

Bundle Quality, Safety & Experience Committee 21 May 2019

Agenda

9.30am

Boardroom, Carlton Court St Asaph LL17 0JG

- 1.0 OPENING BUSINESS AND EFFECTIVE GOVERNANCE
- 1.1 09:30 - QS19/61 Chair's Opening Remarks
- 1.2 09:31 - QS19/62 Declarations of Interest
- 1.3 09:32 - QS19/63 Apologies for Absence
- 1.4 09:33 - QS19/64 Minutes of Previous Meeting Held in Public on the 19th March 2019 for Accuracy, Matters Arising and Review of Summary Action Log
- QS19.64a Minutes QSE 19.3.19 Public v0.03.docx
- QS19.64b Summary Action Log QSE Public Live.docx
- 2.0 FOR DISCUSSION
- 2.1 09:43 - QS19/65 Patient Story - Mrs Deborah Carter
- Video presentation*
- 2.2 09:58 - QS19/66 Integrated Quality & Performance Leads - Mr Mark Wilkinson
- Recommendation:*
The Committee is asked to note the report.
- QS19.66a IQPR coversheet.docx
- QS19.66b IQPR April 2019.pdf
- QS19.66c IQPR End of Year.pdf
- 2.3 10:18 - QS19/67 Infection Prevention & Control - Safe Clean Care Update: Mrs Deborah Carter
- Presentation slides*
- QS19.67 IPC Safe Clean Care.pdf
- 2.4 10:28 - QS19/68 All Wales Standards for Accessible Communication and Information for People with Sensory Loss - Update on Implementation - Mrs Deborah Carter
- Recommendation:*
To consider taking forward the recommendations in the organisational action plan and where possible embed in the wider organisation and governance performance framework
- QS19.68 All Wales Standards for Accessible Communication_no embeds.docx
- 2.5 10:43 - QS19/69 Clinical Audit : The Proposed Way Forward : Dr Evan Moore
- Recommendation:*
The Committee is asked to:
- (1) endorse the proposed way forward in terms of managing the clinical audit function;
- (2) endorse the proposals in relation to the clinical audit plan for 2019/20 acknowledging that the plan will be further refined over coming months to provide assurance against risks to the Quality Improvement Strategy by September 2019.
- (3) agree the proposal in relation to future reporting via QSE and Audit Committee as outlined, and as a consequence stands down the JAQS meeting in November 2019.
- QS19.69a Clinical Audit coversheet V0.2.docx
- QS19.69b Clinical Audit paper v6 10.5.19 at 1750.doc
- QS19.69c Clinical Audit Appendix 1 Summary Action Log JAQS Committee v3.doc
- QS19.69d Clinical Audit Appendix 2 logic diagram v2.docx
- 2.6 11:13 - COMFORT BREAK
- 2.7 11:18 - QS19/70 Quality Assurance "CLICH" Report : Mrs Deborah Carter
- Recommendation:*
The Committee are asked to note the content of this report.
- QS19.70 CLICH Report Q1 v03.docx
- 2.8 11:33 - QS19/71 Review of Corporate Risks Assigned to the QSE Committee : Executive Leads
- Recommendation:*
The Committee is asked to consider the relevance of the current controls, review the actions in place and consider whether the risk scores remain appropriate for the presented risks.
- QS19.71a CRR_coversheet.docx
- QS19.71b CRR02.pdf
- QS19.71c CRR03.pdf
- QS19.71d CRR05.pdf

[QS19.71e CRR13.pdf](#)

[QS19.71f CRR16.pdf](#)

- 2.9 11:48 - QS19/72 Putting Things Right Annual Report : Mrs Deborah Carter
Recommendation:
The Committee is asked to approve the annual report
[QS19.72a PTR annual report coversheet.docx](#)
[QS19.72b PTR annual report 2018-19 V8.1.docx](#)
- 2.10 12:03 - QS19/73 Safeguarding and Protection of People at Risk of Harm Annual Report 2018-19 : Mrs Deborah Carter
Recommendations:
It is recommended that the Committee:
1. Note the progress made this year within the Corporate Safeguarding Team, particularly in relation to the implementation of the HASCAS/DO recommendations.
2. Note the emphasis of the Corporate Safeguarding Team on embedding continual improvement through developing benchmarking, peer review and identifying data led areas for improvement in an open and transparent way
3. Approve the Corporate Safeguarding Priority Action Plan for 2019-20 for delivery
[QS19.73a Safeguarding coversheet.docx](#)
[QS19.73b Safeguarding Annual Report FINAL.doc](#)
- 2.11 12:18 - QS19/74 Reducing Avoidable Mortality - Update on Progress : Dr Evan Moore
Recommendations:
The Committee is asked to:
1. Note the report for information
2. Consider whether the revised format meets the Committee's needs.
[QS19.74 Mortality report.docx](#)
- 2.12 12:33 - QS19/76 Health and Safety Update Report : Mrs Sue Green
Recommendation:
The Committee is asked to note the position outlined in this report.
[QS19.76 Health and Safety Update Report v5.docx](#)
- 2.13 12:43 - LUNCH BREAK - attendees to provide their own lunch
- 2.15 12:58 - QS19/77 HMP Berwyn Health and Well-Being Annual Quality & Performance Report 2018-19 : Dr Chris Stockport
Recommendation:
To receive and note the report.
[QS19.77a HMP Berwyn coversheet v2.docx](#)
[QS19.77b HMP Berwyn Annual Performance Report 18-19.docx](#)
- 3.0 13:13 - FOR CONSENT
- 3.1 13:23 - QS19/78 Policies, Procedures or Other Written Control Documents for Approval
- 3.1.1 QS19/78.1 Pandemic Influenza Plan Distribution - Collection & Delivery of Antivirals : Dr Evan Moore
Recommendation:
The Committee is asked to approve the Policy
[QS19.78.1 Pandemic flu policy.docx](#)
- 3.1.2 QS19/78.2 Cardiopulmonary Resuscitation (CPR) Policy : Mrs Deborah Carter
Recommendation:
The Committee is asked to approve the changes to the Cardiopulmonary Resuscitation Policy
[QS19.78.2a CPR RES03_coversheet.docx](#)
[QS19.78.2b CPR RES_03_Final_Doc_with_updates_x2.docx](#)
[QS19.78.2c CPR EqIA Screening.docx](#)
- 3.1.3 QS19/78.3 PTR1 Concerns Policy (Complaints, Claims and Incidents) - Mrs Deborah Carter
Recommendation:
The Committee is asked to approve the revised policy
[QS19.78.3a PTR01 concerns policy_coversheet.docx](#)
[QS19.78.3b PTR01 concerns policy BCUHB Jan 19 v0.02 tracked changes.doc](#)
- 3.1.4 QS19/78.4 Policy for Administration and Use of Emergency and Non Emergency Oxygen in Adults in Managed Services : Dr Evan Moore
Recommendation:
The Committee is asked to approve the Policy

QS19.78.4 Oxygen Policy.docx

3.1.5 QS19/78.5 Unlicensed Medicines Policy : Dr Evan Moore

Recommendation:

The Committee is asked to approve the Policy

QS19.78.5 Unlicensed Medicines Policy.docx

3.1.6 QS19/78.6 Medicines Policy : Dr Evan Moore

Recommendation:

The Committee is asked to approve the Policy

QS19.78.6 Medicines policy v2 without embeds.doc

3.1.7 QS19/78.7 Mental Health & Learning Disabilities Division Section 17 Leave of Absence Policy : Mr Andy Roach

Recommendation:

The Committee are asked to approve this policy for ratification

QS19.78.7a Section 17 Leave of Absence Policy coversheet.docx

QS19.78.7b Section 17 Leave of Absence Policy v3 Final.doc

QS19.78.7c Section 17 Leave of Absence Policy EQIA.doc

3.1.8 QS19/78.8 Mental Health & Learning Disabilities Division Therapeutic Engagement & Observation Policy : Mr Andy Roach

Recommendation:

The Committee are asked to approve this policy for implementation.

QS19.78.8a Therapeutic Engagement & Observation Policy coversheet.docx

QS19.78.8b Therapeutic Engagement & Observation Policy.docx

QS19.78.8c Therapeutic Engagement & Observation Policy eqia.doc

3.2 13:38 - QS19/79 Quality Safety Group Assurance Report : Mrs Deborah Carter ****FOLLOW ON PAPER****

Recommendation:

3.3 13:48 - QS19/80 Progress report of Recommendations Arising from HASCAS Independent Investigation and Ockenden Governance Review : Mrs Deborah Carter

Recommendation:

To note the progress against the recommendations to date

QS19.80a HASCAS & Ockenden Review coversheet and paper.docx

QS19.80b HASCAS & Ockenden table.docx

3.4 14:03 - QS19/81 Continuing NHS Health Care Assurance Report - Dr Chris Stockport

Recommendations:

The Committee is asked to :

- 1. Note issues identified in this report*
- 2. Note the development of Corporate CHC Team and Functions*
- 3. Note the current position of the Health Board on the processing of retrospective claims;*
- 4. Note the review of national policy and delivery systems that may include a review of the role of the National Complex Care Board;*
- 5. Note the Health Board position on the current WG mandated performance measures, and the work underway which aims to embed CHC performance within the wider outcomes frameworks in future years.*
- 6. Note the immediate priorities for the CHC department*

QS19.81a CHC coversheet.docx

QS19.81b CHC report.doc

4 FOR DECISION

4.1 14:08 - QS19/82 Annual Quality Statement 2018-19 - Mrs Deborah Carter

Recommendations:

The Committee are asked to:

- 1. Approve the AQS.*
- 2. Note that the final formatting will take place following approval in preparation for publication on 31st May 2019.*

QS19.82a AQS coversheet.docx

QS19.82b Annual Quality Statement 2018-2019_draft v3.pdf

5.0 14:23 - FOR INFORMATION

5.1 QS19/83 Issues Discussed in Previous In Committee Session

Recommendation:

The Committee is asked to note the information in public.

QS19.83 In Committee items reported in public.docx

5.2 QS19/84 Documents Circulated to Members

15.3.19 QSG notes February

4.4.19 SUI data

11.4.19 Amber Review Implementation Programme report (WAST)

15.4.19 QSG notes March

14.5.19 QSG notes April

5.3 QS19/85 Issues of Significance to inform the Chair's Assurance Report

5.4 QS19/86 Date of Next Meeting

Tuesday 16th July 2019 @ 9.30am

5.5 QS19/87 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 (QSE) Committee

Minutes of the Meeting Held in public on 19.3.19 in The Boardroom, Carlton Court, St Asaph

Present:

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

In Attendance:

Ms Clare Bevan	Director of Quality, Safety & Patient Experience WAST (for Minute QS19/25+27)
Mrs Deborah Carter	Associate Director, Quality Assurance
Mr Steve Forsyth	Director of Nursing Mental Health & Learning Disabilities (MHLDS) (for Minute QS19/38)
Mrs Sue Green	Executive Director of Workforce & Organisational Development (OD)
Ms Debra Hickman	Secondary Care Nurse Director (for Minute QS19/48)
Dr Louise Howard-Baker	Assistant Director, Pharmacy (for Minute QS19/37)
Dr Evan Moore	Executive Medical Director (part meeting)
Dr Jill Newman	Director of Performance
Dr Berwyn Owen	Chief Pharmacist (for Minute QS19/37)
Miss Teresa Owen	Executive Director of Public Health
Ms Dawn Sharp	Assistant Director and Deputy Board Secretary
Dr Chris Stockport	Executive Director of Primary and Community Services
Mr Adrian Thomas	Executive Director of Therapies & Health Sciences

Agenda Item Discussed	Action By
QS19/24 Chair's Opening Remarks The Chair welcomed everyone to the meeting.	
QS19/25 Patient Story QS19/25.1 Members were shown a short video illustrating the difficult experience of a patient and her relatives involving the Welsh Ambulance Service and the Health Board. The Director of Quality, Safety and Patient Experience from Welsh Ambulance Services NHS Trust was present and outlined the positive joint work that had been undertaken by the Health Board and Trust to address the issues highlighted by this incident and improve	

<p>services in terms of the overall patient journey, with particular focus on ambulance and handover delays. The Director also explained the review of Amber calls as part of the discussions (see minute QS19/27)</p> <p>QS19/25.2 The Chair referred to the recent update that had been presented to the Audit Committee in relation to Ambulance handover. Whilst welcoming the reduction in Ambulance handover delays, the report to the Audit Committee had highlighted concerns regarding the associated risk transfer in terms of 'corridor nursing' and had requested assurance that this was being managed. The Associate Director of Quality Assurance set out the overall context and the appropriateness of transferring the risk to the hospital and reminded Members of the greater clinical risks faced by the wider community in circumstances where there was no ambulance resource as a result of handover delays. This was acknowledged by the Committee, however members raised concerns over some recent experiences of patients in the Emergency Departments. It was agreed that members would share individual case information outside of the meeting with the Associate Director of Quality Assurance.</p> <p>QS19/25.3 Discussions continued with regard to the demand for Advanced Paramedic Practitioner roles in both the Ambulance Service and Health Board as part of the ongoing development of multidisciplinary team-working in primary and community services. Members acknowledged the benefits of moving these discussions forward in partnership and the importance of joint workforce planning going forward. The Executive Director of Workforce and Organisational Development agreed to initiate discussions along with the Executive Director of Primary and Community Services.</p> <p>IT WAS RESOLVED THAT:</p> <p>(1) the actions being taken to improve services for patients be welcomed; and (2) the Executive Director of Workforce and Organisational Development initiate workforce planning discussions as outlined.</p>	SG
<p>QS19/26 Listening & Learning From Experience Report <i>The Executive Medical Director joined the meeting.</i></p> <p>QS19/26.1 The Associate Director Quality Assurance presented the report which provided 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). It set out the overall aim for the Patient and Service User Experience Strategy 2019 -2022 which was to promote and sustain a shared ambition for patient/service user experience across the Health Board. This includes identifying 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. The format of the report had been reviewed by a working group and it was recognised it was work in progress. The Committee were asked to support the change in name of the Patient Advice and Support Service to the Patient Advice and Liaison Service</p>	

<p>to assist service users to understand the function in line with a well recognised identity. Members agreed that this would be beneficial and supported the change.</p> <p>QS19/26.2 Members welcomed the revised format of the report and suggested further improvements going forward to present the information in a positive way, condense the information where possible and ensure that graphs were dyslexia friendly. It was agreed that any further feedback on the report or the draft strategy would be forwarded by the end of April 2019.</p> <p>IT WAS RESOLVED THAT :</p> <p>(1) progress be noted and Members forward feedback on the report and the draft Strategy to the Associate Director Quality Assurance by the end of April 2019;</p> <p>(2) 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 be ratified.</p>	All
<p>QS19/27 Discussion with Wales Ambulance Services NHS Trust - Amber Review Report from Emergency Ambulance Services Committee (EASC) <i>(Item taken in conjunction with QS 19/25)</i></p> <p>QS19/27.1 The Director of Quality, Safety & Patient Experience for WAST described the review of the Amber calls within the Welsh Ambulance Services' (WAST's) clinical response model, undertaken by EASC. The 'Amber' category of call was for those patients with serious conditions that were not immediately life-threatening but which were urgent and might need treatment and care at the scene or rapid transport to a healthcare facility. This was an independent review using an expert reference panel which had been launched in May 2018 to understand whether there:-</p> <ul style="list-style-type: none"> • Was a systemic problem with the Amber category that was resulting in worsening outcomes for patients? • Were patients in the Amber category waiting too long for an ambulance response and if so, what was the impact on their health and experience? <p>QS19/27.2 The review made a number of recommendations including:</p> <ul style="list-style-type: none"> • Ensuring that planned resources were 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 <p>QS19/27.3 There was discussion about the numbers of calls in each category and the geographical challenges across North Wales contributing to response times. The Committee noted the significant reduction that had been achieved in ambulance handover delays and whilst it was recognised that there are still</p>	

<p>improvements to be made, this would assist in reducing lost hours for ambulances and long waits for patients in the community as well.</p> <p>IT WAS RESOLVED THAT the report be received and the reductions in Ambulance waits be welcomed.</p>	
<p>QS19/28 Declarations of Interest</p> <p>There were no declarations of interest recorded at the meeting.</p>	
<p>QS19/29 Apologies for Absence</p> <p>The Chair acknowledged apologies of absence received from Gareth Evans, Gill Harris, Melanie Maxwell, Andy Roach and Mark Thornton.</p>	
<p>QS19/30 Minutes of Previous Meeting Held in Public on 22.1.19 for Accuracy, Matters Arising and Review of Summary Action Log</p> <p>QS19/30.1 The minutes were agreed as an accurate record subject to noting the presence of Lyn Meadows from Minute number 19.4.1.</p> <p>QS19/30.2 Updates were provided to the summary action log and recorded therein. The Chair noted a number of actions had not been completed and were overdue. Members were informed that some of the actions had been included as part of the Board papers. The Chair requested that any actions arising from the QSE Committee be reported back to the QSE Committee. The updates should also fully meet the agreed action before it can be closed.</p>	
<p>QS19/31 Public Accounts Committee (PAC)</p> <p>QS19/31.1 The Associate Director Quality Assurance provided the Committee with verbal feedback from the recent attendance by the Health Board at the Public Accounts Committee.</p> <p>IT WAS RESOLVED THAT the update be noted.</p>	
<p>QS19/32 Integrated Quality & Performance Report (IQPR)</p> <p>QS19/32.1 The Chair apologised for the report having only been circulated to Members the previous day instead of on the previous working day as had been agreed. The Chair outlined discussions with the Director of Performance going forwards in order to balance the receipt of the most up to date information against the current difficulties with the data only becoming available on the 10th working day of the month. The report outlined the key performance and quality issues that were delegated to the Committee. This month saw the third presentation of the report in the new format with all measures presented in</p>	

<p>Chapter form as per the Health Board version. The Summary of the report was now included as an Executive Summary within the report itself. The Director of Performance explained that the 2019/20 Annual Delivery Framework was yet to be issued by Welsh Government.</p> <p>QS19/32.2 Members suggested further improvements to the format of the report in terms of consistency and correcting nuances within the document, quality supporting narrative, the ongoing education of leads and the importance of data only being incorporated and presented in a public arena once verified. Further consideration was to be given to the falls data as presented in terms of what was included going forward. The Executive Director of Public Health referred to the Child Adolescent Mental Health (CAMHS) information and the current backlog in central. A deep dive session was to be held and would form part of the continuous improvement programme. Members noted that a Board development session on 18th April was planned. The Executive Director of Public Health confirmed that she was the Executive Lead for CAMHS as the service will not be transferring to the Mental Health and Learning Difficulties Division as previously discussed. The Chair asked that the IQPR be updated to ensure that the correct Executive Leads were identified. A CAMHS divisional update would be provided to the next meeting in May. Concerns were also expressed about the accuracy of the performance being reported for GP practice opening hours. The Executive Director of Primary and Community Services agreed to discuss this further outside the meeting with the Director of Performance.</p> <p>IT WAS RESOLVED THAT: the report be noted.</p>	<p>JN TO CS</p>
<p>QS19/33 Update on Infection Prevention and Control across BCUHB (Item taken following QS19/38)</p> <p>QS19/33.1 Members welcomed the positive update from the Associate Director of Quality Assurance. The need for all Health Boards to reduce avoidable infections remained a high priority across Wales and continues to be scrutinised. Healthcare-associated infection, incorporating decontamination, cleanliness and antimicrobial resistance, remained on the corporate risk register. This had been reviewed by the corporate nursing team and remained with a combined risk score of 20. (Likelihood = 4, Impact = 5). A wide range of mitigating actions and control measures were in place which included implementation of the Safe Clean Care Campaign. Key issues highlighted in the report included:</p> <ul style="list-style-type: none"> • A brief summary of infection performance data for key infections targets, including benchmarking against other Welsh Health Boards. • An update on the Safe, Clean, Care (SCC) campaign. • Update on the Welsh Government review of the decontamination of medical devices across BCUHB. • Update on improvements to environmental cleanliness across BCUHB. 	

QS19/33.2 Members referred to recent walkabouts and the positive feedback received, particularly in terms of the ward dashboard performance. In terms of performance the Health Board was now positioned 3rd best in Wales.

IT WAS RESOLVED THAT: the current performance in relation to key infections, and how BCUHB benchmarks with other Welsh Health Boards be noted together with the progress of key elements of the Safe Clean Care Campaign.

QS19/34 Health & Safety (H&S) Update

QS19/34.1 The Executive Director of Workforce & OD presented the paper which provided an update on the actions approved by the Health Board at its meeting on 1st November 2018. The Board had recognised that the lack of a visible functioning system and structure for the effective management of health and safety presented a significant risk to the organisation. The recruitment of a new Associate Director of Health and Safety and Equality had recently taken place and the new appointee was due to take up post on 13th May. The two Heads of Health and Safety were now also in post and were having a positive impact in addressing the key risks which included a fundamental review of security arrangements.

QS19/34.2 Following concerns raised regarding the process for the management of RIDDOR reporting, a revised interim process had been implemented to ensure:

- Central decision making and reporting to the Health & Safety Executive (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.

QS19/34.3 Between 1st January 2019 and 28th February 2019 there had been 11 staff safety reports and six patient safety reports. As a result of recent chemical exposure incidents, the HSE had indicated that they would be visiting the Health Board to investigate. The Health and Safety Team would be managing the preparation and arrangements for the visit. Evaluation of the process would be undertaken and a Procedure was to be drafted for approval through the Health and Safety Group in May 2019 (following commencement of the new Associate Director). In addition, agreement would need to be reached in relation to the reporting of such 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 1st April 2019.

QS19/34.4 The need for a systematic approach to managing Health and Safety was to be documented in a 3 year Improvement Plan in line with the Workforce Strategy. Members questioned whether the three-year timeframe was too

<p>long. The Executive Director confirmed that all actions in the plan would be progressed simultaneously and an update in terms of percentage compliance against each of the actions would be provided each year. The Committee also emphasised the importance of taking forward the Health and Safety agenda in partnership with staff side.</p> <p>QS19/34.5 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. The current entry on the Risk Register had 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. Members expressed concern that the risk score had been reduced given that the improvements were not yet embedded and that the governance structures were still to be implemented. The Executive Director explained the rationale given the current wording of the risk and agreed to reconsider the scoring in the context of an updated risk description. The Executive Director confirmed that delivering against the actions outlined supported the delivery of the recommendations set out within the Internal Audit Report of 2018.</p> <p>IT WAS RESOLVEDTHAT:</p> <p>(1) the Committee note the position outlined in the report; and</p> <p>(2) the Executive Director of Workforce and OD review the current tier 2 risk entry description and scoring.</p>	SG
<p>QS19/35 Draft Annual Quality Statement 2018-19 <i>(Item taken following QS 19/33)</i></p> <p>QS19/35.1 The Associate Director of Quality Assurance presented the draft Annual Quality Statement (AQS) for comments / feedback on content. The AQS provided an open and honest overview in terms of the quality agenda of the Health Board's services, progress against the previous year's priorities, other areas of development and achievements for the past year. It also provided an overview of areas for focused improvement for the coming year. Data contained within the AQS related to year end quality measures that had been presented to the Committee prior to the AQS inclusion. To support the easy access approach as required for the AQS the data was presented where appropriate as an infographic (as used in the early pages in the draft AQS document). The working draft AQS had been developed following submissions across the Health Board and formatting would take place during the final stages and following feedback from all the groups/committee.</p> <p>QS19/35.2 Members made a number of suggestions regarding the document being too secondary care focussed and including additional information regarding other services; the focus for next year being to demonstrate improvements in organisational learning and ensuring that the Wales for Africa references provided clarity regarding the wider international health links that</p>	

<p>the Health Board had. Members were encouraged to provide any further feedback to the Director by the end of the first week of April.</p> <p>QS19/35.3 The Chair advised the Committee that a discussion had taken place at the Audit Committee with the Welsh Audit Office with regards to reporting progress within the AQS in relation to the Clinical Audit Plan and that further advice is being sought.</p> <p>IT WAS RESOLVED THAT: the comments put forward by the Committee be noted and any further feedback by Members be submitted to the Director by the end of the first week in April.</p>	All
<p>QS19/36 Committee Annual Report 2018-19</p> <p>QS19/36.1 The Associate Director of Quality Assurance presented the draft Committee Annual Report for 2018-19 which had been prepared on a BCU-wide template. The report would require further amendment to incorporate themes from the March Committee meeting and was to be submitted to a workshop of the Audit Committee on the 14th May 2019. Members suggested a correction to the reference regarding an external Health and Safety report. The Committee agreed to provide any further feedback to the Office of the Board Secretary by the end of the first week in April, including any proposed changes to the Terms of Reference to allow for Chair's Action to be taken to submit to Audit Committee workshop.</p> <p>QS19/36.2 The Chair referred to a workshop she intended to hold to review the work and cycle of business of the Committee to improve effectiveness and review the plan for 2019/20.</p> <p>IT WAS RESOLVED THAT:</p> <p>(1) the comments referred to above be taken into account and any further feedback be provided to the Office of the Board Secretary by the end of the first week in April.</p>	<p>All</p> <p>LR/KD</p> <p>KD</p>
<p>QS19/37 Pharmacy & Medicines Management Annual Quality and Safety Report 2018-19</p> <p><i>(Item taken immediately after AS 19/34)</i></p> <p>QS19/37.1 The Chief Pharmacist presented the report which provided an annual statement to the Committee on Pharmacy & Medicines Management's Quality and Safety using the Health & Care Standards Framework. Risks highlighted in the report related to:</p> <ul style="list-style-type: none"> • 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 	

<p>QS19/37.2 Members noted the emphasis being placed on moving to an electronic prescribing system which would follow on from the implementation of a new NHS Wales pharmacy system of which the Health was in the second tranche. It was agreed to make a number of minor drafting changes to the document prior to its presentation to Board.</p> <p>QS19/37.3 Members also raised the issue of sickness in Ysbyty Gwynedd being considerably higher than the other two hospital sites. The Chief Pharmacist explained that a significant number of staff being on maternity leave and temporary staffing support had been contributory factors.</p> <p>QS19/37.4 It was agreed that a further report would be prepared for the September meeting of the Committee and that this would feature on the cycle of business going forward (in addition to the Annual report being presented in March). The report would focus on key risks and how these were being managed, performance indicators together with details of lessons learnt and implementation from incidents. The Chair agreed to discuss the detail of the report with the Chief Pharmacist outside the meeting.</p> <p>QS19/37.5 Members particularly welcomed the work undertaken on suspected medication-related admissions that had 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 had prompted some notable positive local/national changes in practice benefiting NHS Wales' patients, staff and beyond. The Chief Pharmacist agreed to give further consideration to how this might be rolled out across all three sites in North Wales and linking in with the Quality Improvement Hub.</p> <p>IT WAS RESOLVED THAT:</p> <p>(1) the Committee note the report and recommended it to Board subject to minor adjustments discussed at the meeting;</p> <p>(2) a further report be prepared for the September meeting as outlined above; and;</p> <p>(3) the Chief Pharmacist give further consideration to how the work undertaken on suspected medication-related admissions can be rolled out across all three hospital sites.</p>	<p>LR</p> <p>BO</p>
<p>QS19/38 Mental Health & Learning Disabilities Division Update on Quality Improvement Governance Plan</p> <p><i>(Item taken immediately after QS19/37 which was taken out of agenda order). The Director of Nursing (MHLDS) joined the meeting for this item.</i></p> <p>QS19/38.1 The Director of Nursing (MHLDS Division) presented the report which provided an update on the Quality Improvement and Development Plan. Key achievements noted in the report included:</p> <ul style="list-style-type: none"> • Improvements to pathways particularly Older People's Mental Health (OPMH) 	

<ul style="list-style-type: none"> • Staff engagement initiatives and communication • Improvements to the environment • Clinical governance arrangements • Proposed changes to the workforce <p>QS19/38.2 The report also highlighted the direction of travel and key actions for delivery over the next 90 days which would focus on:</p> <ul style="list-style-type: none"> • Production of a Division wide action plan that engages with each of the area teams • Development of the quality improvement strategy to articulate what good looks like for sustained improvement <p>QS19/38.3 Whilst welcoming the report and positive progress, members expressed concerns with regard to the report not providing the necessary detail on how the actions aligned to the strategy with clearly articulated impacts and timelines. The Director of Nursing emphasised the importance of embedding the necessary culture change and the positive feedback from the latest two Healthcare Inspectorate Wales (HIW) inspections which demonstrated sustained improvements. In response to questions relating to savings targets the Director outlined the reporting arrangements to the Finance and Performance Committee and the need to pump prime the new service model. The Chair stated that from an assurance perspective it was important for the report to address all areas for improvement and to clearly articulate how organisational learning was being progressed. Reference was made to previous discussions at the Special Measures Improvement Framework (SMIF) Task & Finish Group and the associated sign off for the mental health actions, and the need for the information and evidence to be presented to the Committee for review. This was particularly important given the continued deterioration in the mental health performance measures in the IQPR with little narrative to explain the worsening position. Members felt that whilst the report provided a lot of commentary about the positive improvements being made as part of the TODAYICAN initiative, there was no acknowledgement or narrative about the current performance levels or clear plans to address areas in need of improvement. The Chair also explained the importance of providing detail on the identification and implementation of lessons learnt as part of a balanced report along with progress against HIW recommendations.</p> <p>QS19/38.4 In order to move matters forward it was agreed to receive an supplementary update from the Mental Health Division addressing additional areas of improvements and request an update from the Director for Mental Health and Learning Disabilities.</p> <p>IT WAS RESOLVED THAT: (1) the contents of the report be noted;</p>	AR/SF
<p>QS19/39 Quality & Safety in Primary Care (Item taken following QS 19/36)</p>	

<p>QS19/39.1 The Executive Director of Primary & Community Services presented the report which provided an overview of the arrangements in place in relation to the quality and safety of primary care services. Demand for services across the NHS and care services was increasing; in addition there was a strategic direction to care for patients closer to home where safe to do so. Across primary care there were also challenges in ensuring that the clinical multi-professional workforce was available to meet demand. The Health Board was continuing to support recruitment campaigns, along with the development of training and primary care services, to ensure the sustainability and quality of provision.</p> <p>QS19/39.2 The Executive Director sought Members' views on the future content of reports and it was agreed that this would be discussed further at the forthcoming workshop.</p> <p>IT WAS RESOLVED THAT:</p> <p>(1) the arrangements in place in relation to Quality and Safety in Primary Care and priorities for 2019/20 be noted; and</p> <p>(2) the future content of reports be discussed at the forthcoming workshop.</p>	LR/KD
<p>QS19/40 Clinical Audit Report</p> <p>QS19/40.1 The Chair informed members of the Audit Committee's feedback following consideration of the report last week. The Audit Committee were not assured with the report in that it did not meet the specific actions identified as part of previous Structured Assessments and the Joint Audit, Quality, Safety and Experience meetings in both 2017 and 2018. Members had expected the report to set out how clinical audit would address the strategic objectives of the organisation taking a risk-based approach to support quality improvement going forward. They felt that the report presented was too high level and were seriously concerned at the time lapse since the issues had been first identified. Wales Audit Office had advised that a clinical audit plan should be presented to the next Audit Committee meeting in May in order to satisfy the requirements in both the Annual Governance Statement and Annual Quality Statement. This was being progressed in partnership with the Executive Team and the Office of the Board Secretary .</p> <p>IT WAS RESOLVED THAT a revised report together with a clinical audit plan for the year ahead be presented to the May Audit Committee and shared with members of the QSE Committee.</p>	AT
<p>QS19/41 Special Measures: Review of expectations allocated to the Quality, Safety & Experience (QSE) Committee</p> <p>QS19/41.1 The Associate Director of Quality Assurance presented the report reminding Members of the background to the report. The SMIF Task & Finish</p>	

Group had 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 Task & Finish Group.

QS19/41.2 Work on the October 2018 – March 2019 section of the Framework had included a session held by the Executive Team in January 2019, dedicated to examining special measures progress in detail. As a result, it had been deemed that several of the expectations had been satisfactorily addressed and could be closed for monitoring purposes. The SMIF T&F confirmed the decisions at its February 2019 meeting.

QS19/41.3 All 'open' SMIF monitoring log expectations allocated to the Committee from the section of the Framework ending March 2019 were presented for comment. Members provided feedback as follows:-

- Line 65 – there was a need to demonstrate that lessons learnt and implementation of HIW recommendations were embedded. As agreed earlier in the meeting a further, more detailed report from the Mental Health Division would be circulated to members.
- Line 66 – Members were not satisfied with the level of detail provided and suggested inclusion of a table clearly setting out the actions taken to address matters.

IT WAS RESOLVED THAT : feedback be provided to the SMIF as detailed above.

QS19/42 Pressure Ulcer Collaborative (Hospital Acquired Pressure Ulcers/HAPU) Update

QS19/42.1 The Associate Director of Quality Assurance presented the report which provided an update of progress to date of the first Health Board Pressure Ulcer Collaborative. The purpose of the Collaborative which had commenced on 3.11.19 was to develop a Health Board standard approach to care with the aim of reducing tissue damage and pressure ulcers for in patients. The Pressure area care standard/bundle of interventions was to be a Health Board '*Always event*' for all inpatients screened as at risk of developing skin damage/pressure ulcers.

QS19/42.2 The report highlighted lessons learned, benefits and challenges whilst facilitating a collaborative across the Health Board in preparation for Health Board wide implementation of the standard and provided valuable lessons in preparation for the Falls collaborative planned to commence April 2019. There had been an increase in the number of incidents being reported for HAPU which was believed to be due to increased staff knowledge, improved surveillance and focus on transparent reporting for all grades of pressure damage. Testing of interventions so far had highlighted inappropriate

seating for patients with reduced mobility and had required that chairs be condemned which will require replacing with more suitable alternatives. The Committee were informed that the Welsh Government had reviewed reporting criteria for HAPU and this may result initially in an increase in numbers reported.

IT WAS RESOLVED THAT :

- (1) the collaborative approach adopted by the Health Board be continued for future collaboratives; and
- (2) the potential of an increase in HAPU reported initially during the roll out phase be acknowledged.

QS19/43 Ward Accreditation Dashboard

QS19/43.1 Members welcomed the report which provided an overview of the Ward Accreditation programme together with an update of implementation, initial themes and initial feedback of the Ward Accreditation programme across the Health Board. The Ward Accreditation process highlighted any areas of concern, issues or risks that were shared with the ward team and senior team immediately or as part of the validation process depending upon the level of risk. The process had highlighted areas requiring financial support and may highlight areas that required further financial support to improve upon as part of patient and staff safety and overall quality agenda. These areas might differ from one ward to another but were being monitored by the quality Improvement team.

IT WAS RESOLVED THAT : support through the Leadership of the Ward Accreditation process be continued and a strong commitment to being a part of the Ward Accreditation process be maintained.

QS19/44 Stroke Services Update

QS19/44.1 The Executive Medical Director presented an update 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. Members noted that the update did not have any financial implications but acknowledged the further work being undertaken in Stroke services which would identify the significant investment needed to improve the service to required performance and patient safety standards. Members were informed that whilst the full business case was not affordable, progress was being made in terms of implementation of key elements that would deliver the greatest benefits.

IT WAS RESOLVED THAT : the report be received and the improvements that have been made within existing resources be noted.

<p>QS19/45 Care Inspectorate Wales Inspection into Older Adult Services in Wrexham County Borough Council</p> <p>QS19/45.1 The Associate Director of Quality Assurance presented the paper which provided an update on the recent Healthcare Inspectorate Wales (HIW) and Care Inspectorate Wales (CIW) joint inspection of Older Persons Services in Wrexham Local Authority.</p> <p>IT WAS RESOLVED THAT:</p> <p>(1) the implementation of a new framework of inspection by CIW with HIW be noted;</p> <p>(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 be noted; and</p> <p>(3) the initial feedback of Inspectors relating to the partnership working of the WCBC and BCUHB be noted.</p>	
<p>QS19/46 Policies, Procedures or Other Written Control Documents for Approval</p> <p>Approval of the following Policies, together with their associated EqlAs was sought, all of which had been approved by the Quality and Safety Group:-</p> <p>QS19/46.1 Medicines Policy</p> <p>IT WAS RESOLVED THAT the Medicines Policy MM01 be approved.</p> <p>QS19/46.2 Medical Gas Staff Responsibilities</p> <p>IT WAS RESOLVED THAT the Policy relating to Medical Gas Staff Responsibilities be approved.</p> <p>QS19/46.3 Non Ionising Radiation Protection Policy</p> <p>QS19/46.3.1 It was agreed to amend the Policy to reflect the Executive responsibility for Health and Safety now sitting with the Executive Director of Workforce and OD.</p> <p>QS19/46.3.2 IT WAS RESOLVED that the Non Ionising Radiation Protection Policy be approved, subject to the amendment outlined above.</p> <p>QS19/46.4 Physical Restraint Guidelines</p>	AT

<p>QS19/46.4.1 The Executive Director of Workforce and OD indicated an amendment required to the wording of the role of security staff and it was agreed that this would be provided outside the meeting.</p> <p>QS19/46.4.2 IT WAS RESOLVED THAT : the Physical Restraint Guidelines be approved for implementation within the Health Board, subject to the amendment clarifying the role of security staff in relation to restraint.</p> <p>QS19/46.5 Proactive Reduction Therapeutic Management Behaviours with Challenge</p> <p>IT WAS RESOLVED THAT the Policy on Proactive Reduction Therapeutic Management Behaviours with Challenge be approved for implementation within the Health Board.</p>	SG
<p>QS19/47 HASCAS Independent Investigation and Ockenden Governance Review: Progress Report</p> <p>QS19/47.1 The Associate Director Quality Assurance presented the paper which provided progress updates as at the end of Q4 against the recommendations arising from both the HASCAS independent investigation and the Ockenden governance review. Additional resources required had been identified for a number of recommendations to progress the necessary work needed to deliver improvements. Members noted that a report was to be submitted for approval to the Executive Team setting out the additional resources and related costings, including any additional workforce requirements. The Chair welcomed the revised format of the report which provided greater clarity on the progress being made against the recommendations.</p> <p>IT WAS RESOLVED THAT : the progress of the recommendations be noted.</p>	
<p>QS19/48 Nurse Staffing Report (<i>This item was taken following QS 19/44</i>)</p> <p>QS19/48.1 The Secondary Care Nurse Director presented the report which set out details of the compliance with the Nurse Staffing Act 2016, highlighting any associated harms as a result of staffing breaches in line with the Act, together with the actions taken to mitigate any identified risks. Members noted that patient acuity data was not available until w/c 11th March 2019 in order to complete a fully triangulated staffing review, which would be included within the May 2019 report.</p> <p>QS19/48.2 The report set out the agreed staffing establishments to meet the requirements of the Nurse Staffing Levels Act 2016, noting that the funded</p>	

<p>establishments did not support additional escalated beds (as indicated in Appendix 1. It was noted that this was the third review of nursing establishments since implementation of the Act. Reference was made to impending changes to the reporting template. The Chair commented that the existing template was helpful and the Director agreed to share these observations with those leading the work.</p> <p>IT WAS RESOLVED THAT:</p> <p>(1) it be noted that a further detailed update will follow in May 2019; and</p> <p>(2) the Secondary Care Nurse Director convey the views of the Chair in relation to the existing template to those leading the work.</p>	
<p>QS19/49 Quality Safety Group (QSG) Assurance Report (Item taken following QS 19/47)</p> <p>QS19/49.1 The Associate Director of Quality Assurance presented the paper which highlighted the following matters:-</p> <ul style="list-style-type: none"> • Instability to Gwanwyn ward – measures had been put in place to use agency staffing, reduction in beds and weekly escalation review of the ward to ensure stability. • District nursing staff in the West were having significant issues with mobile phones and had been informed by informatics that the service would have to purchase new ones if required = Risk score 15 • Endoscopy performance/ surveillance, issues identified with delays. Work programme was being defined to mitigate any risks. • Safeguarding - It had been identified that the new nursing job descriptions have lost the standardised message regarding accountability for safeguarding, and the medical staff job description has lost the wording regarding notifying organisation of any police investigations. The Director of Quality Assurance and Executive Director of Workforce and OD agreed to discuss this further outside the meeting and it was confirmed that the omissions were not from posts currently being advertised. • The positive work being undertaken by the Ward Accreditation team and the positive feedback and engagement being seen from ward/ area staff was highlighted. • Clinical Audit Programme – This had been discussed in the QSG workshop in November and was referred to separately on the QSE agenda. <p>QS19/49.2 The Chair informed Members of ongoing discussions regarding the future format and level of detail reported from QSG to the Committee.</p> <p>IT WAS RESOLVED THAT the update be received.</p>	DC SG
<p>QS19/50 An Update on Incidents Which Occur Within BCUHB Which are Classified as Never Events</p> <p>QS19/50.1 The Associate Director of Quality Assurance presented the update for information at the request of the Executive Director of Nursing and Midwifery. The report was presented monthly to the Executive Management</p>	

<p>Group (EMG). Serious incidents, including Never Events (NE) were reported on a regular basis to local quality and safety meetings, weekly incident review meetings and the Quality and Safety Group. Incidents classed as Never Events were specified by Welsh Government and detailed in WHC/2018/12. Each event was escalated immediately to the clinical executives and as from October 2018, the Independent members were also informed. Never Events were defined as Serious Incidents that were wholly preventable because guidance or safety recommendations were available at a national level and should have been implemented by all healthcare providers. Never Events required full investigation under the Serious Incident Framework and included the need to fully and meaningfully engage patients, families and carers at the beginning of and throughout any investigation. There were a number of questions raised about the detail contained within the report relating to the description and action taken. It was agreed that these would be discussed separately with the Associate Director of Quality Assurance and updates provided to the next meeting as required.</p> <p>IT WAS RESOLVED THAT :</p> <p>(1) Any questions arising from the update would be discussed with the Associate Director of Quality Assurance; and</p> <p>(2) the Committee note the Never Events that have occurred as detailed in the report.</p>	LR/DC
<p>QS19/51 Issues Discussed in Previous In Committee Session</p> <p>IT WAS RESOLVED THAT the report be noted.</p>	
<p>QS19/52 Documents Circulated to Members</p> <p>IT WAS RESOLVED THAT circulation of the following information on the dates indicated be noted:-</p> <ul style="list-style-type: none"> • 6.2.19 Follow up action CRR13 Mental Health • 14.2.19 QSG Notes January • 20.2.19 Ward Accreditation Update 	
<p>QS19/53 Issues of Significance to inform the Chair's Assurance Report</p> <p>The Chair agreed to prepare her assurance report for the Board.</p>	
<p>QS19/54 Date of Next Meeting</p> <p>Tuesday 21st May @ 9.30am in Carlton Court</p>	
<p>QS19/55 Exclusion of Press and Public</p>	

<p>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.'</p>	
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G Harris	QS18/185.3 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. 14.5.19 Incorporated into 'CLICH' report.	March May Closed
J Newman D Carter	QS18/185.3 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. 19.3.19 JN apologised for the exception report not being included with QSE papers and confirmed that an update would be circulated outside the meeting and would be included in the version being presented to March Board. Next iteration to QSE to contain exception report.	May
J Newman	QS18/185.3 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. 19.3.19 – not included within report to QSE in March. Trajectory to be circulated outside meeting. Agreed to close action.	Close
M Denwood	QS18/184.2 Reflect on format of future safeguarding reports and how best to include appropriate	January	Ongoing conversations between the Associate Director of Safeguarding and Associate Director of Quality Assurance, and Executive Director of Nursing & Midwifery.	

	level of detail around HASCAS and Ockenden recommendations.		19.3.19 – keep open pending next report to May QSE. 24.4.19 Expectations of the Chair in terms of the format of the report were provided to Associate Director of QA.	Closed
A Roach	QS18/178.1 Provide a briefing note on email to explain the recommendation to decrease the corporate risk register score (CRR13)	December	22.1.19 Committee noted that this action remained outstanding. To be followed up urgently with Director of MHLDS 6.2.19 Briefing note circulated on behalf of Director of Nursing MHLDS. 19.3.19 – Committee wish to keep this action open pending wider risk register/management review. This work is being overseen by the newly established Risk Management Group who ultimately will report to the Board in due course.	Complete Indicative timeline April 2020
G Harris	QS18/178.2 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. 19.3.19 Action updated re radio isotopes. Lots of mitigating action in place to ensure continuity of supply of medicines generally. Committee agreed to close.	Close
22nd January 2019				
D Carter	QS19/8.4 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	19.3.19 To be circulated outside meeting. 24.4.19 Spreadsheet has been provided to the Chair who has requested a narrative providing the background to the position, the improvement plan that is in place, age profile and how this will be monitored.	

D Carter	QS19/9.2 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 19.3.19 – keep open. 13.5.19 – briefing note provided to Committee Chair for approval before circulation.	
19th March 2019				
S Green	QS19/25.3 Work with Executive Director of Primary and Community Services to initiate discussions with WAST regarding Advanced Paramedic Roles and the development of multidisciplinary team working.	July	14.5.19 Ongoing action as part of the Care Closer to home and Workforce Strategy implementation. To be monitored through CCTH and Workforce Improvement Groups	Closed
All	QS19/26.2 Provide any further feedback on the Listening & Learning report or the draft strategy by the end of April 2019.	May	No further comments received.	Closed
J Newman	QS19/32.2 Ensure members' comments were incorporated into future iterations of the IQPR, and that the correct Executive Leads were listed.	May		
T Owen C Stockport	QS19/32.2 Provide CAMHS divisional update to next meeting.	May	Exec lead now changed to Chris Stockport Children's item deferred to July	July
C Stockport	QS19/32.2 Discuss the accuracy of the performance being reported within the IQPR for GP practice opening hours with the Director of Performance.	April		

15/05/2019 13:02

S Green	QS19/34.5 Reconsider the scoring of the Health & Safety risk alongside an updated risk description.	May	14.5.19 Review of Risk to be considered by Strategic Health and Safety Group on 31 st May 2019	
All	QS19/35.2 Provide any further feedback on draft AQS by the end of April 2019.	May	Completed.	Closed
All	QS19/36.1 Provide any further feedback on the draft committee annual report by the 5 th April 2019.	April	Completed and submitted for Audit Workshop	Closed
L Reid K Dunn	QS19/36.2 Arrange workshop for Committee role and cycle of business	June	Provisional date of 20 th June	
L Reid (B Owen)	QS19/37.4 Prepare a further Pharmacy Medicines Management report for the September meeting that this would feature on the cycle of business going forward (in addition to the Annual report being presented in March). The Chair to discuss the detail of the report with the Chief Pharmacist outside the meeting.	Sept		
B Owen	QS19/37.5 Give further consideration to how a safety programme in Wrexham regarding suspected medication-related admissions might be rolled out across all three sites in North Wales and linking in with the Quality Improvement Hub.	July		
A Roach S Forsyth	QS19/38.4 Provide a supplementary divisional update addressing additional areas of improvements within Mental Health	May		

L Reid K Dunn	QS19/39.2 Ensure that format and content of future primary care reports to the committee be considered further at the forthcoming workshop.		Will be built into agenda and structure for the planned workshop	Closed
A Thomas	QS19/40.1 Provide updated clinical audit report and a clinical audit plan to the next meeting	May	Paper on agenda 21 st May	Closed
A Thomas	QS19/46.3.1 Ensure that the Non Ionising Radiation Protection Policy be amended to reflect the Executive responsibility for Health and Safety now sat with the Executive Director of Workforce and OD.	April	15.5.19 Contact has been made with the Head of Quality & Governance, Radiology to communicate the necessary change within the Policy.	Closed
S Green	QS19/46.4.1 Provide an amendment to the Physical Restraint Guidelines in terms of the wording of the role of security staff.	April	14.5.19 Sent to MHLD Division on 21 st March. Policy updated and published	Closed
D Carter S Green	QS19/49.1 Discuss further the suggestion that new nursing job descriptions have lost the standardised message regarding accountability for safeguarding, and the medical staff job description has lost the wording regarding notifying organisation of any police investigations.	April	14.5.19 Generic Job Descriptions for majority of Nursing posts agreed and on the Job Description Library. Reference to Safeguarding is contained within the "General Requirements" section of the All Wales Job Description Templates. All contracts of employment include requirement to notify the employer of police investigations. This would not be appropriate in the Job Description.	Closed
L Reid D Carter	QS19/50.1 Discuss the questions raised about the detail contained within the Never Events report relating to the description and action taken,	May	14.5.19 The report has now been strengthened to include this information. Any new never events will be shared in greater detail.	Closed

	and provide updates to the next meeting as required.			
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Quality, Safety & Experience Committee	 GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board To improve health and provide excellent care
21.5.19	

Report Title:	Integrated Quality & Performance Report
Report Authors:	Mr Ed Williams, Head of Performance Assurance Dr Jill Newman, Director of Performance
Responsible Director:	Mr Mark Wilkinson, Executive Director of Performance and Planning
Public or In Committee	Public
Purpose of Report:	This report provides the Committee with a summary of key quality and performance indicators.
Approval / Scrutiny Route Prior to Presentation:	This paper has been scrutinised, approved and signed off by the Executive Director of Planning and Performance.
Governance issues / risks:	<p>Our report outlines the key performance and quality issues that are delegated to the Quality, Safety & Experience Committee.</p> <p>This month sees the first presentation of the report for 2019/20 Financial Year. There is also a separate Report for the 2018/19 End of Year position.</p> <p>The Summary of the report is now included as an Executive Summary within the report itself.</p>
Financial Implications:	N/A
Recommendation:	The Committee is asked to note the report.

Health Board's Well-being Objectives <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>	√	WFGA Sustainable Development Principle <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			
Special Measures Improvement Framework Theme/Expectation addressed by this paper This paper supports the revised governance arrangements at the Health Board and supports the Board Assurance Framework by presenting clear information on the quality and performance of the care the Health Board provides. It also addresses key indicators for mental health and primary care.			
Equality Impact Assessment 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



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board



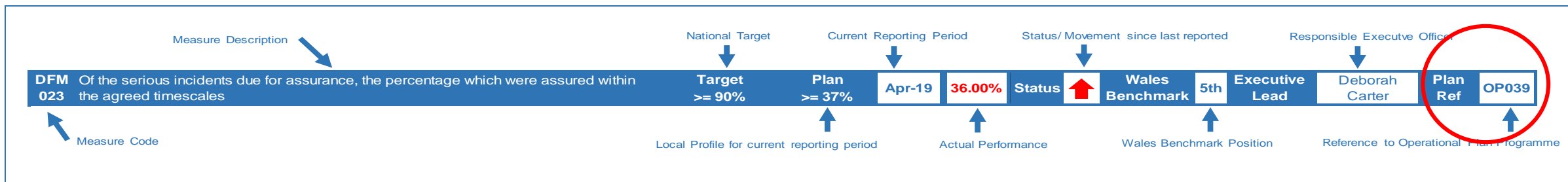
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Sepsis Six	15		

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

The measure code relates to the code applied within the NHS Wales Annual Delivery Framework, which Welsh Government hold the Board accountable for delivering. A key difference in the structure of the IQPR for 2019/20, in comparison to 2018/19 is that it is that the report reflects the organisational priorities as set out in the Operational Plan approved by the Board. The report maps each the measures included against the corresponding work programme within the Operational Plan for 2019/22. This is done via a reference number at the right hand side of the Measure Component Bar (shown below). **Appendix A** contains a list of all the Programmes in the Operational Plan in the order of the reference numbers.

Description of the Measure Component Bar:



Status Key:

Not Achieved Better	Not Achieved Worse	Not Achieved Static	Achieved Static	Achieved Worse	Achieved Better
↑	↓	←	→	↓	↑



Profiles

For each measure the Executive sponsor is confirming the profile of performance expected to be delivered during the year based on the actions and resourcing set out in the operational plan. The report will track performance against this profile. It is noted that profile set will reflect the reporting requirement and rate of change of performance expected. Therefore some indicators are annual, others bi-annual, quarterly, bi-monthly or monthly.

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) they understand the reason(s) for the level of performance being achieved b) that they have a plan and set of actions in place to improve performance, c) that there are measurable outcomes aligned to those actions and d) that they have a defined timeline/ deadline for when performance will be 'back on track', preferably demonstrable through a recovery trajectory. Although these are normally scrutinised by 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.

Cycle of business

As this report is the first report of 2019/20 and for this Committee the meeting cycle is bi-monthly, this report attempts to:

- a) Report to the committee of the year end performance for 2018/19 in respect of monthly indicators included in the 2018/19 report (contained as a separate paper)
- b) Set out the actions in the operational plan and there associated measures which come under the TOR for this committee to scrutinise during 2019/20
- c) Outline the proposed profiles for delivery of the measures assigned to this committee for 2019/20
- d) Provide a report of performance against profile for April 2019 where the measure and profile is reportable monthly

In addition to this report all committees will in future be provided with a RAGP self-assessment of progress against the actions within the operational work programme. This committee will receive this additional report from its July meeting. However the future IQPR reports will be shorter than this report as they will not include elements a-c above,

Operational Plan No

Operational Plan Programme

OP001	Smoking Cessation Opportunities increased through 'Help Me Quit' programmes
OP004	Delivery of ICAN Campaign promoting mental well-being across North Wales communities
OP005	Implement the 'Together for Children and Young People Change Programme'
OP006	Improve outcomes in first 1000 days programmes
OP007	Further develop strong internal and external partnerships with focus on tackling inequalities
OP009	Put in place agreed model for integrated leadership of clusters in at least three clusters, evaluate and develop plan for scaling up
OP013	Develop and implement plans to support Primary Care sustainability
OP015	Implementation of RPB Learning Disability Strategy
OP025	Fully realise the benefits of the newly established SuRNICC Service
OP027	Develop Rehabilitation Model for people with Mental Health or Learning Disability
OP039	Implement Year Three of the 'Quality Improvement Strategy'
OP045	Develop a 'Strategic Equality Plan for 2020-2024'
OP047	Develop an integrated workforce development model for key staff groups with health and social care partners
NIP	Not in Plan <i>i.e. Measures are required by NHS Wales Delivery Framework, but are not linked to Actions in the Operational Plan</i>

Measure Code	Delivery Framework Measure Description	Frequency	Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
DFM008	European age standardised rate of alcohol attributed hospital admissions for individuals resident in Wales	Annual	Reduce	N/A A	N/A A	N/A A	N/A A	N/A A	N/A A	N/A A	N/A A	N/A A	N/A A	N/A A	
DFM009	The percentage of people with learning disabilities who have an annual health check	Annual	>= 75%	N/A A	N/A A	N/A A	N/A A	N/A A	N/A A	N/A A	N/A A	N/A A	N/A A	N/A A	
DFM010	Percentage of compliance for staff appointed to new roles where a child barred list check is required	Biannual	Improve	N/A Bi	N/A Bi	N/A Bi	N/A Bi	N/A Bi		N/A Bi	N/A Bi	N/A Bi	N/A Bi	N/A Bi	
DFM011	Percentage of compliance for staff appointed to new roles where an adult barred list check is required	Biannual	Improve	N/A Bi	N/A Bi	N/A Bi	N/A Bi	N/A Bi		N/A Bi	N/A Bi	N/A Bi	N/A Bi	N/A Bi	
DFM012	Rate number of hospital admissions with any mention of intentional self-harm for children and young people (aged 10-24 years) per 1,000 population	Annual	Reduce	<= 3.76	N/A A	N/A A	N/A A	N/A A	N/A A	N/A A	N/A A	N/A A	N/A A	N/A A	< 3.76
DFM013	Amenable mortality per 100,000 of the European standardised population	Annual	Reduce		N/A A	N/A A	N/A A	N/A A	N/A A	N/A A	N/A A	N/A A	N/A A	N/A A	
DFM014	Percentage of in-patients with a positive sepsis screening who have received all elements of the 'Sepsis Six' first hour care bundle within one hour of positive screening	Monthly	Improve	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
DFM015	Percentage of patients who presented to the Emergency Department with a positive sepsis screening who have received all elements of the 'Sepsis Six' first hour care bundle within one hour of positive screening	Monthly	Improve	>= 66%	>= 68%	>= 70%	>= 72%	>= 74%	>= 75%	>= 77%	>= 79%	>= 80%	>= 81%	>= 83%	>= 85%
DFM016	The number of potentially preventable hospital acquired thromboses	Quarterly	Reduce	N/A Q	N/A Q	0	N/A Q	N/A Q	0	N/A Q	N/A Q	0	N/A Q	N/A Q	0
DFM017	Opiod average daily quantities per 1,000 patients	Quarterly	Reduce	N/A Q	N/A Q	<=4,960	N/A Q	N/A Q	<= 4,940	N/A Q	N/A Q	<= 4,900	N/A Q	N/A Q	<= 4,880

Key - AP = Awaiting Profile N/A Q = Not Applicable - Reported Quarterly

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

April 2019

Measure Code	Delivery Framework Measure Description	Frequency	Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
DFM018	Number of patients aged 65 or over prescribed antipsychotic, as a percentage of all patients aged 65 or over	Quarterly	Reduce	N/A Q	N/A Q	<= 7.04	N/A Q	N/A Q	<= 6.99	N/A Q	N/A Q	<= 6.94	N/A Q	N/A Q	<= 6.89
DFM019	Total antibacterial items per 1,000 STAR-PUs (specific therapeutic group age related prescribing unit)	Quarterly	Reduce	N/A Q	N/A Q	<= 275.5	N/A Q	N/A Q	<=262.9	N/A Q	N/A Q	<= 291.4	N/A Q	N/A Q	<= 308.5
DFM020	Fluroquinolone, cephalosporin, clinamycin and co-amoxiclav items per 1000 patients as a percentage of total antibacterial items dispensed in the community	Quarterly	Reduce	N/A Q	N/A Q	<= 14.32	N/A Q	N/A Q	<= 14.07	N/A Q	N/A Q	<=13.82	N/A Q	N/A Q	<=13.57
DFM022	Number of Patient Safety Solutions Wales Alerts and Notices that were not assured within the agreed timescale	Quarterly	0	N/A Q	N/A Q	<= 5	N/A Q	N/A Q	<= 4	N/A Q	N/A Q	<= 2	N/A Q	N/A Q	0
DFM023	Of the serious incidents due for assurance, the percentage which were assured within the agreed timescales	Monthly	>= 90%	>= 37%	>= 39%	>= 41%	>= 41%	>= 43%	>= 43%	>= 45%	>= 45%	>= 47%	>= 47%	>= 49%	>= 50%
LM023a	Number of Patient Falls reported as Serious Incidents	Monthly	AP	AP	AP	AP	AP	AP	AP	AP	AP	AP	AP	AP	AP
LM023b	Number of Healthcare Acquired Perssure Ulcers reported as Serious Incidents	Monthly	AP	AP	AP	AP	AP	AP	AP	AP	AP	AP	AP	AP	AP
LM023c	Total Number Healthcare Acquired Pressure Ulcers(All Grades)	Monthly	AP	AP	AP	AP	AP	AP	AP	AP	AP	AP	AP	AP	AP
DFM024	Number of new never events	Monthly	0	0	0	0	0	0	0	0	0	0	0	0	0
DFM027	Percentage of universal mortality reviews (UMRs) undertaken within 28 days of a death	Monthly	>= 95%	>= 95%	>= 95%	>= 95%	>= 95%	>= 95%	>= 95%	>= 95%	>= 95%	>= 95%	>= 95%	>= 95%	>= 95%

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DFM028	Crude hospital mortality rate (74 years of age or less)	Monthly	Reduce	<= 0.70%	<= 0.70%	<= 0.70%	<= 0.70%	<= 0.70%	<= 0.70%	<= 0.70%	<= 0.70%	<= 0.70%	<= 0.70%	<= 0.70%	< 0.70%
DFM032	All new medicines recommended by AWMSG and NICE, including interim recommendations for cancer medicines, must be made available where clinically appropriate, no later than two months from the publication of the NICE Final Appraisal Determination and the A	Monthly	100%	N/A Q	N/A Q	100%	N/A Q	N/A Q	100%	N/A Q	N/A Q	100%	N/A Q	N/A Q	100%
DFM038	Number of procedures postponed either on the day or the day before for specified non-clinical reasons	Monthly	Reduce	Reduce	Reduce	Reduce	Reduce	Reduce	Reduce	Reduce	Reduce	Reduce	Reduce	Reduce	
DFM033	Number of Health and Care Research Wales clinical research portfolio studies	Quarterly	Increase	N/A Q	N/A Q	+2.5%	N/A Q	N/A Q	+5%	N/A Q	N/A Q	+7.5%	N/A Q	N/A Q	+10%
DFM034	Number of Health and Care Research Wales commercially sponsored studies	Quarterly	Increase	N/A Q	N/A Q	+1.25%	N/A Q	N/A Q	+2.5%	N/A Q	N/A Q	+3.75%	N/A Q	N/A Q	+5%
DFM035	Number of patients recruited in Health and Care Research Wales clinical research portfolio studies	Quarterly	Increase	N/A Q	N/A Q	+2.5%	N/A Q	N/A Q	+5%	N/A Q	N/A Q	+7.5%	N/A Q	N/A Q	+10%
DFM036	Number of patients recruited in Health and Care Research Wales commercially sponsored studies	Quarterly	Increase	N/A Q	N/A Q	+1.25%	N/A Q	N/A Q	+2.5%	N/A Q	N/A Q	+3.75%	N/A Q	N/A Q	+5%
DFM037	The average rating given by the public (age 16+) for the overall satisfaction with health services in Wales	Biennial	Improve	Improve	Improve	Improve	Improve	Improve	Improve	Improve	Improve	Improve	Improve	Improve	
DFM039	Evidence of how NHS organisations are responding to service user experience to improve services	Quarterly	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
DFM040	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	Quarterly	>= 75%	N/A Q	N/A Q	>= 40%	N/A Q	N/A Q	>= 48%	N/A Q	N/A Q	>= 50%	N/A Q	N/A Q	>= 60%
LM040a	The percentage of concerns that have received a final reply under Regulation 24 up to and including 30 working days from the date the concern was first received by the organisation	Quarterly	N/A	N/A Q	N/A Q	AP	N/A Q	N/A Q	AP	N/A Q	N/A Q	AP	N/A Q	N/A Q	AP
LM040b	The percentage of concerns that have received a an interim reply under Regulation 26 up to and including 30 working days from the date the concern was first received by the organisation	Quarterly	N/A	N/A Q	N/A Q	AP	N/A Q	N/A Q	AP	N/A Q	N/A Q	AP	N/A Q	N/A Q	AP

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DFM041	Percentage of people in Wales registered at a GP practice (age 65 year or over) who are diagnosed with dementia	Annual	Improve	AP	AP	AP	AP	AP	AP	AP	AP	AP	AP	AP	AP
DFM042	Percentage of adults (aged 16+) who had an appointment in the last 12 months, who felt that they were treated with dignity and respect	Annual	Improve	N/A A	N/A A	N/A A	N/A A	N/A A	N/A A	N/A A	N/A A	N/A A	N/A A	N/A A	> 87.9%
DFM043	Percentage of adults (age 16+) who reported that they were very satisfied or fairly satisfied about the care that is provided by their GP/family doctor	Annual	Improve	N/A A	N/A A	N/A A	N/A A	N/A A	N/A A	N/A A	N/A A	N/A A	N/A A	N/A A	
DFM044	Percentage of adults (age 16+) who reported that they were very satisfied or fairly satisfied about the care that they received at an NHS hospital	Annual	Improve	N/A A	N/A A	N/A A	N/A A	N/A A	N/A A	N/A A	N/A A	N/A A	N/A A	N/A A	> 90%
DFM045	Percentage of employed NHS staff completing dementia training at an informed level	Biannual	>= 85%	AP	AP	AP	AP	AP	AP	AP	AP	AP	AP	AP	AP
DFM046	Percentage of GP practice teams that have completed training in dementia or other training as outlined under the Directed Enhanced Services (DES) for mental illness	Biannual	Improve	AP	AP	AP	AP	AP	AP	AP	AP	AP	AP	AP	AP
DFM075	Qualitative report detailing evidence of advancing equality and good relations in the day to day activities of NHS organisations	Biannual	Submit QR	N/A Bi	N/A Bi	N/A Bi	N/A Bi	N/A Bi	N/A Bi	Submit QR	N/A Bi	N/A Bi	N/A Bi	N/A Bi	Submit QR
DFM076	Qualitative report detailing progress against the 5 standards that enable the health and well-being of homeless and vulnerable groups to be identified and targeted	Biannual	Submit QR	N/A Bi	N/A Bi	N/A Bi	N/A Bi	N/A Bi	N/A Bi	Submit QR	N/A Bi	N/A Bi	N/A Bi	N/A Bi	Submit QR
DFM077	Qualitative report detailing the achievements made towards the implementation of the all Wales standard for accessible communication and information for people with sensory loss	Biannual	Submit QR	N/A Bi	N/A Bi	N/A Bi	N/A Bi	N/A Bi	N/A Bi	Submit QR	N/A Bi	N/A Bi	N/A Bi	N/A Bi	Submit QR
DFM078	Qualitative report providing evidence of implementation of the Welsh language actions as defined in More Than Just Words	Biannual	Submit QR	N/A Bi	N/A Bi	N/A Bi	N/A Bi	N/A Bi	N/A Bi	Submit QR	N/A Bi	N/A Bi	N/A Bi	N/A Bi	Submit QR

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Measure Code	Delivery Framework Measure Description	Frequency	Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
DFM021a	Cumulative rate of laboratory confirmed E.coli bacteraemia cases per 100,000 population	Monthly	<= 39	<= 39	<= 39	<= 39	<= 39	<= 39	<= 39	<= 39	<= 39	<= 39	<= 39	<= 39	<= 39
DFM021b	Cumulative rate of laboratory confirmed S.aureus bacteraemias (MRSA and MSSA) cases per 100,000 population	Monthly	<= 12	<= 12	<= 12	<= 12	<= 12	<= 12	<= 12	<= 12	<= 12	<= 12	<= 12	<= 12	<= 12
LM021b1	Number of of laboratory confirmed MRSA cases	Monthly	0	0	0	0	0	0	0	0	0	0	0	0	0
LM021b2	Number of of laboratory confirmed MSSA cases	Monthly	<= 11	<= 11	<= 11	<= 11	<= 11	<= 11	<= 11	<= 11	<= 11	<= 11	<= 11	<= 11	<= 11
DFM021c	Cumulative rate of laboratory confirmed C.difficile cases per 100,000 population	Monthly	<= 14	<= 14	<= 14	<= 14	<= 14	<= 14	<= 14	<= 14	<= 14	<= 14	<= 14	<= 14	<= 14
LM021c	Number of laboratory confirmed C.difficile cases	Monthly	TBC	AP	AP	AP	AP	AP	AP	AP	AP	AP	AP	AP	AP
DFM021d	Cumulative rate of laboratory confirmed Klebsiela cases per 100,000 population	Monthly	<= 9	<= 9	<= 9	<= 9	<= 9	<= 9	<= 9	<= 9	<= 9	<= 9	<= 9	<= 9	<= 9
DFM021e	Cumulative rate of laboratory confirmed Aeruginosa cases per 100,000 population	Monthly	<= 3	<= 3	<= 3	<= 3	<= 3	<= 3	<= 3	<= 3	<= 3	<= 3	<= 3	<= 3	<= 3
DFM005a	Uptake of the influenza vaccination among: a. 65 year olds and over	Monthly	>= 75%	N/A S	N/A S	N/A S	N/A S	N/A S	N/A S	>= 30%	>= 50%	>= 60%	>= 65%	>= 70%	>= 71%
DFM005b	Uptake of the influenza vaccination among: b. Under 65s in risk groups	Monthly	>= 55%	N/A S	N/A S	N/A S	N/A S	N/A S	N/A S	>= 10%	>= 30%	>= 40%	>= 50%	>= 53%	>= 55%
DFM005c	Uptake of the influenza vaccination among: c. Pregnant women	Monthly	>= 75%	N/A S	N/A S	N/A S	N/A S	N/A S	N/A S	N/A S	N/A S	N/A S	N/A S	N/A S	>= 75%
DFM005d	Uptake of the influenza vaccination among: d. Health care workers	Monthly	>= 60%	N/A S	N/A S	N/A S	N/A S	N/A S	N/A S	>= 10%	>= 20%	>= 30%	>= 40%	>= 50%	>= 60%

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Measure Code	Delivery Framework Measure Description	Frequency	Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
DFM001	Of those women who had their initial assessment and gave birth within the same health board, the percentage of pregnant women who gave up smoking during pregnancy (by 36-38 weeks of pregnancy)	Annual	Improve	>= 10%	>= 10%	>= 10%	>= 11%	>= 11%	>= 11%	>= 12%	>= 12%	>= 12%	>= 13%	>= 13%	>= 13%
DFM002	Percentage of children who received 3 doses of the hexavalent '6 in 1' vaccine by age 1	Quarterly	>= 95%	N/A Q	N/A Q	>= 95%	N/A Q	N/A Q	>= 95%	N/A Q	N/A Q	>= 95%	N/A Q	N/A Q	>= 95%
DFM003	Percentage of children who received 2 doses of the MMR vaccine by age 5	Quarterly	>= 95%	N/A Q	N/A Q	>= 91%	N/A Q	N/A Q	>= 92%	N/A Q	N/A Q	>= 93%	N/A Q	N/A Q	>= 93%
DFM004	Percentage of children who are 10 days old within the reporting period who have accessed the 10-14 days health visitor contact component of the Healthy Child Wales Programme	Quarterly	Improve												
DFM006	The percentage of adult smokers who make a quit attempt via smoking cessation services	Quarterly	>= 5%	N/A Q	N/A Q	>= 3.9%	N/A Q	N/A Q	>= 4.1%	N/A Q	N/A Q	>= 4.3%	N/A Q	N/A Q	>= 5%
DFM007	The percentage of those smokers who are CO-validated as quit at 4 weeks	Quarterly	>= 40%	N/A Q	N/A Q	>= 38.0%	N/A Q	N/A Q	>= 38.7%	N/A Q	N/A Q	>= 39.3%	N/A Q	N/A Q	>= 40%

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Measure Code	Delivery Framework Measure Description	Frequency	Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
DFM058	Percentage of patients waiting less than 26 weeks to start a psychological therapy in Specialist Adult Mental Health	Monthly	>= 80%	AP	AP	AP	AP	AP	AP	AP	AP	AP	AP	AP	AP
DFM059	Percentage of children and young people waiting less than 26 weeks to start a neurodevelopment assessment	Monthly	>= 80%	AP	AP	AP	AP	AP	AP	AP	AP	AP	AP	AP	AP
DFM060	The percentage of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral (Combined)	Monthly	>= 80%	*	*	*	*	*	*	*	*	*	*	*	*
LM060a	The percentage of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral (Adult)	Monthly	>= 80%	>= 71%	>= 71%	>= 71%	>= 72%	>= 72%	>= 72%	>= 73%	>= 73%	>= 73%	>= 74%	>= 74%	>= 74%
LM061a	The percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS (Adult)	Monthly	>= 80%	>= 67%	>= 67%	>= 67%	>= 68%	>= 68%	>= 68%	>= 69%	>= 69%	>= 69%	>= 70%	>= 70%	>= 70%
DFM061	The percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS (Combined)	Monthly	>= 80%	*	*	*	*	*	*	*	*	*	*	*	*
LM060b	The percentage of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral (CAMHS)	Monthly	>= 80%	AP	AP	AP	AP	AP	AP	AP	AP	AP	AP	AP	AP
LM061b	The percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS (CAMHS)	Monthly	>= 80%	AP	AP	AP	AP	AP	AP	AP	AP	AP	AP	AP	AP
DFM062	Percentage of qualifying patients (compulsory & informal/voluntary) who had their first contact with an Independent Mental Health Advocacy (IMHA) within 5 working days of their request for an IMHA	Monthly	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
DFM082	The percentage of health board residents in receipt of secondary mental health services (all ages) who have a valid care and treatment plan (CTP)	Monthly	>= 90%	>= 88%	>= 88%	>= 88%	>= 89%	>= 89%	>= 89%	>= 89%	>= 89%	>= 89%	>= 90%	>= 90%	>= 90%
DFM083	All health board residents who have been assessed under part 3 of the mental health measure to be sent a copy of their outcome assessment report up to and including 10 working days after the assessment has taken place	Monthly	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

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DFM079	Number of calls to the mental health helpline CALL (Community Advice and Listening Line) by Welsh residents per 100,000 of the population	Quarterly	Improve	N/A Q	N/A Q	>= 212	N/A Q	N/A Q	>= 212	N/A Q	N/A Q	>= 212	N/A Q	N/A Q	>= 212
DFM080	Number of calls to the Wales dementia helpline by Welsh residents per 100,000 of the population (age 40+)	Quarterly	Improve	N/A Q	N/A Q	>= 9	N/A Q	N/A Q	>= 9	N/A Q	N/A Q	>= 9	N/A Q	N/A Q	>= 9
DFM081	Number of calls to the DAN 24/7 helpline (drugs and alcohol) by Welsh residents per 100,000 of the population	Quarterly	Improve	N/A Q	N/A Q	>= 50	N/A Q	N/A Q	>= 50	N/A Q	N/A Q	>= 50	N/A Q	N/A Q	>= 50

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Executive Summary

There are 76 Measures from the NHS Wales Delivery Framework 2019/20 reported under the remit of the Quality, Safety & Experience (QSE) Committee. Of these, 20 are reported for April 2019. Apart from Mental Health, the remaining 56 Measures are reported on either a Quarterly, Biannual or Annual basis. All 14 Measures in the Mental Health Chapter are reported a month in arrears. (March 2019 performance is included in the March 2019 End of Year version of the IQPR).

Of the 20 Measures reported for April 2019 and compared to the last report, performance has improved against 9, remains static for 3 and is worse for 3. There are 2 measures that have not been reported before (Rates of Klebsiella and Aeruginosa), so there is no comparison for and there are 2 Measures for which we do not have the data, Healthcare Acquired Pressure Ulcers (HAPU).



Quality: Of the 44 Measures in this section, performance for April 2019 is reported for 10. Of these, performance against 6 Measures has improved, 3 remain static and 1 is worse. Data is not available for 2 of the Measures, Healthcare Acquired Pressure Ulcers (HAPU) reported as Serious Incidents and total number of HAPU Reported. The remaining 32 measures in this section are reported on a Quarterly, Biannual or Annual basis.

Infection Control: Of the 12 Measures in this section, performance for April 2019 is reported for 8. The remaining 4 measures relate to Flu Vaccination and will be reported between October 2019 and March 2020. Of the 8 Measures, performance has improved against 4 and is worse against 2. There are also 2 measures that have not been reported before (Rates of Klebsiella and Aeruginosa), therefore no comparison is available at this time.

Prevention: All 6 measures in the Prevention Chapter are reported on a Quarterly basis and will be updated after the end of Quarter 1 (July 2019)

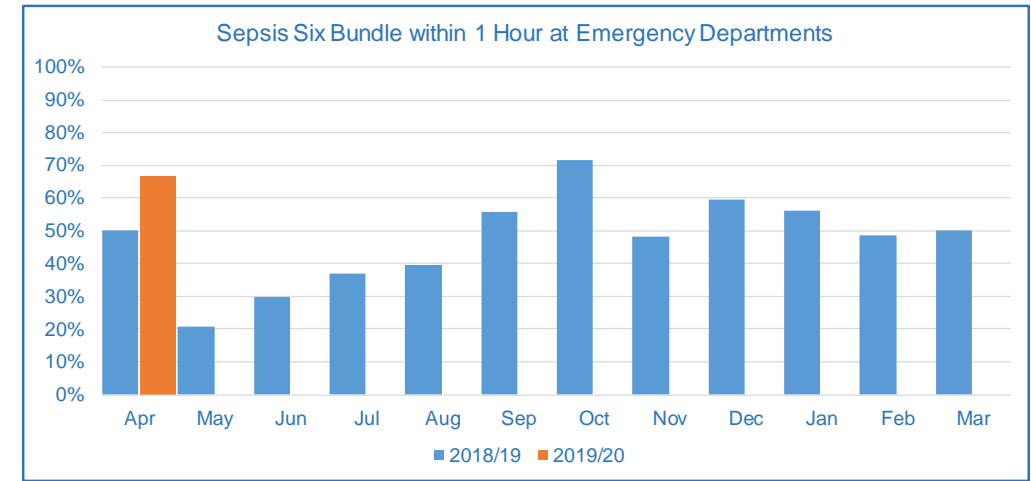
Mental Health: All 14 measures in the Mental Health Chapter are reported a month in arrears. April 2019 (together with May 2019) data will be updated in the next presentation of this report (July 2019). March 2019 performance is included in the March 2019 End of Year version of the IQPR which has also been submitted to this Committee.

Primary Care: All the Measures concerning Primary Care are currently found in Chapter 1: Quality. These Measures are all reported Annually. The Performance Directorate is working with the Executive Director of Primary & Community Care to determine which measures should sit in this chapter. This will be updated for the next presentation of the IQPR for QSE Committee in July 2019.

DFM 014	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 100%	Apr-19	100%	Status 	Wales Benchmark 1st	Executive Lead Evan Moore	Plan Ref OP039
DFM 015	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 >= 66%	Apr-19	66.21%	Status 	Wales Benchmark	Executive Lead Evan Moore	Plan Ref OP039

Actions

The third sepsis collaborative completed in April 2019 with representation from all acute hospitals. It was agreed further work would continue and include further events to keep the work progressing as great progress being made.



DFM 023 Of the serious incidents due for assurance, the percentage which were assured within the agreed timescales

Target
>= 90%

Plan
>= 37%

Apr-19

25.00%

Status



Wales Benchmark

*

Executive Lead

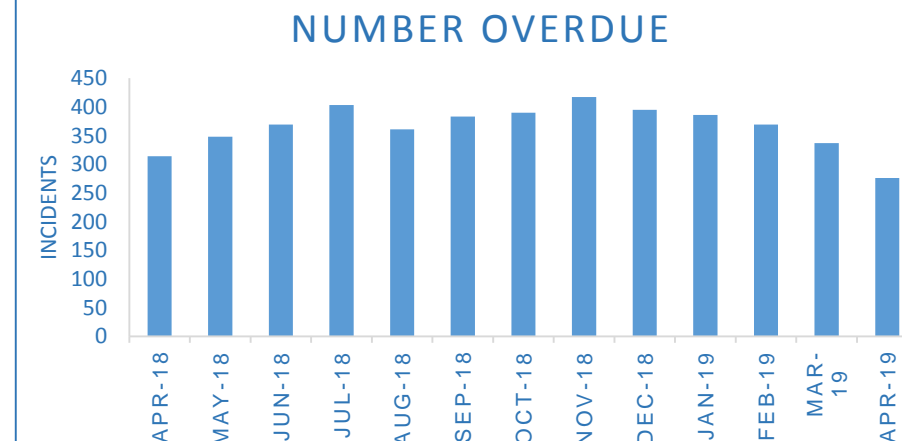
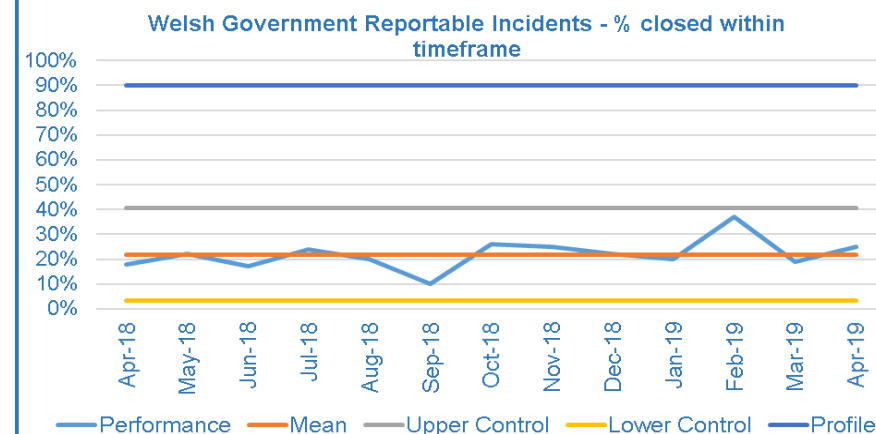
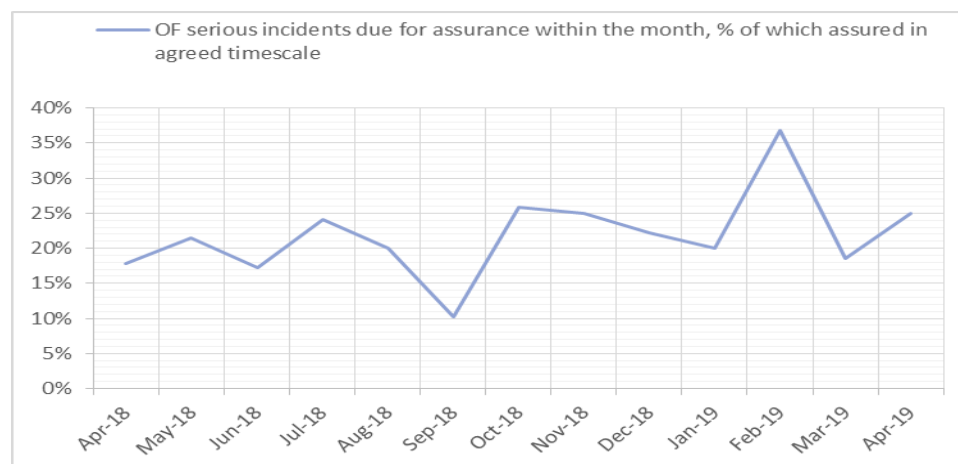
Deborah Carter

Plan Ref

OP039

The performance on closure of incidents is adversely affected by the historical volume of patients overdue and already beyond the expected closure period. This backlog has shown month on month reduction since November 2018 which is positive. However with 276 remaining overdue at the end of April 2019, performance will remain low while this backlog is cleared.

The concerns team are focussed on both reducing the backlog of concerns closed within the 60 days and also in closing newly identified concerns before they reach 60 days. Performance on closure of concerns within 60 days remains variable with the data showing evidence of slight improvement. To enable the continued reduction in the backlog of overdue closures the rate of closure within the 60 days need to increase further. The focus on both backlog reduction and closure of new incidents within 60 days will enable performance to improve.



LM02
3a Number of Patient Falls reported as Serious Incidents

Target
AP

Plan
AP

Apr-19

6

Status



Wales
Benchmark

Executive
Lead

Deborah
Carter

Plan
Ref

NIP

Actions:

Compliance with Mandatory training for the prevention and management of falls for ward based staff
Incidents of falls to be reported effectively, divisional falls groups to consider root cause analysis and lessons learnt.

By exception, monthly reporting of serious incidents of falls to QSG via Divisional leads

Development of a falls collaborative, using the methodology applied for the recent HAPU collaborative, to provide a standardised approach to care with the aim of reducing falls with harm for patients when inpatients.

Evidence of compliance with the Inpatient Falls policy as part of the ward accreditation scheme.

Dissemination of lessons learnt via the strategic inpatient fall groups

Supporting wider initiatives to prevent patient deconditioning within the ward environment, such as such as #endpjaralysis

Outcomes Expected

100% compliance of falls assessment and care planning requirements

85% compliance with mandatory training

100% utilisation of the falls bundle/ pathway

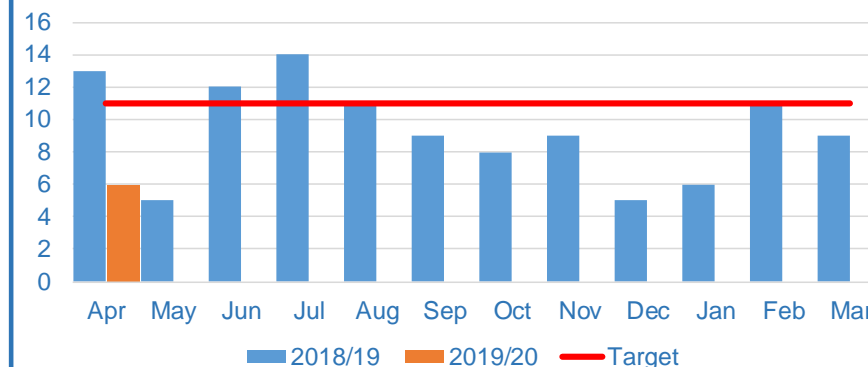
Reduction in the number of falls with harm reported from an inpatient environment.

Monthly reports via Datix and Serious Incident reports

Timeline

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

Number of Patient Falls reported as Serious Incidents



LM02 3b	Number of Healthcare Acquired Pressure Ulcers reported as Serious Incidents	Target AP	Plan AP	Apr-19	N/D	Status	Wales Benchmark	Executive Lead	Deborah Carter	Plan Ref	NIP
LM02 3c	Total Number Healthcare Acquired Pressure Ulcers(All Grades)	Target AP	Plan AP	Apr-19	N/D	Status	Wales Benchmark	Executive Lead	Deborah Carter	Plan Ref	NIP

As of January 2019, it has been agreed with Welsh Government that the Health Board will only report avoidable Grade 3 or above Pressure Ulcers. However, in order to establish whether a Pressure Ulcer is avoidable or unavoidable the investigation into the incident must be completed. These investigations must be completed within 60 working days.

Reporting will re-commence once data is available.

The Health Board has been focusing on improving pressure ulcer reporting and root cause analysis as well as establishing the most prevalent areas in which pressure damage occurs. In November we launched a Pressure Ulcer Collaborative focusing on areas of highest prevalence. This team approach to harm reduction is using improvement methodology to support improvement and culture change. The aim is to develop a Health Board standard approach to care in relation to pressure areas. Cohort 1 included teams from both hospital and community services. A similarly constituted Cohort 2 commenced in December 2018.

Data Not Available

DFM 027	Percentage of universal mortality reviews (UMRs) undertaken within 28 days of a death	Target $\geq 95\%$	Plan $\geq 95\%$	Apr-19	89.70%	Status 	Wales Benchmark	Executive Lead	Evan Moore	Plan Ref	OP039
DFM 028	Crude hospital mortality rate (74 years of age or less)	Target Reduce	Plan $\leq 0.70\%$	Apr-19	0.73%	Status 	Wales Benchmark	Executive Lead	Evan Moore	Plan Ref	OP039

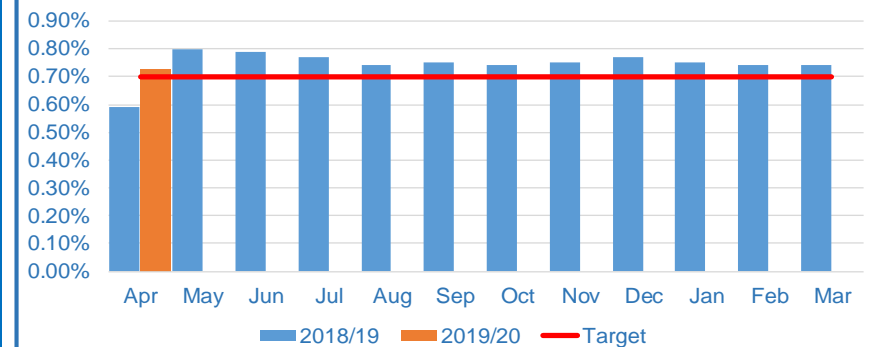
Crude Mortality (74 years of age and under)

Work remains on-going in tackling high mortality areas like sepsis. Further analysis of this measure shows further work needs to be undertaken in areas such as pneumonia and Acute Kidney Injury (AKI). Plans are in development to launch an AKI collaborative during 2019/20 and reduction in pneumonia due to hospital stay plans are to be discussed in the reducing avoidable mortality group which is due to meet again June 2019.

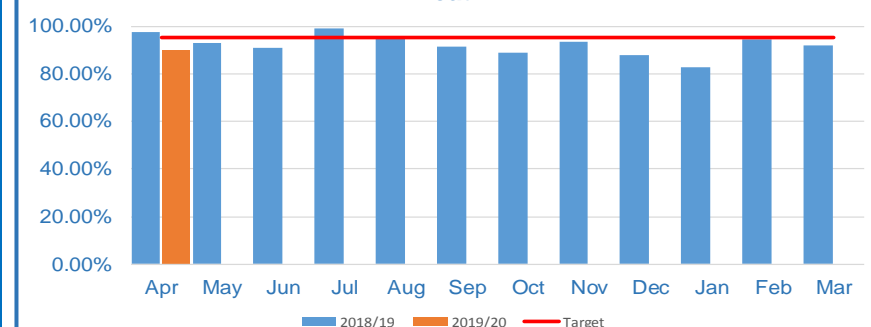
Universal Mortality Reviews (UMRs)



Work remains on-going across sites and plans are currently being developed to roll out an electronic system. Teams from the Office of the Medical Director are working with DATIX and developing a system with them to launch in late Q2/early Q3 of 2019/20. The plans include detailed training package for all staff involved in the mortality reviews and will link in how to extract lessons learned off the system. With the new system it will link into PAS and will improve tracking off all deaths which should improve compliance of deaths with UMR completed within 28 days.

Crude Mortality Rates: 74 years of age and under



Universal Mortality Reviews carried out within 28 Days of Death



WGM 001	Ward Staff Fill Rate Percentage	Target TBC by WG	Plan AP	Apr-19	86%	Status 	Wales Benchmark N/A	Executive Lead Deborah Carter	Plan Ref	NIP
WGM 002	Ward Staff Skill Mix Ratio of Registered v Non-Registered Percentage	Target TBC by WG	Plan AP	Apr-19	55%	Status 	Wales Benchmark N/A	Executive Lead Deborah Carter	Plan Ref	NIP

Actions

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

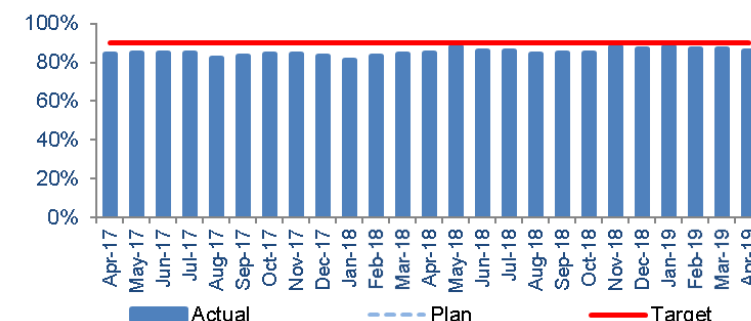
Outcomes

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

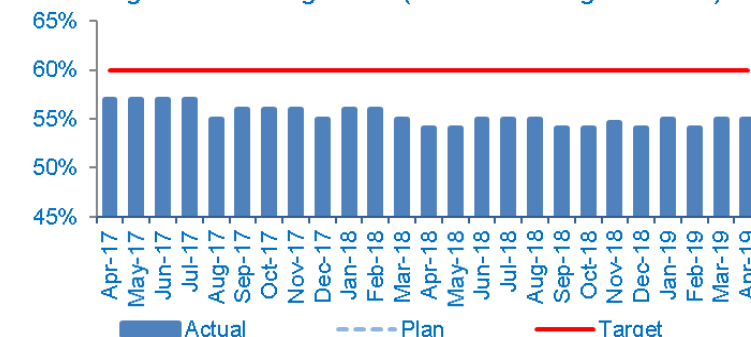
Timelines

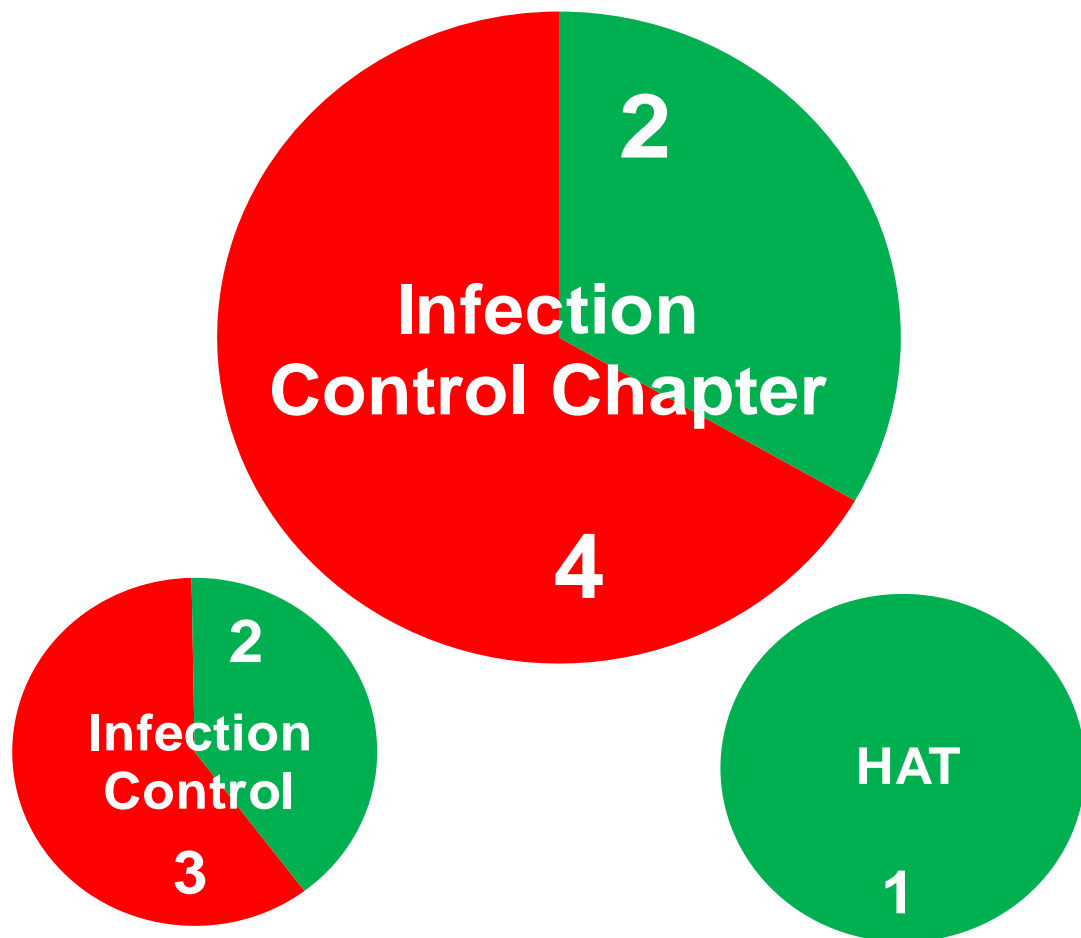
- Improved position expected in the Autumn with 101 new adult graduates expected September 2019. Likely NMC registration November 2019.

Ward Staffing Levels Fill Rate (Medical & Surgical Acute)



Ward Staffing Skill Mix Ratio
Registered : Unregistered (Medical & Surgical Acute)





Measure	Status	(Target)
Infection Prevention: E.Coli	82.85 ↓	<= 67
Infection Prevention: C.Difficile	26.66 ↑	<= 26.00
Infection Prevention: S.Aureus	22.79 ↑	<= 20.00
Infection Prevention: MRSA	0 ↑	0
Infection Prevention: MSSA	14 ↓	<= 11
Preventable Hospital Acquired Thrombosis (HAT)	0 →	0

DFM 021a	Cumulative rate of laboratory confirmed E.coli bacteraemia cases per 100,000 population	Target ≤ 39	Plan ≤ 39	Apr-19	97.85	Status	↓	Wales Benchmark	*	Executive Lead	Deborah Carter	Plan Ref	OP039
DFM 021b	Cumulative rate of laboratory confirmed S.aureus bacteraemias (MRSA and MSSA) cases per 100,000 population	Target ≤ 12	Plan ≤ 12	Apr-19	26.21	Status	↓	Wales Benchmark	*	Executive Lead	Deborah Carter	Plan Ref	OP039
LM02 1b1	Number of of laboratory confirmed MRSA cases	Target 0.00	Plan 0	Apr-19	1	Status	↑	Wales Benchmark	*	Executive Lead	Deborah Carter	Plan Ref	OP039
LM02 1b2	Number of of laboratory confirmed MSSA cases	Target ≤ 11	Plan ≤ 11	Apr-19	11	Status	↑	Wales Benchmark	*	Executive Lead	Deborah Carter	Plan Ref	OP039
DFM 021c	Cumulative rate of laboratory confirmed C.difficile cases per 100,000 population	Target ≤ 14	Plan ≤ 14	Apr-19	19.22	Status	↑	Wales Benchmark	*	Executive Lead	Deborah Carter	Plan Ref	OP039
LM02 1c	Number of laboratory confirmed C.difficile cases	Target AP	Plan AP	Apr-19	11	Status	↑	Wales Benchmark	*	Executive Lead	Deborah Carter	Plan Ref	OP039
DFM 021d	Cumulative rate of laboratory confirmed Klebsiella cases per 100,000 population	Target ≤ 9	Plan ≤ 9	Apr-19	22.72	Status	N/A	Wales Benchmark	*	Executive Lead	Deborah Carter	Plan Ref	OP039
DFM 021e	Cumulative rate of laboratory confirmed Aeruginosa cases per 100,000 population	Target ≤ 3	Plan ≤ 3	Apr-19	1.75	Status	N/A	Wales Benchmark	*	Executive Lead	Deborah Carter	Plan Ref	OP039

* Not published yet

Actions:

In depth review of ALL HCAIS for April 2019 to look for trends, particularly in relation to the Central locality, Klebsiella, E coli and MSSA. Dedicated IPC staff now allocated to community hospitals, mental health and learning disabilities and other community health care provision.

Clean your hands promotional work for w/c 6th May 2019.

Post infection reviews are carried out for all C. difficile infections (CDI) and blood stream infections associated with health care. Some of these are presented to the HCAI Executive reviews held monthly.

Provisional trajectory figures considered until WG provide for 2019/20. Monitor population sizes and demographics in relation to infection rates and trajectories.

Dedicated review for inpatient areas on all invasive devices.

Start smart then focus promoted to also include removal of vascular cannulas.

Meeting took place with Welsh Ambulance regarding a trail of safe/unsafe cannulation so removal is carried out in admission area.

Decant area now available to provide uninterrupted infection prevention clean with HPV.

Outcomes:

Recognising the trends that maybe linked to increase in gram negative blood stream infections.

Monitor population sizes and demographics in relation to infection rates and trajectories.

Keep hand hygiene and bare below the elbows “everyday business” and accountability for providing safe, clean care.

Performance framework populated for the 6 organisms with associated trajectories.

Scrutiny and learning from focused HCAI executive review.

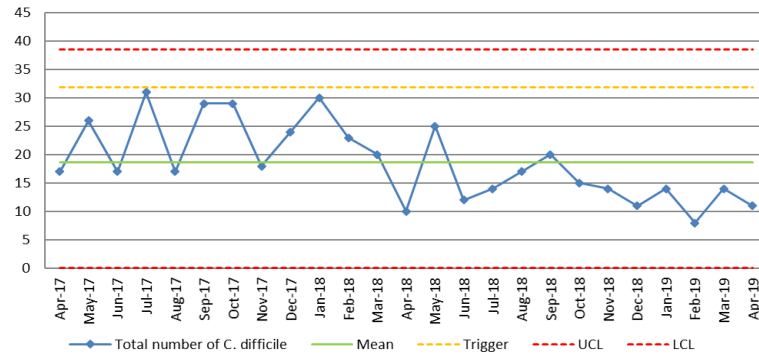
Reduction and removal of unnecessary devices and associated risks.

Timelines:

Continually monitor rates and innovative practice in reducing avoidable infection/harm and remain focused on reducing AVOIDABLE infections .

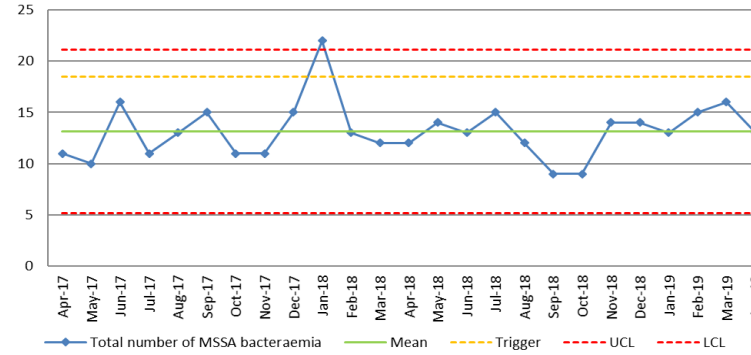
BCUHB

Total monthly number of C. difficile



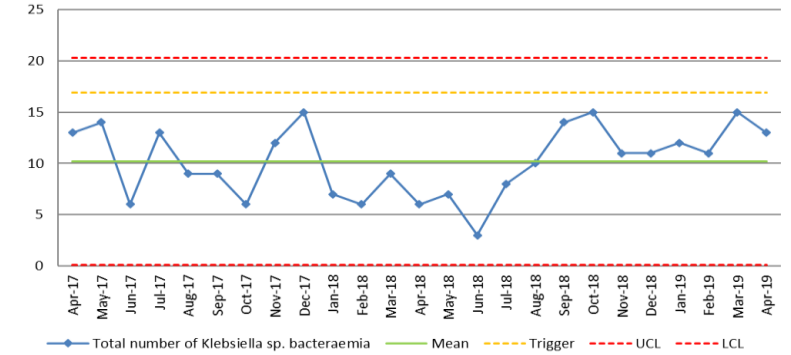
BCUHB

Total monthly number of MSSA bacteraemia



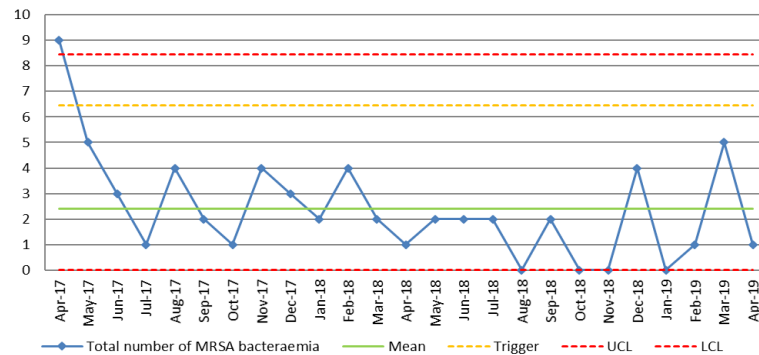
BCUHB

Total monthly number of Klebsiella sp. bacteraemia



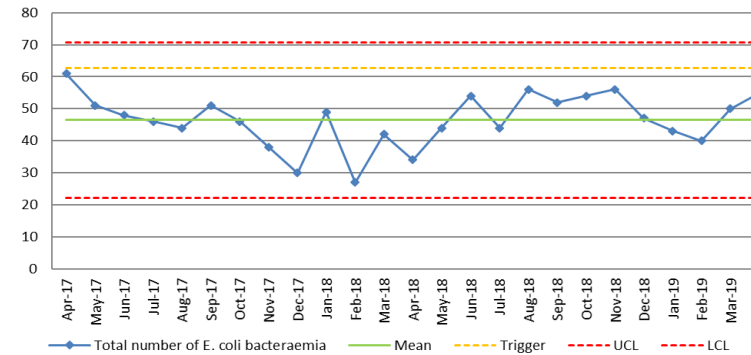
BCUHB

Total monthly number of MRSA bacteraemia



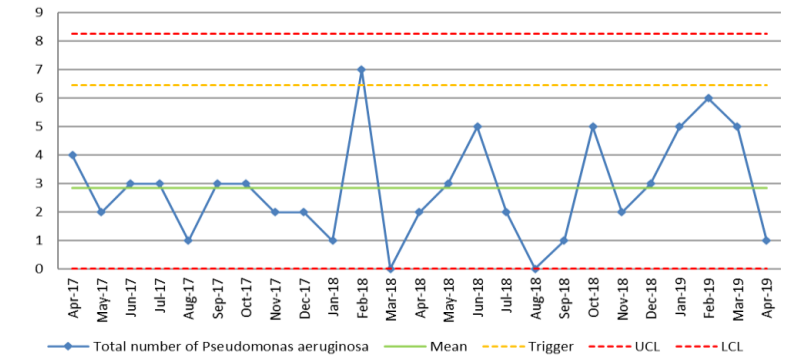
BCUHB

Total monthly number of E. coli bacteraemia



BCUHB

Total monthly number of Pseudomonas aeruginosa



Of the 6 measures included in this chapter, 5 are reported on a quarterly basis and 1 is reported annually. The first update for the measures in this chapter will be at the end of Quarter 1, and reported to Quality, Safety & Experience Committee in July 2019. There is a significant time lag concerning the release of the data for these measures, and it is highly likely that the first reports may not be seen by the committee until September 2019 (QSE Committee is not held in August 2019).

