation exposure to the patient is as low as reasonably practicable and that therapeutic procedures are consistent with the required clinical outcome;
- 4.4 To ensure that employees, contractors and others are adequately informed of identified radiation risks and, where appropriate, ensure they receive instruction, training and supervision;
- 4.5 To consult with employees' representatives on radiation safety issues;
- 4.6 To make arrangements for liaison with other employers, where the activities of one employer could affect the safety of individuals associated with the other;
- 4.7 To safeguard the environment from the effects of the Health Board's activities;

- 4.8 To make available records at the request of authorised external agencies;
- 4.9 To monitor and review the effectiveness of the policy and, where appropriate, implement improvements.

## **5. Organisation and Responsibilities**

### **5.1 The Chief Executive**

Under *The Control of Artificial Optical Radiation at Work Regulations* [SI 2010] and *The Control of Electromagnetic Fields at Work Regulations* [SI 2016], the Employer is ultimately responsible for the radiation protection of all workers on its premises and for work with non-ionising radiation carried out by its staff at other sites. For the BCUHB this responsibility rests with the Chief Executive.

### **5.2 The Health Board**

- 5.2.1 The responsibility for monitoring of the operation of this policy lies with the Board of the BCUHB and its Chief Executive.
- 5.2.2 The employer is also responsible for establishing a Radiation Protection Committee (RPC) to assist it in the discharge of its duties.
- 5.2.3 The BCUHB is responsible for appointing one or more Laser Protection Advisers (RPAs) [MHRA 2015a] and Magnetic Resonance Safety Experts (MRSEs) [MHRA 2015b] to advise on compliance with statutory requirements and safety. They should be members of, and report to, the RPC.

### **5.3 Board Level Directors**

- 5.3.1 The Chief Executive has appointed the Executive Director of Nursing and Midwifery as Board level director for health and safety.
- 5.3.2 The Chief Executive has appointed the Executive Director of Therapies and Health Sciences to be responsible for the co-ordination of radiation-related Health Board activities. This board-level director shall be responsible, through a process of nomination, for the implementation of this policy, facilitating the Overarching Radiation Protection Committee and acting as the Board representative in communications with external radiation inspectorates, including the Healthcare Inspectorate Wales and Health & Safety Executive.

### **5.4 Overarching Radiation Protection Committee (RPC)**

- 5.4.1 The Overarching RPC is responsible for overseeing the management of radiation safety throughout the organisation; it reports to the Clinical Audit and Effectiveness Sub-Group of the Quality and Safety Group and hence to the Executive Board (see Appendix 1).

5.4.2 The Overarching RPC is responsible for formulating and reviewing this policy on non-ionising radiation, and for recommending appropriate action to the Chief Executive via the formalised route where necessary.

5.4.3 In addition, three local RPCs, chaired by the Assistant Director of Therapies and Health Sciences, will consider operational issues and report to the BCUHB Overarching RPC chaired by the Executive Director.

## **5.5 Ultrasound Governance Group**

5.5.1 The Ultrasound clinical governance group is responsible for promoting the safe use of Ultrasound within the Health Board and to ensure compliance with Welsh Ultrasound Governance requirements [WSAC 2013]. This group reports to the Overarching Radiation Protection Committee (see Appendix 1).

5.5.2 The US group oversees replacement of equipment, the establishment and maintenance of service standards and the processes of training, supervision and audit. This will provide assurance on the achievement and maintenance of high levels of competence, performance and patient safety).

## **5.6 Departmental Responsibilities**

5.6.1 The Health Board management arrangements place the responsibility for the day to day operational delivery of services on the Heads of Department.

5.6.2 In every department where radiation is used, the responsibility (under the Chief Executive) for ensuring compliance with this policy and the requirements of legislation and guidance and Local Rules lies with the Head of Department. However, these responsibilities may be delegated to a designated senior member of the Department.

5.6.3 Within each Department the designated officer has the following responsibilities:

5.6.3.1 To ensure that responsibilities for radiation protection are documented.

5.6.3.2 To ensure that there exist written Local Rules, Operating Protocols and Risk Assessments and that these are reviewed regularly.

5.6.3.3 To ensure that all non-ionising equipment users receive appropriate training and that records of training are maintained.

5.6.3.4 To ensure that suitable personal protective equipment is available.

5.6.3.5 To ensure that for medical exposures, rigorous patient and subject identification procedures are followed.

- 5.6.3.6 To ensure that all radiation equipment is selected, installed, acceptance tested and maintained to satisfy radiation safety requirements, and included in their equipment inventory and planned equipment replacement programme.
- 5.6.4 In some departments where non-ionising radiation is used, a competent person should be appointed by the Head of Department as Safety Officer to assist the Head of Department and to ensure that protection measures are carried out, e.g. Laser Protection Supervisor [MHRA 2015a] or Magnetic Resonance Responsible Person [MHRA 2015b]. Their role should be specified in their appointment letter. General guidance on entitlement to appoint an LPS or MRRP is covered in Appendix 2.
- 5.6.5 Before introducing new procedures or equipment, radiation risk assessments should be undertaken, in conjunction with the Medical Physics staff. Thereafter, risk assessments should be dated and reviewed regularly.
- 5.6.6 The medical supervision of staff is the responsibility of the Occupational Health & Wellbeing Service.
- 5.6.7 North Wales Medical Physics aims to provide radiation protection support for medical lasers, phototherapy equipment, ultrasound and MRI equipment.

## **5.7 Individual Responsibilities**

- 5.7.1 It is the duty of all members of staff to protect themselves and others from any hazard arising from their work. Members of staff must not knowingly expose themselves or any other person to non-ionising radiation to an extent greater than is reasonably necessary for the purposes of their work, and shall exercise reasonable care while carrying out such work. Failure to comply with Local Rules or written procedures and protocols for medical exposures may result in disciplinary action.
- 5.7.2 Members of staff must make full and proper use of any personal protective equipment provided and shall report to the Safety Officer or Head of Department any defect in such equipment or any suspected fault in safety warnings or interlocks.

## **6. Protection of Staff and Patients**

### **6.1 Local Rules**

Local Rules should be issued for every department using lasers (Class 3B and 4) and MRI equipment. They should be regularly reviewed and major changes reported to the RPC. Local rules should be readily available to staff for reference and relevant sections may be displayed in the locations to which they refer.



## **6.2 Risk Assessments, Policies and Procedures**

Risk assessments regarding the use of non-ionising equipment should be performed, dated and reviewed regularly. Also, written procedures and protocols should exist for the use of all non-ionising equipment.

## **6.3 Training**

Heads of Departments must ensure that adequate training is provided for all staff working in departments using non-ionising radiation or who regularly enter areas where equipment is used.

# **7. General Management of Radiation Sources**

## **7.1 Equipment Maintenance and Quality Assurance**

All departments using non-ionising radiation equipment on patients must ensure that the equipment is regularly maintained and subject to suitable quality assurance checks at suitable intervals (see BCUHB Medical Devices Policy). A quality control programme may include:

- 7.1.1 Acceptance testing of new equipment before it is used for clinical procedures.
- 7.1.2 Adequate testing of the performance of the equipment at appropriate intervals and after any major maintenance procedure.
- 7.1.3 A programme for testing active engineering controls and warning devices, including lights.
- 7.1.4 Regular assessments of non-ionising radiation exposure delivered to persons undergoing medical procedures.
- 7.1.5 An up-to-date inventory of radiation equipment at each installation.
- 7.1.6 The QA programme shall specify action levels and appropriate remedial actions, including removal from service when necessary.

## **7.2 Incidents and Overexposures**

All radiation work shall be conducted with due regard to minimising exposure of persons (patients, staff and public), in accordance with Local Rules. Breaches of Local Rules, suspicions of over-exposure, equipment faults leading to staff or patient exposures greater than intended, must all be investigated by following procedures for reporting incidents involving non-ionising radiation. Non-ionising radiation Incidents will be reported as Clinical Incidents on the appropriate forms and will be reported to the Radiation Protection Committee.

Further details in respect of the incident and reporting process can be found in the BCUHB Incident reporting and Investigation Procedure.

## 8 References

- 8.1 General health and safety of staff from artificial optical radiation is specified in the *Control of Artificial Optical Radiation at Work Regulations 2010* [SI 2010] and for electromagnetic fields in the *Control of Electromagnetic Fields at Work Regulations* [SI 2016].
- 8.2 Written guidance on good practice is provided for various non-ionising radiation uses including: *Lasers, intense light sources and LEDs - guidance for safe use in medical, surgical, dental and aesthetic practices* [MHRA 2015a]; *Safety guidelines for magnetic resonance imaging equipment in clinical use* [MHRA 2015b];
- 8.3 Further references are provided below regarding safety guidance for other sources of non-ionising radiation.

**BIR 2012.** The safe use of ultrasound in medical diagnosis, 3<sup>rd</sup> edition. British Institute of Radiology. London: BIR

<https://www.birpublications.org/page/ultrasound>

**BSI 2004.** Safety of laser products. A user's guide. British Standards Institution PD IEC TR 60825-14:2004. London: BSI.

**BSI 2006.** Safety of laser products. Guidelines for the safe use of medical laser equipment. British Standards Institution PD IEC/TR 60825-8:2006. London: BSI.

**BSI 2014.** Safety of laser products – Part 1: equipment classification, and requirements. British Standards Institution BS EN 60825-1:2014. London: BSI.

**BSI 2017.** Personal eye-protection equipment. Filters and eye-protectors against laser radiation (laser eye-protectors). British Standards Institution BS EN 207:2017. London: BSI. **BSI 2013.** Medical electrical equipment. Particular requirements for basic safety and essential performance of surgical, cosmetic, therapeutic and diagnostic laser equipment. British Standards Institution BS EN 60601-2-22:2013 London: BSI.

**BSI 2011.** Medical electrical equipment. Part 2-57. Particular requirements for the basic safety and essential performance of non-laser light source equipment intended for therapeutic, diagnostic, monitoring and cosmetic/aesthetic use British Standards Institution BS EN 60601-2-57 London: BSI.

**MHRA 2015a.** Lasers, intense light source systems and LEDs – guidance for safe use in medical, surgical, dental and aesthetic practices Medicines and other Healthcare products Regulatory Authority, London: Department of Health.

<https://www.gov.uk/government/publications/guidance-on-the-safe-use-of-lasers-intense-light-source-systems-and-leds>

**MHRA 2015b.** Safety guidelines for magnetic resonance imaging equipment in clinical use 4<sup>th</sup> edition. Medicines and other Healthcare products Regulatory Authority, London: Department of Health.

<https://www.gov.uk/government/publications/safety-guidelines-for-magnetic-resonance-imaging-equipment-in-clinical-use>

**NRPB 2002.** Health effects from ultraviolet radiation. Documents of the National Radiological Protection Board, Vol. 13 No. 1 2002. Didcot: NRPB.

<https://www.gov.uk/government/publications/ultraviolet-radiation-uvr-health-effects-from-exposure>

**NHS 2010.** Working with radiation in the NHS - Advice for managers and staff. Partnership for Occupational Safety and Health in Healthcare. Leeds: NHS Employers.

**SI 1999.** The Management of Health and Safety at Work Regulations 1999. Statutory Instrument 1999 No. 3242. London: HMSO

<http://www.legislation.gov.uk/uksi/1999/3242/contents/made>

**SI 2002.** The Medical Devices Regulations 2002. Statutory Instrument 2002 No. 618. London: HMSO

<http://www.legislation.gov.uk/uksi/2002/618/contents/made>

**SI 2005.** The Control of Noise at Work Regulations 2005. Statutory Instrument 2005 No. 1643. London: HMSO

<http://www.legislation.gov.uk/uksi/2005/1643/contents/made>

**SI 2010.** The Control of Artificial Optical Radiation at Work Regulations 2010. Statutory Instrument 2010 No. 1140. London: HMSO

<http://www.legislation.gov.uk/uksi/2010/1140/contents/made>

**SI 2016.** The Control of Electromagnetic Fields at Work Regulations 2016. Statutory Instrument 2016 No. 588. London: HMSO

<http://www.legislation.gov.uk/uksi/2016/588/contents/made>

**WG 2018.** Guidance on safe clinical use of Magnetic Resonance Imaging (MRI). Welsh Health Circular WHC/2018/001. Cardiff: Welsh Assembly Government

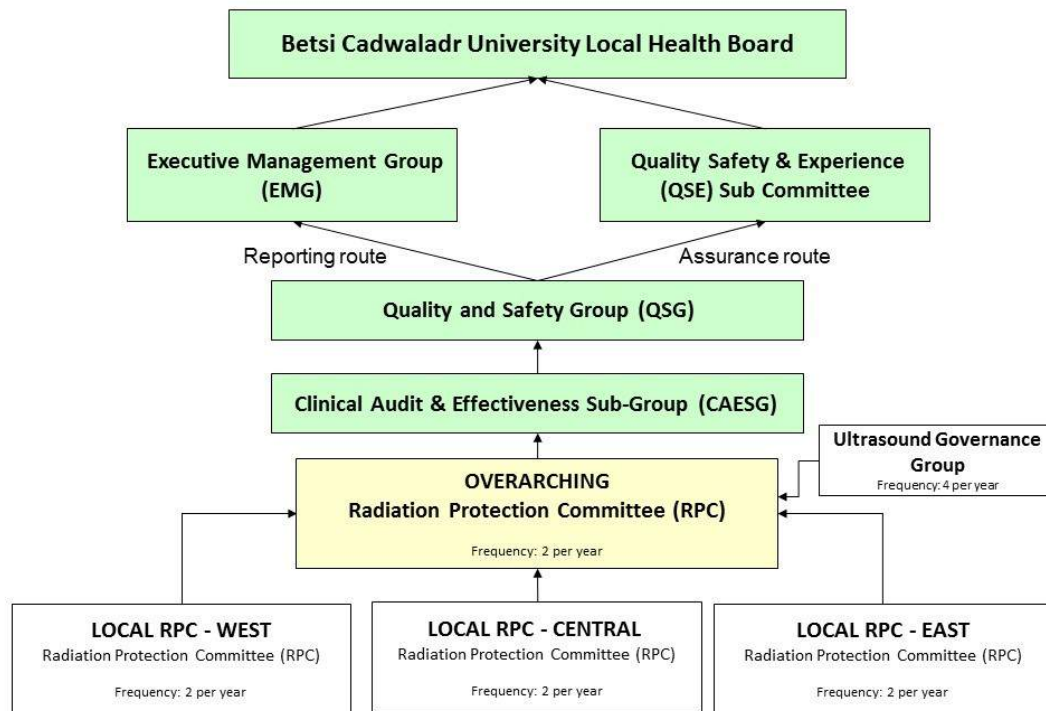
<https://gov.wales/topics/health/nhswales/circulars/health-professional/?lang=en>

**WSAC 2013.** Ultrasound and clinical governance in Wales. The Medical Imaging Sub-Committee (MISC) of the Welsh Scientific Advisory Committee.

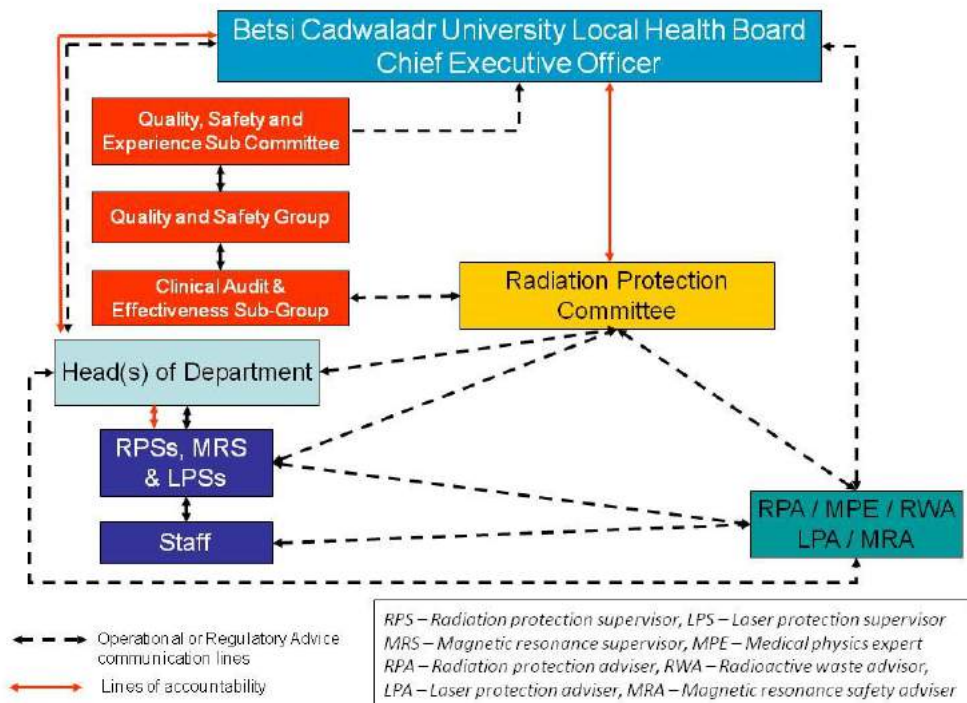
<http://www.wales.nhs.uk/governance-emanual/ultrasound-and-clinical-governance>

## APPENDIX 1 Radiation Protection Organisation

### A1.1 Management Structure



### A1.2 Communication Structure



## **APPENDIX 2      General Guidance on Entitlement**

As discussed above, the legislation and guidance requires the appointment of specified officers. The following gives general guidance on who is permitted by the Health Board to appoint staff into such positions.

### **A2.1      Laser Protection Adviser (LPA)**

Since LPAs are required to provide advice throughout the organisation, they should be appointed by the BCULHB Executive Director of Therapies and Health Science.

### **A2.2      Laser Protection Supervisor (LPS)**

Due to the need to appoint staff who are aware of and can deal with local issues, they should be appointed by the Head of Department responsible for the member of staff.

### **A2.3      MR Safety Expert (MRSE)**

Since MRSEs are required to provide advice throughout the organisation, they should be appointed by the BCULHB Executive Director of Therapies and Health Science.

### **A2.4      MR Responsible Person (MRRP)**

Due to the need to appoint staff who are aware of and can deal with local issues, they should be appointed by the Head of Department responsible for the member of staff.

## **APPENDIX 3      Examples of Non-ionising Radiation Equipment and Uses in Health Board**

### **A.2.1 Lasers**

High power lasers are used in ophthalmology and surgery. Lower power lasers are used in physiotherapy.

Detailed guidance [MHRA 2015a] requires Local Rules to be written and Authorised Users to be approved, for all lasers of Class 3B and 4.

### **A.2.2 Ultraviolet**

UVA and UVB are used for phototherapy, and photo chemotherapy, in Dermatology and physiotherapy departments. UVC sources are used for room decontamination and also Ultrasound probe decontamination.

### **A.2.3 Visible Light (excluding lasers)**

Ophthalmic instruments are high intensity sources of optical radiation, and blue light phototherapy sources are used in Special Care Baby Units (SCBU).

### **A.2.4 Radiofrequency and Microwave Radiation**

Shortwave RF, microwave diathermy and surgical diathermy are used in clinical environments (physiotherapy, theatres) to produce local heating and cutting.

Sources in non-clinical environments include communication systems (see BCUHB policy on radio communication equipment on Health Board premises), microwave ovens, VDUs (see BCUHB policy on Display screen equipment at work).

### **A.2.5 Magnetic Fields**

Magnetic Resonance Imaging (MRI) units, used in imaging departments.

Detailed guidance [MHRA 2015b] requires Local Rules to be written.

### **A.2.6 Ultrasound**

Used in a number of departments for diagnosis or image guidance (including joint injections, biopsies, line-insertions) and for treatment in physiotherapy.

In non-clinical environment, used for cleaning equipment.

### **A.2.7 Acoustic Noise**

Many types of powered machinery and power tools produce acoustic noise which may be hazardous if the noise is particularly loud or exposure is prolonged. (see BCUHB policy on Safe management of noise).



**Members of the Working Group:**

<b>Name</b>	<b>Title</b>
Mr P Hiles	Head of Radiation Physics
Mr J Saunders	Laser Protection Adviser

**Engagement has taken place with:**

<b>Name</b>	<b>Title</b>	<b>Date Consulted</b>
	Radiation Protection Committee (Central)	23 <sup>rd</sup> November 2018
	Radiation Protection Committee (East)	5 <sup>th</sup> November 2018
	Radiation Protection Committee (West)	27 <sup>th</sup> November 2018

## EQUALITY IMPACT ASSESSMENT FORMS

### Form 1: Preparation

1.	<b>What are you equality impact assessing?</b>	Non-Ionising Radiation Protection Policy 2 <sup>nd</sup> edition (reviewed February 2019 – no changes to EQIA required)
2.	<b>Aims and Brief Description of what you are assessing.</b>	There is a need to review this existing document to reflect and underpin the requirements of the BCUHB Health and Safety Policy and new legislation. The production of this Policy is to protect and promote the safety, health and welfare of those who may be affected by the undertakings of the BCUHB and to enable the BCUHB to comply with its statutory duties as detailed in the Health and Safety at Work etc Act and supporting legislation
3.	<b>Who is responsible for the Policy/work you are assessing?</b>	Peter Hiles, Head of Radiation Physics. Jonathan Saunders, Lead Clinical Technologist in Non-ionising Physics
4.	<b>Who is Involved in undertaking this EqIA?</b>	As above
5.	<b>Is the Policy related to other Policies/areas of work?</b>	HS01 Health & Safety Policy
6.	<b>Who are the key Stakeholders?</b>	Medical Physics, Health & Safety, BCUHB Board

7.	What might help/hinder the success of the Policy?	Lack of engagement by staff in the implementation of the Policy
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## Form 2: Information Gathering


	Age	Disability	Gender	Gender Reassignment	Pregnancy & Maternity	Race/Ethnicity or Nationality	Religion or Belief	Sexual Orientation
Is the policy relevant to the public sector general duty relating to each equality characteristic? Answer Yes or No in each box as appropriate (for a definition of Relevance, refer to Toolkit)								
In other words, is the Policy relevant to:	No	No	No	No	No	No	No	No
• eliminating discrimination and harassment in relation to:								
• advancing equality of opportunity in relation to:	No	No	No	No	No	No	No	No
• promoting good relations and positive attitudes in relation to:	No	No	No	No	No	No	No	No
• encouraging participation in public life in relation to disability		No						

<p><b>In relation to disability only, does the Policy take account of difference, even if it involves treating some individuals more favourably?</b></p>		No						
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The Human Rights Act contains 15 rights, all of which NHS organisations have a duty to act compatibly with and to respect, protect and fulfil. The 6 rights that are particularly relevant to healthcare are listed below. For a fuller explanation of these rights and other rights in the Human Rights Act please refer to the Toolkit **Appendix A: The Legislative Framework**.

Depending on the Policy you are considering, you may find the examples below helpful in relation to the Articles.

	Yes	No
<b>Consider, is the Policy relevant to:</b>		
<b>Article 2 : The right to life</b> <b>Example:</b> The protection and promotion of informed consent	Yes	
<b>Article 3 : The right not be tortured or treated in an inhuman or degrading way</b> <b>Examples:</b> Issues of dignity and privacy; the protection and promotion of the safety and welfare of patients and staff; the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travellers; Issues of patient restraint and control	Yes	
<b>Article 5 : The right to liberty and security</b> <b>Examples:</b> Issues of patient choice, control, empowerment and independence; issues of patient restraint and control the protection and promotion of the safety and welfare of patients and staff		No
<b>Article 6 : The right to a fair trial</b> <b>Example:</b> issues of patient choice, control, empowerment and independence		No
<b>Article 8 : The right to respect for private and family life, home and correspondence;</b> <b>Examples:</b> Issues of dignity and privacy; the protection and promotion of the safety and welfare of patients and staff; the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travellers; the right of a patient or employee to enjoy their family and/or private life		No
<b>Article 9 : The right to freedom of thought, conscience and religion</b> <b>Examples:</b> The protection and promotion of the safety and welfare of patients and staff; the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travellers, issues related to treatment that include blood transfusions, wearing religious symbols at work.		No

Equality Characteristic	Please list here details of any Information Gathered e.g. Reports, Statistics, Web links etc that are relevant to your Policy and/or the Characteristics
Age	N/A
Disability	N/A
Gender	N/A
Gender Reassignment	N/A
Pregnancy & Maternity	 Guidance for Pregnant Workers
Race (including Ethnicity and Nationality)	N/A
Religion or Belief	N/A
Sexual Orientation	N/A
Welsh Language	N/A
Human Rights	N/A

**Note:** For detailed guidance on the completion of these forms, please refer to Chapter 3 of the Toolkit that is available on the Equality pages of the BCUHB Intranet site.

**Note: For detailed guidance on the completion of these forms, please refer to Chapter 3 of the Toolkit that is available on the Equality pages of the BCUHB Intranet site.**



### Form 3: Assessment of Relevance and Priority

Equality Strand	Evidence: Existing Information to suggest some groups affected. Gathered from Step 2. (See Scoring Chart A)	Potential Impact: Nature, profile, scale, cost, numbers affected, significance. Insert one overall score (See Scoring Chart B)	Decision: Multiply 'evidence' score by 'potential impact' score. (See Scoring Chart C)
Age	1	-3	-3
Disability	1	-3	-3
Gender	1	-3	-3
Gender Reassignment	1	-3	-3
Pregnancy & Maternity	3	2	6
Race/Ethnicity or Nationality	1	-3	-3
Religion or Belief	1	-3	-3
Sexual Orientation	1	-3	-3
Welsh Language	1	-3	-3
Human Rights	3	2	6

#### Scoring Chart A: Evidence Available

3	Existing data/research
2	Anecdotal/awareness data only
1	No evidence or suggestion

#### Scoring Chart B: Potential Impact

-3	High negative
-2	Medium negative
-1	Low negative
0	No impact
+1	Low positive
+2	Medium positive
+3	High positive

#### Scoring Chart C: Impact Decision

-6 to -9	High Impact (H)
-3 to -5	Medium Impact (M)
-1 to -2	Low Impact (L)
0	No Impact (N)
1 to 9	Positive Impact (P)

Note: For detailed guidance on the completion of these forms, please refer to Chapter 3 of the Toolkit that is available on the Equality pages of the BCUHB Intranet site.

#### Form 4: Outcome Report and Action Plan

<b>Organisation:</b>	<b>BETSI CADWALADR UNIVERSITY HEALTH BOARD</b>
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<b>Sponsored by:</b>	<b>Name:</b>	Grace Lewis Parry
	<b>Title:</b>	<b>Director of Governance and Communications</b>
	<b>Department:</b>	<b>Governance and Communications</b>

<b>Policy Title: (Copy from Form 1)</b>	Non-Ionising Radiation Protection Policy
---	--

<b>Brief Aims and Objectives of Policy: (Copy from Form 1)</b>	There is a need to review this existing document to reflect and underpin the requirements of the BCUHB Health and Safety Policy and new legislation. The production of this Policy is to protect and promote the safety, health and welfare of those who may be affected by the undertakings of the BCUHB and to enable the BCUHB to comply with its statutory duties as detailed in the Health and Safety at Work etc Act and supporting legislation
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<b>Is the Outcome of the Initial Screening to proceed to full Equality Impact Assessment?:</b>	<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input checked="" type="checkbox"/>
	<b>Record Reasons for Decision:</b> Documents being produced are in direct compliance with a Statutory Duty as detailed in the Health and Safety at Work etc Act 1974 and supporting Legislation	

**Note:** For detailed guidance on the completion of these forms, please refer to Chapter 3 of the Toolkit that is available on the Equality pages of the BCUHB Intranet site.

If no, are there any issues to be addressed?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
	Record Details:	

Is the Policy Lawful?	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
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Will the Policy be adopted?	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
	If no, please record the reason and any further action required:	

Are monitoring arrangements in place?	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
	Refer to Action Plan (see below)	

Who is the Lead Officer?	Name:	As detailed on each document cover page
	Title:	As Above
	Department:	As Above
Review Date of Policy:	July 2016	

Signature of all parties:	Name	Title	Signature
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**Note:** For detailed guidance on the completion of these forms, please refer to Chapter 3 of the Toolkit that is available on the Equality pages of the BCUHB Intranet site.

	<b>Peter Hiles</b>	<b>Head of radiation Physics</b>	
	<b>Jonathan Saunders</b>	<b>Lead Clinical Technologist in Non-ionising Physics</b>	
<b>Please Note: An Action Plan should be attached to this Outcome Report prior to signature</b>			

#### **Form 4: Action Plan**

You are advised to use the template below to detail any actions that are planned following the completion of EqIA. You should include any remedial changes that have been made to reduce or eliminate the effects of potential or actual negative impact, as well as any arrangements to collect data or undertake further research. **This Action Plan should be completed in conjunction with the Outcome Report.**

	<b>Response</b>	<b>Proposed Actions</b>	<b>Lead Officer Identified</b>	<b>Timescale</b>	<b>Progress</b>
<b>1. Will the Policy be adopted?</b>	Yes				
<b>2. If No please give reasons and any alternative action(s) agreed:</b>	N/A				

**Note:** For detailed guidance on the completion of these forms, please refer to Chapter 3 of the Toolkit that is available on the Equality pages of the BCUHB Intranet site.

	<b>Response</b>	<b>Proposed Actions</b>	<b>Lead Officer Identified</b>	<b>Timescale</b>	<b>Progress</b>
<b>(If the Policy is not to be adopted please proceed to step 9).</b>					
<b>3. How will the Policy be monitored?</b>	Through the document review process	Develop a review an audit process	Head of Health and Safety	February 2019	Included in H&S cycle of work
<b>4. What monitoring data will be collected?</b>	Implementation of relevant documents and review of incident reports specifically relating to the areas of relevance	Develop a review an audit process	Head of Health and Safety	February 2019	Included in H&S cycle of work
<b>5. How will this data be collected?</b>	Audit and incident reporting	Develop a review and audit process	Head of Health and Safety	February 2019	Included in H&S cycle of work

**Note:** For detailed guidance on the completion of these forms, please refer to Chapter 3 of the Toolkit that is available on the Equality pages of the BCUHB Intranet site.

	<b>Response</b>	<b>Proposed Actions</b>	<b>Lead Officer Identified</b>	<b>Timescale</b>	<b>Progress</b>
<b>6. When will the monitoring data be analysed?</b>	As detailed in the review and audit process	Develop a review and audit process	Head of Health and Safety	February 2019	Included in H&S cycle of work
<b>7. Who will analyse the data?</b>	Health and Safety, Occupational Health, Health and Safety Forum Members	Develop performance reporting process	Head of Health and Safety	February 2019	Included in H&S cycle of work
<b>8. What changes have been made to the Policy as a result of EqIA?</b>	None as the requirement to protect the safety and welfare of others pre dates the requirement for EQIA and the duties as detailed in the documents are a statutory duty	NA	NA	NA	NA

**Note:** For detailed guidance on the completion of these forms, please refer to Chapter 3 of the Toolkit that is available on the Equality pages of the BCUHB Intranet site.

	Response	Proposed Actions	Lead Officer Identified	Timescale	Progress
<b>9. Where a Policy may have differential impact on certain groups, state what arrangements are in place or are proposed to mitigate these impacts?</b>	N/A				
<b>10. Justification: for when a policy may have a negative impact on certain groups, but there is good reason not to mitigate</b>	N/A				
<b>11. Provide details of any actions planned or taken to promote equality</b>	N/A				
<b>12. Describe the arrangements for publishing the EqIA Outcome Report</b>	Reviewed by Health and Safety Forum	Presented to Health and Safety Forum	Phil Townson	February 2019	Included in H&S cycle of work

**Note:** For detailed guidance on the completion of these forms, please refer to Chapter 3 of the Toolkit that is available on the Equality pages of the BCUHB Intranet site.



	Response	Proposed Actions	Lead Officer Identified	Timescale	Progress
<b>13. When will the Policy be subject to further Review?</b>	In accordance with the review dates included on the document front cover however it is not unreasonable to review the documents sooner if there are any changes to legislation or situations indicate that the documents are not fit for purpose	Review documents within the indicated timescale	Head of Health and Safety	As detailed in the document	Included in H&S cycle of work

NOTE: If your decision recorded above is **not to proceed to a Full Equality Impact Assessment**, then you do not need not complete the following forms (5,6 and 7)

**Note:** For detailed guidance on the completion of these forms, please refer to Chapter 3 of the Toolkit that is available on the Equality pages of the BCUHB Intranet site.

**Note: For detailed guidance on the completion of these forms, please refer to Chapter 3 of the Toolkit that is available on the Equality pages of the BCUHB Intranet site.**

## **FORMS 5, 6 AND 7 TO BE USED ONLY FOR FULL EQUALITY IMPACT ASSESSMENT**

### **Form 5: Examine the Information Gathered So Far**

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1.	<b>Do you have adequate information? Refer to Form 2 : Information Gathering for assistance</b>	
2.	<b>Can you proceed with the Policy during EqIA?</b>	
3.	<b>Does the information collected relate to all equality strands?</b>	
4.	<b>What additional information (if any) is required?</b>	
5.	<b>How are you going to collect any additional information needed? State which representative bodies or other organisations or individuals you will be liaising or engaging with in order to achieve this</b>	

**Form 6: Judge/Assess the Potential Impact of the Policy across the Equality Strands**

Detail below whether you have identified any positive/adverse/neutral impact for any of the following groups:					
Equality Strand/Group	Key Equalities Legislation or Policy	Adverse	Positive	Degree of Potential Impact: High (H) Medium (M) Low (L)	Comments
Age	Equality Act 2010				
Disability					
Gender					
Gender Reassignment					
Pregnancy & Maternity					
Race					
Religion/Belief					
Sexual Orientation					
Welsh Language	Welsh Language Act 1993				
Human Rights	Human Rights Act 1998				

**Form 7: Consider Any Alternatives to the Policy which will Reduce, Eliminate or Mitigate any Adverse Impact (As Identified in Form 6)**

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1.	<b>Describe any mitigating actions taken to reduce negative/adverse impact</b>	
2.	<b>Is there a strategy for dealing with any unavoidable but not unlawful negative impacts that cannot be mitigated?</b>	
3.	<b>Describe any actions taken to maximise the opportunity to promote equality, ie: changes to the Policy, regulation, guidance, communication, monitoring or review</b>	
4.	<b>What changes to the Policy have been made as a result of conducting this EqIA?</b>	

<b>Quality, Safety &amp; Experience Committee</b>	 <b>GIG CYMRU NHS WALES</b>   Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board
<b>19.3.19</b>	<b><i>To improve health and provide excellent care</i></b>

<b>Report Title:</b>	Physical Restraint Guidelines
<b>Report Author:</b>	Mr Gareth Owen, Clinical Nurse Specialist/Violence & Aggression Clinical Lead
<b>Responsible Director:</b>	Mr Andy Roach, Director of Mental Health & Learning Disabilities (MHL D)
<b>Public or In Committee</b>	Public
<b>Purpose of Report:</b>	To seek approval to the attached amended guidelines.
<b>Approval / Scrutiny Route Prior to Presentation:</b>	Guidelines have been scrutinised by MHL D Policy Implementation Group, Programme Advisory Group (PAG) and Quality Safety Group (QSG).
<b>Governance issues / risks:</b>	The Physical Restraint Guidelines will ensure that BCUHB complies with relevant legislation and national guidance in this area e.g. NICE Guidelines, MHA 1983 Code of Practice for Wales, Health & Safety. The document has been subject to an Equality Impact Assessment and reveals a neutral impact on protected characteristics.
<b>Financial Implications:</b>	The scope of the policy is applicable to all staff. Moreover, the policy stipulates that respective divisions will be left to determine their own levels of risk and appropriate management strategies including training in restraint. Currently, training in restraint is only delivered to clinical staff within the MHL D division. If other divisions determine that there is a level of risk which necessitates the potential use of restraint, they will, in line with national guidance, be required to train staff to a satisfactory level – this then is likely to incur financial implications although it is not possible to provide a forecast until a thorough training needs analysis has been completed. Professor Peter Lepping has submitted a business case report which makes several recommendations on how restraint related incidents can be managed legally, effectively and efficiently.
<b>Recommendation:</b>	The Committee is asked to approve the amended Physical Restraint Guidelines for implementation within the Health Board.

<b>Health Board's Well-being Objectives</b> <i>(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)</i>	√	<b>WFGA Sustainable Development Principle</b> <i>(Indicate how the paper/proposal has embedded and prioritised the sustainable development principle in its development.</i>	√
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		<i>Describe how within the main body of the report or if not indicate the reasons for this.)</i>	
1.To improve physical, emotional and mental health and well-being for all	X	1.Balancing short term need with long term planning for the future	
2.To target our resources to those with the greatest needs and reduce inequalities		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	X	5.Considering impact on all well-being goals together and on other bodies	
6.To respect people and their dignity	X		
7.To listen to people and learn from their experiences	X		
<b>Special Measures Improvement Framework Theme/Expectation addressed by this paper</b>			
Mental Health Leadership & Governance			
<b>Equality Impact Assessment</b>			
Attached			

*Disclosure:*

*Betsi Cadwaladr University Health Board is the operational name of Betsi Cadwaladr University Local Health Board*





## PHYSICAL RESTRAINT GUIDELINES

Date to be reviewed:	October 2020	No of pages:	27
Author(s):	Gareth Owen Peter Lepping	Author(s) title:	V&A Clinical Lead Consultant Psychiatrist
Responsible dept /director:	Safeguarding – Executive Director – Nursing and Midwifery		
Approved by:	MH&LD Policy Sub Group Safeguarding Committee Programme Advisory Group Quality Safety Group (Corporate)		
Date approved:	10 <sup>th</sup> October 2018		
Date activated (live):	Date becomes live		
Date EQIA completed	13 <sup>th</sup> August 2018		
<b>Documents to be read alongside this document:</b>			
<b>Policies &amp; Procedures</b> BCUHB – HS02 Procedure and Guidance for Protecting Employees From Violence & Aggression, BCUHB – MD01 Consent to Examination or Treatment Policy, BCUHB – WP5 Dignity at Work Policy, BCUHB – WP5a Dignity at Work Guidelines, BCUHB – WP8 – Equality & Diversity Policy, BCUHB – HS01- Health and Safety Policy, BCUHB - Policy and Procedures for the Protection of Vulnerable Adults (POVA), Procedure & Guidance Protecting Employees from Violence & Aggression, Former organisational - Security Policies, Former organisational – Lone Working Policies, Former organisational – Mental Capacity Act 2005 policies / guidelines, Former organisational – Covert Medication Policy, Former organisational – Rapid Tranquilisation Policy.			
<b>Guidance / Relevant Legislation</b> NICE Guidelines NG10/11. Welsh Assembly Government - Reference Guide for Consent to Examination or Treatment, Welsh Assembly Government - All Wales NHS Violence, Welsh Assembly Government ‘Framework for Restraint Policy & Practice’ (2005)Health & Safety at Work Act 1974, The Management of Health & Safety at Work Regulations 1999, Safety Committees and Safety Representative Regulations 1977, The Health Safety (Consultation with Employees) Regulations 1996, The Secretary of State Directions 2003, National Institute for Excellence – Clinical Guidelines 25 Violence, Aggression Training Passport and Information Scheme, Mental Capacity Act 2005 – Code of Practice, Deprivation of Liberty Safeguards – Code of Practice, British Institute of Learning Disabilities – Code of Practice, Mental Health Act 1983 – Code of Practice for Wales (Revised 2016), Human Rights Act 1998, Memorandum of Understanding – The Police Use of Restraint in Mental Health & Learning Disability Settings 2017, Social Service Well being (Wales) Act 2014, Patient Safety Notice PSN023 (Welsh Assembly Government, Jan 2016).			
Review	<b>Purpose of Issue/Description of current changes:</b> Policy amended to comply with newly published national guidelines: NICE Guidelines NG10/11 The Police Use of Restraint in Mental Health & Learning Disability Settings 2017 Mental Health Act 1983 – Code of Practice for Wales (Revised 2016)		
First operational:	July 2011		

Previously reviewed:	date	date	date	date	date
Changes made yes/no:	Yes/no	Yes/no	Yes/no	Yes/no	Yes/no

PROPRIETARY INFORMATION

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**Appendix 2** - Unplanned Restraint Flowchart

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**Appendix 7** – Physical Restraint Clinical Pathway

# 1. Statement of Intent

The Betsi Cadwaladr University Health Board (BCUHB) is committed in its duty to provide a safe and secure environment for patients, staff, and visitors and offers its full support to the Welsh Assembly Government, All Wales NHS Violence and Aggression Training Passport and Information Scheme and will endeavour to protect staff and those visiting Health Board premises.

Care will be delivered without discrimination – no service user will receives less favourable treatment than another. This means that no-one should be disadvantaged by reason of any **protected characteristic** which means:

- Disability;
- Gender or gender reassignment;
- Marital status;
- Sexual orientation
- Religion or belief (or non-belief);
- Race (including ethnicity and nationality);
- Age;
- Pregnancy and maternity

## 2. Introduction and Purpose

This guidance uses as a framework:

NICE Clinical Guideline NG10: 'Violence and aggression: short-term management in mental health, health and community settings' (2015).

DoH: 'Positive and Proactive Care: reducing the need for restrictive interventions' (2014).

Mental Health Act 1983 Code of Practice for Wales (Revised 2016).

Welsh Assembly Government: 'Framework for Restrictive Physical Intervention Policy and Practice (2005)

These documents aim at providing staff with clear evidence based guidance on issues relative to restraint such as legislation, recognising risk, training, management strategies, reporting and staff support.

Occasionally behaviour exhibited by individuals will be challenging enough to warrant restrictive interventions – physical restraint being one such example. This guidance will focus on the legal and ethical principles and practice of managing specific behaviours through the use of physical restraint.

**This policy addresses the use of physical restraint for a variety of reasons, some of which will not relate to violence and aggression. For this reason, the policy does not encompass strategies relating to the management of violence and aggression – for further guidance please refer to:**

**HS02 – Procedure & Guidance Protecting Employees from Violence and Aggression**

### 3. Scope

This document applies to all health board employees, patients and visitors and aims to provide guidance within a legal and ethical framework underpinned by best practice principles for staff implementing restraint intervention.

### 4. Legal Duties

There is a range of legislation which impacts on restraint. These are (in summary):

#### **Employer Legal Duties – Health & Safety at Work Act (HSWA) 1974**

The Health Board's duties with respect to the management of work related violence are determined by the HSWA 1974, which requires the employer to:

- Ensure so far as is reasonably practicable, the health and safety and welfare at work of all their employees.
- Provide and maintain plant and systems of work that are, so far as is reasonably practicable, safe and free from health risks. ('Plant' refers to equipment, for example hoists, wheelchairs etc).
- Provide such information, instruction, training and supervision as is necessary to ensure so far as is reasonably practicable, the health and safety at work of their employees.

From the Management of Health and Safety at Work Regulations 1999, Employers must:

- Assess all risks to the health and safety of their employees
- Identify the precautions needed
- Make arrangements for the effective management of precautions
- Provide information and training to employees

#### **Human Rights Act 1998**

The Human Rights Act 1998 came into force during 2000 and sets out some key principles of fairness, equality, dignity, the right to liberty and security of a person without deprivation of liberty.

The key points are:

- The Act offers a framework to encourage high standards of care and the force of law to make sure that respect of human rights becomes the norm.
- That people should decide and personalise their own care and be treated with respect and dignity when using Health and Social Care Services.

- The use of restraint should only be undertaken in an emergency where staff judge that they must intervene to protect a client /person, someone else or themselves.
- The person affected should be fully involved in all decisions about their care and if the person lacks capacity, the Mental Capacity Act 2005 should be invoked.
- The inappropriate use of restraint is against the law. Physical restrictive intervention can constitute assault, battery or false imprisonment and can lead to both civil and criminal prosecution.

## **Mental Capacity Act 2005**

Section 5 of the Act provides 'protection from liability' for carers and supporters in both everyday tasks of caring and life changing events for people who lack capacity.

However, such action can only receive 'protection from liability' if:

- a) The person is reasonably believed to lack capacity to give permission.
- b) It is in the person's 'best interests'.
- c) It follows the Act's principles.

In relation to restraint, the Act imposes limitations on the protection from liability in "the use of threat or force where a person is resisting and any restriction of liberty of movement, whether or not the person resists".

## **Mental Health Act 1983**

Mental Health Act 1983 Code of Practice for Wales (Revised 2016) sets out the following regarding restraint:

- The employment of de-escalation strategies and approaches should be central to the management of potential violence and aggression. It is recognised that as a last resort, staff may need to employ more restrictive interventions, such as: physical restraint, rapid tranquilisation and seclusion.
- Such physical interventions must never be used to punish a person. Where such interventions are deemed necessary, clinical need and the safety of the persons and others should be the priority.
- When employing such interventions, a balance must be struck between the need to minimise risks to the person and others, and the need to ensure that the least restrictive approach to caring for the person is adopted.
- Any interventions employed to manage disturbed behaviour must be reasonable, proportionate and justifiable, taking into account the risks posed by the person's behaviour or potential behaviour.

## **Deprivation of Liberty Safeguards**

The Mental Health Act 2007 has amended the Mental Capacity Act 2005 to introduce the Deprivation of Liberty Safeguards (DoLS). The Safeguards will apply to hospital and care homes to ensure that people who lack capacity are not deprived of their liberty without lawful authorisation. Staff contemplating restrictive practice must be aware as to what constitutes Deprivation and Restriction of Liberty as defined in the statute and have regard to current case law i.e. Supreme Court judgement in Cheshire West [2014]. Restraint can only be used when:

- The person restraining reasonably believes it is necessary to prevent harm to the incapacitated person; and
- It is proportionate both to the likelihood of harm, and
- The seriousness of harm; and
- It does not constitute detention under Article 5(1) of the European Convention on Human Rights.

The use of a DoLS would be required to authorise detention to lawfully safeguard the person (MCA 2005, Code of Practice, s.6.41).

## **Children Act 1989**

Within the Children Act (1989 and 2004) there is no direct or specific reference to any form of physical restraint management or therapeutic holding of children and young people. However, on page 24 of Children Act (1989 ) there is a reference in relation to 'secure accommodation by health authorities which states that " the children (secure accommodation) regulations (1991) extend the application of section 25 (restriction of liberty) to children "accommodated by health authorities, and the NHS Trusts established under the section 5 of the NHS and Community Care Act 1990 " who are not being detained under any provisions of the Mental Health Act (1983 regulation 5 & 7)". Under this ruling the child's liberty may be restricted if section 25 (1) above applies and only for 72 hours without court approval".

Although there is no specific reference to physical restraint within these documents staff should adhere to the general principles of safeguarding the child and young person, promoting their well being and assessing the risk of significant harm occurring when confronted by decisions relating to all aspects of physical restraint

## **Care Standards Act 2000**

The care standards regulations make a number of references to care that has a bearing on restraint:

"The registered person shall ensure that no person is subject to physical restraint unless restraint of the kind employed is the only practicable means of securing the welfare of that or any other person and there are exceptional circumstances"



## **Safeguarding Vulnerable Groups Act 2006**

The Safeguarding Vulnerable Groups Act 2006 provides that people in certain occupations and carrying out certain activities must be vetted. These are people whose occupation brings them into contact with children and vulnerable adults or puts them in a position of responsibility over children and vulnerable adults ('regulated activity'). The Act provides that people can be barred from participating in regulated activity.

## **5. Responsibilities**

All staff within the health board have an individual responsibility to ensure that the health board policies and standards, including Health Care Standards are adhered to and that health and safety arrangements set out in this guidance are appropriately followed. Failure to observe these duties may result in disciplinary action being taken.

The health board recognises and accepts its responsibility as an employer for providing a safe and healthy workplace and working environment for its employees, and a safe environment for persons, visitors and other members of the public. It will discharge these responsibilities through its managers and will expect its staff to comply with procedures and to act at all times in a responsible manner.

## **6. Definition of Physical Restraint**

Whilst there are alternative terms used for 'physical restraint', for example, NICE use the term 'manual restraint', this document will adopt the term 'physical restraint' as used by the Mental Health Act 1983 Code of Practice for Wales (Revised 2016). In practice, both terms have the same definition:

'A skilled, hands-on method of physical restraint used by trained (in physical restraint techniques) healthcare professionals to prevent service users from harming themselves, endangering others or compromising the therapeutic environment. Its purpose is to safely immobilise the service user'. (NICE NG10)

## **7. Guidance on the use of Physical Restraint**

The principle aim of physical restraint is to limit an individual's autonomy which if deemed inappropriate could infringe upon an individual's right to liberty. Its use therefore must never be as a matter of course, but rather guided by strict criteria. The Mental Health Act 1983 Code of Practice for Wales (Revised 2016) cites the following examples of situations where physical restraint may be deemed reasonable:

- Physical assault
- Dangerous or destructive behaviour
- Non-compliance with lawful treatment (MCA / MHA)
- Likely or actual self-harm
- Sexually inappropriate behaviour
- Extreme and prolonged over-activity on the part of the person, that is likely to lead to physical exhaustion
- Absconding, or the risk of absconding

Additionally, any method aimed at reducing and eliminating behaviours that challenge should take account of the:

- Person's preference if known
- Person's needs
- Person's physical condition
- Environment of care
- Staffing levels and skill mix
- Staff's duty to protect all those under their care.