Of the 14 measures included in this chapter, 11 are reported a month in arrears and 3 on a quarterly basis. The March 2019 position for the 11 Measures reported one month in arrears has been reported in the 2018/19 End of Year version of the Integrated Quality & Performance Report for Quality (IQPR) for Safety Experience (QSE) Committee included in the distributed papers for this Committee Meeting. The first update for the 11 measures reported monthly will be in June 2019, and reported to Quality, Safety & Experience Committee in July 2019. The first update of the measures reported on a quarterly basis will be after the end of Quarter 1 and will also be presented in the IQPR for QSE Committee in July 2019.

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
- Stats Wales www.bcu.wales.nhs.uk
www.statswales.wales.gov.uk

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



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University Health Board



March 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.

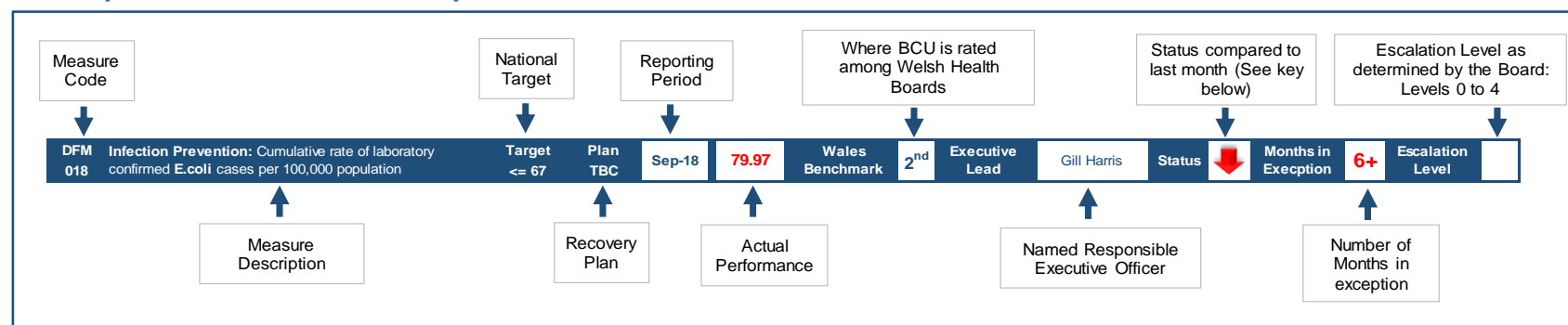
Escalated Exception Reports

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 62 Measures reported under the remit of the Quality, Safety & Experience (QSE) Committee, Performance has improved against 34, remains static for 18 and is worse for 14 in comparison to the last report.

Quality: The Health Board has improved performance against 15 of the 30 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).

	Better	Same	Worse	No Update	Total
Quality	15	9	5	1	30
Infection	2	2	5		9
Prevention	8	0	1		9
Mental Health	8	2	2		12
Primary Care	1	0	1		2
All	34	13	14	1	62

Infection Control: The Health Board is the best performing in Wales with regards reducing S.Aureus infections, and 2nd best for reducing E.Coli infections. However, at 4th in Wales in terms of C.Difficile, there is still room for improvement.

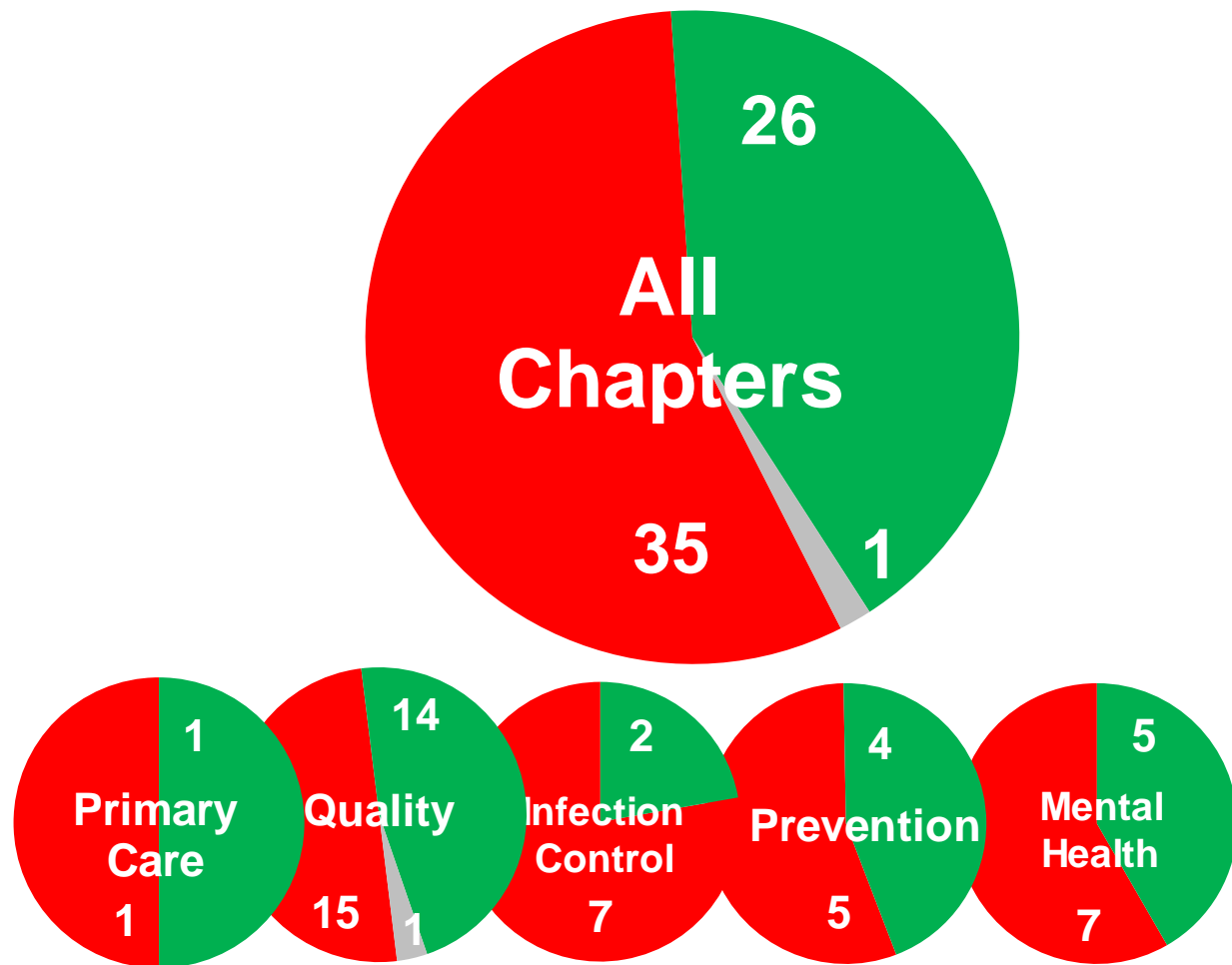
Prevention: The Health Board is the best in Wales with regards Children's Immunisations, being the only Health Board to achieve the 95% rate for Hexavalent 6 in 1 measure, and achieved the highest rate of MMR vaccines. Furthermore, the Betsi Cadwaladr is the best performing Health Board in Wales in terms 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 has continued to improve in March 2019 with particular gains in CAMHS, achieving the 80% target rate for Access to Therapy within 28 days for the first time this year.

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.

Summary Dashboard



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

Headlines

5

Most Improved

Measure	Status	(Target)
Immunisation: 3 doses of 6 in 1	96.60% ↑	>= 95%
Immunisation: 2 doses of MMR	95.60% ↑	>= 95%
GP Open Core Hours	92.45% ↑	>= 91%
MHM2 - Care Treatment Plans (CTP)	90.40% ↑	>= 95%
MHM1b2 - Therapy within 28 Days CAMHS	80.20% ↑	>= 80%

Of Most Concern

Measure	Status	(Target)
Infection Prevention: MSSA	14 ↑	<= 11
Incidents: % Assured within agreed timescales	19.00% ↑	>= 90%
Healthcare Acquired Pressure Ulcers (HAPU)	42 ↑	<= 21
Sepsis Six Bundle: Emergency Department	48.15% ↓	Improve

March 2019

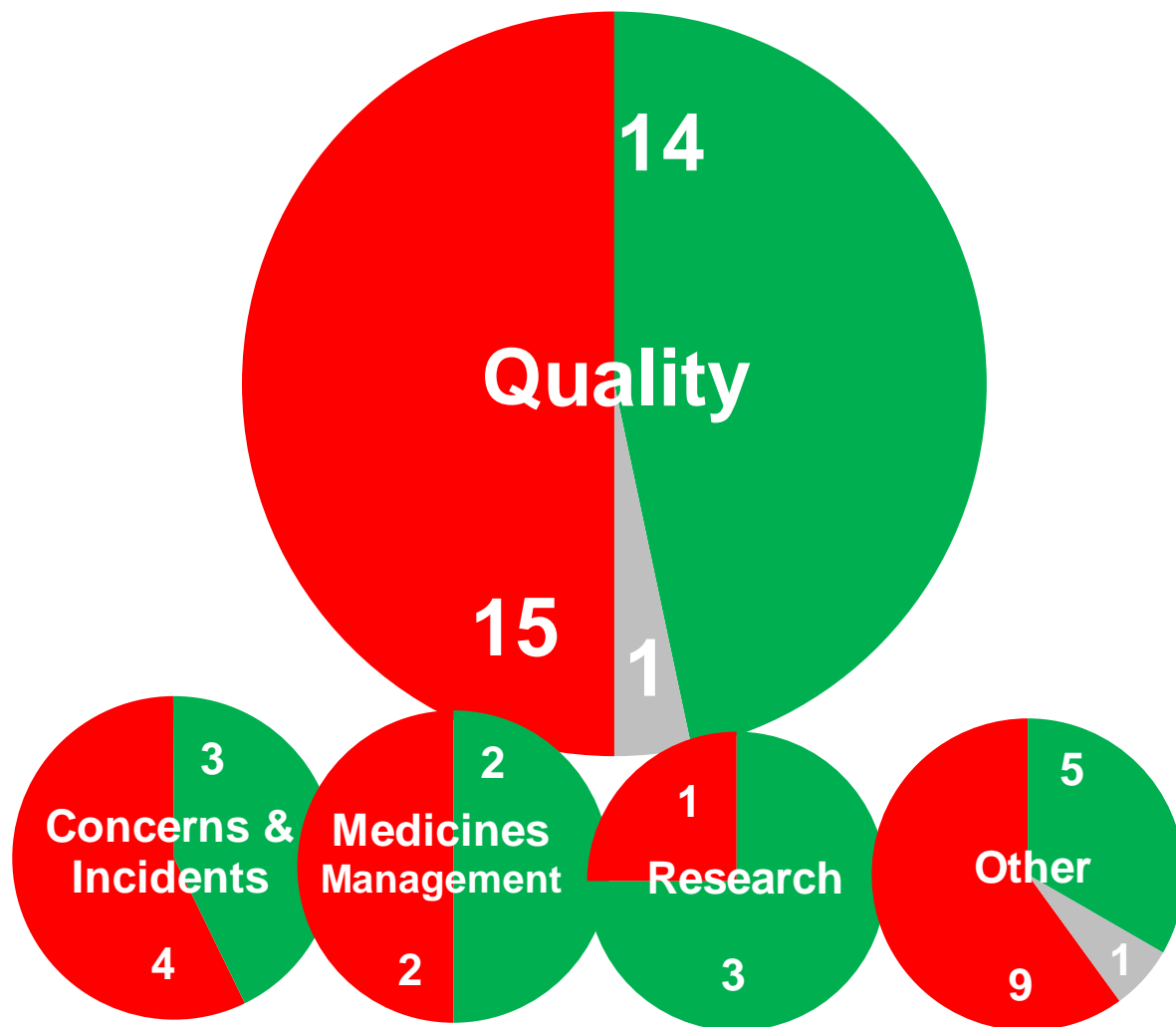
Chapter 1 – Summary Graphic

Quality

6

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.



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

March 2019

Chapter 1 – Summary

Quality

7

Measure	Status	(Target)	Measure	Status	(Target)
Qualitative Reports x 4	Submitted	Submit	Falls Prevention (Reported as Serious Incidents)	7	>= 11
New Never Events	0	0	Antibacterial items per 1000 STAR PUs	274.72	Reduce
Incidents: % Assured within agreed timescales	19.00%	>= 90%	Total Antibacterial Items Prescribed	9.41%	Reduce
Concerns: % Replies within 30 days	27%	>= 75%	NSAIDS per 1000 STAR PUs	1,376	Reduce
Patient Safety Notices: Number Not Assured	6	1	Medication Errors reported as Serious Incidents	0	0
Patient Safety Alerts: Number Not Assured	0	0	Number of H&CRW Studies	70	>= 69 (Q3)
Ward Staffing Levels	85.00%	100%	Number of Commercially Sponsored Studies	9	>= 9 (Q3)
Ward Staffing Skill Mix	55.0%	60%	Number recruited to H&CRW studies	1,173	>= 1500 (Q3)
ITU Delayed Transfers of Care: % Hours Lost	7.81%	<= 5%	Number recruited to Commercial studies	212	>= 72 (Q3)
ITU Delayed Transfers of Care: % Within 4 Hrs	49.10%	>= 95%			
Mortality: Crude Under 75 yoa	0.74%	<= 0.70%			
Mortality: Universal Mortality Reviews	94.50%	>= 95%			

*H&CRW = Health and Care Research Wales

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

March 2019

DFM 077	Evidence of advancing Equality throughout the organisation	Target Submit QRS	Plan Submit QRS	Mar-19	Yes	Wales Benchmark	N/A	Executive Lead	Sue Green	Status	➔	Months in Exception	N/A
DFM 078	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 QRS	Plan Submit QRS	Mar-19	Yes	Wales Benchmark	N/A	Executive Lead	Deborah Carter	Status	➔	Months in Exception	N/A
DFM 079	Qualitative report detailing the achievements made towards implementation of the Wales standard for accessible communication and information for people with sensory loss	Target Submit QRS	Plan Submit QRS	Mar-19	Yes	Wales Benchmark	N/A	Executive Lead	Deborah Carter	Status	➔	Months in Exception	N/A
DFM 080	Evidence of promoting and using the Welsh Language throughout the organisation as per the 'More Than Words' document.	Target Submit QRS	Plan Submit QRS	Mar-19	Yes	Wales Benchmark	N/A	Executive Lead	Sue Green	Status	➔	Months in Exception	N/A

The Qualitative Report Templates for all four measures were submitted to Welsh Government on 30th April 2019.

QRT = Qualitative Report Template

DFM 023	Of the serious incidents due for assurance, the percentage which were assured within the agreed timescales	Target 90.0%	Plan 90%	Mar-19	19.00%	Wales Benchmark	7th	Executive Lead	Deborah Carter	Status	↓	Months in Exception	6+
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Actions

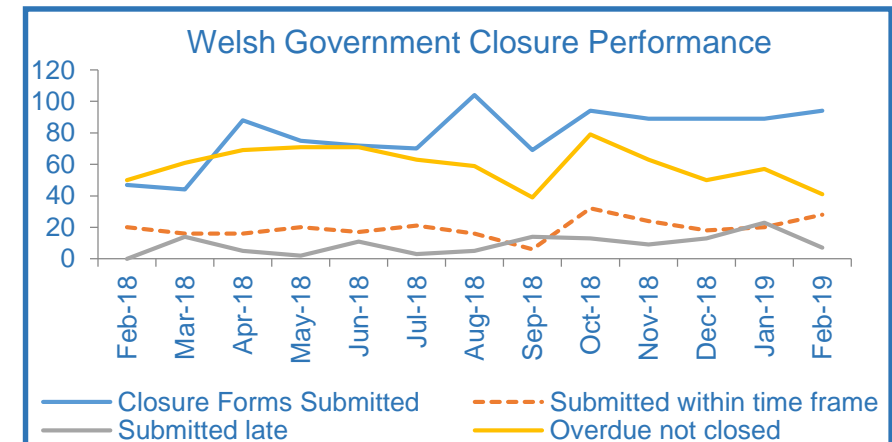
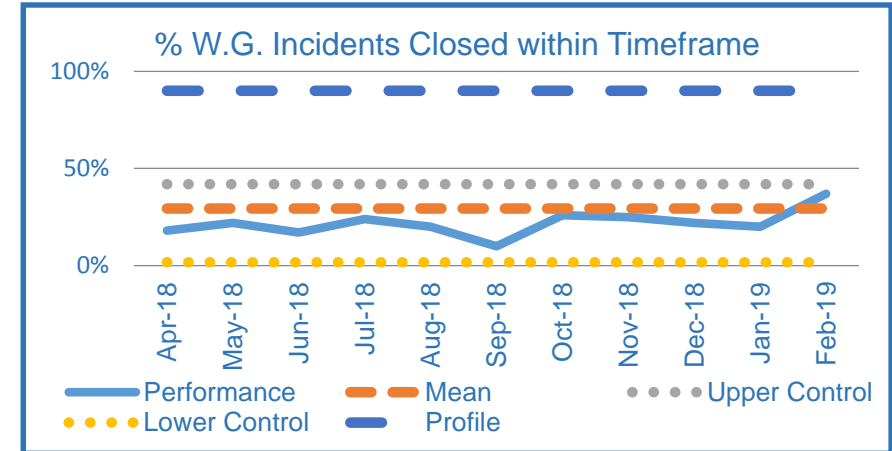
- Weekly Incident Review Meeting in place which is ensuring a more focused approach to managing major and catastrophic incidents. Also focusing on over due incidents which have been reported to Welsh Government
- Review of model for corporate and governance teams to allow greater support to the wider 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



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

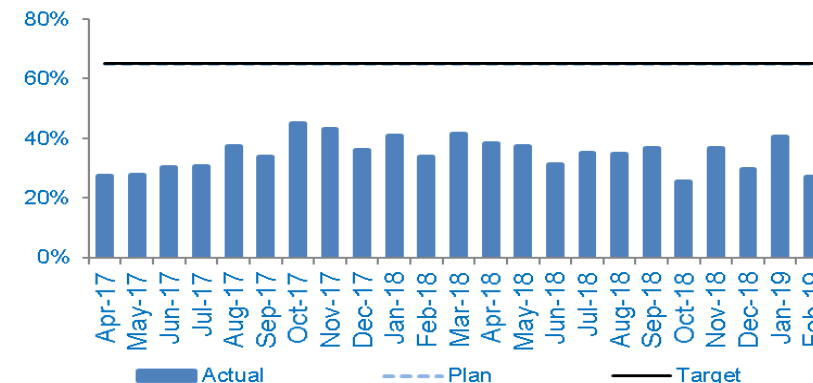
Outcomes:

- 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

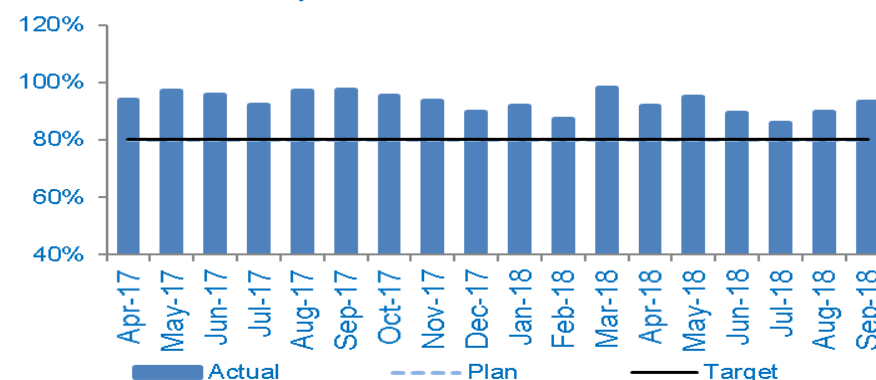
Timelines



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

% of complaints closed within 30 working days



% of complaints closed within 6 months



DFM 022	Number of Patient Safety Solutions Wales Alerts that were not assured within the agreed timescale	Target 0	Plan 0	Mar-19	1	Wales Benchmark	1st	Executive Lead	Evan Moore	Status		Months in Exception	6+
LM 22B	Number of Patient Safety Solutions Wales Notices that were not assured within the agreed timescale	Target 0	Plan 0	Mar-19	6	Wales Benchmark	N/A	Executive Lead	Evan Moore	Status		Months in Exception	6+

At 31st March 2019, 1 of the 9 Patient Safety Alert issued by the Welsh Government (WG) and 6 of the 48 Patient Safety Notices issued by WG remain open.

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.

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. Position Unchanged

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, awaiting plan and compliance statement from Secondary Care

PSN043 Supporting the introduction of the Tracheostomy Guidelines for Wales – compliance due 03/10/2018. Alert due to be updated and replaced by WG in April 2019,

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. Divisions contacted with reminder to provide compliance details.

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”. Position Unchanged

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. Patient Safety Issue (PSI) being developed.

DFM	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 Deborah Carter	Status 	Months in Exception	6+
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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

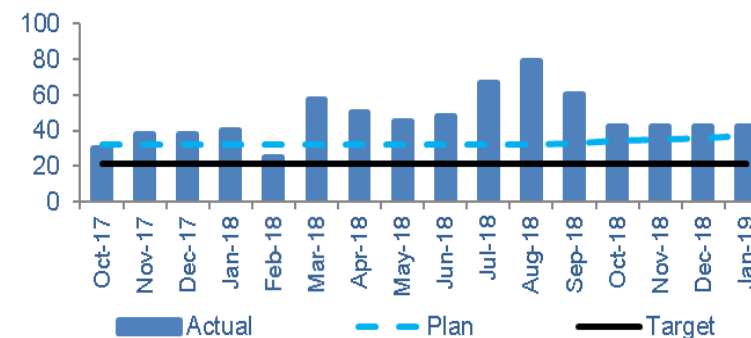
Outcomes

- 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.

Number of Grade 3, 4 & Unstageable healthcare (hospital or community) acquired pressure ulcers (HAPU) reported as Serious Incidents



WG 201	Ward nurse staffing fill rate (%)	Target 100%	Plan	Mar-19	85.00%	Wales Benchmark	N/A	Executive Lead	Deborah Carter	Status	←	Months in Exception	6+
WG 202	Ward nurse staffing skill mix ratio (% Registered)	Target >= 60%	Plan	Mar-19	55.00%	Wales Benchmark	N/A	Executive Lead	Deborah Carter	Status	↑	Months in Exception	6+

Actions

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

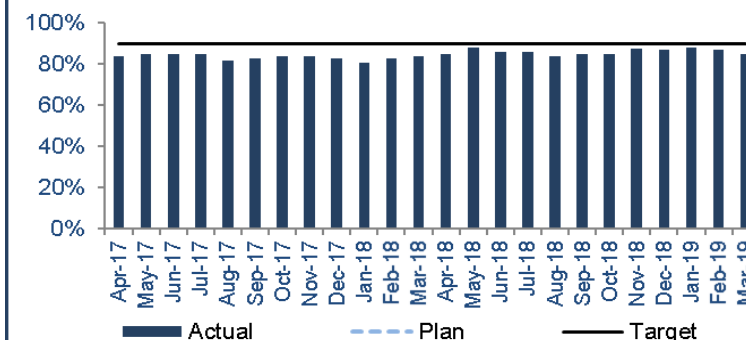
Outcomes

- 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.

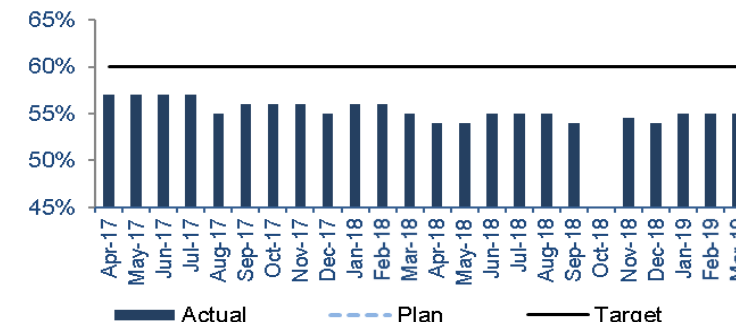
Timelines

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

Ward Staffing Levels Fill Rate (Medical & Surgical Acute)



Ward Staffing Skill Mix Ratio
Registered : Unregistered (Medical & Surgical Acute)



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	Deborah Carter	Status	Months in Exception	6+
LM 131B	Delayed Transfers of Care (DToC): Critical Care - % Discharged within 4 Hours of patient being ready	Target >= 95%	Plan	Jan-19	49.10%	Wales Benchmark	N/A	Executive Lead	Deborah Carter	Status	Months in Exception	6+

Actions

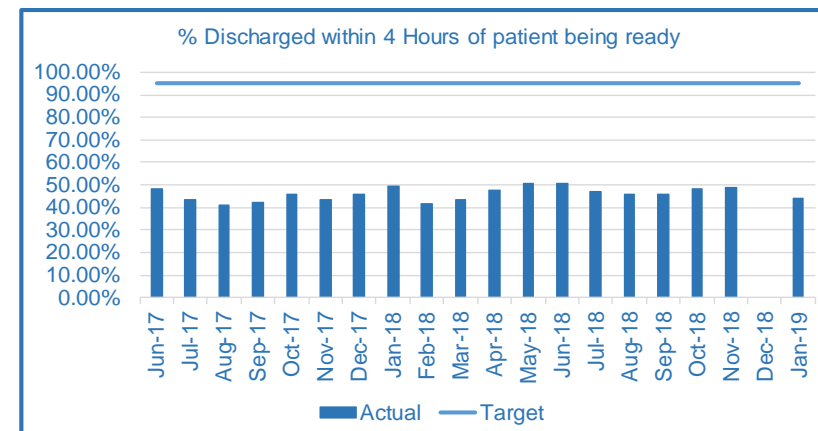
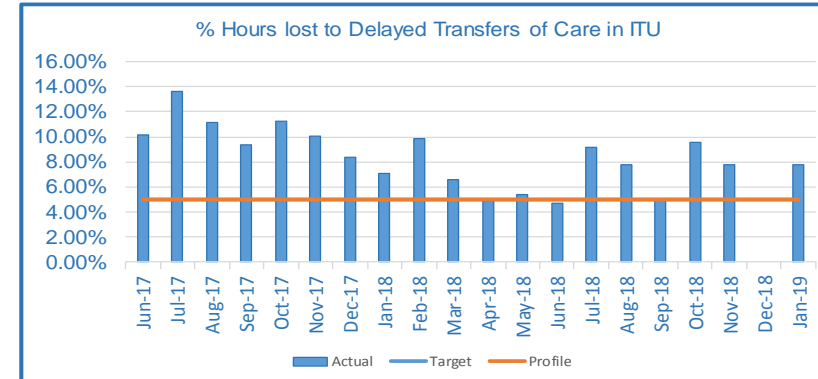
- Performance shared at each site Safety Huddle.
- 3 DToCs prioritised to ensure ICU “emergency bed” available.
- Unscheduled care workstreams ongoing across all 3 sites to improve overall site patient flow.

Outcomes

Deterioration in January 2019 with both measures

Timelines

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



DFM 032	Percentage of universal mortality reviews (UMRs) undertaken within 28 days of a death	Target ≥ 95%	Plan ≥ 95%	Mar-19	94.50%	Wales Benchmark	3rd	Executive Lead	Evan Moore	Status	↓	Months in Exception	6+
DFM 033	Crude mortality rate of patients under 75 years of age	Target Reduce	Plan < 0.70%	Mar-19	0.74%	Wales Benchmark	2nd	Executive Lead	Evan Moore	Status	←	Months in Exception	6+

Actions

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

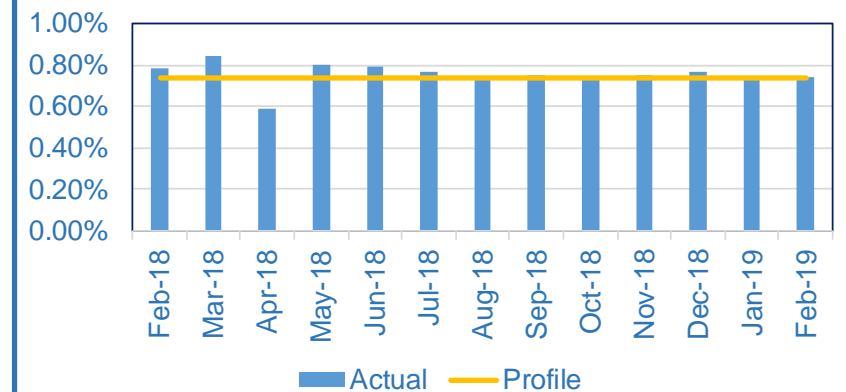
Outcomes



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

Timelines

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

Crude mortality rate of patients under 75 years of age



DFM 035	Percentage episodes clinically coded within 1 month of the episode end date	Target ≥ 95%	Plan ≥ 95%	Mar-19	91.80%	Wales Benchmark	5th	Executive Lead	Evan Moore	Status 	Months in Exception	6+
DFM 036	Percentage of clinical coding accuracy attained in the NWIS national clinical coding accuracy audit programme	Target Improve	Plan TBC	17/18	89.60%	Wales Benchmark	7th	Executive Lead	Evan Moore	Status 	Months in Exception	6+

Actions:

Band 2 coding support vacancy appointed at East, start date TBC. Vacancies at other site to be approved through vacancy control.

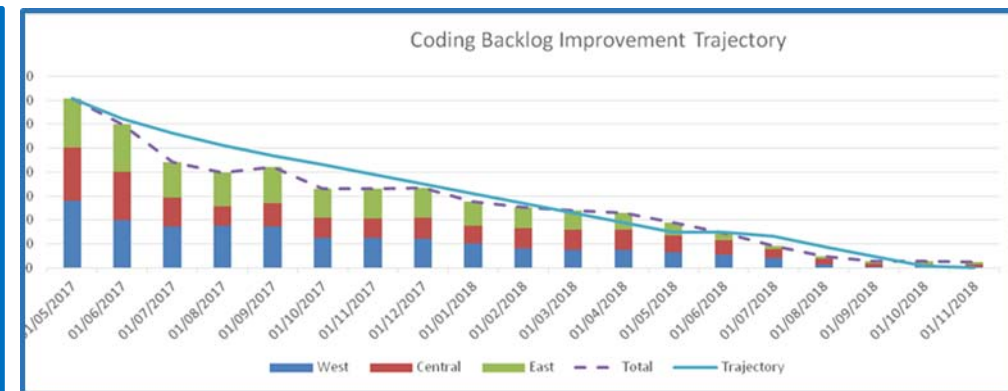
Outcomes:





DFM 035 – March 2019 percentage episode coded within 1 month 91.8%. February 2019 percentage 91.7%.

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.



DFM 038	Number of Health & Care Research Wales clinical research portfolio studies (quarterly Year-To-Date figure)	Target ≥ 89	Plan ≥ 69	Qtr3 18/19	70	Wales Benchmark	3rd	Executive Lead	Evan Moore	Status		Months in Exception	6+
DFM 039	Number of commercially sponsored studies (rolling 4 quarter sum)	Target ≥ 11	Plan ≥ 3	Qtr3 18/19	9	Wales Benchmark	3rd	Executive Lead	Evan Moore	Status		Months in Exception	6+
DFM 040	Number of patients recruited into Health & Care Research Wales clinical research portfolio studies (quarterly Year-To-Date figure)	Target ≥ 2,016	Plan ≥ 1,500	Qtr3 18/19	1,173	Wales Benchmark	5th	Executive Lead	Evan Moore	Status		Months in Exception	6+
DFM 041	Number of patients recruited into commercially sponsored studies (rolling 4 quarter sum)	Target ≥ 92	Plan ≥ 72	Qtr3 18/19	212	Wales Benchmark	1st	Executive Lead	Evan Moore	Status		Months in Exception	6+

Actions:

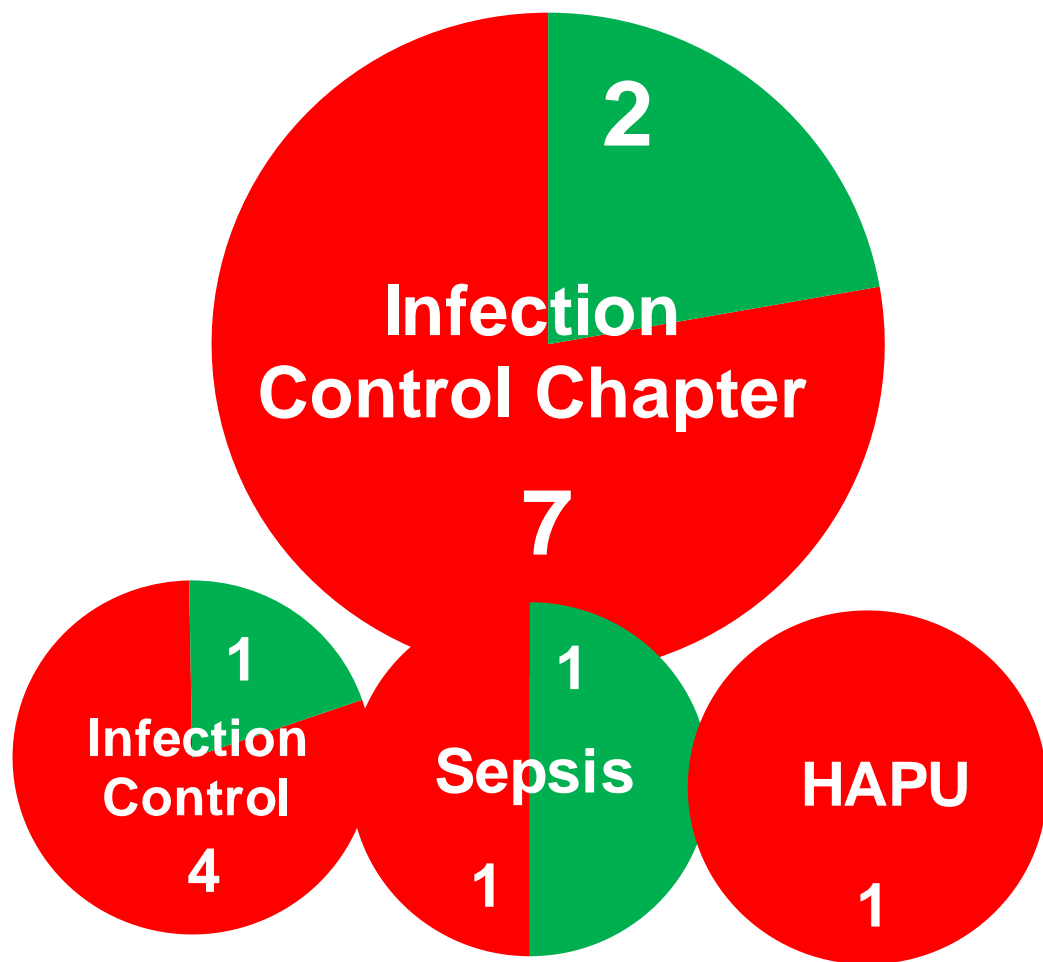
- Weekly performance meetings and reviews take place to ensure we are actively seeking out studies
- Streamlining our expression of interest process to ensure we open appropriate studies
- Regular communications with all staff regarding performance to target.
- Bank research delivery staff are now in 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	84.22	≤ 67
Infection Prevention: C.Difficile	24.56	≤ 26.00
Infection Prevention: S.Aureus	25	≤ 20.00
Infection Prevention: MRSA	1	0
Infection Prevention: MSSA	14	≤ 11
Healthcare Acquired Pressure Ulcers (HAPU)	42	≤ 21
Sepsis Six Bundle - Emergency Departments	48.15%	100%
Sepsis Six Bundle- Inpatients	100%	100%
Preventable Hospital Acquired Thrombosis (HAT)	1	0

DFM 018	The cumulative rate of laboratory confirmed E.coli bacteraemias cases per 100,000 population	Target ≥ 67	Plan ≥ 67	Mar-19	82.44	Wales Benchmark	2nd	Executive Lead	Deborah Carter	Status	↓	Months in Exception	6+
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	Mar-19	25.00	Wales Benchmark	1st	Executive Lead	Deborah Carter	Status	↓	Months in Exception	6+
DFM 020	The cumulative rate of laboratory confirmed C.difficile cases per 100,000 of the population	Target ≤ 26	Plan ≤ 26	Mar-19	24.56	Wales Benchmark	4th	Executive Lead	Deborah Carter	Status	↑	Months in Exception	6+
LM 019a	Number of laboratory confirmed cases of MRSA	Target 0	Plan 0	Mar-19	4	Wales Benchmark	N/A	Executive Lead	Deborah Carter	Status	↓	Months in Exception	6+
LM 019b	Number of laboratory confirmed cases of MSSA	Target ≤ 11	Plan ≤ 11	Mar-19	14	Wales Benchmark	N/A	Executive Lead	Deborah Carter	Status	↓	Months in Exception	6+

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.

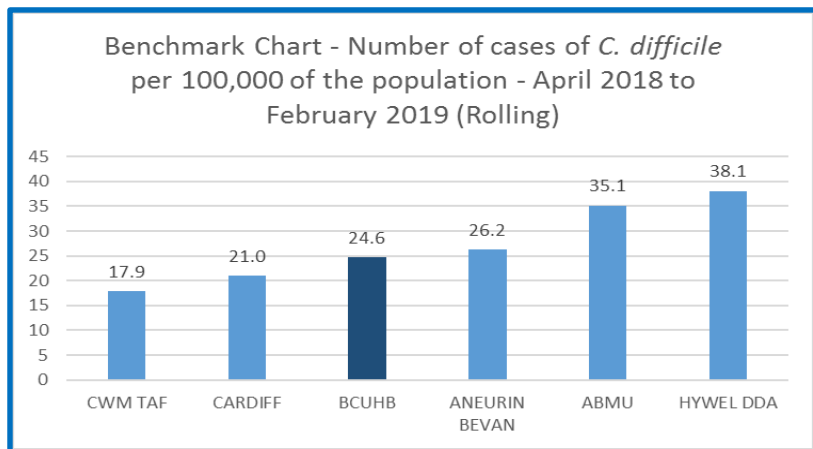
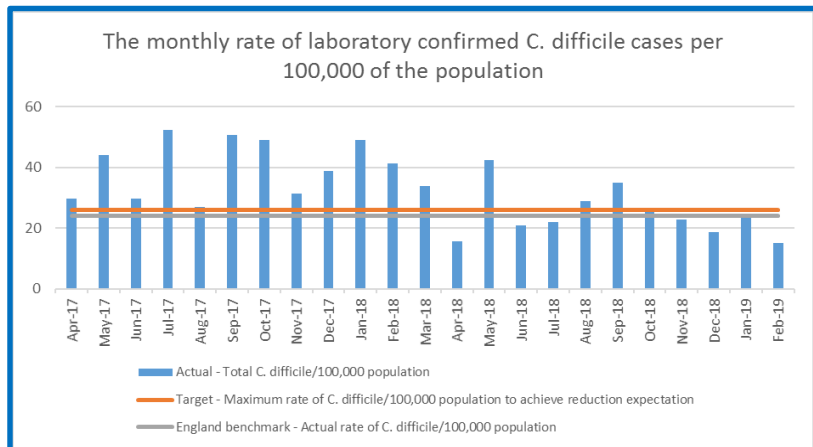
Outcomes:

- 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.

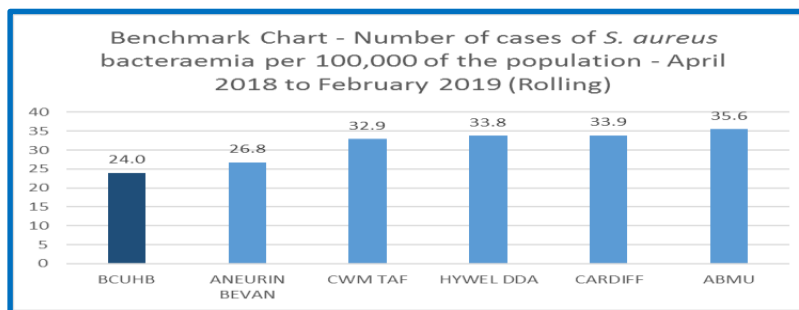
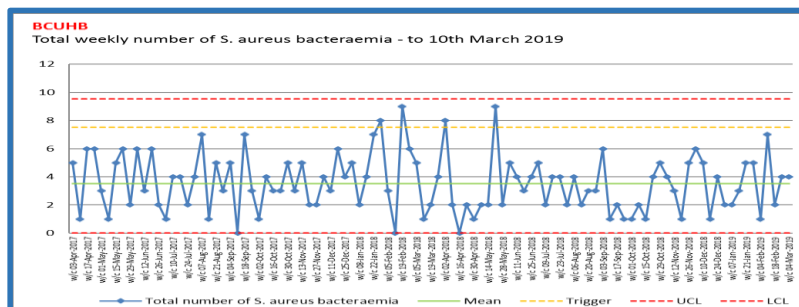
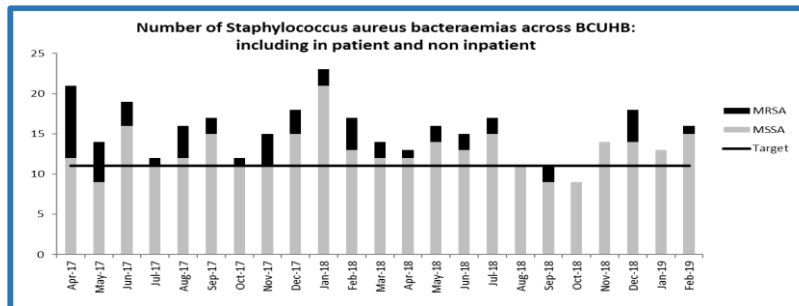
Timelines:

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

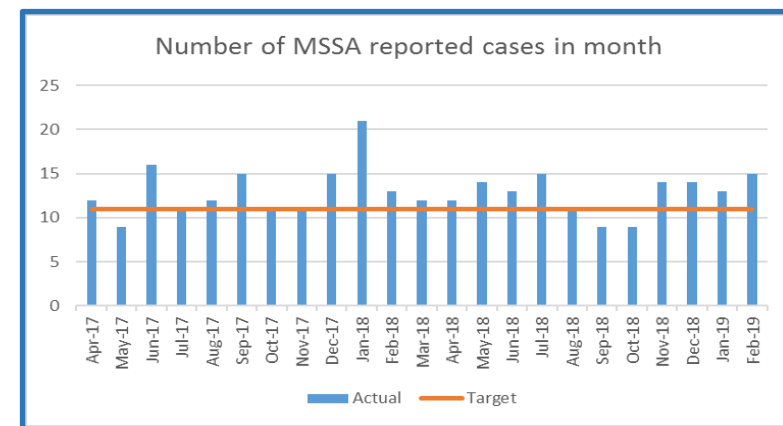
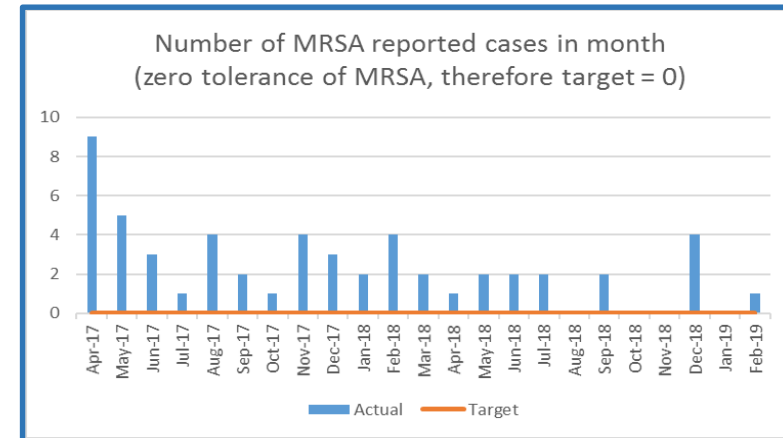
Clostridium Difficile



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
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	48.60%	Wales Benchmark	3rd	Executive Lead	Evan Moore	Status	Months in Exception	6+

Actions

- Sepsis collaborative in progress, specific focus is on the emergency departments (ED) and the introduction of DRIPS.
- Sepsis e-form developed along with dashboard to enable staff on front line to enter data and review in timelier manner.

Outcomes

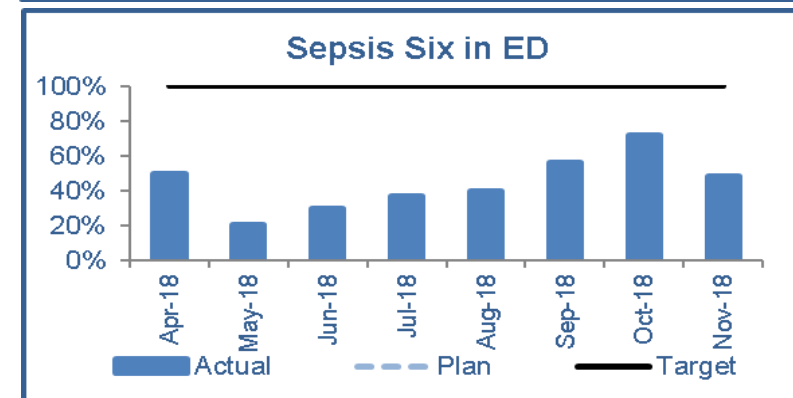
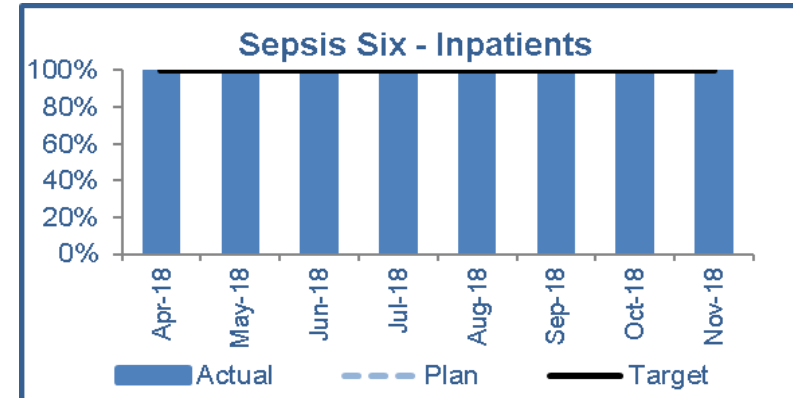
- DRIPS meetings in place in all Emergency departments
- Compliance in ED with sepsis 6 bundle is improving.

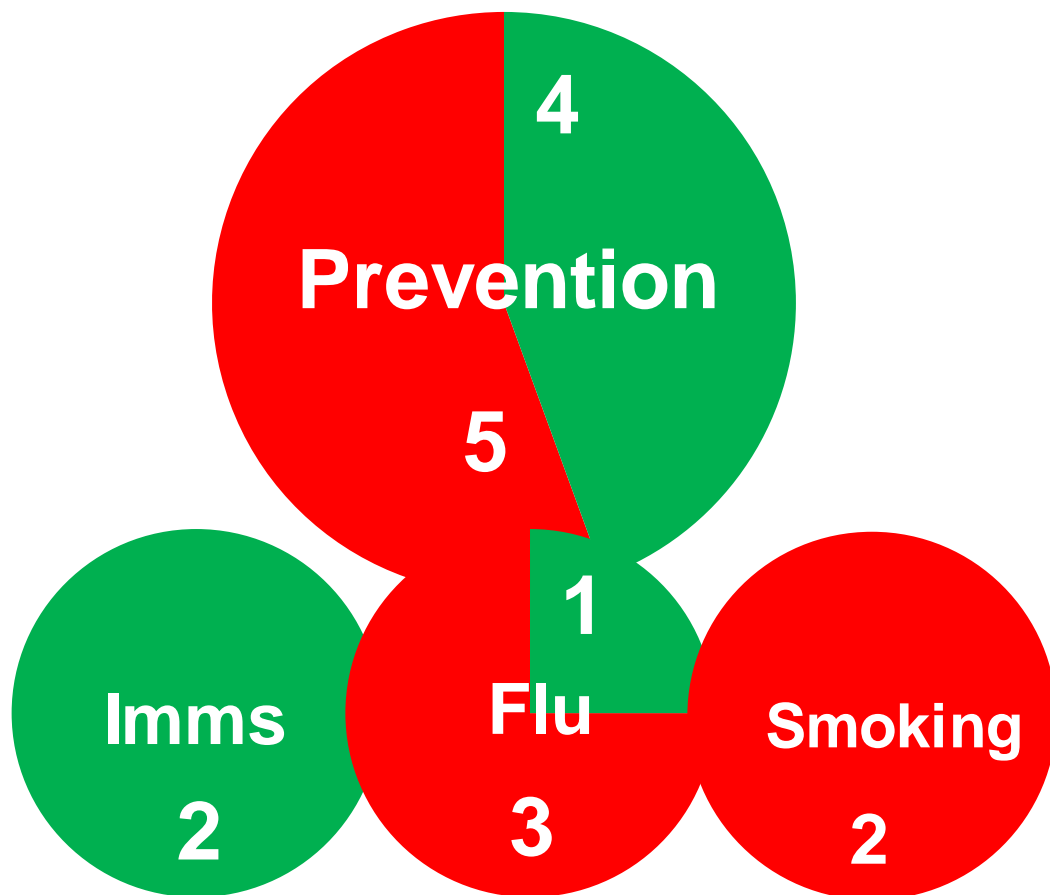
Timelines

- 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	95.60%	>= 95%
Flu Vaccination: Under 65's at Risk Group	47.90%	>= 55%
Flu Vaccination: Over 65's	71.00%	>= 75%
Flu Vaccination: Pregnancy	75.00%	>= 75%
Flu Vaccination: Healthcare Workforce	51.20%	>= 60%
Smoking Cessation: % Service Use	2.64%	>= 5%
Smoking Cessation: Validated as Quit	37.90%	>= 40%
Healthy Child Wales Programme	94.00%	>= 91%

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%	Qtr3 18/19	96.60%	Wales Benchmark	4th	Executive Lead	Teresa Owen	Status	Months in Exception	6+
DFM 003	Percentage of children who received 2 doses of the MMR vaccine by age 5	Target 95.0%	Plan 95.00%	Qtr3 18/19	95.60%	Wales Benchmark	2nd	Executive Lead	Teresa Owen	Status	Months in Exception	6+

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

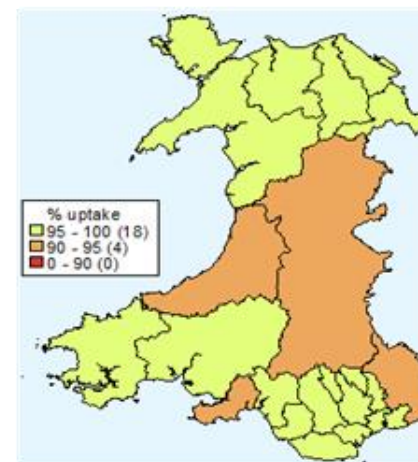
Outcomes

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

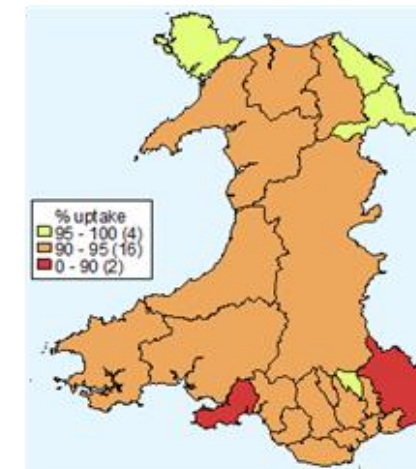
Timelines

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 into 2019/20.

Uptake of 6 in 1 at 1st birthday



Uptake of 2nd MMR at 5th birthday



To note: 2nd MMR at 5th birthday

- BCUHB is the only Health Board to exceed 95% target for 2nd 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%	Mar-19	47.90%	Wales Benchmark	1st	Executive Lead	Teresa Owen	Status	↑	Months in Exception	6+
DFM 005b	% Uptake of influenza vaccine in Over 65's	Target ≥ 75%	Plan ≥ 72%	Mar-19	71.00%	Wales Benchmark	1st	Executive Lead	Teresa Owen	Status	↑	Months in Exception	6+
DFM 005c	% uptake of the influenza vaccine in pregnant women	Target ≥ 75%	Plan ≥ 75%	Mar-19	75.00%	Wales Benchmark	N/A	Executive Lead	Teresa Owen	Status	↑	Months in Exception	N/A

The flu vaccination activity ceased at the end of the campaign on 31st March 2019.

Actions:

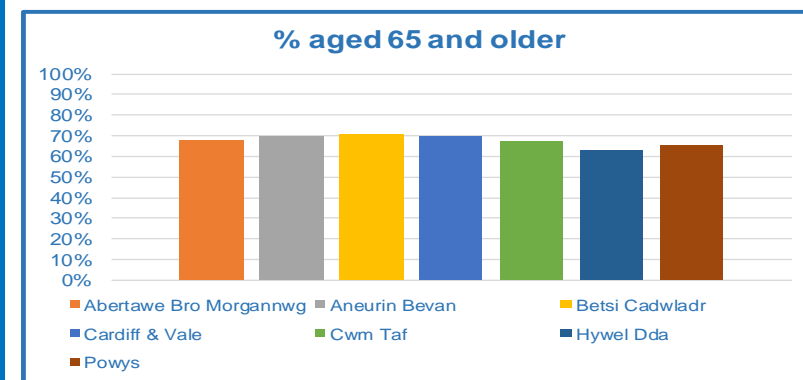
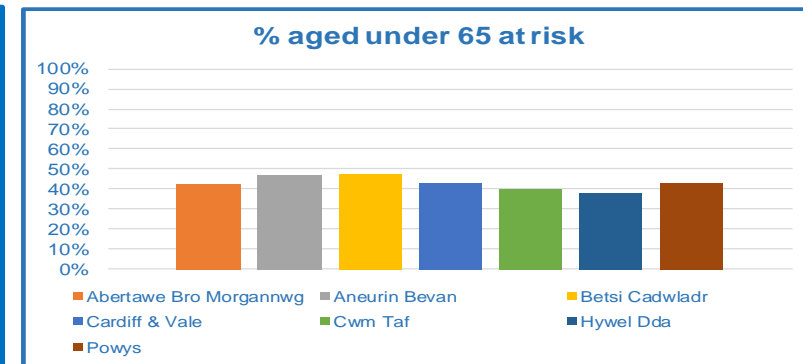
- Scrutiny of the flu vaccines recorded on GP practice systems is currently taking place
- Uptake on pregnant women will be available in April following a Point of Delivery Audit conducted in January
- A Flu Debrief has taken place to evaluate the current campaign which adopted a whole system approach 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 :

- 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.



DFM 005d	Uptake of influenza vaccination among: Health care workers	Target >= 60%	Plan >= 60%	Mar-19	51.20%	Wales Benchmark	5th	Executive Lead	Teresa Owen	Status	↑	Months in Exception	6+
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Actions

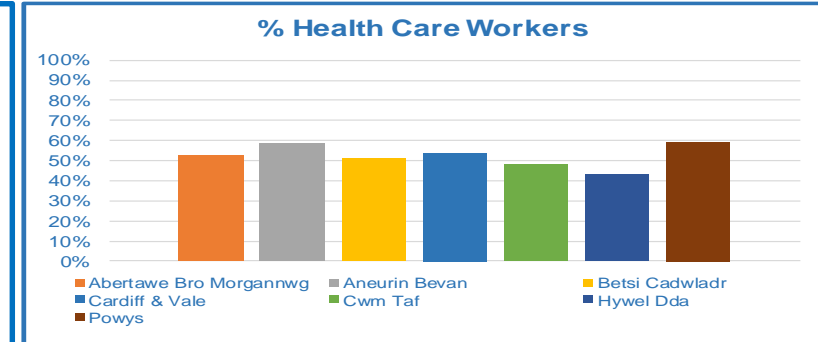
- To achieve 60% (n10,667) flu vaccination uptake for BCUHB staff.
- Increase staff flu vaccination up-take in our 67 high risk areas to 75% compliance
- Evaluate the effectiveness of local flu vaccinators to deliver flu campaign
- Target communication messages to identified low performing areas outlined 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

- 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



	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	Mar-19	7	Wales Benchmark	7th	Executive Lead	Deborah Carter	Status ↑	Months in Exception	N/A
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Actions

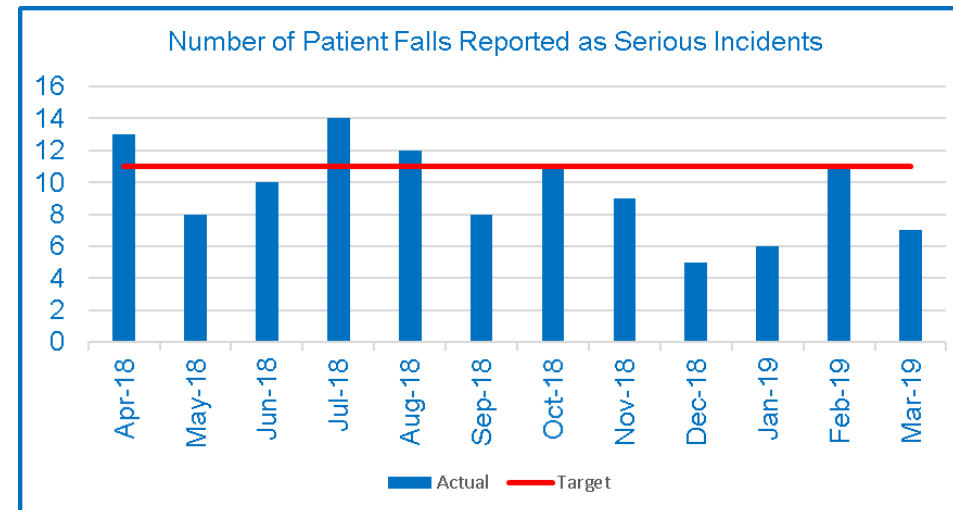
- Each site are required to undertake an RCA/desktop review with MDT involvement for all falls with Harm that are WG reportable e.g. fall resulting in fractures, severe head injury lessons learned shared with local quality and safety meetings
- Falls collaborative planned to commence in April 2019 using 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

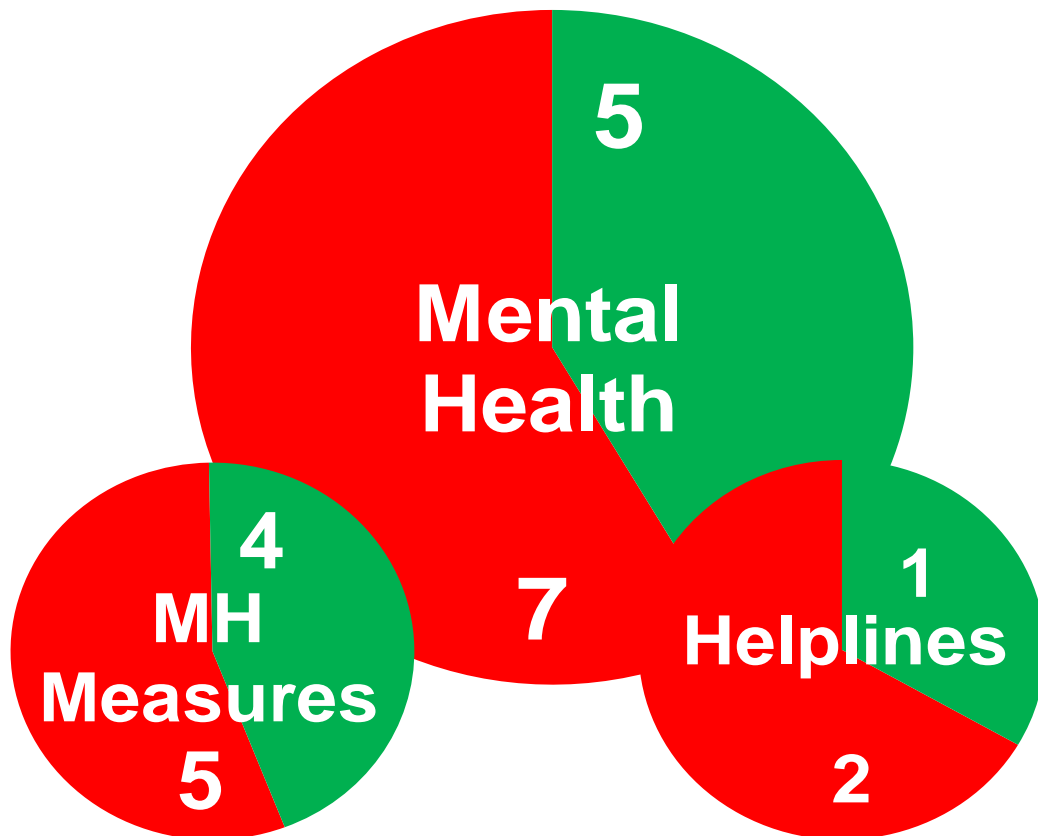
It is anticipated that there will be a reduction in falls with Harm during the work of the collaborative for the selected wards and then as Health Board.

Timelines

Falls collaborative planned to commence April 2019 with a Health Board standard for implementation December 2019.



Chapter 4 - Summary



Mental Health

27

Measure	Status	(Target)
MHM1a - Assessments within 28 Days	75.70% ↑	>= 80%
MHM1b - Therapy within 28 Days	68.00% ↑	>= 80%
MHM1a - Assessments within 28 Days (Adult)	75.70% ↑	>= 80%
MHM1b - Therapy within 28 Days (Adult)	66.30% ↑	>= 80%
MHM1a - Assessments within 28 Days (CMAHS)	75.20% ↑	>= 80%
MHM1b - Therapy within 28 Days (CAMHS)	80.90% ↑	>= 80%
MHM2 - Care Treatment Plans (CTP)	90.40% ↑	>= 95%
MHM3 - Copy of Agreed plan within 10 Days	100% →	100%
Advocacy Arrangements	100% →	100%
Helplines: CALL	210.5 ↓	Improve
Helplines: DAN	37.8 ↑	Improve
Helplines: Dementia	8.0 ↓	Improve

LM 074A	% of assessment by the LPMHSS undertaken within 28 days of the date of referral: Adult	Target $\geq 80\%$	Plan	Mar-19	75.70%	Wales Benchmark	N/A	Executive Lead	Andy Roach	Status	Months in Exception	6+
LM 075A	% of therapeutic interventions started within 28 days following an assessment by LPMHSS: Adult	Target $\geq 80\%$	Plan	Mar-19	66.30%	Wales Benchmark	N/A	Executive Lead	Andy Roach	Status	Months in Exception	6+

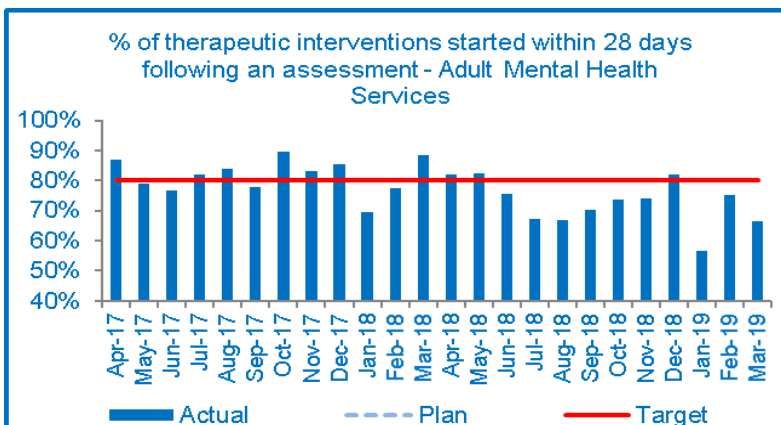
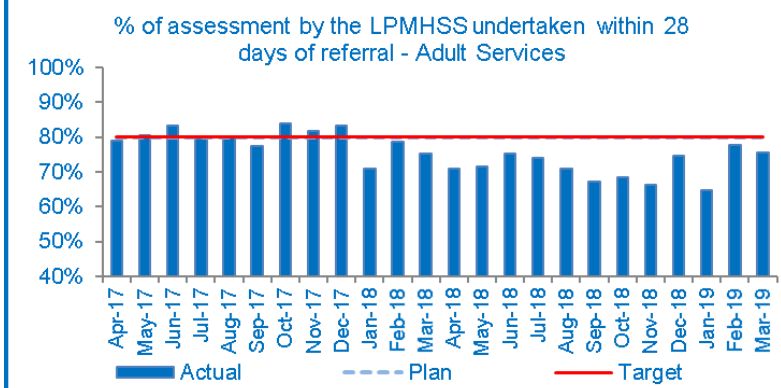
Actions: Patients are treated in turn has been widely adopted which has impacted on performance and is clinically the right action for patients

- Timely weekly reporting direct to teams
- MHM Lead(s) supporting allocated area to increase focus on specific issues / actions plan
- Regular and timely data cleansing & validation
- Closer monitoring & scrutiny of referral activity
- Increased Senior Manager focus & support
- Clinical & Social care staff deployed to focus on areas performing below target
- Exploring other opportunities to respond to demand
- 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.



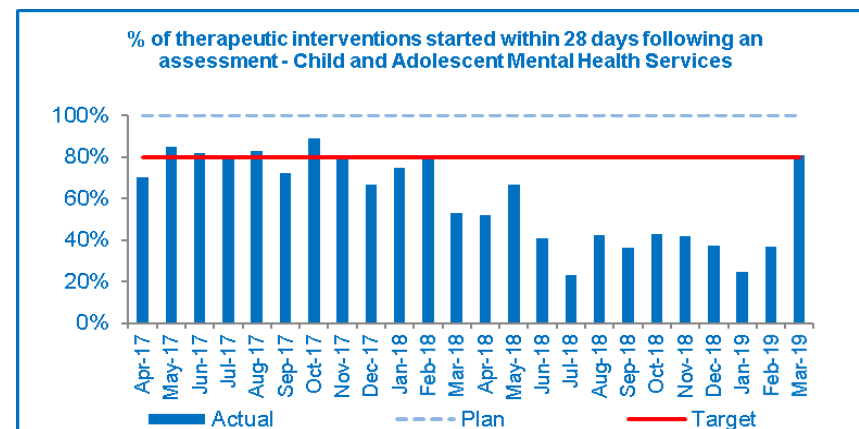
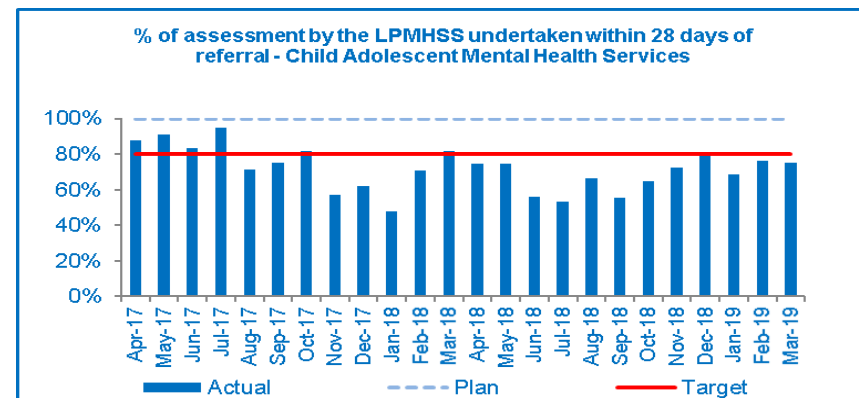
LM 074B	% of assessment by the LPMHSS undertaken within 28 days of the date of referral: CAMHS	Target ≥ 80%	Plan Mar-19	75.20%	Wales Benchmark N/A	Executive Lead Andy Roach	Status ↑	Months in Exception 6+
LM 075B	% of therapeutic interventions started within 28 days following an assessment by LPMHSS: CAMHS	Target ≥ 80%	Plan Mar-19	80.90%	Wales Benchmark N/A	Executive Lead Andy Roach	Status ↑	Months in Exception 6+

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.



DFM 085	% of LHB residents (all ages) to have a valid CTP completed at the end of each month	Target ≥ 90%	Plan 89.7%	Mar-19	90.40%	Wales Benchmark	5th	Executive Lead Andy Roach	Status 	Months in Exception 6+
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Actions:

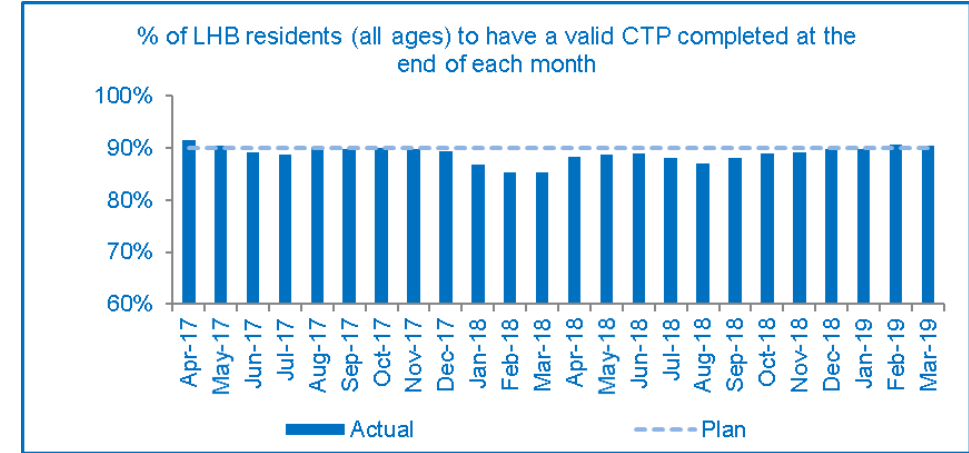
Detailed & timely reports disseminated to teams and individual care coordinators.
 The Mental Health Measure Leads are aligned to local areas to improve performance and overall quality of services to patients.
 Regular data cleansing & caseload validation
 Close and regular monitoring of activity and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

Outcomes

Further education
 Correct & validated information
 Teams informed and engaged

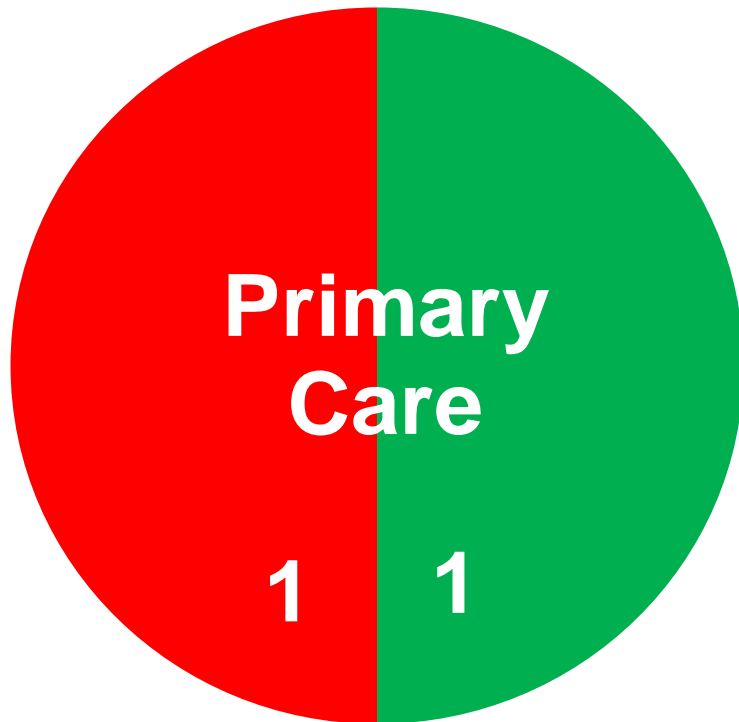
Timelines

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	210.5	Wales Benchmark	2nd	Executive Lead	Andy Roach	Status	↓	Months in Exception	6+
DFM 083	Number of calls relating to dementia to the 'Dementia' helpline	Target Improve	Plan Improve	Qtr3 18/19	8.00	Wales Benchmark	1st	Executive Lead	Andy Roach	Status	↓	Months in Exception	6+
DFM 084	Number of calls relating to drugs and alcohol to the 'DAN 24/7' helpline	Target Improve	Plan Improve	Qtr3 18/19	37.80	Wales Benchmark	1st	Executive Lead	Andy Roach	Status	↑	Months in Exception	6+

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	92.5%	Wales Benchmark	4th	Executive Lead	Chris Stockport	Status ↑	Months in Exception	
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	66.04%	Wales Benchmark	4th	Executive Lead	Chris Stockport	Status ↓	Months in Exception	

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
- Stats Wales www.bcu.wales.nhs.uk
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>

Safe Clean Care (SCC)

Update

as at 01/05/2019



Safe Clean Care Celebrations 14th of March 2019



Safe Clean Care Celebrations 14th of March 2019

The bug story



The sing along



Presentations from all areas / sites



1000Li team support



Some of the SCC awards



Further improvement & Sustainability



- SCC will continue through the IPC plans.
- All teams will continue with their local plans and report monthly.
- SCC steering board will continue to monitor progress, improvement and support staff with challenges faced.
- Further areas for support will be Mental Health, Schools, Nursing and Residential homes and the community settings.

Current Measures

BCUHB
Total monthly number of C. difficile

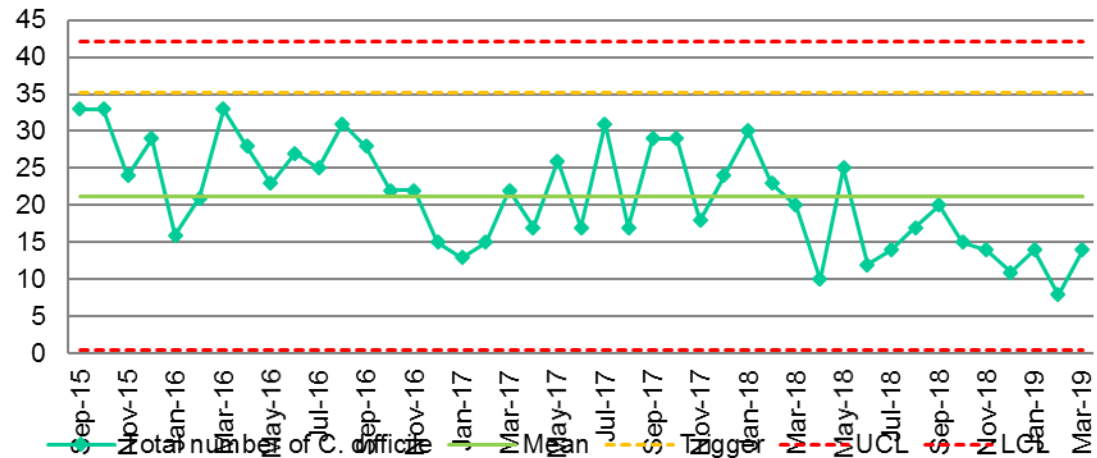


September 2017

March 2019

BCUHB

Total monthly number of C. difficile



SCC recourses available on line



<http://howis.wales.nhs.uk/sitesplus/861/page/72969>



**Click here to
download our
useful resources:**

- Signature banner
- Posters
- Logo
- Commitment forms



Any Questions?



**GOFAL
DIOGEL
GLÂN**



**SAFE
CLEAN
CARE**



Quality, Safety & Experience (QSE) Committee 21.5.19	 <div style="display: inline-block; vertical-align: middle; margin-left: 10px;"> Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board </div> <p><i>To improve health and provide excellent care</i></p>
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Report Title:	All Wales Standards for Accessible Communication & Information for People with Sensory Loss – Update on Implementation
Report Author:	Mrs Barbara Jackson Assistant Director Service User Experience Mr Peter Morris Patient Experience Manager (West)
Responsible Director:	Mrs Deborah Carter, Interim Executive Director of Nursing and Midwifery
Public or In Committee	Public
Purpose of Report:	<p>The All Wales Standard for Accessible Communication and Information for People with Sensory Loss sets out the standards of service delivery that people with sensory loss should expect when they access healthcare. These standards apply to all adults, young people and children. The Accessible Information Standard requirements sit alongside the ‘Standards’ as an enabler to implementing them.</p> <p>Progress against the organisation’s action plan for the current operational year is reported bi-annually to Welsh Government.</p>
Approval / Scrutiny Route Prior to Presentation:	This paper has been shared with Welsh Government March 2019
Governance issues / risks:	<p>The following have been identified as potential risks for the Health Board with the controls in place to mitigate each element:</p> <p>Risk1: Lack of proactive involvement of some areas in the self-evaluation and audit process</p> <p>Control1: Controlled for by the appointment of the PALS officers and the devolution of the work stream to East, West and Centre – and closer working relationships with the governance teams in each of the operating areas, including primary care – see below.</p> <p>Risk2: Lack of accountability within primary Care especially in relation to non-managed practices.</p> <p>Control2: Improved collaboration/coproduction with primary care governance teams and cluster development leads on a regional basis, supported with relevant learning materials.</p> <p>Risk3: Recording of language communication needs including BSL within primary and secondary care information systems, and the</p>

	<p>utilisation of this information to create triggers for action such as the booking of WITS interpreters.</p> <p>Control3: Encourage service users to identify any specific communication needs to reception and clinical staff and develop the skills necessary to utilise existing fields to accurately record this information and the continued funding of the Accessible Health Care scheme.</p>
Financial Implications:	The continued funding of the Accessible Health Care Scheme to ensure continuity
Recommendation:	To consider taking forward the recommendations in the organisational action plan and where possible embed in the wider organisation and governance performance framework

Health Board's Well-being Objectives <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>	√	WFGA Sustainable Development Principle <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	√		
Special Measures Improvement Framework Theme/Expectation addressed by this paper			
Engagement			
Equality Impact Assessment			
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

Accessible Communication and Information

NHS Organisation	Betsi Cadwaladr University Health Board
Date of Report	March 2019
Report Prepared By	Peter Morris Barbara Jackson

The [All Wales Standard for Accessible Communication and Information for People with Sensory Loss](#) sets out the standards of service delivery that people with sensory loss should expect when they access healthcare. These standards apply to all adults, young people and children. The Accessible Information Standard requirements sit alongside the 'Standards' as an enabler to implementing them.

Reporting Schedule: Progress against the organisation's action plan for the current operational year is to be reported bi-annually. This form is to be submitted on 31 October and 31 March.

Complete form to be returned to: hss.performance@gov.wales

Does the organisation have an action plan in place to implement the All Wales Standard for Accessible Communication & Information for People with Sensory Loss?

Update on the Actions to Implement the All Wales Standards for Accessible Communication & Information for People with Sensory Loss:

Needs Assessments	Key Actions Achieved during 2018-19	Risks to Delivery	Corrective Actions
All public & patient areas should be assessed to identify the needs of people with sensory loss	<p>BCUHB has developed an self-evaluation tool which enables managers to evaluate compliance with the standards in relation to their service points and include a section related to Environmental Signage and wayfinding and is supported by addition guidance.</p> <p>The self-evaluation tool is utilised as an integral component of organisational governance and performance management in relation to compliance the AHCS.</p> <p>Evaluation Tool has been reviewed and a primary care version has been developed and is currently being rolled out to managed practices.</p>	Utilisation of the evaluation instrument are not uniform BCUHB and tend to be better within Acute wards and departments, and does not always lead to effective action planning and improvement.	<p>Specific Performance targets in relation to compliance with the standards have been included within the BCUHB's intermediate performance plan and are reportable to Board as an integral component of the organisational assurance framework.</p> <p>BCUHB will introduce a new ward accreditation system to begin in Q4-2018/2019 which will included explicit reference to improved compliance with AHCS.</p> <p>Utilisation of existing performance, quality assurance and governance arrangements to support (i) improved utilisation of the evaluation tool and resultant action planning and (ii) exception reporting to relevant</p>

	<p>The primary care roll out and implementation has been supported with specifically developed intranet resources.</p>	<p>The majority of GP Practices are not Managed practices</p>	<p>organisational scrutiny groups where this is not occurring. Area governance Teams are aware of the issue and supporting via Cluster Development programmes.</p> <p>Continue to ensure as an integral component of BCUHB's Patient Experience Strategy that Area Governance Teams, and Cluster Development Officers have the resources necessary to support improved compliance with AHCS.</p> <p>Performance in relation to compliance against the standards is reported via organisational Quality & Safety Group and Quality Safety and Effectiveness Sub-Committee of the board.</p> <p>BCUHB is in the process of appointing and extra 4 x 1.0 wte Patient Advice & Liaison Officers (PALS) who in addition to other duties will have a specific responsibility to operationally support compliance with AHCS.</p>
<p>All public information produced by organisation should be assessed for accessibility prior to publication.</p>	<p>Generally information is available in accessible format to service users after publication and on request. Although locally within Audiology and Ophthalmology there are some really good examples of information eg patient information leaflets etc., which have been designed in large print, alternative formats etc.</p> <p>Policy ISU02 Written Information for Patients, has been updated and includes explicit reference to the processes for ensuring written</p>	<p>Throughout 2018/2019 this will remain a major challenge for BCUHB, especially given the quantity and variation of information provided to service users.</p>	<p>POLICY; ensure that the current review of Policy ISU02 Written Information for Patients includes explicit reference to compliance with AHCS.</p> <p>PERFORMANCE Management; (see above comments) and ensure that this requirement is explicitly referenced within the proposed ward accreditation scheme.</p> <p>OPERATIONAL Requirements; ensure that the 'Readers Panel' who review</p>

	<p>information for service users is available in alternative formats.</p> <p>Policy is currently being reviewed.</p>	<p>These objectives are dependent in part on wider project plans in relation to developing our intranet and communication strategies.</p>	<p>new public information leaflets are aware of the requirements of AHCS.</p> <p>RESOURCES/AWARENESS; prioritise on NEW Information, and standard information which has high usage levels, to ensure that these can be made available in (i) easy read, (ii) variable font size, (iii) audio format, (iv) Video BSL, and (v) Braille – where required. (It is not proposed to create over large repositories but rather to create increased awareness of the processes to create alternative formats as required).</p> <p>Corporate Governance Team have been supporting the development of easy read versions of patient information where there has been a specific request from Staff or Service Users. Service Level Agreement with WITS enables BRAILLE translation where requested.</p> <p>BCUHB is in the process of migrating towards a new Content Management System for intranet content, and high usage materials are currently being identified</p> <p>BCUHB Patient Experience Strategy for (2019/2021) reinforces a trilingual (English, Welsh and BSL) approach to communicating with service users. There remains significant work to be done to achieve this aim and work streams associated with the new Patient Experience Strategy will reflect this work.</p>
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Standards of Service Delivery	Key Actions Achieved during 2018-19	Risks to Delivery	Corrective Actions
Health Prevention (Promotion Screening, SSW, Flu Vaccination, Bump Baby & Beyond). Priority areas include:			
<p>Raising staff awareness</p>	<p>The latest version of the Sensory Loss Toolkit contains (i) factsheets (1-4) relating to best practice for dealing with service users with sensory loss and (ii) endorses the use of the NHS Wales e-sensory loss module. This is reinforced by the baseline evaluation tool (section 3 – see above).</p> <p>Additionally BCUHB participates proactively in Sensory Loss Awareness month, and has encouraged and supported the presence of voluntary organisations within key clinics eg Vision Support , COSS at Ophthalmic OPD in order to provide addition staff awareness and support to service users, throughout the year.</p> <p>BCUHB mandatory training policy has been amended to ensure that the NHS e-sensory loss module is offered as an alternative to the 3-year mandatory equality training refresher.</p> <p>The above approach will begin in June 2019</p>	<p>Currently sensory loss training is not mandatory within the NHS in Wales and this does pose a significant risk in relation to increasing staff awareness, especially given the pressure to complete other mandatory training.</p> <p>Access to (enrolment on) e-learning modules which are not an integral component of the ESR learning suite, is for some staff groups problematic due to lack of access to computers during work hours and the need to search for and add these enrolments to ESR at an individual learner level.</p> <p>The policy framework underpinning national compliance with the standards does not include specific reference to performance targets associated with training/staff awareness.</p> <p>There have been considerable technical difficulties in relation to making changes to the NHS e-learning infrastructure to enable the local (BCUHB level) mandatory enrolment of the NHS Sensory Loss Module – these have now been overcome.</p>	<p>BCUHB Mandatory Training Policy has been amended for 2019/2020 to include the option for <i>ALL</i> staff completing the e-sensory loss module, as an alternative to mandatory equality refresher training, which may over a 3 year period improve overall compliance.</p> <p>Guidance on searching for, and adding NHS e-learning modules to ESR enrolments has been placed on BCUHB's relevant intranet pages.</p> <p>Additionally section 3.2 of the sensory loss Toolkit contains similar guidance and as an additional control where access to the e-learning module is not possible request that;</p> <p><i>"3.2 Have frontline staff undertaken sensory loss e-learning module AND/OR have factsheets 1, 2, 2b, 3 & 4 been (i) discussed during a documented staff meeting, (ii) been copied and distributed to frontline staff and (iii) a signed record exists that staff have 'read understood and are able to act in accordance with these guidelines.'" (Baseline Evaluation Tool, p.4)</i></p> <p>The above option will remain as an additional control and audited via the Baseline Evaluation Tool for 2019/2020. The appointment of</p>

	<p>The new ward accreditation system, audit instrument will make reference to the requirement for services points to become compliant with the AHCS</p> <p>The experience of service users with Sensory Loss is continuously monitored via BCUHB's real time feedback system, and is reported via local and organisational Quality Safety and Effectiveness, and for inclusion in the Annual Equalities report. Thus providing 'ward to board' accountability and is a key organisational performance metric. Feedback for Q1, Q2 and Q3 2018/2019 indicates that service users who report that they are 'Deaf or Hearing Impaired' or 'Blind or Partially Sighted' report higher levels of overall satisfaction with their experience compared with 'All' other categories of service user. As a whole this is clearly indicative of a service which is becoming more aware of the needs of users who report a sensory loss and of one more able to respond their needs.</p>	<p>The specificity of this requirement remains to be worked through.</p> <p>Not all service points have currently been accredited using this standard, however, a key objective of the project plan is to roll out to all acute and community wards and departments within 2019/2020.</p> <p>In collaboration with the third sector partners actively participate in Sensory Loss Awareness Week, (May 2019).</p>	<p>additional PALS officers see above will help provide additional support in respect of this.</p> <p>Service Experience Manager (West) to liaise with the Transforming Care team to determine the most appropriate format. (The preferred option at the time of writing this report is to include a single metric for compliance which is derived from the BCUHB AHCS Self Evaluation Tool against a twice yearly time base).</p> <p>Ensure that primary care cluster development officers and area governance teams have the materials and support necessary to support GP practices as described above.</p> <p>Continue to monitor and report on the experiences of service users with sensory loss in order to provide organisational assurance that we are listening, learning and acting of service user experience and as an indirect measure of the effectiveness of efforts to raise staff awareness.</p>
Ensuring all public information is accessible for people with sensory loss	<p>See 'Needs Assessment' above.</p> <p>Putting Things Right/Complaints internet pages have been altered to ensure that there is a direct link to the CEHR video BSL information guide.</p>	<p>See 'Needs Assessment' above.</p> <p>Need to ensure migration of this link when the new CMS is implemented.</p>	<p>See 'Needs Assessment' above.</p> <p>Moving forward the new Patient Experience Strategy (2019/2021) contains specific work streams aimed at making it easier for service users with sensory loss are able to provide feedback on their experiences, eg revised patient story policy and</p>

			guidelines, improved reporting of real time feedback by protected characteristics, the development of a planned series of engagement events etc.
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Standards of Service Delivery	Key Actions Achieved during 2018-19	Risks to Delivery	Corrective Actions
<p>Accessible appointment systems</p>	<p>National project management under the auspices of the All Wales Information Service (WIS), has ensure that systems are enabled in line with phase II of the Accessible Information Standard (AIS) to record communication needs and include these in e-referrals received by the Health Board.</p> <p>The Health Board has continued to fund the Accessible Health Care Worker (AHCW) scheme to facilitate access to and participation in health care for service users with sensory loss.</p> <p>Continued development and funding of the Accessible Health Care Scheme which in conjunction with the Centre for Sign Sight & Sound (COSS) and other voluntary organisations provides support for service users with sensory loss so that they are able to access information and services on the same basis as other service users.</p> <p>The use of type talk to facilitate access to centralised booking system. Working in conjunction with AHCW (see above) booking staff are able to facilitate improved access to the appointment system for service users with sensory loss. Additionally text reminders are utilised for appointments.</p>	<p>Utilisation of an IM&T infrastructure which relies on communication needs related to sensory loss being recorded within primary care and then transferred via electronic referral to secondary care. At a time when BCUHB is migrating to the merged WPAS platform and primary care is in the midst of a tendering process for the next generation of primary care MIS.</p> <p>Following on from the above;</p> <ul style="list-style-type: none"> • Reliance on service users to request that communication needs relating to sensory loss are communicated to health care providers (primary, community & secondary). • Lack of standardised generic reference values for recording communication needs within WPAS within BCUHB. <p>The above risks will largely remain throughout 2019/2020 until current National WIS projects are completed, and implemented operationally.</p> <p>Currently the appointment system does not automatically create an alert reminding HCPs to book BSL interpreter, and this</p>	<p>BCUHB Head of Information has requested that NWIS regularly audit whether fields relating to sensory loss are being populated within primary care.</p> <p>Reference values to be agreed and standardised within all BCUHB patient information systems.</p> <p>BCUHB Head of Information in conjunction with service managers, and service users to develop the capability to utilise information relating to communication needs to provide exception reports which enable HCPs and other staff to proactively respond to the communication needs arising from sensory loss, eg flagging TCI lists, clinic lists etc.</p> <p>The above are currently be implemented in line with national NWIS project plan.</p> <p>Posters developed by the NHS Wales Centre for Equality and Human Rights in conjunction with the Snr Officers group, to be forwarded to all managed practices and to Cluster Development Managers/Officers within BCUHB to encourage service users with sensory to request that their communication needs are recorded within primary care information systems.</p>

	<p>The above actions have been on-going throughout 2018/2019 and will continue into 2019/2020.</p> <p>The collaboration with the Centre for Sign Sight and Sound (COSS) to deliver the Accessible Health Care Scheme (sometimes referred to as the Health Advocacy Scheme) has been an effective and innovative model that other NHS organisations are beginning to emulate, and an exemplar of collaborative practice. Data for the period (Nov 2018 – January 2019) provided by the COSS indicates that the scheme supported the following activity;</p> <table><tr><td>Appointments Made on behalf of deaf people</td><td>282</td></tr><tr><td>Booking hospital transport</td><td>22</td></tr><tr><td>Communication support issues</td><td>43</td></tr><tr><td>Access to health services</td><td>52</td></tr><tr><td>Translation and sign posting</td><td>83</td></tr><tr><td>Emergency dental, phoning for test results or x ray</td><td></td></tr><tr><td>Clarification of WITS</td><td></td></tr><tr><td>Contacting pharmacy for queries</td><td>27</td></tr><tr><td>Support to health professionals on changes to booking communication support</td><td>105</td></tr><tr><td>TOTAL</td><td>614</td></tr></table>	Appointments Made on behalf of deaf people	282	Booking hospital transport	22	Communication support issues	43	Access to health services	52	Translation and sign posting	83	Emergency dental, phoning for test results or x ray		Clarification of WITS		Contacting pharmacy for queries	27	Support to health professionals on changes to booking communication support	105	TOTAL	614	<p>relies on local knowledge of the service user’s needs being passed on to the service point. Although this risk is partially ameliorated via the AHCW scheme and the local knowledge</p> <p>Given the above risks it is important that staff are aware of the needs of service users with sensory loss and that actions relating to increasing awareness cited above are implemented within and across BCUHB.</p>	<p>Completion of the above along with specifically designed and curated intranet pages to support improved compliance with AHCS within primary care.</p> <p>Continued funding for BCUHB’s accessible health care worker scheme for financial year 2018/2019.</p> <p>Funding for the Accessible Health Care Scheme to continue for 2019/2020. (See also actions above in relation to increasing staff awareness).</p>
Appointments Made on behalf of deaf people	282																						
Booking hospital transport	22																						
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Support to health professionals on changes to booking communication support	105																						
TOTAL	614																						

<p>Communication models</p>	<p>The WITS interpreter service continues to provide front line face to face BSL interpretation and feedback on whole is positive. The ability of the Service Level Agreement with WITS to support Braille translation has been effective on a small number of occasions.</p> <p>Digitally Accessed Interpretation Services have been piloted within a managed practice in the Conwy region of the health board using SKYPE™ for business across the public WiFi system.</p> <p>Additional Skype™ licences sourced for Roll out of DAISY. IM&T working through security issues.</p> <p>Digitally accessed interpretation services can now be supported via BCUHB internet based on Skype™ Technology, although these are not yet mainstreamed.</p>	<p>Staff Awareness in relation to the responsibility of HCPs to book a WITS interpreter as required; this risk is sometimes compounded where communication needs are unknown to the HCP/Service Point (see note above).</p> <p>IM&T infrastructure and resources required to support DAISY implementation.</p> <p>Feedback from Service Users indicates that the preference for a face to face interpretation service; and such an approach is supported via the Accessible Health Care Scheme.</p> <p>Staff have been sent specific alerts in relation to their responsibility to book interpretation services – and this is reinforced in materials and guidance recently developed for primary care settings.</p>	<p>As above AHCW scheme partially controls for this risk and support for this scheme moving forward into 2019/2020 is essential.</p> <p>Funding for the Accessible Health Care Scheme to continue for 2019/2020.</p> <p>Following on from the above the Accessible Health Care Communication card, is credit card available to all service users who wish to identify their communication needs.</p> <p>Seek internal IM&T support to Roll out DAISY within ED & OPD within West by end of 2018/2019.</p> <p>Take action to Improve Staff Awareness as previously.</p> <p>Continue to implement technological solutions where these are practically possible and commensurate with the identified needs of service users.</p>
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Primary and Community Care. Priority areas include:			
Standards of Service Delivery	Key Actions Achieved during 2018-19	Risks to Delivery	Corrective Actions
Raising staff awareness	<p>(See also Above).</p> <p>Community version of the Toolkit developed for use in the Community and Primary Care Settings and available on the BCUHB's intranet page.</p> <p>Primary Care Version of the Toolkit and evaluation Tool developed to support improved compliance with the AHCS within GP practices.</p>	<p>(See also Above).</p> <p>Geographic distribution of service points, and difficulty of engaging staff and service users in 'remote' locations.</p> <p>The majority of GP Practices are autonomous and not directly managed and therefore integrating these practices within BCUHB's governance frameworks relies on good will and the skill of the Cluster Development teams.</p> <p>As above, but the provision of easily available resources will enable the Primary Care Governance and Cluster Development teams to better support compliance with AHC (WG, 2013), in 2019/2020 compared with 2018/2019. (See also previous actions in relation to the appointment of 4 x 1wte PALS officers which will ensure improve coverage of community and primary care sectors moving forward).</p>	<p>(See also Above).</p> <p>Engagement of managed practices, cluster development teams and community matrons. Ensure compliance with AHCS is a regularly reported within Areas Governance and Matron's meeting.</p> <p>Following on from the above, utilisation of the self-evaluation Toolkit to ensure that compliance is regularly monitored and action plans for improvement are developed as appropriate. Include data in relation to compliance within local Quality Safety and Effectiveness and Quality and Safety Group (QSG) reports.</p> <p>Continue as cited above, ensure that the Primary Care Governance Teams have the information and support necessary to support improved staff awareness and therefore compliance with AHCS (WG, 2013). (Build into the work plans of the newly appointed PALS officers June 2019).</p>
Accessible appointment systems	(See Above).	(See Above).	(See Above).
Communication models	(See Above).	(See Above).	(See Above).