Physical restraint techniques are not 'approved' nor do they have any legal standing – it is the context of their application which makes them **defensible**.

## 8. Types of Restraint

Restraint can take many forms and in each case are viewed as deliberate on the part of other person(s) that restrict an individual's movement, liberty and/or freedom to act independently. Broadly speaking, these are categorised as:

**Physical** (see definition part 6.)

**Chemical:** Chemical restraint involves using medication to restrain. It differs from therapeutic sedation in that it does not have a directly therapeutic purpose but is primarily employed to control undesirable behaviour.

**Mechanical:** Mechanical restraint involves the use of equipment which may have clinical approval, for example, specially designed mittens in intensive care settings but can also include circumstances where equipment is used inappropriately and has no legal basis such as using a heavy table to stop person getting out of their chair. Staff must exercise judgement and ensure that their actions do not unnecessarily or unlawfully deprive individuals of their human rights.

**Environmental:** Designing the environment to limit peoples' freedom of movement such as locking doors, use of electronic key pads, and baffle locks. An example of environmental restraint would be seclusion. Seclusion is defined as: 'the supervised confinement of a patient in a room, which may be locked. Its sole aim is to contain severely disturbed behaviour that is likely to cause harm to others'.

**Psychological:** Can include constantly telling a person not to do something, or that doing what they want to do is not allowed or is too dangerous. It may include depriving a person of lifestyle choices by, for example, telling them what time to go to bed or get up. Psychological restraint might also include depriving individuals of equipment or possessions they consider necessary to do what they want to do, for example taking away walking aids, glasses, outdoor clothing or keeping the person in nightwear with the intention of stopping them from leaving.

## 9. General Principles

There may be occasions when staff need to consider the use of physical restraint as a management strategy. The purpose of restraint is first to take immediate control of a serious, significant or dangerous situation and second to contain or limit the person's

freedom for no longer than is necessary to end or reduce significantly the threat to themselves or those around.

The person in control of the incident will have to carefully assess the situation and use their own judgement as to what may be deemed 'serious' or 'significant' before employing such interventions. Furthermore, any physical restraint used must **be justifiable, appropriate, reasonable and proportionate to a specific situation and should be applied for the minimum possible duration.**

Restraint should be viewed as a last resort and only used when all other interventions have failed. Following important advances in knowledge pertaining to the management of violence and aggression, all current guidelines (e.g. NICE NG10) convey the same clear and unambiguous directive – any use of coercive measures should be preceded by proactive approaches. Examples of proactive interventions include positive engagement whereby service users are encouraged to participate in the planning of their care, advanced statements (a non-legally binding written statement that conveys a person's preferences, wishes, beliefs and values about their future treatment and care) and advanced decisions (a written statement made by a person 18 yrs or over that is legally binding and conveys a person's decision to refuse specific treatments and interventions in the future), positive regard, effective communication and de-escalation. It should be remembered that person centred care and effective communication should not cease during restraint as this will help in terms of gaining co-operation and returning autonomy as soon as possible as well as ensuring that the intervention has therapeutic value and that the therapeutic relationship is maintained.

Broadly speaking, the need to use physical restraint can arise from two distinct circumstances – those which are planned and those which are unplanned:

**Unplanned physical restraint refers to those incidents requiring restrictive physical interventions which are unforeseen and unexpected. In these circumstances the immediacy of the incident does not allow time to plan ahead and staff are guided by legislation, case law, best practice guidelines, training or common law.**

**Planned physical restraint refers to those incidents requiring restrictive physical interventions which have been predicted via risk assessment and where there is an anticipation that they are likely to occur. There is time to plan ahead and such plans are structured and documented in health care records. Areas where planned restraints are likely to occur must ensure that any such interventions are supported by a robust training programme.**

It is recognised that all incidents of restraint are unique and varied in their cause, character, risk and outcome. However, despite these variations, there are common approaches which will ensure the situation is managed as safely as possible.

## **9.1 Physical Restraint**

The following are guidelines which should be adopted prior to the implementation of physical restraint:

- All persons should be treated with dignity and respect, irrespective of race, age, culture, gender, diagnosis, sexuality, disability, ethnicity or religious / spiritual beliefs, gender reassignment or marital status.
- Under no circumstances should the use of physical restraint be threatened or intended as disciplinary sanction, or as a means to intentionally humiliate, degrade or to discriminate e.g. corporal punishment, deprivation of food or sleep, inappropriate clothing and restrictions on visits.
- CPR trained staff and resuscitation equipment, including pulse oximeters must be available in all clinical environments where restraint is likely to take place.
- Should an incident arise, staff assistance should be called for using the appropriate emergency alert system or by calling a pre-determined verbal command.
- Approach the person in a side on stance to maintain balance, reduce target area, protect vital organs and to appear less threatening. Arms should be held upwards for protection although care must be taken not to appear confrontational.
- Make a visual check for weapons. If a weapon is seen or suspected staff should withdraw, isolate the patient and contact the police immediately.
- Staff must adopt a team approach with clearly defined roles - one member of staff assuming responsibility for taking the lead and guiding the team throughout the incident. This person will also take responsibility for protecting and supporting the patient's head, monitoring the person's breathing - ensuring that the airway and breathing are not compromised, monitoring vital signs and noting the skin tone to ensure adequate blood circulation. Other team members should isolate and support the patient's arms and legs and support the process of monitoring vital signs and blood circulation – if necessary, perform passive exercise of affected limb, alter the person's position or release them if medical concerns arise.
- Aim at restraining arms and legs from behind if possible. Exceptions are persons with hearing difficulties/deafness and children, who should be approached within their field of vision.
- Physical restraint must not be used in a way that interferes with a person's breathing, circulation or dignity, for example, by applying pressure to the neck, chest, abdomen or groin, or obstructing the airway.
- Physical restraint must not be used in a way which impedes a person's ability to communicate or orientate themselves, for example, obstructing the eyes, ears or mouth.
- When using physical restraint, avoid taking the person to the floor unnecessarily. If it does become necessary, use the supine position (face up) if possible. If it is necessary to use prone position (face down), for example, to

administer dorsogluteal intra-muscular medication, use for as short a time as possible. **Do not routinely use the prone position.**

- Do not routinely use physical restraint for more than 10 minutes. Instead, consider alternatives such as rapid tranquilisation or seclusion.
- In some community settings there may not be a possibility to easily access other members of staff. These situations need to be addressed individually with staff safety in mind. The relevant Divisions will develop guidance for their staff based on this document.
- All persons and staff not directly involved in the incident will leave the immediate area of restraint but be prepared to support colleagues if necessary – audiences are known to escalate violence.
- Staff involved will be allocated specific tasks in relation to the person being restrained.
- During restraint, staff should maintain communication with the person. Staff should explain the reasons for action taken and seek to gain his/her co-operation as soon as possible.
- In situations where a person is attacked by another person, sufficient staff must be present to ensure that both aggressor and victim can be contained. This is important to ensure that the victim is unable to carry out a reprisal attack. Where staff are not able to safely contain such a situation the police should be contacted.
- To mitigate risk, as far as is reasonably practicable, a registered practitioner must be present to oversee any incidents of physical restraint. This is an important measure to ensure that quality and safety standards are maintained and that non-qualified staff are supported during such duties.
- On rare occasions, incidents may occur which are unforeseen and where a registered practitioner may not be present. To lessen the likelihood of this, staff should ensure that risk assessments are completed as appropriate and that robust care plans are produced to include clear guidelines relating to the use of physical restraint. Such incidents must be reported immediately to a registered practitioner who will be expected to attend if available
- Whilst all incidents of restraint will differ in nature and severity, it must be recognised that the ability and confidence of staff to effectively manage such events will vary from person to person. It is therefore extremely important that staff are able to access additional support to ensure a safe and satisfactory outcome for all concerned.
- The person in charge of the incident will be responsible for deciding when additional support is required and who should be notified. Where incidents are considered serious (e.g. injury to persons), the Senior Clinical Manager and on-call Consultant should be notified. When the person's Consultant is in the

locality they should personally attend to offer clinical expertise and support to staff.

- When it is safe to do so, restraint will be relaxed in gradual manner to allow the individual to regain autonomy.
- It has become increasingly recognised that harm can also occur during and in the period following restraint. The person's physical and psychological health must be monitored during and after restraint for as long as is clinically necessary and in any event for a minimum of 24 hours. Further guidance on the importance of this is given in the **Patient Safety Notice PSN023 (Jan 2016)**.

**9.2 Unplanned physical restraint** incidents carry greater risks than planned and should only be carried out when staff are satisfied that they have the skills and resources necessary to do so safely. Extreme care should be taken under these circumstances to minimise risks to all concerned.

**9.3 Planned physical restraint** incidents also carry risks to all concerned and should be afforded extreme care – risk factors should anticipated whenever possible in advance and sufficient resources made available to manage the situation as safely as possible. Any plans along with advance statements/decisions should be documented carefully in the person's care plan. Planned physical restraint may occur in connection with Mental Capacity Act Best Interest decisions to treat or examine, in which case the use of the Health Board's "Assessment of capacity and best interest decision form" is recommended.

**9.4** If **chemical restraint** is needed please refer to MHL0 0004 – Rapid Tranquillisation Protocol for further information.

**9.5** The use of **mechanical restraints** is normally only permitted in high-secure settings, however in some exceptional circumstances, where the severity of a patient's behaviour leads to an identification of such a management strategy, then mechanical restraint may be considered - however this decision must be agreed by the hospital managers and made in collaboration with Healthcare Inspectorate Wales (HIW).

**9.6 Security staff:** The Health Board will through its procurement processes ensure that there is evidence of appropriate and ongoing training for all security staff employed directly by the Health Board or through a third party.

## **10. Minimising Physical Restraint**

All episodes of restraint involve a degree of risk to the recipient, which can include restraint related deaths. Furthermore, staff who carry out restraint can be exposed to risk particularly when the individual is aggressive or violent. **Before using physical restraint other strategies must be considered. For details see pathways for planned and unplanned restraint (Appendices 2 and 3).**

The Department of Health's '*Positive and Proactive Care: reducing the need for restrictive interventions*' (April 2014) emphasises the importance of delivering person-centred care whereby treatment should take into account individual needs and preferences. Service

users should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals. Part 36 of this document gives specific guidance on an appropriate care plan structure. All service users who exhibit, or by virtue of risk assessment, are likely to exhibit behaviours which challenge services, including violence and aggression, should have in place a person centred behavioural support plan (**appendix 5**).

Whilst training will significantly reduce the risks, restraint should be avoided where possible and alternatives considered. Effective communication between staff and aggressor is proven to have positive value in the implementation of restraint, and should be regarded as the underpinning principle. The following are examples of effective non-physical interventions which are intended to de-escalate situations.

- Staff should ensure that their own body language does not convey hostile intentions. Adopt a non-threatening side-on stance, employ fluid gestures and use only intermittent eye contact to avoid staring.
- Maintain and allow the person sufficient space to avoid a sense of being trapped.
- Employ the principles of two-way communication – actively listen to what the individual is trying to communicate.
- Use the components of speech to emphasise what is being said – pay attention to pitch, tone, volume and pace.
- Use open-ended questions to encourage dialogue (e.g. why do you feel angry?) and use closed questions to clarify issues (e.g. are you saying that you want to go for a walk?).
- Empathise with the individual – show concern and attentiveness through appropriate verbal and non-verbal responses.
- Avoid negative responses such as refusals whenever possible – negotiate and offer alternatives and solutions where available. When negative responses are unavoidable consider apologising for the situation.

## **11. Persons with potential vulnerabilities**

- Elderly and learning disabilities patients often have higher risk of cardiac or pulmonary complications. Elderly patients are particularly vulnerable to fractures as well as other age related conditions and staff should adapt physical restraint techniques, adjusting them for age and frailty – where possible staff should avoid taking an elderly person to the floor.
- Patients with cognitive impairment will often not understand oral explanations, and additional consideration has to be taken.
- Consideration should be given to the person's gender – restraint should not be applied in a way that could be construed as sexual. If appropriate (e.g. has a



history of sexual abuse), at least one member of the restraining team should be the same gender as the person.

- Consideration should be given to the person's cultural and ethnic background. In the event of language barriers, please refer to interpretation and translation policy.
- Pregnant women **must not** be placed in the prone position – a wedge or cushion should be placed under their right side so that they are tilted over slightly; this stops the baby pressing on the large vessels (if more than 5 months pregnant. A record of this should be entered in the person's healthcare record.
- Staff who are responsible for providing clinical care to children should familiarise themselves with relevant local guidelines.
- All staff who are responsible for providing care to people from disadvantaged vulnerable or under represented groups e.g. groups that may experience social exclusion, for example gypsies, travellers and gay, lesbian, bisexual and transgendered people, should ensure that the delivery of care is commensurate with that person's needs. Particular care must be taken not to perpetuate stereotypes.
- Any restraint of persons with physical disabilities should be tailored to that individuals needs. Care should be taken not to cause pain or aggravate any physical conditions.

## **12. Physical Restraint in the Administration of Treatment without Consent**

There may be occasions where it is necessary to administer lawful treatment to a person without their consent (MHA/MCA). In such circumstances, it is deemed good practice to use effective communication skills in an attempt to gain the person's cooperation before considering the use of physical restrictive intervention. Furthermore, staff should familiarise themselves with the relevant legislation and satisfy themselves that the use of force to administer treatment is both urgent and necessary.

## **13. External Agency Involvement (Police)**

In addition to any current security arrangement which may be in place, staff may also be required to call on external intervention from the police. Once this plan has been instigated, the management of the situation lies with the police. In some extreme situation there might be a conflict of interest between staff responsibilities and the jurisdiction of the police who will act solely within the legal framework, but may also be restricted by health consideration of the person. Further guidance can be found in:

Memorandum of Understanding – 'The Police Use of Restraint in Mental Health & Learning Disability Settings' (2017).

## 14. Post Incident

- Following all incidents of restraint measures should be taken to ensure the continued health and well being of the restrained person. For persons these measures will include incident and care plan recording, monitoring the individual's welfare and health, responding to any injuries or health concerns and ensuring that the individual has the opportunity to make representation or complaint.
- All incidents that involve physical restraint should be subject to a post incident review that allows lessons to be learned for both individuals and professionals.
- Line managers are required to assess whether staff involved in an incident require help / support.
- Support should be offered to ALL staff who have been subject of an assault to avoid discrimination, and thus avoid acceptance of help by members of staff.
- All incidents of serious or unplanned restrictive physical intervention should be documented in the BCUHB Datix Web (Incident Reporting) using local agreed practices on reporting. To assist staff in judging what constitutes a reportable restrictive physical intervention, they should refer to the Physical Restraint Reporting Guide:

<http://howis.wales.nhs.uk/sitesplus/861/document/467986>

- Clinical restraint incidents should be entered in the healthcare record and the care plan reviewed accordingly. Additionally, the care plan should include under what circumstances restraint may be used and what form the restraint may take.
- **In certain circumstances it may be useful to assess the assailant's capacity after the incident to aid potential future prosecutions by the Crown Prosecution Service. It is the senior clinicians' responsibility to document carefully in the notes the details of the incident and the capacity of the assailant at the time of the incident. There is also an expectation that BCUHB staff assist the police and provide witness statements where appropriate.**
- Following any incident of restraint involving persons, support should be offered and the opportunity to review the circumstances that led to their being restrained.
- In some circumstances it may be appropriate to offer additional support to other persons who may have been directly or indirectly affected by the incident. It is important however to maintain confidentiality.
- Following a restraint incident, staff should review the incident. Divisions will develop their own incident review processes. Any review should be conducted within a climate of open and honest discussion where staff can express concerns, learn from

the incident and consider the precipitating factors and alternatives that may have been used.

- For a quick reference to the restraint process, staff should refer to **Appendix 7**.
- Following any serious incident of aggression or violence, the nominated Divisional Lead may meet to perform a post-incident investigation which will include root cause analysis.

## 15. Risk Assessment & Prediction

All service areas must undertake an identification of hazards and determine the significant risks caused by or affecting their particular areas of responsibility. The risk assessment must be as comprehensive as possible. It is recommended that where appropriate, a multidisciplinary approach be taken using available skills and resources e.g. departmental/ward staff, risk assessors, safety representatives, technical staff etc.

Consider using an actuarial prediction instrument rather than unstructured clinical judgement alone to monitor and reduce incidents of violence and to help develop a risk management plan, for example the **Dynamic Appraisal of Situational Aggression (Appendix 6)**.

Where possible and appropriate it is advised that risk assessment is undertaken in conjunction with partner agencies and persons/carers. It is the responsibility of the relevant Division to ensure that a robust mechanism is in place for risk assessment in their respective area of responsibility

## 16. Training

The importance of training cannot be over-emphasised. As well as satisfying legal obligations, training ensures that employees are equipped with the skills necessary to fulfil their duties in a confident and safe manner within a legal and ethical framework.

The BCUHB is committed to providing its employees with an ongoing training programme within this field and is a participant of the '**All Wales NHS Violence and Aggression Training Passport and Information Scheme**' which sets an approved national standard against which NHS employers in Wales can be judged. Moreover, it signifies the Health Board's willingness to educate and train its staff to a consistent standard. Whilst the Passport Scheme sets out minimum expected standards, the Health Board endeavours to exceed these standards to ensure that staff receive the best possible support in the course of their duties.

Service users will be given the opportunity to become actively involved in the design of training agenda's to ensure that programmes are commensurate to the needs of person groups, in particular those with potential vulnerabilities.

The level and frequency in which staff are trained in physical restraint will be determined by their area of work and risk assessment. Managers will be responsible for ensuring that staff (including Bank Staff) receive training, which appropriately reduces risk and enhances service provision during the execution of their duties.

It will be left to the respective divisions to decide the level of risk requiring appropriate training strategy, i.e. whether such is defined as mandatory or statutory. However, all clinical areas which experience aggression and violence are expected to train up the appropriate number of staff to allow a safe and appropriate response to a violent incident, including the need for restraint.

## 17. Links to Governance & Communications

Divisions contemplating developing local policy or procedures specific to restrictive practice for their clinical areas should, wherever possible, use this 'overarching' guideline as a reference. This will ensure that policies, protocols and guidelines are developed in line with BCUHB policy and Welsh Government Assembly guidelines. Issues relating to the use of restraints such as monitoring and data collection will be presented to Divisional Safety and Standards Groups.

## 18. References

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Helpline Learning Disabilities.

**This table should be completed and added at the end of the document:**

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Programme Advisory Group	October 2018
MHLD Division Senior Staff and relevant persons	September 2018
Manon Gwilym, Office of the Medical Director	September 2018

## ***MENTAL CAPACITY ACT 2005 – 10 key points***

1. Everyone aged 16 or over is assumed to have capacity unless proven otherwise. However, whenever a particular intervention or treatment is being proposed for a patient, the health professional has a duty on every occasion to assess that patient's capacity to make the decision to agree to or refuse what is being proposed.
2. Capacity only ever relates to a particular point in time and a particular decision that needs to be made. A patient's capacity can fluctuate and may recover.
3. All practicable and appropriate steps should be taken to enable the patient to make the particular decision.
4. A patient should not be treated as being unable to make a decision merely because their decision is unwise in your opinion. However, seek advice if a young person aged 16 or 17 is refusing treatment, particularly when this decision is against the wishes of a person with parental responsibility.
5. Somebody lacks capacity if they have an impairment or disturbance of the mind or brain **and** they are unable to do one or more of the following: understand **or**, retain **or** weigh up the information given to them **or** if they are unable to communicate a decision.\*
6. If a patient is assessed as lacking capacity to make a particular decision, the health professional or treating team (the decision maker(s)) has to decide whether the patient should undertake the intervention or treatment in their best interests on their behalf.
7. When making best interest decisions, decision makers should do all of the following: encourage the patient's participation, identify all relevant circumstances, find out the patient's views, avoid discrimination, consider whether the patient will regain capacity, consult others and use the least restrictive option of treatment. Any decision made under the Mental Capacity Act is protected by law if the requirements and terms of the act are followed and documented correctly. \*
8. Where necessary, proportionate and reasonable restraint that is necessary to prevent the patient from harm can be used to implement best interest decisions. However, authorisation to deprive the patient of their liberty under the Deprivation of Liberty Safeguards may have to be applied for in cases where the patient is under continuous supervision and continuous control and not free to leave
9. Patients may have appointed an Attorney under a Lasting Power of Attorney or a Deputy appointed by the Court who can make personal health (medical) and welfare decisions on their behalf if they lose capacity. They may also have an advance decision to refuse certain treatments, which is legally binding if valid and applicable. Advanced statements detailing the patient's past and present wishes and feelings are **not** legally binding upon the decision-maker, but ought to be seriously considered when best interest decisions are made.

10. In certain situations, a patient who lacks capacity and who has no-one else to represent them or no-one appropriate to consult, has a right in law to the support of an

Independent Mental Capacity Advocate (IMCA). An IMCA **must** be instructed by the decision-maker, when serious medical decisions or a prolonged stay in (or move to) a hospital or care home is proposed. An IMCA **may** be instructed for care reviews. In adult protection cases an IMCA may be instructed, despite the availability of friends or family. An IMCA makes recommendations about what is in the patient's best interests, but does **not** make decisions on behalf of the decision maker.

\* Use the 'Assessment of Capacity' and 'Best Interest Decision' form to assist you.



### UNPLANNED RESTRAINT

Immediate risk to staff, patient or member of public by patient, member of public or staff

↓  
Assess risk



↓  
Call police or other assistance if risks are significant

↓  
Optimise safety of patients, staff and public  
Use least restrictive measures first:

Distraction, de-escalation, withdrawal from situation, additional support  
(staff, family, friends)

↓  
If restraint has been used assess need for continuation if  
situation does *not* resolve (see planned restraint)

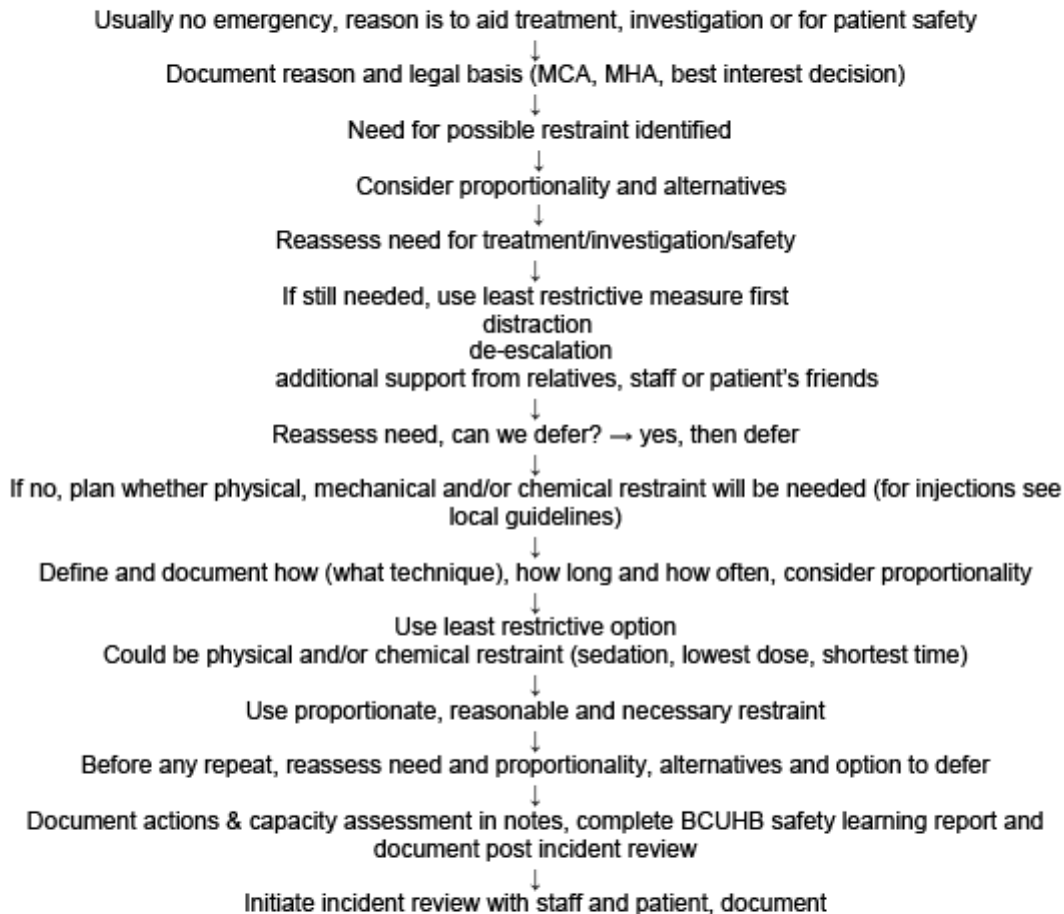
↓  
Further action depends on circumstances  
Consider medical assessment of assailant

↓  
Document actions and, when appropriate,  
capacity assessment; complete BCUHB safety learning report and document post incident review

**REMEMBER**  
BE PROACTIVE  
PREPARE  
PLAN  
PREVENT  
INCIDENT  
POST INCIDENT  
REVIEW

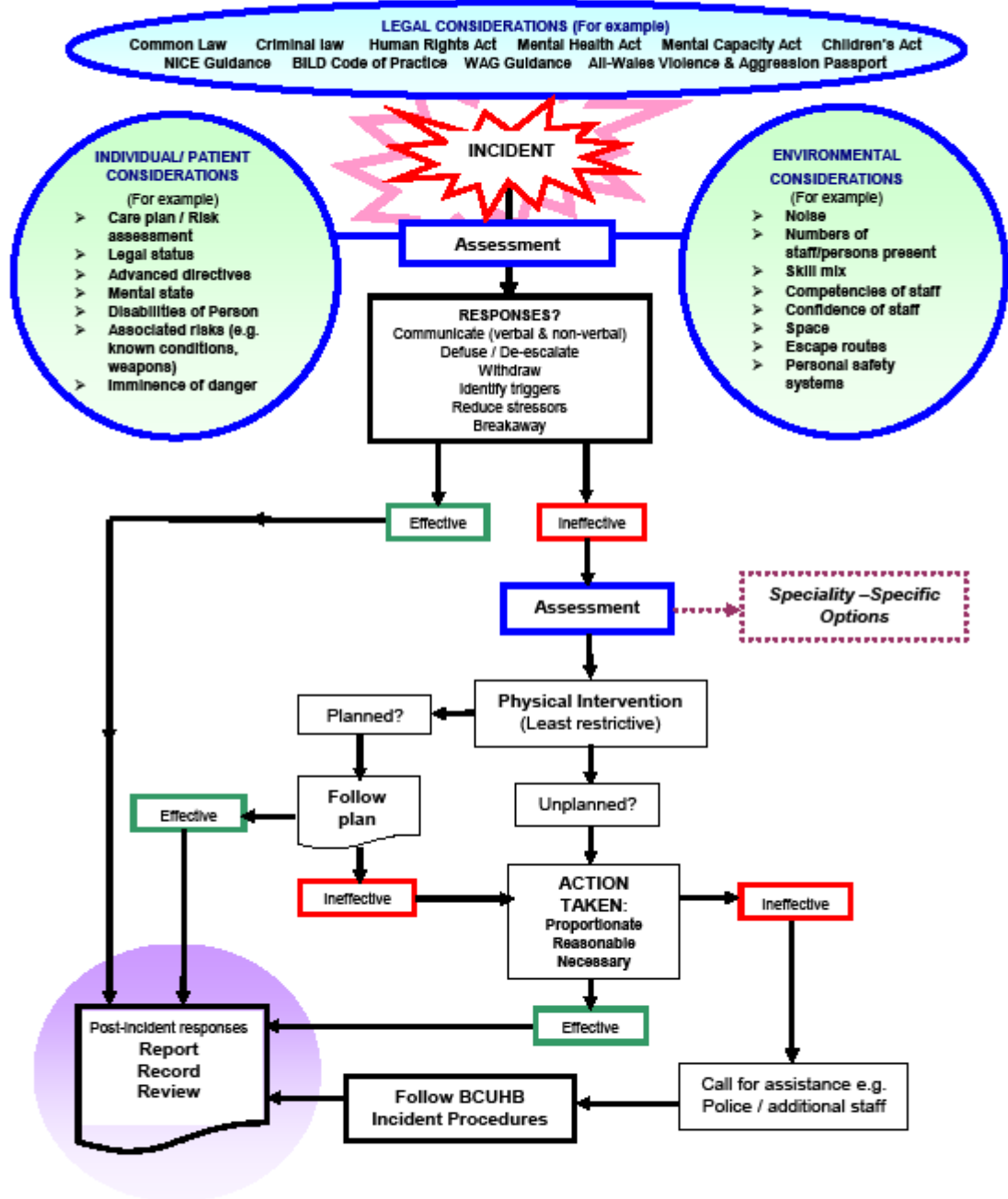


### PLANNED RESTRAINT



**REMEMBER**  
BE PROACTIVE  
PREPARE  
PLAN  
PREVENT  
INCIDENT  
POST INCIDENT  
REVIEW

**Clinical decision-making process in response to Aggression / Challenging behaviour.**



PJ/11/10

Person Centred Behavioural Support Plan

PATIENT I.D.  
LABEL

Ward:

Named Nurse:

Date:

These are the early signs that behaviour is escalating:

These are the behaviours that other people may find challenging or risky:

**Slow triggers for behaviours** *(These are the events that build up slowly and may affect behaviour over time):*

**Fast triggers for behaviours** *(These are the events that may immediately affect behaviour):*

What may be the reasons for the behaviours?

**Primary Prevention: *What can reduce the risk of challenging behaviour. (Prevent triggers from occurring)***



**Secondary Prevention: *What can be done to reduce the impact of triggers.***

**Crisis Management: *How to Provide Support in a Crisis.***

Staff Signature:

Date Reviewed:

Patient Signature:

Date Reviewed:

Carer Signature:

Date Reviewed:

Please tick if care-plan was completed on behalf of patient. ☐

### **Dynamic Appraisal of Situational Aggression (DASA)**

#### **Instructions for Use**

The Dynamic Appraisal of Situational Aggression (DASA) allows for the risk of aggression to be assessed on a day-to-day basis. It is a simple, efficient tool which should be filled out by the patients' key-worker (e.g. named nurse) and should take about five minutes to complete. The results will give an indication of the likelihood of aggression being exhibited by the patient along with suggested actions to mitigate the risk.

#### **Step 1**

The DASA chart should be filled out at the same time each day so that a consistent 24 hour period is assessed. The person completing the assessment will be required to gage seven behaviours over the past 24 hours and provide a score against each. If the behaviour is present then a score of **1** is given and if the behaviour is absent then a score of **0** is given. For example, when scoring the patients' level of irritability – if they are calm and relaxed whilst alone or in the company of others, a '**0**' should be recorded. If however, they are easily annoyed or angered and unable to tolerate the presence of others, a '**1**' should be recorded.

**N.B. Where a well known patient habitually exhibits behaviours such as irritability but has not become aggressive, a score of '0' should be recorded.**

#### **Step 2**

Having completed the chart, the key-worker should total the score and record this. The total score will indicate the level of risk (low, moderate or high) and the appropriate action should be taken as indicated in the '**Actions Required**' section.

## DASA Simplified Scoring Guide

**0-1 = Low Risk      2-3 = Moderate Risk      4-7 = High Risk**

Name:		Ward:		Score						
Item	Basic Description of Patient *Relating only to past 24 hours*	Mon	Tue	Wed	Thu	Fri	Sat	Sun		
<b>Irritability</b>	<b>0</b> = Has been calm and relaxed. They are comfortable and relaxed in the company of other patients and staff.									
	<b>1</b> = Is considered easily annoyed or angered and unable to tolerate the presence of others.									
<b>Impulsivity</b>	<b>0</b> = Has been affectively and behaviourally stable.									
	<b>1</b> = Has been sudden, impulsive and unpredictable in their affect or behaviour.									
<b>Unwillingness to follow directions</b>	<b>0</b> = Is generally compliant with any requests and directions.									
	<b>1</b> = Becomes angry and/or aggressive when they were asked to adhere to some aspect of their treatment or to the ward's routine.									
<b>Sensitivity to perceived provocation</b>	<b>0</b> = Does not tend to get angry or see everything around them as provocative. Not being overly sensitive or provocative.									
	<b>1</b> = Has tended to see others' reactions as deliberate and harmful. May misinterpret others' behaviour or respond with anger in a disproportionate manner to the extent of provocation. Over sensitive and quick to anger.									
<b>Easily angered when requests are denied</b>	<b>0</b> = Is calm and accepting when they are asked to wait whilst their request is attended to. Understands and accepts if their request is unable to be fulfilled at that time.									
	<b>1</b> = Has tended to become angry when their requests have not been granted immediately. Does not accept the delay in gratification of their request.									
<b>Negative attitudes</b>	<b>0</b> = No negative attitudes apart from occasional pessimism.									
	<b>1</b> = Definite/serious negative attitudes exhibited.									
<b>Verbal Threats</b>	<b>0</b> = Has not been verbally aggressive.									
	<b>1</b> = Verbally aggressive or has displayed a verbal outburst (more than just a raised voice) where there is a definite attempt to intimidate or threaten another person. The person may shout angrily, insult others or curse.									
<b>Total Score:</b>										

## Actions Required Based on DASA Scores

Score	Level of Risk	Actions Required
0-1	Low	Continue with the person centred behavioural support plan's <b>primary prevention</b> strategies
2-3	Moderate	<p>The patient should be monitored for additional indicators of risk</p> <p>Implement the person centred behavioural support plan's <b>secondary prevention</b> strategies</p>
4-7	High	<p>The patient should be monitored for additional indicators of risk</p> <p>Implement the person centred behavioural support plan's <b>secondary prevention</b> strategies</p> <p>Consider the person centred behavioural support plan's <b>crisis management</b> strategies</p> <p>Consider undertaking a clinical team review</p>

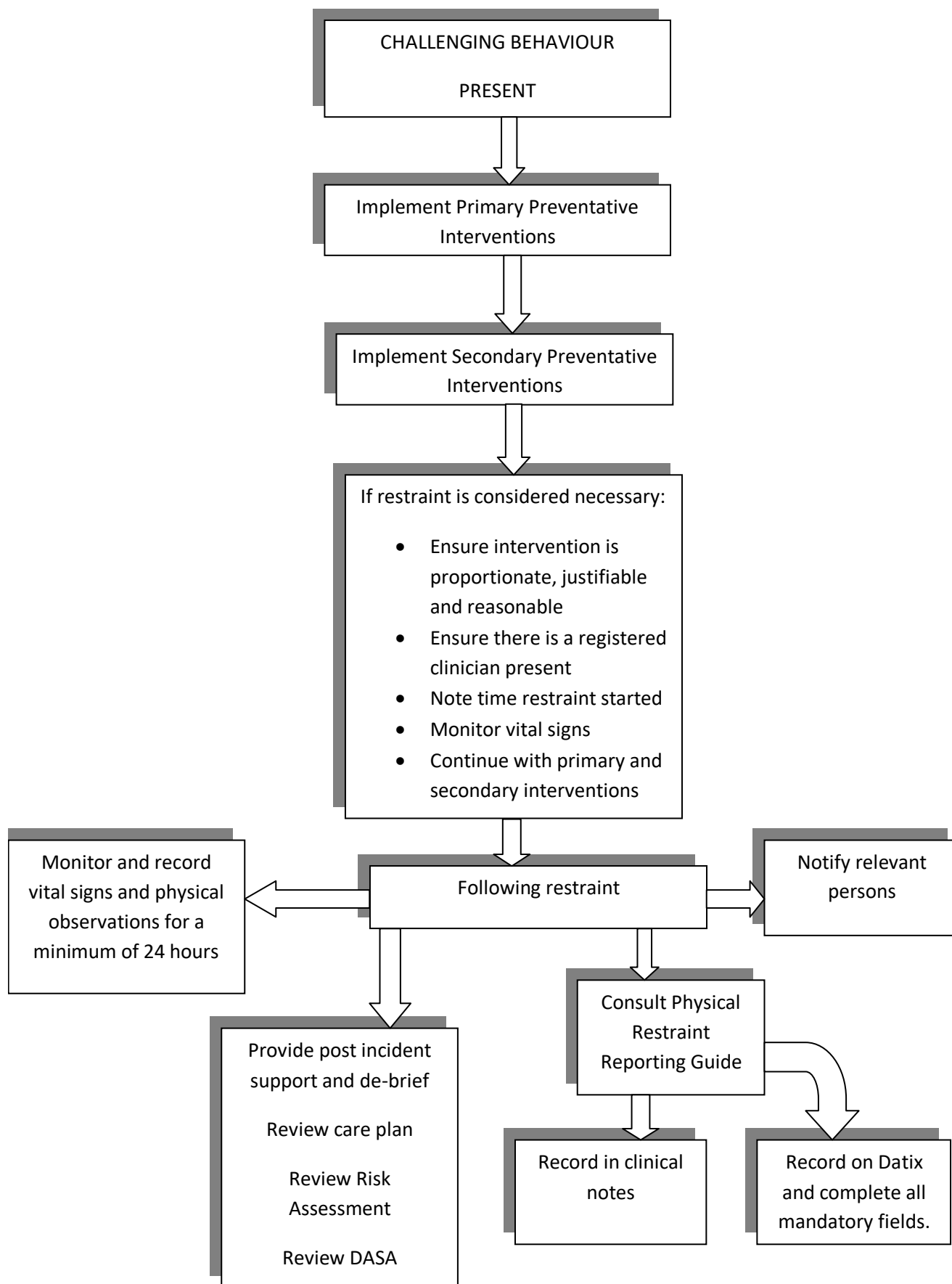
Persistent moderate/high scores may indicate a need for the clinical team to review care and treatment programmes (care plans, medication, involvement of other agencies, supervision/observation levels, risk management strategies etc).

Wards with high number of patients scoring high risk:

- Are there any known dynamic tensions (conflict) between individual patients? If so, tensions should be discussed and attempts at remediation considered.
- Consider enhancing environmental security e.g. Give warm drinks rather than hot until the risk is reduced, remove items which may be dangerous etc.
- Consider the skill /gender mix of the staff on duty.
- Identify an appropriate response plan.



# Physical Restraint Clinical Pathway







GIG  
CYMRU  
NHS  
WALES

Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board

## EQUALITY IMPACT ASSESSMENT FORMS

### PARTS A and B: SCREENING AND OUTCOME REPORT

#### Introduction:

These forms have been designed to enable you to record, and provide evidence of how you have considered the needs of all people (including service users, their carers and our staff) who may be affected by what you are writing or proposing, whether this is:

- a policy, protocol, guideline or other written control document;
- a strategy or other planning document e.g. your annual operating plan;
- any change to the way we deliver services e.g. a service review;
- a decision that is related to any of the above e.g. commissioning a new service or decommissioning an existing service.

**This is not optional:** Equality Impact Assessment is a specific legal requirement on public sector organisations under equalities legislation and failure to comply could result in a legal challenge to a decision or strategy. More importantly, equality impact assessment helps to inform better decision-making and policy development leading to improved services for patients. **This form should not be completed by an individual alone, but should form part of a working group approach.**

#### The Forms:

You must complete:

- **Part A** – this is the Initial Screening that is always undertaken and consists of Forms 1 to 3; these forms are designed to enable you to make an initial assessment of the potential impact of what you are doing, and decide whether or not you will need to proceed to a Full Impact Assessment (Part C);

AND

- **Part B** – this is the Outcome Report and Action Plan (Form 4) you will need to complete whether or not you proceed to a Full Impact Assessment;

Together, these forms will help to provide evidence of your Impact Assessment and how you have shown “due regard” to the duties.

You may also need to complete Part C (see separate Form) – if parts A and B indicate you need to undertake a Full Impact Assessment. This enables you to fully consider all the evidence that is available (including engagement with the people affected by your document or proposals) to tell you whether your document or proposal will affect people differently. It also gives you the opportunity to consider what changes you may need to make to eliminate or mitigate any adverse or negative impact you have identified.

Remember that these forms may be subject to external scrutiny e.g. under a Freedom of Information request.

To enter text, click on the grey box in the part of the form you are completing. Help text will appear in the status bar at the foot of the page. Some boxes have drop-down lists from which you can select options. Others may simply be a box to answer a question. Once completed, the EqlA Forms should accompany your document or proposal when it is submitted to the appropriate body for approval.



**GIG**  
CYMRU  
**NHS**  
WALES

Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board

## Part A

### Form 1: Preparation

1.	What are you equality impact assessing? What is the title of the document you are writing or the service review you are undertaking?	PHYSICAL RESTRAINT GUIDELINES SCH016	
2.	Provide a brief description, including the aims and objectives of what you are assessing.	Ensuring the safety, dignity and wellbeing of patients and staff during incidents where the use of physical restraint is being utilised/considered and to minimise its use in clinical settings	
3.	Who is responsible for the document/work you are assessing – i.e. who has the authority to agree/approve any changes you identify are necessary?	Steve Forsyth MHLD Director of Nursing.	
4.	Who is Involved in undertaking this EqIA? Include the names of all the people in your sub-group.	Name	Title/Role
		Gareth Owen	Clinical Nurse Specialist Violence & Aggression Management
5.	Is the Policy related to, or influenced by, other Policies/areas of work?	Yes	
6.	Who are the key Stakeholders i.e who will be affected by your document or proposals?	Patients Staff Police	
7.	What might help/hinder the success of whatever you are doing, for example communication, training etc?	Training, Fiscal Resources, National Guidelines, Staff Attitudes	

## Form 2: Considering the potential impact of your document, proposals etc in relation to equality and human rights

Characteristic or other factor to be considered	Potential Impact by Group. Is it:-		Please detail here, <u>for each characteristic listed on the left</u> :- (1) any Reports, Statistics, Websites, links etc. that are relevant to your document/proposal and have been used to inform your assessment; and/or (2) any information gained during engagement with service users or staff; and/or (3) any other information that has informed your assessment of Potential Impact.
	Positive (+) Negative (-) Neutral (N) No Impact/Not applicable (N/a)	Scale (see Table A on next page)	
Age	(N)	Neutral (N)	NICE Guidelines NG10, WP8: Equality, Diversity & Human Rights Policy, Mental Health Act 1983 Code of Practice for Wales (Revised 2016), Framework for Restrictive Physical Intervention Policy & Practice - WAG 2005, Healthcare Commission National Audit of Violence 2006-7 Final Report - Older people's services, Patient Safety Notice PSN 023, Positive and proactive Care: reducing the need for restrictive interventions - DoH 2014
Disability	(N)	Neutral (N)	NICE Guidelines NG10, WP8: Equality, Diversity & Human Rights Policy, Mental Health Act 1983 Code of Practice for Wales (Revised 2016), Framework for Restrictive Physical Intervention Policy & Practice - WAG 2005, Patient Safety Notice PSN 023, Positive and proactive Care: reducing the need for restrictive interventions - DoH 2014
Gender Reassignment	(N)	Neutral (N)	NICE Guidelines NG10, WP8: Equality, Diversity & Human Rights Policy, Mental Health Act 1983 Code of Practice for Wales (Revised 2016), Framework for Restrictive Physical Intervention Policy & Practice - WAG 2005, Patient Safety Notice PSN 023, Positive and proactive Care: reducing the need for restrictive interventions - DoH 2014
Pregnancy & Maternity	(N)	Neutral (N)	NICE Guidelines NG10, WP8: Equality, Diversity & Human Rights Policy, Mental Health Act 1983 Code of Practice for Wales (Revised 2016), Framework for Restrictive Physical Intervention Policy & Practice - WAG 2005, Patient Safety Notice PSN 023, Positive and proactive Care: reducing the need for restrictive interventions - DoH 2014
Race / Ethnicity	(N)	Neutral (N)	NICE Guidelines NG10, WP8: Equality, Diversity & Human Rights Policy, Mental Health Act 1983 Code of Practice for Wales (Revised 2016), Framework for Restrictive Physical Intervention Policy & Practice - WAG 2005, Patient Safety Notice PSN 023, Positive and proactive Care: reducing the need for restrictive interventions - DoH 2014, Independent Inquiry into the death of David Bennett 2003

Religion or Belief	(N)	Neutral (N)	NICE Guidelines NG10, WP8: Equality, Diversity & Human Rights Policy, Mental Health Act 1983 Code of Practice for Wales (Revised 2016), Framework for Restrictive Physical Intervention Policy & Practice - WAG 2005, Patient Safety Notice PSN 023, Positive and proactive Care: reducing the need for restrictive interventions - DoH 2014
Sex	(N)	Neutral (N)	NICE Guidelines NG10, WP8: Equality, Diversity & Human Rights Policy, Mental Health Act 1983 Code of Practice for Wales (Revised 2016), Framework for Restrictive Physical Intervention Policy & Practice - WAG 2005, Patient Safety Notice PSN 023, Positive and proactive Care: reducing the need for restrictive interventions - DoH 2014
Sexual Orientation	(N)	Neutral (N)	Stonewall website, NICE Guidelines NG10, WP8: Equality, Diversity & Human Rights Policy, Mental Health Act 1983 Code of Practice for Wales (Revised 2016), Framework for Restrictive Physical Intervention Policy & Practice - WAG 2005, Patient Safety Notice PSN 023, Positive and proactive Care: reducing the need for restrictive interventions - DoH 2014
Welsh Language	(N)	Neutral (N)	WP8: Equality, Diversity & Human Rights Policy
Human Rights	(N)	Neutral (N)	The Human Rights Act 1998, NICE Guidelines NG10, WP8: Equality, Diversity & Human Rights Policy, Mental Health Act 1983 Code of Practice for Wales (Revised 2016), Framework for Restrictive Physical Intervention Policy & Practice - WAG 2005, Patient Safety Notice PSN 023, Positive and proactive Care: reducing the need for restrictive interventions - DoH 2014

Guidance on completing Form 2: For each of the characteristics listed, and considering the aims and objectives you detailed in Q2 on Form 1, you need to consider whether your document or proposal likely to affect people differently, and if so, will this be in a positive or negative way? For example, you need to decide:

- will it affect men and women differently?
- will it affect disabled and non-disabled people differently?
- will it affect people in different age groups differently? - and so on covering all the protected characteristics.

Use the table below to indicate the scale of any impact identified. The factors used to determine an overall assessment for each characteristic should include consideration of scale and proportionality as well as potential impact.

**Table A**

High negative	Note: It is important to understand that we will be required to demonstrate what we have considered and/or done in order to mitigate or eliminate any negative impact on protected groups identified within the assessment. Details should be recorded in sections 3a/3b in the Action Plan in Form 4.
Medium negative	
Low negative	
Neutral	
Low positive	
Medium positive	
High positive	
No impact/Not applicable	

### Form 3: Assessing Impact Against the General Equality Duty

As a public sector organisation, we are bound by the three elements of the “General Duty”. This means that we need to consider whether (if relevant) the policy or proposal will affect our ability to:-

- Eliminate unlawful discrimination, harassment and victimisation;
- Advance equality of opportunity; and
- Foster good relations between different groups

1. Describe here (if relevant) how you are ensuring your policy or proposal does not unlawfully discriminate, harass or victimise

By ensuring that the policy recognises and gives due regard to the impact which physically restraining and restricting autonomy can have on both minority groups and general populations. The policy ensures that a fair and consistent approach is taken in all situations where physical restraint is used. The policy is written within the framework of wider legislation, for example, The Human Rights Act, NICE Guidelines NG10.



2. Describe here how your policy or proposal could better advance equality of opportunity (if relevant)	N/A
3. Describe here how your policy or proposal might be used to foster good relations between different groups (if relevant)	N/A

# Part B:

## Form 4 (i): Outcome Report

Organisation:	BETSI CADWALADR UNIVERSITY HEALTH BOARD
---------------	---

1. What is being assessed?	A health board wide policy pertaining to the physical restraint of patients
----------------------------	---

2. Brief Aims and Objectives:	Ensuring the safety, dignity and wellbeing of patients and staff during incidents where the use of physical restraint is being utilised/considered and to minimise its use in clinical settings.
-------------------------------	--

3a. Could the impact of your decision/policy be discriminatory under equality legislation?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
3b. Could any of the protected groups be negatively affected?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
3c. Is your decision or policy of high significance – consider the scale and potential impact across BCUHB including costs/savings, the numbers of people affected and any other factors?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>

4. Did the assessment of potential impact on Form 2, coupled with your answers to the 3 questions above indicate that you need to proceed to a Full Impact Assessment?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>	
	Record Reasons for Decision i.e. what did the assessment of scale on Form 2 indicate in terms of positive and negative impact for each characteristic? Assessment indicated that the policy showed due regard to both minority groups and wider populations and had a neutral impact in all the characteristics column. A full impact assessment is therefore not necessary.		
5. If you answered 'no'	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>	Not applicable <input type="checkbox"/>

above, are there any issues to be addressed e.g. mitigating any identified minor negative impact?	Record Details:	
---	-----------------	--

6. Are monitoring arrangements in place so that you can measure what actually happens after you implement your document or proposal?	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
	How is it being monitored?	Staff's ability to restrain safely will be evaluated annually during their RPI training updates. Systems are in place to ensure reporting of restraint incidents and to scrutinise such practices - these are documented within the policy.
	Who is responsible?	
	What information is being used?	E.g. will you be using existing reports/data or do you need to gather your own information? Existing reporting systems will be used
	When will the EqlA be reviewed? (Usually the same date the policy is reviewed)	EqlA will be reviewed alongside policy review (to be set once policy is ratified)

7. Where will your decision or policy be forwarded for approval?	
--	--

8. Describe here what engagement you have undertaken with stakeholders including staff and service users to help inform the assessment	Engagement has taken place with a broad spectrum of clinical areas to ensure effective assessment i.e. all relevant divisions.
--	--

	Name	Title/Role
--	------	------------

9. Name/role of person responsible for this Impact Assessment	Gareth Owen	Clinical Nurse Specialist in the Management of Violence
10. Name/role of person <u>approving</u> this Impact Assessment		
<b>Please Note: The Action Plan below forms an integral part of this Outcome Report</b>		

#### Form 4 (ii): Action Plan

This template details any actions that are planned following the completion of EqlA including those aimed at reducing or eliminating the effects of potential or actual negative impact identified.