<p>Implementation of the Accessible Information Standard</p>	<p>Targets including within the BCUHB IMTP. Key outcomes include;</p> <ul style="list-style-type: none"> • Continue with awareness raising sessions and promotion of e-learning package. • In partnership with third sector colleagues, seek funding for pilot study for remote access to BSL interpretation. • Repeat audit of compliance with standards in secondary care. • Explore accountability systems and processes within BCUHB with a view to including audit of standards within these systems to ensure ownership within Divisions. • Continue engagement with people with sensory loss; utilising feedback to inform service development. • Work with All Wales Sensory Loss Group to advise and support development of national approach to identification and recording of communications needs (Phase 2 of pilot study). <p>The above continue to be central to organisational governance and performance reporting and moving forward are integral to the new Patient Experience Strategy (BCUHB, 2019/2021)</p> <p>See also note above in relation to reporting service user experience.</p>	<p>Level of staff and managerial engagement given other priorities. See above note in relation to the non-mandatory nature of sensory loss training.</p> <p>Large geographical distribution of services across three operating areas (East, Central, West), and localised governance arrangements result in a large strategic and operational span of control. Culturally governance and organisational assurance have not always been viewed as an integral component of operational management.</p> <p>The above risks remain relevant moving forward into 2019/2020. Key controls (see above) include;</p> <ul style="list-style-type: none"> • Continued funding of the Accessible Health Care Scheme (AHCS) • Efforts to Improve Staff Awareness • Changes in the reporting of local and Organisational Quality Safety and Effectiveness and Organisational Assurance data to specifically include progress made against agreed organisational plan for improved compliance with AHCS • Development of the systems and data models to facilitate the above as included within a 	<p>(See Above)</p> <p>AHCS compliance now reportable on a quarterly basis to Trust Board.</p> <p>Operational accountability for this work stream was reviewed by Deputy Director for Operations in September 2018 in order to improve collaboration and establish priorities.</p> <p>Compliance with AHCS to be included within BCUHB's new ward accreditation system beginning in acute settings in Q4-2018/2019 and then rolled out to community care settings in 2019/2020.</p> <p>See controls op cited., and actioned cited above in relation to inclusion of compliance metrics within the Ward Accreditation system.</p>
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		recent review and re-contracting for BCUHB's real time feedback system.	
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Secondary Care. Priority areas include:			
Raising staff awareness	(See also Primary & Community Care and Health Prevention)	(See also Primary & Community Care and Health Prevention)	(See also Primary & Community Care and Health Prevention) Compliance with AHCS to be included within BCUHB's new ward accreditation system beginning in acute settings in Q4-2018/2019 and then rolled out to community care settings in 2019/2020. Inclusion of AHCS compliance data within Scrutiny meetings as an integral component of local governance arrangements – commenced in the West operating area Q2-2018/2019 and continued in Q3 and Q4 2018/2019.
Accessible appointment systems	(See also Primary & Community Care and Health Prevention)	(See also Primary & Community Care and Health Prevention)	(See also Primary & Community Care and Health Prevention)
Communication models	(See also Primary & Community Care and Health Prevention)	(See also Primary & Community Care and Health Prevention)	(See also Primary & Community Care and Health Prevention)
Implementation of the Accessible Information Standard	(See Primary & Community Care Above)	(See Primary & Community Care Above)	(See Primary & Community Care Above)

Standards of Service Delivery	Key Actions Achieved during 2018-19	Risks to Delivery	Corrective Actions
Emergency & Unscheduled Care. Priority areas include:			
Raising staff awareness	(See also Primary & Community Care and Health Prevention)	(See also Primary & Community Care and Health Prevention)	(See also Primary & Community Care and Health Prevention)
Communication models	(See Primary & Community Care Above)	(See Primary & Community Care Above)	(See Primary & Community Care Above)

Concerns & Feedback (CF). Areas include:			
Highlighting current models of CF in place which would support individuals with sensory loss to raise a concern or provide feedback	<p>Whilst the PTR internet pages can be read via voice recognition software. In practice the support of AHCW may be required to ensure that service users with sensory loss are able to access the PTR framework on the same basis as other service users.</p> <p>Service user feedback is regularly collected and fed back to service managers via (i) CRT/Viewpoint Real-Time Patient Feedback System (ii) Complaints and Incident Monitoring, (iii) Patient Stories and (iv) NHS Wales Inpatient Satisfaction Survey – 2017/2018 Q1 only. The data from these sources is segmented by protected characteristic and included in the Organisational Listening and Learning from Experience report and included on the agenda of the Equalities Strategic Group.</p> <p>Reporting as cited above for Q3 and Q4 2018/2019. The terms of reference for the Listening & Learning from Experience Organisational Group are currently being reviewed in order to improve organisational capability and accountability to listen, learn and most importantly act on service user experience, including from service users who report a sensory loss.</p>	<p>Accessing the PTR system for service users with sensory loss.</p> <p>Ensuring Feedback to local managers such that learning from patient experience results in improved service provision and increased compliance with AHCS. (See previous notes on large Geographic span of control and governance arrangements)</p> <p>The above still remains a risk, however moving forward the new Patient Experience Strategy (BCUHB, 2018/2019) and associated work streams coupled with the extra resourcing in 2019/2020 resulting from the appointment of 4 x 1 wte PALS officers is designed to largely mitigate the above cited risk.</p>	<p>See note below relating to the Head of Service Experience West to lead a review into learning from complaints and incidents, and improving access to PTR for service users with sensory loss.</p> <p>See also op cited controls</p> <p>Appointment of 4 x 1 wte PALS officers and the implementation of a new PALS model based around a Care2Share approach, will provide increased organisational capacity to objectively listen, learn and act on service users with sensory loss as well as other service users. The Care2Share approach will have as its outcome an action plan for improvement agreed with the ward/department manager, including specific improvement metrics derived from existing real time feedback frameworks.</p>

	BCUHB has reviewed and re-contracted for the provision on a real time feedback system on the basis to include the ability to report on service user experience by protected characteristic.		
Highlight any CFs received in sensory loss and actions taken	<p>There have been no formal concerns received in relation to sensory loss. Informal issues have arisen due to; (i) unavailability/booking of the WITS interpreter and/or interpreter of choice, (ii) accessing the appointment system to confirm or change an appointment, (iii) the provision of information in Braille.</p> <p>As an integral component of Sensory Loss awareness week (Nov 2017) BCUHB in collaboration with the Centre for Sign Sight and Sound curated a collection of patient stories – which highlighted key issues in relation to (i) making, confirming and changing appointments, (ii) booking BSL interpreter and (iii) making a complaint – accessing PTR</p> <p>As with Q1 2018/2019, within Q2, Q3 & Q4 2018/2019 there have been no formal complaints relating specifically to access or progression within health services provided by BCUHB on the basis of protected characteristics related to sensory loss. Whilst there have been some occasions where access to interpretation services (BSL) and making and changing appointments</p>	<p>Feedback from Service Users, their advocates, CHC and service managers would suggest that there are occasions where the service provided by BCUHB falls short of its mandatory responsibilities. The challenge for BCUHB is to capture and share this experience so that it can be utilised for service improvement.</p> <p>Making, changing and emending hospital and other health care appointments remains challenging for many service users with sensory loss, and this finding is reinforced through engagement events. Capturing and acting on this experience in real-time also remains a challenge and whilst the current approach 'to design out' such situations in has to be recognised that these will arise and BCUHB</p>	<p>The Head of Service User Experience (West) to lead a review aimed at developing improved processes for learning from both formal and informal complaints and embedding this into governance arrangements – the work stream to commence Oct 2018.</p> <p>Following on from the above, a review of the PTR internet pages to enable improved access for service users with sensory loss, to include the inclusion of video BSL signage.</p> <p>The Intranet Pages now provide limited spoked access and improved visual access compared with 2017/2018., and the resources comply with Web Content Accessibility Guidelines (WCAG) 2.1 and include an ability to change font size and support for a variety of accessibility add-ins such as Adobe™ – Read Out Loud</p>

	<p>have become an issue for service users with sensory loss, and whilst initially the service provided by BCUHB fell below that which is defined by the AHCS, these have been resolved either by local intervention or via referral to the Accessible Health Care Service. Thus, underling the importance of the collaboration between BCUHB and the Centre for Sign Sight and Sound.</p> <p>BCUHB patient story protocol (ISUE01) and guidelines are currently being reviewed for inclusion in the Patient Experience Strategy for April 2019., and include (i) a specific focus on the need to be sensitive to the needs of service users with a sensory loss, (ii) the need to build and disseminate a library of stories from such service users and (iii) guidelines to improve the recording and transcribing of patient stories from service users with sensory loss.</p>	<p>needs to ensure that we are able to respond to these in a proactive manner.</p> <p>Service users with sensory loss are very willing to tell us about their experiences, the challenge for the Health Board remains to incorporate these into the learning and planning processes.</p>	<p>The PTR Internet Pages now include a link to the CEHR BSL video guide to making a complaint.</p> <p>Continued funding of the AHCS.</p> <p>Engagement with service users with sensory loss 'on their terms' is a priority work stream for 2019/2020. Service Experience Managers in each of the three operating regions will have specific responsibility to develop, implement and report on a series of engagement events. Collectively these will be reported within the organisational Quality Safety and Effectiveness and Listening & Learning from Experience Group and for inclusion into the IMTP.</p>
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Patient Experience*	Key Actions Achieved during 2018-19	Risks to Delivery	Corrective Actions
<p>Mechanisms are in place to seek and understand the patient's experience of accessible communication and information</p>	<p>BCUHB utilises a variety of mechanisms to survey and learn from service user experience – see above. The DATIX complaints monitoring enables the segmentation of feedback via equality/discrimination which provides an indirect ability to monitor concerns via protected characteristics. The CRT/Viewpoint Real Time Patient Feedback Survey and the NHS Inpatient Survey enables the self-reporting of service user feedback by protected characteristics and a report is forwarded to BCUHB's strategic Equality Group on a quarterly basis and included in the Listening and Learning and Quality Safety & Effectiveness reports.</p> <p>Continued into Q3 & Q4 2019/2020</p>	<p>The utilisation of the CRT/Viewpoint tends to be greater in acute than community and primary care settings, and it is constant challenge to ensure sufficient returns to provide meaningful feedback and universal coverage.</p> <p>The Data model underpinning CRT/Viewpoint requires additional processing to report the data by protected characteristic, by service point(s), by time period(s).</p>	<p>Each operational area (East, West, Centre) has a Service Improvement Manager with specific responsibility for the implementation of CRT/Viewpoint.</p> <p>Local data mining and processing of the underpinning CRT/Viewpoint™ Data Model now enables be-spoke reporting of service user experience by protected characteristics for both quantitative and qualitative feedback. The development by CRT/Viewpoint™ of a new dashboard and reporting functions as a result of the ongoing contract review process has resulted in improved capability to report by protected characteristic including sensory loss. This has significantly improved the reporting capabilities from Q4-2018/2019 onwards. See reporting extract below, also cited above.</p>

	Key Themes	Corrective Actions
The key themes to emerge from patient experience feedback (both positive and negative)	<p>Protected Characteristic Pt Experience Report for Q2-2018/2019</p> <p>In summary for Q1, Q2 & Q3, 2018/2019; the self reported satisfaction scores indicate that service users who are blind or partially sighted report higher levels of satisfaction than service users who are deaf or hearing impaired across all items with the exception of '<i>did staff introduce themselves to you?</i>' and '<i>did you feel that you were listened to?</i>'. Service users who report that they have a mental health condition report the lowest levels of satisfaction compared with other reported protected characteristics. This may be due to the complexity of their condition, and in relation to deaf or blind service users, that staff are more aware of the needs of blind service users and therefore are more able to respond to these. However, overall the themes which are cited by service users who self-report a protected characteristic are similar to those who do not report a protected characteristic.</p>	<p>(See Also previous cited corrected actions/controls).</p> <p>Ensure the continuation of reporting by protective characteristic and sharing of learning as an integral component of organisational and local governance arrangements. And that this is meaningfully represented within the new ward accreditation system.</p> <p>Continue to proactively utilise Datix™ to monitor complaints under the auspices to PTR.</p> <p>See comment above in relation to improved reporting capability derived from CRT/Viewpoint™ Real Time Feedback System. The next stage in this process is to develop the capability to automatically theme qualitative feedback and to integrate feedback from CRT/Viewpoint with other systems such as DATIX complaints/Concerns monitoring.</p>
<p>* Patient experience mechanism and themes to be documented in this return applies specifically to patients with sensory loss who have accessible communication and information needs. There is a requirement in the NHS Delivery Framework for NHS organisations to provide an update on patient experience for all patients (not just for those with accessible communication or information needs). This is to be reported on a separate pro-forma entitled 'Evidence of how organisations are responding to patient feedback to improve services' and links to the NHS Framework for Assuring Service User Feedback.</p>		

BCUHB Organisational Action Plan for Increased Compliance with All Wales Standards for Accessible Information & Communication for People with Sensory Loss (AHCS) (WG, 2013) – ACTION PLAN

Staff Awareness; the standard states *all frontline staff should be trained in how to communicate effectively with someone with sensory loss.*

Objective	Key actions	Responsibility	Completion By (Date)
Sensory Loss Toolkit to be readily available and its existence known to all frontline staff.	Audit of Wards/Departments to ensure that the toolkit is present and up to date.	SUExp Managers (E, W, C), SUExp Coordinator (W) Ward/Department Managers	EOF Q4-2018/2019
	Ensure that Toolkit is reviewed and up to date	SUExp (W), SUExp Coordinator (W)	EOF Q4-2018/2019
Mandatory Training Policy (WP30) amended to ensure that the NHS e-sensory loss module is mandatory for all staff groups – to be refreshed every 3 years.	Submission to Mandatory Training Committee.	SUExp (W)	Nov 2018
	Follow up at executive level.	Dep Director of Operations	Dec 2018
	E-Sensory Loss module added to mandatory enrolments for all Staff Groups.	WOD	EOF Q4-2018/2019
	Staff to complete E-Sensory Loss Module with a 3 year refresher period.	ALL Staff/Managers	Beginning Q1-2019/2020
In the absence of the above, ward and departmental managers to utilise Factsheets 1-4 (BCUHB Sensory Loss Toolkit, Ver 0.2, 2017)	Ward/Departmental Managers to maintain documentary evidence that these have been (i) discussed during a documented staff meeting, (ii) been copied and distributed to frontline staff and (iii) a signed record exists that staff have 'read understood and are able to act in accordance with these guidelines'.	Ward/Department Managers SUExp Managers (E, C & W)	EOF Q1-2019/2020

	Completion to be audited using the self-report (baseline evaluation) audit instrument from all acute specialities, community hospitals and managed practices.	SUExp Managers (E, C & W)	EOF Q1-2019/2020
Curation of intranet resources to support improved staff awareness.	Library objectives created, translated, video compressed, links tested. Critical Review and Publish.	SUExp Man (W), SUExp Coordinator (W) SUExp Man (E), COSS, Head Of Concerns (W)	EOF Nov 2018 EOF Dec 2018
Proactive involvement in Sensory Loss Awareness Month 2018.	Plan events, book venues, publicise these, (Internet and Intranet).	SUExp Man (W), SUExp Coordinator (W) & Voluntary Partners	EOF Nov 2018

Staff Awareness; the standard states *A “Flagging” system should be in place on patients’ computer or paper records to enable staff to clearly understand patient communication needs.*

Objective	Key Actions	Responsibility	Completion By (Date)
Ward accreditation system <i>to include an explicit requirement</i> for the utilisation of ‘at a glance symbols’ for service users with sensory loss, supported where required by alert cards, and SBAR style handover.	Version 1 of Ward Accreditation system to be utilised with acute wards such that all acute wards achieve bronze accreditation by April 2019 – as per the agreed roll out plan.	Transforming Health Care Team Head of Transforming Care Deputy Director of Nursing (Governance) Ward Managers	EOF Q4-2018/2019
Primary care practices enabled to record service user communication needs as an integral component of PHASE II of WIS Accessible Information Standards (AIS) project.	InPactice and EMIS enabled to record communication needs as per WIS AIS project plan	BCUHB Head of Information/WIS	December 2018
To encourage primary care service user to ‘tell’ their practices of any	NHS Wales CEHR Posters made available to Primary Care practices which prompt service users to ask the	SUExp Man (W), SUExp Coordinator (W), Cluster Development Leads	November 2018

specific communication needs that they may have.	practice to record specific communication needs.		
Following on from the above; ensure that ALL <i>managed practices</i> are recording communication needs relating to sensory loss, and that all information is correct and up to date and in accordance with GDPR (UK, 2018).	Audit of practices within BCUHB to determine the extent to which communication needs are recorded as an integral component of the primary care data set. (This is an important prerequisite for populating similar fields in secondary care, as this data set is transferred as an integral component of the e-referral process).	BCUHB Head of Information/WIS	
Following on from the above; ensure that <i>secondary and emergency care</i> information systems are utilised to correctly record communication needs relating to sensory loss, and that all information is correct and up to date and in accordance with GDPR (UK, 2018).	Development of standard approach to recording sensory loss information within secondary care patient information management systems. Ensure that frontline staff are aware of such standards and at the interphase of care take every opportunity to check the accuracy of such information.	BCUHB Head of Information/WIS	

Staff Awareness; the standard states *People with Sensory loss should be able to make an appointment using a variety of methods, as a telephone based system may be inaccessible to them; this would include, text, e-mail, internet, smartphone etc.*

Objectives	Key Actions	Responsibility	Completion By (Date)
Service users with sensory loss are able to access information about primary care services and make & amend appointments.	Primary Care practices encourages to utilise MyHealthOnline in order to ensure that information is accessible to service user with sensory loss and that they are able to make, confirm and amend appointments.	SUExp Man (W) /Cluster Development Leads/Practice Managers	As per established WIS project plan.
Service users with sensory loss are able to access information about planned and unscheduled care services and make & amend appointments.	BCUHB to develop the capability to enable service users with sensory loss to make, confirm and amend appointments; in line with the current WIS AIS project and ensuring compliance with GDPR (UK, 2018).	BCUHB Head of Information/WIS	As per established WIS project plan.

	BCUHB Booking Centres to ensure that Service Users are able to interact with the appointments process, via text, talk type, etc.	BCUHB Head of Information/WIS SUExp Managers (E/W/C) Head of Welsh Language	Q4-2018/2019
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Environment; Standard States that *all reception and consultation areas should be fitted with a hearing loop system and/or other appropriate support should be given to people with sensory loss.*

Objective	Key Actions	Responsibility	Completion By (Date)
All reception and treatment areas to ensure that there is a functioning hearing loop system and that frontline staff understand how to use this.	(NB Section 4 of the self-reporting 'audit' tool developed to enable ward/department managers to evaluate compliance with AHCS (WG, 2013), relates specifically to the Environment).		
	Managers to be proactive providing evidence that they have utilised this tool to support action planning in this area.	Ward/Department Managers SUExp Managers (E, C & W) SUExp Manager (E, C & W) – ensure completion of self-reported audit	EOF Q1-2019/2020
	Hearing Loop audit to be completed by the end of 2018/2019 and extended to managed practices and community hospitals. Each service point to receive feedback in relation to any improvements which need to be undertaken and these need to be documented within the action plan section of the AHCS 'audit' tool.	SUExp Managers (E, C & W) Estates	EOF Q1-2019/2020
Improve Signage and Wayfinding	Ward and Department Managers to ensure that all temporary signage complies with Wayfinding Guidance, (BCUHB, 2016).	Ward/Department Managers SUExp Manager (E, C & W) – ensure completion of self-reported audit	EOF Q1-2019/2020

	Use service users to undertake a Walkabout	Service Users/COSSS	EOF Q1-2019/2020
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Participation in Health Care Services/Provision of Information and Involvement/Engagement; *(Actions additional to those cited above).*

Objective	Key Actions	Responsibility	Completion By (Date)
Improving access to and participation in PTR for service users with sensory loss;	Ensure that the BSL Signed guidance in relation to PTR which has been developed by the COSS and is available on the NHS CEHR web page, is also available on BCUHB's intra and internet PTR pages.	SUExp Manager (W), SUExp Coordinator (W) Head of Concerns (West)	Nov 2018
	Additionally, ensure that easy read version of the PTR leaflet are also available on BCUHB's intra and internet PTR pages.	SUExp Manager (W), SUExp Coordinator (W) Head of Concerns (West)	Dec 2018
	Ensure GP practices are aware of these resources and are able to access BCUHB intranet	SUExp Manager (W), SUExp Coordinator (W) Head of Information	Dec 2018 (and as issues are reported)
Introduction of Digital Remote BSL Interpretation.	Building on existing Primary care pilot, develop the capacity to support Digitally Accessed Interpretation Services in ED within DGHs	Head of Welsh Language Head of Information	Pilot by EOF Q4-2018/2019
To ensure that WITS services are delivered in accordance with the SLA and enable the provision of BSL interpretation in line with needs of service users.	Quality of provision to be reviewed quarterly in line with SLA with current provider.	Head of Welsh Language	Quarterly Review
	Issues relating to non-compliance to be escalated to the provider.	Head of Welsh Language Deputy Director of Operations	On-going/as required.
		Head of Welsh Language	Quarterly Review

	Quality and activity reports to be tabled for Equalities Strategic and Operational Groups and LLExp Group.		
To ensure that service users with sensory loss are supported in accessing information and services on the same bases as all other service users.	Continued funding of the Accessible Health Care Worker Scheme to facilitate access to and participation in health care for service users with sensory loss on the same basis as other service users for 2019/2020	Deputy Director of Operations	EOF Q4-2018/2019 for continuation in 2019/2020

Organisation of Work Stream/Developing the Infrastructure; *(Actions additional to those cited above).*

Objective	Key Actions	Responsibility	Completion By (Date)
Provision of Organisational/Board Assurance	Compliance levels with the AHCS to be reported to the organisational QSE, QSG and LLExp groups, and a quarterly report on service user experience by protected characteristic to be forwarded to the Organisational Equality Group. Collectively these will form the basis of Quality Assurance give to board in relation to IMTP plan targets.	Deputy Director of Nursing (Governance) Deputy Director of Operations SUExp Manager (W)	Quarterly Review
Ensure appropriate Policy Support.	Ensure Policy ISU01 – Written Information for Patients and CG06 – Protocol to delivery Interpretation Services, provides adequate and contemporaneous guidance in relation to compliance with AHCS (WG, 2013)	Head of Welsh Language SUExp Man (W)	EOF Q2-2018/2019
Provision of effective project management and operational compliance.	Re-establish the Accessible Health Care Steering group	Deputy Director of Operations SUExp Manager (W)	EOF Q4-2018/2019
Provision of effective operational and clinical governance; and local accountability.	Ensure the explicit inclusion within the Ward Accreditation System of the utilisation of the BCUHB AHS 'Audit' tool as an integral component of reported/documented service improvement efforts.	Deputy Director of Operations Deputy Director of Nursing (QA & Governance) Head of Transforming Care SUExp Manager (W)	EOF Q4-2018/2019

<p>Ensure improved compliance and action planning at a local department/ward and GP practice level.</p>	<p>All service points including community hospitals and managed practices to proactively participate in an annual 'audit' of compliance with the AHCS, utilising BCUHB AHS 'Audit' tool including the development of an action plan for improvement.</p> <p>Self-reported levels of compliance and non-participation reported to the Equalities Strategic and Operational Groups and LLExp Group, and issues escalated to Matrons and Clinical Management Teams as required.</p>	<p>Ward/Department Managers Practice Managers SUExp Managers (E, C & W)</p> <p>SUExp Manager (W)</p> <p>Matrons, Hospital Managers, Local Clinical Managers and Practice Managers as required/appropriate.</p>	<p>EOF Q4-2018/2019</p> <p>Quarterly</p> <p>As required.</p>
<p>Listen and learn from service users, other HBs, and voluntary partners.</p>	<p>Proactive participation in the 'Senior Officers' Group</p> <p>Review TOR and membership of the accessible health care reference group to ensure improved attendance and participation.</p>	<p>SUExp Man (W)</p> <p>SUExp Man (W)</p>	<p>Quarterly</p> <p>Nov 2018</p>
<p>Listen and learn from service users, other HBs, and voluntary partners. (.../Ctd)</p>	<p>Review complaints and incidents and CRT/Viewpoint feedback relating to sensory loss/protective characteristics and report and act on this.</p> <p>Include summary of Learning in Protected Characteristics Report for Organisational & Operational Equality Groups and the LLExp Group.</p>	<p>Head of Concerns (E, C, W) SUExp Man (W) & SUExp Coordinator (W) Head of Equalities</p> <p>SUExp Man (W) & SUExp</p>	<p>On-going as an integral component of PTR, issued of significance reported to local PTR/Scrutiny groups.</p> <p>Quarterly</p>
<p>Provision of adequate support for the work stream from within</p>	<p>If lead responsibility for this work stream continues to rest within Service User Experience Department, then in order to</p>	<p>Deputy Director of Operations Head of Concerns (E, C, W)</p>	<p>EOF Q3-2018/2019</p>

BCUHB's Service User Experience function.	improve the span control it would be logical to devolve regional responsibility for 'leading' the work stream to the Service User Experience Mangers in the East, Central and West, as is the case with other work streams.		
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Glossary of Terms

AHCS	Accessible Health Care Scheme
AHCW	Accessible Health Care Worker
AIS	Accessible Information Standard
BCUHB	Betsi Cadwaladr University Health Board
BSL	British Sign Language
CEHR	NHS Centre for Equality and Human Rights
CHC	Community Health Council
COSS	Centre of Sign Sight & Sound
CRT/Viewpoint™	Consumer Research Technology™ (Real/Near Time Service User Experience Feedback System)
DAISY	Digitally Accessed Interpretation System
IM&T	Information Management & Technology
IMTP	Integrated Medium Term Plan
LLExp	Listening and Learning From Experience (group)
MIS	Management Information System
PTR	Putting Things Right
QSE	Quality Safety & Effectiveness (committee)
QSG	Quality and Safety (committee)
SBAR	Situation Background Analysis/Assessment Recommendation (Communication/Planning Tool)
SLA	Service Level Agreement
SUExp	Service User Experience
WIS	Wales Information Services
WITS	Wales Interpretation Service
WOD	Work Force and Organisational Development
WPAS	Welsh Patient Administration System



Title:	Clinical Audit – the proposed way forward	
Author:	Dr Melanie Maxwell SAMD/1000 Lives Clinical Lead	
Responsible Director:	Dr Evan Moore, Executive Medical Director Mr Adrian Thomas, Executive Director of Therapies & Health Sciences	
Public or In Committee	Public	
Strategic Goals	1. Improve health and wellbeing for all and reduce health inequalities	X
	2. Work in partnership to design and deliver more care closer to home	
	3. Improve the safety and outcomes of care to match the NHS' best	X
	4. Respect individuals and maintain dignity in care	
	5. Listen to and learn from the experiences of individuals	
	6. Use resources wisely, transforming services through innovation and research	X
	7. Support, train and develop our staff to excel.	
Approval / Scrutiny Route	Principles discussed at Executive Team meeting.	
Purpose:	This paper seeks to address concerns raised by the Audit Committee at its meeting on 14 th March 2019 and in doing so, strengthen the arrangements for Clinical Audit within the organisation and ensure that a robust plan of action is presented to the next meeting in order to satisfy the requirements of both the Annual Governance and Annual Quality Statements.	
Significant issues and risks	<ul style="list-style-type: none"> National audits do not always reflect local priorities and lack synergy with organisational quality risks Audit resources are limited, and do not support the entire patient pathway. There is very little digital support. There is a lack of robust planning for Tier 2 audits There is a lack of clinical engagement in audit with moves to Quality improvement activity; this may impact on the effectiveness of audit. 	

Special Measures Improvement Framework Theme/ Expectation addressed by this paper	Leadership and Governance
Equality Impact Assessment	An equality impact assessment is not considered necessary for this type of report.
Recommendation/ Action required by the Committee	<p>The Committee is asked to:</p> <p>(1) endorse the proposed way forward in terms of managing the clinical audit function;</p> <p>(2) endorse the proposals in relation to the clinical audit plan for 2019/20 acknowledging that the plan will be further refined over coming months to provide assurance against risks to the Quality Improvement Strategy by September 2019.</p> <p>(3) agree the proposal in relation to future reporting via QSE and Audit Committee as outlined, and as a consequence stands down the JAQS meeting in November 2019.</p>

Disclosure:

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

Clinical Audit – The Proposed way forward

1. Purpose of report

This paper seeks to address concerns raised by the Audit Committee at its meeting on 14th March 2019 and in doing so, strengthen the arrangements for Clinical Audit within the organisation and ensure that a robust plan of action is presented to the next meeting in order to satisfy the requirements of both the Annual Governance and Annual Quality Statements.

2. Introduction/Context

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. Furthermore the Joint Audit and Quality and Safety Committee (JAQS) meeting in November 2017 and 2018 had raised concerns in relation to improving assurance of the effectiveness of clinical audit and echoed the concerns raised within the Structured Assessment.

Clinical audit is an integral part of the quality framework, providing information to support quality planning and delivering quality assurance; the results of clinical audit help determine quality improvement priorities. However, it must be recognised that significant resource is used to support nationally mandated clinical audit, these are predominantly within secondary care and therefore may not fully align with the Health Board's Quality Improvement Strategy. Furthermore, resources are used to collect and submit the audit data, with little capacity for action planning and change.

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.

3. Clinical Audit – Leadership and Resources

Following internal discussions, it has been agreed by the Chief Executive that responsibility for clinical audit at Board level will be under the Executive Leadership of the Medical Director. This decision was taken at the end of March 2019, and as a consequence work now needs to be undertaken to implement it.

This will include reviewing roles and responsibilities of staff within the Clinical Audit Team, ensuring they have the capacity, skills and resources to deliver clinical audit activities across the Health Board that address the key organisations risks to the quality improvement strategy priorities.

4.	Clinical Audit Plan
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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 services against national standards and/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). These are predominantly based within secondary care, have identified clinical leads on each site and are supported by the corporate audit team; however, there is inequity in how these are resourced.

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 and so are based on risk. These clinical audits should be aligned to the priorities set out within the Health Board's Quality Improvement Strategy. The Audit Committee is responsible for approving the clinical audit plan identified at this level to support risk management and service improvement. These are currently supported by the corporate audit team.

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/service development recognising that this may cover a wider clinical network for example Dermatology. These projects are not usually supported by the corporate audit team.

An outline plan for Tier 2 projects was agreed by the Corporate Quality and Safety Group on 13th March 2019. However, the plan requires further development and whilst work is on-going to progress key risk based audits (consent/ record keeping) there is further work to do. The plan will be reviewed following completion of the Annual Plan and three year outlook scheduled to be represented to the Health Board in July 2019. It is envisaged that a renewed audit plan will be presented in September 2019. The draft document can be made available to members on request.

The Annual Clinical Audit Plan going forward will be based upon the key priorities and risks and include tier 1 & 2 audits. The focus of the plan will be to review gaps in assurances as directed by the accountable management as well as meeting mandated requirements. This will no longer include the additional quality improvement projects supporting delivery of the QI strategy that will be reported elsewhere.

The governance for Tier 3 audits needs to be held at the service level and only by exception be reported to the Corporate Quality & Safety Group

A policy will need to be developed and implemented to ensure all staff are clear about the organisational expectations relating to clinical audit.

5.	Actions from the Joint Audit and Quality, Safety and Experience (JAQS) Committee
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Set out in Appendix 1 is the combined summary action log from the JAQS meetings in November 2017 and 2018. This provides the latest update position with regard to each of the actions including providing narrative to explain where actions have been superseded or have been progressed through another means.

6.	Role of Audit Committee, Quality, Safety and Experience (QSE) Committee
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In relation to Clinical Audit relevant extracts from the Audit and QSE Committees terms of reference are detailed below:-

Audit Committee – ‘... work with the Quality, Safety and Experience Committee to ensure that there is an effective clinical audit and quality improvement function that meets the standards set for the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer.’

Quality, Safety and Experience 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: sources of internal assurance (including clinical audit) are reliable;’

It is equally important to note that it is not the role of the Audit Committee to establish and maintain processes for governance, risk management and internal control. This is the responsibility of Executive Directors and the Accountable Officer. The Audit Committee should review all reliable sources of assurance (i.e. Internal and External Audit, self-assessment) and feel satisfied with the course of action being taken by the Executive, and that the sources of assurance demonstrate that controls in place are effective. In relation to internal audit plans (including clinical audit), the Audit Committee need to be satisfied that audit work programmes are aligned to the Health Boards Risk Register. It is proposed that in relation to Clinical Audit, the roles of the two committees are summarised as;

- Quality, Safety and Experience Committee – Being assured there is an effective audit function, adequately resourced, that delivers robust audit supporting quality planning and assurance; leading to safe high quality services.
- Audit Committee – Provide assurance to the Board that the function is effective and that the annual clinical audit plan prioritises key risks and supports delivery of the quality improvement strategy.

Over recent years the value of having a separate annual JAQS meeting has been questioned. Clearly there are merits of bringing together the two Committee in terms of gaining assurance that the clinical audit plan is fit for purpose. An option going forward is to invite those Members of QSE (not already Members of Audit Committee) to attend Audit Committee for a combined discussion at the appropriate point in the business cycle.

Set out below is a simple annual cycle of reporting activity designed to illustrate the role, involvement and interaction of the Audit Committee and the Quality Safety & Experience Committee in relation to clinical audit.

Item	Quality, Safety and Experience Committee Action	Audit Committee Action	Frequency
Clinical Audit Annual Plan		Approval at Audit Committee with QSE Members invited for relevant part of the meeting	Annually in March each year.
Progress against Tier 1 & 2 clinical audit plan	Summary assurance report from QSG		Quarterly
Clinical Audit Annual Report	Approval at QSE		Annually in July each year
Formal Internal & External Audit Reports relating to Clinical Audit function		Formal receipt of reports and monitoring of implementation of recommendations via TeamMate.	Each meeting as appropriate

The Quality and Safety Group will provide overview and scrutiny for the tier 1 & 2 audits agreed in the clinical audit plan.

7. Assessment of risk and key impacts

Key risks are:

- National audits do not always reflect the priorities of the local organisation but are mandated and so supported by the corporate audit services. The impact of this is the perceived lack of synergy between organisational risk and audit.
- Lack of resources to undertake audit. Most audit activity supported by the corporate team relates to secondary care; there is limited information about audit in other BCU services. The impact of this is quality assurance may not be as visible for services outwith the hospitals and does not go across whole pathways.
- Lack of robust audit planning for Tier 2 audits. The plan is predominantly re-audit work undertaken by the corporate audit team; with no transparent

planning process. This needs to be addressed within the clinical audit policy and process going forward.

- Lack of clinical engagement in developing and implementing a new framework with increased accountability for closing the audit cycle and delivering change (capacity and capability for quality improvement). This may hamper the transition from quality planning to quality improvement and subsequent service improvements.
- Lack of resources to support a robust governance system – including IT infrastructure to capture all audit activity and subsequent action plan monitoring. This will lead to lack of assurance that audit is effective.

8. Equality Impact Assessment

An equality impact assessment is not considered necessary for this type of report.

8. Conclusions / Next Steps

The Board has raised concerns about the robustness and effectiveness of the clinical audit process in terms of providing assurance or leading to quality improvement activity. There is concern that the annual plan does not reflect organisational risks to delivering the Quality Improvement Strategy.

To facilitate and improve this, the clinical audit function has now moved to the Executive Medical Director's portfolio and will be aligned to the developing Quality Improvement hub.

Key next steps are to:

- review the current corporate audit resource capacity and deployment
- review the annual audit plan and ensure it is aligned to provide assurance against the key quality risks by September 2019.
- ensure the audit process is effective (see logic diagram attached at Appendix 2) by April 2021

7. Recommendations

That the Committee:-

(1) endorses the proposed way forward in terms of managing the clinical audit function;

(2) endorses the proposal in relation to the clinical audit plan for 2019/20 acknowledging that the plan will be further refined over coming months to provide assurance against risks to the Quality Improvement Strategy by September 2019.

(3) agrees the proposal in relation to future reporting via QSE and Audit Committee as outlined, and as a consequence stands down the JAQS meeting in November 2019.

Officer	Minute Reference and Action Agreed	Original Timescale	Latest Update Position	Revised Timescale
Actions from meeting held on 9.11.17				
Adrian Thomas	<p>JAQS 17/5 Clinical Audit Report – Future reports to take on board the suggestions put forward by the Committee namely:-</p> <ul style="list-style-type: none"> • Future plans to have a unique identification number against each project • Intended outcomes to be captured as well as progress on specific recommendations • Summary of main headlines to be captured for reporting to the Board. • RAG rating system to be adopted and whether recommendation was implemented and within timeframe • Trajectory showing whether improvements are being made year on 	November 2018	<p>All these suggestions will be considered during the development of a clinical audit policy and template for a clinical audit annual report. The development of assurance for clinical audit will be an iterative process.</p> <p>Some of these actions will need to take place at divisional level or below and through reporting mechanisms and we will seek to ensure the suggestions are addressed. The audit reporting needs to be concise and provide assurance on both the audit process and value/outcome of activity undertaken.</p> <p>Where actions require an electronic solution – such as tracking action plans, investment may be required.</p> <p>Commissioned services will be monitored through the contracts system and will not be incorporated into the annual report. It should be noted that some services already participate in nationally mandated audits.</p>	Close

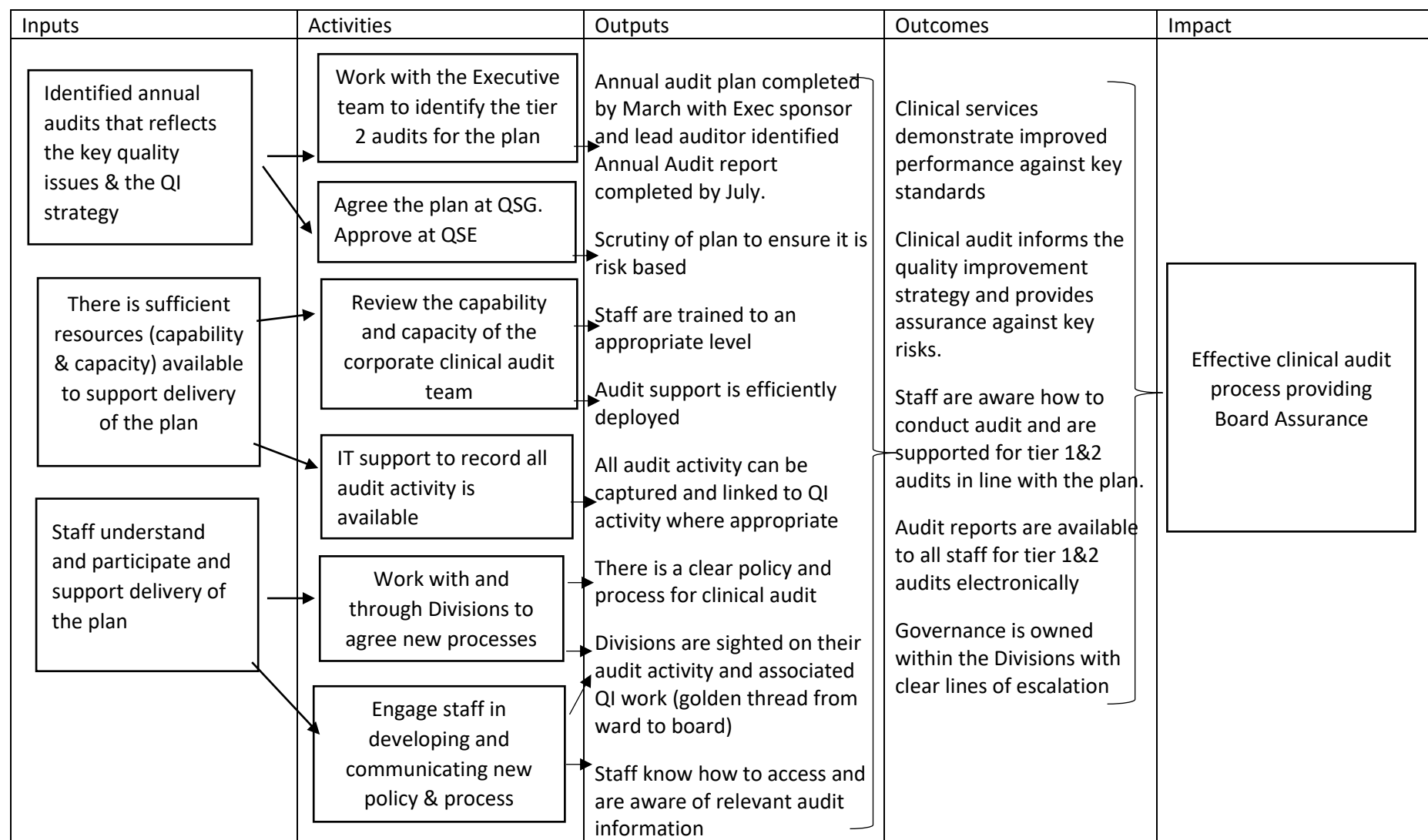
	<p>year</p> <ul style="list-style-type: none"> • Indicators to show whether all leads within a particular area are working to the same level • Consideration to be given to whether commissioned services should be included within future Audit Plans • Emphasis to be placed on reflective learning and examining the results of audits in conjunction with performance data in order to provide effective triangulation; 			
Gill Harris/Adrian Thomas	JAQS 17/5 Clinical Audit Report – GH &AT to discuss highest risk factors outside the meeting.	December 2017	Revised interim plan includes risk assessment - this will be strengthened going forward (Sept 2019)	Close
Adrian Thomas – Dawn Sharp	JAQS 17/5 Clinical Audit Report – Future Audit Committee to give consideration to how recommendations from Clinical Audits are followed up.	November 2018	. This will be included within the new clinical audit policy and process	Close


Gill Harris	JAQS 17/5 Clinical Audit Report – Areas of concern noted around stroke. GH agreed to liaise with MD Radiology re forthcoming report on Stroke.	December 2017	Action superseded. Subsequent reports presented to QSE Committee.	Close
Adrian Thomas	JAQS 17/5 Clinical Audit Report – Dementia Strategy to be cross checked against clinical audit plan	November 2018	This will be considered as part of the revised annual plan (Sept 2019)	Close
Adrian Thomas	JAQS 17/5 Clinical Audit Report – good news stories to be included in future reports	November 2018	This will form part of the reporting system to be developed (QSE reports)	Close
Adrian Thomas	JAQS 17/6 Clinical Audit Plan – AT to give further consideration to the process around inclusion of individual clinical audits within the plan and review the arrangements for the tracking of clinical audit recs with a view to adopting a similar system to that in place for internal and external audit recs.	November 2018	. This will be reviewed as part of the development of the clinical audit policy and process. Tracking actions will require additional resources.	Close
Dawn Sharp	JAQS17/7 – Quality Assurance Frameworks and Governance Arrangements – report to be presented to the December 2017 QSE	December 2017	This will be reviewed as part of the development of the clinical audit policy and process.	Close
Dawn Sharp	JAQS17/8.1 – Chair's assurance report – to be prepared.	December 2017	Actioned. Complete.	Close

Dawn Sharp	JAQS17/8.2 – consideration be given to holding an additional meeting prior to November 2018 should the need arise.	November 2018	No additional meeting required	Close
Actions from JAQS meeting 6.11.18				
Dawn Sharp	JAQS18/4 – action log to be prepared and updated to reflect the progress of those actions not yet complete from last meeting	March 2019	Complete	Close
Adrian Thomas	JAQS18/9&10 – Clinical Audit and Outcome Review Plan and update reports – ET re-examine the BCU elements of the clinical audit plan and the process going forward including future presentation, tracking and follow up of recommendations arising, with input from Internal Audit as appropriate.	March 2019	This will be reviewed as part of the development of the clinical audit policy and process. Tracking actions will require additional resources.	Close

Effective Clinical Audit – theory of change

Appendix 2



Quality Safety & Experience (QSE) Committee 21.5.19	<div style="text-align: center;">  <div style="display: inline-block; vertical-align: middle; margin-left: 10px;"> GIG CYMRU NHS WALES </div> <div style="display: inline-block; vertical-align: middle; margin-left: 10px;"> Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board </div> </div> <p style="text-align: center;"><i>To improve health and provide excellent care</i></p>															
Title:	Quality Assurance – “CLICH” report – January – March 2019															
Authors:	Mrs Barbara Jackson, Assistant Director Service User Experience Mr Mathew Ross, External Reporting Support Manager Mrs Alison White, Senior Project Support Officer, Transforming Care Team															
Responsible Director:	Mrs Deborah Carter, Acting Executive Director of Nursing & Midwifery															
Public or In Committee	Public															
Strategic Goals	<p><i>(Indicate how the subject matter of this paper supports the achievement of BCUHB’s strategic goals –tick all that apply)</i></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="padding: 5px;">1. Improve health and wellbeing for all and reduce health inequalities</td> <td style="text-align: center; width: 50px;">✓</td> </tr> <tr> <td style="padding: 5px;">2. Work in partnership to design and deliver more care closer to home</td> <td style="text-align: center;"> </td> </tr> <tr> <td style="padding: 5px;">3. Improve the safety and outcomes of care to match the NHS’ best</td> <td style="text-align: center;">✓</td> </tr> <tr> <td style="padding: 5px;">4. Respect individuals and maintain dignity in care</td> <td style="text-align: center;"> </td> </tr> <tr> <td style="padding: 5px;">5. Listen to and learn from the experiences of individuals</td> <td style="text-align: center;">✓</td> </tr> <tr> <td style="padding: 5px;">6. Use resources wisely, transforming services through innovation and research</td> <td style="text-align: center;">✓</td> </tr> <tr> <td style="padding: 5px;">7. Support, train and develop our staff to excel.</td> <td style="text-align: center;">✓</td> </tr> </table>		1. Improve health and wellbeing for all and reduce health inequalities	✓	2. Work in partnership to design and deliver more care closer to home		3. Improve the safety and outcomes of care to match the NHS’ best	✓	4. Respect individuals and maintain dignity in care		5. Listen to and learn from the experiences of individuals	✓	6. Use resources wisely, transforming services through innovation and research	✓	7. Support, train and develop our staff to excel.	✓
1. Improve health and wellbeing for all and reduce health inequalities	✓															
2. Work in partnership to design and deliver more care closer to home																
3. Improve the safety and outcomes of care to match the NHS’ best	✓															
4. Respect individuals and maintain dignity in care																
5. Listen to and learn from the experiences of individuals	✓															
6. Use resources wisely, transforming services through innovation and research	✓															
7. Support, train and develop our staff to excel.	✓															
Approval / Scrutiny Route	No prior scrutiny															
Purpose:	To provide a high-level summary in relation to the numbers and high-level themes & trends from Complaints, Incidents and Inspections. It also provides a summary of the numbers of Legal claims received and closed along with adverse feedback received as part of the coronial process. The report represents a range of issues under the executive responsibility of the Executive Director of Nursing & Midwifery.															
Significant issues and risks	No key risk issues highlighted within the report															
Special Measures Improvement Framework Theme/	Concerns are monitored via the Special Measures Framework															

Expectation addressed by this paper	
Equality Impact Assessment	An EqlA is not required for this report; this report is applicable to all staff.
Recommendation/ Action required by the Committee	The Committee are asked to note the content of this report.

Betsi Cadwaladr University Health Board
Quality Assurance – CLICH report – January – March 2019

Table of Content

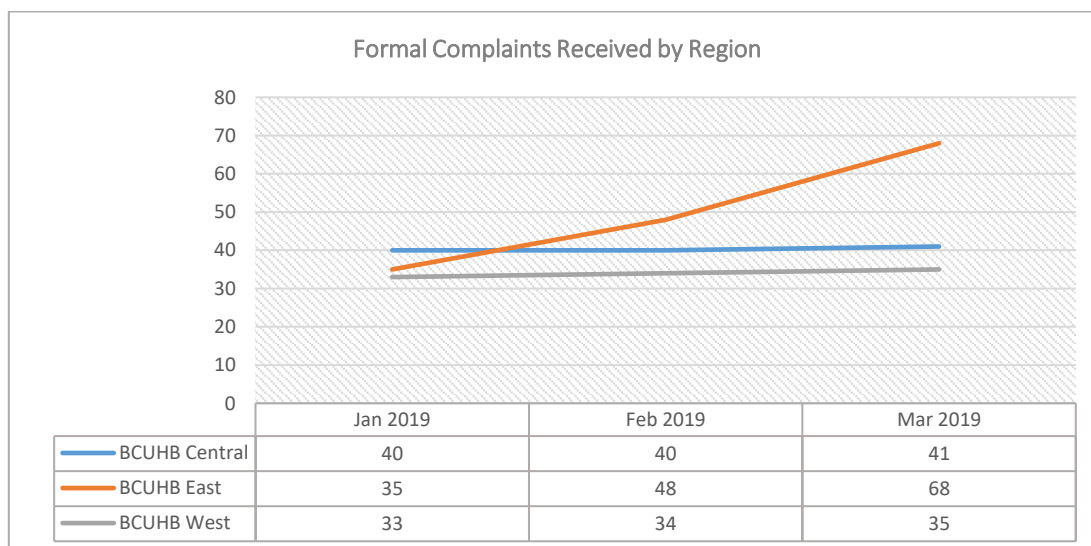
- 1) Introduction
- 2) Complaints
- 3) Litigation (Claims)
- 4) Incidents
- 5) Never Events
- 6) Coroners Inquests
- 7) Health Inspectorate Wales

1) Introduction

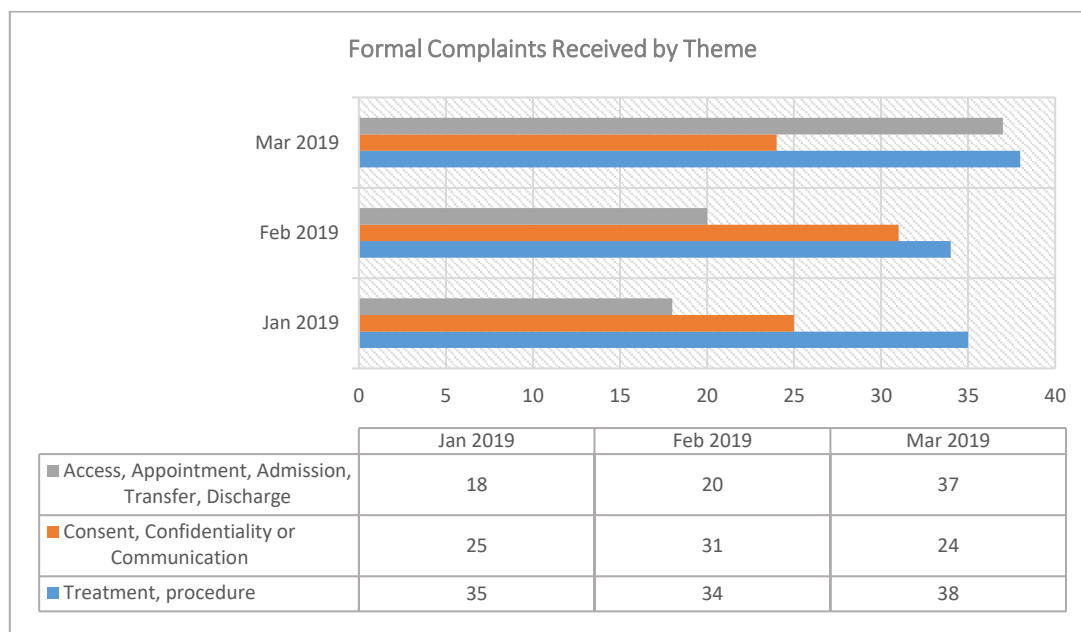
The CLICH report is designed to provide a high-level summary for the Quality, Safety and Experience Report in relation to the numbers and high-level themes & trends from Complaints, Incidents and Inspections. It also provides a summary of the numbers of Legal claims received and closed along with adverse feedback received as part of the coronial process. The report represents a range of issues under the executive responsibility of the Executive Director of Nursing & Midwifery.

2) Complaints

Between January and March 2019, the Health Board has received 374 formal complaints of which 85% (317) received an acknowledgment within 24 hours of receipt.



Of the 374 formal complaint received, the below themes are consistently the highest received on a monthly basis and equate to 70% of those received in this period.



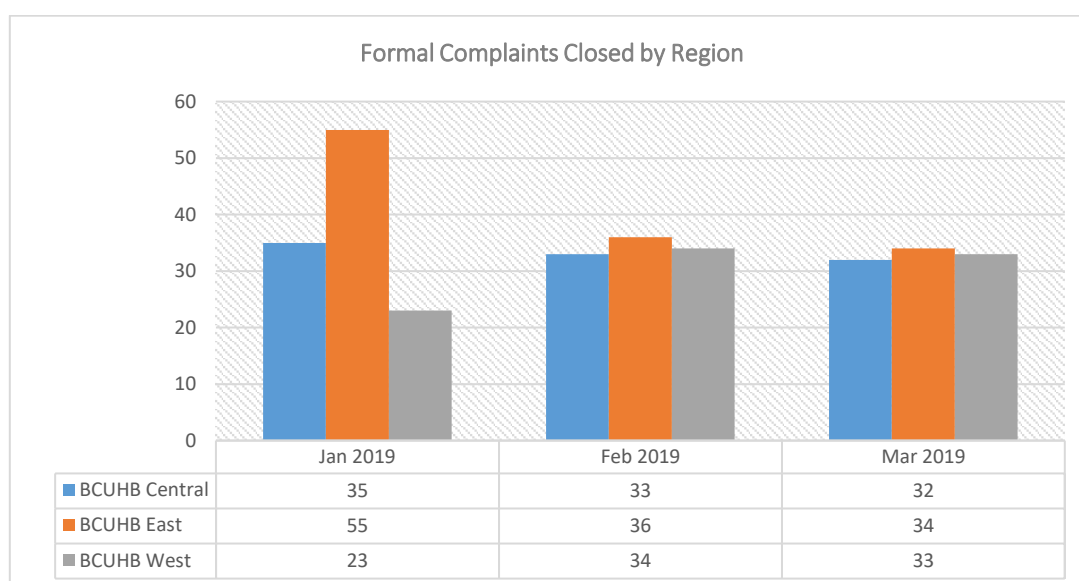
The remaining 30% relate to the below themes.

<i>Themes – January to March 2019</i>	Total
Clinical assessment (investigations, images and lab tests)	36
Medication	18
Abusive, violent, disruptive or self-harming behaviour	17
Implementation of care or ongoing monitoring/review	16
Patient Information (records, documents, test results, scans)	7
Continuing Healthcare Decisions - non AIR	5
Infrastructure or resources (staffing, facilities, environment)	5
Medical device/equipment	4
Concerns Handling	3
Security, including patients property	1
Total	112

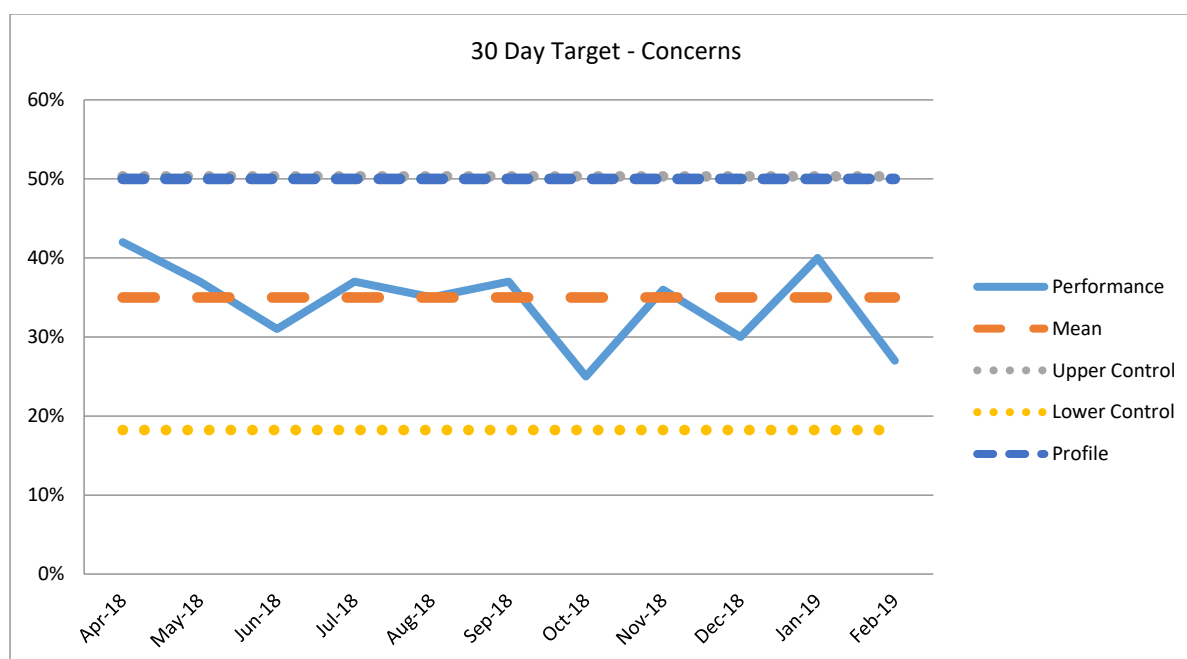
Information on all complaints are provided to the Quality and Safety Groups of each division who are responsible for the consideration of learning and improvement. Each division provide a monthly report to the Quality and Safety Group where further themes, trends and hot spots can be identified and shared.

In relation to the issue of appointments a number relate to specific specialities such as ophthalmology, urology and endoscopy. In order to elevate pressures regarding these delays, the Health Board has created working groups to tackle and work through the current backlog.

Closed Complaints



Of the 315 formal complaints closed in the above period, 33% (105) received a response within the 30 working day timeframe. Previous months performance can be seen below:



'On the spots' (OTS)

The Health Board received 857 complaints managed as OTS; of these 362 were resolved by the next working day, and 267 within 5 working days, the remaining cases exceeded the 5 day target. Where the target was exceeded it would be with the complainant's agreement.

However in relation to OTS complaints, it should be noted that the PTR regulations do state that 'a concern which is notified verbally, either in person, or on the

telephone and is resolved to the satisfaction of the person who notified the concern not later than the next working day after the day on which the concern was notified'. However the guidance issued by WG in 2013 to implement the regulations does state that resolution should be 'ideally by the next working day). All Health Boards across Wales, in an effort to be helpful to complainants have allowed the time scale for resolving an OTS to the complainant's satisfaction to be flexible up to 5 working days.

The Welsh Government has now revisited this section of the regulations with all Health Boards and are clear the regulations must be applied strictly. This means all complaints received verbally, in person, by telephone and, they have added, by email must be resolved by the end of the next working day following receipt. Should this not be possible then the complaint MUST be made formal and managed under the PTR procedures. This will increase the number of formal complaints being received by the Health Board.

Lessons Learnt

Each complaint will provide an opportunity for learning and each division takes this learning through their governance and quality and safety arrangements to share and disseminate. This is also taken by each division to the Quality and Safety Group who consider learning on a BCUHB wide basis.

Some examples of learning related to the main themes highlighted include:

➤ Appointments and access:

- The Health Board has launched an online complaint form to assist and guide people to access the complaints procedure
- Working groups in place for the specialities with particular challenge in waiting times and appointments

➤ Communication:

Where trainee staff are working:

- We ensured that posters in department regarding students are prominently displayed.
- Staff are reminded to introduce themselves at the beginning of a scan.
- Verbal consent must be obtained for a student to be present at any part of an examination

The Health Board received a complaint in relation to the lack of explanation for the delay in receiving the results of a blood test.

- Staff are encouraged to provide information and an explanation to patient/families if a test is sent to another laboratory and will therefore take slightly longer to receive the results.

Actions being taken to improve

Following a concerted focus on moving to real time management of complaints, the overall numbers open and overdue had significantly decreased. However, during 2018 this improvement plateaued and the progress has begun to slide in 2019. Trajectories have been set to deliver real-time management of complaints by the end of June 2019. As not all complaints will be resolved within the 30 days, the following tolerances have been set:

- no grade 1/2 complaints overdue
- no more than 15 grade 3 complaints overdue and none overdue by more than 3 months
- no more than 30 grade 4/5 complaints overdue
- no more than 5 complaints overdue by more than 6 months and these must only be at grade 5

As of 30/04/2019 there was only 1 complaint over 6 months and this is as a result of a police investigation and therefore cannot be closed until the police advise.

The progress against trajectories is being monitored weekly. In terms of the divisions, for grade 2s MHL and Women's are the below trajectory, with all other divisions over trajectory, for grade 3's all divisions are above trajectory and need plans to regain a positive position.

All complaints open beyond 3 months are reviewed as part of the weekly Incident view meetings.

PSOW

The Ombudsman has been in contact with the Health Board on 37 occasions between January and March. Of the 37, 10 were enquiries only, 11 became full investigations, 10 proposals and PSOW chose not to investigate 6.

53 PSOW cases were closed in the same period, of the 53, 8 were fully upheld & 14 were partially upheld with the Health Board required to pay £7,325.00 in redress.

The main themes for contacting PSOW relate to, delay in corporate response, delay in diagnosis, delay in treatment and mis-diagnosis.

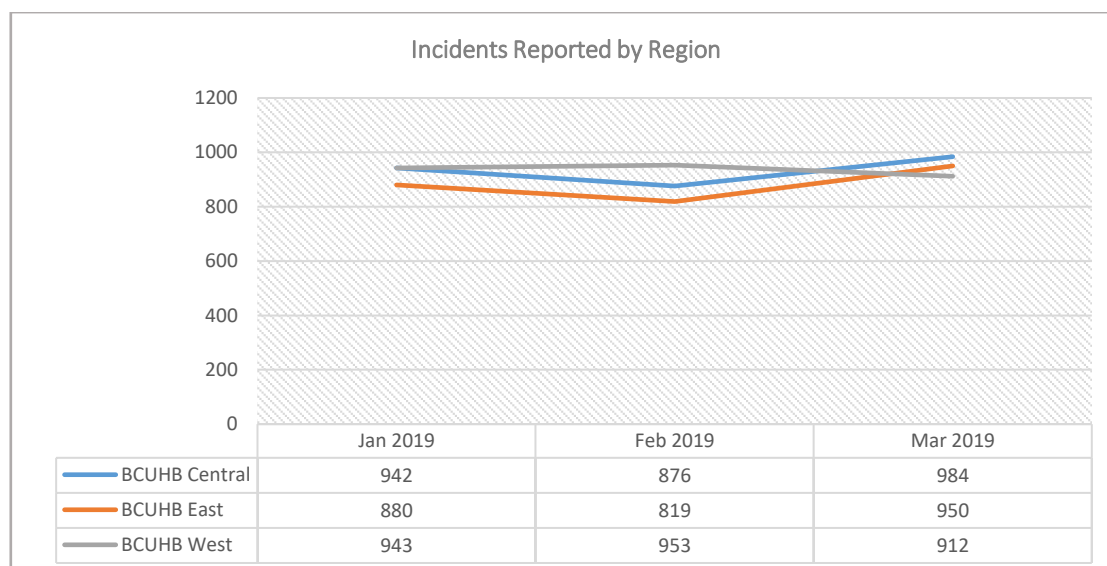
3) Litigation (Claims)

Between January and March 75 new claims have been opened, 10 as Personal Injury claims the remainder as Clinical Negligence claims.

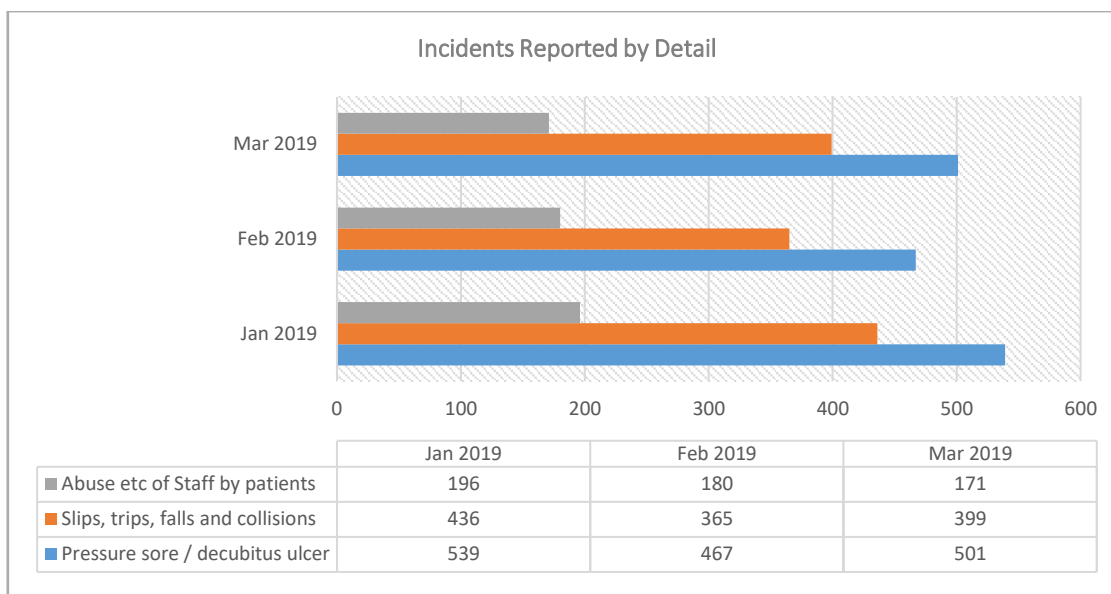
	Jan 2019	Feb 2109	March 2019
Clinical negligence	16	23	26
Personal injury	1	8	1

For the same period 59 claims were closed, 13 of which were Personal Injury claims, the rest Clinical Negligence. The expected cost to the organisation is £17,663,770

4) Incidents



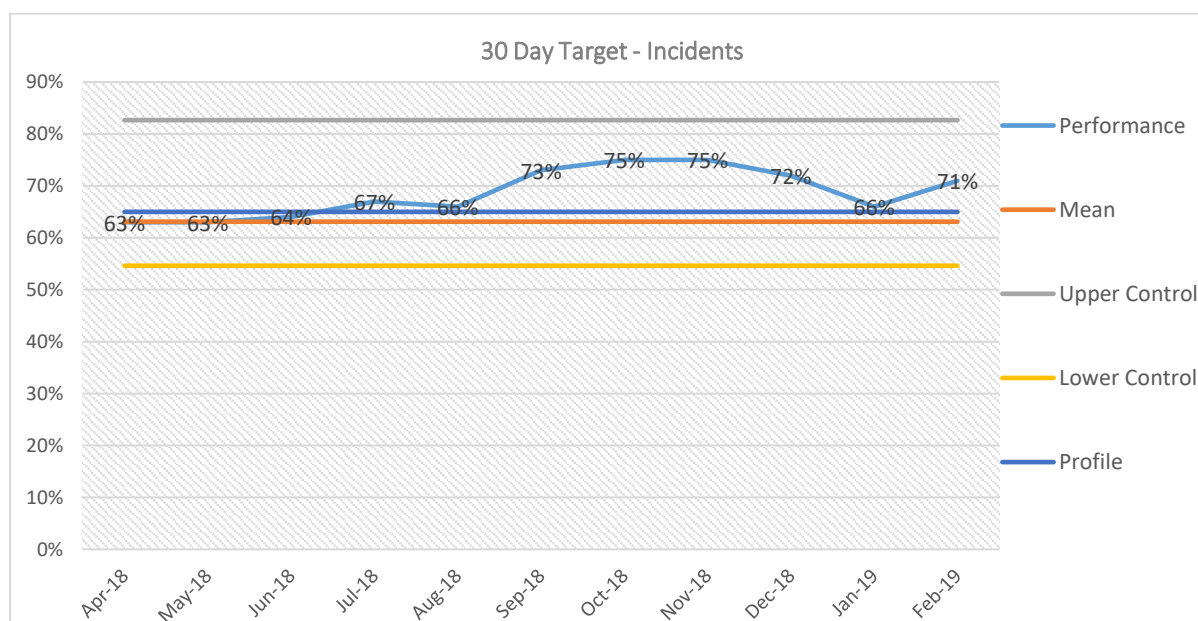
Between January and March, 8259 incidents have been reported onto the Datix system. Over a third of the incidents reported were in relation to Pressure Ulcers and Falls.



The remaining incidents are broken down as below:

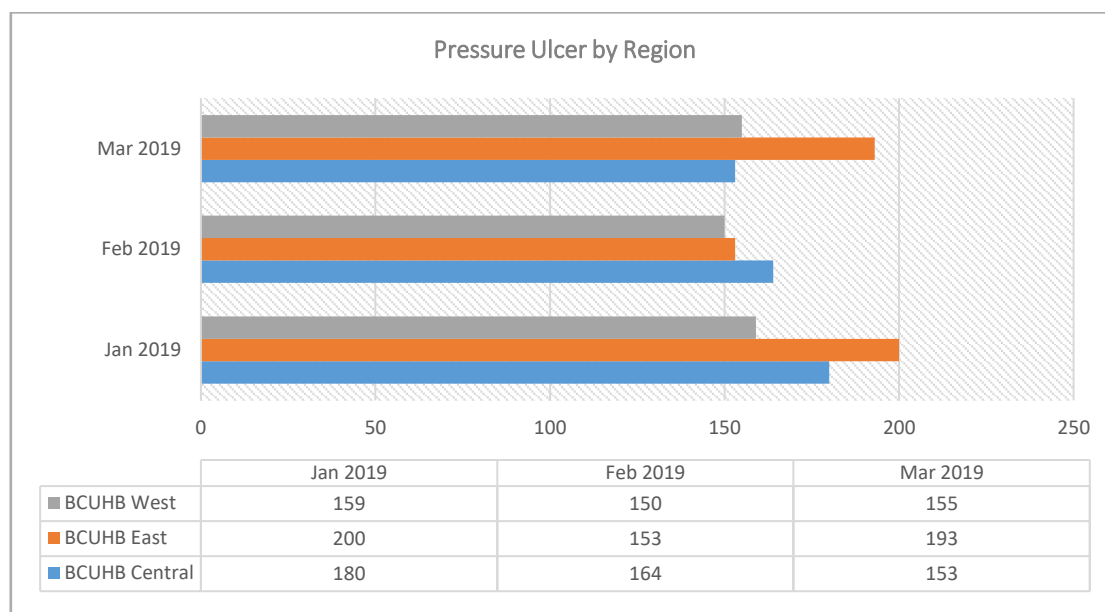
Themes - Incidents between January & March 2019	Jan 2019	Feb 2019	Mar 2019	Total
Implementation of care or ongoing monitoring - other	92	132	154	378
Accident caused by some other means	104	106	111	321
Security - other	96	104	65	265
Infrastructure or resources - other	79	65	82	226
Appointment, Admission, Transfer, Discharge - other	83	66	63	212
Administration or supply of a medicine from a clinical area	64	64	74	202
Lack of/delayed availability of facilities/equipment/supplies	48	57	48	153

Of the 8259 incident reported between January and March 2019, (72%) 5931 have been fully investigated and closed within timeframe. Previous months performance can be seen below

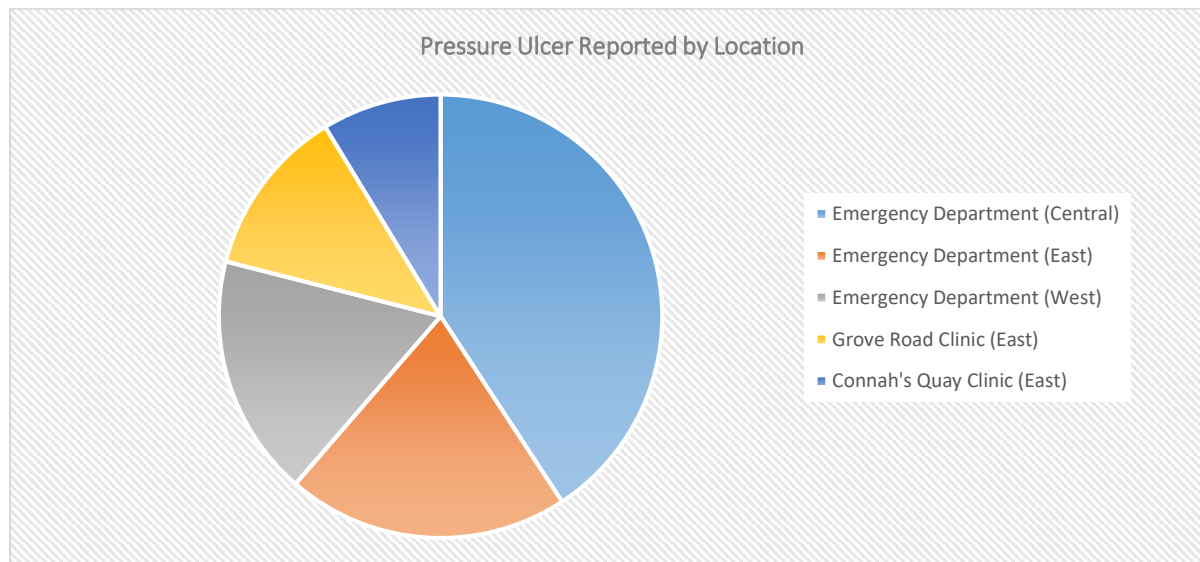


Pressure Ulcer

East region have reported the highest number of Pressure Ulcers for the period.



However, the department that has reported the most Pressure Ulcer incidents between January and March is Emergency Department Central.



Of the 1,507 incidents reported relating to Pressure Ulcers, 578 were noted present upon admission, 249 were not. The remaining have yet to be categorised.

Mobility Issues and Medical Condition are the most common contributory factors RE Pressure Ulcer incidents.

Actions

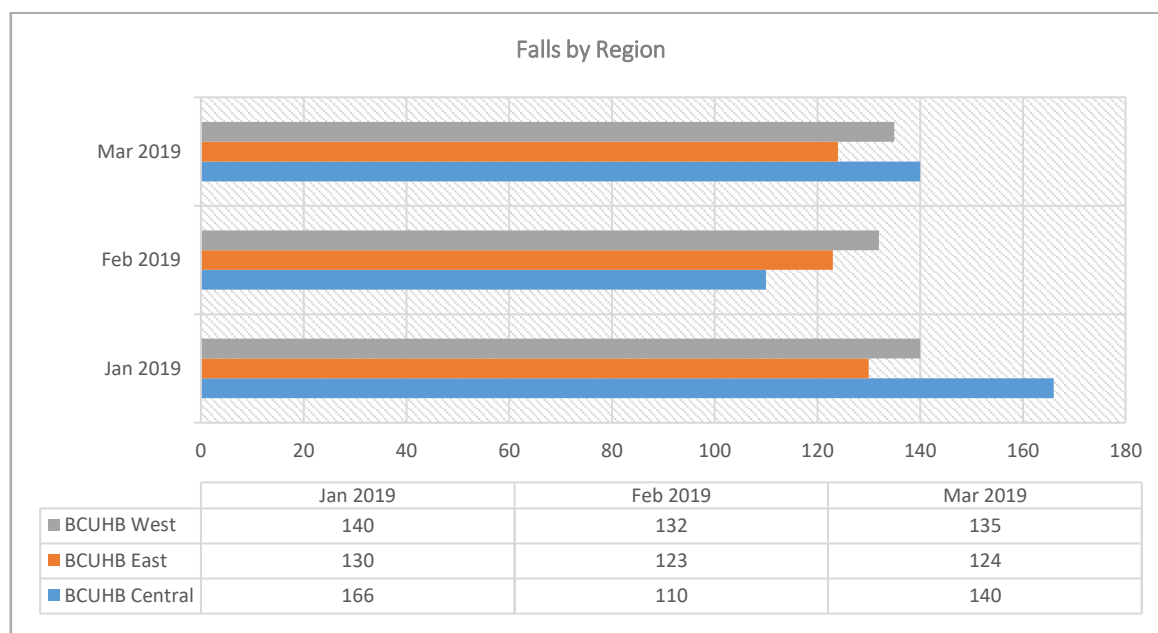
Staff involved in the care of patients at risk of developing Pressure Ulcers are aware of the importance of clear, accurate documentation. Staff awareness raised about providing air mattress for patients that have been Maelor risk assessed.

The importance of communication between day staff and night staff with regard to presence of pressure sore. Along with the importance of completing a Datix incident report on the discovery of pressure sore as soon as it is practically possible.

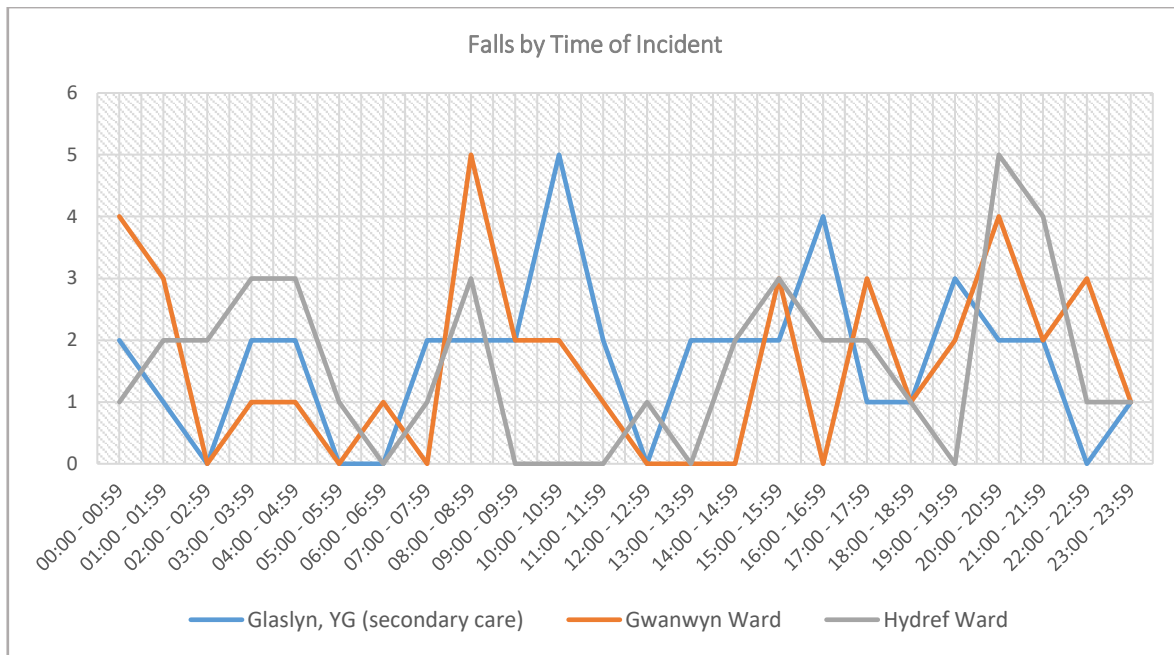
Regular encouragement to patients to mobilise/reposition regularly to minimise pressure.

Falls

1,200 fall incidents have been reported between January & March. Central region have reported the highest number of incidents for the period.



The wards that have reported the highest number of falls between January & March are Glaslyn YG, Gwanwyn Heddfan Unit & Hydref Heddfan Unit.



Mobility issues and Dementia are the most common contributory factors relating to falls.

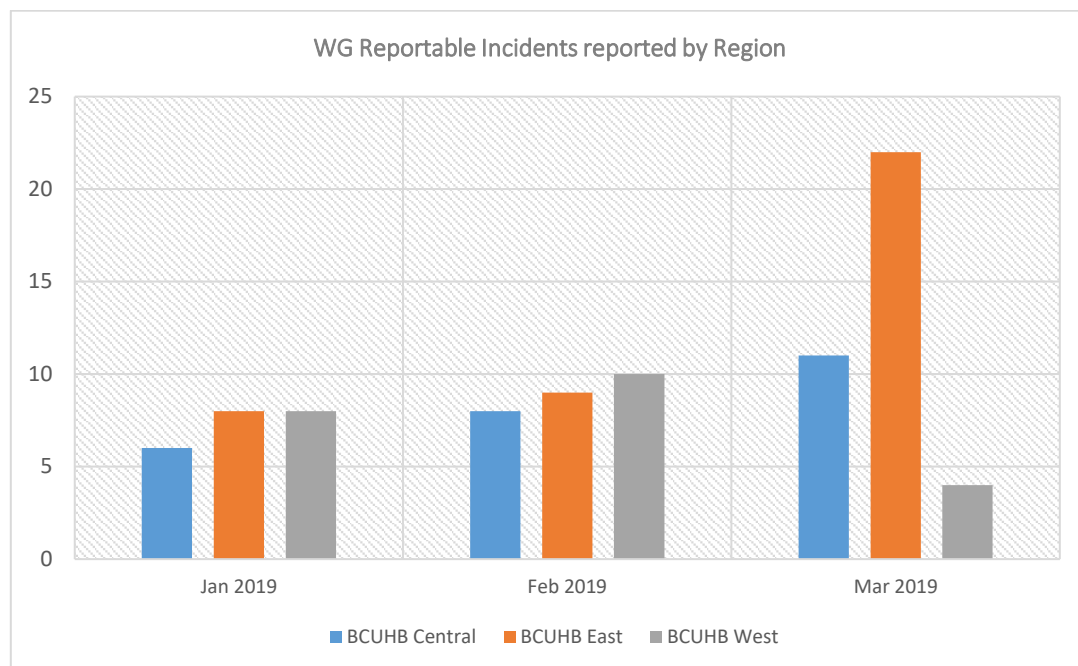
Action

Patients with mobility issues are encouraged to use call bell and ask for assistance when required. Staff must ensure that mobility aid is kept close to patient at all times.

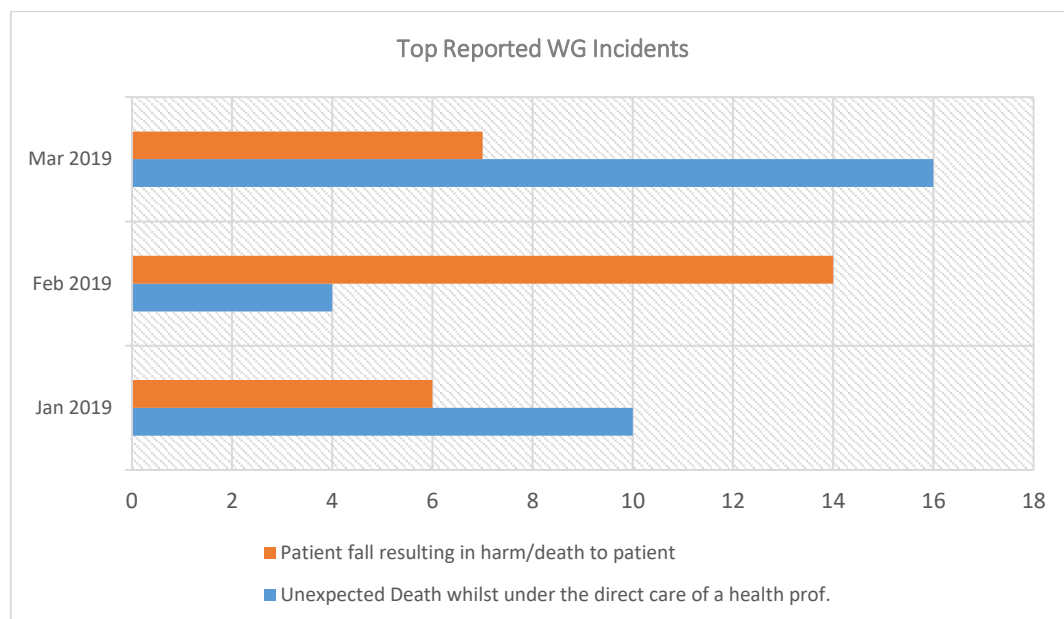
Continue to complete and educate regarding the importance of risk assessments and audit to ensure quality care obtained.

Lying and standing BP to be carried out on all patients at risk of falls.

Welsh Government



Between January and March, 86 incidents have been reported to Welsh Government, with East region reporting the highest overall.

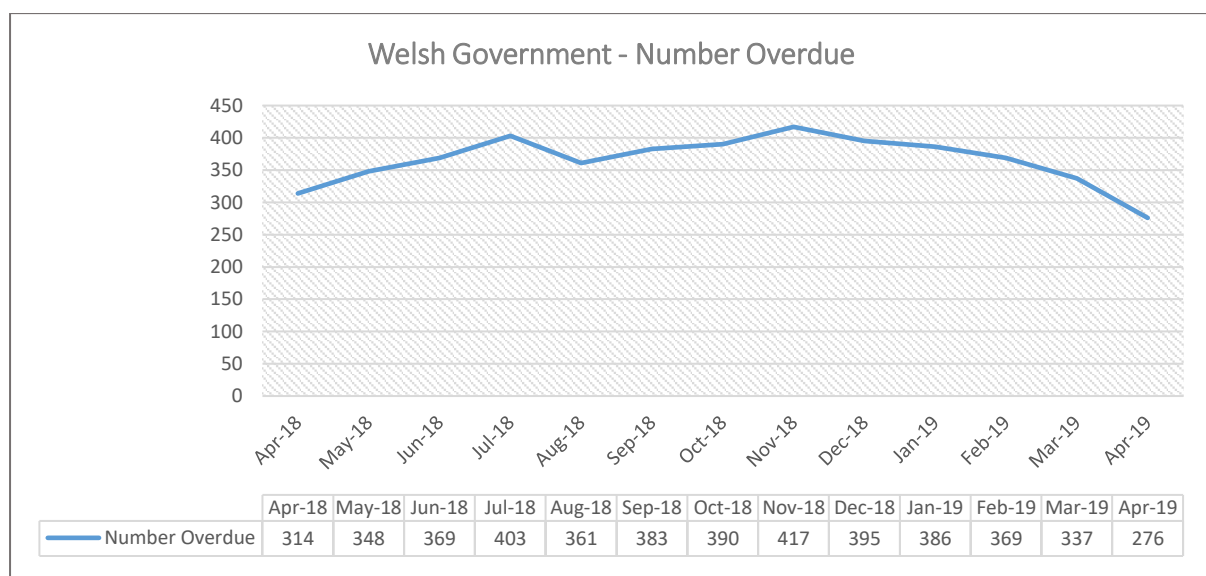
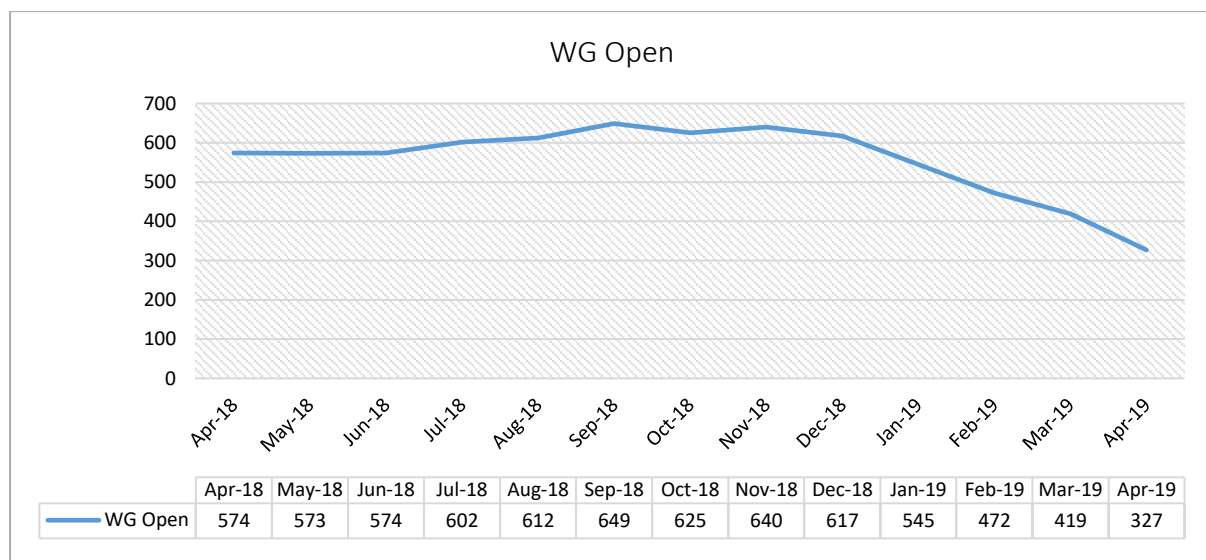


The most reported incidents to Welsh Government are, Patient Falls & Unexpected Death whilst under the direct care of a health prof, the above incidents make up to 67% of incidents reported to Welsh Government for the period.

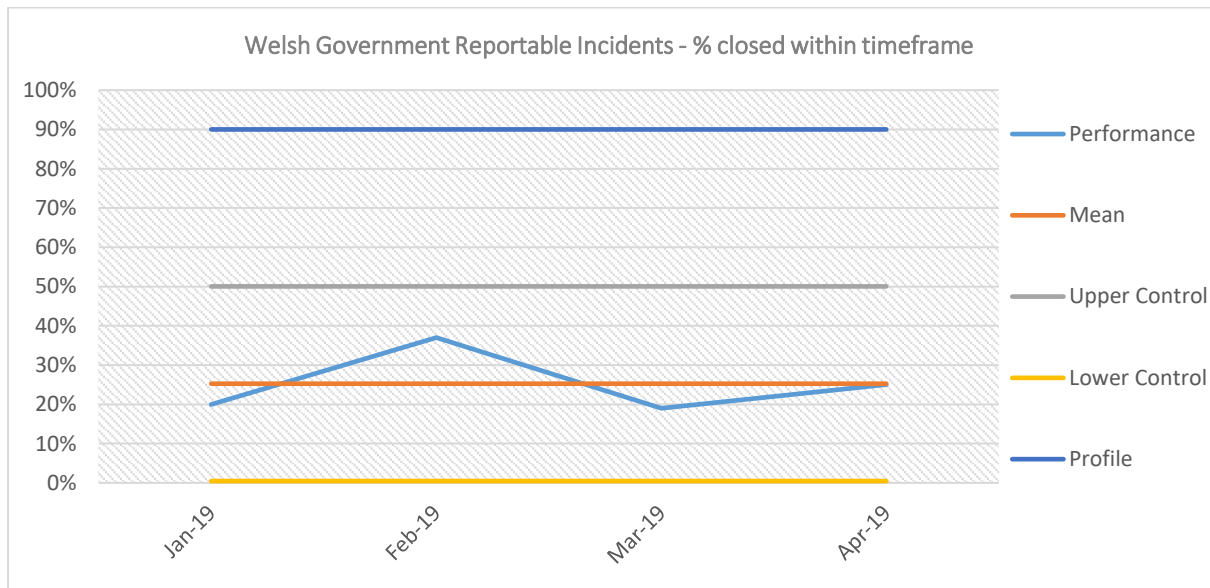
With the remaining 33% consist of the below:

Welsh Government reportable incidents – January to March 2019		Total
Other type of incident		8
Grade 3 or above healthcare associated pressure ulcer develops		4
HCAI outbreaks resulting in the death or harm to patients		4
Abandonment of detained patient assessed as high risk		3
Suicide(or attempted) or homicide committed by an NHS MH patient		3
Mental Health - Attempted suicides as inpatients		2
Sensitive Issue		2
Data loss and information security (serious Breaches)		1
Major Harm Caused		1
Serious Medication-related error		1

In recent months the Health Board has seen a substantial decreases in the number of Welsh Government incidents open and the number of incidents overdue.



The % of Welsh Government incidents closed within timeframe in recent months is 25%, this is likely down to the renewed focus on reducing the backlog.



5) Never Events

Never Events are defined as Serious Incidents that are wholly preventable because guidance or safety recommendations are available at a national level and should have been implemented by all healthcare providers.

Each Never Event type has the potential to cause serious patient harm or death. However, serious harm or death does not need to have happened as a result of a specific incident for that incident to be categorised as a Never Event.

Each Never Event is fully investigated to include full and meaningful engagement with patients, families and carers at the beginning of and throughout the investigation. All investigations identify the learning from the Never Event and is crucial to prevent future harm.

There have been no Never Events within the Health Board during the time period covered by this report; the last Never Event having occurred in December 2018. Investigations for all previous Never Events have been completed and lessons learnt identified.

Any new Never Events that might occur in the future will be reported on within this report moving forward.

6) Coroner Inquests

For the period the Health Board has received one Regulation 28 report from Her Majesty's Coroner.

The report relates to unacceptable delays experienced with patients being kept waiting for long periods in ambulances and ambulance resources consequently being unavailable for allocation to other calls.

Actions

In October 2018, the Health Board launched the first series of 90-day improvement plan methodologies; known as 'Building Better Care'. The improvement plans focus on 3 work streams within our unscheduled care pathways.

- Capacity and Demand
- Flow within the Acute Sites
- Discharge Planning

All of these work streams support improvements within the unscheduled care pathways, the second wave started on 4th March 2019. This cycle continues to focus on ambulance handovers and improving patient flow directly from the emergency department to assessment areas. BCU has also engaged with the National ED improvement programme as early adopters of quality improvement strategy known as CAREMORE.

BCUHB and WAST's plans are focused heavily on clinically safe admission avoidance with A+E very much the final consideration for our population. We have introduced a Single Integrated Clinical Assessment and Triage (SICAT) service to support the signposting of pathways and prepare for the introduction of NHS111. This model is delivered by GPs who provide over the telephone assessments and advice. Since its launch on 12th November 2018 to 20th February it has taken 366 calls, of those 27% were referred on to an ED. Review of the calls and previous data suggested that all of these patients would have previously been directed to an ED. This is a potential reduction of almost 300 attendances over a 3 month period.

To support clinical staff and leadership we have introduced internal professional standards as a benchmark of best practice. Teams are encouraged to use simple quality improvement (QI) methodologies to test new ways of working to identify the most effective changes to enhance quality, safety and patient experience. BCU has launched a QI hub (<https://bcu-qi.wixsite.com/aa-betsicadwaladr-qi>) and training programme to support this. Staff receive bronze and silver training and then undertake small change improvement projects that are shared on the web site.

All 3 acute hospital sites have adopted the SAFER approach to improve communication between ward staff and ensure that patients receive timely decision-making, interventions and discharge. This provides information to support discharge planning and co-ordination. Each hospital has a daily safety huddle where the teams identify the current risk and actions required to reduce that risk. This meeting is led by the hospital management team and is designed to 'set the scene' for the day. The template and information is tested and reviewed to ensure continuous improvement.

The Health Board have developed a number of Community Pathways in partnership with WAST which support care closer to home. The main pathways are:

- Minor Injuries unit utilisation

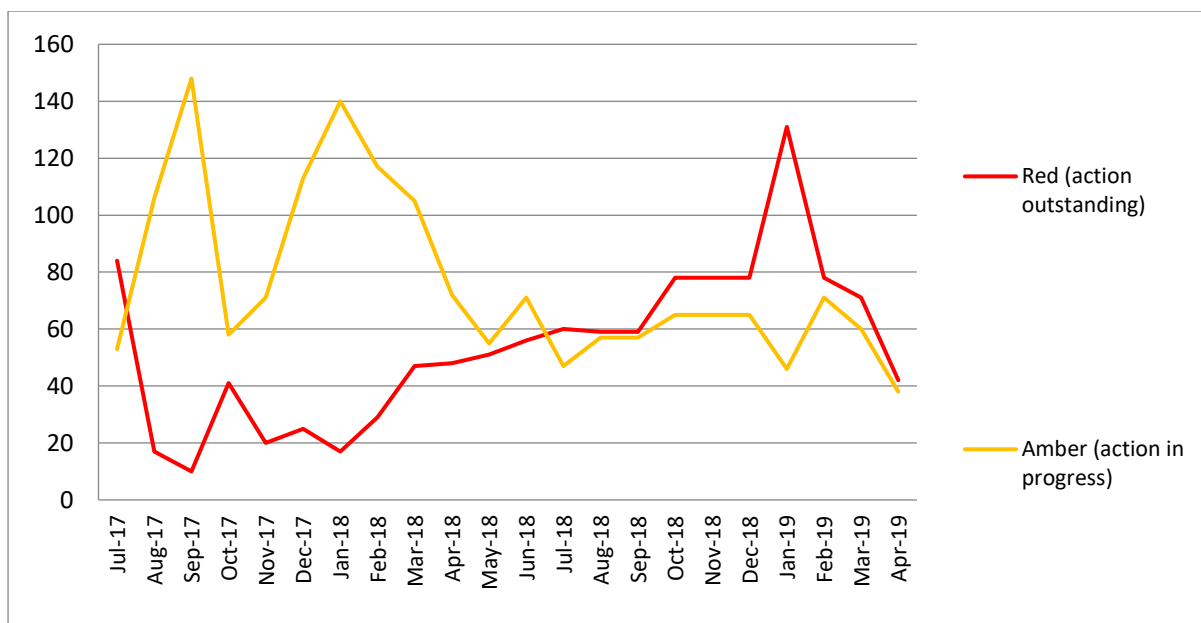
- Early data has identified that there has been a rise in WAST conveyances to MIU however there is further work ongoing to maximise the capacity and benefit of the MIU as an alternative pathway.
- Ambulatory Care
 - An ambulatory Care Unit has recently opened in Llandudno hospital which receives direct GP referrals for assessment and diagnostics to avoid admission of patients to the acute sites.
- Falls
 - Home visits by district nursing teams to avoid an Emergency department (ED) attendance. WAST are also using minor injury pathways to manage some of these patients.
 - An urgent Care Practitioner has been appointed to support the Dwyfor Cluster and has provided 152 home visits to patients during Nov / Dec for primary care and the Community Response Team
- District Nursing
 - One example is the night owls scheme on Anglesey; they are supported by Health and Social care workers, who are providing input from 10pm to 8am. From April to December 385 patients were supported to remain at home, 322 crisis calls through to Galw Gofal, received 64 patient fall related calls instead of WAST and 413 bed days saved.
- Mental Health
 - Providing better access to mental health liaison support in the community to avoid ED attendances. Focus on emotional well-being and continued work based on the principle of 'TODAY I CAN'.

The impact of these interventions is starting to demonstrate improvement in some parameters. Of particular reference is the improvement in the number of delayed handovers of patients from WAST to BCU. We have demonstrated small improvements in other system measures and intend for this to continue as part of our Building Better Care program.

7) Health Inspectorate Wales

HIW inspections, actions and outstanding matters are tracked / recorded via an excel tracker tool. This Tracker Tool records all inspections and subsequent actions, plus preparatory references where inspection reports and Thematic Reviews are expected.

Below is a summary of current BCUHB **internal actions** against HIW recommendations to 30th April 2019 (where stated "action outstanding", this refers to the date of completion for actions communicated to HIW when the initial action plan was returned following receipt of the inspection report):



AMBER 38 actions in progress from date confirmed in HIW action plan as follows:	YGC	Ward 1 & 2b <i>Lead: Alison Griffiths</i>	<ul style="list-style-type: none"> Dignified Care (Staff identification).
		ED <i>Lead: Alison Griffiths</i>	<ul style="list-style-type: none"> Effective Care (Documentation); Safe Care (HAPU & Falls Assessment, IP Policy / procedures, Medicines Management & Fluid intake / output charts); Staff & Resources (Mandatory Training).
	BCUHB wide	Ophthalmology <i>Lead: Barry Williams</i>	<ul style="list-style-type: none"> Staying Healthy (Health promotion).
	MH/LD	<ul style="list-style-type: none"> Heddfan Deeside Ablett Hergest Nant y Glyn CMHT <i>Lead: Andy Roach</i>	<ul style="list-style-type: none"> Staying Healthy (Personal alarms & Advocacy Services); Staff & Resources (Role of Care Coordinator, Ward Clerk capacity, Disciplinary hearings being heard in a timely manner & staffing levels); Safe Care (Documentation, S136 Suite arrangements, Bath available to use with hoist, Extractor Fans in kitchens, Garden lighting, Refurbishment work, Ligature Point risk assessments, Hand wash basin in clinic room (re IP) Management of Patient Monies, Garden works); Effective Care (Records Management); Timely Care (service provision, OOH assessments for under 18s, privacy measures for patient toilets, audit of discharges & availability & access to Psychological therapies); Access to LAs intranet (including PARIS case file system) & joint electronic case system and access to relevant CMHT records. Dignified Care (Patient storage, Access for persons with limited mobility & Advocacy Services); Implementation of WCCIS.
	Care Homes	Care Home Review <i>Lead: Marianne Walmsley</i>	<ul style="list-style-type: none"> Workforce (Staff training needs & clarity re roles and responsibilities of Community Nurses); Individual Care (Information pack re service availability & Continence support); Dignified Care (Dementia Care); Scope of joint quality monitoring tool; Effective Care (co-production of a learning & development programme re meeting needs of older people);

RED 42 actions in progress from date confirmed in HIW action	WXM	ED <i>Lead: Naomi Holder</i>	<ul style="list-style-type: none"> Effective Care (Communication methods: in waiting area & referral to OOH).
	MH / LD	<ul style="list-style-type: none"> Heddfan Ty Llewelyn <i>Lead: Andy Roach</i>	<ul style="list-style-type: none"> Safe Care (Documentation & Medicines Management); Dignified Care (Vision panels); Application of the Mental Health Act (Policies & Procedures).
	BCUHB wide	Ophthalmology <i>Lead: Barry Williams</i>	<ul style="list-style-type: none"> Effective Care (Electronic records); Workforce (Workforce plans).

plan as follows:	Care Homes	Care Home Review <i>Lead: Marianne Walmsley</i>	<ul style="list-style-type: none"> • Effective Care (Partnership care and support – CRTs); • Individual Care (Accessing Therapist Support & reporting of concerns whilst their residents are in hospital); • Workforce (Staff training & staff responses to HIW questionnaire); • Timely Care (patient discharge & Safer Discharge Group role review and refresh);
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Providing Assurance:

Each Area Lead are required to submit an update on a monthly basis against their open actions. These updates are co-ordinated by the Office of the Executive Director of Nursing and provided for discussion at QSG on a monthly basis.

The Corporate Quality Improvement Team have tested the assurance methodology as outlined in the HIW Management Plan whereby meeting local leads individually and / or secondary care governance leads led to closure of actions, sharing of good practice and provided assurance against open actions.

In addition, the Corporate Quality Improvement Team tested the Site Walk around methodology (also detailed within the HIW Management Plan) with local leads which again at the time provided momentum and closure of open actions and sharing of good practice.

These approaches provided opportunity for rigorous and meaningful action planning. it is envisaged with the complete recruitment of the Business Support Manager working closely with Director of Quality Assurance this tested process will be fully implemented and embedded to offer support and assist in sharing of lessons learned.

BCUHB Wide actions:

The following 2 HIW actions have been identified by Quality Safety Group (QSG) for implementation pan BCUHB:

Originally highlighted in	Date of HIW inspection	HIW action	BCUHB Lead
Pen y Maes Health Centre (BCUHB Managed Practice)	April 2017	The health board should review arrangements in respect of managed practices and consider whether there needs to be a separation of its role as commissioner and provider of primary care services, whilst at the same time ensuring that equitable resources are secured for both functions.	Lynn Joannou
Ward 1 & 2b, YGC	July 2017	The health board must take measures to ensure that patients' capacity to make decisions is recorded consistently.	???

Future / expected HIW activity:

- A review of **Substance misuse services** in Wales. The report was published in August 2018 and will be presented to a future QSG meeting 2018 to note the actions that BCUHB are taking in partnership with other agencies as part of Area Planning Board.
- HIW Inspection planned for **18th June 2019** to GP Surgery **Stables Medical Centre Hawarden**. Assistant Director for Primary Care East informed and will support the practice as required. Please note this is not a BCUHB managed practice.
- An **Independent Monitoring Board Annual Report (March 16 to Feb 18)** has been received and a Ministerial response being developed for HMP Berwyn. This report will be presented at a future QSG by Mr Simon Newman, Head of Healthcare, HMP Berwyn.
- HIW have started undertaking **inspections of Surgical Departments** throughout Wales, taking into account NatSSIPs which were introduced in Wales in September 2017. As part of this programme of work, all Health Boards across Wales were required to undertake a self-assessment to assess progress towards meeting NatSSIPs – the BCUHB self-assessment was submitted to HIW in June 2018. No further communications have been received from HIW, however it should be noted that inspections will be unannounced.

**Quality, Safety &
Experience Committee**
21.5.19

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 Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

To improve health and provide excellent care

Report Title:	Review of Corporate Risks Assigned to the Quality, Safety & Experience Committee
Report Author:	Mr Peter Barry, Head of Risk & Assurance
Responsible Director:	CRR02 Executive Director of Nursing and Midwifery CRR05 Executive Director of Nursing and Midwifery CRR16 Executive Director of Nursing and Midwifery CRR03 Director of Primary and Community Care CRR13 Director of Mental Health and Learning Disabilities
Public or In Committee	Public
Purpose of Report:	<p>The attached report has been produced from the web-based Datix system and details the risk entries allocated to the Quality, Safety & Experience Committee namely:</p> <p>CRR02 Infection Prevention and Control CRR03 Continuing Healthcare CRR05 Learning From Patient Experiences CRR13 Mental Health Services CRR16 Safeguarding</p> <p>A new Lead Manager (handler) for CRR03 Continuing Healthcare (CHC) has been identified who will be responsible for the ongoing development and review of this Risk Register entry. Changes within the CHC governance arrangements will be reflected in an in depth review of this risk during May/June 2019.</p> <p>It has been agreed that the CRAF risks will be reviewed twice per year by the Board's Committees. These risks will next be presented to the Committee in November 2019.</p>
Approval / Scrutiny Route Prior to Presentation:	The full Corporate Risk and Assurance Framework (CRAF) is scrutinised by the Health Board twice per year and is published on the Board's external facing website. Individual risks are allocated to one of the Board's Committees for regular consideration and review.
Governance issues / risks:	The report provides for the identification of the risk, the arrangements in place presently to control the risk and further mitigation action/s required.

Financial Implications:	These are identified through the development of business cases and plans required as part of the further actions to achieve the target risk score, as detailed in each risk register entry.
Recommendation:	The Committee is asked to consider the relevance of the current controls, review the actions in place and consider whether the risk scores remain appropriate for the presented risks.

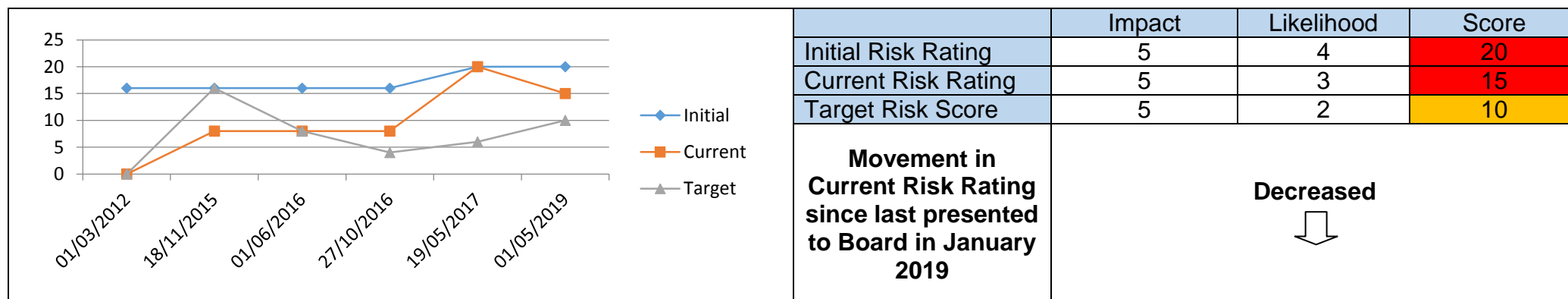
Health Board's Well-being Objectives <i>(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)</i>	√	WFGA Sustainable Development Principle <i>(Indicate how the paper/proposal has embedded and prioritised the sustainable 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			
Special Measures Improvement Framework Theme/Expectation addressed by this paper			
Governance – management of risk Strategic and Service Planning			
Equality Impact Assessment			
Not applicable for governance paper of this nature.			

Disclosure:

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

CRR02	Director Lead: Executive Director of Nursing and Midwifery	Date Opened: 01/03/2012
	Assuring Committee: Quality, Safety and Experience Committee	Date Last Reviewed: 01/05/2019
	Risk: Infection Prevention & Control	Target Risk Date: 27/09/2019

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

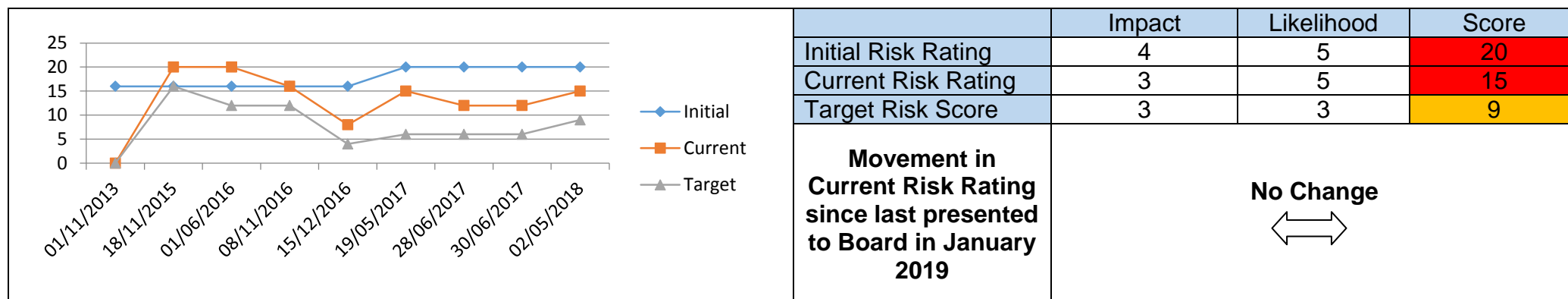


Controls in place	Further action to achieve target risk score
<ol style="list-style-type: none"> 1. Infection Prevention Sub-Group scrutinise trajectories and performance through the regular cycle of business, quarterly and annual reports to Quality and Safety Group. 2. Surveillance systems and policies/SOPs in place for key infections, with data presented through the governance route to Board. 3. Areas and Secondary Care sites governance arrangements. 4. Site Management Team lead reviews of root-cause analysis on each site. Monthly Executive-led scrutiny meetings to review infections and learning from each site in place. 5. Continued progress on ANTT staff training, with key trainers in place, increased focus on medical staff supported by MDs, competencies held by individuals managers. 6. External review performed August 2017; report on further actions presented to Board. Next external review planned for May 2019. 7. Safe Clean Care Programme (SCC) launched 29-01-18, 	<ol style="list-style-type: none"> 1. Continue the implementation of SCC and IP via annual work programmes. (Await re visit from Janice Stevens in May 2019 for any further recommendations). 2. Implement the other actions identified in the 2019-20 annual infection prevention programme. 3. Implement actions in response to Welsh Government Antimicrobial Delivery Plan, relevant Welsh Health Circulars and in response to multi-drug resistant organisms. Part of the ARK study. 4. Continue to progress key actions from Duerden report 2016 in relation to Consultant Microbiologist staffing and capacity, Antimicrobial Stewardship, Estates and Facilities, Infection Prevention Team staffing to support Areas, Care bundle and pathway implementation. 5. Progress work on ward environment improvement, including work to standardise key elements of ward design, storage, signage, provision

consideration to align SCC with IP annual work programme. 8. UTI safety thermometer designed and launched Oct 2018.	of hand wash basins and bay doors. This is embedded within the 90-day plans. 6. Progress work on influenza preparedness in preparation for winter 19-20.
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Assurances	Links to		
1. Professor Duerden report 2016. 2. WG review of decontamination. 3. Demonstrable improvement in line with National Benchmarks. 4. CHC Bug watch visits. 5. HSE reviews. 6. Internal Audits of Governance Arrangements.	Strategic Goals	Principal Risks	Special Measures Theme
	1 2 3 4 5 6 7	PR1	Leadership

CRR03	Director Lead: Director of Primary and Community Care	Date Opened: 01/11/2013
	Assuring Committee: Quality, Safety and Experience Committee	Date Last Reviewed: 08/05/2019
	Risk: Continuing Health Care	Target Risk Date: 01/07/2019
There is a risk that the CHC Framework and process will not be fully adhered to. This is due to inconsistent application and service pressures including availability of suitable provision. This could lead to poor patient experience and outcomes and associated complaints and retrospective claims.		

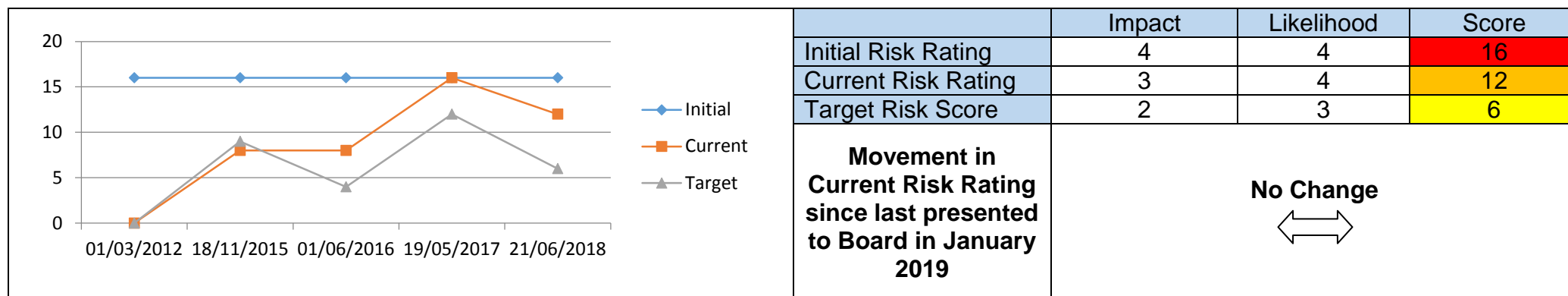


Controls in place	Further action to achieve target risk score
<ol style="list-style-type: none"> 2014 national CHC Framework. Revised CHC structure in place including Practice Development Team. All Wales Retrospective Claims process (Powys). Joint LA & BCU CHC Regional Implementation Group. Revised BCUHB CHC Governance Framework agreed. PMO Scheme for CHC with associated project management and reporting in place. Annual WG self assessment. North Wales care home market place community project. Contracts and contract monitoring team in place. Implemented Scheme of Delegation Process within Areas. Implemented Skills and Knowledge Framework. Recruited to Retrospective Team. Implemented revised national retrospective claims procedure. 	<ol style="list-style-type: none"> Implement revised CHC Governance and Strategic Commissioning Team. Finalise and implement regional SOP. Development of dashboard KPI's for CHC with Broadcare. Monthly exception reporting. Develop CHC commissioning strategy. Implement the Older Persons Commissioner and Operation Jasmine action plans. Roll out Bevan Exemplar care home support team. Finalise and implement joint quality monitoring tool across north Wales. Implement patient and family feedback process. Increase partnership working with the sector to include shared services. Develop training and workforce strategy for Care Homes.

14. CHC Contracts in place for all placements. 15. Care Home QAF in place. 16. Care Home Market position statement developed.	15. Development of training and workforce strategy for CHC process.
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Assurances	Links to		
	Strategic Goals	Principal Risks	Special Measures Theme
1. Regular meetings with Regulators (CSSIW). 2. Inter-agency processes in place to review escalated concerns. 3. FNC Judicial Reviews of NHS Wales fee setting methodology implemented. 4. National reporting on CHC placements.	2 3 4 5 6 7	PR1	Strategic and Service Planning

CRR05	Director Lead: Executive Director of Nursing and Midwifery	Date Opened: 01/03/2012
	Assuring Committee: Quality, Safety and Experience Committee	Date Last Reviewed: 27/02/2019
	Risk: Learning From Patient Experiences	Target Risk Date: 27/09/2019
There is a risk that the Health Board does not listen and learn from patient experience due to the untimely management and investigation of concerns. This could lead to repeated failures in quality and safety of care.		

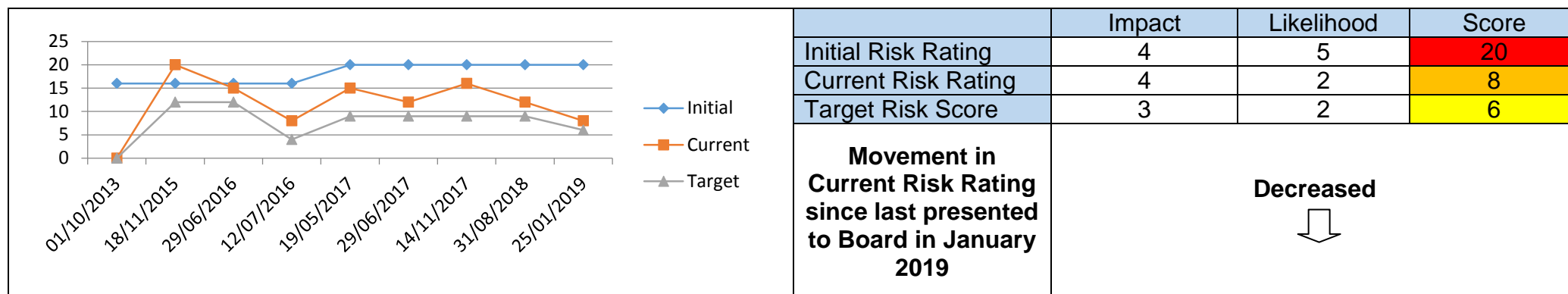


Controls in place	Further action to achieve target risk score
<ol style="list-style-type: none"> Corporate concerns team embedded in operational management structures. Performance and accountability reviews include concerns monitoring. Weekly divisional PTR meetings being held. Monthly reporting and monitoring of performance and learning to QSG. Enhanced monitoring of claims with Welsh Risk Pool. Ongoing programme of work in place as part of the IMTP to deliver improvement. Patient Advice and Support Service established in YGC initially. Minimum data sets provided monthly to all divisions regarding Concerns. Initial review (72hr) of serious incidents implemented. Revised trajectories agreed as part of IMTP. Significant reduction in total numbers of complaints open - focus on 	<ol style="list-style-type: none"> Concerns management and investigation processes being reviewed with support of new ADQA with a particular emphasis on incident management. Review and revision of corporate concerns management to enhance learning in the divisions and create capacity to support training and development for the divisions. Manage performance in line with revised trajectories.

resolving complaints as OTS where possible. 12. Harm dashboard launched and being informed by Datix. 13. Weekly teleconference with corporate and divisions to monitor complaints. 14. Associate Director Quality Assurance in post. 15. Process commenced to manage historic incidents to closure and learning. 16. Additional support identified to manage overdue complaints and allow divisions to focus on new complaints raised. 17. Weekly Incident review meeting established to review all serious incidents and complaints over 3 month overdue.	
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Assurances	Links to		
	Strategic Goals	Principal Risks	Special Measures Theme
1. Welsh Risk Pool Reports. 2. Monthly review by Delivery Unit. 3. Public Service Ombudsman Annual Report, Section 16 and feedback from cases. 4. Regulation 28 Reports from the Coroner.	3 4 5 6	PR7	Leadership

CRR13	Director Lead: Director of Mental Health and Learning Disabilities	Date Opened: 01/10/2013
	Assuring Committee: Quality, Safety and Experience Committee	Date Last Reviewed: 07/05/2019
	Risk: Mental Health Services	Target Risk Date: 28/06/2019
There is a risk that patients receive inappropriate care within Mental Health Services due to failings in leadership and governance at all levels within the Division which could result in poor quality outcomes for patients.		

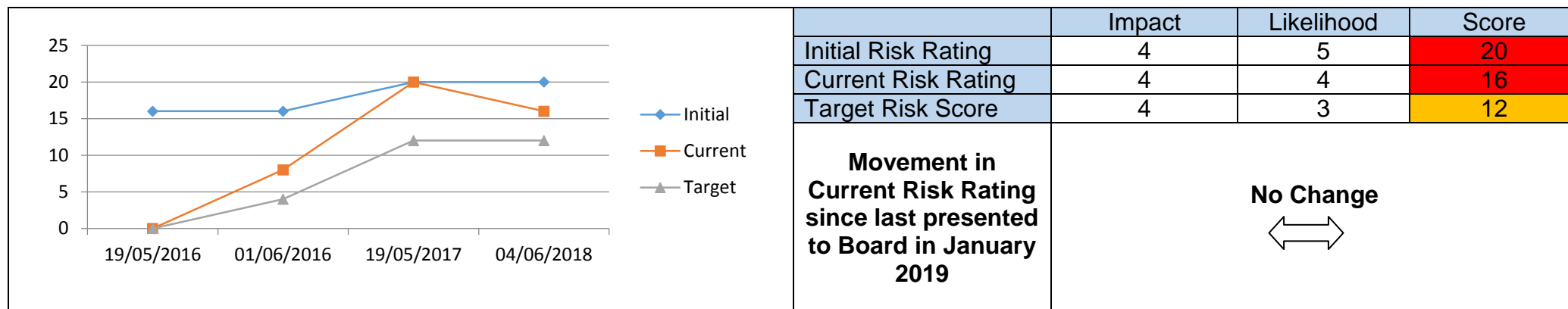


Controls in place	Further action to achieve target risk score
<ol style="list-style-type: none"> 1. Improvement plan in place and subject to ongoing review. 2. Enhanced monitoring in progress at Board level. 3. Renewed focus and escalation arrangements for dealing with operational issues. 4. Governance Framework developed and implemented within mental health. 5. Mental Health Strategy approved by the Board. 6. Senior Management and Clinical Leadership holding structure in place. 7. Older Person's Mental Health action plans in place. 8. Weekly PTR meeting in place. 9. Revised interim leadership, management and governance arrangements in place November 2017. 	<ol style="list-style-type: none"> 1. Ongoing implementation of performance and accountability reviews across the division. 2. Continue to improve internal divisional communication systems. 3. Contribute to HASCAS investigation and wider governance review. 4. Undertake review of demand, capacity and skill mix. 5. Ongoing review of staffing levels. 6. Consultation on permanent structure to be completed. 7. Embed revised arrangements for safeguarding, and dynamic risk assessment. 8. Standardise operational procedures for acute inpatient care.

Assurances	Links to		
	Strategic Goals	Principal Risks	Special Measures Theme
	1 2 3 4 5 6 7	PR1	Mental Health

CRR16	Director Lead: Executive Director of Nursing and Midwifery	Date Opened: 19/05/2016
	Assuring Committee: Quality, Safety and Experience Committee	Date Last Reviewed: 07/05/2019
	Risk: Safeguarding	Target Risk Date: 31/07/2019

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



Controls in place	Further action to achieve target risk score
<ol style="list-style-type: none"> 1. Regular meetings between the Executive Lead and the Associate Director are in place to ensure effective scrutiny of Safeguarding activity. 2. Refreshed Governance procedures have been established which includes the new Reporting Framework, clear Terms of Reference, with specific emphasis on policies and procedures and training - key themes arising from HASCAS. 3. An appetite for effective Risk Management is being embedded within Safeguarding. Risks are discussed operationally in order to identify and escalate or mitigate issues as they arise. Local Risk Management Procedures (RM04) are being implemented to ensure this process is robust. 4. Emphasis on data analysis is being embedded and encouraged by the production of a Safeguarding Performance Dashboard that allows for the triangulation of trends in Adult and Child at Risk Reports. The 	<ol style="list-style-type: none"> 1. Service reconfiguration is ongoing. Job Descriptions have now been finalised and approved. Advertisement for the Senior Management posts will go live by the end of May 2019. Successful recruitment and appointment to these posts will be key in ensuring that the Safeguarding agenda is fully embedded across BCUHB. 2. A Safeguarding Cycle of Business and Performance Dashboard are being produced which will ensure that scrutiny is given to the right agenda items at the right time, this is due to be finalised and implemented by June 2019. 3. Further structural activity needs to take place to ensure business continuity and stability within the Safeguarding Team on an ongoing basis. 4. A complete review of Phase 1 of Safeguarding policies and procedures has been completed which has identified priority procedures. A second Phase is now underway which will identify a

<p>governance and reporting arrangements will feed through the refreshed Reporting Framework to QSE.</p> <p>5. Safeguarding Communications have undergone review. A new intranet site has been published, alongside a refreshed Safeguarding Bulletin. Governance and accountability arrangements for both have been produced to ensure that content is managed, up to date and relevant.</p> <p>6. The Regional Safeguarding Business Team is now established and the Safeguarding Business Manager is in post who will support the implementation of some of this activity.</p> <p>7. A new structure was agreed in 2017, implementation has taken place throughout 2018. However some senior management positions are still seconded - see further action.</p>	<p>second set of procedures for review in 2019-20.</p> <p>5. A Safeguarding Communications Strategy is being produced which will outline key messages, target audiences and delivery mechanisms for Safeguarding Communications. This will include a presence on the Staff App and the population of external web pages. Completion by August 2019.</p> <p>6. The programme of works relating to the governance and accountability of Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act is under review and implementation of key tasks including signatory training is underway.</p> <p>7. A review of the DoLS structure and service provision will take place and begin on completion of the Safeguarding Structure implementation.</p> <p>8. The appointment of a Named Doctor, Safeguarding Adults is still outstanding. However discussions are underway to resolve by end of June 2019. This post holder will also hold a position on the NWSAB.</p> <p>9. A Training Needs Analysis will be undertaken that feeds into a 2019-2020 Training Strategy. This will ensure that training undertaken engages with the right people in the right place in order to reduce Safeguarding risks. This will be completed by the end of June 2019, with the Training Strategy being ratified by September 2019.</p>
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Assurances	Links to		
	Strategic Goals	Principal Risks	Special Measures Theme
1. Strengthened Governance and Reporting arrangements. 2. Enhanced engagement with partner agencies. 3. Safe and effective data collection and triangulation of organisational data to identify risk. 4. Improved compliance against recognised omissions relating to the review and development of Safeguarding policies and Training materials. 5. Regional Safeguarding Boards.	3 7	PR9	Governance

Quality, Safety & Experience Committee	 GIG Cymru NHS Wales Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board	To improve health and provide excellent care
21.5.19		

Report Title:	Putting Things Right Annual Report 2018/19
Report Author:	Mrs Barbara Jackson, Assistant Director Service User Experience
Responsible Director:	Mrs Deborah Carter, Acting Executive Director of Nursing and Midwifery
Public or In Committee	Public
Purpose of Report:	This annual report has been prepared in line with the Regulations and is intended to provide an overview of the 2018/2019 position in terms of how the Health Board has managed Concerns for the period. It provides an overview of themes and trends emerging from Concerns and a high-level summary of lessons learnt. It is not intended to provide detail on learning in individual cases; this is shared on a regular basis through the Divisional Quality and Safety Groups, the BCUHB Quality and Safety Group (QSG) and the Quality, Safety & Experience (QSE) Committee.
Approval / Scrutiny Route Prior to Presentation:	Prepared in line with the regulations. Unable to present to QSG due to scheduling of the QSE calendar
Governance issues / risks:	Required by 2011 No.704(W.108) National Health Service, Wales The National Health Service (Concerns, Complaints and Redress arrangements) (Wales) Regulations 2011 51 (1)
Financial Implications:	None
Recommendation:	The Committee is asked to approve the annual report

Health Board's Well-being Objectives <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>	√	WFGA Sustainable Development Principle <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	√		
Special Measures Improvement Framework Theme/Expectation addressed by this paper			
Engagement			
Equality Impact Assessment			
The policy reflects national legislation			

Disclosure:

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



ANNUAL REPORT: PUTTING THINGS RIGHT

2018/19

Concerns, Incidents, Compliments, Claims & Redress cases for 2018/19

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EXECUTIVE SUMMARY

INTRODUCTION

The NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 (the Regulations) came into force on the 1st April 2011, to enable Responsible Bodies to effectively handle concerns.

The aim of the regulation was to streamline the handling of concerns and under the '*Putting Things Right*' (PTR) arrangements, all NHS Wales organisations should aim to "investigate once, investigate well", ensuring that concerns are dealt with in the right way, the first time around. The term "Concern" relates to any complaint, claim or reported patient/service user safety incident (about NHS treatment or service)



Rhoi cleifion yn gyntaf
Put patients first

PURPOSE

This annual report has been prepared in line with the Regulations and is intended to provide an overview of the 2018/2019 position in terms of how the Health Board has managed Concerns for the period. It provides an overview of themes and trends emerging from Concerns and a high-level summary of lessons learnt. It is not intended to provide detail on learning in individual cases; this is shared on a regular basis through the Divisional Quality and Safety Groups, the BCUHB Quality and Safety Group and the Quality, Safety & Experience Committee.

BACKGROUND

Sometimes things do go wrong and we let our patients down but concerns remain a rich source of intelligence to support our Goals. We respond to the concerns (complaints, claims and serious incidents) raised in line with PTR, to investigate and ensuring that the concern is dealt appropriately, identifying areas for learning and to improve the quality of care.

EXECUTIVE SUMMARY

BACKGROUND

As a Health Board, our Corporate Goals include:

- Improve the safety and outcomes of care to match the NHS's best
- Respect individuals and maintain dignity and care
- Listen to and learn from the experiences of individuals
- Support, train and develop our staff to excel

CONCERNS CONTEXT AND ACTIVITY

Efforts are made to resolve concerns raised by patients/service users and their carers/relatives as they arise; these are referred to as 'on the spot'. In 2018-19, the Health Board recorded 3,455 concerns, which were resolved 'on the spot'. However, some patients/service users, their carers/relatives choose to make a formal complaint. These totalled 1,408 in 2018/19, a decrease of 18 (>1%) on the previous year.



Dysgu ac arloesi
Learn and innovate

CONCERNS MANAGEMENT

All Concerns are managed in line with the PTR regulations and Being Open principles and policy. Efforts are made to contact a complainant and clarify the issues being raised to ensure we answer their concerns correctly the first time. Where possible, and for cases where there is no allegation of harm, the Health Board will offer the complainant early resolution and resolve these as an 'On the spot'. Complaints managed on this basis must be resolved to the complainant's satisfaction. Should this not be possible it will be managed as a formal complaint in line with PTR.

There has been significant improvement in the number of complaints open overall, and the timeliness of responses. This remains challenging but actions are ongoing to continue to improve.

In terms of incidents, the introduction of the rapid review for all serious incidents is aimed at improving the level, robustness and timeliness of investigations.

EXECUTIVE SUMMARY

COMPLAINTS

During 2018/19 there was a concerted focus on improving the timeliness of resolving complaints. At the end of March 2019 there were 183 (54%) cases open over 30 days out of a total of 342 active cases.

The 30 day target improved through 2018/19; this was however variable ranging from 25% to 40% with an average of 34%. This position was positive in light of the ongoing work to reduce the overall number.

NATIONAL INDICATORS OF CONCERNS MANAGEMENT

In 2018/19, there were 1,408 formal complaints received (and 1,300 closed). The overall performance compliance rates were as follows:

- Complaints acknowledged within 2 working days - 93%
- Complaints responded to within 30 working days – 34% average

COMPLIMENTS

A total of 810 expression of thanks/positive feedback comment cards were received and recorded on the Datix system with many more thank you cards received directly by wards and departments.

PATIENT ADVICE AND SUPPORT SERVICE

The PASS is available at Glan Clwyd Hospital, serving secondary and community services in the central area. The PASS officers will listen to any comments or suggestions service users and the public have, and make every effort to resolve any issues as soon as possible. They also provide details of other organisations that can provide information or advice. It is intended to rebrand this service and extend it to the other areas of the Health Board overtime.



Gwerthfawrogi a pharchu ein gilydd
Value and respect each other

EXECUTIVE SUMMARY

SERIOUS INCIDENTS

A total of 32,458 incidents were recorded onto the Datix System, of these 24,384 (75%) were patient safety incidents of which 867 (2.6%) were recorded as serious incidents and reported to Welsh Government.

These numbers are lower than the previous year.

CLAIMS

During 2018/19, the Health Board received 282 new claims and had a total of 800 claims open. Payments totalled £22,346,261 in damages and claimants costs and £1,051,205 in defence costs with the Health Board contributing £2,965,180 (£25,000 per case) in line with Welsh Government Risk Pool requirements.

These numbers are higher than the previous year.

CLAIMS

The Health Board has a legal duty of care towards those it treats, together with members of the general public and its staff. People who consider they have suffered harm from a breach of this duty can make a claim for compensation and damages against the Health Board, either:

- clinical/medical negligence claims
- personal injury claims



Gweithio gyda'n gilydd
Work together

EXECUTIVE SUMMARY

SUMMARY

The main challenge for the Health Board throughout the financial year has been to manage its concerns in a timely way. The Health Board recognises that staffing issues and significant operational pressures have contributed to some investigations being delayed, and offers its unreserved apologies to those who have been affected.

Significant work has been undertaken to combat this, to include investment to develop the Patient Advice and Support Service (PASS), initially in Ysbyty Glan Clwyd. This will be rolling this out to the other areas during 2019/20. This service provides support, advice and resolution to patients, and awareness of the Service is raised amongst staff, and members of the public, across all hospital sites. The serviced will be rebranded as Patient Advise and Liaison service (PALs) as from April 2019.

During the past financial year the central concerns team received 1,880 concerns, of which 980 were resolved by PASS (with early intervention to the complainant's satisfaction) and 900 concerns required an investigation under PTR.

For detailed information about "Putting Things Right: Raising your concerns about the NHS", please follow the website link :

<http://howis.wales.nhs.uk/sites3/Documents/932/Healthcare%20Quality%20-%20Guidance%20-%20Dealing%20with%20concerns%20about%20the%20NHS%20-%20Version%203%20-%20CLEAN%20VERSION%20-%202020140122.pdf>



Cyfathrebu'n agored ac yn onest
Communicate openly and honestly

SUMMARY

Much work has been undertaken in 2018/19 including concluding a significant number of overdue complaints. There has been a review of the Concerns PTR procedure and the introduction of a rapid review for all serious incidents. This has improved the immediate learning and sets in motion the investigation process in a timelier manner.

EXECUTIVE SUMMARY

SUMMARY

The divisions are focused on putting in place sustainable structures and procedures that assist learning and improvement

Each division has also further developed their governance structures to ensure Concerns are managed as part of the quality and safety structures.

An increased emphasis on contacting complainants directly on receipt of a complaint has been pursued during the year in an effort to resolve complainants earlier, and to ensure the investigation is focused and answers the right questions from the complainant's perspective.

The Health Board is highly committed to improving the patient experience, welcoming feedback from patients and continually improving systems and processes which seek to improve clinical outcomes and experiences for our patients.

For people who work in healthcare, as well as service users, it really does make a difference to know that what is being done has helped to make someone's experience better.

Positive feedback has been received during the year via 'Viewpoint' our real time feedback system, Comment cards and monthly patient questionnaires. Providing easier ways for patients (inpatient and outpatients), their families and members of the public to feedback their experiences, whether good or bad, and improving services based on this information is a priority for the Board.

During 2018 two external reports were received by the Health Board, the HASCAS investigation report and Ockenden Governance Review. These reports include comments and recommendations related to complaints handling. The themes included:

- Respond in a timely manner
- Be clear regarding how to make a complaint
- Be clear what happens once a complaint has been made
- Listen to the complainant
- What support is there for a complainant

COMPLAINTS

Overview arrangements for managing concerns

The Chief Executive has overall responsibility for dealing with concerns. This responsibility has been delegated on a day-to-day basis as described below:

- *The Executive Director of Nursing* has delegated authority on behalf of the Chief Executive to ensure that there is a robust process in place to support the effective management of the concerns process. This transferred from the Director of Corporate Services in May 2017.
- *The Divisional Nurse Directors* for secondary care, Areas and Mental Health services are responsible for the delivery of investigations into Concerns and for ensuring lessons are learnt.
- *A Concerns Champion*, an Independent Board Member, has a strategic and scrutiny role to monitor the Board's handling of concerns.

Overview of the Concerns Process

- In line with the Regulations, the Health Board receives Concerns (complaints) into a single point of contact. All complaints are received by

the Corporate Concerns Hub and reviewed by the relevant Corporate Concerns Team, graded according to the PTR guidance (level 1-5) based on levels of potential harm and relevant consent obtained. All Concerns are entered onto the Datix integrated management system and passed to the relevant Division or corporate function for investigation and to draft a response.

- Incidents are entered directly onto the web based Datix integrated management system by staff.
These are reviewed by senior staff and investigated appropriately. Learning and outcomes should be recorded on Datix and when the senior management team are satisfied the incident is closed on Datix and staff reporting the incident should receive feedback.
- The Regulations promote open and transparent investigations, "Investigate once investigate well". The level and depth of the investigation is proportionate to the grading and complexity of the concern.

COMPLAINTS

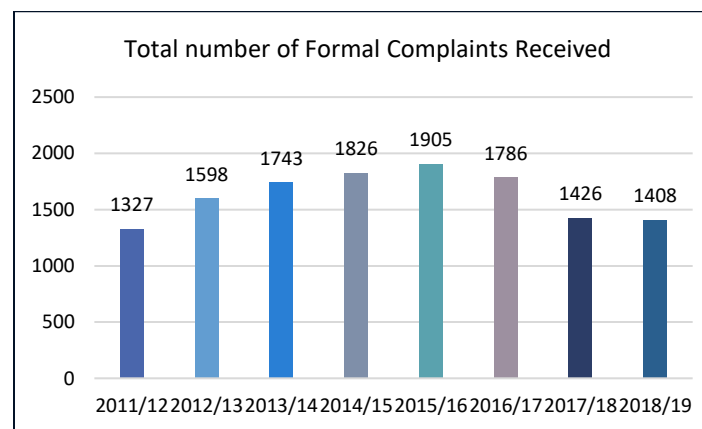
Overview of improvements during 2018/19

- Decrease in total number of complaints and serious incidents open and overdue
- Restructuring of corporate and divisional teams to better manage complains and incidents
- Strengthening of the initial stages of the investigation to identify early learning and actions to make safe
- Review of processes and procedures
- Provision of training programmes related to concerns management
- Introduction of an online complaints form
- Review of response letters for complaints under Putting Things Right
- Audits of all main sites to ensure posters and leaflets available on how to complain
- Develop an updated video clip in BSL to inform people who use BSL of how to make a complaint. This is being developed as part of the All Wales network

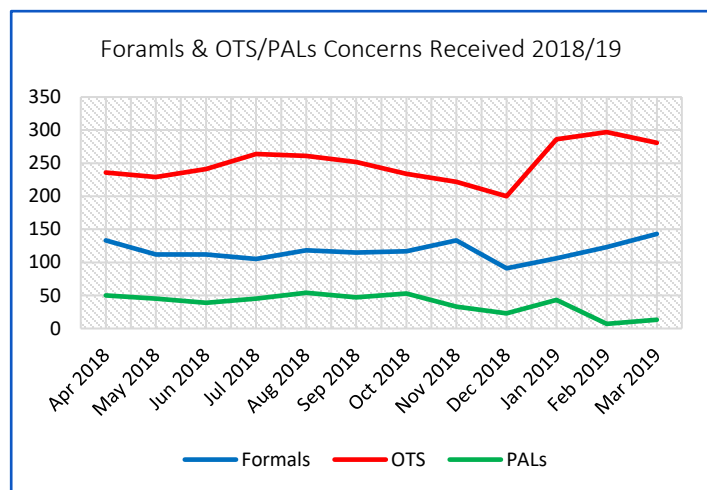
Complaints activity:

In 2018-19, the Health Board recorded 3,455 concerns which were resolved “on the spot” (split between the Concerns and PALs team) this is a decrease from 2017-18 of 692. Every effort is made to resolve concerns raised by patients/service users and their carers/relatives as they arise and figures this year are encouraging that the Health Board has been more effective in this area.

However, some patients/service users, their carers/relatives choose to make a formal complaint. These totalled 1,408 in 2018/19, a decrease of the previous year of just over 1%.



COMPLAINTS



Complaints received are categorised by each Division – Area (x 3), Secondary Care including Women's and Childrens services, and Mental Health and Learning Disabilities (MHLD).

The Health Board launched an online form to make sharing concerns with us easier. This can be found at -

<https://www.smartsurvey.co.uk/s/BCUHBconcernsform/>

There is a requirement to acknowledge the receipt of a formal complaint within 2 working days.

Complaints Acknowledged in 2 Working Days

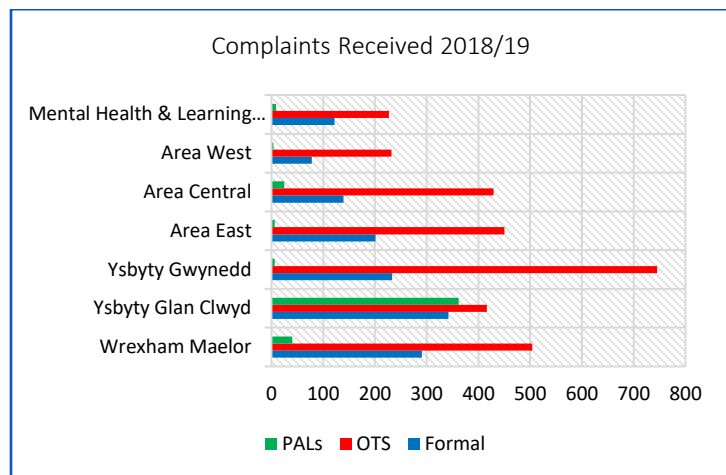
93%

Of the total formal complaints received (1,408), 1,312 were acknowledged within 2 working days against a target of 100%.

The 100% target was not achieved in 2018/19 due to a number of factors including staffing issues including sickness/vacancies in the Corporate Team and delays in complaints received outside of the Corporate Hub being forwarded to the Corporate Concerns Teams for acknowledgement.

Actions have been taken to ensure all staff are aware of the need to forward complaints received outside of the Hub to the team as soon as possible. However, complainants do continue to write to other addresses, despite extensive information available on how to complain.

COMPLAINTS



Complaints Response times

34% (ave)

The Regulations require complaints to aim to be responded to within 30 days of receipt. Of the total 1,408 formal complaints received of which 1,086* (86%) have been closed. Of these, 430* (34%) were responded to within 30 working days.

**Excluding March 2019, as concerns received still within time for investigation*

93%

For more complex cases the Regulations allow an extended time for response of up to 6 months, but require the complainant to be kept informed of progress throughout the process. During 2018/19, 93%* of cases were closed within 6 months.

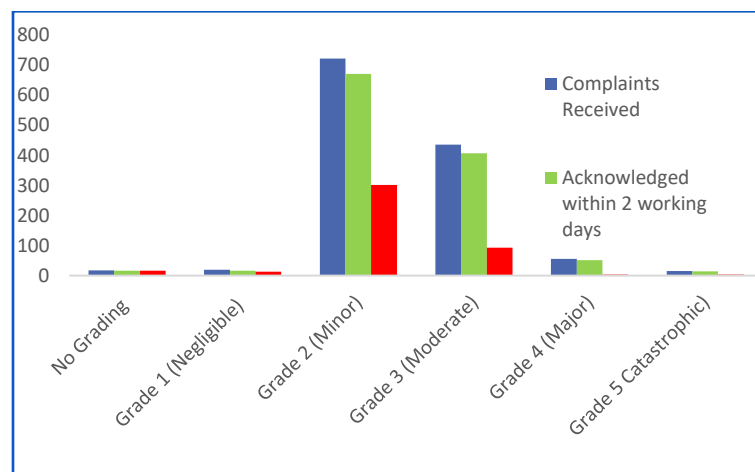
Significant effort was put into closing all historic complaints that remained open and this was monitored as part of the Special Measure Framework.

Complaints by Initial Grading

All formal complaints received are graded on receipt in line with the All Wales grading framework and this informs the level of investigation required for the complaint. The grading represents the assessed level of harm on an ascending basis with grade 1 being no harm.

COMPLAINTS

In 2018/19* the majority of complaints received were graded at grade 2.



**Excluding March 2019, as concerns received still within time for investigation*

Of the formal complaints received in 2018/19, the top 3 reasons for making a complaint were:

On The Spot Concerns – Most received by subject	Total
Access, Appointment, Admission, Transfer, Discharge	1139
Consent, Confidentiality or Communication	884
Abusive, violent, disruptive or self-harming behaviour	274

Formal Concerns - Most received by subject	Total
Treatment, procedure	395
Consent, Confidentiality or Communication	314
Access, Appointment, Admission, Transfer, Discharge	269

Every complaint offers the Health Board an opportunity to learn and improve the services we offer to our service users.

Examples of things changed as a result of a complaint are:

COMPLAINTS

Examples of learning from complaints:

You Said	We Did
Concerns regarding patients on an End of Life (EoL) Pathway who have not been triaged appropriately (i.e. prioritised) when contacting GP Out of Hours (GPOOH) Service	As a result of patient and family experience, GPOOH have implemented systems to be more alert to patients on an EoL pathway. Systems are now in place to put an alert on the IT system, allowing for review of patients known to be on EoL pathway. This enables the service to prioritise better by blocking off appointments (for a GP to attend a patient at home if required). Similarly, District Nurses may be asked to attend if patients and family require input and support to ensure that all efforts are made to keep patients in their own home and in accordance with their wishes.
You said that waiting times in our Emergency Department were too long	We have introduced a Single Integrated Clinical Assessment & Triage Service that has ensured that only patients who absolutely need to be in the Emergency Department are conveyed to hospital. So far, about 750 unnecessary admissions to hospital have been avoided.
Patients have complained that we have not been taking enough notice of patient's likes and dislikes particularly if the patient has a diagnosis of dementia.	The Health Board has relaunched the 'This is me' document that is used to provide details about a person living with dementia and ensures the ward staff understand more of a patient's personal history and background including details of a person's cultural and family background.

P.A.S.S.



A regular report on themes and trends from the PASS service is provided to the Hospital Management Team to support and inform the improvements to services on an ongoing basis.



Theme	No Comments	Opinions	
Communication	2403	-ve 1123 opinions	+ve 3491 opinions
Pain	129	-ve 188 opinions	+ve 180 opinions
Treatment	2418	-ve 937 opinions	+ve 5052 opinions
Medication	125	-ve 95 opinions	+ve 109 opinions
Discharge	405	-ve 261 opinions	+ve 497 opinions
Disturbance	99	-ve 95 opinions	+ve 116 opinions
Nutrition and Hydration	808	-ve 382 opinions	+ve 1049 opinions
Respect & dignity	715	-ve 352 opinions	+ve 1230 opinions
Staff Behaviour	8108	-ve 2785 opinions	+ve 13857 opinions
Environment	1160	-ve 707 opinions	+ve 1649 opinions
Efficiency	6165	-ve 2333 opinions	+ve 9870 opinions
Improvement	1606	-ve 1008 opinions	+ve 2637 opinions

HASCAS & OCKENDEN REPORTS

Independent Investigation Completed by HASCAS Consultancy Limited

In September 2015, the Health Board commissioned HASCAS Consultancy Limited to lead an independent investigation in relation to the complaints, concerns and professional regulation and employment issues arising from the significant failings in care on Tawel Fan ward.

HASCAS Consultancy Limited published the Lessons for Learning Report on 3rd May 2018, which provided the Health Board with a full, evidence-based view that is the result of a comprehensive investigative process which included over 100 interviews of families and staff and reviewing of over half a million pages of information including police transcripts, medical records, staff records and corporate records.

The Ockenden Review of Governance Arrangements published in July 2018 provided an independent governance review relating to Tawel Fan ward, prior to closure and current governance arrangements in older people's mental health

What the Health Board did next

Putting Things Right (PTR)

Following release of the Lessons for Learning Report, the Health Board commenced the work of sharing the individual patient reports with Tawel Fan patients and families. Each of the individual patient reports were received between May and August 2018 and the Health Board worked through the individual patient reports to produce an accompanying PTR response letter.

All active cases for the 105 individual patient reports were successfully delivered to Tawel Fan patients and families between June and September 2018.

In terms of Redress, of the total 105 reports received, 60% were Regulation 24 (determined no harm caused) and 40% were Regulation 26 (determined harm caused).

Between June and October 2018, 19 meetings have been held with patients and/or relatives to review their individual report and Putting Things Right (PTR) letter.

HASCAS & OCKENDEN REPORTS

In terms of the Ockenden report, the recommendations were accepted by the Health Board, as were the recommendations of the HASCAS report and work streams to address the improvement required were put in place.

Commencement of the Improvement Group and Stakeholder Group

Gill Harris Executive Director of Nursing & Midwifery, established a taskforce comprising an Improvement Group and a Stakeholder Group in August 2018. The Improvement Group meets bi-monthly and monitors the actions identified for each recommendation, led by an operational lead.

The Stakeholder Group, which is a subgroup of the Improvement Group, has membership from representatives of the Community Health Council, Bangor University, St Kentigern Hospice, North Wales Police, North Wales Local Authorities, Community Voluntary Councils, North Wales Adult Safeguarding Board and Care Forum Wales, as well as Tawel Fan family members. The aim of the group is to provide external scrutiny and input to guide the work of the improvement group.

HASCAS and Ockenden recommendations- one year on

The work of the Improvement Group and Stakeholder Group has since evolved due to the significant work undertaken to drive forward the recommendations.

The Stakeholder Group meets on a quarterly basis and Stakeholder members have started to engage directly with operational leads and respective working groups established for some of the recommendations and contribution is being made to some of the work.

Progress has been made with each of the 36 HASCAS and Ockenden recommendations, with 20 recommendations on track to deliver and some due to complete, 13 are in progress and require some additional focus or support to address some challenges and 2 are completed; these are relation to Board Development and the recruitment of the second Consultant Nurse for Dementia (due to commence in the role on 17th June 2019)

OMBUDSMAN

Public Service Ombudsman for Wales (PSOW)

Complainants, if not satisfied by the Health Board response to their complaint, can ask the Public Service Ombudsman Wales to undertake a further independent investigation.

In 2018/19, 137 complainants made the decision to approach the Ombudsman. Of those 137 cases, the Ombudsman decided to investigate 49 cases, 37 enquiries were received where the Health Board were requested to provide PSOW with information, 22 cases were not investigated by the Ombudsman and 29 were dealt with as a Proposal where the Health Board agreed to carry out actions in order to resolve outstanding issues. These figures are slightly lower than 2017/18, when 146 people approached the Ombudsman who decided to investigate 70 cases; during 2016/17, 134 people reported their case to the Ombudsman with 59 cases being investigated.

Of the 49 cases investigated during 2018/19, 9 have been either fully or partially upheld and 7 were not upheld. Information on the remaining 33 cases has not yet been received from the

Ombudsman's Office who continue with their investigations.

Further details of the cases reviewed by the Ombudsman will be available online in the Public Service Ombudsman for Wales Annual Report at: <https://www.ombudsman.wales/annual-report-accounts/>

Public Interest S16 Cases

The PSOW does not routinely publish his reports, however where there is significant concern regarding the matters investigated, the PSOW will issue a Public Interest Section 16 report.

BCUHB have not received any Section 16 reports during 2018/19 compared to 2017/18 when the Ombudsman found serious failings in two cases from BCUHB, which were reported as Section 16 public interest reports.



REDRESS

Redress

Whilst the Health Board always strives to ensure it delivers the best possible care and treatment, sometimes things may not go as well as expected. When that happens, there are Regulations which the Health Board must follow to consider whether what has gone wrong has caused the patient any harm. If it has, we have a duty to try to make it better. This is called Redress, and can include one or more of the following:

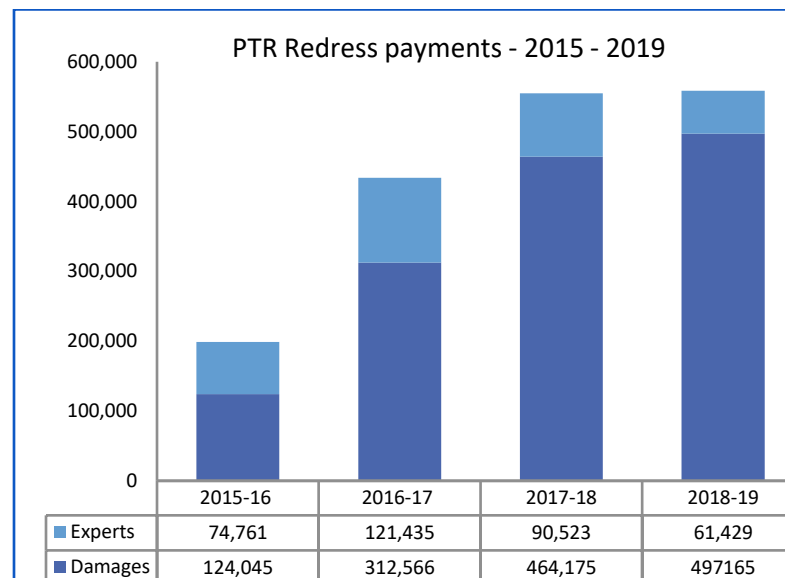
- A full explanation of what happened
- an apology
- an offer to provide care or treatment (where appropriate)
- a report on action which has been, or will be taken to prevent similar cases arising
- and/or financial compensation (maximum £25,000).

The Health Board concluded 94 cases under the Putting Things Right (PTR) Redress Regulations in 2018/19 compared to 81 during 2017/18:

- Financial compensation as redress - 75
- Apology only as redress - 1

- Concerns which exceeded the amount of financial redress allowed under the PTR limit - 18

Putting Things Redress Costs



Learning from Redress cases:

For each case where something has gone wrong and it has caused harm, evidence of action taken in an endeavor to reduce the risk of recurrence had to be provided to the Welsh Government (Welsh Risk Pool with effect from July 2018).

Examples of learning from the redress cases concluded within 2018/19 include:

REDRESS

What went wrong	Impact on Patient	Action Taken
Six month delay in patient obtaining correct cushion for motorised wheelchair	Deterioration in spinal posture as a result of being bed bound whilst for cushion	System introduced to ensure mobility equipment is quality checked by specific staff
Patient fitted with IUS (coil) without pregnancy being ruled out	Patient suffered a miscarriage	Changes implemented in how clinics are managed and patients assessed
Delay in diagnosing prostate cancer	Patient caused additional symptoms unnecessarily	Multidisciplinary review of Urology services produced plan for future provision of services
Patient did not receive procedure she had consented for and was discharged without being told.	Patient continued to experienced symptoms and required further surgery	Clinical Director sent a communication to all medical staff to ensure all patients are given a full de-brief after surgery
Failure to explain the potential side effects and complications before administering medication to patient.	Extravasation caused discolouration of patient's arm	New information provided by the University of Wales in reducing risk of staining following extravasation of an iron infusions, shared with staff
Patient discharged without medical review following episodes of hypoglycemia and elevated NEWS	Patient would not have died when she did had she remained in hospital	The BCUHB algorithm for the hospital management of hypoglycaemia in adults with diabetes has been reviewed and amended A ward development plan has been written in conjunction with senior hospital nursing staff to improve care and documentation in relation to patient dietary requirements, discharge, and monitoring of patients with diabetes and acute illness.

INCIDENTS

During 2018/19 a total of 32,458 incidents have been reported, of which 24,384 were patient safety incidents.

When Incidents are reported they are scored using a severity matrix. The table below sets out the recording of all patient safety incidents reported.

<i>Severity</i>	<i>2017/18</i>	<i>2018/19</i>	<i>Increase/Decrease (%)</i>
Negligible	18,358	18,073	(-) 1.5%
Minor	3,770	3,888	(+) 3%
Moderate	2,201	2,203	(+) .09%
Major	276	140	(-) 49%
Catastrophic	112	78	(-) 30%

*These terms are standard terms used as part of the grading system within the electronic recording system.

Numbers of serious incidents have decreased significantly over the past year.

Of the 78 cases graded as catastrophic, the table below shows the reported reason for these. Each incident is investigated to the appropriate level guided by the grading.

In 2018/19 a weekly incident review meeting has been established. This is chaired by the Associate Director of Quality and Assurance and attended by all divisions across BCUHB. The meeting reviews all serious incidents reported on Datix in the previous 7 days. These are broadly categorised as those graded as catastrophic, major, Never Events however any incident deemed by the division to need discussion can be presented. Upcoming inquests will also be reviewed and all serious or significantly overdue complaints.

INCIDENTS

Incident description	Lessons learned	Actions
Delay in diagnosis of fracture following an initial assessment in the Emergency Department (ED)	<ul style="list-style-type: none"> • Importance of assessing both hip and knee when patients complain of pain due to the possibility of referred pain. • A full joint examination (hip/knee) should be carried out and clearly documented in the case notes, even if there is no suspicion of fracture, or if the x-ray shows 'normal' appearances. • Admission discharge transfer (ADT) team involvement is recommended for all elderly patients with a history of fall (this service is available in ED) 	<p>Development of flow-chart within ED to be followed by clinicians when assessing patients presenting in ED after a fall.</p> <p>The learning was shared via Departmental Governance meetings as well as being communicated widely amongst ED clinical staff.</p>
Delay in identifying the need for emergency Caesarean section in a patient admitted with decreased fetal movement (DFM) and an abnormal fetal heart monitoring (Cardiotocography CTG).	<ul style="list-style-type: none"> • Identification and consideration of risk factors, such as reduced fetal movements, must be standard practice when reviewing CTG. It is also important to ensure an holistic approach, including face to face review taking into account risk factors for both mother and baby when making management decisions. 	<p>Learning was shared via directorate governance meetings.</p> <p>A review of the Caesarean Section Integrated Care Pathway is currently being undertaken by the Improvement Midwife and BCUHB Pathways Lead.</p>

INCIDENTS

Incident description	Lessons learned	Actions
Inpatient falls, some resulting in harm are all are investigated in line with BCUHB policies.	<p>Common learning from falls includes:</p> <ul style="list-style-type: none"> • failure to complete the Falls Pathway fully – and no mechanism in place to alert staff that elements of the pathway remained incomplete • Failure to complete next of kin information in the Falls Risk document – important in the presence of a dementia diagnosis as in this case. • Failure to utilise a 'Post Falls' sticker in the patient notes. The sticker was being trailed in this area at the time of the fall. 	<p>All ward staff have been reminded of the importance of completion of all BCUHB documentation to the required standard. This has been achieved via the ward team meeting, by the Lead Nurse, Deputy Lead Nurse and Ward Manager.</p> <p>Staff were also reminded that the 'Post Falls check sticker' must be used for every patient following a falls incident.</p> <p>Compliance is monitored by way of:</p> <ul style="list-style-type: none"> • Spot checks • Weekly quality and safety walk rounds (Deputy Lead Nurse) • Monthly documentation audits • Monthly quality and safety audit. <p>Learning from previous falls has identified the importance of using patient Falls Tab Alarms; ensuring appropriate, non-slip footwear is worn; increasing staffing levels in line with increased care needs of patients on the ward; use of high/low beds to minimise the risk of harm should a patient fall from bed.</p>

INCIDENTS

All serious incidents recorded on Datix go through a final validation process prior to uploading to the National Reporting and Learning System (NRLS). This is carried out on completion of the investigation. A significant number of incidents are downgraded from catastrophic if the investigation concludes that BCUHB did not cause harm. The validation work for 2018/19 had been partially completed at the time of preparing this report (64 of the 78 not validated as still under investigation), thus the numbers of confirmed catastrophic incidents is very likely to be lower than reported above.

WELSH GOVERNMENT REPORTABLE INCIDENTS

Welsh NHS bodies are required to report all serious patient safety incidents to the Improving Patient Safety Team of the Welsh Government (WG) within 24 hours of the incident.

867 incidents were reported (excluding no surprises/sensitive issues) to Welsh Government in 2018/19. This is a decrease of 72 on 2017/18. By the end of March 2019 there were 291 still open for 2018-19, 223 of which were overdue. This represents a closure rate within 60 working days of 22%.

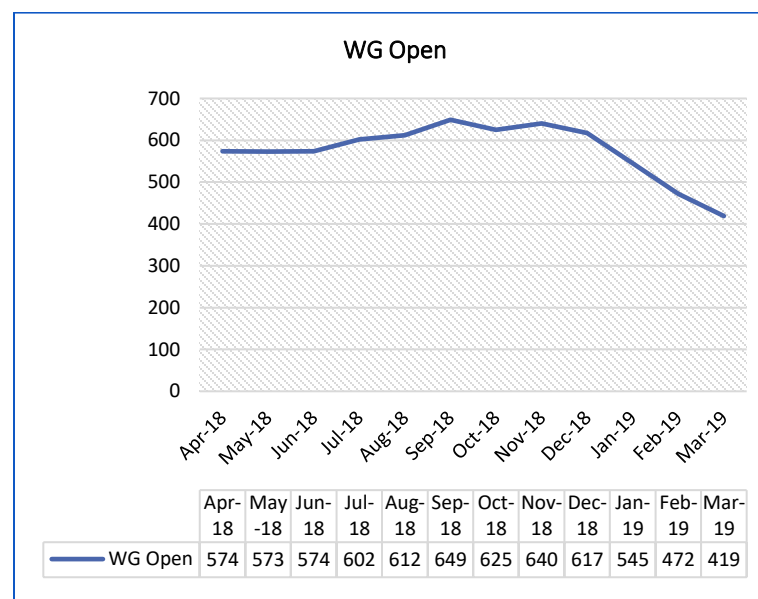
Of those reported in 2018/19 the top 3 reasons for reporting were:

Grade 3 or above hospital acquired pressure ulcer develops - 484 (*down 5% on previous*)

Unexpected death whilst under the direct care of a health professional - 139 (*up 2% on previous*)

Patient falls resulting in harm/death to patient – 116 (*up 2% on previous*)

The outstanding historic cases remain open mainly due to other statutory investigations such as Protection of Vulnerable Adults (POVA) investigations preventing internal investigation being concluded. Further work has been progressed to ensure that all historic cases in the gift of the Health Board are closed.



NEVER EVENTS

Some serious incidents are categorised by the Department of Health and Welsh Government as “Never Events” (things that are largely preventable and should never happen).

In 2018/19 there were 8 ‘Never Events’ recorded:

- Misplaced Naso or oro-gastic tubes
- Overdose of Methotrexate for non-cancer treatment
- 2 incidents recorded as retained foreign object post-operation
- Wrong route administration of medication
- 3 incidents recorded as wrong site surgery

All of these cases were fully investigated and closed with identified learning.

Case 1 – 14.05.18

Never event classification: Wrong site surgery

Incident: biopsy from wrong side

The learning included:

- World Health Organisation (WHO) Safer Procedure checklist modified for all procedures undertaken in the department;

- When site not clear / secondary issues in same area – photographs are taken with patient’s consent and marked to indicate site that biopsy is to be taken from.

Case 2 – 21.06.16

Never event classification: Overdose of Methotrexate for non-cancer treatment

Incident: Poor transcription of a drug chart

The learning included:

- Consultant ward rounds include review of the drug charts **on every occasion** (drug charts will not go to pharmacy at these times);
- additional pharmacy staff capacity has been committed to long-term to improve clinical checking of charts;
- Relevant staff have been retrained on the transcribing policy;
- Methotrexate prescribing and administration has been added into the back to basics training for registered nurses.

NEVER EVENTS

Case 3 – 10.08.18

Never event classification: Retained foreign object post-operation

Incident: cotton wool ball retain following a clinical procedure

The learning included:

- Gauze balls (radio opaque) as opposed to cotton wool balls now in use across the 3 sites;
- Pre packed packet of 5 balls now used to aid counting;
- Ball count completed prior to and after procedure and recorded.

Case 4 – 21.08.18

Never event classification: Misplaced naso or oro-gastric tubes

Incident: misplacing of an intubation tube

The learning included:

- routine use of capnography (the monitoring of the concentration or partial pressure of carbon

dioxide (CO₂) in the respiratory gases) implemented for all intubated patients;

- The anesthetic induction programme for Doctors reviewed to ensure awareness of all high-risk areas are included.

Case 5 – 19.09.18

Never event classification: Wrong route administration of medication

Incident: a local anesthetic nerve block administered to the wrong site

The learning included:

- Clinical Alert 'Stop before you Block' redistributed to all Clinical staff;
- The induction process for new doctors now includes mentorship and close monitoring procedures;
- 'Stop before you block' checks added to WHO Surgical Safety Checklist

NEVER EVENTS

Case 6 – 25.09.18

Never event classification: Wrong site surgery

Incident: a local anesthetic nerve block administered to the wrong site

The learning included:

As for case 5 – two incidents investigated jointly

Case 7 – 25.09.18

Never event classification: Wrong site surgery

Incident: cardiac catheter inserted in wrong blood vessel

The learning included:

- Relevant Standing Operating Procedures written to ensure universal approach to care in line with national guidance
- training of clinical staff as appropriate

Case 8 – 07.12.18

Never event classification: retained foreign object post operation

Incident: guidewire for a central line not removed as required

The learning included:

The incident was confirmed as human error and in fact the clinical involved identified to error themselves.

- Clinical alert issued to remind other clinicians
- Individual undertook reflection and learning
- Signed 'sticker' added to case notes confirming removal of guidewire

HER MAJESTY'S CORONER

Inquests

There are many reasons why the Coroner may hold an inquest when someone dies and the Health Board will provide evidence as requested by the Coroner. In 5 cases the coroner was critical of the care provided and action has been taken to address these concerns.

The relationship with the North Wales Coroners and their officers has continued to develop, with the Heads of Concerns (previously known as the Senior Investigation Managers) being the main Health Board point of contact. The Coroners have previously expressed concern regarding the timeliness of the submission of Incident reports and also regarding assurances that appropriate actions had been taken. By improved utilisation of the DATIX system there is now a cross reference between Coroners' Inquests and incidents and complaints investigation.

289 inquests were held in relation to patients under the care of the Health Board during 2018/19.

Coroner's Rule 28 Reports

The Coroner has a statutory duty to issue a report to any person or organisation where it is their opinion that action should be taken to prevent future deaths in similar circumstance. These were known as "Reports on actions to prevent future deaths – Rule 28"

The Health Board has been issued with 5 rule 28 reports during 2018/19, which are sent directly to the Chief Executive for action. Each of these requires a formal response from the Health Board within 56 days outlining actions taken by the Clinical teams and managers to assure the Coroner that all areas of concern have been resolved.

Case 1 – 17.05.2018

The report expressed concerns in regards to a number of factors including (but not exclusively) capacity and patient flow problems, staffing issues and administrative/escalation failures, there was a delay in the patient being assessed and treated, and the patient's condition deteriorated, and sadly the patient passed away in the early hours of the following morning.

HER MAJESTY'S CORONER

Learning in this case related to the following

- The Health Board has revised the model for investigating serious incidents
- The Health Board has introduced a weekly Incident Review Meeting; the meeting is chaired by the Associate Director of Quality Assurance and attended by senior staff
- Project Management approach to be used when conducting a comprehensive investigation with milestones for completion

Case 2 – 12.06.2018

The report raises issue of ambulance delays, admission to the Emergency Department/availability of resources/patient flow and the multi factorial problems associated with cases of this nature

Learning in this case related to the following

- Work to improve assessment times / flow in ED

Case 3 – 26.06.2018

The report raises issue of ambulance delays, admission to the Emergency Department/availability of resources/patient flow

and the multi factorial problems associated with cases of this nature

Learning in this case related to the following

- Work to improve assessment times / flow in ED

Case 4 – 12.09.2018

The report raises issue of ambulance delays, admission to the Emergency Department/availability of resources/patient flow and the multi factorial problems associated with cases of this nature

Learning in this case related to the following

- Work to improve assessment times / flow in ED

Case 5 – 11.02.2019

The report raises issue of ambulance delays, admission to the Emergency Department/availability of resources/patient flow and the multi factorial problems associated with cases of this nature

Learning in this case related to the following

- Work to improve assessment times / flow in ED

CLAIMS

Claims Management

The Health Board has a legal duty of care towards those it treats, together with members of the general public and its staff. People who consider they have suffered harm from a breach of this duty can make a claim for compensation and damages against the Health Board, either:

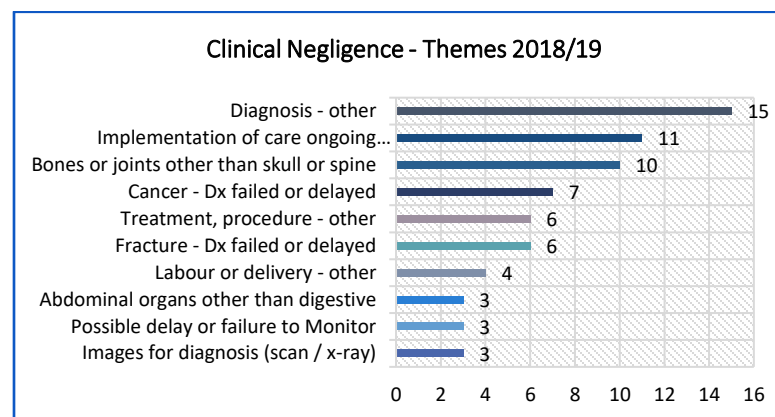
- clinical/medical negligence claims
- personal injury claims

Clinical Negligence and Personal Injury claims are managed by the Health Board on the basis of legal advice provided by NHS Wales Shared Services Partnership Legal and Risk Services. The Welsh Risk will reimburse the Health Board for all losses incurred above an excess level of £25,000 on a case by case basis.

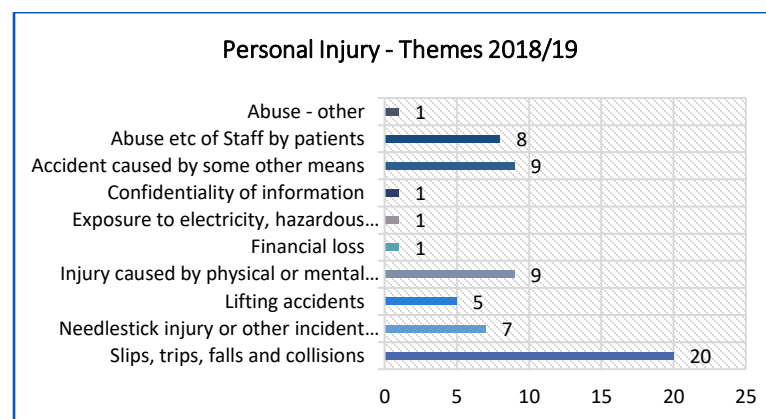
There have been a total of 282 new claims opened between 1st April 2018-31st March 2019.

Of the new claims opened 220 were Clinical Negligence and 62 were Personal Injury claims.

Of the 220 Clinical Negligence claims, the following themes have been identified during 2018/2019:



Of the 62 Personal Injury claims the following themes have been identified during 2018/2019:



CLAIMS

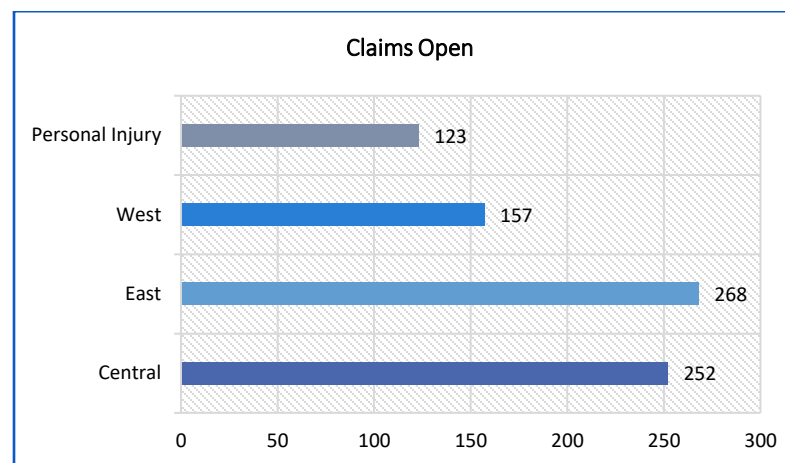
Comparison of Years

In recent years, the Health Board has witnessed a decrease in the number of new claims opened, with a notable decrease in Staff Personal Injury claims.

Open Claims

There has been a decrease in the number of claims received by the Health Board in 2018/19. Improved data collection within the claims function is now in place to ensure accurate monitoring and to improving the quality of trends analysis.

There were a total of 800 open claims in March 2019.

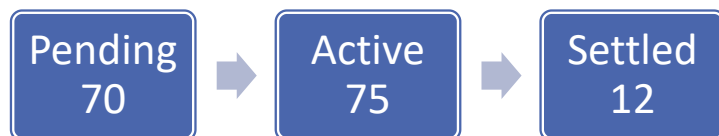


*Those listed as west/east/central are clinical negligence claims

As would be expected the largest number of open claims related to Surgery, Specialist Medicine and Women's Maternal Care. This is not an unusual profile of specialties within the NHS.

CLAIMS

A change in working practice has been adopted in the West supported by the Welsh Risk Pool and has provided good results. This approach will continue to be rolled out across the Health Board. The new way of working in the West has allowed the Team to provide more detailed information on their cases:



Damages Paid – All Wales Trend Analysis

During 2018/19, the Health Board received 282 new claims and had a total of 800 claims open; a decrease of 12 and a decrease of 12 claims respectively on 2017/18.

Payments totalled £22,346,261 in damages and claimants costs and £1,051,205 in defence costs with the Health Board contributing £2,965,180 (£25,000 per case) in line with Welsh Risk Pool requirements.

Damages Paid

MEDICAL NEGLIGENCE (CASH PAYMENTS LOSSES EXC. REDRESS)



	Damages	Defence	BCU Contribution	WRP
■ 2016/17	11,168,199.45	489,558.53	1,583,626.59	(10,074,131.39)
■ 2017/18	14,097,807.67	821,528.96	1,958,648.33	(12,960,688.30)
■ 2018/19	21,960,591.00	911,803.00	2,541,815.00	(20,330,579.00)

PERSONAL INJURY (CASH PAYMENTS LOSSES EXC. REDRESS)



	Damages	Defence	BCU Contribution	WRP
■ 2016/17	501,749.28	113,832.06	289,915.03	(325,666.31)
■ 2017/18	808,368.30	194,285.47	576,766.13	(425,887.64)
■ 2018/19	385,670.00	139,402.00	423,365.00	(101,707.00)

CLAIMS

Learning

Learning from claims and action taken is required to be evidenced to the Welsh Risk Pool once a claim is settled in an endeavour to reduce the risk of recurrence.

Examples of learning from concluded clinical negligence claims within 2018/19 include:

Failings identified	Action taken
Failure to diagnose fracture in ED	<p>The orthodox method of scaphoid examination is taught to all new doctors starting in the ED.</p> <p>Since the time of this incident, we have also expanded the number and working hours of our Emergency Nurse Practitioners, who now see the majority of limb injuries attending the ED.</p> <p>Scaphoid examination is also specifically taught during their training.</p> <p>The usual method of scaphoid examination is also recorded in the Oxford Handbook of Emergency Medicine (several copies of which are available in the department).</p> <p>A one-day Minor Injuries course at YG last year. Consultant gave a talk on upper limb injuries in adults, with a specific focus on the injuries which are easiest to miss.</p> <p>The practice is now that X-ray generate a list of examinations done for the ED each day and the receptionists mark off the reports as they arrive. After a week, they notify X-ray of any reports that have not arrived and these are then delivered. This was the product of months of effort and will reduce the number of abnormal x-rays which go unnoticed.</p>

CLAIMS

Failings identified	Action taken
<p>1. Incorrect interpretation of radiology images.</p> <p>2. Equivocal radiology report not discussed in MDT meeting and Specialist opinion not sought before changing patient's care from curative to palliative</p>	<p>1. To be discussed in discrepancy meeting</p> <p>2. Health Board to bring in Human Factors training</p> <p>3. Lessons Learned Summary developed and shared with Clinical Leads</p>
Careful use of diathermy during dissection of Calot's triangle and if possible the use of dissecting scissors	An audit on consents on patients undergoing laparoscopic cholecystectomy undertaken. Annual audit on laparoscopic cholecystectomy (elective and emergency) in terms of complications and return to theatre will be undertaken.
Claimant suffered a grade 4 pressure sore on her left heel as well as a sacral pressure sore which persisted until her death.	<p>1. Nurses reminded of the importance of assessing all pressure areas on admission in order that appropriate action can be taken and patient's provided with the appropriate care, treatment and monitoring.</p> <p>2. Audit to be undertaken to review the action taken with regards to the assessment and treatment of pressure areas following admission.</p>
<p>Failure to refer patient to liver centre following CT scan</p> <p>Failure to arrange follow up appointment following CT scan</p>	<p>To put a system in place to ensure results are reviewed and acted upon appropriately.</p> <p>Consultants are now encouraged to have a system in place to ensure results are acted upon in a timely manner. A log of all requests are kept by the secretaries and they are marked off as the procedures and performed and acted upon.</p>

CLAIMS

Failings identified	Action taken
Twice appointments were delayed when should have been urgent	Papers relating to eye health care presented to Board outlining proposals for the future model to ensure improved eye care for patients Eye Care Measure an All Wales initiative introduced
Screening tests not done in GP Out of Hours Ophthalmology lost to follow up	Medical Advisor for West to include case in newsletter to ensure all clinicians aware that in rare circumstances to think of contributing factors to the presenting complaint such as e.g. diabetes in infected wounds. Papers relating to eye health care have been presented to Boards outlining proposals for the future model to ensure improved eye care for patients Eye Care Measure an All Wales initiative introduced.

Key achievements in claims

The Executive Team for the Health Board now have a greater involvement in the financial approval of claims. A new process has been developed ensuring Executive approval is obtained on all claim payment and authority requests over £100,000.

A report of cases where authority has been provided to agree liability and settle damages and costs has also been put in place and is sent to the Associate Director of Quality Assurance on a weekly basis.

As mentioned above a change in working practice has been adopted in the West supported by the Welsh Risk Pool as part of an All Wales pilot which has provided good results. This approach will continue to be rolled out across the Health Board. The new way of working in the West has allowed the Team to provide more detailed information on their cases and they are able to provide accurate evidence of learning to the Quality and Safety Meeting.

WAY FORWARD AND CONCLUSION

Context

A significant amount of work has already taken place to address challenges in performance with increased scrutiny and challenge. The Concerns systems and processes have been reviewed on an ongoing basis, with the strengthening of the rapid review and of the Being Open approach improving the quality of investigations.

The further development of the harms dashboards has allowed greater viability of data and increased the opportunities for this to lead improvement and prevent further harms. Data is pulled from the Datix system.

The changes to the corporate and divisional teams to better support complaints and incident management is bedding in and will be key to supporting the culture of learning within the Health Board.

The Health Board is keen to reduce the need for people to complain, by learning and improving. The learning from complaints, incidents and claims is a continuous process of improvement with learning being shared locally, organisationally and nationally.

However should people have the need to complain we are also keen to improve people's experiences of the complaints process. In 2019/20 the Health Board will be introducing a regular system to gather feedback from complainants regarding their experiences and this will inform how we manage complaints moving forward.

The Health Board does however acknowledge that challenges still exist in relation to our systems, responsiveness and systematic learning.

Plan for 2019/20

A plan for 2019/20 is incorporated within the Annual Operational Plan. The Key Actions/ Deliverables in 2019/20 are:

We will make continual improvement in the management of concerns, specifically:-

- To reduce the backlog of complaints and incidents and establish real-time working
- To review the complaints and incidents processes to make them easier to implement for staff

WAY FORWARD AND CONCLUSION

- To further develop the model for organisational learning
- Conduct a training needs analysis in order to support the development of an effective training programme
- To gain feedback from complainants about their experience of raising complaints with the Health Board
- To rebrand the PASS service and rollout as PALs across the remaining area
- To further embed Being open and the principles of duty of candour
- To continue to build the harms dashboard to include patient experience data.



Report Title:	Safeguarding and Protection of People at Risk of Harm Annual Report 2018-19
Report Author:	Michelle Denwood, Associate Director of Safeguarding
Responsible Director:	Mrs Deborah Carter, Interim Executive Director Nursing and Midwifery
Public or In Committee	Public
Purpose of Report:	<p>This annual report 2018-19 provides an overview of progress made by the Corporate Safeguarding Team in relation to safeguarding adults, children and young people at risk of harm, Violence against Women, Domestic Abuse, and Sexual Violence (VAWDASV), Deprivation of Liberty Safeguards (DoLS), Dementia and the overarching safeguarding activities under the remit of the Harm agenda.</p> <p>It also sets out the strategic priorities of the Corporate Safeguarding Team for 2019-20 demonstrating our commitment to continual improvement.</p>
Approval / Scrutiny Route Prior to Presentation:	<p>The Annual Safeguarding Report has had full engagement with the Corporate Safeguarding Team as part of its development.</p> <p>It has engaged with and been informed by relevant partner agencies such as the North Wales Safeguarding Board for both Adults and Children.</p> <p>The content has been developed through the Safeguarding Governance and Performance Group, and the Safeguarding Reporting Framework as part of its approval process.</p> <p>A consultation has taken place with the Corporate Safeguarding Team to develop their proposals for inclusion in the 2019-2020 Priority Action Plan.</p> <p>This process captures the specialist knowledge of the Corporate Safeguarding Team and ensuring that changes in national, regional, policy and legislative changes are reflected in activity planned for 2019-20.</p>
Governance issues / risks:	All activity undertaken in 2018-19 and planned for 2019-20 contributes to reducing and mitigating safeguarding risk.

	<p>Early identification of risk has been embedded throughout the Safeguarding Reporting Framework and the Area/Secondary Care Forums ensuring that risks are identified and escalated as they arise. There are currently six (6) divisional risks identified on the Corporate Risk Register, and each has a clear mitigation plan.</p> <p>There is only one Corporate Level risk identified within this report. This currently has a Risk Score of 16, with a target Risk Score of 12.</p> <p>Based on the planned activity for 2019-20 it is anticipated that the trajectory of the risk will reduce when successful implementation of activity occurs.</p>
Financial Implications:	There are no financial implications arising from this report.
Recommendation:	<p>It is recommended that the Committee:</p> <ul style="list-style-type: none"> • Note the progress made this year within the Corporate Safeguarding Team, particularly in relation to the implementation of the HASCAS/DO recommendations. • Note the emphasis of the Corporate Safeguarding Team on embedding continual improvement through developing benchmarking, peer review and identifying data led areas for improvement in an open and transparent way • Approve the Corporate Safeguarding Priority Action Plan for 2019-20 for delivery

Health Board's Well-being Objectives <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>	√	WFGA Sustainable Development Principle <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	√		
Special Measures Improvement Framework Theme/Expectation addressed by this paper			
Leadership and Governance Mental Health			
Equality Impact Assessment			
An Equality Impact Assessment is not required for this report.			
Equality Impact Assessments will be required for individual projects outlined in the Priority Activity 2019-20 and will be undertaken as part of implementation.			

Disclosure:

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

BCUHB Corporate Safeguarding Team
Safeguarding and Protection of People at Risk of Harm
Annual Report 2018-19

1. Executive Summary

1.1 Introduction

Safeguarding people at risk and their families forms part of everyone's core business. Employees of BCUHB, commissioned services, providers and contractors must engage, support and as necessary escalate with the ultimate aim of promoting well-being, to reduce risk and ultimately harm.

1.2 The annual report 2018-19 provides an overview of progress made by the Corporate Safeguarding Team in relation to safeguarding adults, children and young people at risk, Violence against Women, Domestic Abuse, and Sexual Violence (VAWDASV), Deprivation of Liberty Safeguards (DoLS), Dementia and the overarching safeguarding activities under the remit of the Harm agenda.

1.3 It also sets out the strategic priorities of the Corporate Safeguarding Team for 2019-20, demonstrating their commitment to continual improvement.

1.4 2018-19 in Review

This has been a year of challenge and improvement for the Corporate Safeguarding Team. Activity this year has been driven by recommendations made by the Health and Social Care Advisory Service (HASCAS) investigation and by the review conducted by Donna Ockenden and good progress has been made.

1.5 In April 2019, the Associate Director of Safeguarding reported and recommended that four (4) of the six (6) recommendations were actioned, highlights are below.

1.6 Summary of Key Activity in 2018/19 relating to HASCAS

Priority Area:	Key highlights:
Safeguarding Training	All training packages have been refreshed. Implementation of the Training Sub Group has enabled greater accountability for compliance with increases in some areas of over 20% Level 3 training packages for high-risk areas E.g. Mental Health and Learning Disability (MHLD).
Informatics, and Documentation	Implementation of a performance management reporting framework for Adults at Risk. Data triangulation leading to improved accuracy. Implementation of an interactive dashboard, which enables staff to access and interrogate data.
Policies and Procedures	A review of priority procedures has taken place. 8 are now published, and 6 are due for publication in 2019-20. The Adult at Risk procedure is now published pending the National procedures publication.
Tracking Adults at Risk across North Wales	The Lead Practitioner approach has been developed in conjunction with North Wales Safeguarding Adults Board.

- 1.7 It is important to note that these remain key areas of work and priority activity will continue beyond the HASCAS / DO recommendations. Full details of 2019-20 activity is outlined in Appendix 2 of the Safeguarding Annual Report.
- 1.8 Two (2) recommendations remained outstanding from HASCAS/DO in relation to the review and implementation of the Safeguarding Team Structure, and the review of the Deprivation of Liberty Safeguards (DoLS) work plan. These continue to be high priority, and high-risk areas, but work is underway to mitigate risk. Activity in these areas has been brought forward into the 2019-20 work plan.
- 1.9 Other significant achievements in year include the implementation of nine (9) recommendations arising from an Internal Audit conducted in July 2018 and the full implementation of the Safeguarding Reporting Framework, which sets out the governance, reporting and accountability framework for safeguarding.
- 1.10 Risk Management and Control**
Early identification of risk has been embedded throughout the Reporting Framework and the Area/Secondary Care Forums ensuring that risks are identified and escalated as they arise.
- 1.11 All activity undertaken and planned for 2019-20 contributes to reducing and mitigating the current safeguarding corporate risk that 'The Health Board fails to discharge its statutory and moral duties in respect of safeguarding'. Activity is planned to ensure that all reasonable steps are taken to discharge our duty of care and meet legislative requirements.
- 1.12 Currently the corporate risk for safeguarding has a Risk Score of 16 with a target Risk Score of 12. Based on the planned activity for 2019-20 it is anticipated that this Risk Rating will reduce when successful implementation occurs.
- 1.13 Looking Forward to 2019-20**
The recent independent review of the North Wales Safeguarding Adults Board concluded that there is a positive story to tell around multi-agency progress following events at Tawel Fan.
- 1.14 The Corporate Safeguarding Team are confident based on progress made in 2018-19 that a robust and meaningful multi-agency partnership will continue to thrive in 2019-20 to support this complex and challenging agenda.
- 1.15 A fully resourced team is essential for this progress to take place, and the implementation of the Corporate Safeguarding Structure in 2019-20 is critical.
- 1.16 Developing the performance management framework in 2019 will also be a priority – ensuring that safeguarding activity is intelligence led, enabling the identification of high-risk areas and resource and support to be targeted accordingly.

1.17 Conclusion

Clear leadership, and a real emphasis on priorities for 2019-20 will ensure that the improved trajectory within BCUHB continues and is sustained in key areas.

1.18 Safeguarding activity must be integral to every element of service provision, commissioned services, care and treatment to be effective and the Corporate Safeguarding Team will strive to achieve this in 2019-20.

1.19 Successful and collaborative multi-agency working is key to achieving this goal.

1.20 Recommendations

It is recommended that the Committee:

- Note the progress made this year by the Corporate Safeguarding Team, particularly in relation to the implementation of the HASCAS/DO recommendations.
- Note the emphasis of the Corporate Safeguarding Team to implement and evaluate continual improvement through developing benchmarking, peer review and identifying data led areas for improvement in an open and transparent way
- Approve the Corporate Safeguarding Priority Action Plan for 2019-20 for delivery



BCUHB Corporate Safeguarding Team Safeguarding and Protection of People at Risk of Harm Annual Report 2018-19

1. Purpose of Report

- 1.1 This annual report 2018-19 provides an overview of progress made by the Corporate Safeguarding Team in relation to safeguarding adults, children and young people at risk of harm, Violence against Women, Domestic Abuse, and Sexual Violence (VAWDASV), Deprivation of Liberty Safeguards (DoLS), Dementia and the overarching safeguarding activities under the remit of the Harm agenda.
- 1.2 It also sets out the strategic priorities of the Corporate Safeguarding Team for 2019-20 demonstrating our commitment to continual improvement.

2. Introduction

- 2.1 This has been a year of challenge and improvement for the Corporate Safeguarding Team. Activity has been driven by recommendations made by the Health and Social Care Advisory Service (HASCAS) investigation and by the review conducted by Donna Ockenden, following the closure of a mental health ward based on allegations of abuse and poor care.
- 2.2 The recommendations arising from the HASCAS investigation and the subsequent Ockenden review have set the direction and pace of the improvement journey for the Corporate Safeguarding Team in 2018-19.
- 2.3 Throughout the report, individual sections will summarise progress made throughout the year. Identified risks and Priority Actions for 2019-20 will be outlined in each section. A review of 2018-19 activity is presented in Appendix 1 and a 2019-20 activity plan is summarised in Appendix 2.

3. The Legislative Context

- 3.1 Betsi Cadwaladr University Health Board (BCUHB) has a statutory duty to safeguard people who are at risk and are accessing services or those deemed vulnerable in accordance with the legislative framework of the Children Act 1989, Children Act 2004, Criminal Justice and Courts Act (2015), Violence against Women, Domestic Abuse, Sexual Violence Act (2015), and the Social Services Well-being Wales Act (2014) alongside other overarching legislation and guidance.

- 3.2 The Social Services and Well Being (Wales) Act 2014 came into effect in April 2016. The Act provides for the first time in Wales a legal framework for Adults at Risk of Harm and improving the well-being of people who need care and support (including carers) and for transforming social services in Wales.
- 3.3 Safeguarding people at risk and their families forms part of everyone's core business. Employees of BCUHB, commissioned services, providers and contractors must engage, support and as necessary escalate with the ultimate aim of promoting well-being, to reduce risk and ultimately harm.
- 3.4 Alongside this legislative framework, national inquiries and local, regional and national reviews provide evidence to both drive learning, and hold organisations to account. Regionally the North Wales Safeguarding Board for both Adults and Children holds a statutory function of which BCUHB is a recognised partner.
- 3.5 Successful safeguarding engagement requires collaborative multi-agency working, a financial commitment and effective multi-disciplinary partnerships in order to drive this complex and high-risk agenda.

4. Quality Assurance

- 4.1 **The HASCAS Investigation and Donna Ockenden Review**
The HASCAS investigation (May 2018) and Donna Ockenden review (June 2018) have both published key recommendations some of these are specifically aligned to the safeguarding agenda.
- 4.2 The Corporate Safeguarding Team have welcomed the findings and responded constructively to the recommendations. These recommendations have been a key driver for safeguarding activity within 2018-19.
- 4.3 The HASCAS Improvement Group monitors the implementation and progress of these recommendations across BCUHB. The Associate Director of Safeguarding is a member and reports on progression and compliance.
- 4.4 In April 2019, the Associate Director of Safeguarding in consultation with the Chair reviewed the trajectory and reported and recommended four (4) of the six (6) HASCAS/DO recommendations were fully actioned, with only two (2) outstanding.

4.5 HASCAS/DO Recommendation Position March 2019

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

4.6 The Associate Director of Safeguarding engages with four (4) members of the HASCAS Stakeholder Group who have expressed an interest in the activities related to the identified safeguarding recommendations. This activity will continue as a priority for 2018-19.

4.7 PR01 Priority Action – HASCAS Stakeholder Engagement

To continue to meaningfully engage with nominated HASCAS Stakeholders from the HASCAS Stakeholder Group.	March 2020
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4.8 HASCAS 8/DO 6 Corporate Safeguarding Team - Structure

Work remains ongoing to address the key omissions identified in the revised Corporate Safeguarding Structure implemented under the Organisational Change Process during 2017- 2018. This will incur a financial pressure.

4.9 Since April 2018, with the recognition of additional financial resource, the Corporate Safeguarding Team have appointed to new roles in order to overcome the previous challenges reported in 2017-2018 in terms of resources and capacity.

4.10 Following the return of the Senior Leadership Team in January 2018, and a number of key appointments, the Safeguarding Senior Leadership Team can evidence improvement in both strategic and operational activity.

4.11 Full implementation of the Safeguarding Structure is now required to ensure that the structure is fit for purpose. The current structure does not have the capacity to provide an effective Out of Hours service

4.12 Corporate Safeguarding Divisional Risk (2545)

Risk detail	Current Risk Rating	Mitigating Activity	Target Risk Rating
That BCUHB fail their duty of care to adults, children and young people at risk through a lack of Out of Hours safeguarding provision.	12	Service redesign is in progress in order to ensure cover is provided.	8

4.13 PR02 Priority Activity – Corporate Safeguarding Structure

To ensure full implementation of the Safeguarding Structure	Oct 2019
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4.14 **HASCAS 12/Ockenden 9 Deprivation of Liberty Safeguards (DoLS)**

The DoLS provision was previously managed under the Office of the Medical Director. It transferred to the Office of the Executive Director of Nursing and Midwifery during the period of 2016-18.

4.15 Both the HASCAS and Donna Ockenden reviews identified the DoLS work plan as a high-risk area, which required a full review. This remains a high priority in the Corporate Safeguarding work plan for 2019-20 as the demand, complexity and challenging nature of this specialist area requires a sound infrastructure to meet the needs of the client group and organisation. Consultation on the revised DoLS Structure is due to commence in June 2019.

4.16 PR03 Priority Activity – Deprivation of Liberty Safeguards

Implementation and review of the Deprivation of Liberty Safeguards (DoLS) work plan identified in 2017-18 for implementation in 2018-19	Dec 2019
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4.17 **Deprivation of Liberty Safeguards (DoLS) Legislation**

The Deprivation of Liberty Safeguards (DoLS) was introduced in April 2009. The safeguards as set out in Schedule A1 and are an amendment to the Mental Capacity Act 2005 introduced by the Mental Health Act 2007. DoLS is also supported by a supplement to the Mental Capacity Act Code of Practice.

4.18 A DoLS authorisation provides a legal framework and protection when a deprivation of liberty is considered unavoidable and in the person's best interest when in a hospital setting. The safeguards were introduced to ensure that any deprivation of liberty of a person who may lack capacity complies with the Convention on Human Rights (ECHR).

4.19 Any application, on which a DoLS is granted, can be referred on s21 Appeal for a best interest decision to the Court of Protection. This can have significant implications in terms of damages awarded. Over the past 12 months, there have been six (6) cases, the potential cost of which is not yet fully understood. The Corporate Safeguarding Team are currently estimating the likely impact.

4.20 In addition to this, the legal framework is set to become more complex as there are further amendments going through parliament relating to Liberty Protection Safeguards. This could have significant implications on future demand, where there could be an increase of up to 1500 cases, and will result in an increased training demand. This new legislation is likely to be enacted in 2020/21.

4.21 PR04 Priority Activity – Deprivation of Liberty Safeguards (DoLS)

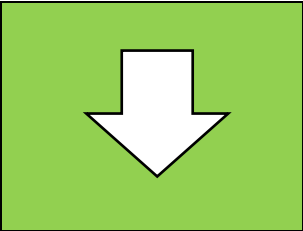
To undertake a risk assessment of the implication of the new legislation, and develop an action plan to ensure that BCUHB are suitably prepared to respond.	March 2020
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4.22 **Deprivation of Liberty Safeguards (DoLS) Performance Reporting**

DoLS activity is reported annually to Healthcare Inspectorate Wales (HIW). This annual report is completed jointly by HIW and Care Inspection Wales (CIW).

4.23 The latest available Health Inspectorate Wales Monitoring Report for 2015/16 shows that Health Boards (HBs) in Wales received 3,506 applications. The rate has been greater for Health Boards than for councils with an increase of 41.0% (2,486 applications were received in 2014/15).

4.24 BCUHB DoLS Applications 2014-2019

Year	Total DoLS Applications	
2014/15	414	
2015/16	787	
2016/17	964	
2017/18	854	
2018/19	742	

4.25 The period following the successful Supreme Court judgement in the case of P v Cheshire West [2-2014] and P & Q v Surrey CC [2014], resulted in a significant increase in the next two years of DoLS applications.

4.26 Although this year has seen a drop in applications, DoLS applications are likely to increase in 2019/20 as training, audit and enhanced engagement with the clinical teams will improve organisational learning.

4.27 PR05 Priority Action - Deprivation of Liberty Safeguards (DoLS)

The development and implementation of new arrangements for recording DoLS data to improve the quality of the annual HIW report submission.	March 2020
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4.28 **Best Interest Assessors**

The appointment of Best Interest Assessors was a recommendation arising from the HASCAS/DO reports. Significant progress has been made in this area, as five (5) of the six (6) Best Interest Assessor posts are now filled. They have all undertaken Level 7 specialist training to support them in their role.

4.29 Office accommodation remains a constant challenge and is currently unsuitable for the Best Interest Assessor post in the West, the proposal of a solution for this remains a priority for 2019-20.

4.30 PR06 Priority Action - Deprivation of Liberty Safeguards (DoLS)

The Best Interest Assessor accommodation in the West needs an alternative solution to be proposed and implemented.	June 2019
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4.31 The DoLS procedural document was last updated in 2012. It is a large, complex document and requires a priority review following a recent case law judgement.

4.32 PR07 Priority Action - Deprivation of Liberty Safeguards (DoLS) Documentation

Complete refresh and review of the DoLS procedural documents in line with recent case law.	Dec 2019
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4.33 DoLS Signatory Position

The Corporate Safeguarding Team have implemented a governance, supervision and training programme for DoLS signatories, which is the first in Wales. The lack of signatories had been identified as a key risk. Progress to increase the number of named signatories has been a priority activity, which remains ongoing. An adequate supply of signatories reduces the risk of adults at risk being detained unlawfully and is an important element of safeguarding.


Corporate Safeguarding Divisional Risk (2548)

2018-19 Divisional Risk	Current Risk Rating	Mitigating Activity	Target Risk Rating
There is a risk that BCUHB could unlawfully deprive adults of their liberty.	16	<p>Conducting DoLS Signatory Training.</p> <p>Increasing the numbers of qualified signatories.</p> <p>Increasing the number of Best Interest Assessors.</p> <p>A full review of the DoLS work plan to ensure that it is fit for purpose.</p>	6

4.34 During 2018, there was a lack of clarity regarding organisational responsibility and accountability of the Mental Capacity Act (MCA). This has now been resolved, and it is now confirmed that accountability for MCA lies with the Office of the Medical Director.

4.35 Internal Audit 2018 – Progress and Actions

An Internal Audit took place relating to the period 2017 – 2018 with the outcomes presented on 31 July 2018. The audit reviewed the compliance of safeguarding services against the Health and Care Standards 2016/17 and included both children and adults at risk. Nine (9) recommendations were identified for action.

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

4.36 All nine (9) Internal Audit recommendations have been fully implemented during the 2018-19 period. Two recommendations recorded as Low Risk, whilst completed are subject to further development in the 2019-20 work plan.

4.37 PR08 Priority Action – Patient Feedback

Patient feedback will be collected in order to improve Safeguarding Services and patient experience.	Sept 2019
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4.38 PR09 Priority Action – Welsh Language

The strategic Framework for Welsh Language 'More than just words' will be adopted and implemented in Corporate Safeguarding.	May 2019
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4.39 **Safeguarding Maturity Matrix – Self Assessment**

The Safeguarding Maturity Matrix (SMM) was piloted across all Health Board's/Trusts. BCUHB participated in the self-assessment of its safeguarding arrangements, and a Peer Review took place in November 2018. The five (5) standards included – Governance and Rights, Safe Care, ACE Informed, Learning Culture and Multi-agency Partnership Working.

4.40 BCUHB's overall self-assessment score was three (3) out of five (5) and an improvement plan has been developed. The lowest score was a score of two (2) out of five (5) for evidence of a Learning Culture, the highest was a score of three (3) for all remaining domains.

4.41 PR10 Priority Activity – Safeguarding Maturity Matrix

To engage in the Maturity Matrix process with the aim to increase the Learning Culture from a two (2) to three (3) and the overall BCUHB score from a three (3) to a four (4).	Sept 2019
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5. Corporate Safeguarding Governance

5.1 **The Safeguarding Reporting Framework**

The Safeguarding Reporting Framework has been implemented this year. At the heart of this is the Safeguarding Governance and Performance Group, whose function is to ensure that BCUHB complies with safeguarding and statutory legislation.

5.2 The Safeguarding Governance and Performance Group acts as the approval and scrutiny function on behalf of the Associate Director of Safeguarding and ultimately on behalf of the Executive Director of Nursing and Midwifery and reports directly into central scrutiny functions of Quality and Safety Group (QSG), and Quality, Safety and Experience Committee (QSE) and ultimately the Board.

5.3 Within the Reporting Framework, sit a number of Area Fora and themed Task Groups. Each of these have a clear remit and Terms of Reference, which specifies membership and their specific area of focus to ensure that the group operates effectively.

5.4 Priority Activity – Reporting Framework

Further develop and embed the Reporting Framework including the implementation of a Performance and Scrutiny Task Group with clear lines of escalation and progression for information and decision making.	May 2019
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5.5 There are two divisional risks in relation to the Safeguarding Reporting Framework they are summarised below.

5.6 Corporate Safeguarding Team Divisional Risk (2546)

Risk detail	Current Risk Rating	Mitigating Activity	Target Risk Rating
That the Safeguarding Governance structure becomes ineffective due to a lack of staff engagement	9	Induction and support will be provided to Area Forum Chairs. Attendance will be monitored and non-attendance highlighted.	6

5.7 Corporate Safeguarding Divisional Risk (2547)

Risk detail	Current Risk Rating	Mitigating Activity	Target Risk Rating
A lack of clarity relating to Safeguarding obligations in Job Descriptions and NHS Code of Conduct which could lead to a Safeguarding breach.	9	WoD are progressing to ensure that BCUHB Job Descriptions /CoC are updated accordingly.	6

5.8 **A strengthened Regional Business Support Function**

2018 has seen the creation of a Regional Safeguarding Business Team, which includes the appointment of a Safeguarding Business Manager, and Data Analyst. This resource is to provide the organisation with greater assurance relating to governance, planning, data quality, communications and risk.

5.9 **Safeguarding Communications – Implementation of a Learning Culture**

In order to ensure that good safeguarding practice is embedded across BCUHB, a Safeguarding Bulletin has been established to share best practice and learning experiences. It is distributed through the corporate communications bulletin and is published on a monthly basis.

5.10 Quarterly, a 'Learning Edition' is published, and encourages an open and transparent approach to learning and sharing learning examples within BCUHB.

5.11 7-minute briefings have been developed and published with a focus upon learning arising from Practice Review recommendations, case law or legislation/guidance.

5.12 Improved Safeguarding Communications have been underpinned by the launch of a new Safeguarding Homepage, which is a vehicle for staff to seek information, guidance, documentation and provides contact details of the Corporate Safeguarding Team should further support be needed.

5.13 PR11 Priority Activity – Corporate Safeguarding Communications


To produce and implement a Safeguarding Communications Strategy which identifies key messages, audiences, and methods of engagement	Dec 2019
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6. Safeguarding Policies/Procedures/Standard Operating Procedures

6.1 A key activity was to complete a review and to identify those policies and procedures for immediate review, development and implementation.

6.2 This has now taken place with actions taken to have an accurate picture of activity and develop and update all procedures in order to achieve full compliance.

6.3 Policy and Procedure Position Comparison 2018 - 2019

Safeguarding Policy/Procedure/SOP	2017- 2018	2018-2019	Trajectory
Number In Date	3	8	
Number Under Review	0	6	
Number out of Date	10	0	
Total Number	13	14	

6.4 A key priority was the development of the Adult at Risk Procedure. This was ratified by the Quality & Safety Group in April 2019 and subsequently published and implemented.

6.5 The Corporate Safeguarding Team have fully engaged with the consultation and development of the National Procedures for both Children and Adults at Risk, which are to be launched in November 2019. Active engagement is evidenced with the North Wales Safeguarding Board and the Policies and Procedures Sub Group.

6.6 PR12 Priority Activity – Policies and Procedures

To establish a Register of Safeguarding Policies and Procedures and identify the second phase of policies and procedures that need review and implementation in 2019-20.	April 2019
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6.7 PR13 Priority Activity – Professional Allegations

a) To establish a Safeguarding Employee Professional Allegations Task group b) Develop and implement a Safeguarding Employee Professional Allegation Procedure, which supports this activity.	May 2019 Sept 2019
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7. Corporate Safeguarding Training

7.1 Safeguarding Training Activity 2018-19

Safeguarding Training has seen a significant activity this year. All training packages have undergone a major refresh to ensure that they are fully compliant with legislation.

7.2 The Adult at Risk training packages have been mapped against the Intercollegiate Document for Safeguarding Adults 2018 to ensure that they are fully compliant with its requirements.


7.3 The Corporate Safeguarding Team continue to engage fully with the Corporate Safeguarding Practice Development and Training Task Group, the North Wales Safeguarding Board, NHS Wales Safeguarding Training Network, Mandatory Training Review Group and VAWDASV Training Group in order to ensure that continuous learning is embedded and programmes remain current.

7.4 The delivery of packages is conducted by a variety of methods including e-learning, face to face, and group activity. This takes place on an organisational, divisional, ward, or staff grouping basis. This has included Webinars to GP practices, Older Peoples mental health, and Continuing Healthcare.

7.5 All packages are compliant with legislation and best practice guidance. Performance data, incidences and risks influence bespoke packages and delivery.

7.6 Data analysis on Employee Self Service (ESR) does not allow for data reporting on compliance for Level 3. Compliance against Level 2 and Level 3 data packages are combined in the overall %.

7.7 BCUHB Mandatory Training Compliance

BCUHB Training Compliance	2016-17	2018-19		Trajectory
	All staff	All Staff	Permanent Staff	
Adults – Level 1	68.0%	74.6%	81.4%	
Adults – Level 2/3	67.6%	74.7%	68.9%	
Children – Level 1	68.5%	74.8%	82.9%	
Children – Level 2/3	53.4%	74.2%	60.8%	

7.8 For this period, Level 2 Children evidences the greatest increase in compliance from 53.4% to 74.2%.

7.9 The target for 2019-20 has been set at 85% by the Mandatory Training Group and the Corporate Safeguarding Team will aspire to support the organisation to achieve this.



7.10 Ward by Ward Mandatory Safeguarding Training Compliance

Number of Wards	Number of Wards <50%	Number Wards <70%
120	7	26

7.11 The training package for VAWDASV was developed in line with the National Training Framework by the safeguarding Practice Development Lead and is now the agreed package for Wales. This was endorsed by the Chief Nursing Officer and the All Wales Domestic Violence Group. This is a significant accolade.

7.12 Compliance has seen a significant improvement in each quarter for both VAWDASV and the Mental Capacity Act.

7.13 BCUHB VAWDASV and MCA Compliance

SECOND VAWDASV and MCA Compliance						
By Quarter	Mental Capacity Act		Trajectory	VAWDASV		Trajectory
Q1	64.0%	-		39.4%	-	
Q2	68.0%	+4.0%		50.5%	+11.1%	
Q3	72.0%	+4.0%		64.1%	+13.6%	
Q4	74.7%	+2.7%		73.0%	+8.9%	
Year End Position	74.7%			73.00%		

7.14 Additional targeted DoLS and MCA training is delivered by the Safeguarding Specialist Practitioner and Deprivation of Liberty Safeguards Team (DoLS).

Programme	Number of Sessions	Number of Attendees
DoLS & MCA	26	443
Total	26	443

7.15 Level 3 Training Compliance

A key area of data led activity is Level 3 safeguarding training compliance in MHL. To support the division a Level 3 training package has been developed and will be delivered to the Mental Health and Learning Disability Division from May 2019. This requires significant redirected resource.

7.16 Level 3 Named Doctor Training – Medical Training

Level	Hours delivered	Numbers attended
Level 3	60 hours	600+
Topics included: Fabricated and induced illnesses, the child protection medical examination, interesting and challenging cases and county lines.		

7.17 PR 14 a-e Priority Actions – Corporate Safeguarding Training


a) Develop a Training Needs Analysis to demonstrate our current position and identify areas for development.	May 2019
b) Review and publish the Safeguarding Training Strategy, the content of which will be informed by the Training Needs Analysis.	Sept 2019
c) To implement the Safeguarding Champions role across the organisation beginning with a pilot by September 2019.	Dec 2019
d) Develop and implement a Safeguarding Induction package and declaration to Health Board Members.	Sept 2019
e) Ensure that the Mandatory Training Reporting includes the Level three (3) training data to ensure that compliance is accurate.	Jul 2019 WoD

8. Safeguarding Adults at Risk

8.1 Adult at Risk Performance Reporting

There has been a steady rise in the number of Adult at Risk Reports received, representing an 11% increase over the last 3 years across BCUHB.