	Proposed Actions	Who is responsible for this action?	When will this be done by?
1. If the assessment indicates significant potential negative impact such that you cannot proceed, please give reasons and any alternative action(s) agreed:	N/A		
2. What changes are you proposing to make (or have already made) to your document or proposal as a result of the EqlA?	N/A		
3a. Where negative impact(s) on certain groups have been identified, what actions are you taking or are proposed to mitigate these impacts? Are these already in place?	N/A		
3b. Where negative impact(s) on certain groups have been identified, and you are proceeding without mitigating them, describe here why you believe this is justified.	N/A		

	Proposed Actions	Who is responsible for this action?	When will this be done by?
4. Provide details of any actions taken or planned to advance equality of opportunity as a result of this assessment.	N/A		

**NOTE: If your decision recorded above is that you will need to proceed to a Full Equality Impact Assessment, then you should refer to the Full Impact Assessment Forms (Part C)**

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<b>Quality, Safety &amp; Experience Committee</b>	 <b>GIG Cymru NHS WALES</b> Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board
<b>19.3.19</b>	<b><i>To improve health and provide excellent care</i></b>

<b>Report Title:</b>	Proactive Reduction & Therapeutic Management of Behaviours which Challenge Policy
<b>Report Author:</b>	Mr Gareth Owen, Clinical Nurse Specialist/Violence & Aggression Clinical Lead
<b>Responsible Director:</b>	Mr Andy Roach, Director of Mental Health & Learning Disabilities (MHLDD)
<b>Public or In Committee</b>	Public
<b>Purpose of Report:</b>	To seek approval to the attached new policy.
<b>Approval / Scrutiny Route Prior to Presentation:</b>	Policy has been scrutinised by MHLDD Policy Implementation Group, Programme Advisory Group (PAG) and Quality Safety Group (QSG). Policy has been out for corporate wide consultation.
<b>Governance issues / risks:</b>	The policy will ensure that BCUHB complies with relevant legislation and national guidance in this area e.g. NICE Guidelines, MHA 1983 Code of Practice for Wales, H&S. The document has been subject to an Equality Impact Assessment and reveals a neutral impact on protected characteristics.
<b>Financial Implications:</b>	This policy provides guidance on the latest evidence passed practice to proactively manage aggression and violence – this guidance is already made available to staff through mandatory training programmes (the All Wales Passport & Information Scheme which BCUHB subscribes to). Implementation of the policy will require no additional resources as there are existing structures in place to ensure this. The policy is likely to result in fewer incidents of violence and demonstrates compliance with legal and ethical frameworks. Over the long-term, this may result in financial savings and a safer workforce.
<b>Recommendation:</b>	The Committee is asked to approve the Policy for implementation within the Health Board.

<b>Health Board's Well-being Objectives</b> <i>(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)</i>	√	<b>WFGA Sustainable Development Principle</b> <i>(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.)</i>	√
---	---	---	---

1.To improve physical, emotional and mental health and well-being for all	X	1.Balancing short term need with long term planning for the future	
2.To target our resources to those with the greatest needs and reduce inequalities		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	X	5.Considering impact on all well-being goals together and on other bodies	
6.To respect people and their dignity	X		
7.To listen to people and learn from their experiences	X		
<b>Special Measures Improvement Framework Theme/Expectation addressed by this paper</b>			
Mental Health Leadership & Governance			
<b>Equality Impact Assessment</b>			
Attached			

*Disclosure:*

*Betsi Cadwaladr University Health Board is the operational name of Betsi Cadwaladr University Local Health Board*





## Proactive Reduction & Therapeutic Management of Behaviours which Challenge

<b>Date to be reviewed:</b>		<b>No of pages:</b>	16
<b>Author(s) title:</b>	Gareth Owen, V&A Clinical Lead MH		
<b>Responsible dept / director:</b>	Steve Forsyth, Director of Nursing Mental Health & Learning Disabilities.		
<b>Approved by:</b>			
<b>Date approved:</b>			
<b>Date activated (live):</b>			
<b>Documents to be read alongside this document:</b> <b>Policies &amp; Procedures</b> BCUHB – HS02 Procedure and Guidance for Protecting Employees From Violence & Aggression  BCUHB – SHC016 Physical Restraint Guidelines  <b>Guidance / Relevant Legislation</b> NICE Guidelines NG10 & NG11. All Wales Violence & Aggression Training Passport and Information Scheme, Mental Health Act 1983 – Code of Practice for Wales (Revised 2016), Human Rights Act 1998			
<b>NEW</b>	<b>Purpose of Issue/Description of current changes:</b> New policy for Betsi Cadwaladr University Local Health Board. It addresses a requirement to take all reasonable precautions to minimise incidence of behaviours which challenge services in line with statutory and mandatory directives.		
<b>First operational:</b>			
<b>Previously reviewed:</b>			
<b>Changes made yes/no:</b>			

### PROPRIETARY INFORMATION

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## 1. Statement of Intent

The Betsi Cadwaladr University Health Board (BCUHB) is committed in its duty to provide a safe and secure environment for patients, staff, and visitors and offers its full support to the Welsh Assembly Government, All Wales NHS Violence and Aggression Training Passport and Information Scheme and will endeavour to protect staff and those visiting Health Board premises.

The implementation of safeguards to protect individuals from behaviours which challenge services will not prioritise the needs of one group of individuals over another thereby ensuring that no-one will be disadvantaged by reason of any **protected characteristic**:

- Disability
- Gender or gender reassignment
- Marital status
- Sexual orientation
- Religion or belief (or non-belief)
- Race (including ethnicity and nationality)
- Age
- Pregnancy and maternity

## 2. Introduction and Purpose

The purpose of this guide is to help employees and carers to implement proactive approaches and strategies to reduce and manage behaviours which challenge. **The aim is to prevent these behaviours from occurring or escalating using proactive approaches – this document focuses on primary and secondary preventative interventions which rely on effective communication and interpersonal skills. The document does not address crisis management interventions such as physical restraint, chemical restraint or seclusion.**

This guidance uses as a framework:

NICE Clinical Guideline NG10: 'Violence and aggression: short-term management in mental health, health and community settings' (2015).

NICE Clinical Guideline NG11: 'Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges' (2015).

Mental Health Act 1983 Code of Practice for Wales (Revised 2016).

### **3. Scope**

This document applies to all health board employees, patients, visitors and carers and aims to provide guidance within a legal and ethical framework underpinned by best practice principles for employees.

### **4. Legal Duties**

Applicable Legislation:

#### **Management of Health & Safety at Work Regulations (MHSWR) 1999**

The Regulations were introduced to reinforce the Health and Safety at Work etc Act 1974. The MHSWR places duties on employers and employees including those who are clients, designers, principal contractors or other contractors

The Health Board's legal duties:

- Assess all risks to the health and safety of their employees
- Identify the precautions needed
- Make arrangements for the effective management of precautions
- Provide information and training to employees

Employee's legal duties:

- Report any shortcomings in health & safety arrangements
- Report dangerous situations
- Use equipment in accordance with training and instruction
- Take reasonable care of their own health & safety and those of others who may be affected by their acts or omissions

## **Human Rights Act 1998**

The Human Rights Act 1998 came into force during 2000 and sets out some key principles of fairness, equality, dignity, the right to liberty and security of a person without deprivation of liberty.

## **5. Responsibilities**

All staff within the Health Board have an individual responsibility to ensure that the Health Board policies and standards, including Health Care Standards are adhered to and that health and safety arrangements set out in this guidance are appropriately followed

The Health Board recognises and accepts its responsibility as an employer for providing a safe and healthy workplace and working environment for its employees, and a safe environment for persons, visitors and other members of the public. It will discharge these responsibilities through its managers and will expect its staff to comply with procedures and to act at all times in a responsible manner.

## **6. Definitions & Glossary of Terms**

The term 'behaviours which challenge' replaces a variety of terms which once suggested that the problem was located within a person (e.g. problem behaviour) and instead refers to a range of behaviours which are a challenge to services or others such as carers.

This document will adopt the following definition of behaviours which challenge:

*'Behaviour can be described as challenging when it is of such an intensity, frequency, or duration as to threaten the quality of life and/or the physical safety of the individual or others and it is likely to lead to responses that are restrictive, aversive or result in exclusion'* (Royal College of Psychiatrists, British Psychological Society, Royal College of Speech and Language Therapists, 2007).

Whilst behaviours which challenge generally have a negative impact, they may serve a purpose for the person exhibiting such behaviours, for example, by producing sensory stimulation, attracting attention, avoiding demands and communicating with other people – it is important, therefore, to try and understand the purpose of such behaviours and offer appropriate and safe alternatives.

Behaviours which challenge are most often seen in people with health problems that affect the brain and communication, such as learning disabilities, autism, dementia, psychosis, strokes and acquired brain injuries although some of these behaviours may be a result of fear, anxiety, frustration, pain and poor physical environments and can manifest themselves in anyone.

Behaviours which challenge may include (but are not limited to):

- Aggression
- Self-harm
- Destructiveness
- Disruptiveness
- Violence
- Withdrawal
- Sexual disinhibition

## **7. General Principles**

One of the key tenets of delivering effective care is to maintain the values of putting patients first and ensuring that the care delivered is patient centred. The following principles should be upheld at all times and represent the important characteristics of proactively reducing behaviours which challenge:

- Understanding people's behaviour allows their unique needs, aspirations experiences and strengths to be recognised and their quality of life to be enhanced.
- People must be treated with compassion, dignity and kindness.
- People must have opportunity to express personal choice in their day to day lives.
- Staff must actively employ approaches which promote appropriate behaviours.
- People who exhibit behaviours that challenge must have a meaningful positive person-centred behavioural support plan in place (appendix 1), which is mutually agreed and regularly reviewed by the multi-disciplinary team.

- Involvement and participation of people with care and support needs, their families, carers and advocates is essential, wherever practicable and subject to the person's wishes and confidentiality obligations
- Services must offer a range of valued residential, occupational, social and leisure opportunities for each service user.
- Patients' with specific disabilities (e.g. sensory, communication, mobility) must receive appropriate therapies to help maximise their potential in these areas.
- Patients' must be afforded personal space which is always respected.
- Prescribed interventions must always promote the best interests and well being of the service user.

## **8. Triggers for Behaviours Which Challenge**

A key principle of proactively reducing behaviours which challenge is to identify the triggers for this behaviour and to remove them where possible. Triggers can be described as events which occur before the behaviour and result in the activation of the behaviour.

These triggers can be immediate and cause quick activation of the behaviour (Fast Triggers), for example, being refused something, or they can build up over time and be wider reaching, for example, a lengthy wait for treatment whilst in pain in a noisy environment (Slow Triggers).

These triggers can be broadly divided into four distinct categories although it is important to emphasise that the list is not exhaustive:

### **8.1 Physical causes**

- Drug abuse
- Alcohol abuse
- Adverse reaction to treatment
- Pain – actual
- Sleep deprivation
- Hunger
- Hormonal

### **8.2 Psychological causes**

- Fear
- Frustration or 'goal blocking'

- Pain – perceived
- Humiliation
- Lack of autonomy
- Confusion/misunderstanding
- Language barriers

### **8.3 Sociological causes**

- Learnt behaviour
- Negative regard e.g. racism, sexism
- Negative role models
- Emotional or financial gain
- Strict, inflexible routines

### **8.4 Environmental causes**

- Oppressive environment/poor fabrication
- Heat/cold
- Excessive noise levels
- Poor lighting/lack of natural light
- Physical barriers/restrictions e.g. locked doors
- Lack of privacy

To help identify triggers and to determine an appropriate and proportionate prevention and therapeutic management plan, staff should consider using an actuarial prediction instrument rather than unstructured clinical judgement alone to monitor and reduce incidents of violence and to help develop a risk management plan, for example the **Dynamic Appraisal of Situational Aggression (DASA)** (Appendix 2).

Having identified the trigger(s) which may cause or have previously led to behaviours which challenge, staff should aim to remove these. Often, this can be achieved without much difficulty, for example, if someone is hungry, try offering food or if someone is frightened, give reassurance. Occasionally though, it is not possible to remove the trigger due to circumstances beyond staff's control, in which case different interventions are required.

## **9. Reducing Behaviours which challenge**

Where it is not possible to identify or remove triggers, staff need to utilise a wide range of skills and approaches in order to safely manage situations.

### **9.1 De-escalation**

De-escalation can be defined as:



*The existence of a set of verbal and non-verbal skills which if used selectively and appropriately may reduce the level of an aggressor's hostility and the associated risks of assault by calming anger and lowering arousal.*

The following techniques are proven and positive interventions in resolving challenging situations:

- Ensure that body language does not convey hostile intentions. Adopt a non-threatening side-on stance, employ fluid gestures and use only intermittent eye contact to avoid staring.
- Recognise and respect the need for personal space - maintain and allow the person sufficient space to avoid a sense of being penned in.
- Employ the principles of two-way communication – as well as talking, actively listen to what the individual is trying to communicate.
- Use the components of speech to emphasise what is being said – pay attention to pitch, tone, volume and pace as this can change the meaning of what is being spoken, for example:

I didn't say... (It wasn't me)

I didn't say... (I didn't do it)

I didn't say... (I did something else)

- Use open-ended questions to encourage dialogue (e.g. “why do you feel angry”?) and use closed questions to clarify issues (e.g. “are you saying that you want to go for a walk”?).
- Empathise with the individual – show concern and attentiveness through appropriate verbal and non-verbal responses which are fitting to the situation. Listening and validating the experience of the individual is an important aspect of co-produced healthcare.
- Avoid negative responses such as refusals whenever possible – negotiate and offer alternatives and solutions where available. When negative responses are unavoidable consider apologising for the situation.
- Encourage individuals who exhibit behaviours which challenge to explore and recognise their own triggers for behaviours which challenge - encourage them to identify early warning signs and include this information in care plans/ person centred behavioural support plans.

- Encourage individuals who exhibit behaviours which challenge to discuss and negotiate their wishes with regards to how this behaviour should be managed beforehand. These wishes must be presented in the form of advanced statements and entered into the person's care plan. Staff must be made aware of these wishes and aim to comply with them whenever possible.
- In order to avoid arguments, staff should endeavour to listen to the perspectives of the patient attentively so that their views are respected - try distraction or provide friendly help.
- Avoid putting the person in situations which may produce anxiety, fear, frustration or disorientation - prepare the person by explaining what is going to happen, what is expected of them or where they are going.
- Use encouragement, praise & affection, rather than criticism, anger or frustration.

## **9.2 Environmental Considerations**

Another key principle of proactively reducing the causes of behaviours which challenge is to consider the impact which the environment can have. Whilst it may not be possible to change the structure of an environment, staff can significantly and positively alter the effect an environment has upon such behaviours. The following are practical considerations which may prove useful.

- Fabrication of the environment – report any damage to furniture, structures and equipment etc.
- Ensure the environment is conducive to the individuals needs – ensure adequate ventilation by opening/closing windows, ensure that the temperature is comfortable and make sure that rooms have sufficient lighting for daily activities or darkness for sleeping etc. It is also important to enable individuals to regulate their own environment where possible by, for example, providing blankets and night lights etc.
- Consider the impact which noise levels can have on people – some people may prefer peace and quiet whilst others a more stimulating atmosphere - It may be appropriate to provide quiet areas or encourage the use of headphones etc. Also, be mindful that sleep is an important physiological need often requiring a quiet environment for many.
- Ensure that individuals are afforded as much privacy as is possible and remember that the need for additional privacy may be needed in certain circumstances, for example, during visits.

- Consider the impact which environmental constraints may have upon an individual's ability to access daily necessities and offer solutions or assistance wherever possible.
- Anticipate the potential for items to be used as weapons and remove if appropriate.

## **10. Recording & Reporting**

For full details of how, when and where staff should record and report incidents of challenging behaviour, please refer to:

[HS02 Procedure and Guidance for Protecting Employees from Violence & Aggression](#)

## **11. Post Incident Debrief & Review**

Challenging behaviours of any description can be a traumatic experience for all concerned even the persons exhibiting such behaviours. It is therefore important that there is a process of review as soon as possible after the event so that lessons can be learnt and appropriate support needs identified. This section will concern itself with this process which will include the perspective of the patient - further information relating to staff support can be found in policy HS02.

All units must have systems in place which enable and encourage both an informal and formal process of debrief and review. On an informal level, this means providing immediate post-incident support to all involved in an incident – this must include identifying physical and psychological injuries, a review of the risk, reviewing safe staffing levels, and ensuring that everyone is clear of their roles and duties.

In addition to this, a formal debrief and incident process should follow as soon as possible and no later than 72 hours. This should:

- Be held within a climate of honesty which is open and free from blame.
- Includes the person exhibiting the challenging behaviour, staff, witnesses, a person who is independent of the incident, and relatives and patient advocates if appropriate.
- Evaluate the longer term physical and emotional impact on everyone involved, including witnesses.
- Help staff and patients identify and understand what led to the incident and what could have been done differently.

- Determine whether there were any barriers or constraints which may have prevented the incident from occurring or whether a viable resolution of the incident may have been possible with a different strategy.
- Identify what changes can be made to avoid a reoccurrence of the incident, which should include recommendations of changes to the service, practice, policies or the environment.
- Aim to proactively learn from the incident and prevent future reoccurrences.

## 12. Training

The importance of training cannot be over-emphasised. As well as satisfying legal obligations, training ensures that employees are equipped with the skills necessary to fulfil their duties in a confident and safe manner within a legal and ethical framework.

BCUHB is committed to providing its employees with an ongoing training programme within this field and is a participant of the '**All Wales NHS Violence and Aggression Training Passport and Information Scheme**' which ensures that staff receive training in awareness of violence and aggression, theory of personal safety and de-escalation and breakaway techniques. Staff should complete the necessary training module(s) as directed in the 'My Compliance & Competency' section of their ESR portal.

## Appendix 1

### Person Centred Behavioural Support Plan

PATIENT I.D.  
LABEL

Ward:

Named Nurse:

Date:

These are the early signs that behaviour is escalating:

These are the behaviours that other people may find challenging or risky:

**Slow triggers for behaviours** *(These are the events that build up slowly and may affect behaviour over time):*

**Fast triggers for behaviours** *(These are the events that may immediately*

What may be the reasons for the behaviours?

**Primary Prevention: *What can reduce the risk of challenging behaviour.  
(Prevent triggers from occurring)***

**Secondary Prevention: *What can be done to reduce the impact of  
triggers.***

**Crisis Management: *How to Provide Support in a Crisis.***

Staff Signature:

Date Reviewed:

Patient Signature:

Date Reviewed:

Carer Signature:

Date Reviewed:

Please tick if care-plan was completed on behalf of patient. ☐

## Appendix 2

### **Dynamic Appraisal of Situational Aggression (DASA)**

#### **Instructions for Use**

The Dynamic Appraisal of Situational Aggression (DASA) allows for the risk of aggression to be assessed on a day-to-day basis. It is a simple, efficient tool which should be filled out by the patients' key-worker (e.g. named nurse) and should take about five minutes to complete. The results will give an indication of the likelihood of aggression being exhibited by the patient along with suggested actions to mitigate the risk.

#### **Step 1**

The DASA chart should be filled out at the same time each day so that a consistent 24 hour period is assessed. The person completing the assessment will be required to gauge seven behaviours over the past 24 hours and provide a score against each. If the behaviour is present then a score of **1** is given and if the behaviour is absent then a score of **0** is given. For example, when scoring the patients' level of irritability – if they are calm and relaxed whilst alone or in the company of others, a '**0**' should be recorded. If however, they are easily annoyed or angered and unable to tolerate the presence of others, a '**1**' should be recorded.

**N.B. Where a well known patient habitually exhibits behaviours such as irritability but has not become aggressive, a score of '0' should be recorded.**

#### **Step 2**

Having completed the chart, the key-worker should total the score and record this. The total score will indicate the level of risk (low, moderate or high) and the appropriate action should be taken as indicated in the '**Actions Required**' section.

### DASA Simplified Scoring Guide

Name: _____ Ward: _____		Score						
Item	Basic Description of Patient *Relating only to past 24 hours*	Mon	Tue	Wed	Thu	Fri	Sat	Sun
<b>Irritability</b>	<b>0</b> = Has been calm and relaxed. They are comfortable and relaxed in the company of other patients and staff.							
	<b>1</b> = Is considered easily annoyed or angered and unable to tolerate the presence of others.							
<b>Impulsivity</b>	<b>0</b> = Has been affectively and behaviourally stable.							
	<b>1</b> = Has been sudden, impulsive and unpredictable in their affect or behaviour.							
<b>Unwillingness to follow directions</b>	<b>0</b> = Is generally compliant with any requests and directions.							
	<b>1</b> = Becomes angry and/or aggressive when they were asked to adhere to some aspect of their treatment or to the ward's routine.							
<b>Sensitivity to perceived provocation</b>	<b>0</b> = Does not tend to get angry or see everything around them as provocative. Not being overly sensitive or provocative.							
	<b>1</b> = Has tended to see others' reactions as deliberate and harmful. May misinterpret others' behaviour or respond with anger in a disproportionate manner to the extent of provocation. Over sensitive and quick to anger.							
<b>Easily angered when requests are denied</b>	<b>0</b> = Is calm and accepting when they are asked to wait whilst their request is attended to. Understands and accepts if their request is unable to be fulfilled at that time.							
	<b>1</b> = Has tended to become angry when their requests have not been granted immediately. Does not accept the delay in gratification of their request.							
<b>Negative attitudes</b>	<b>0</b> = No negative attitudes apart from occasional pessimism.							
	<b>1</b> = Definite/serious negative attitudes exhibited.							
<b>Verbal Threats</b>	<b>0</b> = Has not been verbally aggressive.							
	<b>1</b> = Verbally aggressive or has displayed a verbal outburst (more than just a raised voice) where there is a definite attempt to intimidate or threaten another person. The person may shout angrily, insult others or curse.							
<b>Total Score:</b>								

**0-1 = Low Risk      2-3 = Moderate Risk      4-7 = High Risk**



## Actions Required Based on DASA Scores

Score	Level of Risk	Actions Required
0-1	Low	Continue with the person centred behavioural support plan's <b>primary prevention</b> strategies
2-3	Moderate	<p>The patient should be monitored for additional indicators of risk</p> <p>Implement the person centred behavioural support plan's <b>secondary prevention</b> strategies</p>
4-7	High	<p>The patient should be monitored for additional indicators of risk</p> <p>Implement the person centred behavioural support plan's <b>secondary prevention</b> strategies</p> <p>Consider the person centred behavioural support plan's <b>crisis management</b> strategies</p> <p>Consider undertaking a clinical team review</p>

Persistent moderate/high scores may indicate a need for the clinical team to review care and treatment programmes (care plans, medication, involvement of other agencies, supervision/observation levels, risk management strategies etc).

Wards with high number of patients scoring high risk:

- Are there any known dynamic tensions (conflict) between individual patients? If so, tensions should be discussed and attempts at remediation considered.
- Consider enhancing environmental security e.g. Give warm drinks rather than hot until the risk is reduced, remove items which may be dangerous etc.
- Consider the skill /gender mix of the staff on duty.
- Identify an appropriate response plan.

**This table should be completed and added at the end of the document:**

**Members of the Working Group:**

<b>Name</b>	<b>Title</b>
Gareth Owen	V&A Clinical Lead, MH
Jane Williams	Day Services Manager LD
Ian Jones	Practice Development Nurse

<b>Engagement has taken place with:</b>	





GIG  
CYMRU  
NHS  
WALES

Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board

## EQUALITY IMPACT ASSESSMENT FORMS

### PARTS A and B: SCREENING AND OUTCOME REPORT

#### Introduction:

These forms have been designed to enable you to record, and provide evidence of how you have considered the needs of all people (including service users, their carers and our staff) who may be affected by what you are writing or proposing, whether this is:

- a policy, protocol, guideline or other written control document;
- a strategy or other planning document e.g. your annual operating plan;
- any change to the way we deliver services e.g. a service review;
- a decision that is related to any of the above e.g. commissioning a new service or decommissioning an existing service.