8.2 Adult at Risk Reports – Annually 2016-2019

2016-17	2017-18	2018-19	
986	1034	1113	

8.3 Since the introduction of the Social Services and Wellbeing (Wales) Act 2014, it was acknowledged by all partner agencies that Adult Safeguarding reporting was likely to increase, and this has been the case.

8.4 Increased activity does not necessarily mean that more individuals are at risk. Social factors could also play a role in the increased data. People are living longer, and may need increased support as they grow older.

8.5 Improved training compliance, media interest and improved staff engagement may also support earlier and improved detection of harm or abuse.

8.6 Identifying Areas for Improvement

The new and improved reporting and performance data has enabled the teams to establish high priority locations based on the number of reports, the identification and numbers of incidences and concerns regarding an individual or perpetrator.

8.7 This enables proactive safeguarding engagement and reporting to establish a position, provide advice, and engage with staff at the earliest opportunity.

8.8 This data analysis has resulted in a number of key activities with the full support of colleagues and partner agencies. A recent review found that the number of incidences reported was as the result of changes to the patient cohort on the ward.

8.9 A multi-agency desktop review found that whilst all Adult at Risk reports were raised correctly, it was identified there were key lessons for all agencies relating to patient on patient incidences. The development of this activity is being taken forward by the North Wales Safeguarding Adult Board.

8.10 PR15 a-b Priority Activity – Adults at Risk

a) To support the implementation of the recommendations arising from the desktop review and ensure that improvement is sustained.	Aug 2019
b) To continue to embed the multi-disciplinary approach and use the application of the MHLDD safeguarding dashboard to support this.	Aug 2019

8.11 Informatics – Adult at Risk

Adult at Risk reports are now being captured in a Performance Management framework, which enables detailed data reports to be reported into the relevant Area Forum for scrutiny and appropriate action. This reporting allows more detailed data to be scrutinised including Adult at Risk numbers by geographical area, Local Authority Area, and perpetrator.

8.12 In addition, an Interactive Dashboard has been developed which enables staff to search using bespoke search criteria to access and interrogate the data as and when required. This revised and updated system went live in March 2019.

8.13 The Adult at Risk reporting system is undergoing a further development to ensure that Adult at Risk data is routinely triangulated and integrated within the Safer Wards reporting, Datix reporting, and concerns data. The activity will be managed and monitored through the Performance and Scrutiny Task Group.









8.14 Corporate Safeguarding Divisional Risk (2620)

Risk detail	Current Risk Rating	Mitigating Activity	Target Risk Rating
There is a risk that an Adult at Risk report may be identified through the Datix system, and in doing so, bypass the formal Adult at Risk Reporting process.	8	Currently, Datix and Adult at Risk are triangulated weekly. Planned activity includes a review of the Datix reporting system.	4

8.15 PR016 Priority Activity – Adult at Risk Triangulation

Further development of the Adult at Risk reporting information to ensure that all Adult at Risk data is triangulated and reported comprehensively.	August 2019
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8.16 Category of Alleged Abuse (Numbers reported) Annually 2017/8 – 2018/19

	2017-18	2018-19	Difference	Trajectory
Neglect	452	407	-45	
Physical	320	389	+ 69	
Emotional	78	118	+ 40	
Financial	87	93	+ 6	
Sexual	58	67	+ 9	
Self-Harm	8	12	+ 4	
Multiple	22	3	-19	
N/A	9	24	+ 15	
Grand Total	1034	1113		

8.17 This data does not provide the outcome detail of each Adult at Risk report. Analysis and interrogation of the period 2019-2020 will form part of the priority activity for 2019-20 and will be actively managed by the Lead Practitioner.

8.18 **Priority Activity – Adult at Risk Process**

To develop the Adult at Risk process to ensure that it captures the outcome of the report for robust performance reporting.	Aug 2019
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8.19 **Developing the Patient Pathway - Lead Practitioner Pilot**

A pilot Lead Practitioner programme, identified by the Corporate Safeguarding Team was agreed to be progressed in partnership with the North Wales Safeguarding Adults Board (NWSAB). The training programme to develop the role is to be implemented during 2019-2020. Over seventy (70) key BCUHB staff have been identified to participate in the pilot and undertake the Lead Practitioner training, which will be completed by June 2019.

8.20 This pilot represents a major change in how Adult at Risk reports are coordinated and managed across the Health Board we envisage this will result in a more individualised and improved experience for the patient with improved outcome data collection. This delivery is a key priority for 2019-20.

8.21 **Adult at Risk – Priority Activity**

To implement the Lead Practitioner pilot.	July 2019
Conduct an evaluation of the impact of the Lead Practitioner, and identify next stages for further implementation across BCUHB.	Oct 2019

8.22 **The Sexual Safety Task Group**

The **MHLD** Division and Corporate Safeguarding are currently co-producing a service user led policy that offers guidance to staff and patients when an individual is admitted onto a Mental Health ward in relation to sexual safety.

8.23 A task and finish group has been established to develop guidance to both patients and staff in relation to sexual safety. Consultation sessions have taken place across North Wales between BUCHB staff, partner agencies, third sector agencies and service users to determine what, where and why a policy on sexual safety is required.

8.24 **Priority Activity – Sexual Safety**

To support on the development and implementation of a multi-agency co-produced policies for patients and staff on Sexual Safety.	Oct 2019
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8.25 **Nursing Homes - Adult at Risk Reports**

The Corporate Safeguarding Team monitor and report on Adult at Risk reports received from Nursing Homes within the North Wales region.

8.26 Detailed Performance Reports identify trends in location, and multiple reports, ensuring that any escalation in reporting is identified.


- 8.27 This information is reported quarterly through the Area Forums, where anomalies are identified, and followed up by a Safeguarding Specialist.

	BCUHB Area		
	East	Central	West
Nursing Home 1	6	29	14
Nursing Home 2	6	16	11
Nursing Home 3	6	6	9

- 8.28 The Performance Information also proactively identifies the Nursing Homes with the highest levels of Adult at Risk reports. Individual action plans are then developed with these Nursing Homes collaboratively with Continuing Healthcare Commissioning Teams.

8.29 Adult Practice Reviews (APRs)

- 8.30 Extended Adult Practice Reviews (APRs) Annually 2016-2019

2016-2017	2017-2018	2018-2019	
2	2	1	

- 8.31 Of the five APRs that have taken place over the last 3 years, three reports have been published, and two remain an ongoing activity. The recommendations are fully implemented.

- 8.32 BCUHB achieved 100% attendance at the North Wales Safeguarding Adult Practice Review Sub Group in 2018-19 to support and drive the Adult Practice Review agenda.

9. Safeguarding people living with Dementia

9.1 The Dementia Strategy

The BCUHB Dementia Strategy 2018-20 was launched in May 2018. It outlines how the Health Board will become a 'more dementia friendly organisation' and reiterates that safeguarding remains at its heart.

- 9.2 Implementation of the strategy has been enhanced by the appointment of an Adult Safeguarding /Dementia Safeguarding Clinical Specialist within the Corporate Safeguarding Team and who works closely with the Dementia Nurse Consultant MHLD.

- 9.3 A number of 'Tell us Your Story' events were held to listen to the voice of patients and their carers about their experiences. This information to improve the experiences of people living with dementia.

9.4 PR17 Priority Activity – People with Dementia

To continue support the implementation of the Dementia Strategy to improve patient experience.	Jun 2019
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10. Safeguarding Children at Risk

10.1 The Legislative Framework

The Social Services and Wellbeing (Wales) Act was implemented in April 2016. The Act reinforces existing safeguarding legislation for children through the introduction of a new duty to report to the local authority any child suspected of being at risk of, or experiencing, abuse or neglect.

10.2 Looked After Children (LAC)

The potential vulnerability of Looked After Children is well documented. The accountability and portfolio of this service sits outside of the Corporate Safeguarding Team. The Head of Safeguarding Children attends the LAC Team meetings to ensure robust information sharing in relation to safeguarding.

10.3 The NHS Wales Notification Pathway for the health assessment of Looked After Children (LAC) states that notifications must be sent within 5 days of a child being placed.

10.4 Number of Review Health Assessments are identified.

County	Number of Review Health Assessments
In County	1059
Out Of North Wales	70
Total	1129

Assessment by	% of RHA
Health Visitor	19%
School Nurse	17%
LAC Nurse	49%
Paediatrician	14%

10.5 PR18 a-b Priority Activity – LAC Reporting

a) To identify and strengthen data collection, governance and reporting arrangements for Looked after Children with Corporate Safeguarding	Dec 2019
b) To review safeguarding supervision and escalation pathways for Looked after Children Specialist nurses	Dec 2019

10.6 Children at Risk – Performance Reporting

In December 2018, a Task and Finish Group was developed to look at the development and implementation of a Safeguarding Children's report/referral IT data collection tool and the development of a Performance Reporting Framework. This key activity is to go 'Live' on the 1st May 2019. The data gathered will inform future reports and practice.

10.7 PR19 a-b Priority Activity – Children at Risk

a) Full implementation of the Child at Risk data capture process within BCUHB, and Child at Risk Performance Reporting	Nov 2019
b) Review and evaluate the tool, data collection and outcomes generated.	Monthly, for 6 Months


10.8 Child Protection Medical Examinations

During the working hours Monday to Friday across BCUHB, community paediatricians are available every afternoon at the request of social service and the police to provide examinations for suspected physical abuse, sexual abuse and neglect.

10.9 The hospital paediatricians carry out examinations for children whose injuries require them to be admitted to hospital, and they undertake the examinations for physical abuse and neglect out of hours or at weekends.

10.10 Non-accidental injuries are recorded for all incidences, which occur within BCUHB boundaries. The data also includes children and young people from outside of the area who have had an examination within BCUHB.

10.11 Non Accidental Injury (NAI) Examinations Annually 2014-2019

Year	NAI Examinations	Trajectory
2018-19	264	
2017-18	274	
2016-17	297	

10.12 The data identifies a clear reduction in the Numbers of Non Accidental Injury examinations undertaken by BCUHB. However, this data does not capture the complexity and challenges relating to each case, or the legal activity to support criminal investigations.

10.13 Sexual Assault Referral Centre (SARC)

Six (6) community paediatricians provide a 24 hour service for the forensic examination of children from 0 – 17, where sexual abuse is suspected. North Wales is the only area in Wales, which provides a 24 hours forensic service, by a paediatrician, for children of this age range, where sexual abuse has been suspected. The forensic examinations are carried out in the North Wales Sexual Assault Referral Centre (SARC).

10.14 It has been recognised that the SARC and the Corporate Safeguarding Team would benefit from a strengthened relationship with the safeguarding agenda.

10.15 PR20 Priority Action – SARC Collaboration

The Corporate Safeguarding Team will evidence a collaborative relationship with the SARC specifically developing further policy and procedural links with the Sexual Safety Task and Finish Group and within the Sexual Exploitation/Sexual Violence arena.	Feb 2020
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10.16 **Procedural Response to Unexplained Deaths in Childhood (PRUDiC)**

In 2018 the National PRUDiC Procedure was revised, updated and implemented. One of the key changes was that the North Wales Safeguarding Children's Board monitors the PRUDiC processes initiated within North Wales.


10.17 All cases are now monitored through the Regional Child Practice Review (CPR) Sub Group. The Head of Safeguarding Children is BCUHB's Single Point of Contact and supports staff in this process. BCUHB have actively engaged with the NWSCB in the development of a PRUDiC Information Sharing Protocol (ISP), which is awaiting final sign off.

10.18 A PRUDiC Standard Operating Procedure (SOP) has been ratified at the Safeguarding Governance and Performance Group this provides the Corporate Safeguarding Team with a governance framework to support practitioners to engage with the process.

10.19 PRUDiC Cases 2018-19


West	Central	East	Total
2	4	8	14

10.20 PRUDiC Cases - Annually 2016-2019

2016-17	2017-18	2018-19	
13	16	14	

10.21 **Child Practice Reviews (CPR's)**

10.22 Regional Child Practice Reviews (CPRs) Annually 2016-2019

2016-2017			2017-2018			2018-2019			
MAPF	ECPR	CCPR	MAPF	ECPR	CCPR	MAPF	ECPR	CCPR	
0	3	0	0	1	0	0	2	1	

10.23 In addition to the above, there has been a further one (1) Learning Event, which followed England legislation during this period and required engagement with the NWSCB Sub Group.

10.24 As well as implementing actions following CPRs in the North Wales Region, the Corporate Safeguarding Team ensure that BCUHB is benchmarked and learns lessons from other published reviews. One example is the Cardiff & Vale Child Practice Review. One of the recommendations arising from this was:

10.25 *"The Accident & Emergency Department have a weekly safeguarding meeting to consider head injuries and burns in children aged under one".* This has now been extended to include fractures in children aged under two years old.

10.26 A pilot has commenced in Ysbyty Glan Clwyd (YGC) Emergency Department (ED) implementing this recommendation. This will be evaluated after 3 months.

- 10.27 The Corporate Safeguarding Team have fully engaged with North Wales Safeguarding Children's Board Child Practice Review Group and has achieved 100% attendance in 2018.

PR21 a-b Priority Actions – Child Practice Reviews

To evaluate the success of the ED pilot, arising from the Cardiff and Vale CPR and consider full implementation	Feb 2020
The development and implementation of a Safeguarding Critical Debrief Model	July 2019

- 10.28 Children at Risk - Learning and Audit Activities

Review of Childhood Suicides

The Head of Safeguarding Children and the Named Doctor Safeguarding Children are developing an observational report looking at childhood suicides in North Wales from 2013-18.

PR 22 Priority Activity – Childhood Suicides

Findings from the report identifying trends/themes within childhood suicides will be undertaken and incorporated into an action plan to inform practice.	May 2019
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- 10.29 **Child Death Overview Panels (CDOPs)**

Child Death Overview Panels (CDOPs) are well established across North Wales. They are Multi-Agency meetings and are managed as a key statutory requirement of the North Wales Safeguarding Children Board. All child deaths in North Wales are discussed to ensure the appropriate actions have been taken, identified learning, and escalation relating to Safeguarding and or Public Health.

- 10.30 Following a number of tragic deaths due to overlay, BCUHB undertook to review and updated guidance for BCUHB health staff with regard to the information which is shared with parents to help them make the sleep environment as safe as possible for their baby.

- 10.31 **Mothers and newborn babies requiring 24-hour supervision on Maternity units when safeguarding concerns have been identified**

When an unborn is deemed to be at risk of harm Local Authorities cannot apply to court for Interim Care Orders until the baby is born. The consequence of this is delayed discharge.

- 10.32 A Task and Finish Group has been established to develop a procedural response to this issue. In March 2019, a draft Children and Young People's Delayed Discharge Procedure was consulted upon. This will be ratified and implemented as a priority activity this year.

- 10.33 PR23 Priority Action – Delayed Discharge Procedure

A BCUHB wide Children and Young People's Delayed Discharge Procedure is to be developed, ratified and implemented.	July 2019
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10.34 **Child Sexual Exploitation (CSE)/Trafficking**

Child sexual exploitation is the coercion or manipulation of children and young people into taking part in sexual activities. It is a form of sexual abuse involving an exchange of some form of payment which can include money, mobile phones and other items, drugs, alcohol, a place to stay, 'protection' or affection'.

10.35 The Safeguarding Team Manager Central and the Head of Safeguarding Children attend this All Wales Group. Engagement has taken place on the overview of the revised CSE (CSERQ15) guidance and completion of the action plan.

10.36 Corporate Safeguarding have also supported BCUHB staff who are engaged in the 'Armour' Programme. The programme offers multi agency support to young people identified as being at risk of CSE. The programme has been very successful and won a Social Care Accolade. Corporate Safeguarding engage in Community Practice Events arranged by the North Wales Safeguarding Board.

10.37 **Child Sexual Exploitation (CSE) Operations**

During 2018-19 there have been two CSE police operations ongoing. Operation Lenten remains active. The Gold Command strategic activity is attended by the Associate Director of Safeguarding and the Head of Safeguarding Children fully engages with information sharing. Due to multi-agency engagement, the criminal convictions of two very high-risk individuals were successful. The frontline Victim Contact Team thanked the Health Board for their invaluable contribution.

10.38 Operation Cassata was another CSE Operation, which required strong engagement from BCUHB during 2018, who were actively engaged with the development of an Information Sharing Protocol. The police thanked the Corporate Safeguarding Team for their contribution, following this operations conclusion.

10.39 **Under 18's assessed for Section 136 assessments April 2018- March 2019**

Area	Number	Age range	Outcome
East	13	13-17yrs	
Central	5	14-16yrs	
West	7	14-17yrs	
Total BCUHB	25		7 Inpatient Admissions

10.40 Work is ongoing to review the Exceptional Admission of Children under the Age of 18yrs to an Acute Psychiatric Inpatient Unit (MH02) Procedure. This will form part of Phase Two of the of priority procedures.

10.41 The Corporate Safeguarding Team, Child Adolescent Mental Health Services (CAHMS) and Looked After Children (LAC) have been fully engaged with the Mental Health & Learning Disability Division (MHLD) in the provision of an age appropriate bed in the Heddfan Mental Health Unit. This will provide a bed for 16-17yrs old who are deemed appropriate. Level 3 Safeguarding Children training has been delivered to all those staff who will be involved with the young person to support this activity.

11. Safeguarding Midwifery

11.1 Health Birth Pre Assessment

In 2018-19 an audit undertaken by North Wales Safeguarding Children's Board, alongside Child Practice Review (CPR) identified that a review of the Health Pre-Birth Assessment (HPBA), was required. The implementation of the Health Pre-Birth Assessment (HPBA) procedure is a priority will form part of the second phase of policies and procedures.

11.2 Serious Case Reviews (SCRs)


Learning from a recent Serious Case Review (SCR) included the development of a 7-minute briefing on Professional Curiosity, and the requirement for a procedural review, which will be published in 2019-20 as part of Phase Two implementation of policies and procedures.

11.3 Female Genital Mutilation (FGM)

FGM is a form of child abuse and adult abuse and comprises of all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons (WHO, UNICEF, UNFPA, 1997).

11.4 This year the Corporate Safeguarding Team have developed and published a Standard Operating Procedure (SOP) for FGM. This procedure reinforces the Mandatory Duty to Report as legislated by the Serious Crime Act (2015) for all registered and regulated health care professionals to report all identified cases of FGM in children to the police.

11.5 FGM reports annual comparison 2016-2019

Year	2016-17	2017-18	2018-19	Trajectory
Cases of FGM	6	6	5	

12. Violence against Women Domestic Abuse and Sexual Violence (VAWDASV)

12.1 The Welsh Government Strategy recognises that violence against women is a violation of human rights and is a cause and consequence of gender inequality.

12.2 In 2015, the Violence Against Women, Domestic Abuse and Sexual Violence (Wales) Act was implemented, aiming to improve the public sector response in Wales to violence against women, domestic abuse and sexual violence.

12.3 Head of Safeguarding Children has delegated responsibility for VAWDASV within the allocated portfolio and delegates responsibility for Domestic Abuse to the Safeguarding Specialist Midwife and Sexual violence to the Safeguarding Strategic Lead for MHL.

12.4 Activity in 2018-2019 to support the VAWDASV agenda has included:

- ❖ Review and implementation of a VAWDASV training package.
- ❖ Re-implementation of Domestic Abuse Workplace Safety Groups, and development of monitoring systems.
- ❖ Review of the Domestic Abuse Procedure – which is now VAWDASV and has been divided into service user and staff procedures.
- ❖ Head of Safeguarding Children is a member on the National VAWDASV Group.

12.5 Domestic Abuse and Sexual violence are both a fundamental violation of human rights, a cause and consequence of inequality, and has far-reaching implications for families, children and communities affected by it.

12.6 VAWDASV - Midwifery Audit

Welsh Government set a National Domestic Abuse Audit requirement, which requires Community Midwives to undertake Routine Enquiry with pregnant women. The Audit requires Midwives to ask twice if there are any Domestic Abuse concerns. An annual audit monitors BCUHB compliance.

12.7 Midwifery National Audit Compliance 2018-19

	West	Central	East	BCUHB	Current Trajectory
Asked Once	65%	72%	73%	70%	↓
Asked Twice or More	38%	40%	36%	38%	↓
Not Asked at All	35%	28%	27%	30%	↓

12.8 Further interrogation of this data will take place.

12.9 PR24 a-b Priority Action – National Audit

a) To engage with the development of a National Audit Tool to improve a standardised approach to data collection. Routine Enquiry Domestic Abuse/Review of Minimum Standards with Public Health Wales (PHW)	January 2020
b) To support the Midwifery division to achieve 100% compliance required by the National Audit, unless there is mitigation.	March 2020

12.10 VAWDASV Regional Board and Sub Groups

The Regional VAWDASV Board continues to meet quarterly with 100% engagement from BCUHB. The newly elected Vice Chair is the Head of Safeguarding Children. The Commissioning and the Training Sub Groups are also well attended by BCUHB with active participation.

12.11 PR25 a-c Priority Action - VAWDASV

a) Development and implementation of a VAWDASV Service User Procedure	Aug 2019
b) Implementation of a Domestic Abuse Work Place Safety Group	Aug 2019
c) VAWDASV Workplace Procedure	Aug 2019

12.12 Domestic Homicide Reviews (DHRs)

DHRs usually take around 2 years to fully complete from the date of commissioning. Over the past 12 months, six (6) Domestic Homicide Reviews, (DHRs) have been undertaken.

12.13 DHRs undertaken in 2018/19

Number of live DHRs Each Year	Number Signed Off	Number Ongoing
6	3	3


12.14 MARAC Information Sharing / Domestic Abuse Alert. (National):

An all Wales group was established to implement a pilot to review the sharing of MARAC information within Primary Care.

12.15 The screening and monitoring of BCUHB referrals are managed within the Corporate Safeguarding Area Teams.

12.16 Whilst Nationally, North Wales have reported that the number of MARACs have significantly increased, in BCUHB the MARAC position has remained the same. This requires further interrogation of the North Wales position as part of the Police review.

12.17 MARAC Reports Annual data 2017-2018 and 2018-2019

Year	Qtr 1	Qtr 2	Qtr 3	Qtr 4	Annual Total	
17-18	59	45	49	40	193	
18-19	53	30	55	33	171	




13. Multi-Agency Public Protection Arrangements (MAPPA)

13.1 The Criminal Justice Act 2003 provides for the establishment of Multi-Agency Public Protection Arrangements (MAPPA) in England and Wales. These are statutory functions to protect the public (including previous victims of crime) from serious harm by sexual and violent offenders, with regulatory management under the Home Office.




13.2 BCUHB have a duty to cooperate under MAPPA arrangements and attend MAPPA 2 (Violent Offenders) and MAPPA 3 (Other Dangerous Offenders). Both MH/LD division (including Forensic services) and Corporate Safeguarding are represented at MAPPA 2 (clinical specialists) and MAPPA 3 (strategic leads).

- 13.3 Attendance rates at MAPPA 2 and MAPPA 3 were noted as a challenge in 2017-18. In 2018-19 statutory Health attendance at MAPPA 2 and MAPPA 3 conferences have improved significantly and are summarised below:

13.4 Health Attendance at MAPPA 2 Meetings 17/18 - 18/19 comparison

Category	2017-2018	2018-2019	Trajectory
Health	90%	96%	
Mental Health	89%	92%	
Health (overall)	85%	94%	

13.5 Health Attendance at MAPPA 3 Meeting 17/18 - 18/19 comparison

Category	2017-2018	2018-2019	Trajectory
Health	96%	100%	
Mental Health	92%	94%	
Health (overall)	94%	98%	

13.6 **Strategic Management Board (SMB)**

The supervision of MAPPA work is carried out by the overarching Strategic Management Board (SMB). It has a range of governance-related functions, including monitoring performance, ensuring anti-discriminatory practice, measuring compliance with the MAPPA Key Performance Indicators (KPIs), and producing the annual MAPPA report.

- 13.7 The Board meet regularly and is attended on behalf of BCUHB by the Associate Director of Safeguarding and the Head of Nursing MHL D.

- 13.8 BCUHB attendance at the SMB meetings for 2018-19 was 100%.

14. County Lines and the Harm agenda


- 14.1 researching the current knowledge base of all partner agencies in North Wales to support the development of a more universal approach to tackling County Lines and its associated activity such as people trafficking, Cuckooing and Modern Day Slavery.
- 14.2 Corporate Safeguarding lead this activity on behalf of BCUHB and have engaged with MHL D, Children's Services (including CAMHS), and Emergency Departments, this has been welcomed by NWP who will now evaluate the data.
- 14.3

15. Multi-Agency Working NWSB – Adults and Children

- 15.1 An independent review of the North Wales Safeguarding Adults Board was commissioned by Welsh Government in September 2018 and the report was published in January 2019.
- 15.2 The reviewers concluded that there is a positive story to tell about the progression of the HASCAS recommendations following events at Tawel Fan. They specifically commented on the strong partnership working and shared accountability that members of the North Wales Safeguarding Board and its partners had developed.
- 15.3 Consistent representation at the appropriate level was noted as a key challenge during 2016-2017 and 2017-2018. BCUHB attendance at the North Wales Adults and Children's Safeguarding Boards in 2018-19 has been 100% this reflects the commitment that BCUHB members have to supporting the multi-agency agenda.
- 15.4 The Associate Director of Safeguarding is Vice Chair of the North Wales Safeguarding Adults Board (NWSAB). The Head of Children is Vice-Chair to a number of Multi-agency Safeguarding Forums. All teams are fully engaged Locally, Regionally and Nationally.
- 15.5 Feedback from the NWSB indicated BCUHB engagement this year with the multi-agency agenda has been 'excellent'. Which is a significant accolade.
- 15.6 This year will see the launch of the new Adult at Risk and Child at Risk procedures nationally, alongside changes to the DoLS legislation.
- 15.7 The Corporate Safeguarding Team will continue to support, develop and inform regional, and national policy and in doing so, multi-agency working will ensure that Corporate Safeguarding Team remain at the forefront of any changes to legislation, and in the best place to amend and inform practice within BCUHB.

16. Risk Management and the Corporate Risk Register

- 16.1 Early identification of risks and ensuring mitigating action is in place is critical to effective governance systems. Throughout 2018-19 the Corporate Safeguarding Team have embedded early identification of risk throughout the Reporting Framework and the Area/Secondary Care Forums ensuring that risks are identified and escalated as they arise.
- 16.2 Improved performance information, informatics, and reporting will also enable risks to be identified earlier and proactively.
- 16.3 The Corporate Safeguarding team have identified one (1) high profile risk which is published on the Corporate Risk Register. All activity conducted within the Corporate Safeguarding Team is delivered to ensure that this safeguarding failure does not occur.

Ref	2018-19 Corporate Risk	Previous Risk Rating	Current Risk rating	Target Risk rating	Trajectory
1078	That the Health Board fails to discharge its statutory and moral duties in respect of safeguarding.	20	16	12	

16.4 Over the past three (3) years, there has been considerable movement in the Corporate Risk Register, at its highest the Safeguarding risk was reported as 25, and at its lowest 20.

16.5 Due to significant progress made during 2018, the risk rating has reduced. The current the Risk Rating of 16 indicates a reduction in the likelihood, of this risk occurring. The trajectory of risk management and commitment to identifying and managing risk reduction is good. The implementation of the Safeguarding Structure, will further improve the risk position.

17. Conclusion

17.1 During the period of 2017-18 the lack of any implementation or reflection of the Social Services and Wellbeing (Wales) Act 2014 within the safeguarding arena was a significant risk for the organisation.

17.2 It is clearly reported throughout that the level of activity during 2018-2019 has been substantial to ensure an improved position for safeguarding those most vulnerable and at risk of harm whilst accessing our services.

17.3 A key achievement is the implementation of the HASCAS and Ockenden recommendations from their published reports. The BCUHB Safeguarding Annual Report of 2017-2018 and action plan 2018-2019 clearly referenced the same position, which has allowed the Corporate Safeguarding Team to have some pace to ensure implementation.

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

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

17.6 The agenda and legislative footprint is vast and requires true multi-agency partnership working. Our report evidences we have again shown vast improvement with this engagement, it is sustained, relevant and due to the









number of accolades from our partners' we have clearly made a welcomed difference. Our trajectory of compliance and identification of performance data have shown vast improvement in areas. It is envisaged, due to our expectation of further enhanced reporting and triangulation of data we will continue to evidence greater compliance but more importantly this will demonstrate the impact our activities have made on those and their families who are deemed most vulnerable.






- 17.7 We have identified priority activities for 2019-2020, to ensure true implementation this requires organisational engagement and transparency at all levels.
- 17.8 Safeguarding activities must be integral to every service provision, commissioned service and every aspect of care and treatment.

18. Recommendations

- 18.1 It is recommended that the Committee:
- Note the progress made this year by the Corporate Safeguarding Team, particularly in relation to the implementation of the HASCAS/DO recommendations.
 - Note the emphasis of the Corporate Safeguarding Team to implement and evaluate continual improvement through developing benchmarking, peer review and identifying data led areas for improvement in an open and transparent way
 - Approve the Corporate Safeguarding Priority Action Plan for 2019-20 for delivery.

Appendix 1: Review of the 2018/19 Work Plan

Ref	Comments	Timescale	Comment	End of Year
1	Full Implementation of the Corporate Structure	Timescale = Q4	This has been brought forward into 2019-20 priority activity.	
2	Further review of the Deprivation of Liberty Safeguards Structure	Timescale = Q4	This has been brought forward into 2019-20 priority activity.	
3	Ratification and implementation of the 5 updated Policy and Procedures	Timescale = Ratification December 2018.	These are now fully updated and are published online.	
4	The development and review of cohort 2 of the outstanding Policy and Procedures	Timescale = Ratified in Q4.	The outstanding policies have now been updated and published. A second Phase of policies and procedures is being identified for implementation in 2019-20.	
5	Development of the public facing intranet	Timescale = Q4.	The BCUHB intranet pages have been refreshed.	
6	Development of a standalone Safeguarding Datix module	Timescale = 2019-2020 Q2	Work is underway to ensure that the current Datix process accurately records Adult at Risk. This forms part of the 2019-20 work plan as planned.	
7	Finalise the Safeguarding activity onto the Harm Dashboard and implement a Deprivation of Liberty Safeguards [DoLS] data programme.	Timeline = Q4.	This work has commenced and includes Adult at Risk data. Further activity is required to ensure improvement and accuracy.	
8	Finalise and implement the 'gold standard' DoLS application form	Timeline = Q4.	This high priority, complex task began as planned in the period 2018-19. It will be completed in 2019-20. Quarter 2.	

9	Implementation of the new framework and governance for the DoLS Signatories	Timeline = Q4	As reported in the 2018-19 annual report, the refreshed DoLS Signatory training package has been implemented in Quarter 4 2018-19.	
10	Implementation of the 'Lead Practitioner' role relating to Adult at Risk referrals/reports	Timeline = Q4	Implementation of the Lead Practitioner role began in Q4 2018-19. Full implementation is a priority action in the 2019-20 work plan.	
11	Recommendation 9: Informatics. Development of pathways and recording and reporting	Timescale = Q4 and 2019-2020 Q2	Much progress has been made on improving informatics and data reporting process as reported in the 2018-19 Annual Report. 2019-20 priority activity will emphasise the Performance Management reports and the escalation routes for scrutiny.	
12	Procedural Response to Unexpected Deaths In Childhood (PRUDIC): ratification of the Standard Operating Procedure.	Timescale = Q4	The PRUDiC Standard Operating Procedure was ratified as planned in Quarter 4 2018-19.	
13	Continue the agreed trajectory and implementation of recommendations and actions as agreed by the Audit Committee, HASCAS Improvement Group and BCUHB Board for the Safeguarding Annual Report action plan 2018-2019	Timescale = Reporting Safeguarding Annual Report 2019-2010.	The HASAS Investigation and Ockenden Review have been key drivers for activity in 2018-19. At the end of year – it had been recommended to the HASCAS Improvement Group that four (4) of the six (6) recommendations were actioned.	

Appendix 2: Priority Activity 2019-20

		By When				By Whom	Key Driver			
		Quarter 1	Quarter 2	Quarter 3	Quarter 4		HASCAS/DO	Internal Audit	Risk Register	Legal/Region/ National
PR01	To continue to meaningfully engage with nominated HASCAS Stakeholders from the HASCAS Stakeholder Group.					ADoS				
PR02	To ensure full implementation of the Safeguarding Structure					ADoS/WoD				
PR03	Implementation and review of the Deprivation of Liberty Safeguards (DoLS) work plan identified in 2017-18 for implementation in 2018-19					SSDoLS				
PR04	To undertake a risk assessment of the implication of the new DoLS legislation, and ensure that BCUHB are suitably prepared to respond.					SDoLS				
PR05	The development and implementation of new arrangements for recording DoLS data to improve the quality of the annual HIW report submission.					SSDoLS				
PR06	The Best Interest Assessor accommodation in the West needs an alternative solution to be proposed and implemented.					SSDoLS				
PR07	Complete refresh and review of the DoLS procedural documents in line with recent case law.					SSDoLS				
PR08	Patient feedback will be collected in order to improve Safeguarding Services and patient experience.					SBM				
PR09	The strategic Framework for Welsh Language 'More than just words' will be adopted and implemented in Corporate Safeguarding.					SBM				

Appendix Two: Priority Activity 2019-20

		By When				By Whom	Key Driver			
		Quarter 1	Quarter 2	Quarter 3	Quarter 4		HASCAS/DO	Internal Audit	Risk Register	Legal/Region /National
PR10	To engage in the Maturity Matrix process with the aim to increase the Learning Culture from a two (2) to three (3) and the overall BCUHB score from a three (3) to a four (4).					HoSC SBM				
PR11	To produce and implement a Safeguarding Communications Strategy which identifies key messages, audiences, and methods of engagement					SBM				
PR12	To establish a Register of Safeguarding Policies and Procedures and identify the second phase of policies and procedures that need review and implementation in 2019-20.					SBM				
PR13a	To establish a Safeguarding Employee Professional Allegations Task group					SBM				
PR13b	Develop and implement a Safeguarding Employee Professional Allegation Procedure, which supports this activity.					SBM				
PR14a	Develop a Training Needs Analysis to demonstrate our current position and identify areas for development.					PDL				
PR14b	Review and publish the Safeguarding Training Strategy, the content of which will be informed by the Training Needs Analysis.					PDL				

Appendix 2: Priority Activity 2019-20

		By When				My When	Key Driver			
		Quarter 1	Quarter 2	Quarter 3	Quarter 4		HASCAS/DO	Internal Audit	Risk Register	Legal/Region/ National
PR14c	To implement the Safeguarding Champions role across the organisation beginning with a pilot by September 2019.					PDL				
PR14d	Develop and implement a Safeguarding Induction package and declaration to Health Board Members.					PDL				
PR14e	Ensure that the Mandatory Training Reporting includes the Level three (3) training data to ensure that compliance is accurate.					PDL				
PR15a	To support the implementation of the recommendations arising from the desktop review of MHLD wards and ensure that improvement is sustained.					PDL				
PR15b	To continue to embed the multi-disciplinary approach and use the application of the MHLD safeguarding dashboard to support this.					PDL				
PR16	Further development of the Adult at Risk reporting information to ensure that all Adult at Risk data is triangulated and reported comprehensively.					PDL				
PR17	To continue support the implementation of the Dementia Strategy to improve patient experience.					SSDem				
PR18a	To identify and strengthen data collection, governance and reporting arrangements for Looked after Children with Corporate Safeguarding					SS DoLS				

Appendix 2: Priority Activity 2019-20

		By When				By Whom	Key Driver			
		Quarter 1	Quarter 2	Quarter 3	Quarter 4		HASCAS/DO	Internal Audit	Risk Register	Legal/Region/ National
PR18b	To review safeguarding supervision and escalation pathways for Looked after Children Specialist nurses					HoC				
PR19a	Full implementation of the Child at Risk data capture process within BCUHB, and Child at Risk Performance Reporting					HoC				
PR19b	Review and evaluate the tool, data collection and outcomes generated.					HoC/SBM				
PR20	The Corporate Safeguarding Team will evidence a collaborative relationship with the SARC specifically developing further policy and procedural links with the Sexual Safety Task and Finish Group and within the Sexual Exploitation/Sexual Violence arena.					HoC				
PR21a	To evaluate the success of the ED pilot, arising from the Cardiff and Vale CPR and consider full implementation					SSMid				
PR21b	The development and implementation of a Safeguarding Critical Debrief Model					HoC				
PR22	Findings from the report identifying trends/themes within childhood suicides will be undertaken and incorporated into an action plan to inform practice.					HoC				

PR23	A BCUHB wide Children and Young People's Delayed Discharge Procedure is to be developed, ratified and implemented.					HoC				
Appendix 2: Priority Activity 2019-20		By When				By Whom	Key Driver			
		Quarter 1	Quarter 2	Quarter 3	Quarter 4		HASCAS/DO	Internal Audit	Risk Register	Legal/Region/ National
PR24a	To engage with the development of a National Audit Tool to improve a standardised approach to data collection. Routine Enquiry Domestic Abuse/Review of Minimum Standards with Public Health Wales (PHW)					HoC				
PR24b	To support the Midwifery division to achieve 100% compliance required by the National Audit, unless there is mitigation.					SSMid				
PR25a	Development and implementation of a VAWDASV Service User Procedure					SSMid				
PR25b	Implementation of a Domestic Abuse Work Place Safety Group					SSMid				
PR25c	Implementation of a VAWDASV Workplace Procedure					SSMid				

Resources Key	
ADoS	Associate Director of Safeguarding
HoSC	Head of Safeguarding Children
HoSA	Head of Safeguarding Adults
SSDoLS	Safeguarding Specialist - DoLS
SSDem	Safeguarding Specialist - Dementia
SSMid	Safeguarding Specialist - Midwifery
PDL	Practice Development Lead
SBM	Safeguarding Business Manager

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To improve health and provide excellent care

Report Title:	Reducing Avoidable Mortality - An Update on Progress
Report Authors:	Dr Brian Tehan, Medical Director for Quality and Transformation Mrs Mel Baker, Manager Office of Medical Director (OMD) - Centre Dr Melanie Maxwell, Senior Associate Medical Director/ 1000 Lives Clinical Lead
Responsible Director:	Dr Evan Moore, Executive Medical Director
Public or In Committee	Public
Purpose of Report:	Reducing avoidable mortality is central to the Quality Improvement Strategy, and a number of formal Welsh Government targets. This paper is presented as a quarterly update on current position.
Approval / Scrutiny Route Prior to Presentation:	This paper was submitted for review by the Quality Safety Group in March 2019
Governance issues / risks:	<ul style="list-style-type: none"> • BCU system mortality has yet to show the expected improvement in trajectory • Flagged for improvement mortality from Hip Fractures has improved overall, on the basis of outcomes in Wrexham Maelor Hospital (WMH) and a static position in Ysbyty Gwynedd (YG) and Ysbyty Glan Clwyd (YGC) • Opportunities remain for improvement, which include Stroke, Myocardial Infarction and sepsis. • Processes in place to review all in-patient deaths while close to Welsh Government target, have yet to achieve reliability. Outputs from this process fall short of the expectations set out in the Learning from Deaths policy • Emergency Department mortality is still a concern at YGC, and the subject of continuing work. • While BCU sepsis outcomes are reported as good, there is still room for improvement. Compliance with sepsis 6 bundles at the 'front-door' the focus of a breakthrough collaborative, this shows early signs of improvement
Financial Implications:	Progress on Stroke may require investment to establish Hyper Acute Stroke Unit (HASU)

Recommendation:	The Committee is asked to: 1. Note the report for information and 2. Consider whether the revised format meets the Committee's needs.
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Health Board's Well-being Objectives <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>	√	WFGA Sustainable Development Principle <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	√		
Special Measures Improvement Framework Theme/Expectation addressed by this paper			
Strategic and Service Planning Leadership and Governance			
Equality Impact Assessment: this applies equally to all and EQIA therefore does not apply			
Not necessary for update paper			

Disclosure:

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

Reducing Avoidable Mortality- An Update on progress-

BACKGROUND

BCUHB has set a strategic direction to reduce avoidable mortality. This is reported as Crude Mortality & RAMI for those over 75 years old.

Welsh Government require

- ✓ Reduction in crude hospital mortality rate (74 years of age or less) – DFM033
- ✓ Retrospective Case Record review systems are in place, with a requirement a minimum of 95% of universal mortality reviews (UMR) undertaken within 28 days of death–DFM032
- ✓ A 12 month improvement trend is expected specifically in percentage survival within 30 days of emergency admission for hip fracture- DFM079

CURRENT POSITION

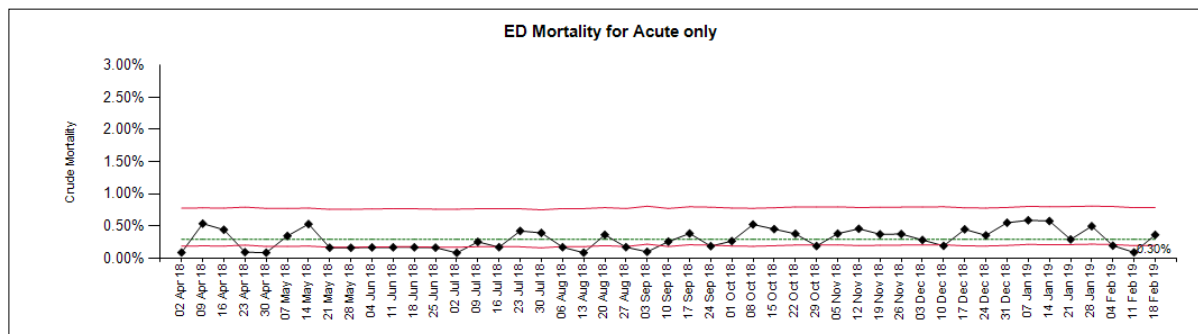
A. Formal Targets

DFM033 In Patient CDR in <75 year olds	<p>Crude mortality for those under 75yo remains stable.</p> <p>It shows an expected seasonal variation (2018/19 WMH 1.67; YGC 1.44; YG 1.39)-</p> <p>RAMI 2017– reportable to October 2018 this a stable process, with a mean of 92.7. <i>This is better than average (100)</i></p> <p>While RAMI is better than average and Crude Mortality for those under 75yo is stable, with no special cause for concern, further work is required to achieve the downward trajectory expected.</p>
DFM032 Screening deaths for potential harm	<p>This refers to completion of Stage 1 (UMR) mortality review within 72 hours of death.</p> <p>Full 2018 year performance is reported as YGC (98%); YG (94%); WM (94%).</p>

	<p style="text-align: center;">% UMR undertaken within 28 days of death</p> <p>While near expected target, further work is required to ensure this achieved consistently.</p> <p>Referrals to Stage 2 review have increased from 13.1% (2017) to 19.3% (2018). It is likely this is due to a mandatory requirement to review those with learning disability and serious mental illness.</p>
DFM079 – # Hip mortality	<p>Meeting a required downward trajectory, this continues better than Welsh Peer.</p> <p>Taken from the National Hip Fracture Database (October 2018), this comprises a fall to 2.3%, at Wrexham, while both YG and YGC, in this period have remained stable at 6.5%. This 6.5% is on par with the UK National performance of participating units.</p>

B. Mortality areas of concern requiring focus-

A. ED Mortality



As currently available, crude ED mortality rate has reduced slightly in 2018/19 (to Feb 2019); this is common cause variation. Data has been cleansed to ensure those patients deemed to be dead on arrival have been reassigned the correct group. There is still a higher proportion of deaths within 1 hour and those staying > 12 hours in the department. These are often the patients waiting for an inpatient bed. Wales Ambulance Services Trust (WAST) are reviewing all arrested patients to ensure care aligned with their policies. At a recent meeting we have agreed to identify those patients who are end of life to primary care and WAST to undertake case reviews; 4 patients have been identified for review.

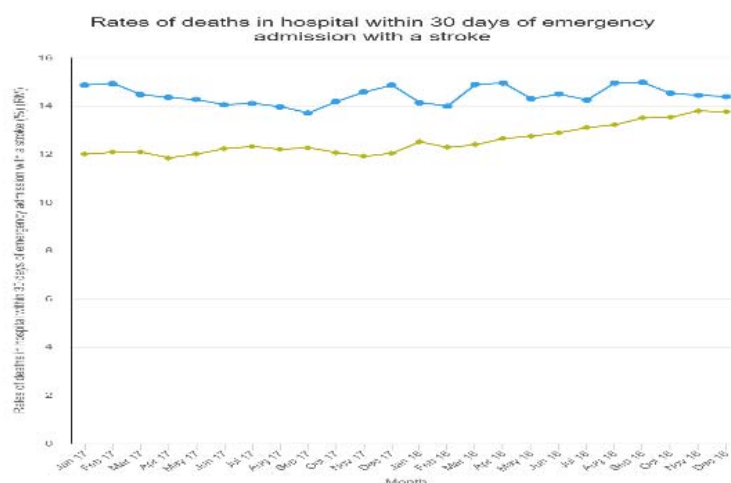
Clinical Audit in the department is behind schedule due to the lead consultant needing to be on the floor; currently audit is up to October 2018; mortality and morbidity meetings are now being incorporated into business meetings to broaden the audience and support learning.

BCU is piloting a structured judgement review document and training has been given to senior nurses and doctors in the department to expand the reviewers. To date they have not tried to use this as they are concerned about time constraints and are only keen to use this where concerns are raised about care.

Department is actively involved with the sepsis collaborative; "DRIPs" meetings have been introduced, data is regularly being scrutinised and shared with staff to promote sepsis 6.

B. Stroke

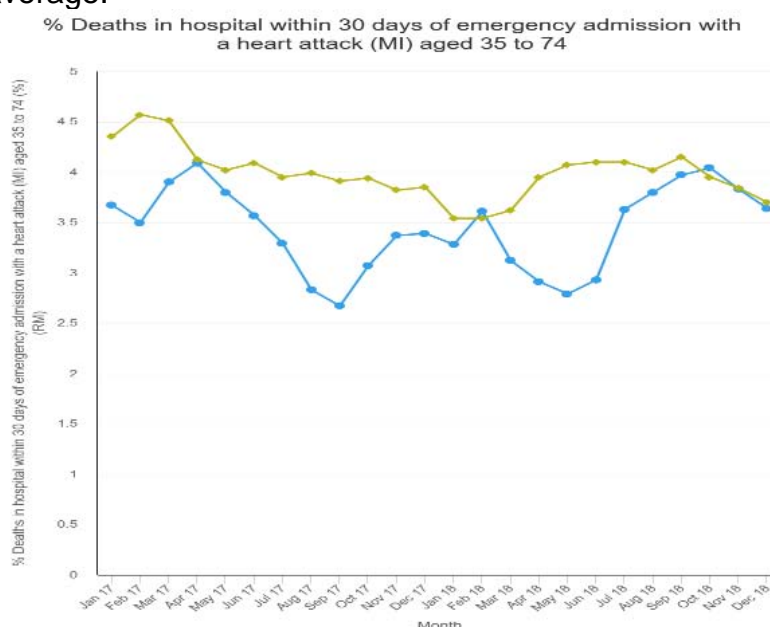
Third best in Wales, mortality within 30 days of stroke (October 2018) was 14.4%. Nevertheless, this is above Welsh peer average of 12.2%. Trajectory can be seen from the following, where **BCU in blue and Welsh Peer in green**.



Based on experience elsewhere in the UK of step changes in outcomes, a proposal is under consideration by the Executive Team, to develop a Hyper Acute Stroke Unit in North Wales (HASU).

C. Myocardial Infarction

Where BCU in blue and Welsh Peer in green, 3rd Best in Wales, performance is on par with peer average.



In December 2018 (2016/17 data) NCAP (National Cardiac Audit Programme) have published their annual report on MINAP (Myocardial Ischaemia National Audit Project) outcome data. In the period described mortality for STEMI (A type of Myocardial Infarct) patients, at Glan Clwyd mortality offered Percutaneous Coronary Intervention (PCI), was 11.22%. This is better than the English average of 14.74%. A proportion of patients presenting to WMH (43%) or YG (54.5%) did not receive

reperfusion therapy. This appears worse in comparison with the combined average for England, Wales and Northern Ireland (24.4%). Recognising the characteristics of those patients with STEMI admitted to non-primary PCI hospitals is likely to be substantially different to those of patients admitted to primary PCI hospitals, the MINAP report urges caution in interpretation.

D. Sepsis-

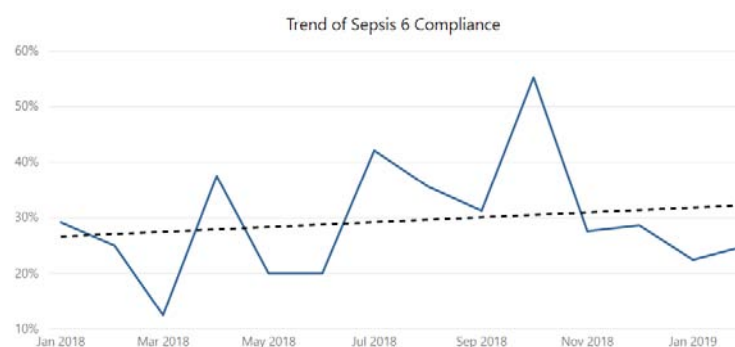
Mortality from sepsis has fallen in BCU since January 2018.



In 2018, mortality for sepsis was c 15%, the second best in Wales. Further work is progressing to confirm this data is accurate, as is the work to improve recognition and timely response to this common condition.

Poor completion of sepsis forms across all three District General Hospitals suggests recognition and response to sepsis could improve. With the support of the Office of the Medical Director, BCU Improvement Hub, a Breakthrough Improvement collaborative lead by the Senior Associate Medical Director and sponsored by the Secondary Care Medical Director, is currently working on this.

While the graphic below, shows some improvement until January 2019, observing significant improvement in completion of Sepsis Six forms and establishing regular DRIPs meetings on each site, further step-ups in sepsis 6 compliance can be expected in future reports, with potential impact on mortality.



ANALYSIS

- BCU system crude mortality has yet to show the required improvement in trajectory
- Flagged for improvement mortality from Hip Fractures has improved overall, on the basis of outcomes in WMH and a static position in YG and YGC
- Opportunities remain for improvement, which include Stroke, Myocardial Infarction and sepsis.
- Processes in place to review all in-patient deaths while close to WG target, have yet to achieve reliability. Outputs from this process fall short of the expectations set out in the Learning from Deaths policy
- ED mortality is still a concern at YGC, and the subject of continuing work.
- While BCU sepsis outcomes are reported as good, there is still room for improvement. Compliance with sepsis 6 bundles at the 'front-door' the focus of a breakthrough collaborative, shows early signs of improvement

POTENTIAL BARRIERS

Resources– these limit ability to focus on multiple projects with effect

Mortality reviews- Work is progressing to deploy a new IT system. At the same time its expected NWSSP will commence implementation of a new process for death certification, and Medical Examiners. It's anticipated this will require some leadership support and investment, especially from secondary care.

Sepsis- pressures on EDs, and staff shortages, limit engagement and ability to focus on, and deliver bundles within the hour expected.

STEPS TO GET BACK ON TRAJECTORY

- ED mortality- WMH & YGC reviewing deaths and piloting a new BCU Methodology. Agreement from YG to follow in due course.
- Work lead by Dr. Maxwell focussed on mortality in ED at YGC. Potentially will benefit all 3.
- A DATIX mortality module has been purchased for Wales and work progressing to install this in BCU. In context of introduction of Medical Examiners, changing the process to align with Learning from Deaths policy, and requiring training of reviewers, completion likely to take until September 2019.
- Improvements in stroke mortality are anticipated to require further investment, with progress contingent on progress with HASU.
- Sepsis- Breakthrough collaborative in progress.
- Further analysis work in progress to identify conditions associated with death. This will advise further collaboratives going forward.

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To improve health and provide excellent care

Report Title:	Health and Safety Update Report
Report Author:	Mr Stephen Roscoe, Head of Health and Safety Centre/West Mr Gary Monaghan, Head of Health and Safety, East
Responsible Director:	Mrs Sue Green, Executive Director of Workforce and Organisational Development
Public or In Committee	Public
Purpose of Report:	This report provides an update on the actions to improve the management of Health and Safety across the Health Board.
Approval / Scrutiny Route Prior to Presentation:	No prior scrutiny- update report
Governance issues / risks:	<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>
Financial Implications:	There are no direct financial implications from this report
Recommendation:	The Committee is asked to note the position outlined in this report.

Health Board's Well-being Objectives <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>		WFGA Sustainable Development Principle <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	√		
Special Measures Improvement Framework Theme/Expectation addressed by this paper			
Engagement			
Equality Impact Assessment			
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 to improve the management of Health and Safety across the Health Board.

2. Background and Progress

2.1 Capacity and Capability

The two new Heads of Health and Safety have started to embed systems across the health board however at the compilation of this report, Head of Health and Safety (East) has resigned and departed the organisation. A review of the structure will be undertaken by the incoming Associate Director of Health, Safety and Equality before any decision to replace is taken. In the meantime, the remaining Head of Health and Safety will assume responsibility for all regions including departments falling under Head of Health and Safety (East) remit including Moving and Handling Team recently transferred from Organisational Development.

Responsibility for Security, in accordance with 'Security Management Framework for NHS Trusts in Wales' has moved under the remit of Health and Safety including establishing and ensuring appropriate and correct systems in place to manage security across the organisation to manage and monitor the contract for security services in secondary care.

2.2 Governance and Management System/Plan and Progress

Work continues in scoping the gaps in the current Health and Safety Management System (HSMS) and has included

- The Health and Safety Team have reviewed the existing departmental self-assessment toolkit and reduced the number of questions from a daunting 150 to a more appealing and effective 50. The review of the toolkit was formulated against the current corporate review documentation allowing both monitoring systems of the current HSMS to be aligned. The self-review document was developed alongside clinical colleagues who are the end users of the system. The consultation and engagement process conducted around change has seen the self-assessment document embraced with initial returns showing to be well in excess of the 30% return from last year. The revised review documentation will be considered for agreement at the Strategic Health and Safety group to be held on 31st May 2019.
- Much work has been carried out in developing the 3 Year Improvement Plan for Health and Safety with significant interrogation on current data around Health and Safety allowing a plethora of intelligence gathered to prioritise actions needed to fulfil the plan. This 3 Year Plan is based on BCUHB

Strategic Objectives, HSE Strategic Objectives and the Workforce 3 Year Plan. This will allow BCUHB Corporate and HSE Strategic Direction to be aligned and help to prevent occupational accidents and ill health, deliver savings, reduce staff absence through occupational incidents and improve quality of service. The Improvement plan is in draft form until reviewed by the incoming Associate Director and considered by the Strategic Health and Safety Group. The intention is to submit the Plan to this Committee on 16th July and then to the Board on 25th July 2019.

- The Strategic Health and Safety Group has relaunched with date for first meeting end of May 2019 set. This Group will merge the previous Corporate Health and Safety, and Safety and Health and Wellbeing committees into one committee. The attendees at this Group will include specialist advisors, staff side representatives and Divisional Management Team representation. Executive Director Workforce and Organisational Development will chair the Group. This Group will ensure appropriate aspects of work have the correct governance processes for providing assurances and escalating any concerns that the Board may need to be cognisant of relating to Health and Safety within the organisation.
- Meetings with new contracted security provider, Samson Security together with Information Governance and Operational Estates have taken place to identify and acknowledge gaps in the security provision, compliance with Welsh Risk Management Standard 33 (referred to as The Standard) and aforementioned Security Management Framework document.

Data Protection Impact Assessment CCTV Provision for BCUHB has been conducted and Data Policy and Procedures on the Management of CCTV AND Surveillance Systems completed. These include the management and use of body worn camera as used by Samson Security personnel. Subsequent meeting is to be held on 28th May 2019 with Information Governance, Estates and Head of Health and Safety to review completed actions identified at initial meeting which included a complete and thorough audit of assets and security hardware across the Health Board to include CCTV systems, their types including camera and alarm systems. This will also include confirmation of levels of compliance and purpose including Crime Prevention measures.

- Scoping of the current security provision across the organisation continues which has clearly identified this as a major project with the need to draw down into all aspects, root and branch, to ensure a robust and compliant security management policy, practice and procedure is in place and entrenched within the Health Board.
The scope of this full review is being developed for review by the incoming Associate Director and consideration of the plan and resource implications by the Executive Directors Team in the first instance.

2.3 Health and Safety Executive (HSE) Input and Visits to the Health Board

Subsequent to the last report, there have been several visits to the Health Board by the HSE.

- Resultant of the 2 previous chemical exposure incidents that were reported under the dangerous occurrences section of RIDDOR, both involving Formalin, the HSE visited the Wrexham Maelor Site on 22nd March 2019. The inspector concentrated on one of the incidents; incorrect use of Formalin on Bonney ward (Women's Division). The HSE was informed of Pan BCU systematic improvements around Formalin that had been instigated as a result of the incident including auditing the storage use of Formalin and interrogating potential emergency responses to Formalin. The HSE inspector was appreciative of improvements made to Formalin use since the incident, however did observe contravention to the COSHH regulations that caused the original incident. As such, a Material Breach of Contravention of law was identified and the health board issued with a Fee for Intervention notice.
- The National Health and Safety Inspector, Mr Gary Martin visited the Trust on 3rd April 2019. The purpose of the visit was to meet with the Director of Estates and Facilities to conduct a debriefing of the YGC Asbestos improvement project that commenced in 2010.
- Additionally, at the request of the 2 Heads of Health Safety and the Executive Director for Health and Safety, a pro-active meeting was convened with Mr Martin on 11th April 2019. The purpose of this meeting was to discuss with the HSE the strategic and systematic improvements planned around Health and Safety. The meeting was positive with evidence of delivery being noted even in the short time period of the new team being in place. Feedback on the Objectives for 2019/20 together with engagement in the development of the 3 year plan continues to be positive and beneficial.

4.	Assessment of risk and key impacts
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Previous entries on the Risk Register have been reviewed relating to;

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.

This score has again be reviewed and will be considered at the Strategic Health and Safety Group before being re submitted to this Committee.

5.	Conclusions / Next Steps
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Having taken a systematic approach to the improvement of Health and Safety across the health board, some progress has been made regarding all aspects of Health and Safety, it is however, apparent that concerns remain across the organisation relating to the control, management, safe use and storage of chemicals.

To that end the Health and Safety team will continue to engage and establish more robust communication and support across the Health Board. The new self-assessment tool has already demonstrated itself to be an invaluable asset regarding this based on the feedback and calls for support from various departments across the organisation. One such department worthy of note for looking to embrace and develop their safe systems and processes is Pathology and Histology based at Ysbyty Glan Clwyd.

The imminent arrival of the newly appointed Associate Director of Health, Safety and Equality will further augment the structured approach being taken.

The next reports to be submitted to the Committee will be in July as follows:

Health and Safety Annual Report 2018/19
Health and Safety Improvement Plan 2019 - 2022

6.	Recommendations
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The Committee is asked to note the position outlined in this report.

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To improve health and provide excellent care

Report Title:	HMP Berwyn Health and Wellbeing Annual Quality, Safety & Performance Report 2018 – 2019
Report Author:	Mr Simon Newman, Head of Healthcare
Responsible Director:	Dr Chris Stockport, Executive Director of Primary & Community Services
Public or In Committee	Public
Purpose of Report:	This report provides a review of the delivery of Health and Wellbeing services during the last 12 months at HMP Berwyn. The report looks at progress made during this period and identifies current performance and improvements being made.
Approval / Scrutiny Route Prior to Presentation:	No prior scrutiny or consultation. Report is for information only
Governance issues / risks:	Risks are identified in the report. All risks are fully integrated on the East Area risk register and are formally discussed at local and area governance and operational meetings in addition to the Prison Health, Wellbeing and Social Care Partnership Board
Financial Implications:	There are a number of potential financial risks to the Health Board associated with the project. As the provision of health services at HMP Berwyn is being fully funded, the risk is minimal.
Recommendation:	To receive and note the report.

Health Board's Well-being Objectives <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>	√	WFGA Sustainable Development Principle <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			
Special Measures Improvement Framework Theme/Expectation addressed by this paper			
Leadership & Governance			
Equality Impact Assessment			
EqIA not applicable to submitted report			

Disclosure:

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

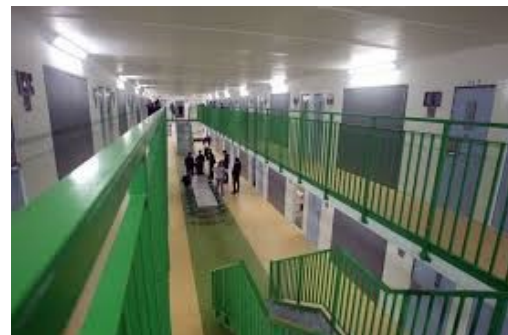


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HMP Berwyn Health and Wellbeing Annual Quality, Safety & Performance Report for Quality and Safety Experience Committee 2018 - 2019



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1. **Purpose of Report**

This report provides a review of the delivery of Health and Wellbeing services during the last 12 months at HMP Berwyn. The report looks at progress made during this period and identifies current performance and improvements being made.

2. **Overview**

The ramp up of men during 2018-19 has not been in line with expectations during the project phase. The current occupancy is 61% of capacity, with the Health Board having not received notification for the implementation of remand men into the prison as yet.

The DNA rate for Health and Wellbeing appointments has been changeable over the last 12 months, with the lowest rate being 13.2% and the highest being 19.1% during the period. The Health and Wellbeing Peer Mentor Service has been instrumental in supporting the reduction of DNA's with the prison, the Regime Supervisor has been introduced whose responsibility is to deliver appointment slips for all Health and Wellbeing appointments. Peer Mentors contact all men who have missed more than three appointments in any one month to discuss the reasons for not attending and discuss the consequences of not attending on both themselves and the wider community.

Attendance at secondary care continues to be low for men from HMP Berwyn; a pilot has taken place during early 2019 on the introduction of a Paramedic to the Health and Wellbeing team at HMP Berwyn. The pilot proved very successful with the Paramedic able to support the emergency responses alongside various other tasks. Pending approval by WAST Executive Team and amendment to the Memorandum of Understanding, recruitment will take place to implement this service as a permanent measure.

The first inspection of HMP Berwyn took place in March 2019, the Health and Wellbeing Services were inspected jointly by Her Majesty's Inspectorate of Prisons (HMIP) and Health Inspectorate Wales (HIW). The feedback from the inspection team was positive about the Health and Wellbeing services provided and the full report will be published in the coming months.

Incident reporting remains consistent with all incidents impacting on patient care being reported through the Datix system. All incidents reported are reviewed on a monthly basis at the Health Operational Leader's Meeting and HMP Berwyn Health and Wellbeing Quality, Safety and Performance Group. All medicine related incidents are also reviewed at the monthly Medicines Management Group.

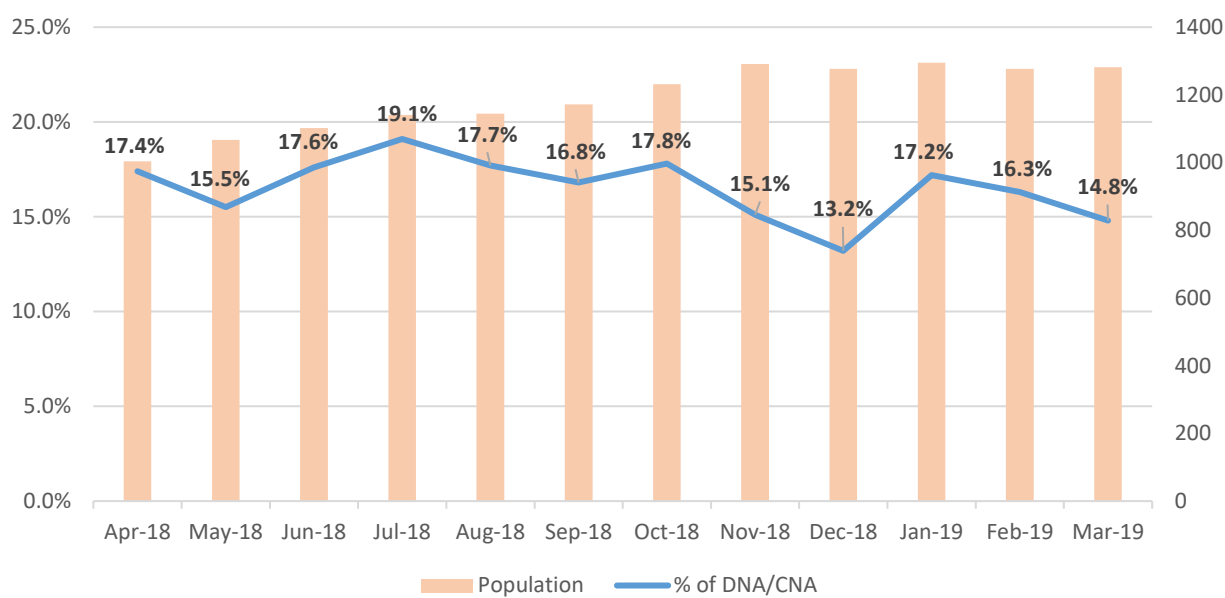
Recruitment and retention appear as two separate risks on the HMP Berwyn Health and Wellbeing Risk Register. The risk register is integrated with the East Area. Recruitment difficulties relate primarily to registered nurses and the teams are reviewing structures and utilising alternative professionals such as pharmacy technicians and allied health professionals where possible.

Access to services is good. HMP Berwyn report referral to treatment (RTT) data to Welsh Government, through the Health Board on a monthly basis. The dental service

have experienced a high waiting time due to issues in relation to recruitment, however improvements have been made in early 2019 which has seen a reduction in waiting times.

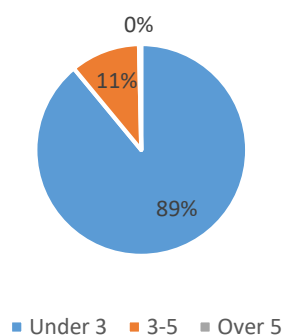
3. DNA / CNA

The DNA / CNA rate across all services in March was 14.8%, with 417 appointments classified as DNA and 242 as CNA.

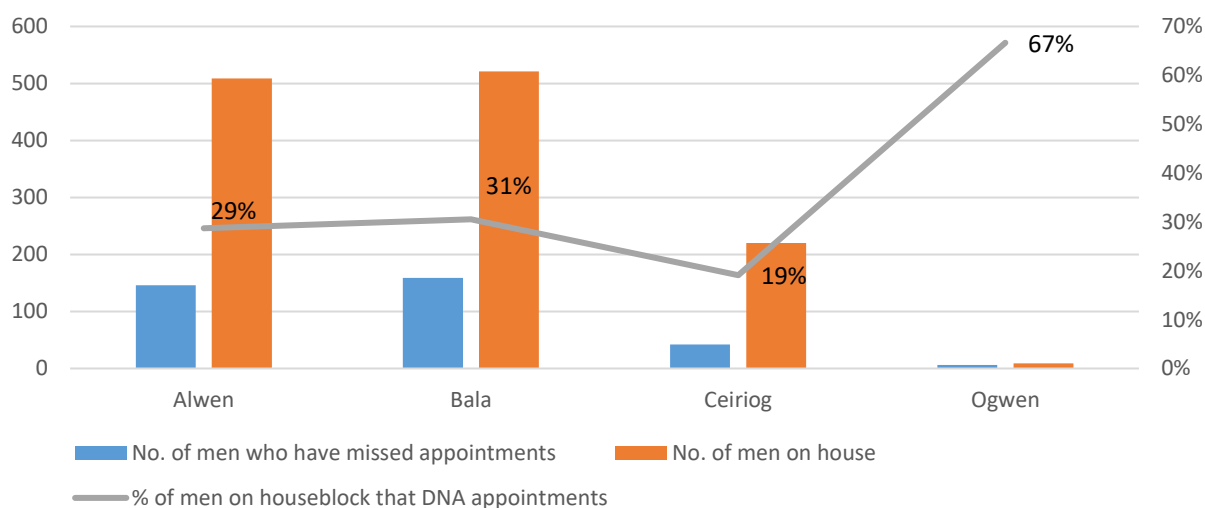


As per agreement at Local Health Delivery Group in January, from March 1st 2019 men who miss more than three appointments with the Health and Wellbeing team in one month will receive a negative entry on their P-Nomis record. This was initially a suggestion by the men who make up the Health and Wellbeing Focus Group. This initiative has led to more men cancelling their appointments and encouraged men to contact the Health and Wellbeing Helpline if they cannot get to their planned appointment due to a prison operational issue, this is shown above by the increase in could not attend (CNA) figures for March.

Of the 291 men who missed appointments during March, only 1 man missed more than 5 appointments, with the large majority, 89% of men missing less than 3 appointments in one month.



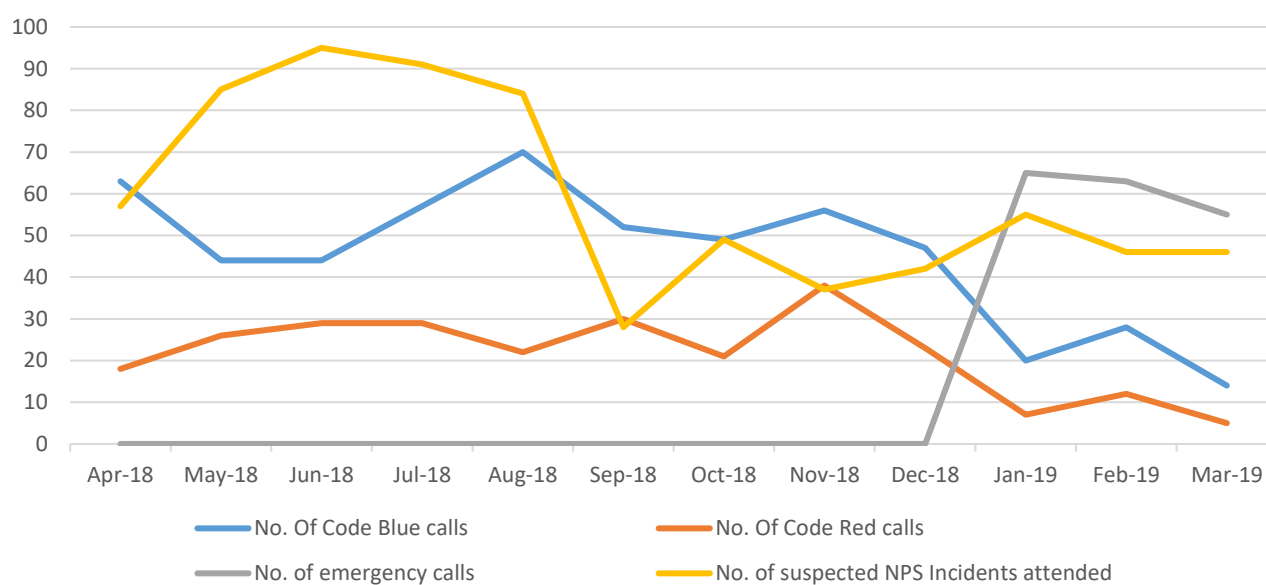
The following graph shows the number of men on each houseblock that have missed one or more of their planned health and wellbeing appointments during March. Bala has the highest number of DNA appointments, but it continues to be an issue across all houseblocks.



The monthly Quality, Safety and Performance Report included detail on the number of men who have not attended health and wellbeing appointments broken down into communities within each houseblock. This report is shared with HMPPS senior management team.

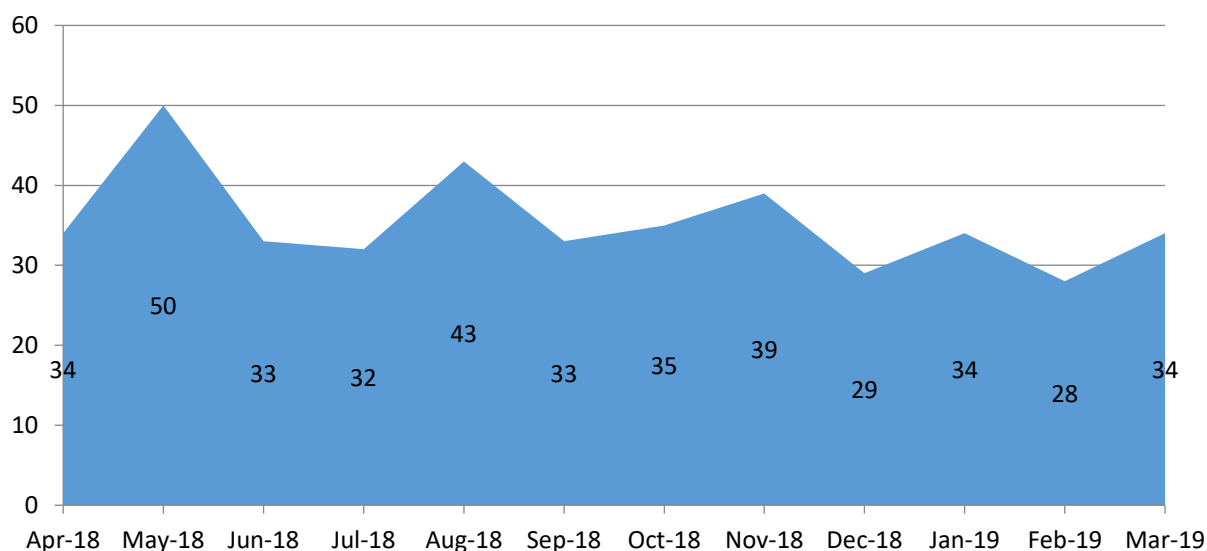
4. Emergency Care

The chart below shows the number of emergency calls responded to within HMP Berwyn by the Health and Wellbeing team. The introduction of the emergency calls was made in January 2019 as the prison staff were calling the emergency response team to incidents which did not warrant an emergency code (red or blue) being called over the radio.

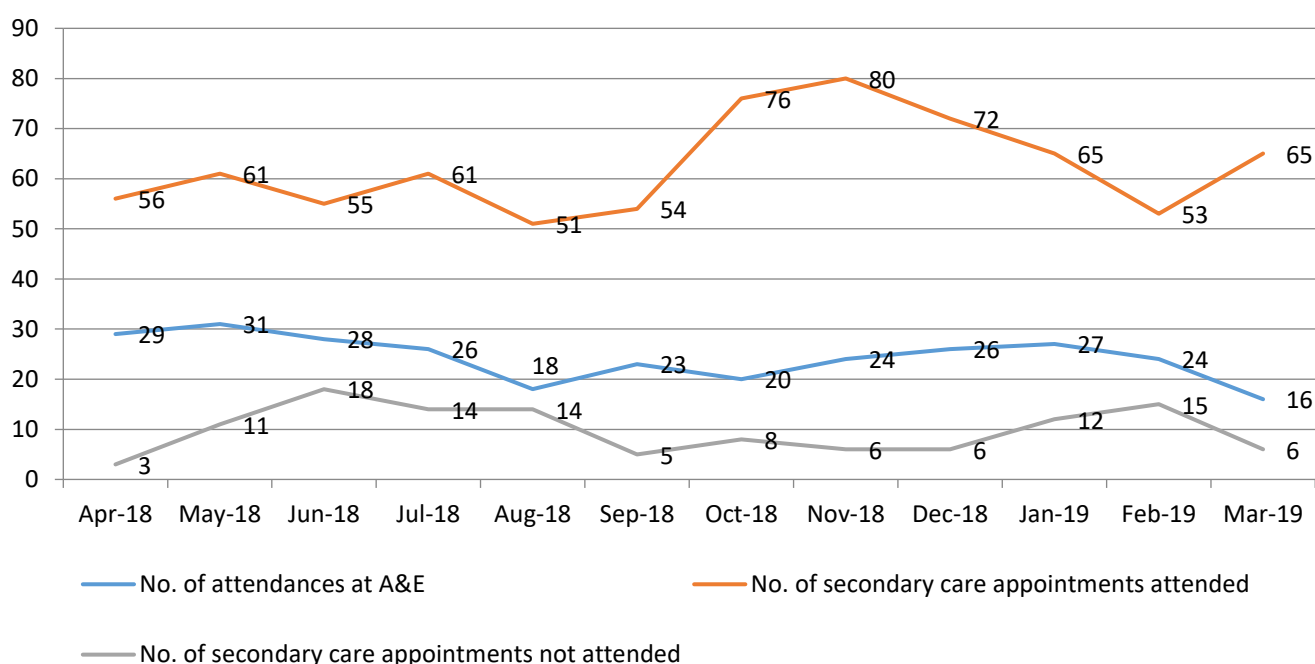


5. Secondary Care

The number of referrals to secondary care continues to be monitored by the Lead GP and is across all specialities. The number of referrals has remained static at approximately 3% of the population over the last 12 months with a slight spike in May with 50 referrals equating to 5% of the population.

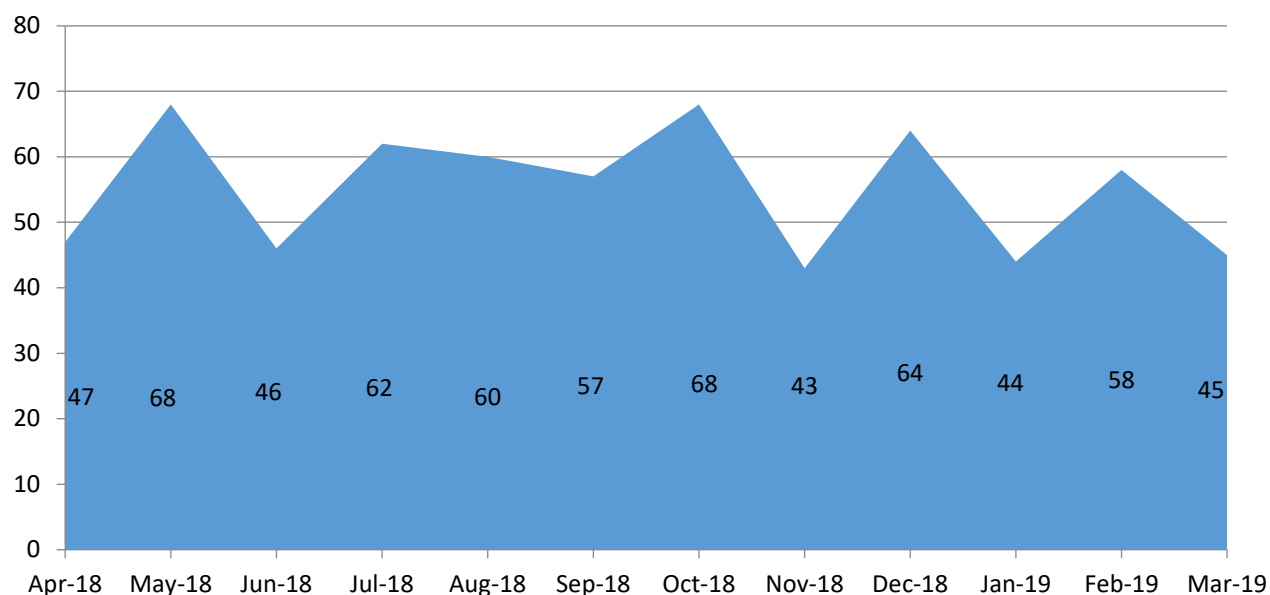


The chart below shows the number of men utilising secondary care services from HMP Berwyn. The number of men attending the Emergency Department at Wrexham Maelor Hospital has not exceeded 3% of the population and the number of men attending planned outpatient appointments has not exceeded 7% of the population in any one month.

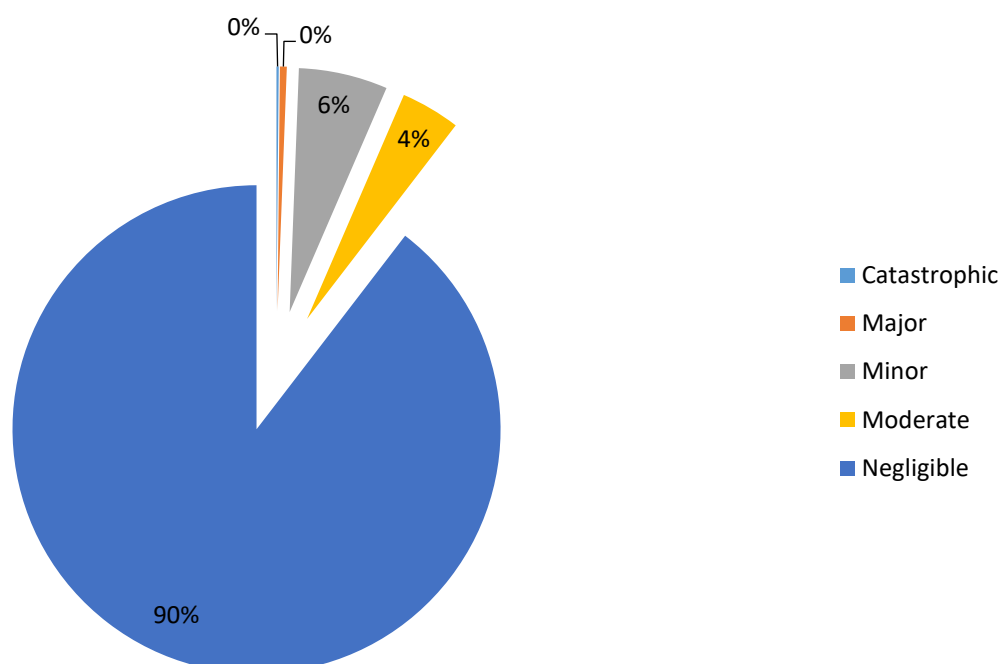


6. Incidents

All incidents are reported using the Datix system and are reviewed within the HMP Berwyn Health Operational Leaders and Quality, Safety and Performance meetings which are held monthly. The number of incidents reported each month is shown below:



The large majority, 90% of incidents reported between April 18 and March 19 were negligible with only one incident classed as catastrophic, which was a death in custody.

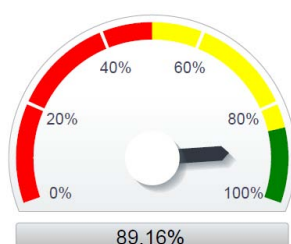


7. Workforce

There are 97 staff in post at March 2019 with 24 vacancies, the majority of which are registered nurse posts. Work is ongoing within the senior team to review vacancies to ascertain whether an alternative professional such as a pharmacy technician or member of the therapies could be utilised instead of a registered nurse. The overall staff turnover rate for 2018-19 at HMP Berwyn is 16%.

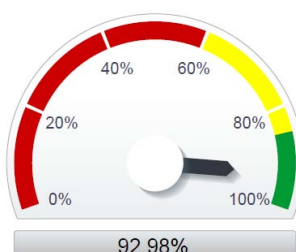
PDRs (Appraisals)

The PADR compliance rate has decreased by 3% since February to 89%. Managers continue to receive monthly reminders of staff who have PADR's due to expire, there are a number of team members who are away from work due to maternity leave or long term sickness, who are included in the numbers who have outstanding PADR's.



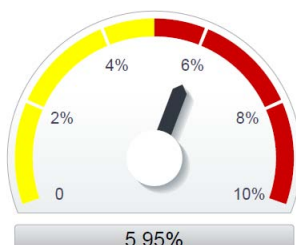
Statutory and Mandatory Training

The Team's compliance rate for statutory and mandatory training increased slightly to 93% in March. All staff are supported to complete this suite of training and to regularly maintain compliance.



Sickness Absence

The sickness absence level for March 2019 is 5.95%, this is above the BCUHB target of 4.55%.



The management of sickness absence is a priority for the team and is being actively managed by individual Line Managers. Both long-term and short-term absences are being addressed with adherence to the Sickness Absence Policy. The majority of absences continue to be due to stress and anxiety issues.

8. Risk Register

The following list shows all the risks which currently form the HMP Berwyn Health and Wellbeing Operational Risk Register. All risks are allocated to members of the Health Operational Leaders group with responsibility for review and update. The Risk Register is an agenda item on Health Operational Leaders Group and Quality Safety and Performance Meeting and Local Health Delivery Group which meet monthly; the later is a partnership meeting and includes representation from HMPPS, WCBC and IMB. The agenda item is for review and comment. The Risk Register is also an agenda item on the quarterly Clinical Governance Group meeting.

TITLE	DESCRIPTION	RISK RATING
Design of non adapted room toilet	Disabled patients are at risk of falling whilst using the toilet. This is because the design of toilets in all non-adapted rooms are not able to accommodate any adaptive equipment which would provide a raised toilet seat or seat with arms for men who may require this to use the toilet safely. The consequence of a fall would be an injury to the patient and potential litigation.	12 (High)
Poor design of low mobility rooms to accommodate disabled men	Disabled patients are at risk of falling whilst located in low mobility rooms. This is because the design of rooms in all low mobility rooms are not able to accommodate any men with disabilities. The consequence of a fall would be an injury to the patient and potential litigation. This is a shared risk with Wrexham Borough Council and HMPPS. This risk is reviewed monthly at the Local Health Delivery Group.	12 (High)
The high use of PS substances in HMP Berwyn	There is a risk to the health and safety of men and staff. This is because of the illicit use of psychoactive substances by men at HMP Berwyn. The consequences for men are the adverse health effects associated with the use of PS and, the for staff the adverse health effects associated with secondary exposure to PS. Additional consequences include an increased demand on clinical services and psychosocial substance misuse services as a result of increased PS use. This is a shared risk with HMPPS and is reviewed monthly at the Local Health Delivery Group.	12 (High)
Inadequate progress to resolve clinically critical/operational IT functionality	There is a risk that clinical services cannot be delivered. This is because critical clinical and operational IT functionality is not available to all staff. Namely ICE integration with SystmOne, Radis integration with SystmOne, installation of JAC, installation of Wifi to Ogwen and stabilisation community in Ceiriog. The consequence of this is the inability to deliver aspects of care resulting in patient safety concerns and potential litigation. Lack of SystmOne access from BCUHB laptops working under virtual private (VPN) network tokens at home whilst on-call. This prevents the clinical management of patients whilst on-call and could negatively impact on individual patients and BCUHB corporate responsibilities.	10 (High)
Insufficient accommodation to deliver planned service model	There is a risk to patient care as patients will not be seen within a timely manner. This is because HMPPS have not provided the Health Board with an adequate number of appropriate rooms allocated to healthcare in order to facilitate the delivery of services. The existing shortfall is as follows: Two group rooms AM/PM to provide mental health and substance misuse interventions Inadequate office desk space Inadequate non clinical consulting rooms to provide mental health and substance misuse services with rooms to undertake assessments and 1:1 interventions This could result in increased patient waits, inability to deliver interventions resulting in delayed patient care and subsequent litigation should appropriate care not be delivered.	10 (High)

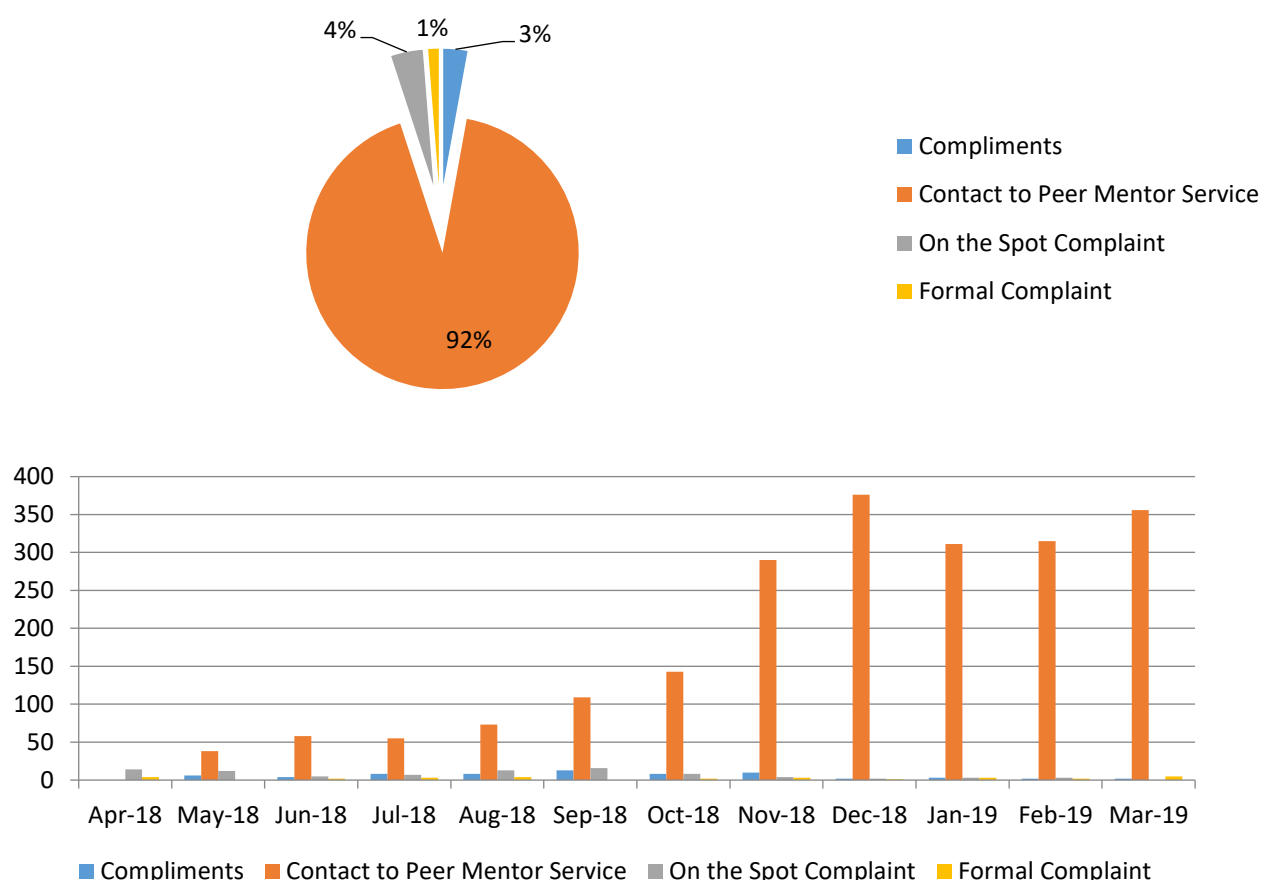
	This is a shared risk with HMPPS and is reviewed monthly at the Local Health Delivery Group.	
No IT platform is available to the men to access on line mental health and substance programmes	<p>There is a risk that we will not be able to deliver mental health and substance misuse on line programmes.</p> <p>This is because an appropriate IT platform has not been provided by the prison that is accessible to the men.</p> <p>This could result in increased patient waits, inability to deliver interventions resulting in delayed patient care and subsequent litigation should appropriate care not be delivered.</p> <p>This is a shared risk with HMPPS and is reviewed monthly at the Local Health Delivery Group.</p>	10 (High)
Recruitment of health and wellbeing staff	<p>There is a risk of not having adequate staff to deliver health and wellbeing services.</p> <p>This is because of difficulties recruiting suitably trained staff and the lengthy recruitment process required to work in the prison setting.</p> <p>The consequences is the inability to deliver the health and wellbeing services resulting in delayed patient care and potential litigation.</p>	10 (High)
Retention of health and well being staff	<p>There is a risk of not having adequate staff to deliver health and wellbeing services.</p> <p>This is because of difficulties retaining suitably trained staff and the lengthy recruitment process required to work in the prison setting.</p> <p>The consequences is the inability to deliver the health and wellbeing services resulting in delayed patient care and potential litigation.</p>	10 (High)
Safe dispensing of medication is not achieved in line with the core day	<p>There is a risk that administration of medication is not completed during the allocated time slot to support the prison core day.</p> <p>This is because there is a potential for too many medications to be administered in too short a window.</p> <p>The consequence of this is the inability for HMPPS to deliver their core prison day and operational requirements aligned to this.</p> <p>This is a shared risk with HMPPS and is reviewed monthly at the Local Health Delivery Group.</p>	9 (High)
Clinical and administrative rooms in the Health and Wellbeing building and other areas can be accessed by non-healthcare staff	<p>There is a risk that non health and wellbeing staff access designated health and wellbeing rooms.</p> <p>This is because all health and wellbeing rooms are not on a separate suite key to general offices.</p> <p>The consequence of this is the unauthorised access to health and wellbeing rooms, health and wellbeing equipment, medicines and patient records.</p>	6 (Moderate)
Medication errors from SystmOne EPMA (electronic prescribing and medicines administration)	<p>There is a risk that continued medication errors could be made in medicines processes at HMP Berwyn. This could be caused by a lack of formal training for SystmOne or it could also be attributed to a lack of governant communication regarding changes to the EPMA system from SystmOne's owners TPP. These medication errors if not detected could cause harm to patients and could lead to litigation.</p> <p>These medication errors could also be attributed to a lack of governant communication regarding changes to the EPMA system from SystmOne's owners TPP.</p>	6 (Moderate)

9. Contacts

The last 12 months has seen the development of the Peer Mentor Service at HMP Berwyn. There are currently four full time Health and Wellbeing Peer Mentors, one trainee Peer Mentor and one Regime Supervisor employed to support the Health and Wellbeing team in delivering care to the men at HMP Berwyn.

The Peer Mentor Service support the Health and Wellbeing team in signposting men to the services on offer to them, answering any queries which men may have and discussing concerns. The Health and Wellbeing Helpline was introduced in November 2018, which allows men at HMP Berwyn to contact Health and Wellbeing Peer Mentors via the telephone in their room. The Peer Mentors answer the calls to the Helpline and resolve queries with the support of the Service User Engagement Officer and administrative support. The phone line also allows Peer Mentors to contact men to remind of appointments, notify of cancellations or re-arranged appointments and to chase up any missed appointments promptly.

The following charts show the number of contacts made alongside complaints received by the Health and Wellbeing Service.

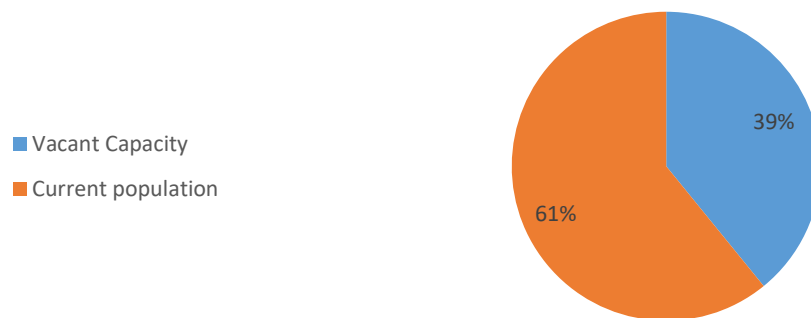


The number of formal complaints received remains low due to the quick resolution of issues by the Peer Mentor Service. Compliments are rarely recorded; however the men at HMP Berwyn value the service offered to them and have expressed so during feedback and within the Health and Wellbeing Focus Group meetings, held on a monthly basis.

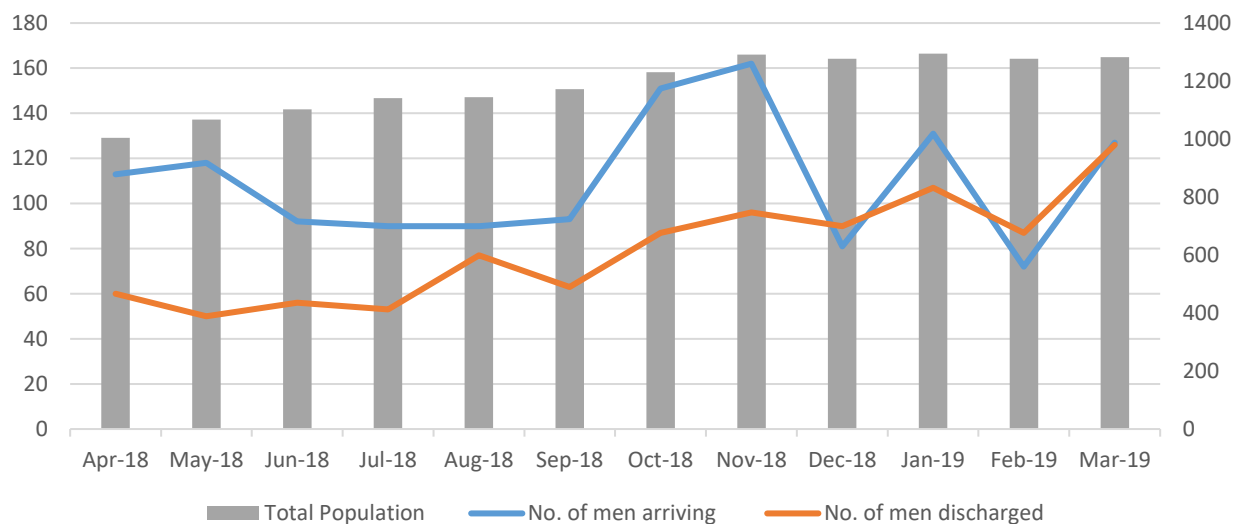
10. Demographics

Since the prison opened in February 2017, there has been a planned ramp up of men to reach full capacity of 2,106. The ramp up has not continued in line with plans due to prison operational issues and the limited availability of purposeful activity places for the men arriving at HMP Berwyn.

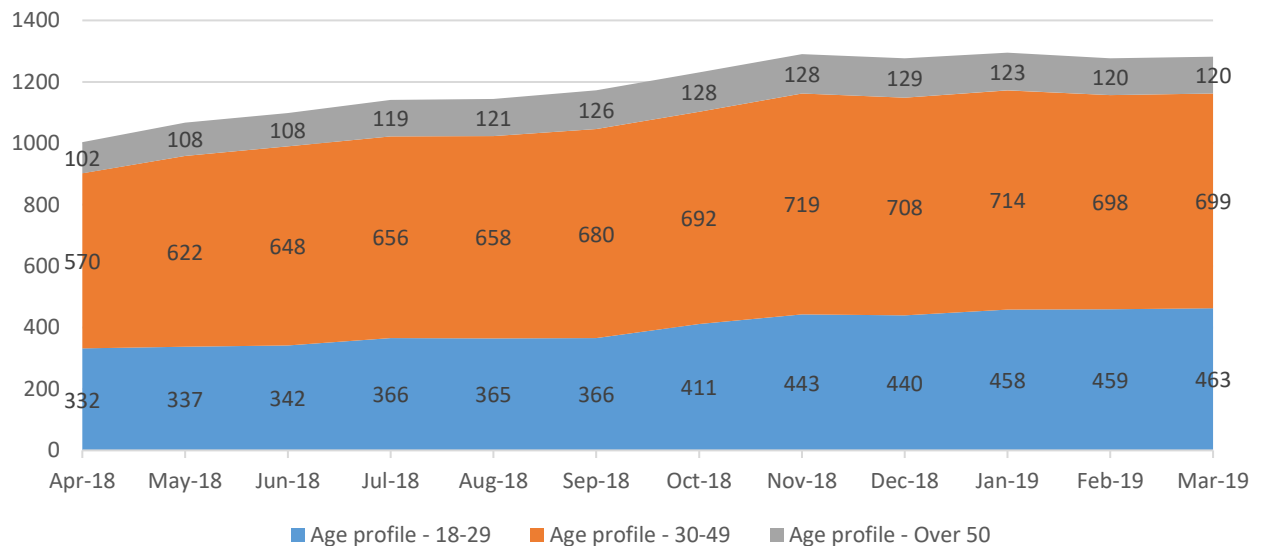
The capacity as at April 2019 is 61% of full occupancy with 1282 men.



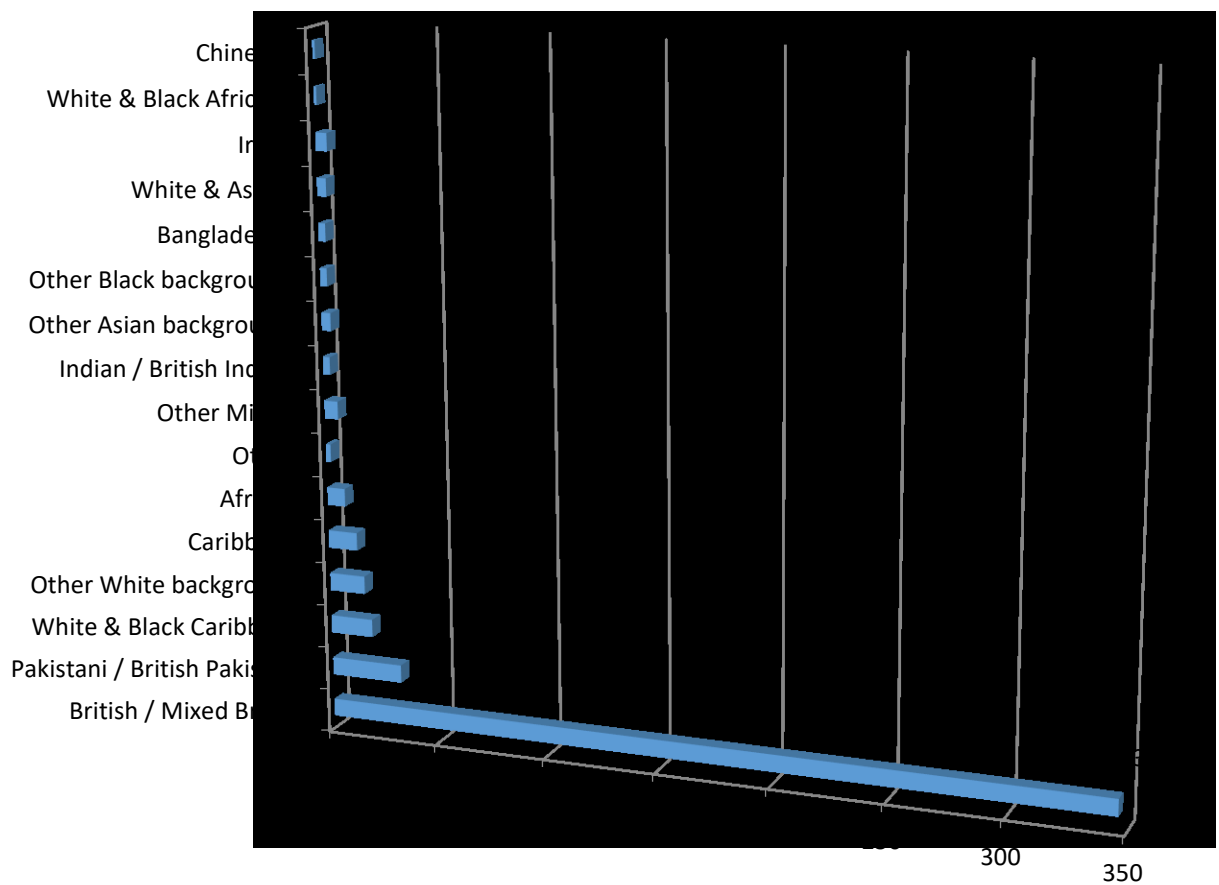
There has been a changeable number of arrivals and discharges of men at HMP Berwyn. The number of discharges of men, due to transfer and release has been higher than expected during the last year of service with 952 men leaving the establishment and 1320 arriving.