**This is not optional:** Equality Impact Assessment is a specific legal requirement on public sector organisations under equalities legislation and failure to comply could result in a legal challenge to a decision or strategy. More importantly, equality impact assessment helps to inform better decision-making and policy development leading to improved services for patients. **This form should not be completed by an individual alone, but should form part of a working group approach.**

#### The Forms:

You must complete:

- **Part A** – this is the Initial Screening that is always undertaken and consists of Forms 1 to 3; these forms are designed to enable you to make an initial assessment of the potential impact of what you are doing, and decide whether or not you will need to proceed to a Full Impact Assessment (Part C);

AND

- **Part B** – this is the Outcome Report and Action Plan (Form 4) you will need to complete whether or not you proceed to a Full Impact Assessment;

Together, these forms will help to provide evidence of your Impact Assessment and how you have shown “due regard” to the duties.

You may also need to complete Part C (see separate Form) – if parts A and B indicate you need to undertake a Full Impact Assessment. This enables you to fully consider all the evidence that is available (including engagement with the people affected by your document or proposals) to tell you whether your document or proposal will affect people differently. It also gives you the opportunity to consider what changes you may need to make to eliminate or mitigate any adverse or negative impact you have identified.

Remember that these forms may be subject to external scrutiny e.g. under a Freedom of Information request.

To enter text, click on the grey box in the part of the form you are completing. Help text will appear in the status bar at the foot of the page. Some boxes have drop-down lists from which you can select options. Others may simply be a box to answer a question. Once completed, the EqlA Forms should accompany your document or proposal when it is submitted to the appropriate body for approval.



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# Part A

## Form 1: Preparation

1.	What are you equality impact assessing? What is the title of the document you are writing or the service review you are undertaking?	Proactive Reduction & Therapeutic Management of Behaviours which Challenge	
2.	Provide a brief description, including the aims and objectives of what you are assessing.	Ensuring the safety, dignity and wellbeing of patients and staff during incidents where behaviours which challenge are being exhibited and to minimise the use of restrictive interventions	
3.	Who is responsible for the document/work you are assessing – i.e. who has the authority to agree/approve any changes you identify are necessary?	Steve Forsyth MHLD Director of Nursing.	
4.	Who is Involved in undertaking this EqIA? Include the names of all the people in your sub-group.	Name	Title/Role
		Gareth Owen	Clinical Lead,Positive Interventions Clinical Support Service
5.	Is the Policy related to, or influenced by, other Policies/areas of work?	Yes	
6.	Who are the key Stakeholders i.e who will be affected by your document or proposals?	Patients Staff Police	
7.	What might help/hinder the success of whatever you are doing, for example communication, training etc?	Training, Fiscal Resources, National Guidleines, Staff Attitudes	

## Form 2: Considering the potential impact of your document, proposals etc in relation to equality and human rights

Characteristic or other factor to be considered	Potential Impact by Group. Is it:-		Please detail here, <u>for each characteristic listed on the left</u> :- (1) any Reports, Statistics, Websites, links etc. that are relevant to your document/proposal and have been used to inform your assessment; and/or (2) any information gained during engagement with service users or staff; and/or (3) any other information that has informed your assessment of Potential Impact.
	Positive (+) Negative (-) Neutral (N) No Impact/Not applicable (N/a)	Scale (see Table A on next page)	
Age	(N)	Neutral (N)	NICE Guidelines NG10, WP8: Equality, Diversity & Human Rights Policy, Mental Health Act 1983 Code of Practice for Wales (Revised 2016), Framework for Restrictive Physical Intervention Policy & Practice - WAG 2005, Healthcare Commission National Audit of Violence 2006-7 Final Report - Older people's services, Patient Safety Notice PSN 023, Positive and proactive Care: reducing the need for restrictive interventions - DoH 2014
Disability	(N)	Neutral (N)	NICE Guidelines NG10, WP8: Equality, Diversity & Human Rights Policy, Mental Health Act 1983 Code of Practice for Wales (Revised 2016), Framework for Restrictive Physical Intervention Policy & Practice - WAG 2005, Patient Safety Notice PSN 023, Positive and proactive Care: reducing the need for restrictive interventions - DoH 2014
Gender Reassignment	(N)	Neutral (N)	NICE Guidelines NG10, WP8: Equality, Diversity & Human Rights Policy, Mental Health Act 1983 Code of Practice for Wales (Revised 2016), Framework for Restrictive Physical Intervention Policy & Practice - WAG 2005, Patient Safety Notice PSN 023, Positive and proactive Care: reducing the need for restrictive interventions - DoH 2014
Pregnancy & Maternity	(N)	Neutral (N)	NICE Guidelines NG10, WP8: Equality, Diversity & Human Rights Policy, Mental Health Act 1983 Code of Practice for Wales (Revised 2016), Framework for Restrictive Physical Intervention Policy & Practice - WAG 2005, Patient Safety Notice PSN 023, Positive and proactive Care: reducing the need for restrictive interventions - DoH 2014
Race / Ethnicity	(N)	Neutral (N)	NICE Guidelines NG10, WP8: Equality, Diversity & Human Rights Policy, Mental Health Act 1983 Code of Practice for Wales (Revised 2016), Framework for Restrictive Physical Intervention Policy & Practice - WAG 2005, Patient Safety Notice PSN 023, Positive and proactive Care: reducing the need for restrictive interventions - DoH 2014, Independent Inquiry into the death of David Bennett 2003

Religion or Belief	(N)	Neutral (N)	NICE Guidelines NG10, WP8: Equality, Diversity & Human Rights Policy, Mental Health Act 1983 Code of Practice for Wales (Revised 2016), Framework for Restrictive Physical Intervention Policy & Practice - WAG 2005, Patient Safety Notice PSN 023, Positive and proactive Care: reducing the need for restrictive interventions - DoH 2014
Sex	(N)	Neutral (N)	NICE Guidelines NG10, WP8: Equality, Diversity & Human Rights Policy, Mental Health Act 1983 Code of Practice for Wales (Revised 2016), Framework for Restrictive Physical Intervention Policy & Practice - WAG 2005, Patient Safety Notice PSN 023, Positive and proactive Care: reducing the need for restrictive interventions - DoH 2014
Sexual Orientation	(N)	Neutral (N)	Stonewall website, NICE Guidelines NG10, WP8: Equality, Diversity & Human Rights Policy, Mental Health Act 1983 Code of Practice for Wales (Revised 2016), Framework for Restrictive Physical Intervention Policy & Practice - WAG 2005, Patient Safety Notice PSN 023, Positive and proactive Care: reducing the need for restrictive interventions - DoH 2014
Welsh Language	(N)	Neutral (N)	WP8: Equality, Diversity & Human Rights Policy
Human Rights	(N)	Neutral (N)	The Human Rights Act 1998, NICE Guidelines NG10, WP8: Equality, Diversity & Human Rights Policy, Mental Health Act 1983 Code of Practice for Wales (Revised 2016), Framework for Restrictive Physical Intervention Policy & Practice - WAG 2005, Patient Safety Notice PSN 023, Positive and proactive Care: reducing the need for restrictive interventions - DoH 2014

Guidance on completing Form 2: For each of the characteristics listed, and considering the aims and objectives you detailed in Q2 on Form 1, you need to consider whether your document or proposal likely to affect people differently, and if so, will this be in a positive or negative way? For example, you need to decide:

- will it affect men and women differently?
- will it affect disabled and non-disabled people differently?
- will it affect people in different age groups differently? - and so on covering all the protected characteristics.

Use the table below to indicate the scale of any impact identified. The factors used to determine an overall assessment for each characteristic should include consideration of scale and proportionality as well as potential impact.

**Table A**

High negative	Note: It is important to understand that we will be required to demonstrate what we have considered and/or done in order to mitigate or eliminate any negative impact on protected groups identified within the assessment. Details should be recorded in sections 3a/3b in the Action Plan in Form 4.
Medium negative	
Low negative	
Neutral	
Low positive	
Medium positive	
High positive	
No impact/Not applicable	

### Form 3: Assessing Impact Against the General Equality Duty

As a public sector organisation, we are bound by the three elements of the “General Duty”. This means that we need to consider whether (if relevant) the policy or proposal will affect our ability to:-

- Eliminate unlawful discrimination, harassment and victimisation;
- Advance equality of opportunity; and
- Foster good relations between different groups

1. Describe here (if relevant) how you are ensuring your policy or proposal does not unlawfully discriminate, harass or victimise	By ensuring that the policy operates within the framework of criminal and civil law and recognises and gives due regard to the impact which it can have on both minority groups and general populations. The policy ensures that a fair and consistent approach is taken in all situations where it is necessary to manage behaviours which challenge. The policy is written within the framework of wider legislation, for example, The Human Rights Act, NICE Guidelines NG10.
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2. Describe here how your policy or proposal could better advance equality of opportunity (if relevant)	N/A
3. Describe here how your policy or proposal might be used to foster good relations between different groups (if relevant)	N/A

# Part B:

## Form 4 (i): Outcome Report

Organisation:	BETSI CADWALADR UNIVERSITY HEALTH BOARD
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1. What is being assessed?	A health board wide policy pertaining to the prevention and management of behaviours which challenge.
----------------------------	---

2. Brief Aims and Objectives:	Ensuring the safety, dignity and wellbeing of patients and staff during incidents where behaviours which challenge are being exhibited and to minimise the use of restrictive interventions
-------------------------------	---

3a. Could the impact of your decision/policy be discriminatory under equality legislation?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
3b. Could any of the protected groups be negatively affected?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
3c. Is your decision or policy of high significance – consider the scale and potential impact across BCUHB including costs/savings, the numbers of people affected and any other factors?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>

4. Did the assessment of potential impact on Form 2, coupled with your answers to the 3 questions above indicate that you need to proceed to a Full Impact Assessment?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>	
	Record Reasons for Decision i.e. what did the assessment of scale on Form 2 indicate in terms of positive and negative impact for each characteristic? Assessment indicated that the policy showed due regard to both miority groups and wider populations and had a neutral impact in all the charecteristics column. A full impact assessment is therefore not neccessary.		
5. If you answered 'no'	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>	Not applicable <input type="checkbox"/>

above, are there any issues to be addressed e.g. mitigating any identified minor negative impact?	Record Details:	
6. Are monitoring arrangements in place so that you can measure what actually happens after you implement your document or proposal?	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
	How is it being monitored?	Monthly and annual statistics are prepared and presented to governance structures to identify trends which indicate an overall reduction of challenging behaviours throughout the organisation.
	Who is responsible?	
	What information is being used?	E.g. will you be using existing reports/data or do you need to gather your own information? Existing reporting systems will be used
	When will the EqIA be reviewed? (Usually the same date the policy is reviewed)	EqIA will be reviewed alongside policy review (to be set once policy is ratified)

7. Where will your decision or policy be forwarded for approval?	
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8. Describe here what engagement you have undertaken with stakeholders including staff and service users to help inform the assessment	Engagement has taken place with a broad spectrum of clinical areas to ensure effective assessment i.e. all relevant divisions.
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	Name	Title/Role
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9. Name/role of person responsible for this Impact Assessment	Gareth Owen	V&A Clinical Lead MH
10. Name/role of person <u>approving</u> this Impact Assessment		
<b>Please Note: The Action Plan below forms an integral part of this Outcome Report</b>		

#### Form 4 (ii): Action Plan

This template details any actions that are planned following the completion of EqlA including those aimed at reducing or eliminating the effects of potential or actual negative impact identified.

	Proposed Actions	Who is responsible for this action?	When will this be done by?
1. If the assessment indicates significant potential negative impact such that you cannot proceed, please give reasons and any alternative action(s) agreed:	N/A		
2. What changes are you proposing to make (or have already made) to your document or proposal as a result of the EqlA?	N/A		
3a. Where negative impact(s) on certain groups have been identified, what actions are you taking or are proposed to mitigate these impacts? Are these already in place?	N/A		
3b. Where negative impact(s) on certain groups have been identified, and you are proceeding without mitigating them, describe here why you believe this is justified.	N/A		

	Proposed Actions	Who is responsible for this action?	When will this be done by?
4. Provide details of any actions taken or planned to advance equality of opportunity as a result of this assessment.	N/A		

**NOTE: If your decision recorded above is that you will need to proceed to a Full Equality Impact Assessment, then you should refer to the Full Impact Assessment Forms (Part C)**

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<b>Report Title:</b>	HASCAS independent investigation and Ockenden governance review: progress report
<b>Report Author:</b>	Mrs Deborah Carter, Associate Director Quality Assurance
<b>Responsible Director:</b>	Mrs Gill Harris, Executive Director of Nursing & Midwifery
<b>Public or In Committee</b>	Public
<b>Purpose of Report:</b>	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
<b>Approval / Scrutiny Route Prior to Presentation:</b>	HASCAS & Ockenden Improvement Group
<b>Governance issues / risks:</b>	Additional resources required have been identified for a number of recommendations to progress the work identified to deliver improvements and address the recommendations.
<b>Financial Implications:</b>	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.
<b>Recommendation:</b>	To note the progress of the recommendations

<b>Health Board's Well-being Objectives</b> <i>(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)</i>	✓	<b>WFGA Sustainable Development Principle</b> <i>(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.)</i>	✓
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	√		
<b>Special Measures Improvement Framework Theme/Expectation addressed by this paper</b>			
Governance & Leadership			
Mental Health			
<b>Equality Impact Assessment</b>			
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 Quality, Safety & Experience Committee meeting

Recommendation	Current position	Progress update	Risks
<p><b>HASCAS 1: Integrated Care Pathways</b> Operational Lead: Reena Cartmell Associate Director of Nursing</p> <p><i>‘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’.</i></p> <p><b>Ockenden 1: Integrated Service Model for Older People and those with Dementia</b> Operational Lead: Reena Cartmell Associate Director of Nursing</p> <p><i>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).</i></p> <p><i>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.</i></p>	On track to deliver	<p><i>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.</i></p> <ul style="list-style-type: none"> <li>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.</li> <li>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.</li> </ul> <p>Progress is reported below on the following actions which aim to integrate the clinical pathway between physical health and OPMH;</p> <ul style="list-style-type: none"> <li>A <b>draft pathway</b> has been developed by BCUHB – ‘<i>Meeting the Physical Health Needs of People Admitted to an Older Person Mental Health Ward</i>’ (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 (Advanced Nurse Practitioner) and the development of an integrated pathway for rapid response.</li> <li>An <b>improvement programme of work</b> 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</li> <li>A <b>scoping exercise</b> 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</li> <li><b>Stakeholder Engagement</b> 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.</li> </ul>	<p>Timescale to achieve review of a broad range of services</p> <ul style="list-style-type: none"> <li>Joint and clear action plan including milestones and timelines to be developed. Progress regularly reported to Improvement Group</li> </ul> <p>Workforce capacity and resource for transformation (reducing duplication / conflicting agendas)</p> <ul style="list-style-type: none"> <li>Ensure joint responsibility of translating strategy into action via an improvement sub-group and map out all forums/groups involved.</li> </ul> <p>Sustainability and differing standards of quality and safety of services (across health, social care, third sector and commissioned services)</p> <ul style="list-style-type: none"> <li>Design a set of agreed principles in partnership along with quality and safety standards to inform the model of care and strategy</li> </ul>
<p><b>HASCAS 2 &amp; Ockenden 8: Dementia Strategy</b> Operational Lead: Chris Lynes, Area Nurse Director (West)</p>	On track to deliver	<ul style="list-style-type: none"> <li>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&amp;LD).</li> </ul>	

## HASCAS & Ockenden Recommendations – update report for Quality, Safety & Experience Committee meeting

Recommendation	Current position	Progress update	Risks
<p><i>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).</i></p> <p><i>The dementia strategy should be developed to work across all relevant clinical services across BCUHB not just within the MH&amp;LD division. The dementia strategy should incorporate care across home, primary care and secondary care.</i></p>		<ul style="list-style-type: none"> <li>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.</li> <li>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.</li> <li>HASCAS Recommendation 2, Ockenden Recommendation 8 and Ockenden Recommendation 14 have been consolidated and the following main action points identified;</li> </ul> <p><b>Action 1. Clear Governance 'Ward to Board'</b> 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.</p> <ul style="list-style-type: none"> <li>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.</li> <li>A task and finish group is being developed in response to BCUHB's Dementia Audit Plan (2018-2020) to undertake audits and all future reporting from 'ward to board'.</li> <li>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.</li> <li>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</li> </ul> <p><b>Action 2. Evidence based policies and clinical standards.</b> 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).</p> <ul style="list-style-type: none"> <li>Review of clinical policies is to be undertaken.</li> <li>The appointment to a second Dementia Nurse Consultant post for BCUHB has been successful, commencement date awaited to help support this piece of work.</li> </ul> <p><b>Action 3: Sustained culture around Dementia.</b> Action required to embed the 'Dementia Care Pathway' across all BCUHB services and the BCUHB 'Dementia Friendly Organisation Action Plan'</p> <ul style="list-style-type: none"> <li>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.</li> <li>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 both primary and secondary care, such as the mental health liaison service within general hospitals.</li> <li>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.</li> <li>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.</li> </ul>	

## HASCAS & Ockenden Recommendations – update report for Quality, Safety & Experience Committee meeting

Recommendation	Current position	Progress update	Risks
		<p><b>Action 4. Over reliance on antipsychotic medication.</b>            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.</p> <ul style="list-style-type: none"> <li>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</li> </ul> <p><b>Action 5. Independent Oversight</b>            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.</p> <ul style="list-style-type: none"> <li>To be progressed.</li> </ul> <p><b>Action 6. Capacity &amp; Capability of the Workforce</b>            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)</p> <ul style="list-style-type: none"> <li>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.</li> <li>Dementia friends' sessions will also be included in all mandatory dementia training across BCUHB.</li> <li>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.</li> </ul> <p><b>Action 7. Accessing Information</b>            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.</p> <ul style="list-style-type: none"> <li>Referrals are now routinely made to the Carers Trust for any individual with a diagnosis of dementia, from BCUHB's memory clinics.</li> <li>A scoping exercise will be planned via the HASCAS/Ockenden work group to review all current BCUHB information making sure that present and future public information is compliant with 'Accessible Communication' standards as per action 8 of the Welsh Government Audiology Framework for Action</li> <li>Dementia Helpline has been launched across BCUHB providing 24hr advice, information and support.</li> </ul> <p><b>Action 8. Dementia Strategy</b>            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 &amp; 12 and HASCAS recommendation 2).</p> <ul style="list-style-type: none"> <li>BCUHB Dementia Strategic Action Plan 2018-2020 developed which is yet to be costed.</li> <li>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.</li> <li>The Action Plan will also be reviewed and measured against the WAG (2018) Dementia Action Plan for Wales.</li> <li>A BCUHB Clinical Dementia Strategy Work Group is in the process of being established 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.</li> </ul>	



## HASCAS & Ockenden Recommendations – update report for Quality, Safety & Experience Committee meeting

Recommendation	Current position	Progress update	Risks
		<b>Action 9. Regional approach to Dementia</b> Action required to subsume this implementation plan and develop alongside the North Wales Social Care and Wellbeing Service Improvement Collaborative. <ul style="list-style-type: none"> <li>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.</li> <li>In addition, this implementation plan will work alongside our partnership programmes:               <ul style="list-style-type: none"> <li>BCUHB's <i>Together for Mental Health Strategy</i></li> <li>The North Wales Social Care and Community Health Workforce Strategy (RPB, 2018)</li> <li>North Wales Population Assessment: Older People and Dementia.</li> <li>North Wales 'Area Plan'.</li> </ul> </li> </ul>	
<b>HASCAS 3: Care Homes and Service Integration</b> Operational Lead: Reena Cartmell Associate Director of Nursing  <i>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.</i>	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: <ul style="list-style-type: none"> <li>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.</li> <li>Review implementation of the "Care Homes for Older People: North Wales Market Shaping Position" (2018) and action plans.</li> <li>Monitor the delivery of recommendations created by "Care Closer to Home Work Programme: Integrated Medium Term Plan for 2019/22 – financial and workforce strategy".</li> <li>Develop a delivery plan to fully implement the "Quality Assurance Framework for Care Homes" developed by the CHC Corporate Team.</li> <li>Arrange a BCUHB Clinical meeting with Care Home Managers and 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).</li> <li>Include Care Home providers within the design of a North Wales Training Programme to make ESR modules accessible (dovetails with Ockenden recommendations 12 &amp; 14).</li> </ul> CIW/HIW Review (November 2018) into Support for North Wales Care Homes Action Plan is in progress, Area Directors are compiling a position statements of progress by the end of March 2019 in order to close off any actions completed and prioritise those outstanding.	
<b>Ockenden 12: Older Persons Long Term Clinical Strategy</b> Operational Lead: Reena Cartmell Associate Director of Nursing  <i>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</i>	On track to deliver	<ul style="list-style-type: none"> <li>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.</li> <li>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.</li> <li>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.</li> </ul>	

## HASCAS & Ockenden Recommendations – update report for Quality, Safety & Experience Committee meeting

Recommendation	Current position	Progress update	Risks
		<ul style="list-style-type: none"> <li>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.</li> <li>The newly appointed Dementia Nurse Consultant 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.</li> </ul>	
<b>HASCAS 4 Safeguarding Training</b> Operational Lead: Michelle Denwood, Associate Director Safeguarding  <i>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</i>	Risk to delivery needs attention	<ul style="list-style-type: none"> <li>A Training Task group has been established with clear Terms of Reference that include delivery of this HASCAS recommendation.</li> <li>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.</li> <li>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.</li> <li>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 31<sup>st</sup> May 2019.</li> <li>The recently published Inter-collegiate documents for both Adults and Children will be used to build upon the existing training provision. The results of this will feed into and inform the proposed 2019-20 Training Plan. To be completed by the end of May 2019.</li> <li>An Annual Training Report is being produced for 2018-19, which will include data analysis on key areas. This will clearly identify priority areas for inclusion within the Training Plan and will be completed by mid-April 2019.</li> </ul>	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.
<b>HASCAS 5 Safeguarding Informatics and Documentation</b> Operational Lead: Michelle Denwood, Associate Director Safeguarding  <i>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;</i> <ul style="list-style-type: none"> <li>The use of the dividers to be re-iterated in safeguarding training, briefings, and other communication activities and a key annual audit activity;</li> <li>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;</li> <li>Team and ward managers to continue to include safeguarding documentation in team meetings and safety briefs.</li> </ul>	On track to deliver	<ul style="list-style-type: none"> <li>The Safeguarding Team have published 1 and 2 of the revised Safeguarding Bulletin with refreshed governance. March 2018 and revised March 2019.</li> <li>The revised and updated training packages include record keeping and the storage of safeguarding records and information ( see recommendation 4)</li> <li>A Clinical records audit is incorporated within the process of Adult Practice Reviews and Multi-agency Practice Forum - May 2018. In addition additional activities to facilitate and include the audit of safeguarding documentation and information during the complaint, incidents and review process has commenced. June 2019</li> <li>Work has been drafted for review and sign off by the Safeguarding lead to; (i) include filing of safeguarding information in Good Record Keeping (GRK) training, and (ii) agree communication cascade via the BCUHB internal communication process for staff, to re-inforce the standards and procedures for filing and storage of documentation.</li> <li>Health Records department are working with the safeguarding lead to support the review and amendment of the safe storage of safeguarding information in clinical records in line with the Social Services &amp; WellBeing Act.</li> </ul>	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.