The age profile has remained static throughout the ramp up of men during the last 12 months with the majority of the population within the 30-49 age range.



As at March 2019, 36% of men at HMP Berwyn have their ethnicity identified on their clinical record, the majority of men, 27% identified as British / Mixed British. A full breakdown is shown below.

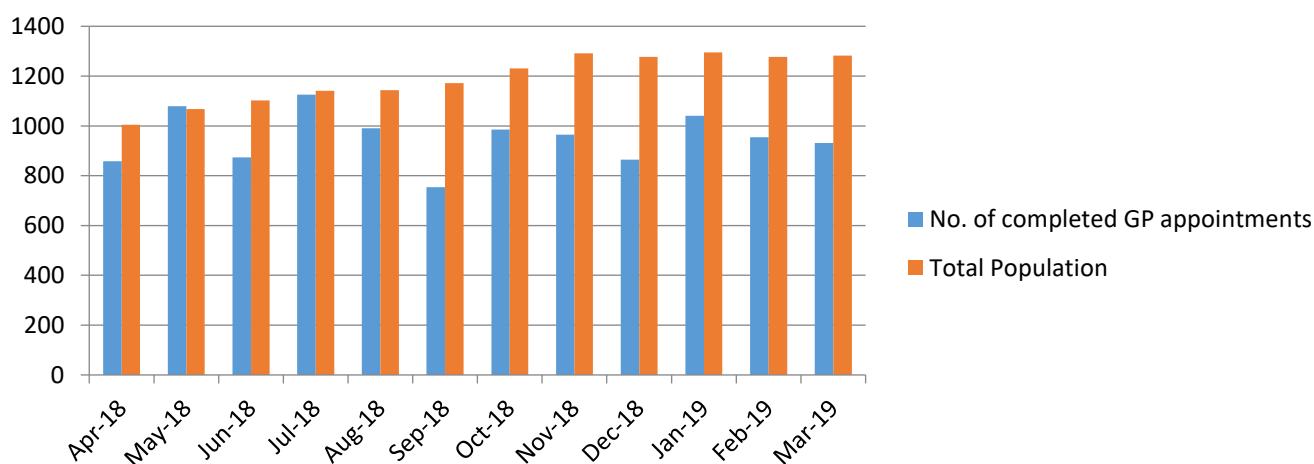


11. Service Delivery

General Practitioner

The GP service is provided by Gables Offender Health Services who provide up to a maximum of 19 sessions each week and are on site for 5 days per week but also provide out of hours cover too.

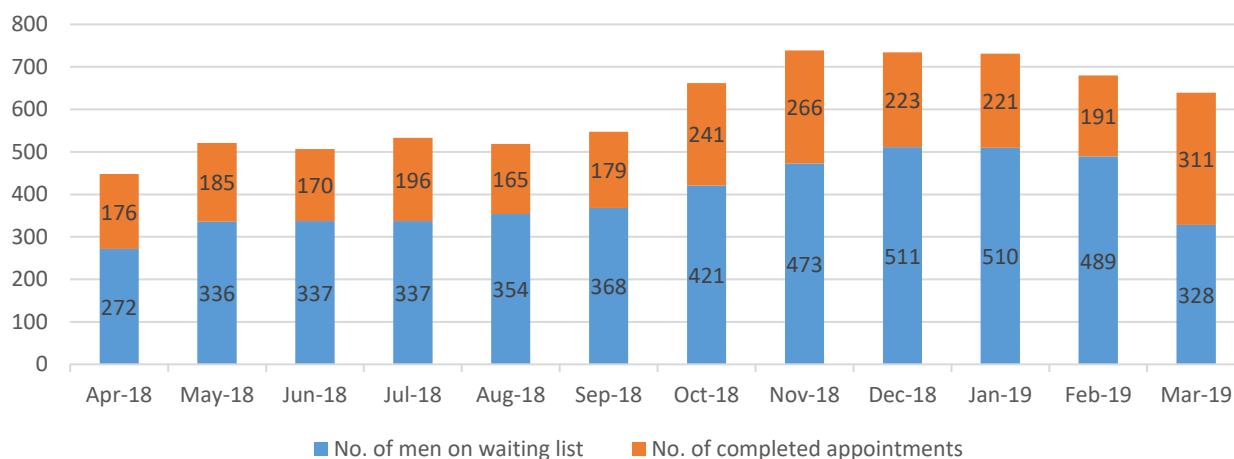
The average waiting time to see a GP for an appointment is 10 days. However, there is an opportunity for men to access a GP on the same day if urgent.



Dental

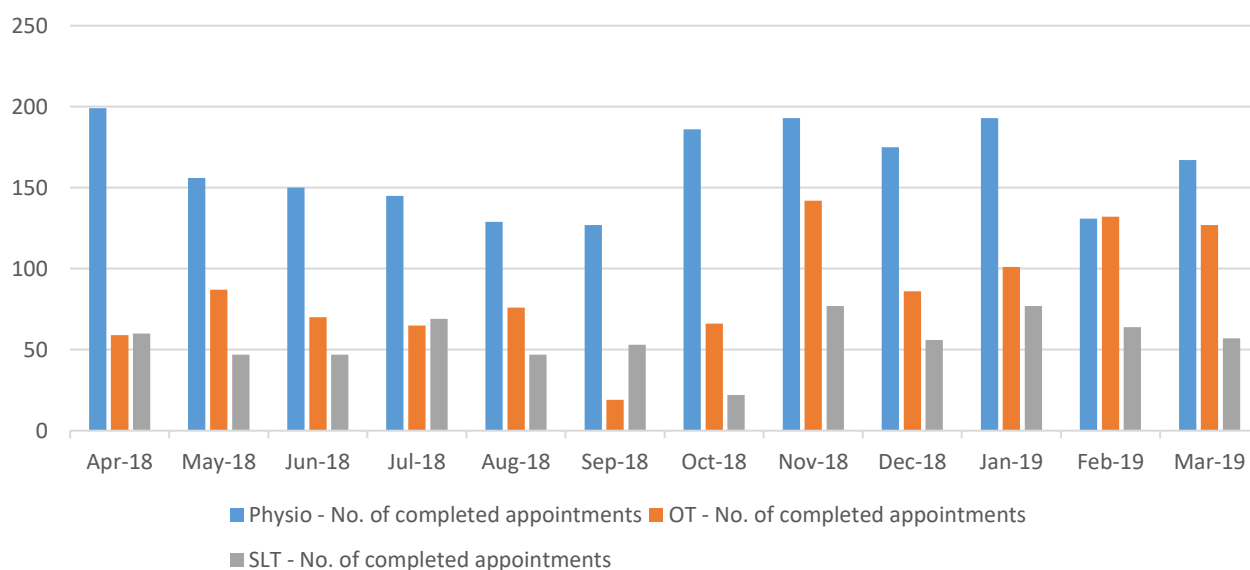
There continues to be a high demand for dental services. There are currently 328 men on the waiting list for routine appointments. There are no men waiting for an urgent dental examination.

Work has been completed by the dental team to reduce the number of men on the waiting list following recruitment issues within the team; there is now full time dental provision which will aid in reducing the number of men waiting for a routine dental appointment. The dental therapist is developing an oral health promotion strategy for the men at HMP Berwyn.



Therapies

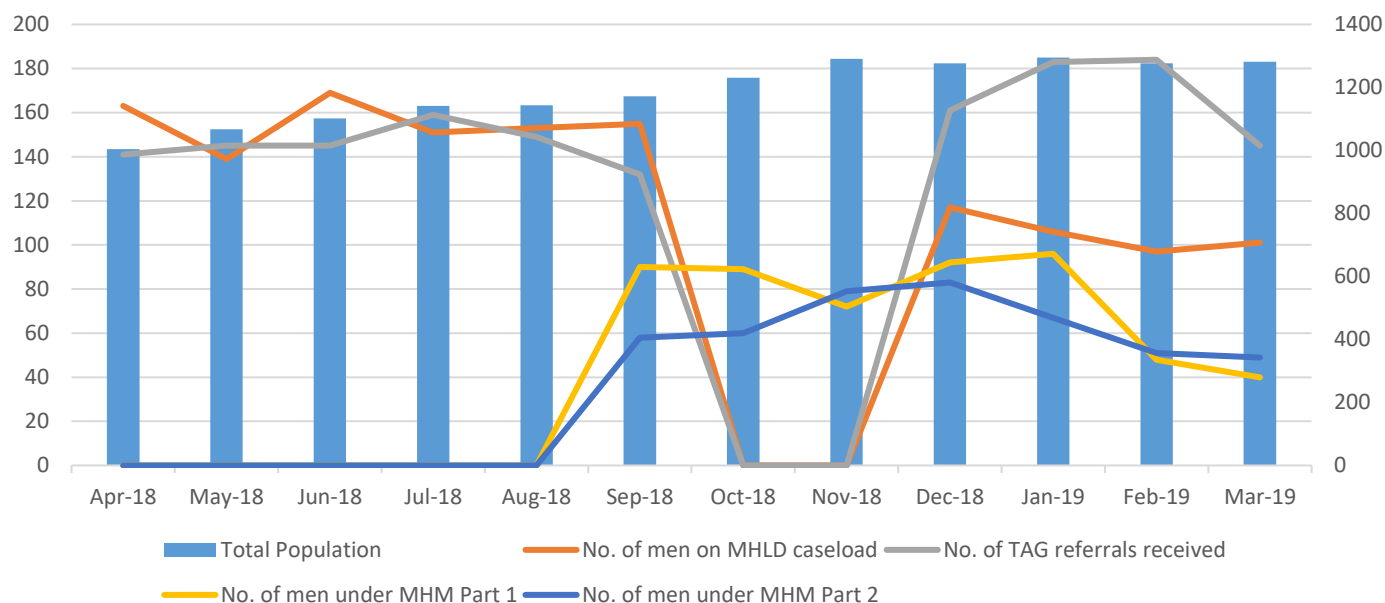
All therapies services are now in place and recording mechanisms have been established to ensure that the waiting times, which are reported to the Health Board, are accurate. There is currently no dietetics service on offer at HMP Berwyn due to recruitment, however, all referrals to the service are reviewed by the Lead Therapist based at HMP Berwyn and discussed with the dietetics service within the east area.



Sessions are provided by audiology (4 x sessions per week), Optical (2 x sessions per week) and Podiatry (2 x sessions per week) who manage their waiting lists well providing a good, accessible service to the men at HMP Berwyn.

Mental Health and Learning Disabilities

Demand continues to be high for the mental health and learning disabilities service at HMP Berwyn.

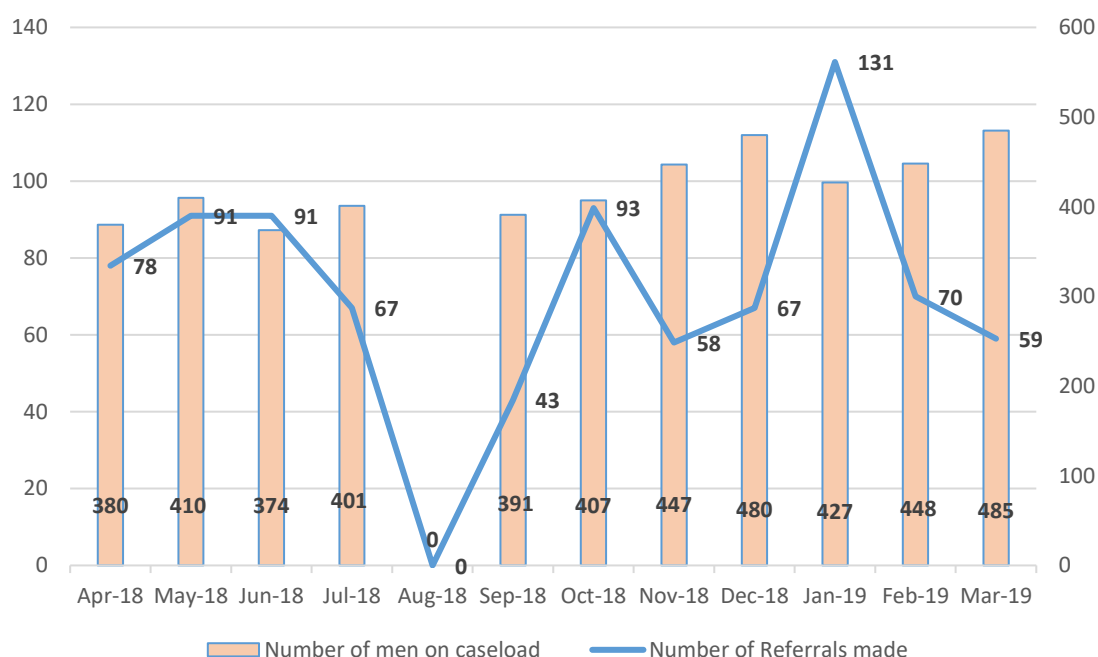


The Mental Health and Learning Disabilities team are expected to comply with the Mental Health Measure recommendations; at March 2019, there are 40 men under Part 1 of the Measure and 49 registered under Part 2 of the Mental Health Measure. The team have decreased in Measure compliance for a further month with 35% of men under Part 2 of the Measure with active care and treatment plans in place; this is a decrease of 6% from last month. A service development plan is in place to improve compliance.

Integrated Substance Misuse Service

The Integrated substance misuse team have focused on the number of men on treatment receiving 13 week reviews over recent months, this has resulted in 88% of men eligible having an in date 13 week review in place.

The chart below shows the number of men on the Integrated Substance Misuse caseload alongside the number of referrals received each month. The number of men on the caseload has remained static over the last 12 months.

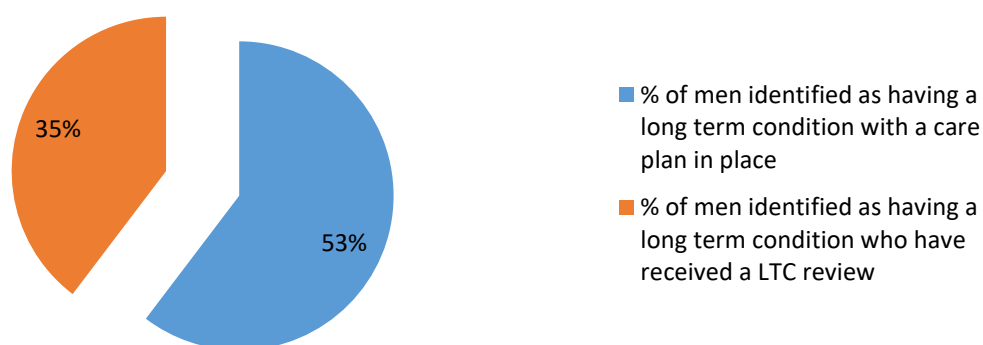


The number of referrals received has been changeable over the last 12 months, with 43 referrals being the lowest and 131 the highest number of referrals received in one month.

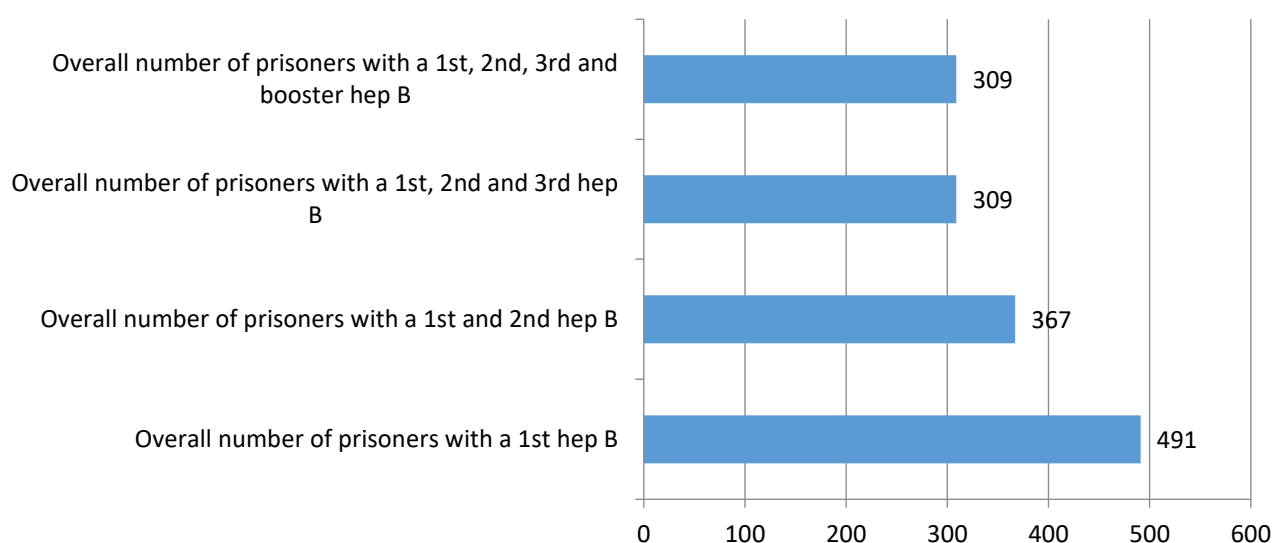
Primary Care

There has been a considerable amount of work undertaken to ensure all men at HMP Berwyn have been offered a dry blood spot test. 22% of men received the test during the last 12 months, with a further 12% being offered and refusing the test.

There are 271 men at HMP Berwyn who have been identified as having a long term condition. The primary care team have been working to cleanse the data within the clinical record to ensure that the information is accurate. 53% of the 271 men have a care plan in place and 35% have received a long term condition review in line with NICE guidance.

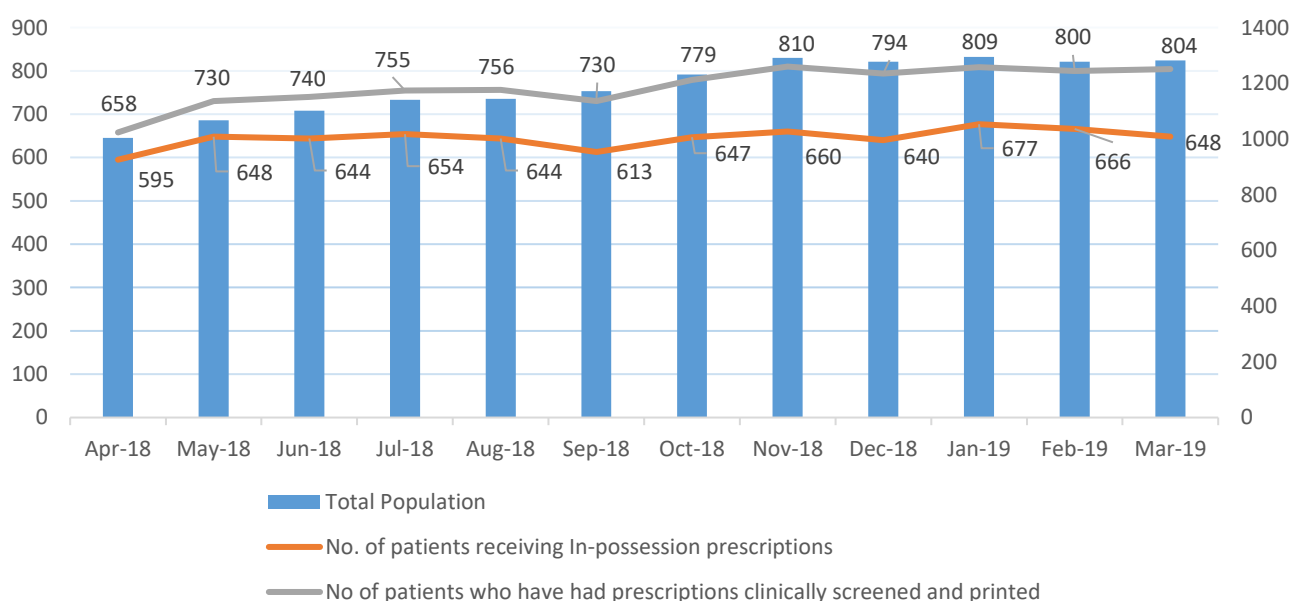


The number of men who are vaccinated against Hepatitis B are reported to Public Health Wales on a monthly basis, the detail below is at March 2019.



Pharmacy

The number of men currently receiving medication continues to be in line with projected numbers.



A total of 2380 items for 804 patients were prescribed and then clinically checked by a clinical pharmacist, before the technician dispensing and accuracy checking processes, between 01/03/2019 and 31/03/2019. Of the above total prescribing 1818 items (76%) were prescribed IP for 648 patients. 99% of patients actively prescribed medicines had an in-possession risk assessment in place with 79% of prescriptions being given as in-possession.

12. Finance

Budget 2018/19

The 2018/19 opening budget for recurrent revenue (operational costs) has been set at £7,010,958. This is inclusive of costs relating to the impact on secondary care, tertiary referrals and Welsh Ambulance Service EMS transport.

Consistent with 2017/18 this budget has been revised based on current capacity, ramp up plan and staffing levels.

This service is being fully funded, therefore an income target has been applied in order to ensure this does not have any financial impact on the Health Board.

Financial Performance

Recurrent costs associated with HMP Berwyn total £5,691,113 as at Month 12 against planned expenditure of £7,010,958. In-month expenditure totalled £501,042, which is £44,901 above Months 1 to 11 average.

Pay related costs increased by £38,768 when compared with Month 11 as a direct result of an increase in Agency costs. Costs of this nature are not expected to continue at this level moving into 2019/20 as the Month 12 cost was primarily due to a backlog of invoices. Total pay costs are back in line with 2018/19 average.

Drug costs continued to reduced by £17,085 during month 12 against the 2018/19 run rate, totalling £23,797. Drug costs have shown a steady increase during 2018/19. It is anticipated that this will continue moving into 2019/20 as the population starts to increase at a higher rate.

Secondary Care costs relating to inpatient stays, ED and OP attendances totalled £19,909 in March. Although a marginal reduction compared with February, costs have remained consistent throughout 2018/19.

Key Financial Risks

There are a number of potential financial risks to the Health Board associated with the project. As the provision of health services at HMP Berwyn is being fully funded, the risk is minimal

A summary of the potential risks is captured below, along with mitigating actions which have been put in place.

HMP Berwyn Financial Risks

Potential Financial Risk	RAG	Mitigating Action
Current Memorandum of Understanding expires March 2019.		An extension to the current agreement has been submitted and is being reviewed by colleagues within HMPS. It is anticipated that this will be formally signed off before 31 st March 2019.
<p>Secondary & Tertiary care</p> <p>Activity in secondary & tertiary care relating to HMP Berwyn not captured/monitored correctly. As a result, accurate recharges will not be appropriately actioned and BCUHB would pick up costs.</p>		Patients are tracked via unique postcode through secondary and tertiary care. Activity data is extracted from Systm1 and can be validated by comparing against IRIS data. This means all activity can be tracked from start to finish and quantified appropriately.
Healthcare needs of men may be greater than anticipated leading to increased impact on services on both prison & hospital sites		Contingency funding available. The Health Board have implemented systems and processes that will be used to demonstrate impact and claim retrospectively.
Additional costs which have not been included in financial plan may be incurred.		Contingency funding available. Any potential costs must continue to be escalated through the formal route and be supported by a business case.
No further mobilisation funding available for further unforeseen 'set up' costs.		The management team have ensured that all potential costs have been identified. It is anticipated that there is enough flexibility within the operational budget to cover any further costs in relation to mobilisation

Quality, Safety & Experience Committee 21.5.19	 <div data-bbox="1027 212 1270 295"> Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board </div> <p>To improve health and provide excellent care</p>
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Report Title:	Pandemic Influenza Plan Distribution: Collection and Home Delivery of Antivirals (updated)
Report Author:	Adam Mackridge, Deputy Head of Pharmacy for Primary and Community Care (East) Sarah Rodger Jones, Pharmacy Assistant
Responsible Director:	Dr Berwyn Owen, Director of the Pharmacy & Medicines Management Division
Public or In Committee	Public
Purpose of Report:	Approval of the Policy.
Approval / Scrutiny Route Prior to Presentation:	BCU Medicines Policies Procedures PGD Subgroup 23.1.19 BCU Drugs and Therapeutics Group 6.2.19 Quality, Safety Group (QSG) 13.3.19
Governance issues / risks:	None identified. Appendix 4: memorandum of Understanding needs signature of Chief Executive BCUH and of all 6 County Councils
Financial Implications:	Update of existing policy – none identified
Recommendation:	The Committee is asked to approve the Policy

Health Board's Well-being Objectives <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>	√	WFGA Sustainable Development Principle <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			
Special Measures Improvement Framework Theme/Expectation addressed by this paper			
Leadership & Governance			
Equality Impact Assessment			
See attached			

Disclosure:

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



PANDEMIC INFLUENZA PLAN

Distribution, Collection and Home Delivery of Antivirals

Author & Title*	Sarah Rodger Jones, Pharmacy Assistant Adam Mackridge, Deputy Head of Pharmacy for Primary and Community Care (East)
Responsible dept / director:	Berwyn Owen, Chief Pharmacist Pharmacy & Medicines Management
Approved by:	BCU Medicines Policies Procedures PGD Subgroup 23.1.19 BCU Drugs and Therapeutics Group 6.2.19 QSG 13.3.19
Date approved:	Xx/xxx/xxxx
Date activated (live):	Xx/xxx/xxxx
Documents to be read alongside this document:	North Wales Resilience Forum Multi Agency Major Human Infectious Diseases Framework Pandemic Influenza Vaccination Plan Communications Pandemic Influenza plan Primary care Influenza Pandemic plan Secondary Care Pandemic Influenza plan Major Emergency Plan Guide to Engaging the Voluntary Sector v2.4 August 2018
Date of next review:	xxx
Date EqlA completed:	28 November 2018

*This document has been adapted from a previous version drafted by Eiriann Turner, Specialist Medicines Management Nurse for Primary Care and Community Services (West)

First operational:					
Previously reviewed:					
Changes made yes/no:					

N.B. Staff are 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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1 Introduction

This guidance is intended to support Health and Social Care (HSC) pandemic preparedness and response planning for Antiviral distribution across Betsi Cadwaladr University Health Board (BCUHB) and forms part of the wider BCUHB strategy for response to an influenza pandemic.

The use of antivirals is likely to minimise the morbidity and mortality resulting from an influenza pandemic and reduce in the need for other health interventions and services.

The effectiveness of antivirals against influenza is most effective if treatment commences within a short time after symptoms have developed. Therefore, to achieve the maximum health gain, BCUHB needs systems in place to distribute antivirals to patients within 12 hours of a decision to treat having been made and no later than 48 hours. To facilitate this, Wales purchases sufficient antivirals to treat all those expected to develop clinical symptoms. All supplies purchased by the Welsh Government are held centrally and ring-fenced for use in Wales only.

In the event of a pandemic, National Policy and proactive media campaigns will encourage those with influenza symptoms to remain at home, with the majority of decisions to treat being made on the basis of home visits, telephone or video calling assessments. This document describes the antiviral distribution process that will be put in place in North Wales through joint working between BCUHB, Local Authorities and the voluntary sector.

1.1 Pandemic planning assumptions

The plans set out in this document are based on the following planning assumptions, which relate to a reasonably worst case pandemic scenario.

- Up to 50% of the population could experience symptoms of pandemic influenza over one or more pandemic waves each lasting 15 weeks.
- 2.5% of those with symptoms could die as a result of influenza, if no treatment proved effective
- 30% of all symptomatic people may need to access primary care.
- 1-4% of symptomatic people may require hospital treatment.
- 25% of hospital patients may require critical care
- 15-20% of staff may be absent on any given day during peak weeks. These figures could be reduced depending on the effectiveness of antivirals and antibiotics.

2 Role of BCUHB

BCUHB will coordinate and monitor the distribution of antiviral medicines within their locality, and will liaise with relevant staff from local authorities and voluntary organisations in order to:

- Coordinate the opening of antiviral collection points (ACP), set out in this document, and ensuring appropriate operational, business and resilience procedures are in place.
- Manage the operation of the antiviral collection points, including appointment of appropriate supervisory staff.

- Obtain supplies of antivirals from the national coordination centre, or other suppliers if appropriate, and deliver these to the collection points and other points of use as appropriate
- Coordinating the delivery of antiviral medicines from the collection points to a patient where, under exceptional circumstances, the patient does not have a representative who is able to collect their medication for them.

Where a decision is made to establish ACPs in the BCUHB area, the BCUHB Chief Pharmacist will nominate a Pharmacist or Registered Pharmacy Technician to act as the Antiviral Collection Point Lead for BCUHB. Roles of key personnel are described in Appendix 1

3 Level of response

At the outset, the eventual severity of the pandemic will not be clear, nor will its impact on health and social care provision. Response plans, therefore, adopt a risk-based approach and are flexible and capable of proportionate scaling up or down.

Arrangements for opening of antiviral collection points will be determined by BCUHB, based on the pressures being faced at the time and national policy and advice.

The Chief Medical Officer (CMO)/Chief Pharmaceutical Officer (CPhO) will issue a letter to health professionals advising on use of antiviral medicines. All healthcare professionals with patient contact should also support members of the public by providing positive health messages, advice on respiratory and hand hygiene measures and support for self-care, including the use of over the counter medicines where appropriate.

GPs, community pharmacies and community health teams will continue to be a key part of the health response. **In a low impact pandemic** it may be possible to maintain service delivery, albeit with some adaptations, dependent upon the level of impact of the pandemic.

In a pandemic of moderate impact, suspension of non-urgent clinical care and non-clinical activities, with other measures such as telephone consultations may free up additional capacity. Close working between primary care, social care, the independent and the voluntary sector will support the majority of patients requiring home care. However, pressure on individual practices may be heavy and single-handed or smaller practices are likely to experience disproportionate difficulties caused by increasing demand and reduced staffing levels. Pre-planned “buddying” arrangements between practices may assist in maintaining continuity of services. In a moderate level scenario, primary care services may still be able to manage distribution of antivirals through normal care pathways. However, planning for opening Antiviral Collection Points (ACPs) should be undertaken to enable response to local changes in the pandemic status and/or failure of local health services.

In a moderate (or higher) impact scenario, all services will be preparing for, or undertaking, a pre-agreed capacity expansion process and may need to consider the implementation of mutual aid arrangements or the reduction of non-urgent work. The decision to activate capacity expansion plans is likely to be made at a local level, as not all parts of Wales will be affected at the same time or to the same extent.

Operators of day care centres may choose to close their facilities to reduce the risk of spreading infection to vulnerable individuals. Staff and volunteers released from duties may then be a valuable redeployment resource as they possess a range of transferable skills and will have been security checked. In closing these facilities,

operators should plan for users for whom absence of day care services would create critical health and welfare risks, paying particular attention to those service users who arrange their own care. Services should also activate plans to provide 'Flu Friends' for those vulnerable people who have no one else to collect medication and provide support if they become ill. A flu friend is a person or persons can be relatives, friends/ neighbours, or representatives of the voluntary sector (eg British Red Cross) who can collect antiviral medicines, food and other supplies on behalf of symptomatic individuals.

Social care providers are aware of, and are in regular contact with, many vulnerable individuals in the community. Such individuals might be either more vulnerable to, or more affected by, pandemic influenza. Other individuals, not normally perceived as vulnerable, may become so in the setting of a pandemic, e.g. single parents with young children, and adults living alone who may be remote from family.

In a high level pandemic, many services will come under pressure and innovative solutions are needed to provide increased capacity and sustainability without diluting expertise. Primary care out-of-hours services are one example where increased pressure may have a disproportionate impact and a knock on effect on other services such as in-hours primary care, emergency departments and ambulance services. All services will need to work closely together so that they can continue to function and that no single area is overwhelmed. It is important to avoid the risk of delay in diagnosis and treatment for patients suffering from serious non-influenza illnesses. In a high level scenario, antiviral collection points should be fully operational.

4 National Pandemic Flu Service

On reaching a High Impact Pandemic scenario the National Pandemic Flu Service (NPFS) will be operational at a national level. Prior to implementation, BCNUB will manage hotspots at a local level.

The NPFS aims to:

- reduce pressure on primary care services;
- allow people with flu like symptoms to remain at home;
- make antivirals accessible without unduly compromising security or patient data
- enable rapid self-service assessment, care advice, GP referral and antiviral authorisation, and
- provide an additional source of data relating to trends in activity and profile of people assessed as suffering from pandemic symptoms.

The service will be available through the web or a dedicated call centre facility to enable members of the public to be assessed and given antiviral medicines if appropriate. The telephone service can be accessed via Textphone and the web version is available in a number of different languages.

The patient pathway process is as follows:

- A symptomatic individual, or their 'Flu Friend', will contact the NPFS and an assessment (using a clinical algorithm) will be undertaken. If required, the individual (or a 'Flu Friend' on their behalf) will be authorised to receive antiviral medicine by using an authorisation number (URN; Unique Reference Number) linked to their patient record.
- The "Flu Friend" (with their own and the symptomatic individual's identification) will then attend an antiviral collection point, provides the authorisation number and collects the antiviral medicines. The NPFS will also direct patients to a GP

practice or other Health & Social Care (HSC) service should they require any additional advice or treatment.

The lead time for the NPFS to become operational is three weeks, during which time arrangements for implementation of ACPs in all local areas will also be completed. Addresses of ACPs that are already set up and operational must be notified to the NPFS by BCUHB as part of the three week mobilisation process. This information will be updated on an ongoing basis so that deliveries can be scheduled, and the locations of the operational collection points can be visible to both the public and call centre operatives.

5 Antiviral medicines

There are currently two medicines recommended for the treatment of influenza in the UK, oseltamivir (Tamiflu) and zanamivir (Relenza), both neuraminidase inhibitors. They will mainly be used for treating symptomatic individuals. However, in certain situations, where individuals with a serious underlying condition or who are pregnant have been in close contact with an infectious case, clinical judgement may be used to offer a course of prophylaxis to protect against infection and reduce the risk of life threatening illness. In addition, prophylaxis with antiviral medicines of close contacts might be considered in the early stages of an outbreak but will not routinely be given to contacts of a case of pandemic influenza infection.

Wales has a stockpile of antiviral medicines aimed to treat up to half of the population in the event of a high impact pandemic involving a clinical attack rate of 50 per cent.

The national stockpile will initially be issued to those who have a clinical need through community pharmacies and dispensing GPs, while this remains viable.

Treatment should be initiated as soon as possible within the first two days of onset of symptoms of influenza. When given therapeutically to influenza patients within 36–48 hours of onset of symptoms and if continued for 5 days. Evidence indicates that zanamivir and oseltamivir can reduce the duration of clinical symptoms by an average of one day, hospitalisation rates by 59% and antimicrobial drug use by 63%. While 48 hours is generally considered to be the window of therapeutic opportunity the earlier the antiviral medication is administered the greater the health benefit.

Oseltamivir (Tamiflu®) or Zanamivir (Relenza®) will be given twice a day for 5 days for treatment and once a day for 10 days for prophylaxis. Dosage should be tailored by patient age and weight, as set out in the current Summary of Product Characteristics or British National Formulary

At the **Detection and Assessment phase**, small quantities on antiviral stock will be available from the stockpile for use by Health Protection Teams. Additional stock will also be issued to BCUHB for storage and onward distribution to each Acute Hospital and Community Pharmacists and local dispensing GP practices, in readiness for the **Treatment and Escalation phase**. Initial distribution and the replenishment of BCUHB stock will be controlled centrally by Welsh Government (WG) Department of Health, Social Services and Children, operating from the WG Emergency Co-ordinating Centre (ECCW) which the Pharmacy Hospital Operations Managers will be responsible for coordinating at a local level.

While pressure on primary care remains manageable, community pharmacies are expected to distribute antivirals, with WP10 prescription forms providing authorisation. Community Pharmacists must inform the GP of all patients who have received antivirals using the notification form provided in Appendix 2.

5.1 Over labelling

The lead production Pharmacists at each hospital site are responsible for overseeing the preparation of the over labelled antiviral packs. Across BCUHB this will be performed in the two units that hold a specials manufacturing license (Wrexham Maelor Hospital and Ysbyty Glan Clwyd) If additional capacity is required it may be necessary to also utilise the unlicensed unit at Ysbyty Gwynedd. Packs will be over labelled according to existing processes in place in the licensed units and will use the relevant dosages as set out in the Summary of Product Characteristics for the antiviral medication. All over labelling will use standard packs and licensed dosages and patients requiring treatment involving unlicensed dosage or products will be managed through normal primary care services. Only packs of solid dosage forms will be over labelled – paediatric patients requiring a liquid formulation would be directed to obtain this through normal healthcare services (e.g. their GP).

In order to ensure that the specific doses and frequencies match with those that will be allocated by the NPFS, these will be determined by the ACP Lead prior to over labelling production commencing and this may include packs suitable for patient groups aged 1 year and above for treatment and/or prophylaxis. Requirements for stock to be over labelled will be communicated by the ACP Lead to the licensed units with as much notice as possible, ideally at least 2 weeks in advance (running in conjunction with orders for additional stock being placed with the central storage facility). The Antiviral Collection Point Lead for BCUHB is responsible for planning the stock requirements during ACP setup and operation. Once stocks are over labelled, these will be passed to the Pharmacy Hospital Operations Manager (or their nominee) for each of the Acute Hospitals for onward distribution (see below).

6 Distribution to Antiviral Collection Points (including Community Pharmacies and Dispensing GP Practices)

In conjunction with the Antiviral Collection Point Lead for BCUHB, the Pharmacy Hospital Operations Manager (or their nominee) for each of the Acute Hospitals will ensure compliance with good distribution practice including safe systems of storage and distribution-with daily recording of temperature at storage points and at antiviral collection points within their local health area.

The Pharmacy Hospital Operations Manager for each of the Acute Hospitals is responsible for overseeing the distribution of pandemic stocks of antivirals to authorised centres that are distributing the medicines directly to patients.

Normal NHS supply chain arrangements will not be used for items in the national stockpile as these items will be supplied without the usual charges and associated invoicing. Therefore, the following process will be used to distribute pandemic stocks of antivirals to collection points, including community pharmacies and dispensing GP practices:

1. Orders are submitted to the pharmacy department by an authorised centre. Orders required for the same day should be received before 12 noon, after this time they will be dispatched the following day.

2. Orders are assembled following standard pharmacy processes and deliveries arranged for each delivery point. Details for each delivery to be entered onto the Antiviral transfer & delivery form (Appendix 3).
4. When the transport driver arrives to collect the order(s) they must physically check the quantity of medicines supplied against the completed record sheet. When they are satisfied the order is correct they must sign for it in the appropriate field on the document.
5. Once signed by the driver the record sheet must be photocopied twice. The driver should be given the original copy and one photocopy. The other photocopy should be kept by pharmacy as proof of issue for delivery.
6. An appropriate individual at the receiving centre must check the delivery and sign both the original and photocopy of the record sheet. The driver should retain the photocopy as proof of delivery and the original copy should be retained by the receiving centre and stored for audit purposes.

To ensure that appropriate supplies of antivirals are ordered and that delivery to the correct locations is timely, the Pharmacy Hospital Operations Manager for each of the Acute Hospitals, in consultation with the ACP Lead and BCUHB Chief Pharmacist, will:

- Notify the national coordination centre of the collection points (via the stock management system) and other exceptional arrangements, including minimum details (i.e. name, address, postcode, telephone, email and fax contact details, special delivery requirements),
- Monitor antiviral medicines stock levels at all collection points and other exceptional arrangements.
- Appoint transport drivers. These will normally be drawn from normal delivery services available within BCUHB. However, where these services are unable to meet demand, drivers/transport may be sourced from other organisation, including the voluntary sector (e.g. British Red Cross).
- Utilise regional and national surveillance information to help monitor demand and supply.
- Ensure follow-up where the local use is not in line with expected take-up and use.
- Notify the national coordination centre of any changes to the collection centres or exceptional arrangements, or any issues or problems they are experiencing.

6.1 Home Delivery

Agreement has been reached with WAST & BCUHB that the British Red Cross (BRC) with other voluntary organisations/ resources can be used to deliver the antivirals and serve as NPFS operators for North Wales should the situation escalate to higher severity levels. To ensure vulnerable groups have access to antivirals, The British Red Cross will liaise with voluntary sector organisations across North Wales, will manage and arrange transport to collect antivirals from ACPs and deliver to the patient's homes, with a follow-up service 2 days after delivery. They will also provide 4x4 drivers during poor weather conditions (only during daytime operation when conditions are severe) in line with the existing Memorandum of Understanding between the BRC and BCUHB.

6.2 Flu Friends

The British Red Cross will train volunteers to act as 'flu friends'. The flu friend will need to ensure that he/she has all the information required as instructed by the NPFS issued with an authorisation numbers to the relevant ACP, or community pharmacy. Following collection of the antiviral, the 'Flu Friend' will need to deliver the antiviral to the symptomatic individual with the self-care leaflet and any instructions regarding dosage to the symptomatic individual within 48 hours of their symptoms first appearing.

7 Antiviral Collection Points

In hotspot areas there will be an increasing need for rapid distribution of antiviral medicines and this may require the early establishment of Antiviral Collection Points (ACPs). This will be coordinated at a local level as it is unlikely that the NPFS will be activated until there is wider geographical pressure on primary care services, from high numbers of patients with flu-like symptoms.

ACPs are nominated locations within the community where 'Flu Friends' can collect antiviral medicines on behalf of a symptomatic person, on presentation of the person's valid authorisation from the NPFS. The purpose of the ACP is to facilitate rapid access to antiviral medicines and minimise the impact on health services and facilities. Non-dispensing GPs will not have stocks of antiviral medicines and hospitals will only supply antivirals to inpatients.

If pressures in hot spot areas overwhelms the capacity in community pharmacies and dispensing GP practices, then ACP's will be required. National protocols authorised by Ministers are needed to allow ACPs to supply medicines. It is anticipated that each ACP will be open for up to 12 hours per day, 7 days per week, with a minimum of 8 hours per day, Monday to Friday. The decision on the number and locations to be opened will be made by the ACP Lead, in collaboration with colleagues from across the health board and this will be influenced by the characteristics and transmissibility of the virus.

Where the NPFS is established in Wales, the Antiviral Collection Point Lead is responsible for ensuring that details of functioning ACPs are entered onto the Collection Point Administration System (CPAS) database and that systems are in place to issue antiviral medicines using both WP10 prescription forms and NPFS authorisation numbers.

A Memorandum of understanding has been drawn up for co-operation and collaboration between BCUHB, 6 Local Authorities, as well as other private ACP facility providers in order to formalise the arrangement to utilise Leisure Centre facilities, Schools and other facilities for the distribution of antivirals (and, when relevant, mass vaccination programmes) during a Flu Pandemic see Appendix 4.

Working with Local Authority Highways' Department officers, the ACP Lead will ensure that appropriate signage is erected to ensure that flu friends are able to locate ACPs easily. Internal signage will be produced and displayed by the Facilities Manager, following agreement on the layout for the individual Centre. Such signage will direct and instruct flu friends throughout the collection process.

7.1 Antiviral Collection Point Staffing

The following staff are required for each ACP:



Role	Daily Staffing per ACP at minimal capacity ¹	Daily Staffing per ACP at full capacity ²	Likely source of staff
Shift Supervisor	1	2 (1 per shift)	BCUHB
Reception Officer	1	4 (2 per shift)	Voluntary Sector
Admin Support Officer (ASO)	1	6 (3 per shift)	Voluntary Sector
Medicines Distribution Officer (MDO)	2	12 (2 per workstation; 6 per shift)	BCUHB/Voluntary Sector
Facilities Manager	1	1	Site Staff

If all ACP sites across BCUHB were operational and running at full capacity (3 workstations for 2 shifts per day), the following staffing requirements would need to be met for each day of operation:

Role	Staff required						
	Anglesey	Gwynedd	Denbighshire	Conwy	Flintshire	Wrexham	Total
Shift Supervisor	2	6	12	10	8	6	46
Reception Officer	4	12	24	20	16	12	92
ASO	6	18	36	30	24	18	138
MDO	12	36	72	60	48	36	276
Facilities Manager	1	3	6	5	4	3	23
Grand total							575

A detailed list of responsibilities for each of the above roles are detailed in Appendix 1. As the purpose of the centre is distribution only there will be no requirement for staff to hold a formal healthcare qualification to fulfil the function provided that standard procedures are defined.

7.2 Antiviral Collection Point location and facilities

Antiviral stock will be held at a national location from which deliveries will be co-ordinated and made to the nominated distribution centres and collection points for distribution to the public. Details of the ACP sites for BCUHB are given in Appendix 5. On establishing an ACP site, the ACP Lead must ensure that the following facilities are available. A Memorandum of Understanding between BCUHB and the Local Authorities sets out which requirements are the responsibility of the host site, with provision of all other facilities being the responsibility of BCUHB.

¹ At minimal capacity, it is assumed that each site will have one workstation operating for 1 shift per day

² When at full capacity, it is assumed that each site will have 3 workstations operating simultaneously, with 2 shifts per day

IT and communication facilities³

- Internet connection Broadband, Dial up or N3
- Computers with:
 - username and password to gain access to operating system
 - an antivirus package with up-to-date signature and patches
 - Microsoft Office - minimum 07
 - Internet Browser⁴ (Internet Explorer 9 or 11, Google Chrome)
 - Access to email - e.g. Windows mail or web-based mail
- Photocopier / printer
- Telephones & Fax

Security

- Lockable building with separately lockable storage for medicines and associated consumables plus temperature recording facilities
- External security of the site and building - fencing, natural barriers, defensive planting, parking area, locking devices for external doors and windows, CCTV
- Interior security of the building – windows and doors, intrusion alarms, CCTV, lighting, ability for natural surveillance by staff

Location

- Accessible to public by public transport
- On-site parking and drop-off site for public
- Disabled and special needs access
- Fire alarms, certification and clear evacuation instructions

Other facilities

- Tables and chairs
- Ability to receive a delivery from a Transit van or similar sized vehicle
- Large indoor space to allow effective crowd management, which should be segregated to maximise flow. Typical segregation areas are:
 - Reception area
 - Waiting/queuing area
 - Issuing area
 - Stock storage area

Site security will be maintained when the facility is used as ACPs. It is anticipated that ad hoc arrangements will be put in place, similar to those used during elections. It is anticipated that initially there will be 1 or 2 per county, and these ACPs will be running in addition to the community pharmacies.

7.3 Antiviral collection point operation

Each ACP site will have a site supervisor who is responsible for oversight of the day to day operation of the supply service, including stock management and clinical queries. They will be supported by a facilities manager, who will ensure that the site is unlocked at the start of each day and is secure at the end of the operations each day. The

³ IT support is available through the NHS Wales IT service desk

⁴ JavaScript and cookies must be enabled.

facilities manager is also responsible for ensuring that the site has appropriate heating, light and hygiene facilities during operational hours.

Each ACP will hold approximately one to two days' worth of antivirals in a secure stock location, under the control of the shift supervisor, with overall responsibility sitting with the ACP Lead for BCUHB. At the start of each shift, the Shift Supervisor will issue stock from this store to Medication Distribution Officer(s) (MDO) working at each workstation (each workstation will have two MDOs to enable accuracy checking. Multiple workstations will be used where staffing allows). Stock issuing and return at the end of each day will be documented on the Workstation Stock Record form (Appendix 6).

The supply process uses a continual flow model, with visitors moving from one zone to the next sequentially. An overview of the ACP flow is given below. Full details are set out in the SOP provided in Appendix 7

- Visitors are first met by a Reception Officer, who will confirm that they are in the correct location and have the necessary documentation/information (ID and URN) to enable a supply to be made. Any patients attending the centre will be asked to leave at this point and send a 'flu friend' in their place to minimise risk of transmission.
- Visitors will then be directed to join the queue for an Administration Support Officer (ASO; each site may have one or more Administration Support Officers working at any one time).
- The ASO then checks the URN against the NPFS Database⁵ and completes Section 1 of the Antiviral Supply Sheet (Appendix 8) and hands this to the flu friend. This step is repeated for each URN that the flu friend is collecting against. The flu friend is then directed to join the queue for supply.
- The flu friend then passes the Antiviral Supply Sheet (Appendix 8) to a Medication Distribution Officer, who then picks the relevant pack and completes section 2 and 3. The flu friend signs for receipt of the medicine in section 4. This step is repeated for each URN that the flu friend is collecting against.
- The flu friend exits the site via the designated exit (separate to the entrance where possible)

----- END -----

⁵ If the URN is not validated, the ASO gives the flu friend information on how to resolve this

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Appendix 1 - Antiviral Collection Point Staff Roles & Responsibilities

Antiviral Collection Point Lead

The Antiviral Collection Point Lead will be responsible for the establishment and ongoing operation of the antiviral collection points across the health board. They will lead on all ACP issues for the health board, including liaison with colleagues in BCUHB, Local Authorities and the Voluntary Sector. In addition, they will take responsibility for:

- Planning which ACP sites will be commissioned and what the stock requirements are for each of these during ACP setup and operation
- Ensuring that required facilities are available at each ACP site when established and during their operation
- Ensuring that appropriate signage is erected to ensure that flu friends are able to locate ACPs easily
- Ensuring that details of functioning ACPs are entered onto the Collection Point Administration System (CPAS) database and that systems are in place to issue antiviral medicines using both WP10 prescription forms and NPFS authorisation numbers
- Ensuring that BCUHB has sufficient stocks in hand/on order to meet anticipated demand
- Populate antiviral supply sheet(s) from the template in Appendix 8 with relevant information for dosage (drawn from extant SPC) and make these available to each ACP
- Supporting hospital operations managers and ACP shift supervisors to ensure that each ACP has sufficient stocks to meet local demand
- Ensuring that each ACP is closed, antiviral stock returned to central BCUHB holdings, and any equipment returned to the owning organisation when the ACP is no longer required.

Facilities Manager

The Antiviral Collection Point Facilities Manager will be responsible for the site facilities for the day, including opening and closing of the facility each day of operation. In addition, they will take responsibility for ensuring:

- All services (heating, lighting, toilet facilities, etc) within the centre are fully functioning and organising any maintenance necessary to maintain services.

- Ensure that evacuation procedure are in place and staff working in the ACP are familiar with these. Ensure that appropriate emergency equipment (e.g. fire extinguishers, defibrillators etc) is available and correctly maintained. Ensure that the main assembly point is clearly marked and clear instructions are available to ACP staff in the event of an emergency such as a fire or other evacuation of the premises.
- The Antiviral Collection Point Manager will arrange for the public to enter through the clearly marked Main Entrance. Display signage as appropriate – to be determined by the ACP Lead on site setup.
- The control office for the building and premises will be the existing main office which will be clearly marked. This office will be the central control point for the management of the facilities on site.
- Make available an antiviral storage area and an office area.
- Ensure that the waiting/reception area is clearly separated from the other two areas, ideally using a partition.

Shift Supervisor

The antiviral collection point shift supervisor will be a registered healthcare professional (e.g. a pharmacy technician, pharmacist, nurse etc) and will assume responsibility for overseeing the day to day operation of the ACP during their shift. Where multiple shifts are running through the day, they must clearly hand over responsibility, along with any key messages, to the shift supervisor taking responsibility for the next shift.

The shift supervisor will be responsible for:

- Supervise ACP and ensure there are sufficient supplies of forms, labels and other paperwork.
- Management and safe storage of antiviral stock, including
 - Receiving stock into the centre (from deliveries)
 - Booking stock out to, and back in from, the workstations
 - Monitoring stock levels and reporting these to the Acute Hospital to ensure appropriate deliveries are made to replenish stock.
- Oversee the setup of each shift, including daily rota for breaks and layout of room and role allocation, appropriate to individual team members' skills and experience.
- Brief shift staff on their role, importance of maintaining accurate records, confidentiality and Data Protection. Update shift staff on any relevant information from the previous shift.
- At the end of each shift reconcile opening stock, stock received and stock issued with actual balance for each issuing desk. Count and check stock with issuers and complete Work Station Stock Record
- Troubleshoot /problem solve as appropriate. Contact BCUHB ACP Lead (or their nominee) regarding any problems such as staff or stock shortages.
- Contact Language Line as appropriate.
- Report any adverse incidents to the BCUHB ACP Lead (or their nominee) and maintain a record of the incident for information.
- Provide daily report to BCUHB ACP Lead (or their nominee) to include number of antivirals distributed by age, gender and BCUHB area in addition to a stock report to relevant Pharmacy Hospital Operations Manager at end of each shift.

Reception Officer

Antiviral collection point Reception Officers will make first contact with visitors to the site and confirm that they are in the correct location and have relevant documentation and information to enable a supply to be made. They will direct

visitors to the start of the supply process and advise those who are not eligible on how to deal with their situation. Key roles and responsibilities are:

- Report to the shift supervisor on arrival.
- Attend the de/briefing session.
- Control the queue of flu friends.
- Filter out inappropriate attenders e.g. people with symptoms, below minimum age for flu friend (12 years), lack of identification (for flu friend and patient), or inappropriate unique reference Number (URN). Refer them back to the Flu Line if necessary.
- Check flu friend has the required unique identification number and that it is valid for that ACP.
- Explain the procedure to the flu friends in the queue including estimate of waiting time.
- Inform shift supervisor of any problems, incidents or potential problems in the reception area
- Support flu friends with queries, but direct any clinical issues, such as: symptoms; side-effects; medication etc. to their GP or other relevant healthcare provider.
- If the flu friend wishes to communicate in a language other than that fluently understood and spoken by the reception officer, or other ACP staff, liaise with Shift Supervisor who will contact Language Line.

Administration Support Officer

The Antiviral collection point Administration Support Officer is responsible for checking URN validity and creating a record of the supply. Key roles and responsibilities are:

- Report to the shift supervisor on arrival.
- Attend the de/briefing session.
- Ask flu friend for unique reference number.
- Enter into database and check details with flu friend – ask flu friend for patient details, do not offer information. Validate Identification for flu friend and patient.
- Check dose from URN with patient age, alert shift supervisor if discrepancy.
- Complete part 1 of Anti-viral Supply Sheet and fill in your name.
- Complete database to show that flu friend has attended.
- Check part 1 of Anti-viral Supply Sheet is completed before flu friend leaves.
- If flu friend is collecting for more than one person complete the Anti-viral Supply Sheets one at a time.
- Advise flu friend how to proceed to antiviral collection point.
- Provide information to the shift supervisor as needed.
- Inform shift supervisor of any problems, incidents or potential problems in the administration area.
- Support flu friends with queries, but direct any clinical issues, such as: symptoms; side-effects; medication etc. to their GP or other relevant healthcare provider.

Medication Distribution Officer

Antiviral Collection Point Medication Distribution Officers are responsible for making supplies to flu friends from their designated workstation, including providing a second check that the correct medicine has been supplied. They are also responsible for maintaining records for their workstation, including antiviral supply sheets and workstation stock record. Key roles and responsibilities are:

- Report to shift supervisor on arrival.
- Attend de/briefing session.
- Familiarise self with dosage instructions at the start of each shift
- At the beginning of each shift count and check stock with shift supervisor and complete Work Station Stock Record.
- Agree plan of action if stock shortage.
- Issue antivirals according to information on Antiviral Supply Sheet (Appendix 8) and protocol:
 - Both issuers check age of patient against antiviral strength from URN. Circle strength on part 2 of Antiviral Supply Sheet.
 - Pick appropriate box of antiviral from the issuing desk supply.
 - Check if patient can swallow capsules, if not or unsure attach additional information label to antiviral box (without covering important information) and give verbal advice.
 - Complete part 2 and 3 of Antiviral Supply Sheet. Second issuer checks the dose and completes their section of the Antiviral Supply Sheet.
 - Supply information sheet relevant to the medicine provided
 - Give verbal information as set out on the Antiviral Supply Sheet (part 3).
 - Ensure that Flu friend completes part 4 of Anti-viral Supply Sheet.
 - Check parts 2, 3 and 4 of Anti-viral Supply Sheet are completed before flu friend leaves.
- Support flu friends with queries, but direct any clinical issues, such as: symptoms; side-effects; medication etc. to their GP or other relevant healthcare provider.
- Complete all required paperwork. Retain Antiviral Supply Sheets as per instructions.
- Inform shift supervisor of any problems, incidents or potential problems.
- Attend debriefing.



Appendix 2 – Community pharmacy notification to GP of supply of antiviral medication

CONFIDENTIAL

Data protection confidentiality note: This message is intended only for the use of the individual or entity to who it is addressed and may contain information that is privileged, confidential & exempt from disclosure under law. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited.

GP Name	
GP Address	

Patient's name		Pharmacy stamp:
Address		
Date of Birth		
Telephone		

The patient presented with a temperature of $\geq 37.8^{\circ}\text{C}$, in addition to at least one respiratory symptom (cough, sore throat or nasal symptoms) and one constitutional symptom (myalgia, chills/sweats, malaise, fatigue or headache): Yes ☐ No ☐

Product supplied	
Dosage	
Frequency of administration	
Period of administration	
General advice given	Yes <input type="checkbox"/> No <input type="checkbox"/>
Follow up or any further Information	

Patient Consent: I agree to the pharmacy passing on this information to my GP:

Patient signature: _____ Date: _____

Appendix 3 - Antiviral transfer & delivery form

Supplying centre:

- ☐ Ysbysty Gwynedd
- ☐ Ysbyty Glan Clwyd
- ☐ Wrexham Maelor Hospital

Date of order: _____ Date of Supply: _____

Name & Address of Delivery point (include post code):

Stock issued:

Drug	Pack size	Number of packs

Name, Role & Signature of issuing person:	
Name and Signature of Driver receiving order:	
Name and Signature of person receiving order:	

Driver to retain original copy, One photocopy to be handed to the receiving centre & supplying pharmacy to retain one copy

Appendix 4 – Memorandum of understanding

Betsi Cadwaladr University Health Board & County Council

Memorandum of Understanding

For co-operation and collaboration between BCUHB and County Councils whilst utilising Local Authority Leisure Centre Facilities for the distribution of anti virals (and, when relevant, mass vaccination programmes) during a Flu Pandemic.

Introduction

The pandemic virus will probably spread so rapidly from source that vaccine availability may be delayed for months after major outbreaks begin. In addition, because the pandemic influenza virus is dramatically different from those that have circulated previously most of the population will be totally susceptible. Measures such as the closing of schools, wearing face masks and social distancing may slow the effects of pandemic influenza but only antiviral drugs inhibitors will be effective for treatment.

Antiviral treatment provides an opportunity to minimise the morbidity and mortality resulting from a flu pandemic, with a consequent reduction in the need for other health interventions and services. However, current antivirals can only be effective if treatment commences within a short time after symptoms have developed, ideally within 12 hours of a decision to treat having been made and no later than 48 hours. Wales has purchased sufficient antivirals to treat all those expected to develop clinical symptoms based on a clinical attack rate of 50% of the population. Stockpiled antivirals will not be available to hospital or community pharmacists through the

traditional supply chain. For this reason and because of the critical nature of their deployment, BCUHB needs an antiviral distribution and collection system that is rapid, efficient, secure and robust.

National Policy will encourage those with symptoms of flu to remain at home. For the majority of people the decision to treat will be made on the basis of telephone assessment or home visit. For a small minority of patients this decision will be made in other health care settings (primary care premises, Emergency Departments, paediatric assessment units etc).

Civil Contingencies Act 2004

The Civil Contingencies Act 2004, and accompanying regulations and non-legislative measures, will deliver a single framework for civil protection in the United Kingdom. Part 1 of the Act establishes a statutory framework for civil protection at a local level setting out clear expectations and responsibilities for all Category 1 responders which include a duty to:

- put in place emergency plans
- put in place Business Continuity Management arrangements
- cooperate and collaborate with other local responders to enhance the co-ordination, efficiency and delivery of local plans.

Purpose of the Memorandum of Understanding

The purpose of this Memorandum of Understanding is to set out the arrangements for co-operation, collaboration and communication between BCUHB and County Councils in relation to the use of the sites listed below, and their associated utilities, as designated antiviral collection points in the event of an influenza pandemic. It is recognised that not all of the sites are owned and operated by the Local Authority, but county councils will undertake to ensure that contracts are in place to enable the activities set out in this MoU at the listed sites in the event of an influenza pandemic.

Antiviral collection points

Antiviral collection points are the locations from which family, friends or carers of symptomatic patients (Flu Friend) can collect their antiviral medicines for them, on referral from the National Flu Line service (i.e. if they are eligible for antiviral treatment). The use of non-health sites as designated antiviral collection points will allow the National Health Service together to cope with the need to manage and treat large numbers of sick people at a time of diminished staff numbers.

Agreed sites where ACPs can be established, if needed, are:

Operator of site	Address	County	Post Code
Ynys Mon Council	Plas Arthur Leisure Centre, Penrallt, Llangefni,	Anglesey	LL77 7LY

Operator of site	Address	County	Post Code
Ynys Mon Council	Holyhead Leisure Centre, Kingsland Road, Holyhead	Anglesey	LL65 2NL
Gwynedd County Council	Arfon Leisure and Tennis Centre, Bethel Road, Caernarfon,	Gwynedd	LL55 1HW
Gwynedd County Council	Glaslyn Leisure Centre, Stryd y Llan, Porthmadog,	Gwynedd	LL49 9HW
Gwynedd County Council	Glan Wnion Leisure Centre, Ffordd Aran, Dolgellau,	Gwynedd	LL40 1LH
Conwy County Borough Council	Eirias Park, Colwyn Bay	Conwy	LL29 7SP
Conwy County Borough Council	Faenol Avenue, Abergelle	Conwy	LL22 7HE
Conwy County Borough Council	Llandudno Junction	Conwy	LL31 9XY
Conwy County Borough Council	Ysgol Dyffryn Conwy, Llanrwst	Conwy	LL26 0SD
Conwy County Borough Council	John Brights Sports Hall, Ysgol John Bright	Conwy	LL30 1LF
Denbighshire County Council	Glan Clwyd School, Upper Denbigh Road, St Asaph	Denbighshire	LL17 0RP
Denbighshire County Council	Brynhyfryd High School, Mold Road, Ruthin	Denbighshire	LL15 1EG
Denbighshire County Council	Grange Road, Rhyl,	Denbighshire	LL18 4BY
Denbighshire County Council	Dinbren Road	Denbighshire	LL20 8TG
Denbighshire County Council	Prestatyn High School, 2 Princes Avenue	Denbighshire	LL19 8RS
Denbighshire County Council	Carrog Road	Denbighshire	LL21 9RW

Operator of site	Address	County	Post Code
Aura Wales	Mold Leisure Centre, Mold Alun Campus Wrexham Road	Flintshire	CH7 1HT
Aura Wales	Jones Pavillion, Earl Street, Flint, Flintshire	Flintshire	CH6 5ER
Aura Wales	Deeside Leisure Centre, Chester Road West, Queensferry	Flintshire	CH5 1SA
Aura Wales	Saltney Sports Centre, School Campus, St. Davids Terrace, Saltney, Flintshire	Flintshire	CH4 0AE
Wrexham County Borough Council	Wrexham Memorial Hall, Bodhyfryd,	Wrexham	LL12 7AC
Wrexham County Borough Council	Bryn Teg Memorial Centre , Quarry Road Brynteg	Wrexham	LL11 6AB
Wrexham County Borough Council	Penley, Maelor School, Overton Road, Penley	Wrexham	LL13 0LU

For the purpose of this plan it has been assumed that all sites will be able to provide a large space, eg. sports hall, upon request. County councils will have back-up contingency arrangements in place should individual sites not be available.

In a pandemic situation, standard NHS services will be used to make supplies of antivirals initially available. Where these are no longer able to meet demand, ACPs will be opened. A limited number will be opened at first and, based on actual and projected figures, additional sites opened as needed. Rapid response to demand may mean sites opening at relatively short notice (a few days).

The minimum requirements for an ACP is:

- Lockable building with separately lockable storage for medicines and associated consumables
- Electricity, lighting, heating, drinking water, and hygiene facilities (toilets/handwashing etc).
- External security of the site and building – e.g. fencing, natural barriers, defensive planting, parking area, locking devices for external doors and windows, CCTV, interior intrusion alarms, lighting, ability for natural surveillance by staff
- On-site parking and drop-off site for public
- Disabled and special needs access
- Fire alarms, certification and clear evacuation instructions
- Tables and chairs
- Ability to receive a delivery from a Transit van or similar sized vehicle
- Large indoor space

One or more member of staff from each site will act as a facilities manager and be responsible for ensuring the ongoing operation of the facilities for the site (as set out above), including health and safety.

BCUHB staff, as set out in the Plan for Distribution of Antivirals, will be responsible for the stock of antivirals and the allocation of Flu Friends.
BCUHB will establish telephone, fax and IT facilities as necessary for the operation of the ACP.

Consultation and Co-operation

BCUHB and the County Councils agree that where it will be beneficial to the other party, they will share appropriate information, maintain effective channels of communication consult each other and co-operate to inform and improve the work of both organisations in accordance with their respective responsibilities under the Civil Contingencies Act 2004.

BCUHB and the County Council will issue such guidance, publicity and information jointly, and in conjunction with other North Wales Resilience Forum Partners.

Confidentiality and Data Protection

BCUHB and the County Council will respect the confidential nature of the information held by each organisation or where relevant shared between them. Where there is a requirement to provide any reports that are likely to be made available to the public, the DRAFT report will be shared and discussed with the other organisation prior to being finalised and released.

Monitoring and Review

Where issues, concerns or problems in the operation of this Memorandum of Understanding are identified by either party individuals from the relevant organisations will seek to resolve them quickly and informally. If this is not possible the Chief Executive Officers of both organisations will take responsibility for achieving a mutually acceptable resolution.

Signatories:

Name	Role	Signature	Date
Gary Doherty	Chief Executive, BCUHB		
Colin Everett	Chief Executive, Flintshire County Council		
Ian Bancroft	Chief Executive, Wrexham County Borough Council		
Judith <u>Greenhalgh</u>	Chief Executive, Denbighshire County Council		
Iwan Davies	Chief Executive, Conwy County Borough Council		

Dilwyn Williams	Chief Executive, Gwynedd County Council		
Gwynne Jones	Chief Executive, Anglesey County Council		

Appendix 5 – Antiviral Collection points Sites

Location	Operator of site	Address	County	Post Code	Phone
Llangefni	Ynys Mon Council	Plas Arthur Leisure Centre, Penrallt, Llangefni,	Anglesey	LL77 7LY	01248 722966 01248 752040
Holyhead	Ynys Mon Council	Holyhead Leisure Centre, Kingsland Road, Holyhead	Anglesey	LL65 2NL	01407 764111
Caernarfon	Gwynedd County Council	Arfon Leisure and Tennis Centre, Bethel Road, Caernarfon,	Gwynedd	LL55 1HW	01286 676451
Porthmadog	Gwynedd County Council	Glaslyn Leisure Centre, Stryd y Llan, Porthmadog,	Gwynedd	LL49 9HW	01766 512711
Dolgellau	Gwynedd County Council	Glan Wnion Leisure Centre, Ffordd Aran, Dolgellau,	Gwynedd	LL40 1LH	01341 423579
Colwyn Bay	Conwy County Borough Council	Eirias Park, Colwyn Bay	Conwy	LL29 7SP	01492 577900
Abergele	Conwy County Borough Council	Faenol Avenue, Abergele	Conwy	LL22 7HE	01745 833988
Llandudno Junction	Conwy County Borough Council	Llandudno Junction	Conwy	LL31 9XY	01492 583592

Location	Operator of site	Address	County	Post Code	Phone
Llanrwst	Conwy County Borough Council	Ysgol Dyffryn Conwy, Llanrwst	Conwy	LL26 0SD	01492 642716
Llandudno	Conwy County Borough Council	John Brights Sports Hall, Ysgol John Bright	Conwy	LL30 1LF	01492 873807
St Asaph	Denbighshire County Council	Glan Clwyd School, Upper Denbigh Road, St Asaph	Denbighshire	LL17 0RP	01745 583369
Ruthin	Denbighshire County Council	Brynhyfryd High School, Mold Road, Ruthin	Denbighshire	LL15 1EG	01824 703880
Rhyl	Denbighshire County Council	Grange Road, Rhyl,	Denbighshire	LL18 4BY	01745 352901
Llangollen	Denbighshire County Council	Dinbren Road	Denbighshire	LL20 8TG	01978 861830
Prestatyn	Denbighshire County Council	Prestatyn High School, 2 Princes Avenue	Denbighshire	LL19 8RS	01745 855632
Corwen	Denbighshire County Council	Carrog Road	Denbighshire	LL21 9RW	01490 412600
Mold	Aura Wales	Mold Leisure Centre, Mold Alun Campus Wrexham Road	Flintshire	CH7 1HT	01352 704330

Location	Operator of site	Address	County	Post Code	Phone
Flint	Aura Wales	Jones Pavillion, Earl Street, Flint, Flintshire	Flintshire	CH6 5ER	01352 704301
Deeside	Aura Wales	Deeside Leisure Centre, Chester Road West, Queensferry	Flintshire	CH5 1SA	01352 704200
Saltney	Aura Wales	Saltney Sports Centre, School Campus, St. Davids Terrace, Saltney, Flintshire	Flintshire	CH4 0AE	01352 704290/704291
Wrexham	Wrexham County Borough Council	Wrexham Memorial Hall, Bodhyfryd,	Wrexham	LL12 7AC	01978 292683
Bryn Teg	Wrexham County Borough Council	Bryn Teg Memorial Centre , Quarry Road Brynteg	Wrexham	LL11 6AB	01978 722942
Penley	Wrexham County Borough Council	Penley, Maelor School, Overton Road, Penley	Wrexham	LL13 0LU	01948 830616

Appendix 6 – Work station stock record

ACP I.D. _____ Work Station I.D. _____ Date: _____

Supervisor Name:	
Issuers Name:	
Shift Times:	

	Opening Stock (Actual count of packs)	Stock Received During Shift		Opening Stock Plus Stock Received	Packs Issued During Shift	Closing Balance (Actual count of packs)	Shift Supervisor to complete: Reconciled /Discrepancy/ Comments
		Quantity	Issuer Initials				
Oseltamivir 75mg (10 capsules)							
Oseltamivir 45mg (10 capsules)							
Oseltamivir 35mg (10 capsules)							
Oseltamivir 2 x 30mg for 60mg dose (2 boxes of 10 capsules = 1 pack)							

Opening Stock Check: Issuer Signature..... Supervisor Signature: Time:

Closing Stock Check: Issuer Signature..... Supervisor Signature: Time:

Appendix 7 - Pandemic Influenza Standard Operating Procedure for Antiviral Collection Points

Procedure for Issue of antiviral packs from Health Board Designated Antiviral Collection Points

For Use By: ACP Shift Supervisors
Administration Support Officers
Medicines Distribution Officers

Objective: To ensure that antivirals are issued to flu friends in a safe and effective manner.

Shift Supervisor

1. Supervise the distribution area.
2. Trouble shoot /problem solve as appropriate. Contact the BCUHB Control Centre Team regarding any problems such as staff shortages.
3. Report any adverse incidents to the BCUHB Control Centre Team according to locally agreed algorithm which may affect other sessions and maintain a record of the incident for information.
4. Provide a daily report to the BCUHB Control Centre team to include number of anti-virals distributed in addition to a stock report to Pharmacy Locality Leads at end of each shift
5. Debrief staff at the end of the shift – take notes to improve on future sessions.

Reception

1. Meet “Flu Friends” as they enter the building and check that:
 - 1.1. They are “Flu Friends” and not patients seeking treatment- refer these patients to the flu line.
 - 1.2. Check that the “Flu Friend” has a valid authorisation number URNs (Unique Reference Number) (12 alphanumeric characters) for this Antiviral Collection Point- refer invalid to the appropriate collection point, a supply cannot be made here.
2. Explain the process to the Flu Friend and advice him/her on how to proceed to antiviral logging in area.

Administration Support Loggers

1. Receive unique identification number(s) (URN) from the patient’s “Flu Friend”.
2. Enter the URN onto the Antiviral Supply Sheet (AVSS)
3. Look up the URN on the North Wales database and check the Patient Details with the “Flu Friend”. Refer any discrepancies to the Shift Supervisor.
4. Complete the Patient Details section of an Antiviral Supply Sheet (AVSS) with the following information:
 - 4.1. First name
 - 4.2. Surname
 - 4.3. Date of Birth and/or Age
 - 4.4. Address and Postcode where available.
5. Check the “prescribed dose” is suitable for the age of the patient. Refer any discrepancies to the Shift Supervisor and sign the “checked by” box in section 1.
6. Repeat this process for all the URNs that the “Flu Friend” is collecting

7. Give the completed Antiviral Supply Sheet(s) to the “Flu Friend” and advise him/her on how to proceed to antiviral distribution area.
8. Collate information systematically and provide hourly reports to the shift supervisor.

Medication Distribution Officer

1. Check and count medication stock at beginning and end of shift with Shift Supervisor
2. Supply of anti-virals:
 - 2.1. Anti-virals can only be supply against the appropriate completed Anti-viral Supply Sheet with a valid Unique Reference Number.
 - 2.2. Only work with one Anti-viral Supply Sheet at a time.
 - 2.3. Check that all the fields in section 1 have been completed.
 - 2.4. In section 2, using the age of the patient, circle the required dose. Check this against the recommendation made by the “Flu Line”. Refer any discrepancies to your supervisor.
 - 2.5. Take the appropriate Anti-viral Supply sheet to the stock picking area and select the correct dose.
 - 2.6. Where multiple packs are required these will have been preassembled by taping two packs together, prior to over labelling.
 - 2.7. Check that the selected pack is labelled correctly. Refer to your supervisor if any incorrectly labelled or assembled stock is found.
 - 2.8. Take the labelled pack back to the workstation
 - 2.9. Complete the label with the following information taken from section 1 of the Anti-viral Supply Sheet
 - 2.9.1. Patients Name
 - 2.9.2. Date of supply
 - 2.9.3. Antiviral Collection Point Code.
 - 2.10. From the pack(s) to be supplied enter the Strength, Batch Number and Expiry date into section 3 of the appropriate Anti-viral Supply Sheet.
 - 2.11. Check the completed pack against Section 1 of the appropriate Anti-viral Supply Sheet. The following items must be checked.
 - 2.11.1. Patients Name
 - 2.11.2. The name and strength of the drug on the Anti-viral Supply Sheet, Label and Pack all agree.
 - 2.11.3. The quantity
 - 2.11.4. The instructions
 - 2.12. For each pack supplied complete section 3 with
 - 2.12.1. The strength of drug supplied
 - 2.12.2. The Batch Number (on the pack end)
 - 2.12.3. The Expiry date (on the pack end)
 - 2.13. When the accuracy check is completed and the pack is correct initial the “Issued by” (Iss) box at the bottom of the label.
 - 2.14. Second Accuracy Check:
 - 2.14.1. A second check by another officer **must** be carried out for all Children’s doses
 - 2.14.2. A second check is **desirable** for the Adult dose if a second person is available.
 - 2.14.3. When the second accuracy check is completed and the pack is correct initial the “Checked by” (Chkd) box at the bottom of the label and section 3 of the Anti-viral Supply Sheet.
 - 2.15. With each pack supply an information sheet.

- 2.16. If necessary a supplementary label for patients who cannot swallow capsules can be applied to the pack.
- 2.17. Go through the pack instructions with the “Flu Friend” and ensure that the “flu Friend” has sufficient understanding so that s/he could pass on the following information.
- 2.17.1. That the medicine is for the named patient only.
- 2.17.2. That the patient should read the Health Boards information leaflet and the patient information leaflet in the pack before to starting the medicine.
- 2.17.3. How to take the medicine.
- 2.18. Complete section 3 of the Anti-viral Supply Sheet signing for the supply.
- 2.19. Complete section 4 with the “Flu Friend” and ask him or her to sign for receipt of the medicine.

Written by	William H Duffield
Authorised by	
Review Date :	

Appendix 8 – Antiviral Supply Sheet

NOTE: Highlighted text in this template must be replaced with appropriate dosage and pack details prior to use

Section 1: Please complete the following PATIENT details from the pandemic flu line database	
Unique Reference Number:	
First Name:	Surname:
Date of Birth:	Age:
Address	
	Post Code:
Medicine and dose: mg	Section 1 Checked by:

Section 2: To be completed by the individual supplying the antiviral			
Please circle the dose of DRUG NAME based on the age of the patient Check this against the recommendation above and seek advice if different.			
Patient Group	Dose	Pack(s) to be supplied	Pack instructions
Age less than 1 year		Refer to GP	
Age 1 year or over but under 3 years	DOSE	PACK DETAILS	DOSAGE INSTRUCTIONS
Age 3 years or over but under 7 years	DOSE	PACK DETAILS	DOSAGE INSTRUCTIONS
Age 7 year or over but under 13 years	DOSE	PACK DETAILS	DOSAGE INSTRUCTIONS
Adults and adolescents aged 13-17 years weighing over 40kg	DOSE	PACK DETAILS	DOSAGE INSTRUCTIONS

Section 3: From the pack(s) supplied please complete:		
Strength: Pack 1	Batch No:	Expiry Date:
Pack2		
Second Accuracy Check carried out by:		
Signature:		Date:
Information and Advice: Supply a Health Board information sheet and ensure that the "Flu Friend" understands: <ul style="list-style-type: none"> • That the medicine is for the named patient only • That the patient should read leaflet in the pack • How to take the medicine 		Yes/ No
Officer making supply:		
Signature:	Date:	Time:
Section 4: To be completed with the "Flu Friend":		
Collected by:	Post Code:	
Signature:	Date:	Time:

Consultation on this document

Consultation has taken place with:

Name	Title	Date Consulted
Aimee Thomas	British Red Cross, Emergency Response Officer	2 Oct 2018
Helen Kilgannon	Emergency Planning Officer, Flintshire County Council & Regional Emergency Planning Service	26 Oct 2018
Berwyn Owen	Chief Pharmacist, BCUHB Associate Director, Pharmacy and Medicines Management (Central)	29 Oct 2018
Sue Murphy	Associate Director, Pharmacy and Medicines Management (West)	29 Oct 2018
Louise Howard-Baker	Associate Director, Pharmacy and Medicines Management (East)	29 Oct 2018
Andrew Merriman	Lead QA and Technical Services Pharmacist	29 Oct 2018
Judith Green	Medicine Lead Pharmacist (East) & Interim Chair, Policy Procedure & PGD Sub Group	29 Oct 2018
Teena Grenier	Medicines Governance Lead Pharmacist	29 Oct 2018
Jacqui Liddle	Pharmacy Hospital Operations Manager (West)	12 Nov 2018
Lis Dubourg	Pharmacy Hospital Operations Manager (Central)	12 Nov 2018
Sue Lord	Pharmacy Hospital Operations Manager (East)	12 Nov 2018
Teresa Owen	Executive Director of Public Health	28 Nov 2018
Chris Stockport	Executive Director for Primary and Community Care	28 Nov 2018
Rob Smith	Area Director (East)	28 Nov 2018
Bethan Jones	Area Director (Central)	28 Nov 2018
Ffion Johnstone	Area Director (West)	28 Nov 2018

Name	Title	Date Consulted
Gareth Bowdler	Area Medical Director (East)	28 Nov 2018
Liz Bowen	Area Medical Director (Central)	28 Nov 2018
Bethan Jones	Area Medical Director (West)	30 Nov 2018
Andrea Hughes	Area Nurse Director (East)	28 Nov 2018
Nicola McLardie	Area Nurse Director (Central)	28 Nov 2018
Chris Lynes	Area Director for Clinical Services (West)	28 Nov 2018
Janet Ellis	Assistant Director, Primary Care (East)	28 Nov 2018
Wyn Thomas	Assistant Director, Primary Care (West)	28 Nov 2018
Clare Darlington	Assistant Director, Primary Care (Centre)	28 Nov 2018
Alison Hughes	Head of Pharmacy for Primary and Community Care (West)	28 Nov 2018
Rory Wilkinson	Head of Pharmacy for Primary and Community Care (Central)	28 Nov 2018
Ben Woodhouse	Head of Pharmacy for Primary and Community Care (East)	28 Nov 2018
William Duffield	Lead Pharmacist, Patient Safety (Central)	28 Nov 2018
Anke Hagemi	Lead Pharmacist, Patient Safety (West)	28 Nov 2018
Karen Pritchard	Lead Pharmacist, Patient Safety (East)	28 Nov 2018
Lois Lloyd	Medicines Procurement & Homecare Lead Pharmacist	28 Nov 2018
Judy Thomas	Director of Contracting, Community Pharmacy Wales	28 Nov 2018

Name	Title	Date Consulted
Emma Binns	Business Continuity Manager	28 Nov 2018
Eiriann Turner	Medicines Management Nurse, Primary Care (West)	3 Dec 2018
Lynne Joannou	Assistant Director, Primary Care Contracting	3 Dec 2018



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EQUALITY IMPACT ASSESSMENT FORMS

PARTS A and B: SCREENING AND OUTCOME REPORT

Introduction:

These forms have been designed to enable you to record, and provide evidence of how you have considered the needs of all people (including service users, their carers and our staff) who may be affected by what you are writing or proposing, whether this is:

- a policy, protocol, guideline or other written control document;
- a strategy or other planning document e.g. your annual operating plan;
- any change to the way we deliver services e.g. a service review;
- a decision that is related to any of the above e.g. commissioning a new service or decommissioning an existing service.

This is not optional: Equality Impact Assessment is a specific legal requirement on public sector organisations under equalities legislation and failure to comply could result in a legal challenge to a decision or strategy. More importantly, equality impact assessment helps to inform better decision-making and policy development leading to improved services for patients. **This form should not be completed by an individual alone, but should form part of a working group approach.**

The Forms:

You must complete:

- **Part A** – this is the Initial Screening that is always undertaken and consists of Forms 1 to 3; these forms are designed to enable you to make an initial assessment of the potential impact of what you are doing, and decide whether or not you will need to proceed to a Full Impact Assessment (Part C);

AND

- **Part B** – this is the Outcome Report and Action Plan (Form 4) you will need to complete whether or not you proceed to a Full Impact Assessment;

Together, these forms will help to provide evidence of your Impact Assessment and how you have shown “due regard” to the duties.

You may also need to complete **Part C** (see separate Form) – if parts A and B indicate you need to undertake a Full Impact Assessment. This enables you to fully consider all the evidence that is available (including engagement with the people affected by your document or proposals) to tell you whether your document or proposal will affect people differently. It also gives you the opportunity to consider what changes you may need to make to eliminate or mitigate any adverse or negative impact you have identified.

Remember that these forms may be subject to external scrutiny e.g. under a Freedom of Information request.

Once completed, the EqIA Forms should accompany your document or proposal when it is submitted to the appropriate body for approval.



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Part A

Form 1: Preparation

1.	What are you assessing i.e. what is the title of the document you are writing or the service review you are undertaking?	PANDEMIC INFLUENZA PLAN: Distribution, Collection and Home Delivery of Antivirals
2.	Provide a brief description, including the aims and objectives of what you are assessing.	Plan for distribution, collection and home delivery of antiviral medication to people with flu, or exposed to flu, in the event of an influenza pandemic.
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?	Dr Berwyn Owen, Chief Pharmacist, BCUHB
4.	Is the Policy related to, or influenced by, other Policies/areas of work?	Linked to wider Pandemic Flu plans.
5.	Who are the key Stakeholders i.e. who will be affected by your document or proposals?	People with flu; family and friends of people with flu (flu friends); Pharmacy departments in BCU acute sites; Local authorities (providers of ACP sites)
6.	What might help/hinder the success of whatever you are doing, for example communication, training etc?	Pandemic situation may hinder implementation of the plan

Form 2: Considering the potential impact of your document, proposals etc in relation to equality and human rights

Characteristic or other factor to be considered	Potential Impact by Group. Is it:-		Please detail here, <u>for each characteristic listed on the left</u> :- (1) any Reports, Statistics, Websites, links etc. that are relevant to your document/proposal and have been used to inform your assessment; and/or (2) any information gained during engagement with service users or staff; and/or any other information that has informed your assessment of Potential Impact.
	Positive (+) Negative (-) Neutral (N) No Impact/Not applicable (N/a)	High Medium or Low	
Age	N		
Disability	N		
Gender Reassignment	N		
Marriage & Civil Partnership	N		
Pregnancy & Maternity	N		
Race / Ethnicity	N		
Religion or Belief	N		
Sex	N		
Sexual Orientation	N		
Welsh Language	N		
Human Rights	N		

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

<p>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:-</p> <ul style="list-style-type: none"> • Eliminate unlawful discrimination, harassment and victimisation; • Advance equality of opportunity; and • Foster good relations between different groups 	
1. Describe here (if relevant) how you are ensuring your policy or proposal does not unlawfully discriminate, harass or victimise	The policy relates to distribution of antiviral medication and all users of the service will be treated with dignity and respect.
2. Describe here how your policy or proposal could better advance equality of opportunity (if relevant)	The service will be provided without prejudice to all individuals affected by influenza and will promote good access to all members of the community
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)	PANDEMIC INFLUENZA PLAN: Distribution, Collection and Home Delivery of Antivirals
---	---

2. Brief Aims and Objectives: (Copy from Form 1)	Plan for distribution, collection and home delivery of antiviral medication to people with flu, or exposed to flu, in the event of an influenza pandemic
---	--

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"/>
	Record here the reason(s) for your decision i.e. what did Forms 2 & 3 indicate in terms of positive and negative impact for each characteristic?	
5. If you answered 'no'	Yes <input type="checkbox"/>	<input checked="" 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 type="checkbox"/>	No <input checked="" type="checkbox"/>
	How is it being monitored?	
	Who is responsible?	
	What information is being used?	E.g. will you be using existing reports/data or do you need to gather your own information?
	When will the EqIA be reviewed? (Usually the same date the policy is reviewed)	

7. Where will your decision or policy be forwarded for approval?	QSG
--	-----

8. Describe here what engagement you have undertaken with stakeholders including staff and service users to help inform the assessment	Consultation with partners and key stakeholders across the health board – detailed in the document
--	--

9. Names of all parties involved in undertaking this Equality Impact Assessment:	Name	Title/Role
	Adam Mackridge	Deputy Head of Pharmacy for Primary and Community Care (East)

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:			
2. What changes are you proposing to make to your document or proposal as a result of the EqlA?			
3a. Where negative impacts on certain groups have been identified, what actions are you taking or are proposed to mitigate these impacts? Are these already in place?			
3b. Where negative impacts on certain groups have been identified, and you are proceeding without mitigating them, describe here why you believe this is justified.			
4. Provide details of any actions taken or planned to advance equality of opportunity as a result of this assessment.			

**Quality, Safety &
Experience
Committee**

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 Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

To improve health and provide excellent care
21.5.19

Report Title:	Cardiopulmonary Resuscitation (CPR) Policy – RES03
Report Author:	Timothy Gardner – Resuscitation Team Manager (Central)
Responsible Director:	(Interim) Executive Director of Nursing & Midwifery
Public or In Committee	Public
Purpose of Report:	The CPR policy (RES03) updated and amended in accordance with Resuscitation council guideline. Amendments include – <ul style="list-style-type: none"> • Commencement of CPR • Management of CPR induced consciousness in the absence of return of spontaneous circulation (ROSC).
Approval / Scrutiny Route Prior to Presentation:	The pan BCU resuscitation committee has approved amendments to the policy. Consultation taken placed with the drugs and therapeutic committee.
Governance issues / risks:	No governance issues identified
Financial Implications:	No Identifiable financial implications
Recommendation:	The Committee is asked to approve the changes to the Cardiopulmonary Resuscitation Policy (Res03) – additions are highlighted in the attached policy.

Health Board's Well-being Objectives <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>	√	WFGA Sustainable Development Principle <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	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	
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	x		
7.To listen to people and learn from their experiences			
Special Measures Improvement Framework Theme/Expectation addressed by this paper			
Leadership & Governance			
Equality Impact Assessment			
Yes - completed during initial consultation process (copy attached). No Issues identified.			

Disclosure:

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

Version:
0.2



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University Health Board

RES03

Cardiopulmonary Resuscitation (CPR) Policy

Date to be reviewed:	2020	No of pages:	30
Author(s):	Timothy Gardner	Author(s) title:	Resuscitation Team Manager (central)
Responsible dept. / director:	Surgery/Scheduled care Dr Nick Nelhans		
Approved by:	Pan BCU Resuscitation Committee		
Date approved:	Date approved		
Date activated (live):	Date becomes live		

Date EQIA completed:	01/07/16
Documents to be read alongside this policy:	All Wales Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) policy (2015) Resuscitation Council (UK) 2015 Guidelines Statutory & Mandatory Training Policy and Procedure (WP30) 2016 Quality Standards for Cardiopulmonary Resuscitation Practice and Training (Resuscitation Council, 2016) Medical Devices & Equipment Management policy (MP02)
Purpose of Issue/Description of current changes: New BCUHB policy to unify three legacy Resuscitation Policies from previous Organisations prior to BCUHB	

First operational:	Date the policy was first operational				
Previously reviewed:	25/10/18	date	date	date	date
Changes made yes/no:	Yes	Yes/no	Yes/no	Yes/no	Yes/no

PROPRIETARY INFORMATION

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1. Introduction and Policy Statement

When a patient suffers a cardiac arrest, every attempt must be made to optimise the chances of survival. The Royal College of Physicians and the Royal College of Nursing have agreed that the management of cardiac arrest must be conducted according to the guidelines of the Resuscitation Council 2015(UK). This policy agrees accordance with these guidelines and all Health Board staff must adhere to them.

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2. Purpose of the Document

The purpose of the policy is to optimise patient care and outcome by –

- Providing guidance and direction for the planning and implementation of a robust, high quality resuscitation service to the organization. The strategy incorporates the current national guidelines for resuscitation and training (Resuscitation Council UK, 2015 & UK Core Skills Framework for Health, 2016).
- Establishing guidelines for training and performance of cardiopulmonary resuscitation, maintaining quality of care for patients and evaluate staff competence and ability to provide resuscitation in accordance with these guidelines.
- Detailing the duties and training requirements for all staff within the organisation relating to CPR, defibrillation, anaphylaxis and recognition and escalation of care of the deteriorating patient.
- Detailing the process and tools utilised for the identification and response to patients at risk from deterioration and cardio respiratory arrest within the organisation (i.e. National Early Warning Score).
- Detailing the process for ensuring continual availability of cardiac arrest equipment within clinical and non-clinical areas throughout BCUHB, where appropriate, and following local risk assessment.
- Detailing the process for monitoring compliance with training and equipment checking.

3. Scope

The policy applies to all BCUHB staff both clinical and non-clinical including locums and agency.

4. Aims and Objectives

The aim of the policy is to support best practice in the event of a patient, member of the public, staff member or contractor requiring resuscitation by a member of clinical staff with direct patient/client contact employed by BCUHB.

5. Roles & Responsibilities

5.1 Resuscitation Committee

The Resuscitation committee are accountable to The Quality & Safety Group (QSG), which in turn reports to the Quality, Safety and Experience Board (QSE).

- Ensure that the resuscitation services throughout the organisation are compliant with BCUHB Policy and DOH / WG / and Resuscitation Council 2015(UK) Guidelines; in particular the Resuscitation Council 2016(UK) document **“Standards for Cardiopulmonary Resuscitation and Training”** which can be accessed online via this link: <https://www.resus.org.uk/quality-standards/>
- Analyse developments and national guidance – planning future requirements in service, education and training accordingly.
- Determine level/type of Resuscitation Training for staff as appropriate to their job role.
- Commission and review audits, examining relevant Resuscitation related issues.
- Provide advice to Clinical Divisions and Clinical Teams to ensure best practice is maintained.
- Receive case reports for review following clinical incidents relating to resuscitation. To guide and assist those investigations and report to QSG.
- Ensuring the provision of appropriate equipment both for resuscitation, training, and those systems are in place to support any required maintenance.
- Ensuring that there are appropriate training programmes for Resuscitation and Advanced Life Support Courses across the Health Board for a variety of specialities, to include, but not exclusive to, adult, paediatric, neonatal and trauma
- Advise and support the Resuscitation Officers, as executive agents of the committee.
- Promote audit of the effectiveness of resuscitation and prodromal factors, and foster systems to reduce its incidence.

The Minutes of the Meetings shall be formally recorded and approved by the Resuscitation Committee chair. The minutes submitted to the next meeting of the committee for any required amendments.

The Resuscitation Committee will report to QSG by submitting the minutes (chair approved) and highlighting any issues through a significant Issues/exception report.

There will be an Annual training report presented at the first resuscitation committee meeting of the calendar year.

The chair of the Resuscitation Committee may raise specific matters with the Sub committees within the divisions, such as finance and performance, quality and safety for information, discussion or approval.

The minutes of the BCUHB Resuscitation Committee will be available on the BCUHB intranet (resuscitation pages), once approved, for information.

Exception reporting on individual issues will be communicated with individual divisions as deemed appropriate.

5.2 Resuscitation Services Department Remit

Resuscitation services department staff & resuscitation officers (RO`s) have the following remit and authority on behalf of the resuscitation committee.

- Coordinating and delivery of resuscitation training across BCUHB in accordance with WP30 (2016) and Resuscitation Council guidelines (2015).
- The Resuscitation services department will maintain accurate records of the training conducted and this information will be entered on the electronic staff register.
- Responsible for the maintenance and cleaning of resuscitation training equipment (Manikin cleaning guideline RES02).
- Responsible for cardiac arrest and 2222 call audit and data collection.
- The provision of consumables for restocking of the Cardiac Arrest equipment via a resuscitation consumables cupboard available 24 hours a day.
- Give specialist advice to the organisation and staff in the subject of resuscitation and related issues.
- If needed conduct or support investigations into resuscitation related incidents providing reports and recommendations.
- Resuscitation officer, when available, will attend any emergency call to ensure adherence to current guidelines and practice, and as a support to the Cardiac arrest team members. If required the Resuscitation Officer may take the role of cardiac arrest team leader.

5.3 Clinical Staff Responsibility

All clinical staff are responsible to;

- Practice within the Resuscitation Council (UK) guidelines and their own codes of professional practice.
- Cooperate and comply with the implementation of this policy.
- Adhere to the guidelines and recommendations set by the Pan BCU Resuscitation committee.
- Have a duty to ensure they have completed the minimum level of mandated life support training required for their role and clinical responsibilities, as directed by WP30 and by resuscitation services (as representatives of the resuscitation committee).
- Must attend mandatory resuscitation training which must be completed annually in accordance with the mandatory training policy (WP30).
- Raise any queries about the policy with their line manager or Resuscitation services department.
- Participate in the daily checking of cardiac arrest equipment to ensure the equipment is, complete, available, (as per checklist) in good working order, clean in accordance with cleaning responsibility framework (link below)
<http://howis.wales.nhs.uk/sitesplus/861/document/414681> .

- Must be aware of how to immediately alert the appropriate response team in the event of an emergency.
- Must be aware of the processes to follow in the event of cardiac arrest equipment failure or is found to be faulty during the operational checks or when being used.
- Must know the location of cardiac arrest equipment within their clinical area. This must be included for new starters as part of their induction process
- Must be able to in accordance with the 'Quality Standards for Resuscitation Practice and Training (2016).
 - Recognise cardio/respiratory arrest;
 - Summon help;
 - Start CPR;
 - Attempt defibrillation, if appropriate, within 3 minutes of collapse using an automated external defibrillator (AED)
- Work for patients and families to provide dignified and compassionate care.
- In the “the event of no explicit decision having been made in advance about CPR and the express wished of a person unknown and cannot be ascertained, there should be an initial presumption that healthcare professionals will make all reasonable efforts to resuscitate the person in the event of cardiac or respiratory arrest” (Resuscitation Council 2016).
- “There will be some people for whom attempting CPR is clearly inappropriate; for example a person in the advanced stages of a terminal illness where death is imminent and unavoidable and CPR would not be successful, but for whom no formal CPR decision has been made and recorded. In addition, there will be cases where healthcare professionals discover patients with features of irreversible death – for example rigor mortis. In such circumstances, any healthcare professional who makes a carefully considered decision not to start CPR should be supported by their senior colleagues, employers and professional bodies” (Resuscitation Council, 2016). However as the RCUK (2016) state “in such emergencies there will rarely be time to make a comprehensive assessment of the persons condition and the likely outcome of CPR. In these circumstances CPR will usually be appropriate”.

5.4 Non Clinical Staff Responsibility

All non-clinical staff must undertake the appropriate resuscitation training, as identified through a training needs analysis by the resuscitation training department. The RCUK expect that non-clinical staff should have the resuscitation skills that would be expected from a layperson. There is an option to complete a BCUHB online eMLS (Level 1) for non-clinical staff.

As a minimum, all non-clinical staff must have awareness of how to alert an emergency team through the hospital internal emergency system. They must also be aware of how to contact the emergency services in the event of an emergency in a community area or outside the main Acute Hospital site.

6. Resuscitation Training

6.1 All clinical staff

- The BCUHB Resuscitation Committee as defined by the Resuscitation Council UK & United Kingdom core skills framework (2016) decides the level and type of resuscitation training.
- Information about the level of training required can be accessed through the BCU Resuscitation Services intranet page or contacting the resuscitation training departments at Ysbyty Gwynedd, Glan Clwyd Hospital or Wrexham Maelor Hospital. <http://howis.wales.nhs.uk/sitesplus/861/page/47717>

6.2 Level 2 Mandatory Life Support (MLS)

This is the minimum standard for all clinical staff with direct patient contact, which would be required to cover the learning outcomes defined in UKCSTF at Resuscitation Level 2 for adults and paediatrics

- The minimum contents of MLS will include but not limited to -
 - ABCDE assessment including chain of survival.
 - National Early Warning Score (NEWS).
 - Sepsis bundle.
 - Adult Basic Life support (BLS) including Paediatric modifications.
 - Automated External Defibrillation.
 - Anaphylaxis.
 - Oxygen delivery.
 - Use of the Portable suction unit.
 - Chocking & recovery position.
 - Cardiac Arrest equipment checking.
 - All Wales DNACPR policy (2015) discussion.

6.3 Level 3 Immediate Life Support (ILS) & Paediatric Immediate Life Support (PILS)

This is the minimum standard for all clinical staff with direct patient contact, which would be required to cover the learning outcomes defined in UKCSTF at Resuscitation Level 3 for adults and paediatrics

- ILS & PILS are a recognised national training course governed by the Resuscitation Council (UK).
- An ILS & PILS certificate are valid for 1 year and must be update annually, this can achieved through a half day recertification course (as applicable).
- The ILS & PILS courses are appropriate for the following people however; this is not an exhaustive list.
 - Doctors – Hospital & community
 - Nurses - Hospital & community
 - Nursing & Medical students
 - Midwives
 - ODP`s
 - Clinical Physiologists *(If not working in Cardiac Catheterisation or physiologist led “stress echo” service. Physiologists in this role will require ALS)*
 - Physiotherapist

- Radiographers
- Dentist & Dental Nurse
- The contents of the courses include but not limited to -
 - Causes & Prevention of cardiac arrest
 - The ABCDE approach
 - Advanced life support Algorithm
 - Initial resuscitation & defibrillation (AED)
 - Airway & Breathing skill station
 - Targeted training i.e. Sepsis, IO insertion, NEWS & DNACPR

6.4 Advanced Life Support (ALS), Advanced Paediatric Life Support (APLS), European Paediatric Advanced Life Support (EPALS) Advanced Trauma and Life Support (ATLS) & Neonatal Life Support (NLS) courses

- Advanced training courses are offered to designated qualified staff that work in specified acute areas including CCU, ICU, SCBU, Maternity, Medical admissions, Emergency department, Theatres, Anaesthetics and other areas as specified via resuscitation services or through the intranet resource “What training Do I Need?”, which can be found via this link:
<http://howis.wales.nhs.uk/sitesplus/861/page/55146>.
- All core members of the Adult & Paediatric Cardiac/Emergency teams must have an up to date advanced life support course appropriate to the emergency team they are allocated.

7. The Hospital Emergency Teams

7.1 Cardiac Arrest / Emergency Collapse

- All core members of the Adult cardiac arrest and Medical emergency team must hold as a minimum a current ILS certificate. The team leader and at least 2 other members of the team must have a current ALS provider certificate.
- All members of the Paediatric cardiac arrest and Paediatric emergency teams must hold as a minimum a current PILS certificate. The team leader and at least two other members of the team must have a current APLS/EPALS provider certificate.
- It is the bleep holder’s responsibility to ensure they are familiar with the layout of the hospital.
- Medical staff who cannot attend the emergency call must arrange for another approved member of their specialty to attend on their behalf

7.2 Medical Emergency Team (MET) & National Early Warning Score (NEWS)

- BCUHB utilises the national early warning score, which is established to identify at risk patients and prevent cardiac arrest.

- All clinical staff must be trained in the use of physiological observation charts and NEWS scoring system to enhance the decision-making process and care. The NEWS system has a clearly defined pathway that must be adhered to.
- When a patient achieves a NEWS score of 9 or above the medical emergency team must be called.

7.3 Switchboard

- The Cardiac arrest/Medical emergency team (where applicable) must be summoned by contacting switchboard on 2222 and stating clearly the emergency and location, for example –`Cardiac Arrest, Acute Medical Unit`. Abbreviations for locations must not be used. Allow switchboard to repeat the message back to the caller to ensure both the message and location have been understood before bleep activation.
- All members of the team will carry emergency response bleeps and will be alerted by the switchboard operator via speech channel.
- The onsite cardiac arrest team/medical emergency team will attend 2222 calls to all areas in and around the 3 main sites to include the car parks and other outlying areas within the main acute sites.
- In the event of a `Crash call` outside the main complex but within the boundary of the hospital staff must phone 2222 & 9/999 summon the cardiac arrest team and an ambulance. The caller must remain on the telephone line as the ambulance service often request information pertaining to the victim's condition and location.
- Switchboard will test the speech channel on a daily basis and record compliance. All Core members of the cardiac arrest/emergency team must respond to the daily test call.
- The resuscitation department must first approve additional bleeps added to the emergency call system.