## HASCAS & Ockenden Recommendations – update report for Quality, Safety & Experience Committee meeting

Recommendation	Current position	Progress update	Risks
BCUHB will reconsider how clinical teams should record safeguarding information and the quality of the information provided.			
<p><b>HASCAS 6 Safeguarding Policies &amp; Procedures</b> Operational Lead: Michelle Denwood, Associate Director Safeguarding</p> <p><i>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;</i></p> <ul style="list-style-type: none"> <li>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</li> <li>Agree a priority list and activity timeframe to review documents within the parameters of corporate safeguarding</li> <li>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 and legislative safeguarding frameworks;</li> <li>Agree a governance structure and reporting framework for all safeguarding policies, procedures and SOPs;</li> <li>Update and maintain the Safeguarding Policy webpage;</li> <li>Continue to actively participate in the Policy and Procedure sub group of the Regional Safeguarding Boards</li> </ul>	On track to deliver	<ul style="list-style-type: none"> <li>A Policy and Procedures Sub Group has been established with clear Terms of Reference that include delivery of the HASCAS recommendations.</li> <li>A Business Planning Cycle has been produced which allows planning across the reporting framework for effective scrutiny, consultation and approval.</li> <li>The following policies have recently been ratified by Safeguarding Performance and Governance Group: <ul style="list-style-type: none"> <li><b>Adult at Risk Procedure</b> – ratified for publication and builds on WG guidance.</li> <li><b>Procedural Response to Unexpected Deaths in Children (PRUDIC) SOP</b></li> <li><b>Supervision Procedure</b> a) Specialist Safeguarding Supervision Procedure b) BCUHB Safeguarding Supervision – ratified for publication (pending clarity around one item)</li> <li><b>Safeguarding Principles for Pressure Damage</b></li> <li><b>Violence against Women, Domestic Abuse, and Sexual Violence (VAWDASV)</b> – Workplace ToR – ratified for dissemination through QSG to support implementation. The group will now recommence and the framework will support the implementation of a Professional Allegations Workplace group.</li> <li><b>Female Genital Mutilation (FGM) SOP</b></li> <li><b>Best Interest Meeting Guidance.</b></li> </ul> </li> <li>Work is ongoing in respect of identification, consultation and engagement of phase 2 of the revision and review of priority procedures with a delivery date of end of May 2019.</li> <li>The Safeguarding Intranet has been reviewed and refreshed and the new Safeguarding homepage is now live. <a href="http://howis.wales.nhs.uk/sitesplus/861/page/74760">http://howis.wales.nhs.uk/sitesplus/861/page/74760</a></li> </ul>	
<p><b>HASCAS 7: Tracking of Adults at Risk across North Wales</b> Operational Lead: Michelle Denwood, Associate Director of Safeguarding</p> <p><i>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.</i></p>	On track to deliver	<ul style="list-style-type: none"> <li>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. 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 MHL as a pilot.</li> <li>The Adult at Risk Procedure has been written and ratified at Safeguarding Governance and Performance Group on 31 January 2019.</li> <li>The development of supporting report templates, aide memoirs for strategy meetings and case conferences are currently under consultation. April 2019</li> <li>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.</li> <li>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</li> </ul>	This is a challenging recommendation due to the diverse nature of operational processes, services and IT systems.



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Recommendation	Current position	Progress update	Risks
		Performance Dashboard then feeds into the Safeguarding Reporting Framework for scrutiny and review. This will be completed by mid-April 2019	
<b>HASCAS 8: Evaluation of Revised Safeguarding Structures / Ockenden 6: Safeguarding Structures</b>  Operational Lead: Michelle Denwood, Associate Director of Safeguarding  <i>BCUHB will evaluate the effectiveness of its new safeguarding structure in the fourth quarter of 2018/2019. This will be overseen by Welsh Government.</i>	Risk to delivery needs attention	<ul style="list-style-type: none"> <li>Following review a revised safeguarding structure is now in place. Further amendments were required to be made to job descriptions and roles and responsibilities including for North Wales / Regional posts and to ensure inclusion of omitted key activities to support the full safeguarding agenda. Banding outcome for one post remains outstanding which is anticipated week commencing 4<sup>th</sup> March 2019.</li> <li>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.</li> <li>Implementation of the Named Doctor Adults at Risk remains outstanding and discussions are ongoing with the Office of the Medical Director to pursue this post with pace.</li> </ul>	The current structure of the Safeguarding Team does not allow it to operate an out of hours/on call service. <ul style="list-style-type: none"> <li>Support from Director of Nursing to establish a structure and revised working pattern and on-call system to strengthen service provision.</li> </ul>
<b>HASCAS 12 Deprivation of Liberties</b> Operational Lead: Michelle Denwood, Associate Director of Safeguarding  <i>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.</i>  <b>Ockenden 9: Deprivation of Liberties</b> <i>BCUHB will complete a review of the 2017-18 DoLS work plan</i>	On track to deliver	<ul style="list-style-type: none"> <li>Activity and progress for the DoLS work plan is included within the Safeguarding Reporting Framework activity and reports to both the Safeguarding Performance and Governance Group and the Mental Health Act Committee</li> <li>A review of the DoLS structure has commenced and this will be embedded as part of the Organisational Change Policy (OCP) process to be completed by end of June 2019</li> <li>Revised DoLS signatory training has been rolled out with good enrolment from staff. There are now currently circa 40 signatories that have completed the training package Jan - March 2019, which has increased from just 1 signatory during the period of 2018.</li> <li>All 6 BIAs have completed the training and are accommodated in the Area Teams or within available space in Secondary Care and Areas, this activity regarding accommodation was challenging. Jan 2019</li> <li>The timed action plan, evidencing resource requirements and challenges will be included within the Safeguarding Annual Report QSE May 2019.</li> </ul>	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.
<b>HASCAS 9: Clinical Records</b> Operational Lead: Dylan Williams, Chief Information Officer  <i>Restructure and redesign of paper records archiving and retrieval systems</i>	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).  JD/PS for the 8b <i>Deputy Head of Health Records</i> has been reviewed following agreement to fund within Informatics; however with the recruitment process this is expected to take up to 4 months (if external) to recruit to and start. The need for additional project management resource requirement has been highlighted in order to progress the actions 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 remain on hold.	<b>R9 Risk 1</b> : The risk that the required resource to undertake and sustain the work for all R5 and R9(i) and (ii) is not provided <i>Update:</i> <ul style="list-style-type: none"> <li>Chief Information Officer has prioritised funding to secure the senior 8b <i>Deputy Head of Health Records</i> post required which will now go through the recruitment process;</li> <li>Resource requirement highlighted for a Project Manager to support delivery of recommendation</li> </ul> <b>R9 Risk 2</b> : 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 <ul style="list-style-type: none"> <li>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.</li> </ul>

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Recommendation	Current position	Progress update	Risks
			<ul style="list-style-type: none"> <li>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).</li> </ul> <p><b>R9 Risk 3:</b> 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</p> <p><i>Update:</i></p> <ul style="list-style-type: none"> <li>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)</li> </ul>
<p><b>HASCAS 10: Prescribing and Monitoring of Anti-psychotic medication</b> Operational Lead: Berwyn Owen, Chief Pharmacist</p> <p><i>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.</i></p> <p><i>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.</i></p>	Risk to delivery, needs attention	<ul style="list-style-type: none"> <li>The Health Board has recently updated guidance on prescribing antipsychotic medication in the presence of a dementia diagnosis and will be subjected to a full audit within 12 months</li> <li>Medicines reconciliation audit has been undertaken in Wrexham on the completion of an accurate drug history within 24 hours of admission. This demonstrated that 24 hour targets are not being met consistently due to lack of pharmacy staffing on the OPMH wards. An improvement plan has been developed for the use of anti-psychotic medication to ensure that patients with a diagnosis of dementia will have 3 monthly reviews of any antipsychotic medication in use upon discharge.</li> <li>CAIR (checklist for antipsychotic initiation and review form) has been developed and distributed to all OPMH and CMHT teams across MH&amp;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</li> <li>Support being provided to care homes and 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.</li> <li>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</li> <li>An all wales audit is to be undertaken 2019-20 to identify the number of people with dementia who are prescribed antipsychotics</li> <li>An audit for inpatient dementia units is planned for March 2019</li> <li>A pilot of the use of an Adverse Drug Reaction (ADRe profile) for use within care homes and OPMH wards will commence March 2019</li> </ul>	<p>Lack of pharmacy staff to deliver training for safe use of antipsychotic and support review</p> <ul style="list-style-type: none"> <li>Resource requirement to support implementation of recommendations. Paper to be submitted to executive team.</li> </ul> <p>Care homes not trained to deliver care that reduces need for antipsychotics</p> <ul style="list-style-type: none"> <li>MDT bid in pace to support this (links to recommendation 2)</li> </ul>
<p><b>HASCAS 11: Evidence Based Practice</b> Operational Lead: Dawn Sharp, Deputy Board Secretary</p> <p><i>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</i></p>	On track to delivery	<ul style="list-style-type: none"> <li>This recommendations dovetails with Ockenden 3 (see below).</li> <li>A review of the overarching policy on policies has been undertaken and the new policy adopted and launched. This sets out new ratification processes.</li> <li>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.</li> </ul>	



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Recommendation	Current position	Progress update	Risks
<i>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.</i>		<ul style="list-style-type: none"> <li>Sessions continue to be held with Governance Leads 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.</li> <li>Staff have been reminded that all clinical policies should be developed using a person centred approach.</li> <li>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.</li> <li>A Project Initiation Document (PID) is being produced and a detailed GANTT chart being populated to ensure there are clear timelines documented which will be completed by end March 2019. The initial testing in terms of transfer of the Information Governance policies has identified a few issues and these are being addressed during February and early March.</li> </ul>	
<b>Ockenden 2a: Quality Impact Assessment</b> Operational Lead: Dawn Sharp, Deputy Board Secretary  <i>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.</i>	On track to delivery	<ul style="list-style-type: none"> <li>A system is in place for Quality Impact Assessment (QIA) of savings schemes and progress will be measured from samples of completed QIAs and a record of outcomes and as part of the internal audit programme 2019/20. The audit is timetabled for Q1-2 in the draft IA plan for next year which is to be submitted for approval to the 14<sup>th</sup> March 2019 Audit Committee.</li> </ul>	
<b>Ockenden 2b: Integrated Reporting</b> Operational Lead: Dawn Sharp, Deputy Board Secretary  <i>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.</i>	On track to delivery	<ul style="list-style-type: none"> <li>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 is currently being drafted and will be circulated to divisions beginning March and a feedback session is planned for learning from the process at end March 2019.</li> </ul>	
<b>Ockenden 3: Policy Review</b> Operational Lead: Dawn Sharp, Deputy Board Secretary  <i>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.</i>  <i>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</i>	On track to delivery	<ul style="list-style-type: none"> <li>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.</li> <li>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.</li> <li>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.</li> </ul>	Clinical staff not being aware of the transfer of key policies to the new site <ul style="list-style-type: none"> <li>Targeted communication plan for each transfer to be agreed with the leads. Redirect system to be in place (from existing location) where possible</li> </ul> Resources to review policies and bring them up to date (across the wider organisation) <ul style="list-style-type: none"> <li>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</li> </ul>

## HASCAS & Ockenden Recommendations – update report for Quality, Safety & Experience Committee meeting

Recommendation	Current position	Progress update	Risks
<p><i>clinical practice as a 'work around solution' to lack of access to policies and guidance electronically.</i></p> <p><i>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.</i></p>		<ul style="list-style-type: none"> <li>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 policies being scrutinised by the Quality and Safety Group to ensure they are fit for purpose and are evidence based.</li> <li>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.</li> </ul>	
<p><b>Ockenden 10: Reviewing external reviews</b> Operational Lead: Dawn Sharp, Deputy Board Secretary</p> <p><i>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.</i></p> <p><i>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.</i></p>	On track to delivery	<ul style="list-style-type: none"> <li>A review has been undertaken of all external reviews and a database established to capture all externally commissioned/produced reports such as the Delivery Unit, Royal Colleges, Royal College of Nursing, BMA, Commissioners {Children's; Future Generations Act; Information; Older Persons}; PWC; Deloitte's etc.(separate effective processes already exist for HIW, WAO Internal Audit and Ombudsman reports). All reports will be centrally logged and a lead officer identified.</li> <li>Further work is being undertaken to improve the system for recording external reports to ensure, logging, cascade and follow up are automated as far as possible. Discussions have taken place with the All Wales Board Secretaries Group to share best practice. Resources in this area have also been strengthened with the assignment of the Compliance Officer to help support this area of work. These improvements will ensure the system logging those reports (other than HIW) is robust and further development of the system will be in place by March 2019.</li> <li>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.</li> <li>All open/outstanding actions arising from these inspection reports continue to be monitored/managed on a monthly basis by the Quality and Safety Group.</li> <li>It was agreed at the 29<sup>th</sup> 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.</li> </ul>	
<p><b>Ockenden 14: Board Development</b> Operational Lead: Dawn Sharp, Deputy Board Secretary</p> <p><i>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.</i></p>	Delivered	<ul style="list-style-type: none"> <li>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 10<sup>th</sup> January 2019.</li> <li>Whilst this action has been completed for Board members, the Executive Director of workforce &amp; OD agreed to take forward an action consider how to incorporate dementia awareness sessions into the induction programme.</li> </ul>	
<p><b>HASCAS 13: Restrictive Practice Guidance</b> Operational Lead: Steve Forsyth Director of Nursing MH&amp;LD</p>	On track to deliver	<ul style="list-style-type: none"> <li>The Task &amp; Finish Group for Recommendation 13, led by the Director of Nursing for Mental Health &amp; 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 a number of actions, which are either complete or on track to deliver.</li> </ul>	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

## HASCAS & Ockenden Recommendations – update report for Quality, Safety & Experience Committee meeting

Recommendation	Current position	Progress update	Risks
<p><i>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.</i></p>		<ul style="list-style-type: none"> <li>Decision is awaited to confirm project support / training role to embed across BCUHB and form part of Workforce and Organisational Development Team.</li> <li>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               <ul style="list-style-type: none"> <li>i) <i>‘Proactive Reduction &amp; Therapeutic Management of Behaviours which Challenge’</i> 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.</li> <li>ii) <i>‘Physical Restraint Guidelines’</i> 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</li> </ul> </li> </ul> <p>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 Health Act 1983 Code of Practice for Wales and the All Wales NHS Violence and Aggression Training Passport and Information Scheme.</p> <p>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</p> <p>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 &amp; 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.</p> <ul style="list-style-type: none"> <li>Work is ongoing 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 – the results indicate that outside of MHL, there are no reports of physical restraint being used. However, to ensure that BCUHB adopts a proactive approach commensurate with the recommendations in national guidelines, a training programme has been developed to support staff in proactively managing behaviours that challenge (and reduce the need for restraint). This training programme will roll out across the health board in mid-March and will initially be delivered with the support of specialists from MHL before the corporate training team assume full responsibility.</li> <li>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.</li> </ul>	<p>restraint on a regular basis, debriefing, observations during restraint, lack of mental health expertise.</p> <ul style="list-style-type: none"> <li>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 MHL Positive Interventions Clinical Support Service (PICSS)</li> <li>If a patient is so distressed and requiring RPI, assessment and or treatment the appropriate clinical pathway will be followed involving clinical advice from MHL professionals for the most appropriate and least restrictive environment.</li> </ul>
<p><b>HASCAS 14: Care Advance Directives</b> Operational Lead: Dr Melanie Maxwell, Associate Medical Director</p> <p><i>BCUHB will conduct an audit to establish how many patients and their families have advance directive documentation within their clinical records together with</i></p>	<p>On track to deliver</p>	<ul style="list-style-type: none"> <li>Audit 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.</li> <li>Three months data now available which will be reviewed going forward</li> </ul>	



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Recommendation	Current position	Progress update	Risks
<i>care plans in relation to choice and preference about end of life care</i>			
<b>HASCAS 15: End of Life Care Environment</b> Operational Lead: Dr Melanie Maxwell, Associate Medical Director  <i>Improve end of life environment on OPMH wards and associated guidance training</i>	On track to deliver	<ul style="list-style-type: none"> <li>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 following which minor amendments were made from stakeholder feedback</li> <li>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.</li> <li>Relative rooms have been developed on each OPMH 'organic' ward,</li> <li>Staff training programme commenced for all older person registered nurses 6<sup>th</sup> December 2018.</li> <li>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</li> <li>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&amp;LD / Area and the Hospice for 2 years.</li> </ul>	Staff not being released for training. – Training is mandated on OPMH wards for Registered Nurses.
<b>Ockenden 2c Workforce Development</b> Operational Lead: Sue Green, Executive Director of Workforce & Organisational Development  <i>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&amp;LD and specifically OPMH with recruitment and retention expertise across medical, nursing and support services going forward. The MH&amp;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&amp;LD going forward.</i>	Risk to delivery, needs attention	<ul style="list-style-type: none"> <li>An Improvement Lead Programme Manager and three TODAY ICAN Change Facilitators commenced in roles within the MH&amp;LD division in January 2019 with a fourth facilitator due to start in April 2019.</li> <li>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.</li> <li>Tier 5 / 6 restructuring has been signed off by Divisional Directors, consultation process commences March 2019</li> <li>Draft workforce strategy to be approved by BCUHB Board prior to publish</li> <li>A nurse recruitment day was held on Monday 11<sup>th</sup> February for MH&amp;LD (and incorporating HMP Berwyn), following which 21 out of 32 applicants were offered vacancies.</li> </ul>	
<b>Ockenden 4a: Staff Engagement</b> Operational Lead: Sue Green, Executive Director of Workforce & Organisational Development  <i>The BCUHB board and the MH&amp;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</i>	Risk to delivery, needs attention	<ul style="list-style-type: none"> <li>Listening leads have been recruited and trained across the MH&amp;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&amp;LD.</li> <li>Using the TODAY ICAN methodology MH&amp;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.</li> <li>To further improve staff engagement, the "Be Proud Pioneer Programme" is now being rolled out with priority teams identified and the MH&amp;LD service have gained 6 places on the very first cohort, which is due to start in March 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</li> </ul>	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 the 4 interim period

## HASCAS & Ockenden Recommendations – update report for Quality, Safety & Experience Committee meeting

Recommendation	Current position	Progress update	Risks
		<p>Development to support individual teams to help build levels of engagement and ultimately improve both team effectiveness and organisational performance.</p> <ul style="list-style-type: none"> <li>• A Mental Health Nurses celebration event was held on 21<sup>st</sup> February to thank and recognise the hard work and commitment of our MHLN nurses.</li> <li>• 100 years of Learning Disability Nursing was celebrated during an event held on St David's Day</li> <li>• 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.</li> <li>• Site visits have been undertaken by divisional directors to ensure visibility and engagement on an individual basis.</li> <li>• Workforce are arranging Lessons learnt stakeholder sessions by end of March 2019</li> </ul>	
<p><b>Ockenden 4b &amp; 4c: Staff Surveys</b> Operational Lead: Sue Green, Executive Director of Workforce &amp; Organisational Development</p> <p><i>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.</i></p> <p><i>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.</i></p>	Risk to delivery, needs attention	<ul style="list-style-type: none"> <li>• 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.</li> <li>• 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 11<sup>th</sup> February 2019.</li> <li>• The MHLN 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.</li> <li>• 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.</li> <li>• 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: <ul style="list-style-type: none"> <li>– a simple way to understand the science behind staff engagement in terms of cause and effect</li> <li>– Clear practical recommendations to improve staff engagement</li> <li>– Regular trend analysis – not a once a year/two years snapshot in time.</li> <li>– Ability to act quickly on data, 2 week turnaround from close of survey to presentation of results</li> <li>– Organisational and team level diagnosis of culture</li> </ul> </li> </ul>	
<p><b>Ockenden 4d: Clinical Engagement</b> Operational Lead: Sue Green, Executive Director of Workforce &amp; Organisational Development</p> <p><i>BCUHB must take urgent and sustained steps to ensure the continued involvement of all clinical colleagues in the leadership and management of BCUHB</i></p>		<ul style="list-style-type: none"> <li>• The second BCUHB Medical and Dental Conference held in partnership with the Welsh NHS Confederation and BMA Wales took place on 7<sup>th</sup> March 2019 to support clinical engagement.</li> <li>• 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.</li> </ul>	•

## HASCAS & Ockenden Recommendations – update report for Quality, Safety & Experience Committee meeting

Recommendation	Current position	Progress update	Risks
<p><b>Ockenden 13: Culture Change</b> Operational Lead: Sue Green, Executive Director of Workforce &amp; Organisational Development</p> <p><i>There will need to be sustained, visible (in clinical areas), stable leadership within MH&amp;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.</i> <i>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&amp;LD but everywhere within BCUHB where care and treatment may be provided to persons with dementia, their families and friends.</i></p>	Risk to delivery, needs attention	<ul style="list-style-type: none"> <li>Dementia friendly awareness session held with Health Board members on 10<sup>th</sup> 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</li> <li>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.</li> <li>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.</li> <li>TODAY ICAN was formally launched on 20<sup>th</sup> 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. The next event is due to take place on 3<sup>rd</sup> April 2019 and is already well subscribed.</li> <li>TODAY ICAN team have completed "train the trainer" by Prof B Dolan on 14<sup>th</sup> 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</li> <li>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.</li> <li>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.</li> <li>The Health Board is strengthening its offer of skilled level dementia training for clinical staff. Current training is aligned to the 'Good Work' framework and we are developing our modules further by placing additional emphasis on the important role of the carer. To support this work is underway with TIDE, an involvement network for carers of people living with dementia, hosted by the Life Story Network CIC. Its mission is to be the voice, friend and future of all carers and former carers of people with dementia. TIDE is supporting carers to share their experiences by training them to acquire appropriate skills and competencies in delivering training. The project is overseen by the Consultant Nurse for dementia.</li> </ul>	
<p><b>Ockenden 5: Partnership Working</b> Operational Lead: Sally Baxter, Assistant Director Health Strategy</p> <p><i>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.</i></p>		<ul style="list-style-type: none"> <li>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.</li> <li>A proposed timeline has been developed for refresh of the strategy which included work to run in parallel with the process to develop the three year plan for the Health Board, engagement with the sector, and refreshed strategy proposals to be finalised by March 2019. The development of the three year plan provides an opportunity to thread partnership working and relationships with the third sector within the three major programmes identified – Health Improvement, Health Inequalities; Care Closer to Home; and Excellent Hospital care.</li> </ul>	<p>Complexity of the Health Board presents challenges in developing a fully embedded approach</p> <ul style="list-style-type: none"> <li>Develop a set of principles to be adopted across the Health Board</li> </ul> <p>Partnership approaches differ across the 6 counties</p> <ul style="list-style-type: none"> <li>Ensure corporate arrangements are supportive of and link closely with county based arrangements</li> </ul> <p>Objectives need review and refresh to reflect the wider strategic approach</p>



## HASCAS & Ockenden Recommendations – update report for Quality, Safety & Experience Committee meeting

Recommendation	Current position	Progress update	Risks
		<ul style="list-style-type: none"> <li>Discussions have taken place with key individuals and engagement is being arranged to allow broader discussion of the current perspectives on relationships with the sector, the priorities for action and areas for inclusion in future collaboration arrangements.</li> <li>Recommendations are being progressed to improve the management of the third sector contracts 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.</li> <li>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. Further engagement sessions with CVC third sector forums have been arranged to consider partnership issues and to allow a broader discussion on priorities for action and the Health Board response to these.</li> </ul> <p>This dovetails with the work ongoing for HASCAS recommendation 3 in relation to integrated care pathways</p>	<ul style="list-style-type: none"> <li>Include wider strategic development within objectives</li> </ul>
<p><b>Ockenden 7: Concerns Management</b> Operational Lead: Deborah Carter, Associate Director Quality Assurance</p> <p><i>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.</i></p> <p><i>It is clear that the BCUHB Board have very little knowledge of the <b>actual</b> 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.</i></p>	Risk to delivery needs attention	<ul style="list-style-type: none"> <li>Work is progressing to respond to the actions identified to better manage concerns in a timely and effective manner.</li> <li>The number of open and overdue incidents has decreased by 844 from 6,130 in October 2018 to 5,286 in February 2019. There has also been a decrease in the number of open Welsh Government closure forms from 611 in January 2019 to 473 at the end of February 2019.</li> <li>A bilingual online complaints form has been launched on the BCUHB internet since January 2019</li> <li>A revised format for reporting listening and learning to the Quality Safety &amp; Experience committee has been agreed</li> <li>A draft patient experience strategy has been shared with the Community Health Council for comment.</li> <li>A revised Putting Things Right (PTR) 1 policy has been drafted for review.</li> <li>Standard Operating Procedure for writing a complaint response has been implemented within the corporate concerns team</li> </ul>	<p>Capacity within divisions to prioritise investigation and report writing for Concerns (against operational priorities)</p> <ul style="list-style-type: none"> <li>Trajectories developed by division to deliver required deadlines by week commencing June 17<sup>th</sup>; No WG incidents overdue by end of June 2019 No complaints graded as 1/2 overdue No more than 15 complaints graded 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</li> </ul> <p>Quality of historic information to support robust learning</p> <ul style="list-style-type: none"> <li>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</li> </ul>
<p><b>Ockenden 11: Estates OPMH</b> Operational Lead: Rod Taylor, Director of Estates &amp; Facilities</p> <p><i>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.</i></p> <p><i>The estates inventory should be prepared for each ward, clinic, department, inpatient unit and hospital department</i></p>		<ul style="list-style-type: none"> <li>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.</li> <li>A site-by-site schedule (inventory) of outstanding repairs and maintenance work for MH&amp;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.</li> <li>A detailed inventory of previous External Audits and Inspections by HIW &amp; CHC relating to MH&amp;LD OPMH facilities has been prepared and all outstanding actions are completed.</li> <li>Funding bids for Disc Capital for 2019/20 have been submitted to the Capital Working Group for consideration within the Health Boards 2019/20 Disc Capital programme. This work will support work stream 2.</li> </ul>	<p>Project management capacity</p> <ul style="list-style-type: none"> <li>Paper to go to executive team for review of resources required</li> </ul> <p>Capital and Revenue funding to undertake identified works</p> <ul style="list-style-type: none"> <li>Funding bids have now been included within the 2019/20 Draft Discretionary Capital Programme</li> <li>Revenue funding bids have been included within Estates and Facilities budget cost pressures for 2019/20</li> </ul>