7.4 Emergency Team Leader

The emergency team leader has a specific role directing the resuscitation team. The team leader must hold a current valid ALS/APLS/EPALS or NLS provider certificate specific for the team they are leading. The team leader will be responsible in ensuring that:

- The clinical emergency is managed appropriately
- Adequate basic life support is performed
- Defibrillation delivered swiftly and safely where appropriate.
- Tasks are designated to the other team members who have the appropriate skills to carry them out
- Current Resuscitation Council guidelines are followed
- All the necessary documentation completed, to include the 2222 Audit form.
- Communication with relatives is undertaken in a timely and appropriate manner,
- The safety of the patient and the emergency team is maintained at all times
- An awareness of how to access individuals who have the skills in:

- Intraosseous insertion
- Cardioversion and external pacing
- Focused ultrasound/echocardiography

7.5 Emergency Team Core Clinical Members

When an emergency call is put out core team members are expected to attend the events as rapidly and safely as possible. Other emergency bleep holders who may not attend events however, they may need to know in order to make provision to cover workload (i.e. Clinical Site, theatre bleep holder etc.).

Core team members must familiar with the emergency equipment available including the cardiac arrest trolley, suction unit and defibrillator (AED). In the case of defibrillators, “manual mode” must only be used by staff specifically trained (and within their current competency period) in manual defibrillation. All other staff must only use defibrillators in “automated external defibrillator (AED)” mode.

Porters may be core non-clinical team members.

8.0 Cardiac Arrest Equipment

8.1 BCUHB Standardised Resuscitation Equipment

BCUHB is committed to providing sufficient cardiac arrest equipment in each patient area to support the patients care and treatment during an emergency event. This complies with Resuscitation Council recommendations. BCUHB will continue to ensure that all equipment is in line with current specifications and technological developments.

- The resuscitation services department together with the Pan BCU resuscitation committee will determine the level and location of all cardiac arrest equipment. This will depend on the anticipated need of each area, and the availability of equipment from nearby departments and factoring in any specific local area needs.
- Equipment for cardiopulmonary resuscitation, including defibrillators and suction units will be standardised across the Health Board wherever possible.
- Cardiac arrest drug boxes will be on all cardiac arrest equipment across the acute sites or where there is provision of staff with advanced life support skills.
- Where new clinical services are being created or services are being relocated, it is the service lead responsibility to obtain and act upon a risk assessment from the resuscitation services department before clinical activity commences.

- Resuscitation drugs and equipment for airway management, circulatory access and fluid administration will be available in all appropriate areas. Those trained to do so must only use this equipment.
- Intraosseous access needles (EZ-IO) are located strategically throughout the acute sites. Only to be used by those staff who have attended an EZIO training course and are deemed competent by means of assessment through the resuscitation services department.
- No clinical area must ever leave itself without resuscitation equipment or immediate access to resuscitation equipment. Following an emergency requiring opening of the resuscitation equipment restocking of the equipment MUST happen at the earliest opportunity.
- The resuscitation services department to ensure compliance with checking procedure and stock levels will audit resuscitation equipment and cardiac arrest trolleys. This result of the audit will be fed back to the Nurse/ Allied Health Professional (AHP) in charge. See appendix 4
- In identified patient areas, where advanced cardiac arrest equipment is not required, basic level resuscitation equipment must be available for staff to use until further help arrives.
- The level of equipment required based on a risk assessment conducted by the resuscitation services department.
- Community hospital, community dental clinics and community mental health units will have equipment based on 'Quality standard for Cardiopulmonary resuscitation practice and training' (RCUK, 2013).

8.2 Resuscitation equipment:

- It is the responsibility of the nurse/AHP in charge to ensure that the appropriate checks are performed as per the trolley contents checklist. The check must be carried out by clinical staff band 5 or above or by specific risk assessment by the resuscitation services department
- Under no circumstances must equipment be added or removed from the resuscitation equipment without first consulting with the resuscitation department.
- Clinical staff must be aware of the checking procedure. Familiarisation with equipment and checking is covered as part of mandatory training.
- Equipment must be kept clean and dust free following infection prevention cleaning guidelines.
- After every use or within 7 days of the previous full contents check, the trolleys/bags must be opened and the contents checked against the standardised checklist in the equipment contents folder. It is the responsibility of the Nurse/AHP in charge to ensure that a qualified member of staff checks and signs the Daily record for checking form.
- Disposable items listed in the equipment contents folder to be replaced from ward stock and/or the cardiac arrest consumables equipment cupboard where available. Items taken from the cupboard must be signed for accordingly.
- The pharmacy department is responsible for the cardiac arrest drug stocks.
- Each clinical area is responsible for checking the expiry date and seals intact within the cardiac arrest equipment.
- The stock contents and quantities listed in the equipment contents list. Staff must keep to the checklist. Under and over stocking represent a clinical risk.

- On paediatric wards and other areas where children are treated, equipment suitable for paediatric resuscitation will be available. Such equipment will be standardised and chosen by the resuscitation services department in association with those who have responsibility for paediatric services and resuscitation guidelines.
- All the current equipment contents lists can be found on the resuscitation services department intranet page.
WWW.howis.wales.nhs.uk/sitesplus/861/page/47717

8.3 Defibrillators

- It is the responsibility of the nurse/AHP in charge to ensure the defibrillator checks are carried out ensuring defibrillator pads are present, unopened and in date.
- Where applicable replacement defibrillator pads can be obtained from the Cardiac arrest equipment consumables cupboard.
- Community sites must contact the resuscitation services department for details of how to replace consumables and defibrillator pads.
- Defibrillators will include the option of paediatric pads in areas where children and babies are treated.
- Defibrillators with the option of cardioversion and external pacing are located strategically around BCUHB. Consult with the Resuscitation services department for exact locations.
- During the daily check if the data card is full, absent or showing any fault, it must be reported immediately to the resuscitation services for attention.

8.4 System for reporting faults

Equipment must be checked on a daily basis and any faults reported to the appropriate department i.e.

- Defibrillators and portable suction units to the medical engineering department (EBME).
- Oxygen cylinders
- All other enquiries contact Resuscitation services department

If during the daily check the defibrillator is found to be non-functional, it must be removed from service and the EBME department must be informed as soon as possible. A replacement machine must be obtained as soon as possible whilst the defibrillator is out of use. If available, these can be requested from EBME and on occasion Resuscitation Services.

9. Defibrillation

- Only staff that hold a current valid Advanced life support (ALS) or Advanced Paediatric Life Support (APLS or EPALS) certification, or who have been competency assessed by resuscitation services have the support of the health board to operate a defibrillator in manual mode.

- Staff that are only trained to use a defibrillator in AED mode are **not** supported by the health board to use manual mode
- Staff who's ALS, APLS or EPALS certificate have expired are only supported to use the AED mode.
- Staff who hold current ALS, APLS or EPALS provider certificate may use the defibrillator in manual mode, but are also encouraged to use AED mode unless they judge that the clinical situation requires a manual shock.

10. Thrombolysis during arrest

During a cardiac arrest, the team may consider using Tenecteplase for suspected or confirmed pulmonary embolism. This has been agreed with the drugs and therapeutics committee.

Tenecteplase is located in the following clinical areas on the acute sites:

- Emergency Department
- Coronary Care Unit
- Maternity
- Intensive Care Unit

Dose: Use 10000 units (50mg) IV

Give undiluted over 10 seconds

Following administration of Tenecteplase, consider performing CPR for a minimum of 60 to 90 minutes before termination of resuscitation attempt.

11. Post Resuscitation Care and Transfer

11.1 Post Resuscitation Care in the Acute Setting

The immediate post resuscitation phase is characterised by high dependency and clinical instability. It is an 'important step in the continuum of resuscitation' (Resuscitation Council, 2015).

Post cardiac arrest/resuscitation may require either coronary care or intensive care treatment. Facilities for ongoing care of the patient may not be available at the location of collapse therefore transfer of the patient may be necessary within BCUHB and specialist centres.

- It is the responsibility of the resuscitation team leader to ensure the transfer of care is coordinated and the receiving centre/department has access to all the necessary information and documentation pertaining to the patient's condition and treatment.
- Continuity of care during this period of resuscitation is vital. It is the responsibility of the team leader to ensure that the transfer of care from the emergency team to the responsible clinician is both appropriate and efficient.

The team must not leave the patient until they have delegated the care to another appropriate colleague.

- The transfer team must have the necessary skills to monitor and respond to changes in the patient condition during the transfer stage
- The patient's condition must be stabilised as much as possible prior to transfer, however the patient condition may warrant transfer to a definitive care/treatment area as not to delay treatment (i.e. theatres, catheter lab).
- There must be the appropriate level of equipment available to transfer the patient in a safe manner, e.g.
 - Portable Oxygen (including spare)
 - ECG, SaO₂ & Blood pressure monitoring
 - Defibrillator & Pacing
 - Ventilator & anaesthetic transfer equipment
 - Emergency drugs & fluids
 - Suitable airway support equipment
- Relatives must be informed about any transfers at the earliest opportunity.

11.2 Post Resuscitation Care in the Community Setting.

The staff involved in the resuscitation must be able to hand over information to the ambulance service to ensure continuity of care. Staff must also be available to speak to the receiving centre and ensure all relevant documentation is available.

12. Manual Handling

In situations where a patient collapses on the floor in a confined space BCUHB moving and handling guidelines must be followed. In the event of a cardiac arrest, the priority must be the safety of the cardiac arrest team and minimise the risk of manual handling related injuries to the patient and staff.

Reference can be made to `Guidance for safer handling during cardiopulmonary resuscitation in healthcare setting` RCUK (2015).

13. Collapsed Patient in MRI Scanner

13.1 Initial Management

No Unauthorised personnel are to enter the magnet room unless under the instruction of an authorised person.

In the event of a cardiac arrest or a medical emergency taking place in the MRI scanner, the patient must be removed immediately from the magnet room before CPR can begin.

Person A

- Call for help (using the intercom if necessary)
- Remove the patient from the magnet-using patient out button or table stop button on gantry that allows manual table movement. Pull the table out of the magnet using the handle at the foot end.

- Assess patient and if necessary, commence resuscitation until person B arrives & stay with the patient.

Person B

- Summon the cardiac arrest team on 2222
- Move the patient from the scanner table
- Evacuate the patient from the magnet room and lock the door then continue resuscitation.
- Retrieve cardiac arrest equipment

13.2 Delays in Management

If there is a delay in removing the patient from the magnet room then CPR must be commenced in the scan room.

13. 3 Rapid Evacuation from MRI Scanner

In order to ensure rapid evacuation and commencement of resuscitation of the patient from the magnet room a non-magnetic stretcher must be available at all times.

References & Associated Documentation

BCUHB (2016) Statutory and Mandatory training policy and procedure (WP30).
BCUHB

www.howis.wales.nhs.uk/sitesplus/861/document/426883

East Cheshire NHS Trust (2014) Cardiopulmonary Resuscitation Policy East Cheshire NHS trust

NHS Wales (2015), All Wales Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) policy. NHS Wales.

WWW.howis.wales.nhs.uk/sitesplus/documents/861/DNACPR%20Policy%20-%20Sharing%20and%20Involving%20-%20ENGLISH.pdf

Portsmouth Hospitals NHS Trust (2014) Cardiopulmonary Resuscitation Policy (including defibrillation and anaphylaxis). Portsmouth Hospitals NHS Trust

Resuscitation Council UK (2015) Guidance for safer handling during cardiopulmonary resuscitation in a healthcare setting, London: Resuscitation council UK

Resuscitation Council (2015) Resuscitation guidelines. www.resus.org.uk/#

Resuscitation Council (2016) Quality standards for cardiopulmonary resuscitation and practice. London: Resuscitation Council UK.

Royal Cornwall Hospitals NHS Trust (2016) Cardiopulmonary Resuscitation Policy V4.1 Royal Cornwall Hospital.

Skills for Health (2015) UK Core skills training framework,
www.skillsforhealth.org.uk/services/item/146-core-skills-training-framework

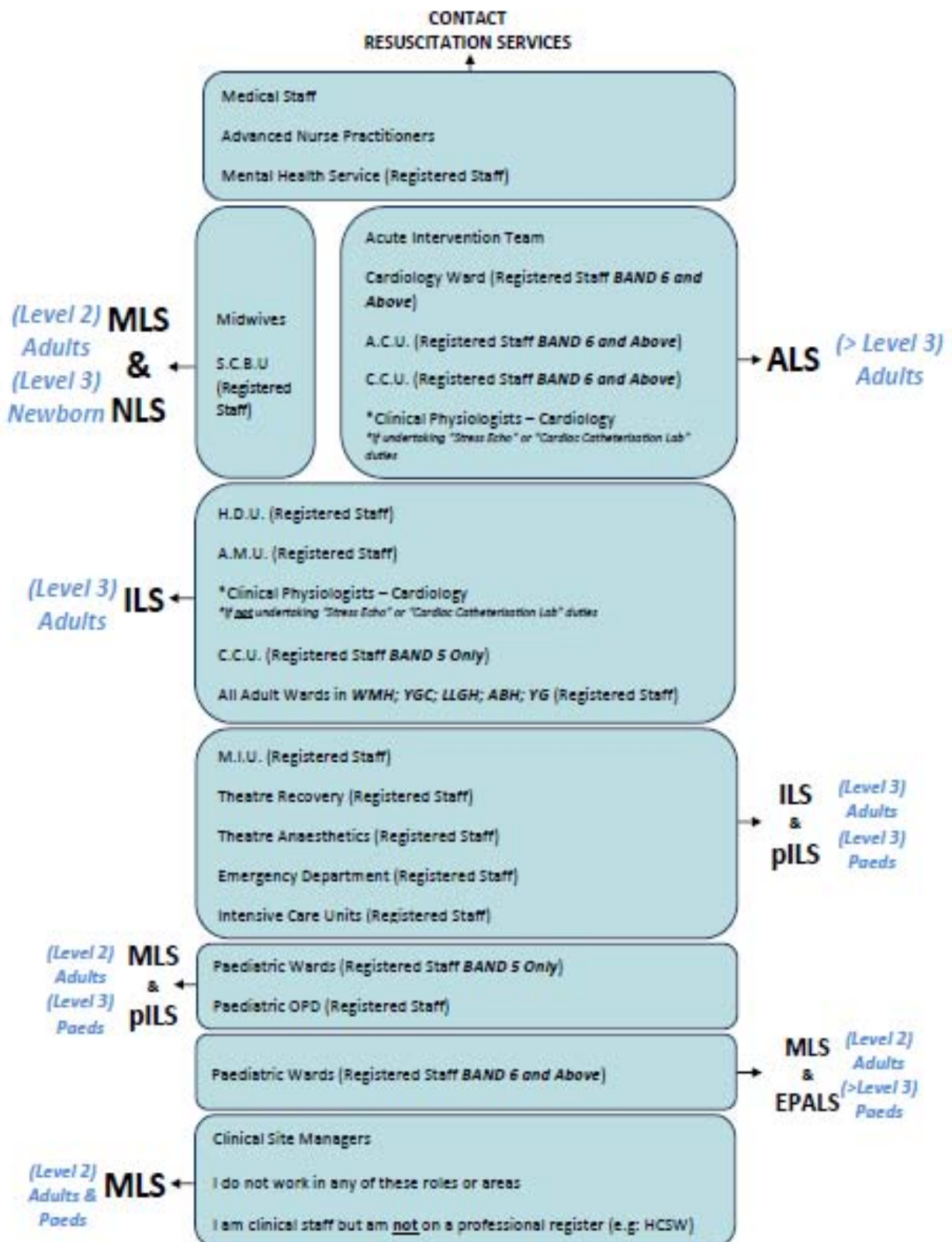
University Hospital Southampton NHS Foundation Trust. (2014) Cardiopulmonary Resuscitation Policy, University Hospital Southampton

Members of the Working Group:

Name	Title
Timothy Gardner	Resuscitation team manager (Central)
Sarah Bellis Hollway	Resuscitation Services manager (Interim)
Christopher Shirley	Resuscitation Officer
Alun Mowll	Resuscitation team manager (West)
Stuart Salisbury	Resuscitation team manager (East)
Dr N Nelhans	Consultant Paediatrician/Clinical director Resuscitation services.

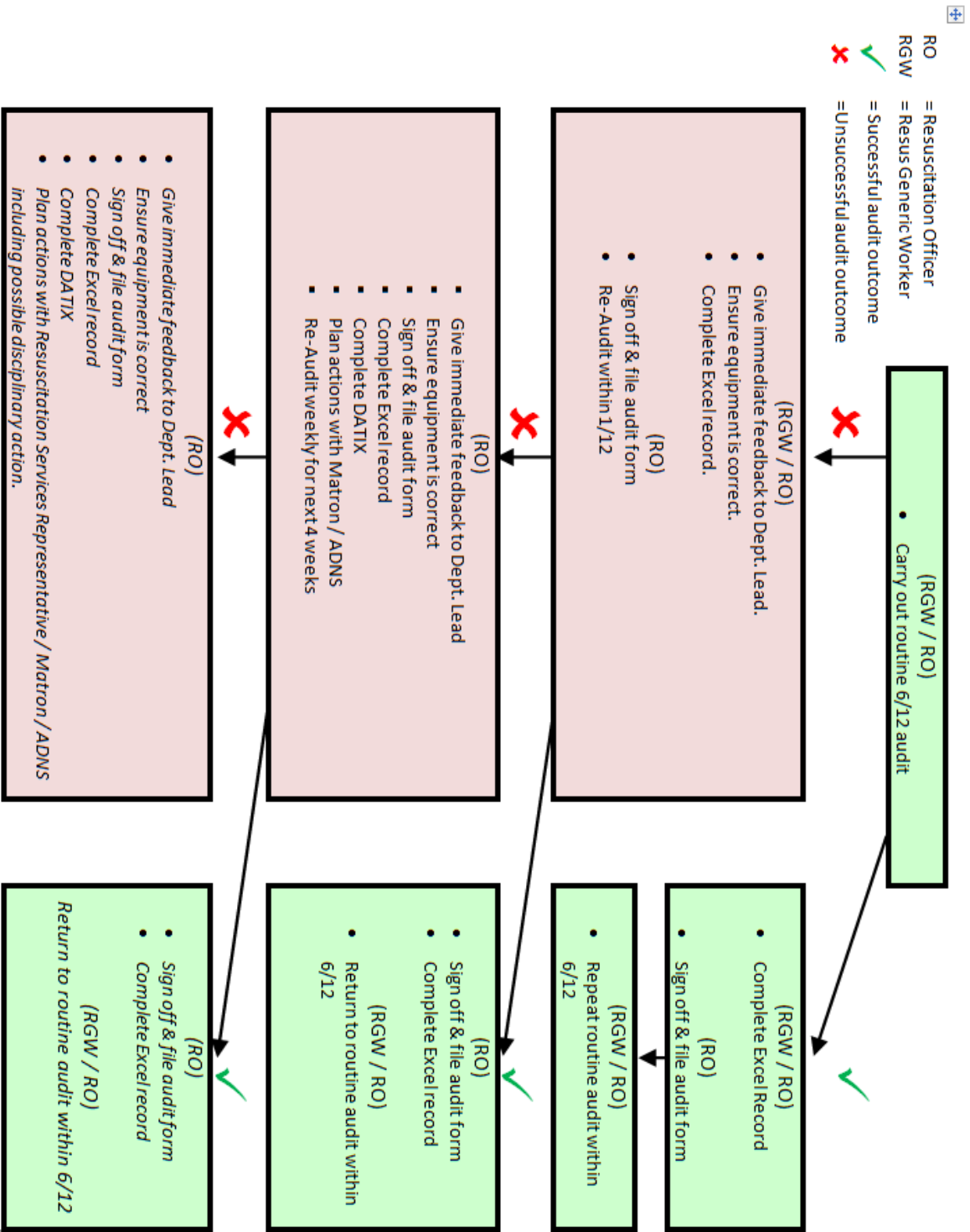
Engagement has taken place with:

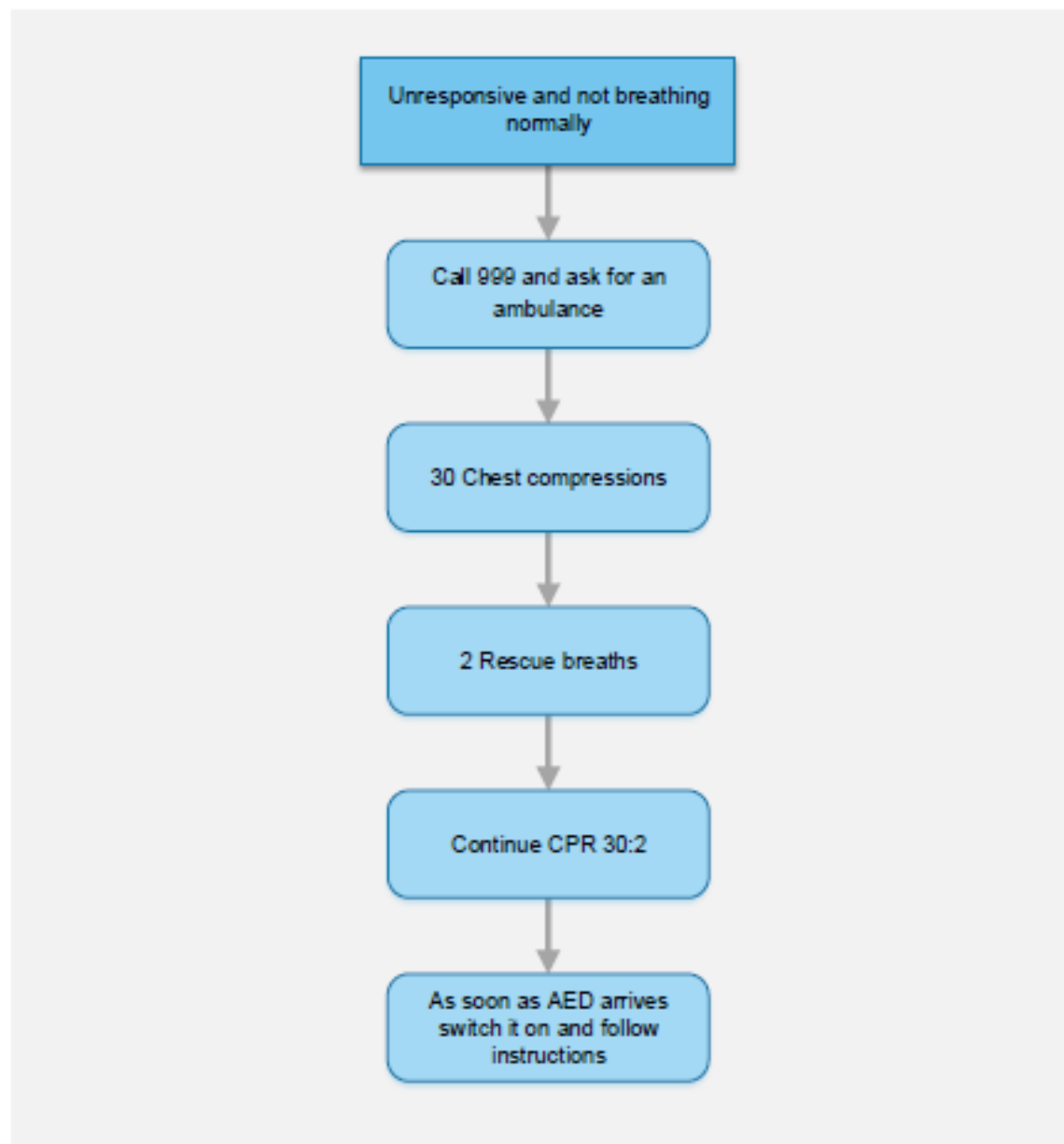
Name	Title	Date Consulted



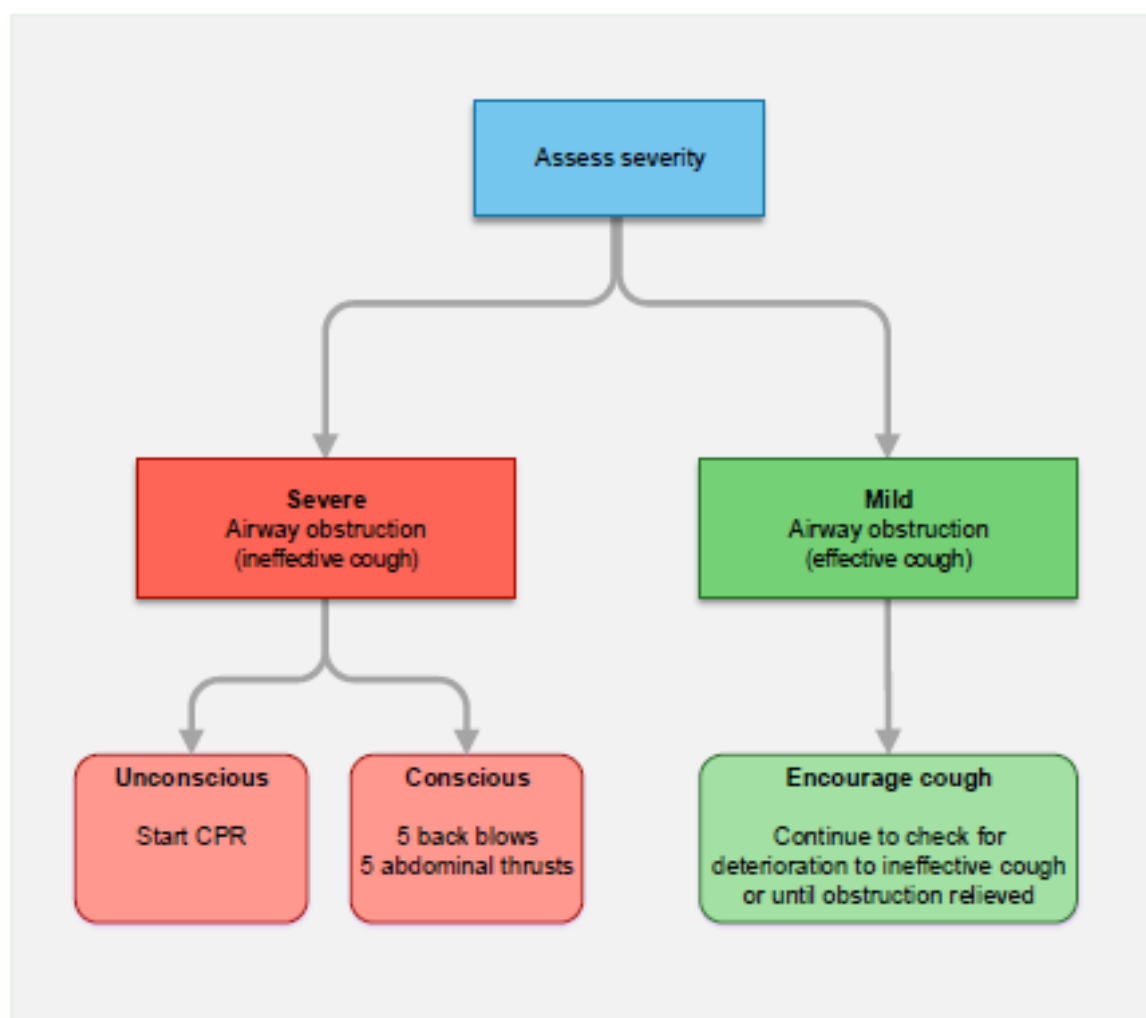
2016 Core Emergency Team Membership *(As approved by the Resuscitation committee)*

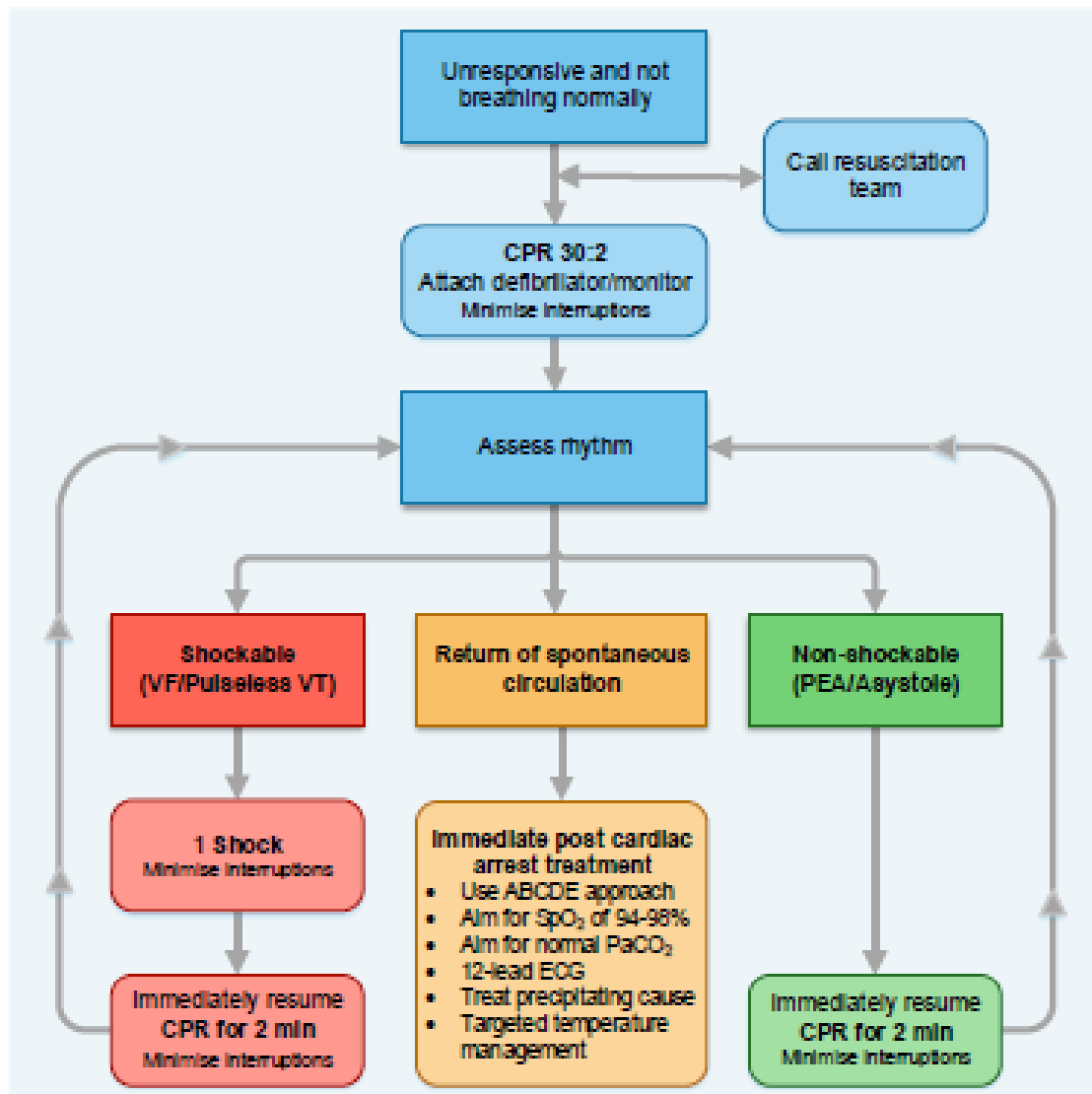
Team	East (WMH)	Central (YGC)	West (YG)
Cardiac arrest team	Anaesthetist Medical Registrar Medical SHO/HO Medical SHO/HO Acute Intervention Practitioner Resuscitation Officer	Medical Registrar Medical SHO COTE SHO Anaesthetist x 2 ODP Acute Intervention Practitioner Resuscitation Officer	Medical registrar Medical SHO (A) Medical SHO (C) Anaesthetist (1 st on call) Medical Nurse Anaesthetist Resuscitation Officer
Trauma team	To Be Confirmed	Orthopaedic Registrar Orthopaedic SHO Surgical SHO Surgical registrar A&E consultant A&E nurse OPD Anaesthetic registrar Anaesthetic SHO Resuscitation Officer	Orthopaedic registrar Orthopaedic SHO Anaesthetist A&E consultant A&E Nurse Medical Nurse Surgical Nurse X-Ray Resus Officer
Paediatric arrest team	To Be confirmed	Paediatric Registrar Paediatric SHO x 2 Anaesthetic Registrar Anaesthetic SHO ODP Paediatric nurse Resus Officer	Registrar neonates SHO neonates SHO Paediatrics Anaesthetist (1 st on call) Paediatric day registrar Paediatric day SHO Resus Officer









**During CPR**

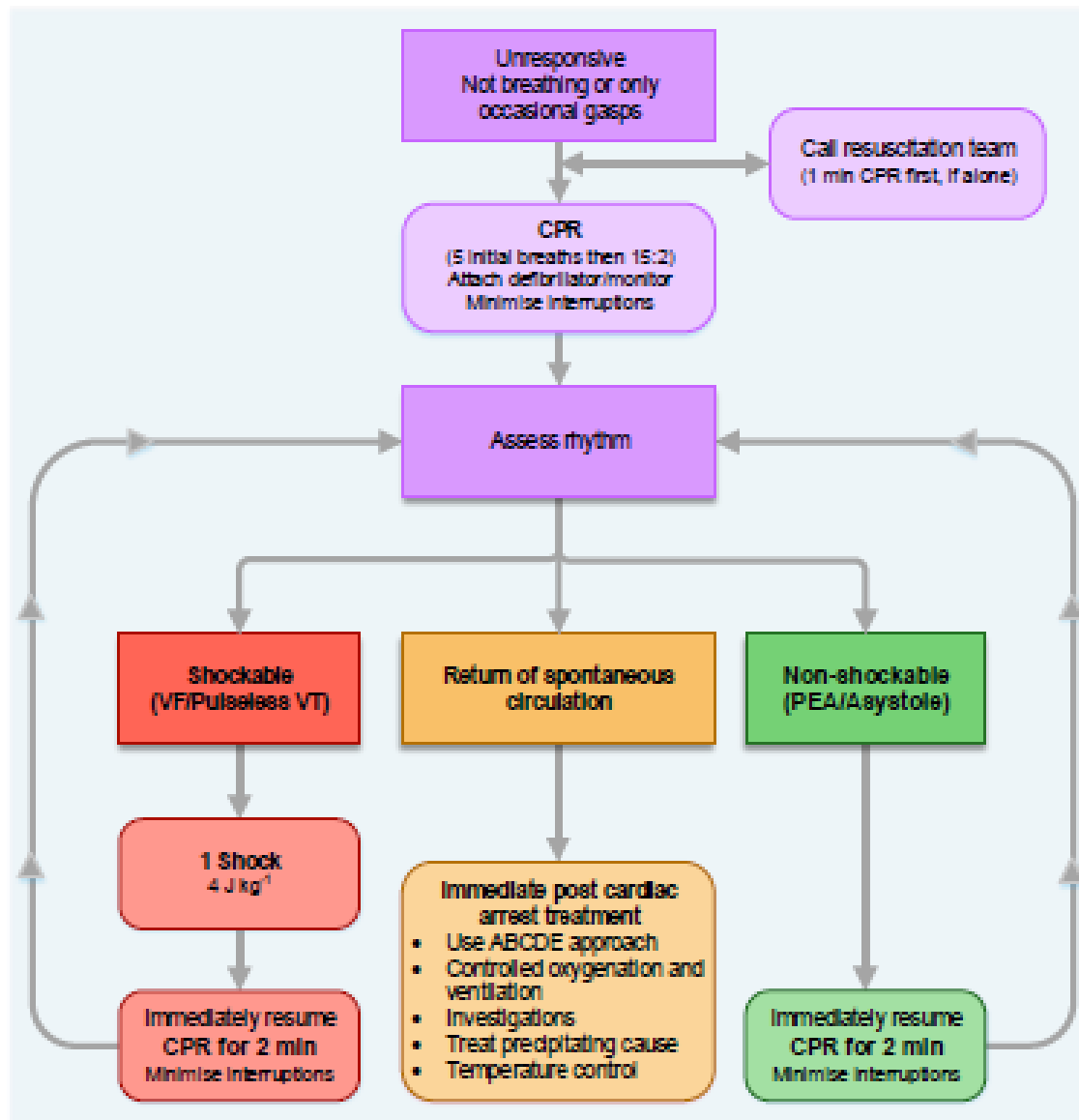
- Ensure high quality chest compressions
- Minimise interruptions to compressions
- Give oxygen
- Use waveform capnography
- Continuous compressions when advanced airway in place
- Vascular access (intravenous or intraosseous)
- Give adrenaline every 3-5 min
- Give amiodarone after 3 shocks

Treat Reversible Causes

- Hypoxia
- Hypovolaemia
- Hypo-/hyperkalaemia/metabolic
- Hypothermia
- Thrombosis - coronary or pulmonary
- Tension pneumothorax
- Tamponade - cardiac
- Toxins

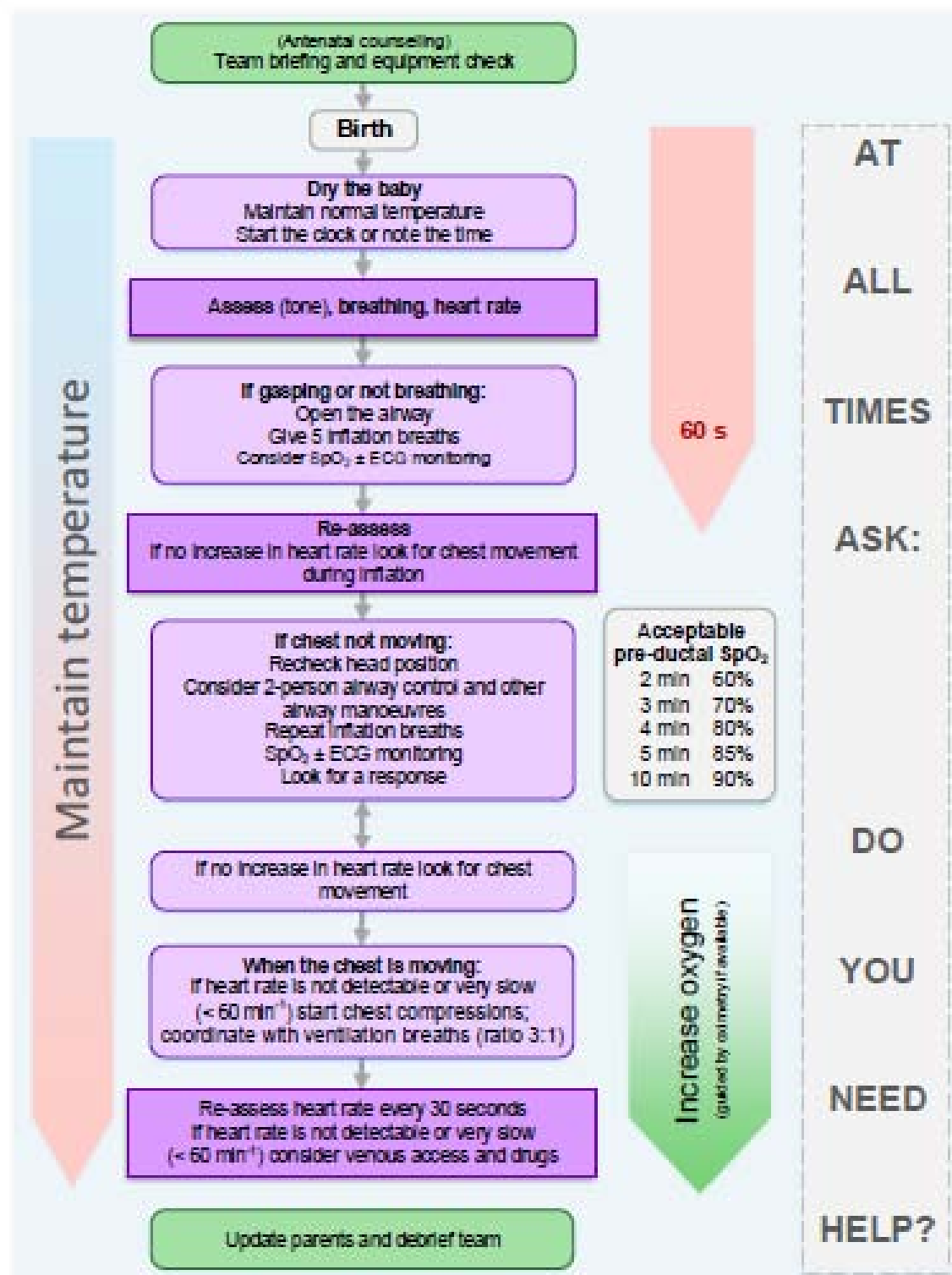
Consider

- Ultrasound imaging
- Mechanical chest compressions to facilitate transfer/treatment
- Coronary angiography and percutaneous coronary intervention
- Extracorporeal CPR

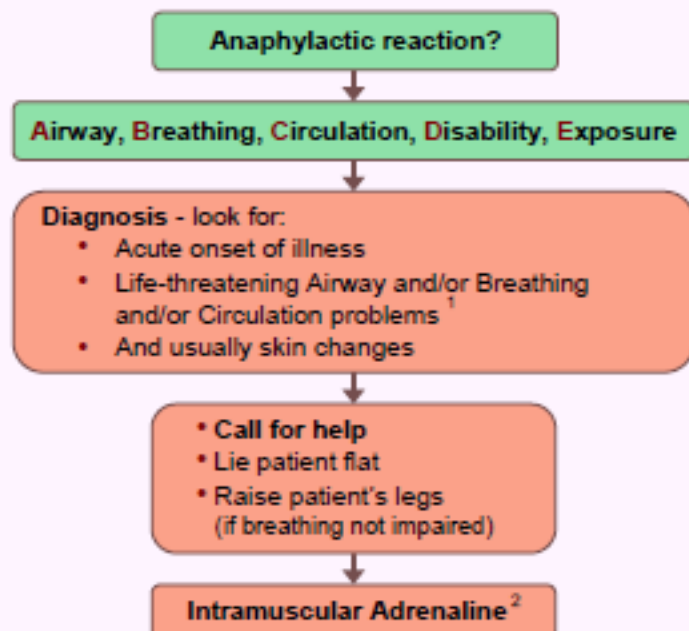


- During CPR**
- Ensure high-quality CPR: rate, depth, recoil
 - Plan actions before interrupting CPR
 - Give oxygen
 - Vascular access (intravenous, intraosseous)
 - Give adrenaline every 3-5 min
 - Consider advanced airway and capnography
 - Continuous chest compressions when advanced airway in place
 - Correct reversible causes
 - Consider amiodarone after 3 and 5 shocks

- Reversible Causes**
- Hypoxia
 - Hypovolaemia
 - Hyperhypokalaemia, metabolic
 - Hypothermia
 - Thrombosis (coronary or pulmonary)
 - Tension pneumothorax
 - Tamponade (cardiac)
 - Toxic/therapeutic disturbances



Anaphylactic reactions – Initial treatment



1 Life-threatening problems:

Airway: swelling, hoarseness, stridor

Breathing: rapid breathing, wheeze, fatigue, cyanosis, SpO₂ < 92%, confusion

Circulation: pale, clammy, low blood pressure, faintness, drowsy/coma

2 Intramuscular Adrenaline

IM doses of 1:1000 adrenaline (repeat after 5 min if no better)

- Adult: 500 micrograms IM (0.5 mL)
- Child more than 12 years: 500 micrograms IM (0.5 mL)
- Child 6 -12 years: 300 micrograms IM (0.3 mL)
- Child less than 6 years: 150 micrograms IM (0.15 mL)

March 2008



EMERGENCY "2222" AUDIT FORM

1 PATIENT DATA							
Name				Date of Admission			
DOB		Gender		Reason for Admission			
Hosp No							
NHS No							
Ward							

2 EVENT ONSET - RECOGNITION OF CLINICAL PROBLEM, LOCATION, REASON FOR CALL, CLINICAL PICTURE PRIOR TO EVENT							
Call Date			Event Location				
Call time			"NEWS" Data	NEWS Scores over last 12hrs			
Reason for 2222 call - <i>Please tick</i>				Highest			Lowest
Cardiac Arrest							
Respiratory Arrest							
Seriously Ill							
Other- <i>please state</i>							
<i>(eg. fit/faint)</i>			Actions taken - <i>Please tick</i>				
			Nurse in charge informed				
			Doctor/Outreach/ANP				
			Reg/Consultant/Critical Care				
			Time and details of Last Observations prior to 2222 call		: hrs		
			RR	HR	BP	Temp	SpO2
							AVPU

3 EVENT INTERVENTIONS / ACTIONS																														
O2 therapy - tick			Members of TEAM present																											
Monitoring - tick			F1/F2			Anaes/Critical Care																								
Defib attached - tick			Reg			AIT/ANP																								
IV / IO access - Circle			Cons			Resus Officer																								
			Actions from TEAM arrival - tick																											
Cardiac Arrest Actions CPR Initiated - tick <input type="checkbox"/> Defib mode: AED Mode - tick <input type="checkbox"/> Manual Mode - tick <input type="checkbox"/>			<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 33%;">Airway</th> <th style="width: 33%;">Breathing</th> <th style="width: 33%;">Circulation</th> </tr> </thead> <tbody> <tr> <td>Oropharyngeal</td> <td>Pocket Mask</td> <td>Fluid therapy</td> </tr> <tr> <td>Nasopharyngeal</td> <td>BVM</td> <td></td> </tr> <tr> <td>Intubated</td> <td>Portable Ventilator</td> <td></td> </tr> <tr> <td>i-Gel</td> <td></td> <td></td> </tr> </tbody> </table>					Airway	Breathing	Circulation	Oropharyngeal	Pocket Mask	Fluid therapy	Nasopharyngeal	BVM		Intubated	Portable Ventilator		i-Gel										
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Amiodorone	300mg																													
<i>Other - please specify</i>																														
<i>Other - please specify</i>																														

4 POST RESUSCITATION CARE							
Time CPR stopped			Due to: ROSC			DNACPR Order	
			Futile			No ROSC	
Pt sedated Post Resuscitation?	Y / N						
Pt Destination Post Resuscitation							
Not transferred			Transferred to - <i>specify</i>				

5 LONGER TERM PATIENT OUTCOME POST RESUSCITATION EVENT & FORM COMPLETION DETAILS							
Patient Deceased?	Date & Time of Death	Hospital Discharge?	Name and Designation of Person Completing this Form	Contact Number	Date		
	/ / : hrs	Y / N			/ /		

PLEASE COMPLETE AND RETURN THIS FORM TO YOUR NEAREST RESUSCITATION SERVICES OFFICE

DAILY RECORD FOR CHECKING OF RESUSCITATION EQUIPMENT - BCUHB
LEVEL 3 EQUIPMENT ONLY

Month: _____ Year: _____ SIDE 1 Ward/Department: _____

	DATE:													
	1st	2nd	3rd	4th	5th	6th	7th	8th	9th	10th	11th	12th	13th	14th
Equipment clean as per Infection Prevention guidance	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
O ₂ Cylinder contents needle in green (size CD). <i>Check Expiry Date</i>	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
1x Adult BVM complete with adult mask	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Defibrillator ready for use with charge indicator showing charging (XL), or ready for use (FR2, FR3, MRx) <i>Carry out DAILY check on Defibrillator</i>	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Defib pads available for use with Defibrillator – <i>Check expiry date</i>	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Suction Unit with canister, tubing, & Yankaeur suction end. <i>Carry out daily check</i>	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Resuscitation equipment documentation folder present and complete	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Check "Tamper Evident" Seals intact. <i>IF "YES" AND LESS THAN 7 DAYS SINCE LAST FULL EQUIPMENT CHECK THEN NO FURTHER CHECKS REQUIRED.</i> <i>IF "NO" OR NOT SEALED, OR IF 7 OR MORE DAYS SINCE LAST FULL CHECK, THEN CARRY OUT FULL EQUIPMENT CHECK ACCORDING TO CONTENTS LIST AND CHECK EXPIRY DATES. RE-SEAL EQUIPMENT IF IT IS ABLE TO BE SEALED.</i> <i>IN CASE OF XL+ OR MRx DEFIBRILLATORS, CARRY OUT FULL OPERATIONAL CHECK.</i>	Sealed? Yes No	Sealed? Yes No	Sealed? Yes No	Sealed? Yes No	Sealed? Yes No	Sealed? Yes No	Sealed? Yes No	Sealed? Yes No	Sealed? Yes No	Sealed? Yes No	Sealed? Yes No	Sealed? Yes No	Sealed? Yes No	Sealed? Yes No
	Full Check Carried out Yes No	Full Check Carried out Yes No	Full Check Carried out Yes No	Full Check Carried out Yes No	Full Check Carried out Yes No	Full Check Carried out Yes No	Full Check Carried out Yes No	Full Check Carried out Yes No	Full Check Carried out Yes No	Full Check Carried out Yes No	Full Check Carried out Yes No	Full Check Carried out Yes No	Full Check Carried out Yes No	Full Check Carried out Yes No
RECORD ANY COMMENTS, ACTIONS REQUIRED, ACTIONS CARRIED OUT IN THIS SPACE.														
Checked by Initials: TOP Band: BOTTOM														

NOTE TO ALL CLINICAL AREAS: THIS EQUIPMENT **MUST ONLY** BE CHECKED; AND THIS DOCUMENT SIGNED BY CLINICAL STAFF AT **BAND 5 OR ABOVE**.

IT IS THE WARD / DEPARTMENT MANAGERS RESPONSIBILITY TO ENSURE THIS CHECK IS CARRIED OUT AND DOCUMENTED AS PER BCUHB RESUSCITATION POLICY.

DAILY RECORD FOR CHECKING OF RESUSCITATION EQUIPMENT
BCUHB
LEVEL 2 EQUIPMENT ONLY

Month: _____ Year: _____ SIDE 1 Ward/Department: _____

	DATE:													
	1st	2nd	3rd	4th	5th	6th	7th	8th	9th	10th	11th	12th	13th	14th
Equipment clean as per Infection Prevention guidance	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
O ₂ Cylinder contents needle in green (size CD). <i>Check Expiry Date</i>	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
1x Adult BVM complete with adult mask or Pocket Mask. 1x (G) size 4	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Suction Unit with canister, tubing, & Yankaeur suction end. <i>Carry out daily check</i>	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Defibrillator ready for use with charge indicator showing ready for use (FR2, FR3) <i>Carry out DAILY check on Defibrillator</i>	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Defib pads available for use with Defibrillator – <i>Check expiry date</i> <i>THIS IS A WEEKLY CHECK</i>	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
RECORD ANY COMMENTS, ACTIONS REQUIRED, ACTIONS CARRIED OUT IN THIS SPACE.														
Checked by Initials: TOP Band: BOTTOM														

NOTE TO ALL CLINICAL AREAS: THIS EQUIPMENT **MUST ONLY** BE CHECKED; AND THIS DOCUMENT SIGNED BY CLINICAL STAFF AT **BAND 5 OR ABOVE**.

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DAILY RECORD FOR CHECKING OF RESUSCITATION EQUIPMENT
BCUHB

LEVEL 1 EQUIPMENT ONLY

Month: _____ Year: _____

SIDE 1

Ward/Department: _____

	DATE:														
	1 st	2 nd	3 rd	4 th	5 th	6 th	7 th	8 th	9 th	10 th	11 th	12 th	13 th	14 th	
Equipment clean as per infection Prevention guidance	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>
O ₂ Cylinder contents needle in green (size CD). Check Expiry Date	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>
1 x Adult BVM complete with adult mask or Pocket Mask.	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>
Suction Unit with canister, tubing, & Yankasur suction end. Carry out daily check	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>
Defibrillator ready for use with charge indicator showing ready for use (FR2, FR3) Carry out DAILY check on Defibrillator	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>
Defib pads available for use with Defibrillator – Check expiry date THIS IS A WEEKLY CHECK	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>
RECORD ANY COMMENTS, ACTIONS REQUIRED, ACTIONS CARRIED OUT IN THIS SPACE.															
Checked by Initials : TOP Band : BOTTOM															

NOTE TO ALL CLINICAL AREAS : THIS EQUIPMENT **MUST ONLY** BE CHECKED; AND THIS DOCUMENT SIGNED BY CLINICAL STAFF AT BAND 5 OR ABOVE.

IT IS THE WARD / DEPARTMENT MANAGERS RESPONSIBILITY TO ENSURE THIS CHECK IS CARRIED OUT AND DOCUMENTED AS PER BCUHB RESUSCITATION POLICY.

Management of CPR induced consciousness in the absence of Return of Spontaneous Circulation ROSC

Several studies and anecdotal evidence have shown that external chest compression coupled with adequate high oxygen ventilation can in certain circumstances cause a situation where adequate brain perfusion is achieved to engage consciousness while still in a non-perfusing cardiac rhythm . This phenomenon of “consciousness in the absence of a return of spontaneous circulation (ROSC)” is becoming more frequently reported with the increased use of automated external compression devices such as LUCAS. Several studies have shown an increase in cerebral blood flow with the use of LUCAS, some to the levels required to engage consciousness; a literary search however also shows examples of this phenomenon with standard manual CPR although with more rarity. Awareness can range from eye opening to physically pushing the cardiac arrest team away, all in the absence of a beating heart and has obvious mental trauma implications to both the patient and staff involved.

Management of Awareness Without ROSC During Ongoing CPR

IV/IO Midazolam 1-2mg slow injection, then titrate in 1mg increments up to a maximum of 7.5mg*

If Available consider a separate

IV / IO Fentanyl 50mcg, then 25mcg increments guided by results^

* reversal agent for Midazolam – Flumazenil

^ reversal agent for Fentanyl - Naloxone

Drug Dosages relate to adult patients and must be appropriately prescribed.



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EQUALITY IMPACT ASSESSMENT FORMS

PARTS A and B: SCREENING AND OUTCOME REPORT

Introduction:

These forms have been designed to enable you to record, and provide evidence of how you have considered the needs of all people (including service users, their carers and our staff) who may be affected by what you are writing or proposing, whether this is:

- a policy, protocol, guideline or other written control document;
- a strategy or other planning document e.g. your annual operating plan;
- any change to the way we deliver services e.g. a service review;
- a decision that is related to any of the above e.g. commissioning a new service or decommissioning an existing service.

This is not optional: Equality Impact Assessment is a specific legal requirement on public sector organisations under equalities legislation and failure to comply could result in a legal challenge to a decision or strategy. More importantly, equality impact assessment helps to inform better decision-making and policy development leading to improved services for patients. **This form should not be completed by an individual alone, but should form part of a working group approach.**

The Forms:

You must complete:

- **Part A** – this is the Initial Screening that is always undertaken and consists of Forms 1 to 3; these forms are designed to enable you to make an initial assessment of the potential impact of what you are doing, and decide whether or not you will need to proceed to a Full Impact Assessment (Part C);

AND

- **Part B** – this is the Outcome Report and Action Plan (Form 4) you will need to complete whether or not you proceed to a Full Impact Assessment;

Together, these forms will help to provide evidence of your Impact Assessment and how you have shown “due regard” to the duties.

You may also need to complete Part C (see separate Form) – if parts A and B indicate you need to undertake a Full Impact Assessment. This enables you to fully consider all the evidence that is available (including engagement with the people affected by your document or proposals) to tell you whether your document or proposal will affect people differently. It also gives you the opportunity to consider what changes you may need to make to eliminate or mitigate any adverse or negative impact you have identified.

Remember that these forms may be subject to external scrutiny e.g. under a Freedom of Information request.

Once completed, the EqIA Forms should accompany your document or proposal when it is submitted to the appropriate body for approval.



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Part A

Form 1: Preparation

1.	What are you equality impact assessing? What is the title of the document you are writing or the service review you are undertaking?	Pan BCU Cardiopulmonary Resuscitation Policy RES03	
2.	Provide a brief description, including the aims and objectives of what you are assessing.	Prior to the formation of BCUHB there were 3 individual CPR policies in existence. The objective is to unify the 3 policies and standardisation across BCU.	
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?	Dr Nick Nelhans Clinical Director – Resuscitation Services BCUHB. Chair of the resuscitation committee	
4.	Who is Involved in undertaking this EqIA? Include the names of all the people in your sub-group.	Name	Title/Role
		Timothy Gardner	Resuscitation Team Manager (Central)
		Sarah Bellis Hollway	Resuscitation Services Manager (Interim)
		Dr Nick Nelhans	Consultant Paediatrician & Clinical Director – Resuscitation Services
5.	Is the Policy related to, or influenced by, other Policies/areas of work?	Statutory & Mandatory training policy (WP30) All Wales Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) Policy (2015) Resuscitation Council (UK) 2015 guidelines Quality Standards for Cardiopulmonary Resuscitation Practice (RCUK, 2015)	
6.	Who are the key Stakeholders i.e who will be affected by your document or proposals?	Pan BCU Resuscitation Committee All patients who may require resuscitation Staff who have the potential involved in resuscitation practice and have access to cardiac arrest equipment	

7.	What might help/hinder the success of whatever you are doing, for example communication, training etc?	Lack of communication with stakeholders. Poor understanding of resuscitation guidelines and practice may hinder the implementation of the policy.
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Form 2: Considering the potential impact of your document, proposals etc in relation to equality and human rights

Characteristic or other factor to be considered	Potential Impact by Group. Is it:-		Please detail here, <u>for each characteristic listed on the left</u> :- (1) any Reports, Statistics, Websites, links etc. that are relevant to your document/proposal and have been used to inform your assessment; and/or (2) any information gained during engagement with service users or staff; and/or any other information that has informed your assessment of Potential Impact.
	Positive (+) Negative (-) Neutral (N) No Impact/Not applicable (N/a)	High Medium or Low	
Age	N		
Disability	N		
Gender Reassignment	N		
Pregnancy & Maternity	N		
Race / Ethnicity	N		
Religion or Belief	N		
Sex	N		
Sexual Orientation	N		
Welsh Language	N		
Human Rights	N		

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:- <ul style="list-style-type: none">• 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	This is a non discriminating policy
2. Describe here how your policy or proposal could better advance equality of opportunity (if relevant)	
3. Describe here how your policy or proposal might be used to foster good relations between different groups (if relevant)	

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)	Pan BCU Cardiopulmonary Resuscitation Policy RES03
---	--

2. Brief Aims and Objectives: (Copy from Form 1)	Prior to the formation of BCUHB there were 3 individual CPR policies in existence. The objective is to unify the 3 policies and standardisation across BCU.
---	---

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 checked="" type="checkbox"/>	No <input 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"/>
	Record Reasons for Decision i.e. what did the Form 3 scale assessments indicate in terms of positive and negative impact for each characteristic? All decisions neutral	
5. If you answered 'no' above, are there any issues to be addressed e.g. mitigating any identified minor	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
	Record Details:	

negative impact?		
6. Are monitoring arrangements in place so that you can measure what actually happens after you implement your document or proposal?	Yes <input type="checkbox"/>	<input checked="" type="checkbox"/>
	How is it being monitored?	Currently there is not a way to measure impact. The will be reviewed on implementation and at regular intervals.
	Who is responsible?	Timothy Gardner
	What information is being used?	E.g. will you be using existing reports/data or do you need to gather your own information?
	When will the EqIA be reviewed? (Usually the same date the policy is reviewed)	2020

7. Where will your decision or policy be forwarded for approval?	Pan BCU Resuscitation Committee
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8. Describe here what engagement you have undertaken with stakeholders including staff and service users to help inform the assessment	Progress has been discussed with other resuscitation department within BCU & Pan BCU resuscitation committee.
--	---

9. Names of all parties involved in undertaking this Equality Impact Assessment:	Name	Title/Role
	Timothy Gardner	Resuscitation Team Manager (central)
	Sarah Bellis Hollway	Resuscitation Services Manager (Interim)

Please Note: The Action Plan below forms an integral part of this Outcome Report		

Form 4 (ii): Action Plan

This template details any actions that are planned following the completion of 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 to your document or proposal as a result of the EqlA?	None		
3a. Where negative impacts on certain groups have been identified, what actions are you taking or are proposed to mitigate these impacts? Are these already in place?	N/A		
3b. Where negative impacts on certain groups have been identified, and you are proceeding without mitigating them, describe here why you believe this is justified.	N/A		
4. Provide details of any actions taken or planned to advance equality of opportunity as a result of this assessment.	Wide promotion of the guidelines across BCUHB – intranet & stakeholders	Resuscitation Training department	November 2016

**Quality, Safety &
Experience Committee**
21.5.19

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To improve health and provide excellent care

Report Title:	PTR1 Concerns Policy (Complaints, Claims and Incidents)
Report Author:	Mrs Barbara Jackson, Assistant Director Service User Experience
Responsible Director:	Mrs Deborah Carter, Acting Executive Director of Nursing and Midwifery
Public or In Committee	Public
Purpose of Report:	The Concerns Policy has been in place since the implementation of Putting Things Right in 2011. The policy was overdue for review. The policy is based on the WG guidance and changes relate predominately to the changes in the structures, infra structure and minor procedural issues of the Health Board which have changed since last written.
Approval / Scrutiny Route Prior to Presentation:	Request for consideration by Chairs action made but not deemed appropriate. Circulated for consultation and comments considered and incorporated as appropriate.
Governance issues / risks:	There is a risk in having an overdue review date on a policy. However there have been no changes to national policy or guidance on which this based since the last review date
Financial Implications:	None
Recommendation:	The Committee is asked to approve the revised policy

Health Board's Well-being Objectives <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>	√	WFGA Sustainable Development Principle <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	√		
Special Measures Improvement Framework Theme/Expectation addressed by this paper			
Leadership and Governance			
Equality Impact Assessment			
The policy reflects national legislation			

Disclosure:

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



CONCERNS POLICY (Complaints, Claims and Incidents)

Date to be reviewed:	December 2020	No of pages:	14
Author(s):	Barbara Jackson	Author(s) title:	Assistant Director Service User Experience
Responsible dept / director:	Executive Director Nursing and Midwifery		
Approved by:	QSG		
Date approved:			
Date activated (live):	January 2012		

Date EQIA completed:	National EQIA on PTR
Documents to be read alongside this policy:	RM01 - Risk Management Policy and Strategy HS02 – Procedure and Guidance protecting employees from violence and aggression Concerns Procedure (PTR Implementation) PTR1a
Purpose of Issue/Description of current changes: Policy in place in response to NHS guidance, the Model Complaints Policy and Guidance for Public Services in Wales and the Putting Things Right Regulations (Welsh Assembly Government, April 2011).	

First operational:	January 2012				
Previously reviewed:	Dec 2016	Jan 19			
Changes made yes/no:	No	Yes			

PROPRIETARY INFORMATION

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1. Introduction and Purpose

The Welsh Government's vision for improving public services in Wales is well documented and it recognises that concerns systems and redress can make an important contribution to the improvement of those services.

The purpose of the policy for handling concerns (hereafter referred to as "the Policy") is to establish:

- Common principles for the effective handling of concerns
- A common model for dealing with concerns

In addition:

- Common data collection procedures
- Common methods for learning from concerns
- A common means to identify and disseminate good practice

Note:

The term "concern" should be taken to mean any complaint, claim or reported patient safety incident (about NHS treatment or services) to be handled under the PTR arrangements.

The Betsi Cadwaladr University Health Board (BCUHB) is committed to dealing effectively with any made about our service. The Health Board treats thousands of patients throughout each year, in a safe and caring environment in a variety of settings. When things have/or are believed to have gone wrong, we want to make sure that any concerns patients, their families, carers or advocates have, are acknowledged, explained and resolved in an open and supportive way, by apologising and where possible trying to put things right. We also aim to learn from our mistakes and use the information we gain to improve our services. The BCUHB is committed to ensuring that:

People will find it easy to complain and get things put right when the service they receive is not good enough.

The procedure to support the implementation of this policy is PTR1a.

2. Scope

This Policy describes how the BCUHB deals with concerns raised by patients, their families/carers or advocates. It provides the organisation's response to several pieces of statutory procedure and best practice advice from the NHS and the Welsh Government; in particular, the National Patient Safety Agency Being Open guidance, the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 and the Model Complaints Policy and Guidance for public services in Wales (July 2011).

The Policy has been developed in line with the guidance issued under existing powers of the Welsh Government in respect of the various sectors of the public service devolved to Wales, and Section 31 of the Public Services Ombudsman (Wales) Act 2005.

PTR01 Concerns Policy

This policy is fully compatible with the Welsh Language Standards that the Health Board must comply with under the Welsh Language (Wales) Measure 2011.

3. Organisational arrangements

Any member of the public, including a child/young person, who has received, or was entitled to receive, a service from the Health Board may raise a concern. The same applies if they have suffered due to the inappropriate action or lack of action by the Health Board.

A concern can also be put forward by someone on behalf of another person as follows:

- a) Someone who has died
- b) A child/young person
- c) Those who lack the capacity (as defined by the Mental Capacity Act 2005)
- d) They have been asked to do so by the person affected
- e) IMCA

In all cases, the Health Board must satisfy themselves, as far as the circumstances of the person affected allow for it, that the representative is acting with the authority of that person and if possible obtain their signature to confirm this (unless the concern must be investigated following statutory Safeguarding procedures).

This procedure is NOT a means for a member of staff to raise employment issues. There are other internal mechanisms for these types of concerns, for example, whistleblowing, bullying or grievance procedures.

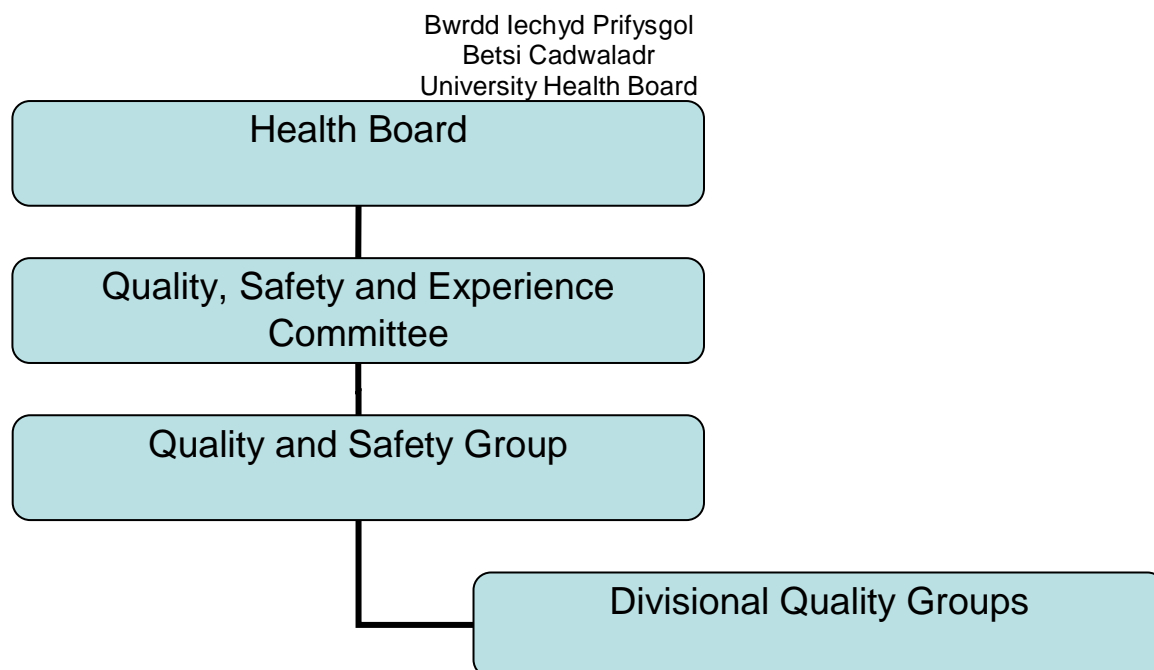
Strategic Overview

Board Champions exist to provide a voice to traditionally underrepresented groups, or issues which need to be at the forefront of Health Board business. Board Champions are Independent members (including the Chair and Vice-Chair) who, in addition to their other responsibilities within the Board, make sure that the issue or group that they are championing are taken into account when Health Board strategy is being developed and decisions are taken.

The independent member for concerns keeps an overview of the concerns process to ensure that concerns are dealt with in compliance with the *Putting Things Right* Regulations.

Monitoring and Scrutiny Arrangements

Arrangements are in place for regular reporting and scrutiny of the number, type and learning from concerns. There is a formal meeting structure to support this:



To support the collaborative working between the Corporate Concerns Team, the Clinical Executives, the Divisions and the Community Health Council (CHC) Advocacy Service, to address the issues raised by the complainant to a satisfactory outcome, there are regular meetings with the CHC complaints advocates and the CHC have a seat at the Quality, Safety and Experience Committee.

Responsible Officer

The Chief Executive is the Responsible Officer for the Putting Things Right (PTR) Regulations and is charged with overseeing the day to day management of the concerns process ensuring that incidents, complaints and claims are dealt with under a single governance arrangement. The Chief Executive has delegated management responsibility to the Director of Nursing and Midwifery.

Senior Investigations Officer

The Associate Director of Quality and Assurance reports to the Director of Nursing and Midwifery and acts as Senior Investigations Officer for the Regulations. The postholder is responsible for the actual handling and consideration of concerns, including co-operating with other persons or responsible bodies (eg primary care providers) to facilitate the handling and investigation of concerns.

Concerns Team

The Health Board's Corporate Concerns Teams report to the Assistant Director of Service User Experience and via the Concerns Hub provide the central point of contact and administrative support for the handling of concerns across the organisation. They are the first point of contact for all concerns received. The teams coordinate the process for the management of concerns and monitor progress in line with the standards set out by the PTR guidance. The Corporate teams acknowledge all complaints and provide the expertise with regards to the regulation in terms of PTR redress and the quality and standard of responses.

Divisions

Each Division and corporate area will have an identified Concerns lead. The divisions are responsible for the investigation of concerns and the preparation of the response.

Organisational Development and Training

The duties of the organisation in relation to staff development and training are that the Health Board will provide Concerns awareness training for all staff as a part of corporate induction and will ensure that appropriate training is provided for all staff, tailored to the requirements identified within their post's Knowledge and Skills Framework (KSF). Examples of the training required include:

- Customer Care
- Communication
- Records Management
- Root Cause Analysis Training
- Legal training/ awareness
- Putting Things Right e-learning training
- Safeguarding Children and Vulnerable Adults
- Sensory Awareness
- Equality and Diversity

All Staff

All staff throughout the organisation should know who to contact in the concerns team for support or advice when a concern is raised.

4. General Principles when someone has a concern

When someone raises a concern, they inevitably have an issue about a service which has been received or not received. Concerns need to be handled in such a way that the complainant is the focus and not the process itself. The following principles should be applied to the process. It should be:

- Well publicised
- Easy to find, understand and use both for public and staff
- Simple and clear instructions for the public about how to raise a concern.
- Has flexibility to meet the different needs of different people, ensuring that those who face challenges in access are not excluded
- Provides information on advocacy and support services
- The stages in the concerns handling process are kept to a minimum

Fair and Impartial

- Concerns are dealt with in an open-minded and impartial way
- Complainants are assured that making a complaint will not adversely affect their future dealings and contacts with the Health Board
- Ensures that complainants get a full response and that decisions are proportionate, appropriate and are fair
- The staff complained about are treated as fairly as complainants

Timely, Effective and Consistent

- Within the parameters of what is appropriate and possible, frontline staff themselves should seek to resolve concerns

PTR01 Concerns Policy

- “Investigate Once, Investigate Well” – when a concern requires formal investigation, this should be done thoroughly to establish the facts of the case
- Dealt with as quickly as possible. It should normally take no longer than 30 working days from receipt at the Formal Stage 5 to resolution. If a concern is more complex, complainants should be told why it may take longer to investigate and how long it is expected to take. Complainants and staff involved should be kept informed of progress throughout.
- Consistent so that people in similar circumstances are treated in similar ways
- Concerns involving more than one public services provider are dealt with in such a way that the complainant’s experience is of one system

Accountable

- Provide honest, evidence-based explanations and gives reasons for decisions
- Information is provided in a clear and open way
- When concerns are found to be justified, as appropriate, the Health Board should:
 - acknowledge mistakes
 - apologise in a meaningful way
 - put matters right
 - provide prompt, appropriate and proportionate redress.
- Follow up to ensure any decisions are properly and promptly implemented
- Where appropriate, the complainant is told about the lessons learnt and changes made to the service, guidance or policy
- Ensures that the complainant are informed of their right to complain to the Public Services Ombudsman for Wales (or other appropriate routes open to them, for example, Welsh Language Commissioner in respect of concerns about compliance with the Welsh Language Standards, Equality and Human Rights Commission, Information Commissioner).

Delivers Continuous Improvement

- Lessons learnt from concerns are gathered and feedback is used to improve service design and delivery
- Systems in place to record, analyse and report on the learning from concerns
- The leadership of the Health Board will:
 - Take ownership of the concerns process
 - Regularly review and scrutinise its effectiveness
 - Receive regular concerns monitoring reports, and
 - Demonstrate what the organisation has done to improve service delivery as a result of concerns

4.2 Key principles which apply to the handling of concerns

A patient, carer, relative or advocate can express a concern by notifying their concern through a single point of entry.

To Raise a Concern – you can contact the Concerns Team by:

Phone: 01248 384194

Fax: 01248 385318

E-mail: ConcernsTeam.bcu@wales.nhs.uk

Letter: The Concerns Team,
Ysbyty Gwynedd,
Bangor, Gwynedd,
LL57 2PW

To see this information in British Sign Language please click on link below.

<https://www.youtube.com/watch?v=G4P0M7JVGgE>

Normally, a concern must be investigated within 12 months of the incident. This is because it is better to look into concerns while the issues are still fresh in everyone's mind. In exceptional circumstances, if strong reasons are provided, a concern may be investigated beyond 12 months if sufficient information is available to allow proper consideration to be given. (In any event, regardless of the circumstances, the Health Board will not consider any concerns about matters that took place more than three years ago.)

If a concern is being expressed on behalf of somebody else, their formal written agreement must be given.

4.3 Providing information about concerns

The BCU Health Board will publish and display information about raising a concern and how concerns are received, managed, investigated and responded to;

- In a variety of formats (leaflets, posters, websites)
- In English and Welsh
- In other languages as required
- Via the online form
- In other formats as required (eg Braille, large print, audio, Easy Read, Child-friendly)

4.4 Equality and Diversity

The BCU Health Board staff will develop an understanding of why some members of the community who may wish to raise a concern might not feel able to do so. This may be due to cultural, social, gender and other reasons, including sensory loss, any of which might result in ineffective communication. Staff should be mindful of the issues which might act as barriers to people raising a concern and look for ways to assure people that it is safe for them to raise an issue. Further discussion about this issue can be found in the Welsh

Government's *Equality Impact Assessment* document (see references).

For people who may need advice/support in making their complaint the Health Board should keep a list of relevant advice and advocacy organisations in the locality (see Concerns Procedure).

5. Informal Resolution – On the spot (concern resolved ideally by the next working day)

This stage offers the opportunity for the informal engagement at the point of service delivery to seek to resolve complaints either at the time the concern arises or very shortly thereafter (in a timescale agreed with the patient/representative when the concern was raised). This will normally be an explanation or other appropriate remedial action by frontline staff.

Staff should be empowered and trained to deal with concerns as they arise with the aim of resolving issues “on the spot” where possible. The informal resolution stage should, ideally, be done immediately or within one working day.

Staff must advise complainants how to progress their concern to the formal investigation stage, if they are not satisfied with the outcome of a concern at the end of the informal stage. It is the complainants' prerogative to seek to take their concern directly to a formal procedure.

An example of the type of concern that can be resolved at the local resolution stage:

- A patient has been waiting for over an hour for their outpatient appointment

Examples of the type of concern that should not be resolved at the informal stage:

- The complainant believes there has been a failure in treatment which has led to serious consequences
- It appears a services failure has occurred due to an obvious systematic problem

In some instances, the Health Board may ask to meet with the complainant to discuss their concern.

6. Formal Investigation

‘Investigate Once, Investigate Well’ is the principle for this state of the process with emphasis placed on one investigation to deal thoroughly with the concerns raised. Almost anyone can raise a concern and the Health Board is under a duty to consider whether it can be investigated. However, it might not always be possible to share the full details of the investigation with the person raising the concern, for instance, if they are not the patient or their next of kin. Details as set out in Regulation 12, can be accessed through the Concerns Procedure PTR1a.

Investigating well also means conducting an investigation in a manner that is proportional to the nature and degree of the seriousness of the concern. All concerns should be sent by the complainant to the central concerns team for the

Health Board. Any staff member receiving a concern form should forward it promptly. The complainant should then receive an acknowledgement from the concerns handler within two working days.

The complainant will be notified who is looking into their concern. The Health Board will set out their understanding of the concern and ask for confirmation that they have got it right as well as asking the complainant what outcome they are looking for. Depending on the nature of the concern the concerns handler may need to obtain the complainant's permission to access their personal file. If the complainant refuses then it should be explained to them that this will have an effect on the ability to conduct a thorough investigation.

The concern will be graded by the Corporate Concerns Team to determine seriousness of the concern. The extent of the investigation will depend on how complex and how serious the issues are. Further detail is provided in the Concerns Procedure,

If the Health Board formally investigates a concern, we will notify the complainant through their preferred method of communication, what we have found out. This could be by letter or email for example. An explanation will be given as to how and why conclusions have been made. Consideration should also be given as to whether face to face meetings and/or mediation could be a means to resolving the concern.

Recommendations arising from investigations should be Specific, Measurable, Achievable, Realistic and Timely (SMART)

If the Health Board finds a fault in the systems or the way we do things, the complainant will be told what it is and how we plan to change things to stop it happening again. If the Health Board gets it wrong, we will apologise.

7. Putting Things Right (PTR) at the end of an investigation

If the Health Board didn't provide a service that a patient should have had, we'll aim to provide it now if that's possible. If we didn't do something well, we'll aim to put it right. If the patient lost out as a result of a mistake on the part of the Health Board we'll try to put the patient back in the position they would have been in if we'd got it right.

If a patient had to pay for a service themselves, when it should have been provided by the Health Board, we will usually aim to make good what has been lost.

The aim of PTR is to provide a common approach for handling concerns by replacing process heavy systems with one that is simple, flexible and places emphasis on getting the most appropriate outcome for individuals and services.

The vast majority of concerns are likely to be about the services provided by the Health Board. In those cases, the detail of how concerns are handled and investigated, are described in the Concerns Procedure.

8. If we haven't resolved the concern

If we do not succeed in resolving a concern, it may be referred by the complainant to the Public Services Ombudsman for Wales. The Ombudsman is independent of all government bodies and can look into a concern if it is believed that:

- The complainant has been treated unfairly or received a bad service through some failure on the part of the Health Board providing it or
- Has been disadvantaged personally by a service failure or has been treated unfairly

The Ombudsman expects the complainant to bring their concerns to Health Board's attention first for the opportunity to put things right. The Ombudsman can be contacted by:

phone: 0845 601 0987

e-mail: ask@ombudsman-wales.org.uk

the website: www.ombudsman-wales.org.uk

writing to: Public Services Ombudsman for Wales 1 Ffordd yr Hen Gae,
Pencoed CF35 5LJ

There are also other organisations that consider concerns. For example, the Welsh Language Commissioner about services in Welsh. We can advise you about such organisations.

9. Learning Lessons from Concerns

The Health Board takes concerns seriously and tries to learn from any mistakes made which have been raised through a complaint; an incident or a claim. The Quality and Safety Group, chaired by the Executive Director of Nursing and Midwifery oversee the implementation of the Quality Improvement Strategy and associated delivery plans. Its primary function is also to routinely monitor clinical risk, escalating and de-escalating as necessary. The Group will seek assurance from its established sub-groups ensuring the triangulation of assurances and evidence of learning from patient experience. It will provide written assurance reports to the Quality, Safety and Experience Committee.

Where there is a need for change, we will develop an action plan setting out what we will do, who will do it and when we plan to do it by. We will let complainants know when changes we've promised have been made.

10. Further Information and Assistance

The BCU Health Board staff will aim to help patients, carers and families to make their concerns known to us. If further help or assistance is needed we will try to put complainants in touch with someone who can help, for example Community Health Council Advocacy service, who may be able to assist.

line chat: <https://www.meic.cymru>

or contact the Children's Commissioner for Wales.

Children & young people's freephone number: 0808 801 1000

Or text 80 800 and start your message with COM

Children's Commissioner for Wales
Oystermouth House
Phoenix Way
Llansamlet
Swansea
SA7 9FS
01792 765600
FAX: 01792 765601
post@childcomwales.org.uk

There is also an online form available at [Contact - Children's Commissioner for Wales](#)

11. Concerns Involving Legal or Disciplinary Proceedings

Occasionally, concerns received will involve legal or disciplinary proceedings. It may be necessary to put the investigation of a concern "on hold" until the conclusion of those proceedings. However, it should not automatically be assumed that this is necessary in every case. An assessment should be made to identify whether it is possible to address the subject of the concern without impacting on the other proceedings underway. It is important that if a complainant is in a continued state of disadvantage as a result of a likely poor service delivery that every step is taken to conclude this part of their concern. This will mean that if the concern is upheld the organisation is doing everything it can to return them as soon as possible to the position they would have been in if that failure had not occurred in the first place.

12. Concerns Involving More than One Service Provider

There are occasions when a concern received will involve more than one organisation. In this case the role of the central concerns handler will be slightly different. Having established the elements of the concern and which organisations are involved, they should contact their counterpart(s) in the other organisation(s) involved. The concerns handler should then decide which of them should lead on co-ordinating the response based on which organisation has the greatest involvement.

13. Concerns Concerning Services Contracted Out

Even though the Health Board may have contracted out the provision of services to private/voluntary or other NHS organisations, this does not absolve them of their responsibility for those functions. Those responsible for drafting contracts must be made aware of the need to include as a matter of course, a provision for concerns handling.

14. What is Expected

In times of trouble or distress, some people may act out of character. There may have been upsetting or distressing circumstances leading up to a concern or complaint. The Health Board does not view behaviour as unacceptable just because someone is forceful or determined.

We believe that all complainants have the right to be heard, understood and respected. However, we also consider that our staff have the same rights. We therefore, expect patients, carers and families to be polite and courteous in their dealings with us. 'Managing unreasonable behaviour –procedure and guidance for staff' can support staff in these situations <http://howis.wales.nhs.uk/sitesplus/documents/861/Dealing%20with%20Unreasonable%20Behaviour-%20procedure%20and%20guidance%20v1.00%20final.pdf>. We will not tolerate aggressive or abusive behaviour, unreasonable demands or unreasonable persistence. We have a separate policy to manage situations where we find that someone's actions are unacceptable (HS02 Procedure and Guidance protecting employees from Violence and Aggression).

References

- National Patient Safety Agency (2009) Being open: communicating patient safety incidents with patients, their families and carers, London: National Patient Safety Agency
- Welsh Assembly Government (2011) Putting Things Right: Guidance on dealing with concerns about the NHS from 1 April 2011, Cardiff: Welsh Assembly Government
- Sivas, M (2010) Being Open Policy, London: Croydon Health Services NHS Trust
- Glover, A (2010) Being Open Policy and Procedure, London: University College London Hospitals NHS Foundation Trust

This table should be completed and added at the end of the document:

Members of the Working Group:

Name	Title
Barbara Jackson Kath Clarke Anne Hall Carolyn Owen Shan Kennedy	Assistant Director Service User Experience Heads of Service User Experience

Consultation has taken place with:

Name	Title	Date Consulted
		24/10/11

**Quality, Safety & Experience
(QSE) Committee**

21.5.19



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Betsi Cadwaladr
University Health Board

To improve health and provide excellent care

Report Title:	MM15 Policy for Administration and use of Emergency and Non-Emergency Oxygen in Adults In Managed Services
Report Author:	Pam Lloyd Respiratory Nurse Specialist/PORT Co-ordinator. Louise Howard-Baker, Assistant Director, Pharmacy and Medicines Management Dr Liz Brohan, Consultant Respiratory Physician
Responsible Director:	Dr Evan Moore, Executive Medical Director
Public or In Committee	Public
Purpose of Report:	Approval of the Policy
Approval / Scrutiny Route Prior to Presentation:	BCU Medicines Policies Procedures PGD Subgroup 20.3.19 BCU Drugs and Therapeutics Group 3.4.19 Quality Safety Group (QSG) 8.5.19
Governance issues / risks:	None identified. Policy up[dated to reflect changes to national guidance (British Thoracic Society 2017)
Financial Implications:	None identified
Recommendation:	The Committee is asked to approve the Policy

Health Board's Well-being Objectives <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>		WFGA Sustainable Development Principle <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,	√	4.Putting resources into preventing problems occurring or getting worse	√

communities - to 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			
Special Measures Improvement Framework Theme/Expectation addressed by this paper			
Leadership & Governance			
Equality Impact Assessment			
See attached			

Disclosure:

*Betsi Cadwaladr University Health Board is the operational name of Betsi Cadwaladr University Local Health Board
Board/Committee Coversheet v10*

Policy for Administration and use of Emergency and Non-Emergency Oxygen in Adults In Managed Services

Date to be reviewed:	May 2022	No of pages:	40
Author(s):	Pam Lloyd Louise Howard-Baker Dr Liz Brohan	Author(s) title:	Respiratory Nurse Specialist/PORT Co-ordinator. Assistant Director, Pharmacy and Medicines Management Consultant Respiratory Physician
Responsible dept / director:	Dr Evan Moore, Executive Medical Director		
Approved by:	QSE		
Date approved:	XX		
Date activated (live):	XX		
Date EQIA completed:	01.04.19		
Documents to be read alongside this policy:	BCUHB Procedure and Guidance Document for Manual Handling WP55 MM01 BCUHB Medicines Policy		
Purpose of Issue/Description of current changes: Updated following 2017 BTS guideline revision			

Summary

The purpose of this Policy is to provide a unified clinical approach of the administration and care of patients requiring supplemental oxygen therapy and to ensure that oxygen is prescribed safely and appropriately with appropriate monitoring and equipment in place.

First operational:	March 2015				
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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1. Introduction and Policy Statement

The administration of supplemental oxygen, which is a treatment for hypoxaemia not breathlessness, is an essential element of appropriate management for a wide range of clinical conditions; however, oxygen is a drug and therefore must be prescribed in all but emergency situations. Failure to administer oxygen appropriately can result in serious harm to the patient. Too much oxygen can be as harmful as too little in some patient groups. The safe implementation of oxygen therapy with appropriate monitoring and handling is an integral component of the Healthcare Professional's role.

2. Purpose of the Document

The purpose of this policy is to provide a unified clinical approach to the administration and care of patients requiring supplemental oxygen therapy and to ensure that oxygen is prescribed and used safely and appropriately with appropriate monitoring and equipment in place.

3. Scope

This policy sets out the minimum standards expected from healthcare professionals in the administration of emergency and non-emergency oxygen.

This policy applies to all areas within Betsi Cadwaladr University Health Board where oxygen is administered to adults. Responsibility lies with registered healthcare professionals (Appendix 1, page 24), who in order to administer oxygen safely must understand:

- The indications for oxygen
- The hazards associated with oxygen therapy
- Oxygen and humidification systems in use
- Potential side effects of usage
- Safe storage of oxygen
- How to transfer patients using oxygen safely

4. Aims and Objectives

4.1 The aim of this policy is to provide a unified clinical approach to the administration and care of adult patients requiring oxygen therapy, within BCUHB. The use of supplementary oxygen is considered to be a medicine and should be managed in the same way as all other medicines in its method of administration.

4.2 All adult patients who require emergency / supplementary oxygen therapy receive therapy that is appropriate to their clinical condition and in line with national guidance (British Thoracic Society Guideline; Thorax, 2017)¹. Oxygen will be prescribed according to a target saturation range. The system of prescribing target saturation aims to achieve a specified outcome, rather than

specifying the oxygen delivery method alone. Those who administer oxygen therapy will monitor the patient and keep within the target saturation range.

- 4.2 This policy outlines the administration and use of oxygen in adults within all BCUHB healthcare settings. The clinical steps which should be taken by registered clinicians before administering oxygen to patients. It also outlines equipment which should be used to administer oxygen therapy and the roles and responsibilities of staff caring for patients receiving oxygen.

5. Roles and Responsibilities

The Chief Executive has overall responsibility for the strategic and operational management of BCUHB, including ensuring that the organisations policies and procedures comply with all legal, statutory and good practice requirements.

5.1 Area Directors, Secondary Care Directors and Directors of Nursing

Responsible for identifying and implementing policies relevant to their area of responsibility. They are also responsible for ensuring that all staff have access to and are made aware of policies that apply to them. All staff are responsible for the implementation of BCUHB policies and procedures as part of their core duties.

5.2 Ward and Department Managers

It is the responsibility of ward managers and department heads to ensure that their staff are trained & competent in the use of oxygen cylinders and the administration of oxygen and maintain the records to demonstrate this. They must also be able to locate and disable the master valve on their ward or department and contact the Authorised Person (AP) Medical Gas Pipeline Systems (MPGS) in the event of a fire.

5.3 Practitioners

It is the responsibility of these individuals to ensure that they are competent to administer oxygen and record the appropriate clinical observations. They must be competent in the use of equipment for the delivery of oxygen, including the use of cylinders (Appendix 2, page 25). In the case of any evident or suspected malfunction or inaccuracy of equipment this should be reported to a senior member of staff and appropriate action taken.

5.4 All Healthcare Professionals

Who are involved in the administration of oxygen (Appendix 1, page 24) should be aware of this policy and its principles. Documentation and communication are pivotal to minimising risks for patients and all actions must be documented contemporaneously or as soon as possible after the event.

The NPSA (2009) Oxygen safety in hospitals - Rapid Response Report – from reporting to learning [NPSA/2009/RRR006](#)², aims to ensure that safe systems are in place to treat patients needing oxygen.

Two further Patient Safety Notices have been issued by Welsh Government in 2016 and 2018 respectively.

[PSN 036](#)³ deals with the risks of accidentally administering medical air to patients instead of oxygen and [PSN041](#)⁴ (2018) reinforces the importance of ensuring that clinical staff understand how to operate oxygen cylinders safely. This followed 400 reported incidents on the National Reporting and Learning System (NRLS) involving the incorrect use of an oxygen cylinder. A similar incident has also occurred more than once in BCUHB and has resulted in a patient death.

6. Summary Oxygen Administration Protocol (and weaning protocol)

Action	Rationale
All patients requiring oxygen therapy will have a prescription for oxygen therapy recorded on the patients drug prescription chart. N.B exceptions- see emergency situations, page 9.	Oxygen should be regarded as a drug and should be prescribed. BTS National guidelines (2017) ¹ . British National Formulary ⁵ .
The prescription will incorporate a target saturation that will be identified by the clinician prescribing the oxygen.	To provide the nurses with guidance for the appropriate target saturation. Certain groups of patients require different target ranges for their oxygen saturation: - patients are at risk of hyperoxaemia, particularly patients with COPD.
The observations chart should be reviewed and signed at every drug round.	To ensure that the patient is receiving oxygen if prescribed and to consider weaning and discontinuation.
Once oxygen is in situ the nurse will monitor observations in line with BCUHB guidance. All patients should have their oxygen saturation observed for at least five minutes after starting oxygen therapy. If a patient is receiving intermittent therapy they may be monitored at least 8 hourly.	To identify if oxygen therapy is maintaining the target saturation or if an increase or decrease in oxygen therapy is required.
The oxygen delivery device and oxygen flow rate should be recorded alongside the oxygen saturation on the bedside observation chart.	To provide an accurate record and allow trends in oxygen therapy and saturation levels to be identified.
Oxygen saturations must always be interpreted alongside the patient's clinical status incorporating the early warning score.	To identify early signs of clinical deterioration, e.g. elevated respiratory rate.
If the patient falls outside of the target saturation range $\leq 3\%$, the oxygen therapy will be adjusted accordingly. The saturation should be monitored continuously for at least 5 minutes after any increase or decrease in oxygen dose to ensure that the patient achieves the desired saturation range. If the saturation rate falls $>3\%$ then the responsible clinician should be contacted.	To maintain the saturation in the desired range.
Action	Rationale

Saturation higher than target specified or >98% for an extended period of time.	
Step down oxygen therapy as per guidance for delivery.	The patient will require weaning down from current oxygen delivery system.
Consider discontinuation of oxygen therapy.	The patient's clinical condition may have improved negating the need for supplementary oxygen.
Saturation lower than target specified	
Check all elements of oxygen delivery system for faults or errors.	In most instances a fall in oxygen saturation is due to deterioration of the patient however equipment faults should be checked for.
Step up oxygen therapy as per protocols in Figure 1, page 8. Any sudden fall in oxygen saturation should lead to clinical evaluation and in most cases measurement of blood gases	To assess the patient's response to oxygen increase, and ensure that SpO ₂ has not risen to an unacceptable level or pH dropped to an unacceptable level and to screen for the cause of deteriorating oxygen level (e.g. pneumonia, heart failure etc).
Monitor Early Warning Score and respiratory rate for further clinical signs of deterioration.	Patient safety.
Saturation within target specified	
Continue with oxygen therapy, and monitor patient to identify appropriate time for stepping down therapy, once clinical condition allows.	
A change in delivery device (without an increase in O ₂ therapy) does not require review by the medical team.	(The change may be made in stable patients due to patient preference or comfort).

7. Figure 1: Oxygen prescription for acutely hypoxaemic patients in hospital



Chart 1 – Oxygen prescription for acutely hypoxaemic patients in hospital. Any increase in FiO₂ must be followed by repeat blood gases in 1 hour (or sooner if conscious level deteriorates) *If pH is <7.35 [H⁺] >45nmol/L) with normal or low PaCO₂, investigate and treat for metabolic acidosis and keep SpO₂ 94-98%. ABG, arterial blood gas; COPD, chronic obstructive pulmonary disease; FiO₂, fraction of inspired oxygen; ICU, Intensive Care Unit; NIV, non-invasive ventilation; PaCO₂, arterial carbon dioxide tension; PO₂, oxygen tension; SpO₂, arterial oxygen saturation measured by pulse oximetry.

MONITORING OF PATIENTS

1. Observe the following: a) Monitor arterial oxygen saturation levels according to BCUHB Oxygen guidance b) Visual observations of skin colour for central cyanosis (blue lips) c) Respiratory rate d) Any sign of respiratory distress should be reported immediately.	In order to accurately monitor the patient for signs of improvement or deterioration.
2. If the arterial oxygen saturation is above or below the target saturation, the observer (often a Health Care Assistant) must inform the personnel who are qualified to administer oxygen (usually a Nurse – see Appendix 1, page 24).	
3. Check the patient's mouth and nose and behind the ears	To identify signs of infections and pressure sores as soon as possible.
4. Record all observations on appropriate chart • 4 hourly if on continuous oxygen. • 8 hourly if on intermittent oxygen.	To ensure adequate record keeping.

Part One: Administration of Emergency Oxygen

8. Emergency Situations

8.1 In the emergency situation an oxygen prescription is not required. Oxygen should be given to the patient immediately, without a formal prescription or drug order, but documented in the patient's record retrospectively as soon as is clinically acceptable. All patients who have had an acute event resulting in a collapse should have oxygen delivered via a 15 L/min reservoir mask along with basic / advanced life support.

8.2 All critically ill patients should be given oxygen via a 15 L/min reservoir mask immediately (see Figure 1, page 8), the aim should be to stabilise the patient and then to achieve greater oxygen saturations for all acutely ill patients. If oximetry is unavailable, continue to use a reservoir mask until definitive treatment is available. Once stable, and oximetry available, titrate the oxygen flow and delivery device to aim for a target saturation range of 94 - 98% (See Figure 1, page 8 and Figure 2, page 12) apart from those at risk of hypercapnic respiratory failure or those receiving terminal palliative care.

8.3 Patients with COPD and other risk factors for hypercapnia who develop critical illness should have the same initial target saturations as other critically ill

patients pending the results of blood gas measurements, after which these patients may need controlled oxygen therapy or supported ventilation if there is severe hypoxaemia and / or hypercapnia with respiratory acidosis (Figure 1, page 8).

Table 1: Examples of Critical illnesses requiring high levels of supplemental oxygen

	Additional comments
<ul style="list-style-type: none"> Cardiac arrest or resuscitation 	<p>Refer to resuscitation guidelines for choice of delivery device during active resuscitation. Give highest possible inspired oxygen concentration during CPR until spontaneous circulation has been restored.</p>
<ul style="list-style-type: none"> Shock, sepsis, major trauma, drowning, anaphylaxis, major pulmonary haemorrhage, status epilepticus 	<p>Also give specific treatment for the underlying condition</p>
<ul style="list-style-type: none"> Major head injury 	<p>Early tracheal intubation and ventilation if comatose</p>
<ul style="list-style-type: none"> Carbon monoxide poisoning 	<p>Give as much oxygen as possible using a bag-valve mask or reservoir mask. Check carboxyhaemoglobin levels. A normal or high oximetry reading should be disregarded because saturation monitors cannot differentiate between carboxyhaemoglobin and oxyhaemoglobin owing to their similar absorbances. The blood gas PaO₂ will also be normal in these cases (despite the presence of tissue hypoxia).</p>
	<p>(British Thoracic Society Guideline, 2017)</p>

8.4 All oxygen prescribing should be in the designated oxygen section of the All Wales Inpatient Medication Administration Record (Appendix 3, page 26) and the appropriate target saturation should be circled (or if target saturations are not indicated the relevant box should be ticked).

8.5 Oxygen should be prescribed to achieve a target level saturation of 94 - 98% for most acutely ill patients or 88 - 92% for those at risk of hypercapnic respiratory failure (Appendix 4, page 27). The target saturation should be written on the drug chart.

****** Some stable patients with chronic disease, especially people aged > 70 years, may have oxygen saturation measurements below 94% and do not require oxygen therapy when clinically stable. ******

8.6 Oxygen should be given by staff who are trained in oxygen administration, and the use of cylinders, using appropriate devices and flow rates in order to achieve the target saturation (Figure 2, page 12). **Any qualified nurse / health professional can commence oxygen therapy in an emergency situation.**

8.7 Oxygen is a treatment for hypoxaemia, not breathlessness (oxygen has not been shown to have any effect on the sensation of breathlessness in non-

hypoxaemic patients). However, a sudden reduction of more than 3% in a patient's oxygen saturation within the target saturation range should prompt fuller assessment of the patient (and oximeter signal) because this may be the first evidence of an acute illness.

- 8.8 The other vital signs of pulse, blood pressure, temperature and respiratory rate, should also be recorded. All acutely ill patients should be assessed and monitored using the National Early Warning Score (NEWS)⁶. Carefully measure respiratory rate and heart rate because tachypnoea and tachycardia are more common than a physical finding of cyanosis in hypoxaemic patients.

Maintaining Oxygen Saturation

Titrate oxygen up or down to maintain the target oxygen saturation. The table below shows available options for stepping dosage up or down. The chart does not imply any equivalence of dose between Venturi masks and nasal cannulae.

Allow at least 5 minutes at each dose before adjusting further upwards or downwards **(except with major and sudden fall in saturation). Falls $\geq 3\%$ also require clinical review.**

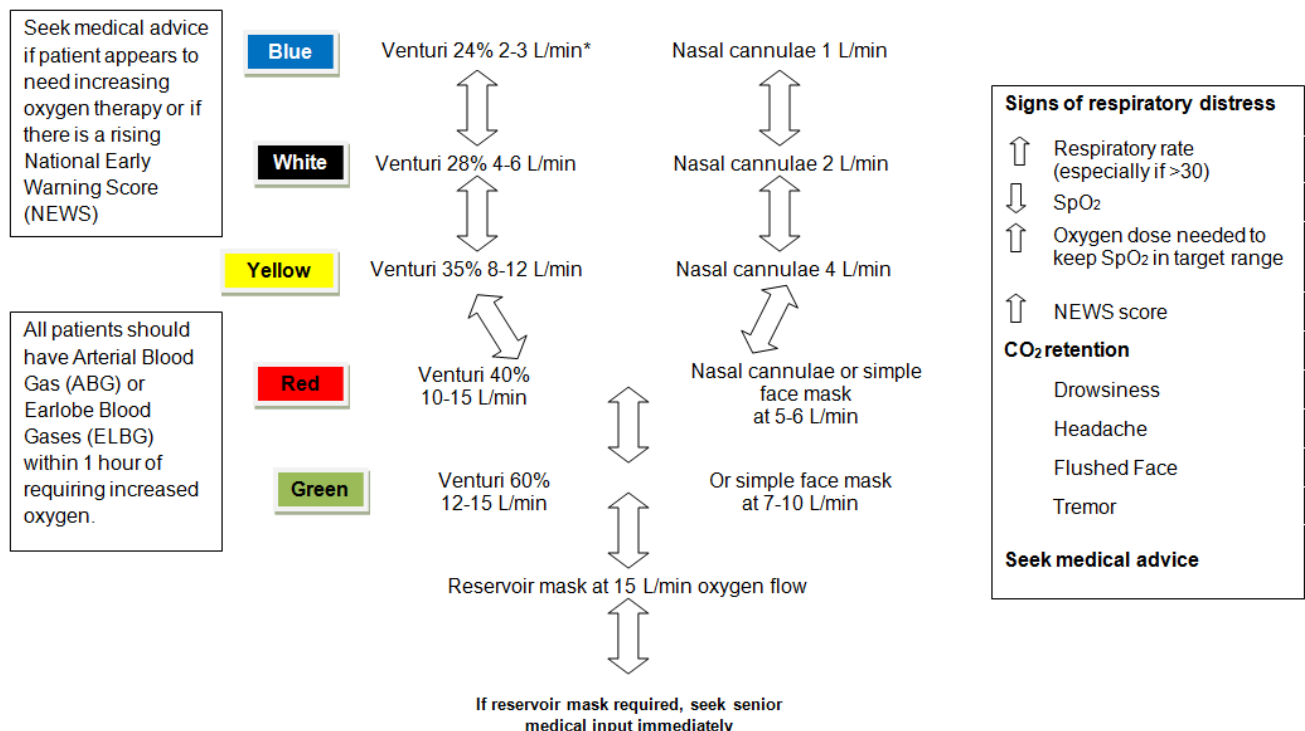
Once your patient has adequate and stable saturation on minimal oxygen dose, consider discontinuation of oxygen therapy.