## HASCAS & Ockenden Recommendations – update report for Quality, Safety & Experience Committee meeting

Recommendation	Current position	Progress update	Risks
<p><i>where care is provided to older people and older people with mental health issues. This includes where care is provided to people with dementia.</i></p> <p><i>The estates inventory should include for each area an audit based on the work for Enhancing the Healing Environment.</i></p>		<ul style="list-style-type: none"> <li>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&amp;LD buildings.</li> <li>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;</li> </ul> <p><b>Workstream 1</b></p> <ul style="list-style-type: none"> <li><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&amp;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 &amp; Ockenden Improvement Group.</li> <li><u>Review recent and previous external audits and inspections (HIW &amp; CHC) relating to MH&amp;LD OPMH facilities to determine outstanding actions.</u> A detailed inventory of previous HIW &amp; CHC audits and inspections relating to MH&amp;LD OPMH facilities has been prepared and all outstanding actions have now been completed.</li> <li><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.</li> </ul> <p>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&amp;LD buildings.</p> <p><b>Workstream 2 – this will commence in April 2019</b></p> <ol style="list-style-type: none"> <li><u>Develop the Enhancing the Healing Environment (EHE) assessment across all wards within MH&amp;LD OPMH facilities.</u></li> <li><u>Determine the scope of work and resources required at each facility.</u></li> </ol> <p>King's Fund dementia environment audits will occur across 2019 as part of the broader dementia friendly hospitals programme.</p>	



**Quality Safety & Experience  
(QSE) Committee**
**19.3.19**

**GIG  
CYMRU  
NHS  
WALES**

 Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board

*To improve health and provide excellent care*

<b>Report Title:</b>	2019 Annual Nurse Staffing Levels(Wales) Act 2016 Report
<b>Report Author:</b>	Debra Hickman Secondary Care Nurse Director
<b>Responsible Director:</b>	Gill Harris Executive Director of Nursing & Midwifery
<b>Public or In Committee</b>	Public
<b>Purpose of Report:</b>	To inform the Committee 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.
<b>Approval / Scrutiny Route Prior to Presentation:</b>	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 by each Site Director of Nursing, escalation of significant issues are to the designated committee (QSE) via the Quality Safety Group (QSG).
<b>Governance issues / risks:</b>	<p>NB. Patient Acuity data is not available till w/c 11<sup>th</sup> March 2019 in order to complete a full triangulated staffing review, this report will follow in May 2019.</p> <ol style="list-style-type: none"> <li>1. The Annual review of each of the sections within the Act 25a – 25e as legislated</li> <li>2. The current vacancy position within the Acute Inpatient wards of which the Act governs</li> <li>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</li> <li>4. Future actions required</li> </ol>
<b>Financial Implications:</b>	<p>The agreed staffing establishments to meet the requirements of the Nurse Staffing Levels Act 2016 are funded as per appendix 1.</p> <p>The funded establishments however do not support additional escalated beds indicated in appendix 1.</p> <p>This is the 3<sup>rd</sup> review of nursing establishments since the Act was implemented.</p>
<b>Recommendation:</b>	The Committee is asked to note the report that a further detailed update will follow in May 2019

<b>Health Board's Well-being Objectives</b> <i>(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)</i>	√	<b>WFGA Sustainable Development Principle</b> <i>(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.)</i>	√
1.To improve physical, emotional and mental health and well-being for all	<b>X</b>	1.Balancing short term need with long term planning for the future	<b>X</b>
2.To target our resources to those with the greatest needs and reduce inequalities	<b>X</b>	2.Working together with other partners to deliver objectives	<b>X</b>
3.To support children to have the best start in life		3. Involving those with an interest and seeking their views	<b>X</b>
4.To work in partnership to support people – individuals, families, carers, communities - to achieve their own well-being	<b>X</b>	4.Putting resources into preventing problems occurring or getting worse	<b>X</b>
5.To improve the safety and quality of all services	<b>X</b>	5.Considering impact on all well-being goals together and on other bodies	<b>X</b>
6.To respect people and their dignity	<b>X</b>		
7.To listen to people and learn from their experiences	<b>x</b>		
<b>Special Measures Improvement Framework Theme/Expectation addressed by this paper</b>  Leadership & Governance Strategic and Service planning			
<b>Equality Impact Assessment</b>  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 is currently being analysed and is due to be reported back to the Trust from the All Wales Group on the 11<sup>th</sup> March 2019, with the analysis presentations due early May 2019. This will then inform the triangulated review and be reported via the Health Board's governance structure in due course.

The Health Board is however, 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	1 <sup>st</sup> April 2018 – 31 <sup>st</sup> March 2019
Requirements of Section 25A	<p>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.</p> <p>To assure compliance with the act, each acute site undertakes a series of activities of which include the following:</p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• 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.</li> <li>• Utilisation of workforce profiling data to ensure focus on recruitment and retention including forward planning and maximising resource and opportunities</li> <li>• Work closely with the commissioned provider for nurse training to secure 'locally grown' nurses into permanent positions upon qualification.</li> </ul>

Financial Year 2018/2019			
<b>Date annual report on the nurse staffing level submitted to the Board</b>	TBC		
<b>Number of adult acute <u>medical</u> inpatient wards where section 25B applies</b>	YWM 7	YG 7/8* *Alaw ward included as an Act ward from Q3	YGC 7
<b>Number of adult acute <u>surgical</u> inpatient wards where section 25B applies</b>	YWM 6 (including Bonney, Women's Division)	YG 5	YGC 6
<b>Number of occasions where nurse staffing level was recalculated in addition to the bi-annual calculation</b>	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)
<b>The process and methodology used to inform the triangulated approach</b>	<p>The process for determining the nurse staffing levels at Betsi Cadwaladr University Health Board has three steps:</p> <ol style="list-style-type: none"> <li>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.</li> <li>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</li> </ol>		

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.
<b>Informing patients</b>	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	
<b>Process for maintaining the nurse staffing levels</b>	<p>The process for maintaining safe nurse staffing levels includes a number of elements of which include:</p> <ul style="list-style-type: none"> <li>• Adult Acute Nurse staffing and Nurse staffing escalation policies are in place and accessible online for staff to refer to</li> <li>• 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</li> <li>• 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</li> <li>• 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</li> <li>• Streamlined fast track recruitment for internal staff</li> <li>• Centralised recruitment team to support campaigns for nurse recruitment</li> </ul>

Section 25E (2a) Extent to which the nurse staffing levels are maintained	
	<ul style="list-style-type: none"> <li>Partnership working with local universities to maximise opportunities for recruitment and retention</li> </ul>
<b>Process for monitoring the nurse staffing level</b>	<p>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</p> <ul style="list-style-type: none"> <li>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.</li> <li>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.</li> <li>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.</li> <li>Quarterly data is collected to review deviations from planned staffing levels and to triangulate theses deviations with any poor performance across the quality indicators.</li> </ul>

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 34	YG 12	YGC 16	YWM Increase of 14	YG Decrease of 11	YGC Decrease of 13	YWM	YG 2/12 (18-19)	YGC
- Falls resulting in serious harm or death (i.e. level 4 and 5 incidents)	YWM 12	YG 22	YGC 20	YWM 14	YG 10	YGC 15	YWM Increase of 2	YG Decrease of 14	YGC Decrease of 5	YWM 1	YG 1/10 (18-19)	YGC 3
- Medication related never events	YWM 0	YG 0	YGC 2	YWM 0	YG 0	YGC 1	YWM	YG	YGC Decrease of 1	YWM	YG	YGC
	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				
<b>Actions taken</b>	<p>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</p>			
<b>Next steps</b>	<p>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.</p> <p>The board are asked to note and support the following next steps:</p> <ul style="list-style-type: none"> <li>• Targeted focus of Nurse recruitment including resource to support campaigns</li> <li>• Exploration of a clinical fellowship programme for nurses</li> <li>• Ongoing analytics regards leavers and 'what could we do better?'</li> <li>• Review new roles to support the nursing recruitment pipeline</li> <li>• Expansion of harm avoidance collaborative to assist in reducing variation</li> <li>• Development of a nurse performance dashboard as a further monitoring and assurance tool.</li> <li>• Host staffing act 'masterclass' for senior nurses to ensure that they are up to date and conversant in the requirements of the staffing act.</li> <li>• Further analysis of deviations from previous reporting periods</li> </ul>			

Quality, Safety and Experience Committee	 Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board
19.3.19	<i>To improve health and provide excellent care</i>
<b>Advisory Group Chair's Report</b>	

<b>Name of Advisory Group:</b>	<b>Quality and Safety Group (QSG)</b>
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<b>Meeting date:</b>	<b>13<sup>th</sup> February 2019</b>
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<b>Name of Chair:</b>	<b>Gill Harris, Executive Director of Nursing and Midwifery</b>
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<b>Responsible Director:</b>	<b>Gill Harris, Executive Director of Nursing and Midwifery</b>
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<b>Summary of key items discussed:</b>	<p><b>mpMRI</b> The HB is expected to develop an implementation plan for pre biopsy mp-MRI of prostate in line with the NICE guidelines due to finalised in April. Noting significant pressures on Radiology capacity, difficulty recruiting to posts, it may be difficult to provide all of the scanning and reporting capacity internally. It is anticipated that there will be a cost pressures in region of £270k in the first year, this cost may be offset by savings arising from the reducing the number of TRUS biopsies undertaken.</p> <p>QSG acknowledged the indicative cost pressure of £270k, possible saving in reduction of biopsies and there may be issues with staff training. A lot of work needs to be done to look at costs, the strong political focus, the fact that it only picks up the mpMRI element and not the bigger pathway picture. And the opportunity for potential disinvestment elsewhere in the pathway.</p> <p><b>Point of Care testing update – David Fletcher</b> There has been a slight slippage in the action plan trajectories which has been reported to POC committee, plans are to bring back to achieve. A Central database for users and training plan has been developed, staff will be starting in posts over the next few months. A small audit in Primary Care highlighted a big gap, for which the team is requesting support to take forward. Suggested to move all POCT device training and competency recorded on ESR, they have identified gaps in engagement with training and agreed the need to implement cascade training</p> <p>Group agreed to support the recommendations, and asked for a</p>
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	<p>updated paper to be presented to the April QSG meeting</p> <p><b>Ward Accreditation</b></p> <p>To date 24 areas, including 1 Critical Care Unit have been visited and a test visit has been conducted on a Mental Health unit. These have resulted in 12 Silver, 6 bronzes, being awarded and 2 areas identified as needing support.</p> <p>The key themes identified and listed in the paper are similar to HIW findings, groups and work have been set up to put systems in place. There is lots of great work taking place that was not previously known and an increase in Harm dashboard usage is being seen.</p> <p>There is very positive feedback from all wards and the process has been very welcomed.</p> <p><b>Policies/ Guidelines</b></p> <p>The group agreed the following:</p> <ul style="list-style-type: none"> <li>• Cytotoxic spillage guideline</li> <li>• SCH06 Restraint guidelines</li> <li>• Proactive reduction and therapeutic management of behaviours with challenge policy</li> <li>• RP02 Non-ionising radiation protection policy</li> </ul>
<p><b>Key advice / feedback for the QSE:</b></p>	<p><b>Risks to highlight:</b></p> <ul style="list-style-type: none"> <li>• Instability to Gwanwyn ward – measures have been put in place to use agency staffing, reduction in beds and weekly escalation review of the ward to ensure stability. – Update will be provided</li> <li>• District nursing staff in West are having significant issues with mobile phones and have been informed by informatics that the service will have to purchase new ones if required = Risk score 15</li> <li>• Endoscopy performance/ surveillance, issues identified with delays. Work programme is being defined to mitigate any risks.</li> <li>• Safeguarding - It has been identified that the new nursing JDs have lost the standardised message regarding accountability for safeguarding, and the medical staff JD has lost the wording regarding notifying organisation of any police investigations.</li> </ul> <p>Group wanted to highlight the positive work being undertaken by the Ward Accreditation team and the positive feedback and engagement being seen from ward/ area staff.</p> <p>Clinical Audit Programme –Whilst this had been discussed in the</p>

	QSG workshop in November. The Chair wanted to highlight that the full proposal has been deferred a number of times and will now be presented to the March meeting.
<b>Special Measures Improvement Framework Theme/Expectation addressed</b>	
<b>Planned business for the next meeting:</b>	To be determined from cycle of business
<b>Date of next meeting:</b>	Wednesday 13 <sup>th</sup> March 2019

*Disclosure:*

*Betsi Cadwaladr University Health Board is the operational name of Betsi Cadwaladr University Local Health Board*

**Quality, Safety &  
Experience Committee**

19.3.19



**GIG**  
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WALES

Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board

*To improve health and provide excellent care*

<b>Report Title:</b>	An update on incidents which occur within BCUHB which are classified as Never Events
<b>Report Author:</b>	Mrs Barbara Jackson, Assistant Director Service User Experience
<b>Responsible Director:</b>	Mrs Gill Harris, Executive Director Nursing and Midwifery
<b>Public or In Committee</b>	Public
<b>Purpose of Report:</b>	This report is provided monthly to the Executive Management Group (EMG) to provide the meeting with an up to date position on open Never Event incidents, and is being shared with the QSE Committee at the request of the Executive Director of Nursing & Midwifery.
<b>Approval / Scrutiny Route Prior to Presentation:</b>	<p>Serious incidents to include Never Events (NE) are reported on a regular basis to:</p> <ul style="list-style-type: none"> <li>• Local quality and safety meetings</li> <li>• Weekly Incident Review Meeting</li> <li>• Quality Safety Group</li> </ul> <p>Each event is escalated immediately to the clinical executives and as from October 2018, the Independent members are also informed.</p>
<b>Governance issues / risks:</b>	<p>Never Events are defined as Serious Incidents that are wholly preventable because guidance or safety recommendations are available at a national level and should have been implemented by all healthcare providers.</p> <p>Each Never Event has the potential to cause serious patient harm or death. However, serious harm or death does not need to have happened as a result of a specific incident for that incident to be categorised as a Never Event.</p> <p>Never Events require full investigation under the Serious Incident Framework. This includes the need to fully and meaningfully engage patients, families and carers at the beginning of and throughout any investigation.</p> <p>Learning from what goes wrong in healthcare is crucial to reducing avoidable harm.</p> <p>The list of incidents to be classed as Never Events is specified by Welsh Government and detailed in WHC/2018/12</p>

	<a href="http://howis.wales.nhs.uk/sitesplus/documents/861/WHC_2018_12%20-%20Never%20Events%20List%202018.pdf">http://howis.wales.nhs.uk/sitesplus/documents/861/WHC_2018_12%20-%20Never%20Events%20List%202018.pdf</a>
<b>Financial Implications:</b>	Costs relating to harm from such incidents.
<b>Recommendation:</b>	The Committee is asked to: 1. Note that the report is considered at EMG monthly and to other relevant forums 2. note the Never Events that have occurred

<b>Health Board's Well-being Objectives</b> <i>(Indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)</i>	√	<b>WFGA Sustainable Development Principle</b> <i>(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.)</i>	√
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			
<b>Special Measures Improvement Framework Theme/Expectation addressed by this paper</b>			
Concerns management are monitored as part of the special measures framework			
<b>Equality Impact Assessment</b>			
Not required for update paper of this nature.			

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## **An update on incidents which occur within BCUHB which are classified as Never Events**

### **1. Purpose of report**

The purpose of this report is to provide the meeting with an up to date position on Never Event incidents which are currently being managed by the organisation.

### **2. Introduction/Context**

Never Events are defined as Serious Incidents that are wholly preventable because guidance or safety recommendations are available at a national level and should have been implemented by all healthcare providers.

Each Never Event has the potential to cause serious patient harm or death. However, serious harm or death does not need to have happened as a result of a specific incident for that incident to be categorised as a Never Event.

Never Events require full investigation under the Serious Incident Framework. This includes the need to fully and meaningfully engage patients, families and carers at the beginning of and throughout any investigation. These incidents are reported to the Welsh Government and can only be finally closed when Welsh Government are assured that learning has been implemented to prevent reoccurrence.

Learning from what goes wrong in healthcare is crucial to preventing harm.

The list of incidents to be classed as Never Events is specified by Welsh Government and detailed in WHC/2018/12

[http://howis.wales.nhs.uk/sitesplus/documents/861/WHC\\_2018\\_12%20-%20Never%20Events%20List%202018.pdf](http://howis.wales.nhs.uk/sitesplus/documents/861/WHC_2018_12%20-%20Never%20Events%20List%202018.pdf)

### **3. Summary of open Never Events**

There are currently 5 Never Events open to the Health Board; 3 occurred in 2017/18 and 2 occurred in 2018/19; 2 incident has been closed by WG in the last month.

The investigation process is complete for two incidents, however they remain open as the Welsh Government have not yet provided final closure. A further two\* incidents have also been submitted to Welsh Government; who have requested additional information to enable closure.

The table below provides further detail regarding progress with the investigation.

**Never Events**

Ref	Incident date	Severity	Region	Unit	Location (exact)	Description	Never Events WG category	Closure Due	Current Position
<b>With WG awaiting closure</b>									
INC150862	14/03/2018	Negligible	BCUHB West	Ysbyty Gwynedd - Acute	Gogarth, YG (secondary care)	IV hydrocortizone given orally, and oral Ranitidine given intravenously through the cannula	Wrong route administration of medication	14/06/2018	All necessary documentation submitted to WG awaiting decision regarding closure
INC134811	20/09/2017	Moderate	BCUHB Central	Ysbyty Glan Clwyd Hospital - Acute	Anaesthetics (secondary care)	PICC line insertion	Retained foreign object post-operation	14/12/2017	Closure form sent to WG and more information required in relation to action plan. Head of Service user Experience and Governance Lead Nurse reviewing.



*INC167650	16/09/2018	Catastrophic	BCUHB Central	Ysbyty Glan Clwyd Hospital - Acute	Ward 7, YGC (secondary care)	Iliac block performed on the right leg not the left fractured leg	Wrong route administration of medication	12/12/2018	Closure form sent to WG
*INC138308	04/10/2017	Negligible	BCUHB East	Wrexham Maelor Hospital - Acute	Radiology (secondary care)	Left sub-talar joint injected instead of the left talo-navic.	Wrong site surgery		Revised report currently with D. C. awaiting submission to WG

### Being investigated

Ref	Incident date	Severity	Region	Unit	Location (exact)	Description	Never Events WG category	Closure Due	Current Position
INC174655	01/12/2018	Major	BCUHB West	Ysbyty Gwynedd - Acute	Coronary Care Unit (secondary care)	Guidewire left in pt's arm	Retained foreign object post-operation	05/03/2019	Investigation completed. Closure form in draft. LOCCSIPP developed as an action from shared learning

**Closed**

Ref	Severity	Region	Unit	Location (exact)	Description	Never Events WG category	Closed	Confirmation of Actions
INC155698	Negligible	BCUHB Central	Ysbyty Glan Clwyd Hospital - Acute	Outpatients (secondary care)	<p>Patient had informed the Consultant at her 3rd subsequent outpatient appointment that she felt her tongue biopsy had been taken from the wrong area. The initial biopsy was confirmed as lichen planus.</p> <p>As there was lichen planus in the same area as the ulcer this may have made it difficult to ascertain exactly where the ulcer was. The ulcer was identified at the outer edge of the lichen planus. A further biopsy was taken and this was confirmed as cancerous. A partial glossectomy was performed and</p>	Wrong Site Surgery	24/01/2019	<p>Modified WHO Safer Procedure checklist for all procedures undertaken in the department has been implemented.</p> <p>When site not clear / secondary issues in same area – photographs will be taken with patient's consent and marked to indicate site that biopsy is to be taken from.</p> <p>Both actions discussed and agreed by Max Fax teams and implemented as changes to practice from lessons learned.</p>

					adjuvant therapy commenced. Consultant discussed the incident with the patient and the family and apologised.			
INC153282	Negligible	BCUHB West	Ysbyty Gwynedd - Acute	Dewi, YG (secondary care)	Anaesthetist attended Dewi ward and patient was subsequently intubated without sedation/bougie (grade 1 view). No carbon dioxide monitor was attached. Upon arrival and assessment, the anaesthetic registrar observed the child to have a distended abdomen with brown liquid visible from the mouth/nose. Visualisation of the endotracheal tube placement revealed the tube to be in the oesophagus. The tube was removed and the child was successfully	Misplaced Naso or oro-gastic tubes	11/01/2019	<p>Arrange for all Anaesthetic staff including ODPs to have swipe access to the Children's wards.</p> <p>There is a clear process in place for all Anaesthetic staff to arrange swipe access to the Children's Unit – however it is not being followed and therefore the learning is to review the current system and ensure that all staff are made aware during induction of the process including induction to the Children's Unit.</p> <p>Ensure compliance for the routine use of capnography for all intubated patients.</p> <p>Case has been discussed at the ACC M&amp;M meeting week 12.11.18</p>

					intubated resulting in resolving the hypoxia.			<p>Review formal anaesthetic induction programme for Doctors and provide assurance that awareness of all high-risk areas are included.</p> <p>Clinical Lead for Anaesthetics to highlight case to colleagues and advise that the child was intubated twice without sedation without a clear clinical justification</p> <p>Case has been discussed at the ACC M&amp;M meeting week 12.11.18</p> <p>Undertake a review into how anaesthetic staff record administered medications in the paediatric setting.</p> <p>Case has been discussed at the ACC M&amp;M meeting week 12.11.18 Agreed that best place to document drugs given would be on the new "sick child" pathway</p> <p>Clinical Service Manager for Paediatrics to review</p>
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									the timing of the child's transfer to the resuscitation area with Dewi staff and to highlight that, where it is anticipated intubation will be required, the child should be transferred to the resuscitation area of the ward in anticipation of the arrival of the anaesthetic team.
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#### **4. Assessment of risk and key impacts**

The timely investigation of Never Events, as for other serious incidents, allows the organisation to identify learning at an early stage to maximise the opportunities to prevent a recurrence.

The learning from these events is shared routinely with the relevant divisional Quality and Safety group and to the QSG monthly.

There are number of themes which have been identified from the Never Event analysis including repeated errors of wrong site/joint injections, retained items following surgery and incidents relating to the prescribing and administration of Methotrexate. All of these areas have prompted system wide learning and changes in practice.

#### **5. Equality Impact Assessment**

Update document


#### **6. Conclusions / Next Steps**

This report will be submitted monthly to the Executive Management Group

#### **7. Recommendations**

The Committee is asked to:

1. Note that the report is considered at EMG monthly and to other relevant forums
2. note the Never Events that have occurred

<b>Quality, Safety &amp; Experience Committee</b>  <b>19.3.19</b>	 <b>GIG CYMRU NHS WALES</b>   Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board  To improve health and provide excellent care
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<b>Report Title:</b>	Summary of In Committee business to be reported in public
<b>Report Author:</b>	Mrs Kate Dunn, Head of Corporate Affairs
<b>Responsible Director:</b>	Mrs Gill Harris, Executive Director of Nursing & Midwifery
<b>Public or In Committee</b>	Public
<b>Purpose of Report:</b>	Standing Order 6.5.3 requires the Board to formally report any decisions taken in private session to the next meeting of the Board in public session. This principle is also applied to Committee meetings.
<b>Approval / Scrutiny Route Prior to Presentation:</b>	The issues listed below were considered by the Committee at its private in committee meeting on 21.1.19 <ul style="list-style-type: none"> <li>• Quality and safety briefings from Executive Directors</li> </ul>
<b>Governance issues / risks:</b>	None identified
<b>Financial Implications:</b>	None identified
<b>Recommendation:</b>	The Committee is asked to note the information in public.

<b>Health Board's Well-being Objectives</b> <i>(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)</i>	✓	<b>WFGA Sustainable Development Principle</b> <i>(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.)</i>	✓
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	✓		
<b>Special Measures Improvement Framework Theme/Expectation addressed by this paper</b>			
Governance			
<b>Equality Impact Assessment</b>			
No equality impact assessment is considered necessary for this paper.			

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