If hypoxaemic, the initial oxygen therapy is nasal cannulae at 2 – 6 L/min or simple face mask at 5-10 L/min unless saturation is below 85% (use reservoir mask) or if at risk from hypercapnia (see below).

The recommended initial target saturation range, unless stated otherwise is 94 -98%. If oximetry is not available give oxygen as above until oximetry or blood gas results are available.

If patients have COPD or other risk factors for hypercapnic respiratory failure, aim at a saturation of 88 - 92% pending blood gas results but adjust to 94 - 98% if the PCO₂ is normal (unless there is a history of respiratory failure requiring NIV or IMV) and recheck blood gases after 30-60 minutes.

Figure 2



British Thoracic Society Guideline, 2017

Part Two Prescribing and Administration of Non-Emergency Oxygen

9. Indications for prescribed oxygen in BCUHB

9.1 Supplementary oxygen therapy is used for a variety of clinical conditions but primarily where the patient is unable to maintain their prescribed/expected oxygen levels.

Table 2 Conditions for which patients should be monitored closely but oxygen therapy is not required unless the patient is hypoxaemic.

	Additional comments
Myocardial infarction and acute coronary syndromes	Most patients with acute coronary syndromes are not hypoxaemic and the benefits/harms of oxygen therapy are unknown in such cases. Unnecessary use of high concentration oxygen may increase infarct size.
Stroke	Most patients with stroke are not hypoxaemic. Oxygen therapy may be harmful for non-hypoxaemic patients with mild-moderate strokes.
Hyperventilation or dysfunctional breathing	Exclude organic illness. Patients with pure hyperventilation or panic attacks are unlikely to require oxygen therapy. Rebreathing from a paper bag may cause hypoxaemia and is not recommended.
Most poisonings and drug overdoses	Hypoxaemia is more likely with respiratory depressant drugs, give antidote if available, for example naloxone for opiate poisoning. Check blood gases to exclude hypercapnia if a respiratory drug has been taken. Avoid high blood oxygen levels in case of acid aspiration as there is theoretical evidence that oxygen may be harmful in this condition. Monitor all potentially serious cases of poisonings in a level 2 or 3 environment (high dependency unit or intensive care unit).
Poisonings with paraquat or bleomycin	Patients with paraquat poisoning or bleomycin lung injury may be harmed by supplemental oxygen. Avoid oxygen unless the patient is hypoxaemic. Target saturation is 85-88%
Metabolic and renal disorders	Most do not need oxygen (tachypnoea may be due to acidosis in these patients)
Acute and subacute neurological and muscular conditions producing muscle weakness	These patients may require ventilator support and they need careful monitoring which includes spirometry. If the patient's oxygen level falls below the target saturation, they need urgent blood gas measurements and are likely to need ventilatory support.
Pregnancy and obstetric emergencies	Oxygen therapy may be harmful to the foetus if the mother is not hypoxaemic.
COPD, chronic obstructive pulmonary disease; IMV, invasive mechanical ventilation; NIV, non-invasive ventilation; PCO ₂ , arterial or arterialised carbon dioxide tension.	

10. Assessing and Monitoring Patients Requiring Oxygen Therapy

- 10.1 On admission to hospital patients should have baseline observations of Temperature, Pulse, Respirations, Blood Pressure and Oxygen saturation levels recorded using a pulse oximeter.
- 10.2 Following admission any patients requiring non emergency oxygen therapy should be reviewed by a doctor/ non-medical prescriber at the earliest opportunity and a prescription for oxygen together with the desired oxygen saturation range clearly documented on the inpatient prescription chart, and National Early Warning Score (NEWS). The correct oxygen administration device can then be selected.

11. Peri-operative and immediately post-operatively

- 11.1 All procedures involving conscious sedation warrant routine continuous monitoring of oxygen saturation via pulse oximetry prior to and during the procedure, and in the recovery period, particularly fibre optic bronchoscopy and upper gastrointestinal (GI) endoscopy where a reduction in arterial oxygen saturation (SaO_2) is common, particularly with concurrent use of sedation.
- 11.2 Significant arterial oxygen de-saturation ($\text{SpO}_2 < 90\%$ or fall of 4% or more that is prolonged ($> 1\text{min}$ during endoscopy procedures)) should be corrected by supplemental oxygen with the aim of achieving target oxygen saturations of 94 – 98%, or 88 – 92% in those at risk of hypercapnic respiratory failure.
- 11.3 Complicated upper GI endoscopy or procedures in patients with cardiorespiratory co morbidity are especially likely to lead to hypoxaemia and may also lead to hypercapnia, especially if the patient is heavily sedated. It is recommended that blood gases should be measured if such patients should require prolonged oxygen administration. The routine administration of oxygen is not recommended as it may delay the recognition of respiratory failure.
- 11.4 During the recovery period after procedures requiring conscious sedation, supplemental oxygen should be titrated to achieve target saturations of 94 – 98% in most patients and 88 – 92% in those at risk of hypercapnic respiratory failure.
- 11.5 Medium-concentration masks and nasal cannulae are usually sufficient (target saturation 94 – 98%) except for patients with known significant COPD who should receive oxygen from a 24% or 28% Venturi mask or 1–2 L/min from nasal cannulae aiming at a saturation range of 88 – 92% (Figure 1, page 8).

12. Identifying Appropriate Target Saturations

- 12.1 This guideline recommends aiming to achieve a normal or near-normal oxygen saturation for all acutely ill patients apart from those at risk of hypercapnic respiratory failure
- 12.2 The recommended target saturation range for acutely ill patients not at risk of hypercapnic respiratory failure is 94 – 98%
- 12.3 For most patients with known chronic obstructive pulmonary disease (COPD) or other known risk factors for hypercapnic respiratory failure (e.g. morbid obesity, cystic fibrosis (CF), chest wall deformities or neuromuscular disorders or fixed airflow obstruction associated with bronchiectasis), a target saturation range of 88 – 92% is suggested pending the availability of blood gas results (Appendix 5, page 28)
- 12.4 Clinical signs of inadequate oxygenation to consider when making an assessment are:
- Is the patient's SpO₂ below 94%?
 - Does the patient have a raised pulse rate?
 - Does the patient have a raised respiratory rate?
 - Does the patient have altered skin colour?
 - Is there cyanosis?
 - Are there signs of agitation, confusion or an altered level of consciousness?
 - Are they using their accessory muscles when breathing?

Consideration should be given to:

- Optimisation of medication and inhalers
- Compliance against prescription
- Inhaler technique
- Evidence of or diagnosis of anaemia
- Is treatment for COPD (saturation will be lower)
- Pre existing respiratory conditions

13. Contraindications

- 13.1 There are no absolute contraindications to oxygen therapy if indications are judged to be present. The goal of oxygen therapy is to achieve adequate tissue oxygenation using the lowest possible rate of administration.
- 13.2 Other Precautions/ Hazards/ Complications of Oxygen Therapy
- Drying of nasal and pharyngeal mucosa (*Do not use petroleum based products to alleviate dry/cracked skin because of the risk of fire*).
 - Oxygen toxicity
 - Skin irritation
 - Fire hazard
 - Potentially inadequate flow resulting in lower oxygen absorption than intended (equipment fault should be considered).

14. Types of equipment to administer oxygen therapy

- 14.1 All staff involved in the provision and administration of oxygen should be able to demonstrate competency with the equipment in use within their clinical area of work.
- 14.2 All equipment should be regularly checked and stocks of consumable equipment readily available and accessible. Where there is both a supply of piped air and oxygen the regulators should be clearly distinguishable and where necessary labelled. See Appendix 6, page 29 for examples of oxygen flow meter and position of 'ball' for correct flow rate. When piped air is not required flow meters should be removed but readily available for use.
- 14.3 Piped oxygen will be the main source of supply, the use of cylinders should be kept to a minimum. All ward managers should be able to locate and disable the master oxygen valve (Area Valve Service Unit AVSU) & contact the Authorised Person (AP) Medical Gas Pipeline Systems (MGPS) in the event of a fire. Where cylinders are in use staff should understand the process for changing the flow meters (usually undertaken by Portering Team). Where the use of oxygen cylinders is unavoidable systems should be in place to ensure that supplies are readily available, accessible and checked on a regular basis (during intentional rounding) when in use. In addition there needs to be clear segregation of full and empty cylinder supplies (Appendix 2, page 25).

15. Administering oxygen

- 15.1 Once the target saturation has been identified and prescribed, guidance regarding the most appropriate delivery system to reach and maintain the prescribed saturation is provided below (also see Figure 1, page 8):
- 15.2 Oxygen administration devices are many and variable (Appendix 6, page 29). For emergency situations where high percentage oxygen is required the mask of choice for those who will tolerate a mask is a non re-breathe mask with reservoir. This can be connected directly to the flow meter with a flow rate of 15 L / min and deliver 85% oxygen. This product is only licensed for emergency situations and once stabilised an alternative mask should be used. Guidance from the British Thoracic Society states that in an emergency, oxygen should always be given immediately and documented later.
- 15.3 Nasal Speculum deliver a low range of oxygen between 24 – 35% and are connected directly to the oxygen with an oxygen flow rate of up to 5 - 6L/min. These are safe and easy to use, are comfortable and allow the patient to eat drink and talk. However, nasal speculum can give variable % of oxygen and FiO₂ can climb unless monitored.
- 15.4 Venturi devices come as individual colour-coded barrels that are attached to an aerosol mask. The system delivers a specific percentage of oxygen to the

patient Different coloured barrels are selected depending on the percentage of oxygen required. The oxygen flow rate needed for the different barrels varies according to the manufacturer and this flow rate will always be stated on the device. This is the device of choice when it is important to deliver an accurate percentage of oxygen (e.g. Type II respiratory failure) (see Figure 1, page 8).

- 15.5 Medium concentration (MC) masks deliver a medium range of oxygen, generally considered to be 35 - 60%. The mask is connected directly to the oxygen flow meter with a flow of 5 – 10 L/min. The oxygen flow should be adjusted according to the flow rate or the desired SpO₂ range stated clearly. This mask is ideal for people who are suffering with Asthma, Pulmonary Embolism, Myocardial Infarction, Pneumonia or other forms of type I respiratory failure. When using this type of mask flow rates should be maintained at 5 L/min or more as lower rates may result in re-breathing of exhaled air. This makes it difficult to achieve a low inspired oxygen concentration and so these masks are generally unsuitable for patients with type II respiratory failure.

16. Nebulised therapy and oxygen, humidification

Humidification is not required for the delivery of low-flow oxygen (mask or nasal cannulae) or for the short-term use of high-flow oxygen. It is not therefore required in pre-hospital care. Pending the results of clinical trials, it is reasonable to use humidified oxygen for patients who require high-flow oxygen systems for more than 24 hours or who report upper airway discomfort due to dryness (Appendix 7, page 35).

- 16.1 Consider use of a large volume oxygen humidifier device for patients requiring high-flow rates or longer term oxygen, especially if sputum retention is a clinical problem.
- 16.2 In the absence of an artificial airway the decision to humidify supplemental oxygen needs to be made on an individual basis but this practice is not evidence-based.

17. Palliative Care

- 17.1 Oxygen use in palliative care patients should be restricted to patients with SpO₂ consistently <90% or patients who report significant relief of breathlessness from oxygen. In non-hypoxaemic patients, opioids and non-pharmacological measures should be tried before oxygen
- 17.2 In general, there is no role for the monitoring of oxygen saturation or PaO₂ in comfort-focused care in the last few days of life. If the patient appears comfortable, oxygen levels are irrelevant and should not influence care.

18. Prescribing, Monitoring and Record Keeping

- 18.1 Oxygen should be prescribed in the designated oxygen section of the All Wales In-patient Medication Administration Record (Appendix 3, page 26) and the

appropriate target saturation should be circled (or if target saturations are not indicated the relevant box should be ticked) on the chart and on the National Early Warning Score Chart.

- 18.2 The doctor, nurse practitioner or specialist nurse, is required to prescribe oxygen and this should be done at the earliest opportunity with guidance on the range of oxygen saturation levels required. The delivery device and flow rate should always be recorded on the physiological observations chart (BTS 2017) this is also in line with BCUHB policies and procedures.
- 18.3 Oxygen therapy will be adjusted to achieve target saturations rather than giving a fixed dose to all patients with the same disease. Nursing staff will be able to adjust the dose delivered (following discussion with a senior clinician competent in the prescription of oxygen clinically responsible for the patient's care) this will be reflected on the prescription chart. The patient's requirement for oxygen should be monitored at each drug round and their oxygen saturation levels recorded. If oxygen is still required the Registered Nurse must sign the observation chart confirming the quantity of oxygen that is being administered.
- 18.4 The on-going requirement for supplementary oxygen should be monitored to assess the patient's progress and requirements for discharge. A Home Oxygen Order Form (HOOFF) will need to be completed, signed by the prescribing clinician and faxed to the home oxygen supplier. This should be undertaken at least 24hrs prior to discharge should patients still require oxygen for discharge following adequate attempts at titration to stop. Oxygen is only required if SpO₂ <92% on air at rest and CBG/ABG P O₂ <7.3 on air at rest and patients are clinically stable. Oxygen may be prescribed at discharge but often will be removed 4-6 weeks later as the patient recovers from the acute phase. If patients require consideration for home oxygen, please contact the Oxygen assessment team:

Wrexham Maelor	☎ 01978 318281
Ysbyty Glan Clwyd	☎ 01745 445659
Ysbyty Gwynedd	☎ 01248 384178

- 18.5 Clinical staff will be required to be competent in the use of applying an Early Warning Score, (BCUHB uses the National Early Warning Score to ensure holistic clinical assessment and appropriate treatment interventions) The patient's oxygen saturation and oxygen delivery system should be recorded on this chart alongside other physiological variables (Figure 1, page 8). All patients on oxygen therapy should have regular pulse oximetry measurements. The frequency of measurements will depend on the condition being treated and the stability of the patient.

19. Weaning and Discontinuation

- 19.1 Oxygen therapy should be reduced in stable patients with satisfactory oxygen saturation levels. Once oxygen has been discontinued the prescription should

be reviewed by the patient's doctor/senior clinician and discontinued on the prescription chart.

20. Transfer and Transportation of Patients Receiving Oxygen

- 20.1 Patients who are transferred from one area to another must have clear documentation of their on-going oxygen requirements and documentation of their oxygen saturation for handover (Appendix 8, page 37)
- 20.2 Patients requiring oxygen therapy whilst being transferred from one area to another should be accompanied by a trained member of the nursing staff wherever possible. If this does not occur, clear instructions must be provided for personnel involved in the transfer of the patient, which must include delivery device and flow rate.
- 20.3 Include pictorial instructions on how to use a cylinder & advice about how long a cylinder will last at different flow rates.
- 20.4 Ensure the cylinder contains enough oxygen for the patient therapy. Calculate how long the cylinder will last and ensure further supplies are available if necessary.
- 20.5 Oxygen cylinders must be handled with care, positioned in specially designed holders, rather than laid on a patient's bed^{2,4}.
- 20.6 If the oxygen is to be used during a patient transfer it is the responsibility of the registered nurse to ensure there is sufficient gas for the whole journey, allowing for changes in requirements and delays such as faulty lifts. They must ensure the cylinder is delivering oxygen to the patient at the prescribed concentration and flow rate prior to transfer. This task cannot be delegated e.g. to a health care assistant.

21. Oxygen Storage and Safety

- 21.1 Oxygen is heavier than air, and so due to natural leakage from masks and nasal specula, the bed clothing may become saturated and therefore a fire hazard.
- 21.2 All BCUHB locations where oxygen cylinders are stored must have gas cylinder signs displayed. Cylinders must be located in a safe and secure environment within wards and departments. Oxygen cylinders must be identified as part of the COSHH assessments and fire risk assessment.
- 21.3 All spare and in-use cylinders must be adequately restrained; they must be stored and secured in an upright position. They must not be free standing as they risk falling over injuring staff or patients, and this could also cause damage to the cylinders.

- 21.4 Where more than one cylinder is available, they must be clearly identified with the appropriate label: FULL, IN-USE or EMPTY. Staff should ensure cylinders are used in strict rotation, so that cylinders with the earliest filling date are used first. All areas that use oxygen should hold a stock appropriate to the needs of that clinical area. A designated person should have the responsibility for maintaining stocks of oxygen cylinder.
- 21.5 All oxygen cylinders must be kept clean, dry and stored away from any sources of heat or ignition. Cylinders should also be handled with care, never knocked violently or allowed to fall over, never roll cylinders along the ground.
- 21.6 CD cylinders may be stored in Emergency Backpacks, if additional CD cylinders are held these should be restrained to the wall by a safety chain or CD holder.
- 21.7 HX cylinders must be stored and transported on an appropriate type and size of oxygen trolley. Additional HX cylinders should be restrained to the wall by a safety chain or on an oxygen trolley when not in use. HX cylinders in use in the ECT department may be stored horizontally in the designated oxygen cradles underneath Patient trolleys.
- 21.8 All equipment must be handled in line with the BCUHB Procedure and Guidance Document for Manual Handling ([WP55](#)).
- 21.9 When using medical gas cylinders it is important that no part of the cylinder valve or equipment is either lubricated or contaminated with oil or grease. Special care is also needed with the use of oil or petroleum-based hand creams as these could provide sufficient contamination to the medical cylinder valve surface when handling the cylinder to cause an ignition when the valve is turned on.
- 21.10 All oxygen valves, cylinder or piped, must be switched off when not in use.
- 21.11 The application of paraffin based skin products to patients, e.g. Diprobase® ointment, emulsifying ointment, white soft paraffin causes an additional potential fire hazard when administering oxygen to them.
- 21.12 Oxygen supports combustion. If a fire occurs in a clinical area where high concentrations of oxygen are present, the consequences can be devastating for both patients and staff. Although many patients receive oxygen every day in hospital, all staff should treat oxygen with respect.
- 21.13 It is important that patients are warned not to smoke when they use oxygen, as there is a risk of facial burns, and fire or explosion.**
- 21.14 All staff should undergo regular training in fire prevention and fire procedures, which should include training in situ in the clinical areas in which they work. Special attention should be given to the location of fire call points, fire extinguishers and medical gas shut off valves.

- 21.15 Any problems with oxygen cylinders and associated equipment must be reported immediately to the medical gas supplier and the Medicines and Healthcare products Regulatory Agency. <https://www.gov.uk/report-problem-medicine-medical-device>.

22. Infection Prevention and Control

- 22.1 All oxygen administration devices should be used in accordance with the manufacturer's guidance and will generally be single patient use unless specifically stated on the packaging.
- 22.2 At all times administration devices should be kept visibly clean and protected from contamination. When in use they should be checked as part of on-going hygiene needs, devices should be cleansed or replaced as indicated by the manufacturer. Prior to use, devices should be stored in a clean area, off the floor and protected from contamination. During intermittent use care should be taken to ensure they are visibly clean and dry before putting into a designated container ready for its next use. For hospital patients this container should be clearly labelled with the patient's name.
- 22.3 In addition to oxygen administration sets, all nebuliser masks, mouthpieces and tubing can be re-used for the same patient unless specifically stated on the packaging. All administration equipment except the tubing should be washed after each use with general purpose detergent and warm water. It should then be thoroughly dried using a disposable soft paper towel. The tubing should be attached to the gas delivery device and turned on for a few seconds, which will remove any dampness from inside the tubing.
- 22.4 With regard to nebulisers: if a compressor is used, when unplugged it will need to be wiped over with a disinfectant wipe, this should be part of routine cleaning schedules (daily/weekly) and in addition should be undertaken between use with different patients or more often if actually contaminated. The compressor should be stored clean and dry without nebuliser equipment attached.
- 22.5 Administration devices should not be stored connected to the oxygen supply, with the exception of those required in emergency situations, which should remain connected and ready for use, the mask and tubing should be protected from contamination ideally by retaining within original packaging which should be included in regular cleaning schedules.
- 22.6 At all times healthcare staff should comply with BCUHB standard infection prevention and control practices within the infection prevention and control policies and procedures guidance on use of personal protective equipment and local cleaning schedules.

23. Training

- 23.1 All nurses, nursing assistants and other healthcare professionals involved in prescribing or administering oxygen should receive teaching on the oxygen policy. Teaching aides are available on www.brit-thoracic.org/emergencyoxygen.
- 23.2 Staff should be able to demonstrate the knowledge of the use of cylinders when administering oxygen (Appendix 2, page 25), together with competency in recording the patient's oxygen saturation and taking the appropriate action required. This should be assessed by an appropriate senior clinician together with equipment used, which should form part of each areas induction pack. Competencies to: Administer oxygen safely and effectively (CHS78) can be found at <https://tools.skillsforhealth.org.uk/competence/show/pdf/id/2597/> and should be completed at induction and reviewed annually.
- 23.3 All doctors should be taught about the oxygen policy. Teaching aids are available on the BTS website. Audits of oxygen prescribing and administration are performed in all clinical areas. BCUHB participates in the national audits organised by the BTS. Teaching aides are available on www.brit-thoracic.org/emergencyoxygen
- .

24. Reference to Legislation

The NPSA (2009) Oxygen safety in hospitals - Rapid Response Report – from reporting to learning NPSA/2009/RRR006, aims to ensure that safe systems are in place to treat patients needing oxygen.

References

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5. Joint Formulary Committee. British National Formulary (online). London: BMJ Group and Pharmaceutical Press <http://www.medicinescomplete.com> accessed on 2018-09-06.
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8. Conway JH et al. Humidification as an adjunct to chest physiotherapy in aiding tracheo-bronchial clearance in patients with bronchiectasis. Respiratory Medicine 1992; 82(2): 109-14.
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PERSONNEL WHO MAY ADMINISTER OXYGEN

Any registered nurse, doctor, RSCN, RN or physiotherapist, in accordance with BCUHB Hospital Medicines Code (MM02) for administration of medicines.

All employees that work directly with patients are expected to be able to recognise patients who require emergency oxygen, call for help and initiate the administration of oxygen immediately. Basic Life Support and/or First Response Intervention may also be required

Nurses and Midwives authorised to administer medicines

All BCU employed nurses and midwives with a current registration with the NMC, including Bank nurses.

All newly qualified nurses administering medication to patients must have completed the BCU Medicines Management Assessment Workbook and Competencies before they can carry out single nurse administration.

Agency nurses, who must be registered with the NMC, may administer medication once the Health Board has received written assurance from the agency that there are no performance issues concerning medicines management.

Registered nurses (Level 2) with a current registration with the NMC following the required competency training in medicines management.

Bank newly qualified nurses or nurses returning to practice after a break must have completed the BCU Medicines Management Workbook and competencies before they can perform appropriate single nurse administration of medication. Bank and agency staff should not administer any medicines in areas they are unfamiliar with

Registered nurses (Level 2) with a live registration with the NMC undertaking a conversion course whilst allocated to their own speciality area.

Non-nursing staff authorised to administer medicines

Registered Medical Practitioners and Dentists

Registered Operating Department Practitioners only with the appropriate training and assessment of competence.

A nurse/midwife/ODP in training under the direct supervision of a registrant, who remains accountable for ensuring that the correct procedure takes place.

After appropriate training and competence assessment specific medicines may be given by registered health professionals. e.g. Pharmacists, Radiographers, Podiatrists, Orthoptists, Clinical Physiologists, Physiotherapists.

By delegation of a nurse registrant, BCUHB care staff who have undergone specific training and assessment of competence in oxygen administration.

Appendix 2

Oxygen Safety Competencies

Subject	Demonstrated	Discussed	Able to use in practice
Can identify where Oxygen Cylinders are kept within the department			
Awareness of BOC Medical Oxygen Cylinder guidance leaflet and understands content			
<u>Preparation and Use:</u> Can demonstrate how to: <ul style="list-style-type: none"> • Check the correct medical gas is being used and expiry date of the cylinder • Check the amount of oxygen in the cylinder before use • Remove all Anti Tamper plastic seals prior to use • Ensure that the flow selector is turned to zero and hand wheel turned off prior to connecting equipment • Connect the delivery tube to the cylinder • Ensure there is enough oxygen in the cylinder to last as long as required • Turn the cylinder on and ensure that oxygen is being delivered to the patient at the correct flow • Check for leaks and what to do if a leak is detected • Inflate the reservoir bag on a non re-breathing face mask 			
<u>During Use:</u> Can demonstrate how to: <ul style="list-style-type: none"> • Place a mask or nasal cannula on to the patient • Ensure stability of the patient during oxygen therapy i.e. pulse oximetry / positioning of cylinder • Check the valve at regular intervals to ensure sufficient gas • Ensure cylinders are transported and stored safely 			
<u>After Use:</u> Can demonstrate how to: <ul style="list-style-type: none"> • Remove the mask or cannula from the patient • Turn off the cylinder and disconnect equipment • Replace outlet cover 			
Understands that empty or near-empty cylinders need to be replaced immediately and know who to contact when cylinders need replacing			

Trainers Signature.....Date.....

Trainee Signature.....Date.....

Appendix 3

AVMROBM

Table 2 **Serious illnesses requiring moderate levels of supplemental oxygen if the patient is hypoxaemic**

Section 8.11

- ▶ The initial oxygen therapy is nasal cannulae at 2–6 l/min (preferably) or simple face mask at 5–10 l/min unless stated otherwise.
- ▶ For patients not at risk of hypercapnic respiratory failure who have saturation < 85%, treatment should be commenced with a reservoir mask at 10–15 l/min.
- ▶ The recommended initial oxygen saturation target range is 94–98%.
- ▶ If oximetry is not available, give oxygen as above until oximetry or blood gas results are available.
- ▶ Change to reservoir mask if the desired saturation range cannot be maintained with nasal cannulae or simple face mask (and ensure that the patient is assessed by senior medical staff).
- ▶ If these patients have co-existing COPD or other risk factors for hypercapnic respiratory failure, aim at a saturation of 88–92% pending blood gas results but adjust to 94–98% if the PaCO₂ is normal (unless there is a history of previous hypercapnic respiratory failure requiring NIV or IPPV) and recheck blood gases after 30–60 minutes.

	Additional Comments	Grade of Recommendation
Acute hypoxaemia – cause not yet diagnosed	Reservoir mask at 10–15 l/min if initial SpO ₂ below 85%, otherwise nasal cannulae or simple face mask Patients requiring reservoir mask therapy need urgent clinical assessment by senior staff	Grade D
Acute asthma		Grade C
Pneumonia		Grade C
Lung cancer		Grade C
Post-operative breathlessness	Management depends on underlying cause	Grade D
Acute heart failure	Consider CPAP or NIV in cases of pulmonary oedema	Grade D
Pulmonary embolism	Most patients with minor pulmonary embolism are not hypoxaemic and do not require oxygen therapy	Grade D
Pleural effusions	Most patients with pleural effusions are not hypoxaemic. If hypoxaemic, treat by draining the effusion as well as giving oxygen therapy.	Grade D
Pneumothorax	Needs aspiration or drainage if the patient is hypoxaemic. Most patients with pneumothorax are not hypoxaemic and do not require oxygen therapy. Use reservoir mask at 10–15 l/min if admitted for observation. Aim at 100% saturation (Oxygen accelerates clearance of pneumothorax if drainage not required).	Grades C and D
Deterioration of lung fibrosis or other interstitial lung disease	Reservoir mask at 10–15 l/min if initial SpO ₂ below 85%, otherwise nasal cannulae or simple face mask	Grade D
Severe anaemia	The main issue is to correct the anaemia. Most anaemic patients do not require oxygen therapy.	Grades B and D
Sickle cell crisis	Requires oxygen only if hypoxaemic (below the above target ranges or below what is known to be normal for the individual patient). Low oxygen tension will aggravate sickling.	Grade B

COPD, chronic obstructive pulmonary disease; CPAP, continuous positive airway pressure; IPPV, intermittent positive pressure ventilation; NIV, non-invasive ventilation; PaCO₂, arterial carbon dioxide tension; SpO₂, arterial oxygen saturation measured by pulse oximetry.

Table 3 COPD and other conditions requiring controlled or low-dose oxygen therapy

Section 8.12

- ▶ Prior to availability of blood gases, use a 28% Venturi mask at 4 l/min and aim for an oxygen saturation of 88–92% for patients with risk factors for hypercapnia but no prior history of respiratory acidosis. Grade D
- ▶ Adjust target range to 94–98% if the PaCO_2 is normal (unless there is a history of previous NIV or IPPV) and recheck blood gases after 30–60 minutes. Grade D
- ▶ Aim at a pre-specified saturation range (from alert card) in patients with a history of previous respiratory acidosis. These patients may have their own Venturi mask. In the absence of an oxygen alert card, but with a history of previous respiratory failure (use of NIV or IPPV), treatment should be commenced using a 28% oxygen mask at 4 l/min in pre-hospital care or a 24% Venturi mask at 2–4 l/min in hospital settings with an initial target saturation of 88–92% pending urgent blood gas results. Grade D
- ▶ If the saturation remains below 88% in pre-hospital care despite 28% Venturi Mask, change to nasal cannulae at 2–6 l/min or simple mask at 5 l/min with target saturation of 88–92%. All at-risk patients with alert cards, previous NIV or IPPV or with saturation below 88% in the ambulance should be treated as a high priority. Alert the A&E department that the patient requires immediate senior assessment on arrival at the hospital. Grade D
- ▶ If the diagnosis is unknown, patients over 50 years of age who are long-term smokers with a history of chronic breathlessness on minor exertion such as walking on level ground and no other known cause of breathlessness should be treated as if having COPD for the purposes of this guideline. Patients with COPD may also use terms such as chronic bronchitis and emphysema to describe their condition but may sometimes, mistakenly use “asthma”. FEV1 should be measured on arrival in hospital if possible and should be measured at least once before discharge from hospital in all cases of suspected COPD. Grade D
- ▶ Patients with a significant likelihood of severe COPD or other illness that may cause hypercapnic respiratory failure should be triaged as very urgent and blood gases should be measured on arrival in hospital. Grade D
- ▶ Blood gases should be rechecked after 30–60 minutes (or if there is clinical deterioration) even if the initial PaCO_2 measurement was normal. Grade D
- ▶ If the PaCO_2 is raised but pH is ≥ 7.35 ($[\text{H}^+] \leq 45 \text{ nmol/L}$), the patient has probably got long-standing hypercapnia; maintain target range of 88–92% for these patients. Blood gases should be repeated at 30–60 minutes to check for rising PaCO_2 or falling pH. Grade D
- ▶ If the patient is hypercapnic ($\text{PaCO}_2 > 6.0 \text{ kPa}$ or 45 mm Hg) and acidotic ($\text{pH} < 7.35$ or $[\text{H}^+] > 45 \text{ nmol/L}$) consider non-invasive ventilation, especially if acidosis has persisted for more than 30 minutes despite appropriate therapy. Grade A

	Additional Comments	Grade of Recommendation
COPD	May need lower range if acidotic or if known to be very sensitive to oxygen therapy. Ideally use alert cards to guide treatment based on previous blood gas results. Increase flow by 50% if respiratory rate is above 30, see recommendation 32.	Grade C
Exacerbation of Cystic Fibrosis	Admit to regional CF centre if possible, if not discuss with regional centre or manage according to protocol agreed with regional CF centre. Ideally use alert cards to guide therapy. Increase flow by 50% if respiratory rate is above 30, see recommendation 32.	Grade D
Chronic neuro-muscular disorders	May require ventilatory support. Risk of hypercapnic respiratory failure. For acute neuro-muscular disorders and sub-acute conditions such as Guillain-Barré syndrome, please see table 4.	Grade D
Chest wall disorders		Grade D
Morbid obesity		Grade D



CF, cystic fibrosis; COPD, chronic obstructive pulmonary disease; CPAP, continuous positive airway pressure; IPPV, intermittent positive pressure ventilation; NIV, non-invasive ventilation; PaCO_2 , arterial carbon dioxide tension; SpO_2 , arterial oxygen saturation measured by pulse oximetry.

Oxygen Devices


EQUIPMENT USED IN THE DELIVERY OF OXYGEN (Choose the appropriate delivery device)

1. Oxygen source (piped or cylinder)
2. Flow meter
3. Saturation monitor
4. Oxygen Delivery system (see appendix j for advice on use of each device)


A) Nasal cannula

DEVICE	DESCRIPTION	PURPOSE
<p><i>Nasal Cannulae</i></p> 	<p>Nasal cannulae consist of pair of tubes about 2cm long, each projecting into the nostril and stemming from a tube which passes over the ears and which is thus self-retaining.</p> <p>Uncontrolled oxygen therapy</p> 	<p>Cannulae are preferred to masks by most patients. They have the advantage of not interfering with feeding and are not as inconvenient as masks during coughing and sneezing.</p>
ACTION		RATIONALE
1. (When using nasal cannula). Position the tips of the cannula in the patient's nose so that the tips do not extend more than 1.5cm into the nose.		Overlong tubing is uncomfortable, which may make the patient reject the procedure. Sore nasal mucosa can result from pressure or friction of tubing that is too long.
2. Place tubing over the ears and under the chin as shown above. Educate patient re prevention of pressure areas on the back of the ear.		To allow optimum comfort for the patient. To prevent pressure sores.
3. Adjust flow rate, usually 2-4 but may vary from 1-6 in some circumstances.		Set the flow rate to achieve the desired target oxygen saturation.

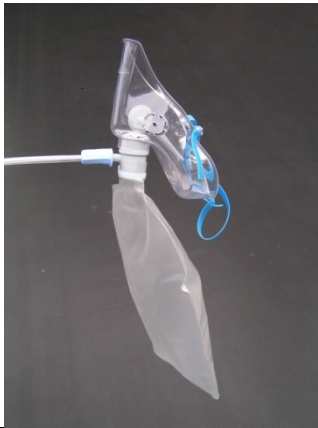
B) Fixed performance mask (Venturi mask and valve)

DEVICE	DESCRIPTION	PURPOSE
Venturi mask 	<p>A mask incorporating a device to enable a fixed concentration of oxygen to be delivered independent of patient factors or fit to the face or flow rate. Oxygen is forced out through a small hole causing a Venturi effect which enables air to mix with oxygen.</p> <p>Controlled oxygen therapy</p>	<p>This is a high performance oxygen mask designed to deliver a specified oxygen concentration regardless of breathing rate or tidal volume.</p> <p>Venturi devices come in different colours for %</p> <p>Blue = 24% White = 28% Yellow = 35% Red = 40% Green = 60%</p>
ACTION		RATIONALE
1. When using Venturi mask, connect the mask to the appropriate Venturi barrel attached firmly into the mask inlet.		To ensure that patient receives the correct concentration of oxygen
2. Fasten oxygen tubing securely.		Correctly secured tubing is comfortable and prevents displacement of mask/cannulae.
3. Assess the patient's condition and functioning of equipment at regular intervals according to care plan.		To ensure patient's safety and that oxygen is being administered as prescribed.
4. Adjust flow rate. The minimum flow rate is indicated on the mask or packet. The flow should be doubled if the patient has a respiratory rate above 30 per minute.		Higher flows are required for patients with rapid respiration and high inspiratory flow rates. This does not affect the concentration of oxygen but allows the gas flow rate to match the patient's breathing pattern.

C) Simple face mask (variable flow)


DEVICE	DESCRIPTION	PURPOSE
	<p>Mask has a soft plastic face piece, vent holes are provided to allow air to escape. Maximum 50%-60% at 15 ltrs/minute flow.</p> <p>Uncontrolled Oxygen therapy</p>	<p>This is a variable performance device. The oxygen concentration delivered will be influenced by:</p> <ul style="list-style-type: none"> a. the oxygen flow rate(litres per minute) used, leakage between the mask and face; b. the patient's tidal volume and breathing rate. <p>NOT to be used for CO₂ retaining patients.</p>
<p>Simple face mask Variable Percentage (Delivers unpredictable concentrations that vary with flow rate)</p> <p><i>Nasal cannulae should be used for most patients who require medium dose oxygen but a simple face mask may be used due to patient preference or if the nose is blocked</i></p>		
ACTION		RATIONALE
<p>If using simple face mask, gently place mask over the patient's face, position the strap behind the head or the loops over the ears then carefully pull both ends through the front of the mask until secure.</p>		<p>Ensure a comfortable fit and delivery of prescribed oxygen is maintained.</p>
<p>Check that strap is not across ears and if necessary insert padding between the strap and head.</p> <p>Adjust the oxygen flow rate. Must never be below 5L/min</p>		<p>To prevent irritation.</p> <p>Flows below 5L/m do not give enough oxygen and may cause increased resistance to breathing and may also cause CO₂ re-breathing due to the small mask size.</p>

D) Reservoir mask (non re-breathe mask)

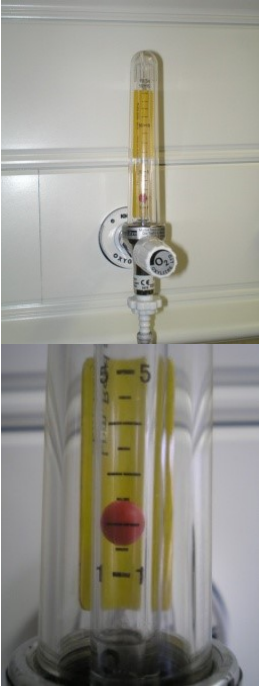
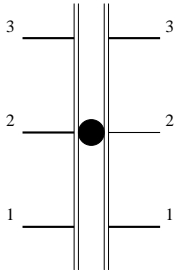
DEVICE	DESCRIPTION	PURPOSE
<p>Reservoir Mask (Non-rebreathe Mask)</p> 	<p>Mask has a soft plastic face piece with flap-valve exhalation ports which may be removed for emergency air-intake. There is also a one-way valve between the face mask and reservoir bag.</p> <p>Uncontrolled oxygen therapy</p>	<p>In non re-breathing systems the oxygen may be stored in the reservoir bag during exhalation by means of a one-way valve. High concentrations of oxygen 80-90% can be achieved at relatively low flow rates.</p> <p>NOT to be used for CO₂ retaining patients except in life-threatening emergencies such as cardiac arrest or major trauma.</p>
ACTION		RATIONALE
1. Ensure the reservoir bag is inflated before placing mask on patient, this can be maintained by using 10-15 litres of oxygen per min.		To ensure the optimal flow of oxygen to the patient.
2. Adjust the oxygen flow to the prescribed rate.		Inadequate flow rates may result in administration of inadequate oxygen concentration to the patient.

In disposable reservoir, oxygen flows directly into the mask during inspiration and into the reservoir bag during exhalation. All exhaled air is vented through a port in the mask and a one-way valve between the bag and mask, which prevents re-breathing.

E) Tracheostomy mask for patients with tracheostomy or laryngectomy

DEVICE 	DESCRIPTION Mask designed for “neck breathing patients”. Fits comfortably over tracheostomy or tracheotomy. Exhalation port on front of mask.	PURPOSE This is a variable performance device for patients with tracheostomy or tracheotomy. The oxygen concentration delivered will be influenced by: a. the oxygen flow rate(litres per minute) used. b. the patient’s tidal volume and breathing rate.
Tracheostomy mask Variable Percentage (Delivers unpredictable concentrations that vary with flow rate)	Uncontrolled Oxygen therapy	Use cautiously at low flow rates in CO₂ retaining patients as there may be no alternative.
ACTION	RATIONALE	
Gently place mask over the patient’s airway, position the strap behind the head then carefully pull both ends through the front of the mask until secure.	Ensure a comfortable fit and delivery of prescribed oxygen is maintained.	

F) Oxygen Flow Meter

DEVICE	DESCRIPTION	PURPOSE
	<p>Device to allow the patient to receive an accurate flow of oxygen, usually between 2 and 15 litres per minute.</p> <p>May be wall-mounted or on a cylinder.</p> <p>Take special care if your hospital uses twin oxygen outlets or if there are air outlets which may be mistaken for oxygen outlets.</p>	<p>To ensure that the patient receives the correct amount of oxygen.</p>  <p><u>Correct Setting for 2 L/min</u></p>
<p>Oxygen flow meter Delivers oxygen to the patient.</p>		
ACTION		RATIONALE
<p>Attach the oxygen tubing to the nozzle on the flow meter.</p> <p>Turn the finger-valve to obtain the desired flow rate. The CENTRE of the ball shows the correct flow rate. The diagrams shows the correct setting to deliver 2 L/min.</p>		<p>To ensure that the patient receives the correct amount of oxygen.</p>

HUMIDIFICATION



Based on a systematic review of the scientific literature, this draft guideline on the use of humidified oxygen in the acute setting has been developed^{7,8}.

Oxygen is used in many settings in BCUHB and at low flow rates is generally delivered via mask or nasal cannulae often without humidification. Humidified oxygen is used where high flow rates of oxygen are being administered and where the patients are likely to remain on it for some period longer than 12-24 hours. Humidification should also be considered in circumstances where airway hydration may be important. Essentially humidified oxygen comes in two forms, simple cold humidification and warmed humidification systems.

Areas where humidification is used:

- Intensive Care and High Dependency Unit
- Postoperative Patients

Humidification is often in these patient groups and seems to be taken as granted as beneficial for this patient group.

Cold Humidification: Step down ICU, HDU, Cystic Fibrosis, Bronchiectasis

Level 2 patients

The purpose of this guideline essentially is going to exclude patients in such patient groups such as critically ill patients where small differences can lead to a significant change in outcome the individual decision must be made for each patient and as such humidification should be available for all patients if required by the clinicians, which is the present situation. We would also feel that any patients stepping down from high dependency care to a medical or surgical ward again should continue humidification as part of their oxygen therapy for a short period of time whilst continuing to recover. Despite the fact there is little evidence to support the use of humidified versus non humidified oxygen there are some studies to support this for example, evidence of short term improvement in oxygenation in patients with COPD with 28% oxygen although such short term improvements in blood gases do not necessarily guarantee improved long term outcome.

Acutely Ill Patients on Medical Wards Including Medical Admissions

If a patient is admitted or becomes unwell on a medical ward with hypoxia a flow rate of 15 L/min should be initiated, as per BCUHB policy. Humidification should be considered initially in the form of simple cold humidification circuit pending review on whether a patient needs transfer to high dependency or intensive care support bed. The routine use of warm humidification should not necessarily be used in such patients (level 2) unless at the request of intensive care or high dependency staff (Comprehensive Critical Care 2000).

Routine humidification for low flow rates of oxygen and for oxygen delivered via nasal cannulae is not recommended and indeed there is no good evidence to support the use of humidified oxygen with a low flow rate and certainly not with nasal cannulae (Cambell EJ *et al* 1988)⁷. In patients with chest conditions such as bronchiectasis and cystic fibrosis there is evidence for use of humidification to aid sputum clearance (Conway JH 1992)⁸. This evidence was obtained using cold humidification as opposed to warm.

Warm Humidification: HDU with difficult expectoration.

This should potentially be available to all patients on high dependency. If it is felt that they are having difficulty expectorating sputum and as such humidification should be continued if there is subjective or objective improvement in the patient's condition including oxygenation with the addition of such humidification. That said the scientific evidence for this is fairly thin although there is little against this either.

Use of Humidified Oxygen in CPAP in Patients with Obstructive Sleep Apnoea

There are studies on the effects of the benefit of humidification in people on continuous CPAP it is not recommended for those using nasal CPAP for obstructive sleep apnoea. There is no evidence of improvement in the physiology of symptoms or subjective response to treatment (Duong M *et al* 2005; Mador MJ *et al* 2005).

A large number of CPAP users do complain of nasal and oral symptoms including dryness but there is no conclusive proof that compliance or symptoms are improved by humidifying the system.

Appendix 8

GIG NHS
Bristol Medical School
Bristol University Health Board

SBAR FOR HANDOVER TAKEN BY RECEIVING WARD
(THIS MUST BE A VERBAL HANDOVER)

Transferring Ward	Receiving ward																																								
Ward Name	Ward Name																																								
Name of Nurse	Date & Time of Handover																																								
Situation																																									
Patient Name	DOB: Hospital No:																																								
Allergies: Admission time & date:																																									
Reason for admission																																									
Present condition/ symptoms:																																									
Resuscitation status																																									
Background																																									
.....																																									
Own Medication brought in Y/N:																																									
Any Medication on order Y/N: Details:																																									
Is the patient on any critical medicines Y/N: Details:																																									
Assessment/ special nursing requirements e.g. behavioural / suction etc																																									
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th>Intervention</th> <th>Result Time & date</th> <th>Medication</th> <th>Outcome/Y/N Time & date</th> <th>Inbuilt</th> <th>Outcome/Y/N Time & date</th> <th>Infection status</th> <th>Outcome</th> </tr> </thead> <tbody> <tr> <td>NEWS Score</td> <td></td> <td>Medication given</td> <td></td> <td>When is insulin next due</td> <td></td> <td>Issues eg MRSA, C.Difficile</td> <td></td> </tr> <tr> <td>MUST score</td> <td></td> <td>Medication omitted</td> <td></td> <td>BM recordings</td> <td></td> <td>Active infection Y/N</td> <td></td> </tr> <tr> <td>VTE assessment</td> <td></td> <td>Controlled drugs transferred</td> <td></td> <td>Diabetic specialist nurse referral</td> <td></td> <td>Isolation required Y/N</td> <td></td> </tr> <tr> <td>Diabetic referral Y/N</td> <td></td> <td>PODs/ Fridge items transferred</td> <td></td> <td>Carbohydrate intake</td> <td></td> <td>O&V - please specify</td> <td></td> </tr> </tbody> </table>		Intervention	Result Time & date	Medication	Outcome/Y/N Time & date	Inbuilt	Outcome/Y/N Time & date	Infection status	Outcome	NEWS Score		Medication given		When is insulin next due		Issues eg MRSA, C.Difficile		MUST score		Medication omitted		BM recordings		Active infection Y/N		VTE assessment		Controlled drugs transferred		Diabetic specialist nurse referral		Isolation required Y/N		Diabetic referral Y/N		PODs/ Fridge items transferred		Carbohydrate intake		O&V - please specify	
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Diabetic referral Y/N		PODs/ Fridge items transferred		Carbohydrate intake		O&V - please specify																																			
Recommendation What is required from the receiving ward and by when etc																																									
<p>Name/Signature of nurse receiving verbal handover</p> <p style="color: red; text-align: center;">To ensure understanding, receiving ward to repeat key information back to transferring ward</p>																																									

CHECKLIST FOR INTERNAL TRANSFERS OF PATIENTS USING OXYGEN THERAPY

Patient details
 Hospital Number
 Name
 DOB
 Address
 NHS number

Transfer from:

Transfer to:

OXYGEN PRESCRIPTION (drug chart and appropriate escort to accompany patient)

Registered ☐

Unregistered ☐

(Taken from prescription)

Target saturations (circle): 88-92% 94-98% other

Oxygen delivery device and flow rate:

Cylinder: CD Other

Cylinder administering oxygen to the patient, following needs to be checked:-

Ensure oxygen cylinder is safely secured in a bed holder	<input type="checkbox"/>	Remove Cap and side safety seal from cylinder	<input type="checkbox"/>
Switch on and ensure oxygen flowing.	<input type="checkbox"/>	Ensure there is adequate O ₂ in the cylinder	<input type="checkbox"/>

PATIENT MONITORING

(Suggest recording saturations every 15 mins, more frequently if patient on a high flow rate of oxygen)

Situation	Time	Saturation	Cylinder check	Signature
Leaving the ward			Ensure FULL and working	
On return to the ward				

This table should be completed and added at the end of the document:

Members of the Working Group:

Name	Title
Pam Lloyd	Respiratory Specialist Nurse/PORT Co-ordinator
Louise Howard-Baker	Assistant Area Director Pharmacy & Medicines Management (east)

Engagement has taken place with:

Name	Date
Medical Gases Group	9/10/18

Name	Title	Date Consulted
Ali Thahseen	Consultant Physician	9/10/18
Alison Griffiths	Assistant Director Nursing YGC	9/10/18
Alun Mowll	Resuscitation Manager, YG	9/10/18
Andrea Hughes	Director of Nursing, Central Area	9/10/18
Anna Holt	Respiratory Specialist Nurse	9/10/18
Ash Basu	Consultant, ED	9/10/18
Asha Umrawsingh	Consultant ED	9/10/18
Ashley Bhageerutty	Consultant ED	9/10/18
Brian Burgess	Consultant ED	9/10/18
Brian Tehan	Medical Director for Quality and Transformation	9/10/18
Campbell Edmondson	Consultant Anaesthetist	9/10/18
Chris Lynes	Director of Nursing, West	9/10/18
Chris Littler	Consultant Anaesthetist	9/10/18
Damian McKeon	Consultant Physician	9/10/18
Dan Menzies	Consultant Physician	9/10/18
David Cartlidge	Consultant ED	9/10/18
Dilip Menon	Consultant ED	9/10/18
Emma Hosking	Assistant Medical Director, YGC	
Grant Benfield	Consultant Physician	9/10/18
Haroon Sabri	Consultant ED	9/10/18
Heather Piggott	Acting Assistant Director Nursing, Wrexham Maelor	9/10/18
Helen Salter	Consultant ED	9/10/18
Hywel Hughes	Consultant ED	9/10/18
Iona Lawson	Consultant Physician	9/10/18
James Kilblane	Consultant Physician	9/10/18
Jane Parry	Respiratory Specialist Nurse	9/10/18
Janette Hamilton	Clinical Governance Lead Nurse, West	9/10/18
Jay Duncan	Practice Development Nurse, ED, YG	9/10/18

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Jayne Sankey	Acting Director of Nursing, East Area	9/10/18
Jo Windle	Practice Development Nurse, ED, Wrexham	9/10/18
Joanne White	Practice Development Nurse, Critical Care, YGC	9/10/18
John Martin	Health & Safety	9/10/18
Julie Smith	Associate Director of Nursing	9/10/18
Julie Williams	Senior Nurse, Clinical Governance, Wrexham	
Karen Mottart	Assistant Medical Director, YG	9/10/18
Kate Clark	Secondary Care Medical Director	9/10/18
Kirsty Evans	Consultant Physician	9/10/18
Linda Dykes	Consultant ED	9/10/18
Mandy Jones	Assistant Director of Nursing YG	9/10/18
Mark Riley	Health and Safety	9/10/18
Mark Steele	Consultant Physician	9/10/18
Melanie Jones	Consultant ED	9/10/18
Narendra Achanta	Consultant ED	9/10/18
Neil McAndrew	Consultant Physician	9/10/18
Nicola Vaughan-Jones	Practice Development Nurse, Critical Care YG	9/10/18
Paul O'Brien	Consultant ED	9/10/18
Pauline Cutting	Consultant ED	9/10/18
Pete Williams	Consultant ED	9/10/18
Rebecca Worsell	Practice Development Sister, ED, YGC	9/10/18
Rhiannon Talbot	Consultant ED	9/10/18
Richard Griffiths	Consultant ED	9/10/18
Rob Perry	Consultant ED	9/10/18
Robin Poyner	Consultant Physician	9/10/18
Robin Roop	Consultant ED	9/10/18
Sabrina Owen	Practice Development Nurse, YGC	9/10/18
Sakkarai Ambalavanan	Consultant Physician	9/10/18
Sam Williams	Oxygen Assessment	9/10/18
Sarah Bloomfield	Secondary Care Quality & Safety Adviser	9/10/18
Sarah Davies	Consultant Physician	9/10/18
Sarah Dyer	Consultant Physician	9/10/18
Seramanperuman Sivaraman	Consultant ED	9/10/18
Sian Morgan	Consultant ED	9/10/18
Stephen Kelly	Consultant Physician	9/10/18
Stephen Stanaway	Consultant Physician	9/10/18
Steve Forsyth	Director of Nursing, Mental Health	9/10/18
Teresa Ching	Consultant Physician	9/10/18
Tim Gardner	Resuscitation Team Manager YGC	9/10/18
Tom O'Driscoll	Consultant, ED	9/10/18
Tracey Harris	Clinical Governance Lead Nurse, YGC	9/10/18
Tracey Radcliffe	Clinical Governance Lead Nurse, Wrexham	9/10/18
Trevor Haughton	Resuscitation Manager Wrexham	9/10/18
Vincent O'Keeffe	Consultant Anaesthetist	9/10/18

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BCUHB Matrons		9/10/18
Medical Gas Committee		9/10/18



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EQUALITY IMPACT ASSESSMENT FORMS

PARTS A and B: SCREENING AND OUTCOME REPORT

Introduction:

These forms have been designed to enable you to record, and provide evidence of how you have considered the needs of all people (including service users, their carers and our staff) who may be affected by what you are writing or proposing, whether this is:

- *a policy, protocol, guideline or other written control document;*
- *a strategy or other planning document e.g. your annual operating plan;*
- *any change to the way we deliver services e.g. a service review;*
- a decision that is related to any of the above e.g. commissioning a new service or decommissioning an existing service.

This is not optional: Equality Impact Assessment is a specific legal requirement on public sector organisations under equalities legislation and failure to comply could result in a legal challenge to a decision or strategy. More importantly, equality impact assessment helps to inform better decision-making and policy development leading to improved services for patients. **This form should not be completed by an individual alone, but should form part of a working group approach.**

The Forms:

You must complete:

- **Part A** – this is the Initial Screening that is always undertaken and consists of Forms 1 to 3; these forms are designed to enable you to make an initial assessment of the potential impact of what you are doing, and decide whether or not you will need to proceed to a Full Impact Assessment (Part C);

AND

- **Part B** – this is the Outcome Report and Action Plan (Form 4) you will need to complete whether or not you proceed to a Full Impact Assessment;

Together, these forms will help to provide evidence of your Impact Assessment and how you have shown “due regard” to the duties.

You may also need to complete Part C (see separate Form) – if parts A and B indicate you need to undertake a Full Impact Assessment. This enables you to fully consider all the evidence that is available (including engagement with the people affected by your document or proposals) to tell you whether your document or proposal will affect people differently. It also gives you the opportunity to consider what changes you may need to make to eliminate or mitigate any adverse or negative impact you have identified.

Remember that these forms may be subject to external scrutiny e.g. under a Freedom of Information request.

Once completed, the 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?	Policy for Administration and use of Emergency and Non-Emergency Oxygen in Adults In Managed Services
2.	Provide a brief description, including the aims and objectives of what you are assessing.	<p>To provide a unified clinical approach to the administration and care of adult patients requiring oxygen therapy, within BCUHB. The use of supplementary oxygen is considered to be a medicine and should be managed in the same way as all other medicines in its method of administration.</p> <p>All adult patients who require emergency / supplementary oxygen therapy receive therapy that is appropriate to their clinical condition and in line with national guidance (British Thoracic Society Guideline; Thorax, 2017)¹. Oxygen will be prescribed according to a target saturation range. The system of prescribing target saturation aims to achieve a specified outcome, rather than specifying the oxygen delivery method alone. Those who administer oxygen therapy will monitor the patient and keep within the target saturation range.</p> <p>This policy outlines the administration and use of oxygen in adults within all BCUHB healthcare settings. The clinical steps which should be taken by registered clinicians</p>

		before administering oxygen to patients. It also outlines equipment which should be used to administer oxygen therapy and the roles and responsibilities of staff caring for patients receiving oxygen.
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?	The authors: Pam Lloyd, Respiratory Specialist Nurse; Louise Howard-Baker, Assistant Director for Pharmacy & Medicines Management (East); Dr Liz Brohan, Consultant Respiratory Physician.
4.	Is the Policy related to, or influenced by, other Policies/areas of work?	MM01 Medicines Policy WP55 BCUHB Procedure and Guidance Document for Manual Handling
5.	Who are the key Stakeholders i.e. who will be affected by your document or proposals?	Healthcare staff Patients
6.	What might help/hinder the success of whatever you are doing, for example communication, training etc?	Communication Training

Form 2: Considering the potential impact of your document, proposals etc in relation to equality and human rights

Characteristic or other factor to be considered	Potential Impact by Group. Is it:-		Please detail here, for each characteristic listed on the left:- (1) any Reports, Statistics, Websites, links etc. that are relevant to your document/proposal and have been used to inform your assessment; and/or (2) any information gained during engagement with service users or staff; and/or any other information that has informed your assessment of Potential Impact.
	Positive (+) Negative (-) Neutral (N) No Impact/Not applicable (N/a)	High Medium or Low	
Age	N		
Disability	N		
Gender Reassignment	N		
Marriage & Civil Partnership	N		
Pregnancy & Maternity	N		
Race / Ethnicity	N		
Religion or Belief	N		
Sex	N		
Sexual Orientation	N		
Welsh Language	N		
Human Rights	N		

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">• Eliminate unlawful discrimination, harassment and victimisation;• Advance equality of opportunity; and• Foster good relations between different groups	
1. Describe here (if relevant) how you are ensuring your policy or proposal does not unlawfully discriminate, harass or victimise	The policy is to ensure that national clinical guidelines are being adhered to in BCUHB and that staff are trained and competent to prescribe and administer oxygen, transport patients and can use and operate an oxygen cylinder whilst being moved, thereby preventing harm to patients.
2. Describe here how your policy or proposal could better advance equality of opportunity (if relevant)	Not relevant
3. Describe here how your policy or proposal might be used to foster good relations between different groups (if relevant)	Not relevant

Part B:

Form 4 (i): Outcome Report

Organisation:	BETSI CADWALADR UNIVERSITY HEALTH BOARD	
1. What is being assessed? (Copy from Form 1)	Policy for Administration and use of Emergency and Non-Emergency Oxygen in Adults In Managed Services	
2. Brief Aims and Objectives: (Copy from Form 1)	<p>To provide a unified clinical approach to the administration and care of adult patients requiring oxygen therapy, within BCUHB. The use of supplementary oxygen is considered to be a medicine and should be managed in the same way as all other medicines in its method of administration.</p> <p>All adult patients who require emergency / supplementary oxygen therapy receive therapy that is appropriate to their clinical condition and in line with national guidance (British Thoracic Society Guideline; Thorax, 2017)¹. Oxygen will be prescribed according to a target saturation range. The system of prescribing target saturation aims to achieve a specified outcome, rather than specifying the oxygen delivery method alone. Those who administer oxygen therapy will monitor the patient and keep within the target saturation range.</p> <p>This policy outlines the administration and use of oxygen in adults within all BCUHB healthcare settings. The clinical steps which should be taken by registered clinicians before administering oxygen to patients. It also outlines equipment which should be used to administer oxygen therapy and the roles and responsibilities of staff caring for patients receiving oxygen.</p>	
3a. Could the impact of your decision/policy be discriminatory under equality legislation?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>

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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 checked="" type="checkbox"/>	No <input 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"/>
	Record here the reason(s) for your decision i.e. what did Forms 2 & 3 indicate in terms of positive and negative impact for each characteristic?	
5. If you answered 'no' above, are there any issues to be addressed e.g. mitigating any identified minor negative impact?	Yes <input type="checkbox"/>	<input checked="" type="checkbox"/>
	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?	Via incident reporting and audit
	Who is responsible?	Medicines Management Nurses/Medical Gas Committee
	What information is being used?	E.g. will you be using existing reports/data or do you need to gather your own information? The incident reports are already collated as part of the incident exception reporting for site Q & S meetings.
	When will the EqlA be	01/02/2022

	reviewed? (Usually the same date the policy is reviewed)	
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7. Where will your decision or policy be forwarded for approval?	BCUHB Policies & Procedures sub-group; Drugs & Therapeutics Group; QSG; 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 has been sent to the following for consultation:</p> <p>Respiratory Teams; Acute Physicians; ED consultants, Medical Directors (Area and Secondary Care); Directors of Nursing (Area and Secondary Care); Consultant Anaesthetists; Medical Gas Committee; Resuscitation Managers; Clinical Governance Lead Nurses; BCUHB Matrons; Practice Development Nurses ED & Critical Care,; HMP Berwyn.</p>
--	---

9. Names of all parties involved in undertaking this Equality Impact Assessment:	Name	Title/Role
	Louise Howard-Baker	Assistant Director for Pharmacy & Medicines Management
	Pam Lloyd	Respiratory Specialist Nurse/PORT Coordinator
	Dr Liz Brohan	Consultant Respiratory Physician

Please Note: The Action Plan below forms an integral part of this Outcome Report

Form 4 (ii): Action Plan

This template details any actions that are planned following the completion of 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:			
2. What changes are you proposing to make to your document or proposal as a result of the EqlA?			
3a. Where negative impacts on certain groups have been identified, what actions are you taking or are proposed to mitigate these impacts? Are these already in place?			
3b. Where negative impacts on certain groups have been identified, and you are proceeding without mitigating them, describe here why you believe this is justified.			

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Betsi Cadwaladr
University Health Board

	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.			



Report Title:	Unlicensed Medicines Policy
Report Author:	Louise Howard-Baker Assistant Director Pharmacy and Medicines Management
Responsible Director:	Dr Berwyn Owen, Director of the Pharmacy & Medicines Management Division
Public or In Committee	Public
Purpose of Report:	Approval of the Policy
Approval / Scrutiny Route Prior to Presentation:	BCU Medicines Policies Procedures PGD Subgroup 24.4.19 BCU Drugs and Therapeutics Group 1.5.19 Quality, Safety Group (QSG) 8.5.19
Governance issues / risks:	<p>None identified.</p> <p>This is a new policy. The Medicines Code (MMO2) historically included a section on unlicensed medicines. The Medicines Code has been reviewed and unlicensed medicines processes are now a standalone policy.</p> <p>The policy describes the processes and procedures for the prescribing, procurement and handling of unlicensed medicinal products. Licensed medicines are subject to stringent control by the Medicines and Healthcare products Regulatory Agency (MHRA). This is not the case for unlicensed medicines. Therefore there is a need for a robust governance process to assure patient safety and prescribers' professional responsibility and potential liability.</p>
Financial Implications:	<p>None identified</p> <p>Governance processes described within the Policy ensure the financial implication of purchasing unlicensed medicines is considered as part of the approval process.</p>
Recommendation:	The Committee is asked to approve the Policy

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

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

Disclosure:

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

Board/Committee Coversheet v10



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CYMRU
NHS
WALES

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Betsi Cadwaladr
University Health Board

**Version &
Reference
Number**

UNLICENSED MEDICINES POLICY

Author & Title	Louise Howard-Baker Assistant Director Pharmacy and Medicines Management				
Responsible dept / director:	Executive Medical Director				
Approved by:	BCUHB Drugs and Therapeutics Group				
Date approved:	Date approved				
Date activated (live):	Date becomes live				
Documents to be read alongside this policy:	NHS Wales Policy MD21 Making Decisions on Individual Patient Funding Requests (IPFR) MM01 BCUHB Medicines Policy MM03 Non medical Prescribing Protocol for Supplementary and Independent Prescribers. MD01 Guide to Consent for Examination or Treatment Management of RED, BLUE & AMBER with Shared Care Prescribing Requests				
Date of next review					
Date EQIA completed:	12 th April 2019				
First operational:	New policy April 2019				
Previously reviewed:	N/A				
Changes made yes/no:					

PROPRIETARY INFORMATION

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1. Executive Summary

The term 'unlicensed medicine' is used to describe medicines that have no licence for use in the UK.

Prescribing unlicensed medicines may be necessary where:

- There is no suitably licensed medicine that will meet the patient's need.
- A suitably licensed medicine that would meet the patient's need is not available.
This may arise where, for example, there is a temporary shortage in supply;

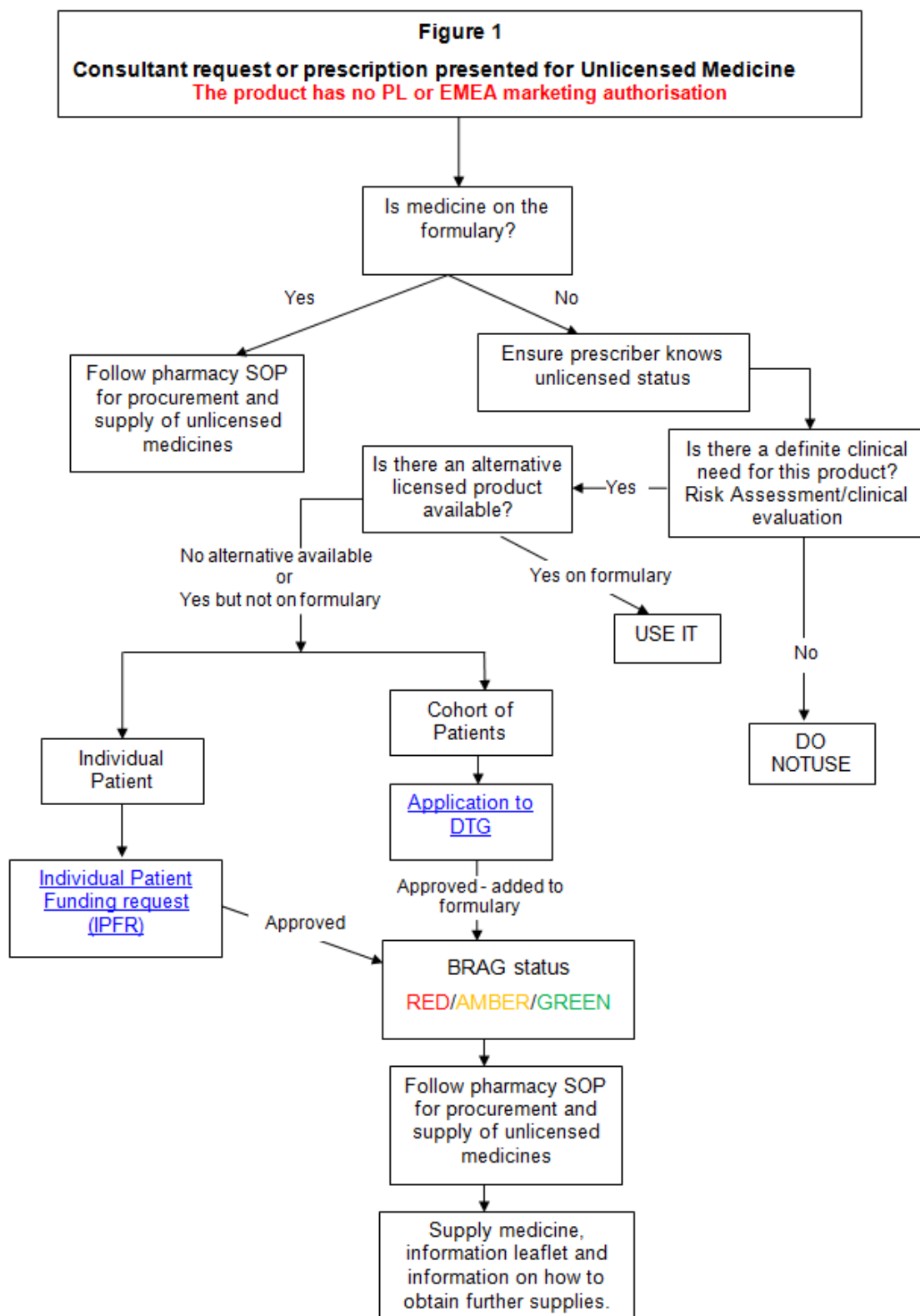
When prescribing an unlicensed medicine clinicians must:

- Be satisfied that there is sufficient evidence or experience of using the medicine to demonstrate its safety and efficacy;
- Take responsibility for prescribing the medicine and for overseeing the patient's care, monitoring, and any follow up treatment, or ensure that arrangements are made for another suitable doctor to do so;
- Make a clear, accurate and legible record of all medicines prescribed and, where common practice is not being followed, the reasons for prescribing an unlicensed medicine.

This policy sets out the process, governance and responsibilities for the use of unlicensed medicines in BCUHB so that in the event of harm to a patient, the liability rests not with the prescriber, but with the organisation.

The flowchart on the following page is a summary of the process to be followed when considering the use of an unlicensed medicine.

In the event of an emergency, consultants may seek approval retrospectively via the same process.



2. Introduction and Policy Statement

This document describes the Betsi Cadwaladr University Health Board (BCUHB) policy and procedure for the prescribing, procurement and handling of unlicensed medicinal products.

Licensed medicines are subject to stringent control by the Medicines and Healthcare products Regulatory Agency (MHRA). However, neither the prescriber nor the pharmacist can make assumptions concerning the quality, safety and efficacy of unlicensed products as the same controls for licensed medicines do not apply. *Prescribing unlicensed medicines alters the prescriber's professional responsibility and potential liability. The prescriber should be able to justify and feel competent in using such medicines and also inform the patient or the patient's carer that the prescribed medicine is unlicensed (BNF).*

Unlicensed medicinal products should only be used to meet the special clinical needs of an individual patient when:

- There is no pharmaceutically equivalent licensed product or suitable alternative licensed product available for use at the time the patient requires it.
- The clinical benefits are expected to outweigh the potential risks of treatment and the use of the product is clearly justified.

As the use of these medicines carries increased liability for the Health Board and the prescriber, The BCUHB Drugs and Therapeutics Group have the responsibility to consider risk implications in the use of medicines to ensure their safe use of medicines within the Health Board.

There is a strict hierarchy to be followed when selecting the medicine to be used:

Most preferred	1 UK or EU licensed medicine.	Lowest
	2 Off label use of a UK or EU licensed medicine.	
	3 An imported product licensed in another country	
	4 A Special product manufactured in the UK by an approved Specials manufacturer or facility.	
	5 An extemporaneously dispensed medicine.	
	6 An imported product not licensed in source country	
Least preferred	7 Non-UK made unlicensed medicine or food supplement	Highest

3. Purpose of the Document

The purpose of this policy is to define the responsibilities of staff involved in the use of unlicensed medicines and this policy should be used in conjunction with the NHS Wales Policy MD21: Making Decisions on Individual Patient Funding Requests (IPFR) and Pharmacy Standard Operating Procedures (Pharmacy Staff).

This policy describes the assessments necessary for unlicensed medicines used within BCUHB to ensure that the provision of treatment for all patients is safe and efficacious.

NHS Indemnity covers negligent harm caused to patients when they receive an established treatment, whether or not in accordance with an agreed external guideline or protocol. This extends to a novel or unusual treatment (including unlicensed and off label use of medicines) which, in the judgement of the health care professional, is appropriate for that particular patient. It also covers patients who participate in authorised clinical research. Therefore BCUHB will apply NHS Indemnity to prescribers in respect to negligence claims related to prescribing. It is essential that prescribers can demonstrate adherence to current legislation, best practice (such as MDT reviews) the BCUHB Unlicensed Medicines Policy and the overarching BCUHB Medicines Policy.

4. Scope

This policy covers the:

- Prescribing, procurement and handling of non-formulary medicines, which are unlicensed, for an individual patient or a cohort of patients.
- The procurement of formulary medicines which are unlicensed.
- Extemporaneous preparation of medicines.

The document is intended for use by all healthcare professionals employed within the BCUHB who are engaged in the prescribing, supply or administration of medicines.

This document should be read in conjunction with all related procedural documents.

This policy does not cover:

- Medicines that have a UK product licence or EMEA Marketing authorisation but the use is 'off-label';
- Investigational medicinal products (clinical trial materials);
- Over-labeling of licensed medicines;
- Medical devices;
- Repackaged licensed products e.g. A & E pre-packs;
- The combination (mixing) of injectable medicines in palliative care^{1,2};
- Cosmetic products;
- Products made by BCUHB aseptic services under their manufacturing specials licence, e.g. antibiotic minibag and minibag plus systems, heparin syringes, insulin syringes and morphine and patient controlled anaesthesia syringes; TPN.
- Manipulation of the presentation e.g. crushing of tablets

¹ Department of Health (2010) Mixing of medicines prior to administration in clinical practice: medical and non-medical prescribing. HMSO, London. Available from: www.dh.gov.uk

² Home Office (2012) Nurse and pharmacist independent prescribing, 'mixing of medicines', possession authorities under patient group directions and personal exemption provisions for Schedule 4 Part II drugs. Circular 009/2012. <https://www.gov.uk>

5. Duties and Responsibilities

5.1 Prescribers

Prescribers are responsible for the patient's welfare and must be aware of this when they are considering prescribing an unlicensed medicine. In the case of adverse events they may be called upon to justify their actions.

The prescriber responsible for the care of the patient is responsible for:

- Being aware of the licensed status of the medicines they prescribe for the indication.
- Considering the possibility that the patient's GP might not accept the prescribing responsibility before starting treatment and therefore the ongoing prescribing and supply for the patient.
- Their knowledge, information or experience to show that they are acting reasonably in the best interests of the patient.
- Ensuring that the use of the unlicensed medicine is justified by the clinical condition of the patient.
- Ensuring that the indication for using an unlicensed medicine is recorded in the patient's medical record.
- Ensuring that the patient has provided informed consent when treatment with an unlicensed medicine is planned and that this is documented. This should include information about all significant risks (including material risks to the patient in question), benefits and alternatives, including no treatment. A Patient Information Leaflet for this purpose is given. These leaflets are available via the intranet for downloading.
- Ensuring that where responsibility for ongoing care is to be transferred to the patient's General Practitioner (GP), which will depend on the BRAG status assigned by the BCUHB Drugs and Therapeutics Group, that the GP is informed of the unlicensed status of the medicine before the responsibility is transferred and that he or she is willing to accept clinical and legal responsibility for prescribing. The hospital prescriber is responsible for continuing treatment if the GP will not accept responsibility for continuing care. The discharge letter and outpatient clinic letter must include the following unlicensed medicine details:
 - i. A statement indicating the unlicensed status of the medicine
 - ii. Indication
 - iii. Duration of treatment
 - iv. Drug name, strength, dose and frequency
 - v. Dosage form (e.g. tablet, capsule, liquid and strength)
 - vi. Confirmation that source of supply of the unlicensed medicine has been provided to the patient
 - vii. Specific formulation needs (e.g. alcohol-free for liquids and strength of liquid)
- Whenever an unlicensed medicine is considered which has not been approved for use for the same circumstances (indication or dose), the consultant must complete and submit the appropriate application form (See

Figure 1). [Refer to BRAG list for complete list of indications and formulary status](#)

- Ensuring that all incidents of adverse effects are recorded and sent to the MHRA commission on Human Medicines via the yellow card scheme and via the Health Board's Datix clinical incident reporting form.

Junior doctors and independent prescribers acting under the direction of a consultant are authorised to prescribe unlicensed medicines, provided the consultant has been authorised to take responsibility for the use of the specified unlicensed medicine in accordance with this policy. The consultant responsible for the care of the patient ensures that the prescriber initiating treatment is familiar with the status of the medicine, and any clinical guidance or treatment protocols relevant to its use.

Non-medical Prescribers can prescribe unlicensed medicines but must follow the same requirements set out in this Policy. (See Non-medical Prescribing Guidance for Supplementary and Independent Prescribers MM03).

Supplementary prescribers may prescribe an authorised unlicensed medicine as part of a clinical management plan.

5.2 Health Board Designated Pharmacist

On behalf of the Chief Pharmacist, the BCUHB Medicines Procurement & Homecare Lead Pharmacist (or in their absence, either the Lead Pharmacist for Patient Safety or Hospital Operations) is the 'designated pharmacist' with overall responsibility for controlling the procurement and supply of unlicensed medicines. The designated pharmacist can delegate specific unlicensed medicines responsibilities to appropriate pharmacy staff in area/on site where the request has been made.

The designated pharmacist is responsible for:

- Ensuring that prescribers are always aware that the medicine they have requested is only available as an unlicensed product, and ensuring that an equivalent licensed product is not available.
- Ensuring that written procedures cover all aspects of the risk assessment, procurement and issue of unlicensed medicines are produced, authorised and reviewed by the Drugs and Therapeutics Group.
- Ensuring that any new unlicensed medicine requests undergo a risk assessment and are assigned a risk category prior to procurement. The Consultant is informed of any unlicensed medicine assessed as high risk.
- Liaising with hospital operations leads to ensure that pharmacy staff have received appropriate training on the procedures covering unlicensed medicines.
- Ensuring that all controls specified in the policy are applied, including the maintenance of appropriate records of use.
- Monitoring and auditing the handling of unlicensed medicines within the Ysbyty Gwynedd, Ysbyty Glan Clwyd and Ysbyty Wrecsam Maelor pharmacy departments.

- ### 5.3 Site Pharmacy Team

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- Procuring and handling unlicensed stock following BCUHB standard operating procedures in line with MHRA standards.
- Completing purchasing for safety risk assessments on receipt of new unlicensed medicines.
- Compiling reports on unlicensed medicines for assessment by BCUHB Drug and Therapeutics Group.

5.4 Pharmacy staff

Pharmacists are responsible for:

- Ensuring that prescribers are aware that the medicine they have requested is only available as an unlicensed product, and ensuring that an equivalent licensed product is not available. If a licensed medicine is available, this should always be used first.
- Ensuring that the use of an unlicensed medicine is justified by clinical circumstances.
- Ensuring that the process on page 7 for the authorisation of the use of an unlicensed medicine is followed
- Ensuring that the prescribing consultant has completed and signed the relevant paperwork before an unlicensed medicine is dispensed.
- Ensuring that the patient has received an unlicensed medicine information leaflet and the GP, community pharmacist and patient know how to obtain further supplies if appropriate.
- Complying with the pharmacy procedures for receipt and releasing of unlicensed medicines within the Health Board where needed.

5.5 BCUHB Drug and Therapeutics Group (DTG)

BCUHB Drug and Therapeutics Group is responsible for:

- Approving the introduction of new medicines, including unlicensed medicines into the Health Board.
- Ensuring unlicensed use of medicines is justified by published evidence or sound therapeutic argument and reviews the risk assessment of the unlicensed medicine carried out by the Pharmacy Medicines Management Team.
- Monitoring all unlicensed medicines used within the Health Board
- The DTG also ensures that appropriate audit systems are in place to monitor compliance with this policy.
- The DTG is responsible for ensuring no suitable licensed alternative product is available for procurement.

6. Liabilities

Liability can include fault (or negligent liability) and strict liability:

Strict Liability – where the manufacturer is liable for defective product under the Consumer Protection Act or Product Liability Directive (EEC/85/374). Should any problems arise because of defects associated with the quality of the medicine, or its use in approved clinical situation, the Health Board can transfer liability to the manufacturer provided the product implicated in the problem can be linked to the manufacturer.

Fault Liability – where a prescriber gives an unlicensed medicine and prescribes or administers it negligently, fails to inform the patient of side effects or fails to obtain informed consent. The patient can bring an action for damages if he/she has suffered injury whilst undergoing a course of treatment and the medicinal product was defective without need to prove negligence.

BCUHB will indemnify an employee in respect of any litigation resulting from the use of an unlicensed medicine, provided that adherence to current legislation and guidance can be demonstrated as specified in this policy. See MM01 BCUHB Medicines Policy.

7. Consent of Patients, Carers and Parents

Health professionals must respect the right of patients, carers and parents to participate in discussions regarding the health care of the patient and to seek to ensure that these decisions are properly informed. The information should include all significant risks (including material risks to the patient in question), benefits and alternatives, including no treatment.

See MD01 Guide to Consent for Examination or Treatment

<http://howis.wales.nhs.uk/sitesplus/documents/861/MD01%20-%20Guide%20to%20Consent%20for%20Examination%20or%20Treatment.pdf>

A record should be made in the patient's clinical notes clearly indicating that such information has been given.

Consent must be obtained from the patient or their carer when treatment with an unlicensed medicine is planned and this must be documented.

Patient Information - when prescribing an unlicensed medicine the responsibility for informing the patient resides with the consultant.

All patients, including outpatients, should receive a generic unlicensed medicines Patient Information Leaflet. The Leaflet should explain why it is necessary to prescribe unlicensed medicines and should be available on wards and in the pharmacy. The information in the leaflet may help to allay any concerns that patients and carers may have about unlicensed or medicines. These leaflets are available via the intranet for downloading.

8. Request for Unlicensed Medicines

The application for an unlicensed medicine should be made by the consultant making the recommendation (where it is not their patient)

Document number here :

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8.1 New Unlicensed Medicine

For new unlicensed medicines applications, divisional support for funding must be agreed and then the following documents should be submitted to the Health Board Medicines Governance Lead Pharmacist or Formulary Pharmacist for processing and submission to the Drugs and Therapeutics Group:

- [Individual Patient Funding Request Form](#) (for individual patients) **or**
- Completed [DTG form](#) for an addition to the BCUHB Formulary (for multiple patients)
- Completed Unlicensed Medicines Risk Assessment (see section 9)

When considering a request to approve an unlicensed medicine, the DTG must be certain that there is no suitable licensed alternative product available.

The supporting clinical data is reviewed with respect to supply chain difficulties, the possibility of interruptions to patient treatment, and any consequences these may have.

8.3 Subsequent Requests

Once approved for cohort use by BCUHB Drug and Therapeutics Group, further supplies of the unlicensed medicine can be made against prescriptions written by:

- The primary requesting Consultant's team and primary care, where the responsibility has been accepted (See page 8).
- Subsequent consultants wishing to use the unlicensed medicine for the same indication as specified by the primary consultant.

Where approval has been given only for an individual patient, any subsequent consultant requests for individual patients will need to be made via the IPFR route, or for a cohort of patients via the formal DTG application process outlined in 8.1.

If a subsequent consultant wishes to use the unlicensed medicine for a **different indication** to that specified by the primary consultant, they must submit their application via the IPFR process for an individual patient or via the Drug and Therapeutics Group route for a cohort of patients for approval.

The consultant prescribing the unlicensed medicine is clinically responsible for its use and any untoward effects that may arise from its use. However, when one consultant *recommends* the use of an unlicensed medicine to a fellow colleague for use in a particular patient, it is both the recommending consultant and the prescribing consultant who are jointly responsible for its clinical use.

8.4 Long term supply problem of licensed products

Where a long term supply problem of a pharmaceutical product is identified by the medicines management team and an unlicensed equivalent is available, then the Health Board designated pharmacist can authorise the procurement subject to

approval from DTG via SBAR and completion of an Unlicensed Medicines Risk Assessment Tool.

A DTG application form together with an Unlicensed Medicines Risk Assessment Tool can be considered by DTG if a medicine is used across the Health Board. However, prior approval will be necessary from the BCUHB Clinical Lead.

9. Risk Assessment of New Unlicensed Medicines

All requests for new unlicensed medicines require an Unlicensed Medicines Risk Assessment. These will be completed by the pharmacy team (See section 8.1).

9.1 Purchasing for Safety Risk Assessment

Following procurement a purchasing for safety risk assessment will be performed by the pharmacy medicines management team on the actual unlicensed medicine product. The initial assigned risk category will be reviewed as part of this process.

An initial low risk unlicensed medicine may become medium or high risk if for example, the labelling details are entirely written in a foreign language or the product's brand name is too similar to an existing approved medicine name.

10. Approval of Unlicensed Medicines

10.1 Urgent Clinical Requests for Unlicensed Medicines

The BCUHB Drug and Therapeutics Group executive can grant approval for the use of a non-formulary medicine or unlicensed medicines for individual patients using the IPFR application prior to a BCUHB DTG meeting.

11. Procurement and Supply of Unlicensed Medicines

Unlicensed medicines must be sourced in line with the BCUHB standard operating procedure, Procurement and Receipt of Unlicensed or Medicines.

Pharmacy will manage the safe and timely issue of approved unlicensed medicines within the Health Board using the pharmacy stock control system (EDS). Specific consultant cost centre codes can be added against each unlicensed medicine on EDS. This restricts the supply of that particular unlicensed medicine to those prescribers approved by BCUHB to prescribe and use it.

Unlicensed medicines will be dispensed against individual patient prescription requests and a record of the unlicensed medicine, patients name, dosage, batch number, expiry date and quantity is made each time an unlicensed medicine is dispensed.

The exception that will be allowed is where the product has been deemed low risk and is needed immediately in department/ward areas as part of patient treatment.

The unlicensed medicine can be supplied from Pharmacy Stores against a ward or department stock list if appropriate.

Unlicensed medicines must not be supplied under a Patient Group Direction (PGD).

12. Monitoring and Review of Unlicensed Medicines

The Medicines Management Team will maintain a list of all unlicensed medicines in use within the Health Board, and the consultants that have been approved to prescribe each medicine. The team will review each product over a five-year cycle and re-evaluate using the current Unlicensed Medicine Risk Assessment documentation. The review will include a re-assessment of the original clinical data, any new clinical data and newly licensed products that may be appropriate. The BCUHB DTG will monitor the review process.

Unlicensed medicines used to manage long term supply problems will be monitored and assessed by BCUHB DTG.

13. Funding of Unlicensed Medicines

Funding needs to be approved for all new unlicensed medicine requests. The Health Board designated pharmacist and the relevant divisional pharmacist will calculate the cost impact based on the request details. Funding approval needs to be gained from the appropriate Area/Secondary Care management team before the application is submitted to DTG for consideration.

14. Clinical Evidence Database

Unlicensed medicines risk assessments will be held on a pharmacy shared drive ensuring that full documentation is available for any future requests.

15. Record Keeping

All records of receipt and issue of unlicensed medicines should be kept for a minimum of 5 years as should all details of any suspected adverse drug reactions to the product supplied. (See section 16).

16. Adverse Drug reactions and Defective Products

Adverse drug reactions and defective products involving unlicensed medicines are handled and reported in the same way as licensed medicines. All healthcare professionals should report serious adverse drug reactions to the Medicines and Healthcare Regulatory Agency using the yellow card system, by either sending the form (copies available in the BNF, MIMS, and ABPI Compendium and Health Board Datix incident reporting systems) or electronically at www.yellowcard.gov.uk.

Suspected defects in unlicensed medicines are reported to the Pharmacy Department or the on-call pharmacist (out-of-hours) who will follow the Pharmacy Department's standard operating procedure for reporting defects.

17. Continuing Supplies of Unlicensed Medicines

17.1 Primary Care

The Drugs and Therapeutics Group will assign a colour coded prescribing status when it evaluates the application and the medicine and its status added to the [BRAG formulary](#).

If the advice is that the treatment with an unlicensed medicine under this policy should be continued following discharge from the Health Board's secondary care, full details of the treatment protocol where applicable and unlicensed medicine details must be provided to the patient's GP via the discharge letter (See Section 5.1 Prescriber Responsibilities for details needed).

If the unlicensed medicine has been assigned a Green or Amber with shared care status, the GP will then decide whether he/she will accept responsibility for the continued use of the unlicensed' medicine in his/her patient.

The GMC states that *'Decisions about who should take responsibility for continuing care or treatment after initial diagnosis or assessment should be based on the patient's best interests, rather than on your convenience or the cost of the medicine and associated monitoring or follow-up.'*

GPs will only consider continuing prescribing when the unlicensed medicine is an unlicensed formulation of a UK licensed medicine, or if it has an international licence, for example, not licensed within the UK, but has a licence within an EU country or from a country with EU mutual recognition.

If the patient's GP agrees to accept responsibility for prescribing the unlicensed medicine, then details of the source of supply of the unlicensed medicine and the patient's preferred community pharmacy must be faxed to the GP. This will be done by the clinical pharmacist responsible for the patient's care.

If the unlicensed medicine has been assigned a Red Status, or the GP will not accept responsibility for the prescribing of the unlicensed medicine, then the Health Board's consultant must decide whether he/she wishes to continue to prescribe the medicine on an outpatient basis with continued supply being met and liability being accepted by the Health Board.

17.2 Secondary Care

If a patient is admitted to the Health Board and is already being prescribed a non-formulary unlicensed medicine from another source (e.g. General Practitioner, a Consultant from another Health Board or tertiary hospital), the prescriber responsible for the care of the patient must decide whether he/she will accept responsibility for the continued use of the unlicensed medicine. If it is decided to continue to use the unlicensed medicine, then an IPFR form is required and all other principles outlined in this policy will apply to the prescribing, supply and administration of the unlicensed medicine.

18. Definitions

A **Certificate of Analysis** is a certificate issued by the supplier of an unlicensed medicine to its recipient, giving details of the analytical testing which has been carried out on the unlicensed medicine, and the results of this testing.

The **Designated Pharmacist** is a pharmacist employed by the Health Board who has been designated as having responsibility for the procurement and supply of unlicensed medicines within the Health Board on behalf of the Chief Pharmacist.

An **Extemporaneously Dispensed** medicine is a medicine which has been prepared “from its individual ingredients” by, or under the supervision of a pharmacist, in response to or in anticipation of a prescription.

A **Manufacturer’s Specials Licence** is a licence issued by the Medicines and Healthcare products Regulatory Agency (MHRA) to organisations wishing to produce batches of unlicensed products and place them on the market in the UK, where the manufacturing site and its operations are inspected for compliance with Good Manufacturing Practice and the conditions of the licence.

A **Marketing Authorisation** (previously a product licence) is a licence granted by the MHRA to manufacturers, but not to those holding a manufacturers specials licence, for medicines, which meet their standards of safety, quality and efficacy. A marketing authorisation is normally necessary before a medicine can be prescribed or sold (unless made by a holder of a manufacturer’s licence). The legal status of medicines is part of the marketing authorisation.

‘off-label’ Use of medicines is when a licensed medicine is used for a clinical indication which is not in the list of approved indications or the approved doses for that product in its product licence/marketing authorisation details e.g. may not be licensed for use in children, or large doses of psychiatric medicines in mental health. Such use presents an increased risk.

Sections 9, 10 and 11 are sections of the Medicines Act 1968 describing the exemption from the need to hold a manufacturer’s licence by doctors (Section 9), pharmacists (section 10) and nurses (section 11) when preparing medicinal products.

Unlicensed Medicines are medicines which have not been licensed for use and do not have a marketing authorisation (MA) by the Medicines and Healthcare products Regulatory Agency (MHRA) or European Medicines Agency (EMA) respectively. It is usually possible to obtain supplies of these medicines from the manufacturer or through a specialist importer.

Unlicensed medicines can be categorised as below:

- Medicines prepared by a UK manufacturer but not on sale in this country.

- Products awaiting the grant of a UK Product Licence.
- Products undergoing clinical trials.
- Manufactured for export or may have been withdrawn from the UK market (e.g. for safety or commercial reasons).
- Medicines prepared for a patient in accordance with a prescriber's instructions. This includes any form of extemporaneous preparation and dispensing:
 - Preparation of liquids
 - Total Parenteral Nutrition (TPN) compounding
 - Intravenous additive
 - Cytotoxic reconstitution services.
- Specials - Unlicensed Medicines obtained from a hospital or commercial supplier with a Specials Manufacturing Licence.
- Re-packed Medicines - when a medicine is removed from its original container and re-packed, the product becomes unlicensed. This can include dispensing or the assembly of small packs for use as ward stock. Such operations can be commissioned from a packaging unit holding a Specials Manufacturing (Assembly) Licence.
- Imported Medicines - these medicines may have a full product licence in a European Union (EU) or non-EU country but do not have a licence in the UK. They are often imported directly from the manufacturer or through a specialist importer.
- Orphan Products - these medicinal products are for diagnosing, preventing or treating rare life-threatening or very serious conditions that do not affect more than 5 in 10,000 persons in the EU. Pharmaceutical companies unwilling to develop such products under normal market conditions are able to apply for marketing authorisation for orphan designation, hence the product does not have a full product licence.

Sources of Unlicensed Medicines

- Commercial 'Specials' manufacturer - holding a 'specials' manufacturing licence e.g. making liquids of commonly used tablets
- 'Ethical' company with a UK base – a company whose main business is the manufacture of licensed products, but who will supply unlicensed products on an individual 'named patient' basis
- Importers of licensed products from an EU country - where a product is licensed in an EU country other than in the UK
- Importer of licensed products from a non-EU country
- UK manufacturer whose product is not on sale in this country
- Importer of unlicensed medicines
- Hospital manufacturing unit holding a 'specials' manufacturing licence

- Unlicensed medicines are sourced in response to, or in anticipation of, the signed order of a prescriber to meet the special needs of individual patients.

A Wholesale Dealer's Licence is a licence issued by the MHRA to organisations carrying out wholesale dealing of licensed and/or unlicensed medicines

19. Reference to Legislation

The Medicines Act 1968

References

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4. Royal Pharmaceutical Society of Great Britain: Medicines, Ethics and Practice (38) July 2014.
5. Nursing and Midwifery Council. Standards for medicines management. February 2008
BCUHB Hospital Medicines Code MM02
<http://howis.wales.nhs.uk/sitesplus/documents/861/MM02%20Hospitals%20medicines%20code%2024.11.14.pdf>
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<http://howis.wales.nhs.uk/sitesplus/documents/861/MM03%20-%20NON%20MEDICAL%20PRESCRIBING%20GUIDANCE%20FOR%20SUPPLEMENTARY%20AND%20INDEPENDENT%20PRESCRIBERS.pdf>
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11. The Association of Paediatric Palliative Medicine Master Formulary.
<http://howis.wales.nhs.uk/sitesplus/documents/861/APPM%20Formulary%202017.pdf>



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Betsi Cadwaladr
University Health Board

EQUALITY IMPACT ASSESSMENT FORMS

PARTS A and B: SCREENING AND OUTCOME REPORT

Introduction:

These forms have been designed to enable you to record, and provide evidence of how you have considered the needs of all people (including service users, their carers and our staff) who may be affected by what you are writing or proposing, whether this is:

- *a policy, protocol, guideline or other written control document;*
- *a strategy or other planning document e.g. your annual operating plan;*
- *any change to the way we deliver services e.g. a service review;*
- a decision that is related to any of the above e.g. commissioning a new service or decommissioning an existing service.

This is not optional: Equality Impact Assessment is a specific legal requirement on public sector organisations under equalities legislation and failure to comply could result in a legal challenge to a decision or strategy. More importantly, equality impact assessment helps to inform better decision-making and policy development leading to improved services for patients. **This form should not be completed by an individual alone, but should form part of a working group approach.**

The Forms:

You must complete:

- **Part A** – this is the Initial Screening that is always undertaken and consists of Forms 1 to 3; these forms are designed to enable you to make an initial assessment of the potential impact of what you are doing, and decide whether or not you will need to proceed to a Full Impact Assessment (Part C);

AND

- **Part B** – this is the Outcome Report and Action Plan (Form 4) you will need to complete whether or not you proceed to a Full Impact Assessment;

Together, these forms will help to provide evidence of your Impact Assessment and how you have shown “due regard” to the duties.

You may also need to complete **Part C** (see separate Form) – if parts A and B indicate you need to undertake a Full Impact Assessment. This enables you to fully consider all the evidence that is available (including engagement with the people affected by your document or proposals) to tell you whether your document or proposal will affect people differently. It also gives you the opportunity to consider what changes you may need to make to eliminate or mitigate any adverse or negative impact you have identified.

Remember that these forms may be subject to external scrutiny e.g. under a Freedom of Information request.

Once completed, the EqIA Forms should accompany your document or proposal when it is submitted to the appropriate body for approval.

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?	Unlicensed Medicines Policy
2.	Provide a brief description, including the aims and objectives of what you are assessing.	<p>The term 'unlicensed medicine' is used to describe medicines that have no licence for use in the UK.</p> <p>Prescribing unlicensed medicines may be necessary where:</p> <ul style="list-style-type: none">• There is no suitably licensed medicine that will meet the patient's need.• A suitably licensed medicine that would meet the patient's need is not available. This may arise where, for example, there is a temporary shortage in supply; <p>The purpose of this policy is to define the responsibilities of staff involved in the use of unlicensed medicines and this policy should be used in conjunction with the NHS Wales Policy MD21: Making Decisions on Individual Patient Funding Requests (IPFR) and Pharmacy Standard Operating Procedures (Pharmacy Staff).</p>

		<p>This policy describes the assessments necessary for unlicensed medicines used within BCUHB to ensure that the provision of treatment for all patients is safe and efficacious.</p> <p>.</p>
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?	Medical Director
4.	Is the Policy related to, or influenced by, other Policies/areas of work?	<p>BCUHB Medicines Policy</p> <p>NHS Wales Policy MD21</p> <p>Making Decisions on Individual Patient Funding Requests (IPFR)</p> <p>MM03 Non medical Prescribing Protocol for Supplementary and Independent Prescribers.</p>
5.	Who are the key Stakeholders i.e. who will be affected by your document or proposals?	Prescribers (Medical and Independent); Pharmacy Staff
6.	What might help/hinder the success of whatever you are doing, for example communication, training etc?	Communication & Training

Form 2: Considering the potential impact of your document, proposals etc in relation to equality and human rights

Characteristic or other factor to be considered	Potential Impact by Group. Is it:-		Please detail here, for each characteristic listed on the left:- (1) any Reports, Statistics, Websites, links etc. that are relevant to your document/proposal and have been used to inform your assessment; and/or (2) any information gained during engagement with service users or staff; and/or any other information that has informed your assessment of Potential Impact.
	Positive (+) Negative (-) Neutral (N) No Impact/Not applicable (N/a)	High Medium or Low	
Age	N		<p>Licensed medicines are subject to stringent control by the Medicines and Healthcare products Regulatory Agency (MHRA). However, neither the prescriber nor the pharmacist can make assumptions concerning the quality, safety and efficacy of unlicensed products as the same controls for licensed medicines do not apply. <i>Prescribing unlicensed medicines alters the prescriber's professional responsibility and potential liability. The prescriber should be able to justify and feel competent in using such medicines and also inform the patient or the patient's carer that the prescribed medicine is unlicensed (BNF).</i> This policy therefore has no impact in relation to equality and human rights. It is about making prescribing practice safer for the BCUHB population as a whole.</p>
Disability	N		
Gender Reassignment	N		
Marriage & Civil Partnership	N		
Pregnancy & Maternity	N		
Race / Ethnicity	N		
Religion or Belief	N		
Sex	N		
Sexual Orientation	N		
Welsh Language	N		
Human Rights	N		

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

<p>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:-</p> <ul style="list-style-type: none"> • Eliminate unlawful discrimination, harassment and victimisation; • Advance equality of opportunity; and • Foster good relations between different groups 	
1. Describe here (if relevant) how you are ensuring your policy or proposal does not unlawfully discriminate, harass or victimise	The EqIA helped to screen the policy for unlawful discrimination.
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)	All patients treated fairly, kept informed of the nature of their treatment (licensed or licensed use).

Part B:

Form 4 (i): Outcome Report

Organisation:	BETSI CADWALADR UNIVERSITY HEALTH BOARD		
1. What is being assessed? (Copy from Form 1)		Unlicensed Medicines Policy	
2. Brief Aims and Objectives: (Copy from Form 1)		<p>The term 'unlicensed medicine' is used to describe medicines that have no licence for use in the UK. Prescribing unlicensed medicines may be necessary where:</p> <ul style="list-style-type: none">• There is no suitably licensed medicine that will meet the patient's need.• A suitably licensed medicine that would meet the patient's need is not available. This may arise where, for example, there is a temporary shortage in supply; <p>The purpose of this policy is to define the responsibilities of staff involved in the use of unlicensed medicines and this policy should be used in conjunction with the NHS Wales Policy MD21: Making Decisions on Individual Patient Funding Requests (IPFR) and Pharmacy Standard Operating Procedures (Pharmacy Staff).</p> <p>This policy describes the assessments necessary for unlicensed medicines used within BCUHB to ensure that the provision of treatment for all patients is safe and efficacious.</p>	
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 & 3 indicate in terms of positive and negative impact for each characteristic?</p> <p>There was a neutral impact on all groups against who discrimination could take place.</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 type="checkbox"/>
	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 type="checkbox"/>	No <input checked="" type="checkbox"/>
	How is it being monitored?	BCUHB Drugs and Therapeutic Group will receive a report on compliance with the Policy, but this will not include any equality issues.
	Who is responsible?	
	What information is being used?	E.g. will you be using existing reports/data or do you need to gather your own information?
	When will the EqIA be reviewed? (Usually the same	

	date the policy is reviewed)	
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7. Where will your decision or policy be forwarded for approval?	Medicines Policies and Procedures sub-group Drugs and Therapeutics QSG QSE
--	---

8. Describe here what engagement you have undertaken with stakeholders including staff and service users to help inform the assessment	The draft has been to consultation with BCUHB consultants, members of Drugs and Therapeutics Group and pharmacy staff
--	---

9. Names of all parties involved in undertaking this Equality Impact Assessment:	Name	Title/Role
	Louise Howard-Baker	Assistant Director Pharmacy & Medicines Management (East)
	Andrew Merriman	Technical Services Lead Pharmacist
	Karen Herbert	Procurement lead Pharmacist
	Suzanne Cotter	Paediatric lead pharmacist
Please Note: The Action Plan below forms an integral part of this Outcome Report		

Form 4 (ii): Action Plan

This template details any actions that are planned following the completion of EqIA including those aimed at reducing or eliminating the effects of potential or actual negative impact identified.

	Proposed Actions	Who is responsible for this action?	When will this be done by?
1. If the assessment indicates significant potential negative impact such that you cannot proceed, please give reasons and any alternative action(s) agreed:			
2. What changes are you proposing to make to your document or proposal as a result of the EqIA?			
3a. Where negative impacts on certain groups have been identified, what actions are you taking or are proposed to mitigate these impacts? Are these already in place?			

	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.			



Report Title:	Medicines Policy (Updated) MM01
Report Author:	Judith Green, Lead Pharmacist Medicine (East)/ Acting BCU Governance Pharmacist
Responsible Director:	Dr Berwyn Owen, Director of the Pharmacy & Medicines Management Division
Public or In Committee	Public
Purpose of Report:	Approval of the Policy
Approval / Scrutiny Route Prior to Presentation:	BCU Medicines Policies Procedures PGD Subgroup 24.4.19 BCU Drugs and Therapeutics Group 1.5.19 Quality Safety Group (QSG) 8.5.19
Governance issues / risks:	<p>None identified.</p> <p>Three amendments:</p> <p>1. Use of Off Label Medicines</p> <ul style="list-style-type: none"> – Section 1.5 on page 5 – New paragraph added to 'Prescriber Responsibility' section on page 17 to address indemnity – New section 4.2.5 prescribing off label medicines (page 29) – New section administration of off label medicines (page 54) <p>2. New legislation for pregabalin and gabapentin</p> <ul style="list-style-type: none"> – Amendment to section 9.94 to address change to CD legalisation <p>3. Chapter 16 'Administration of parenteral medicines for the purpose of saving a life in an emergency'.</p> <ul style="list-style-type: none"> – Addition of glucose 10% and 20% in line with JBDS guidance and BCU guidance on management of hypoglycaemia <p>All amendments highlighted in yellow</p>
Financial Implications:	None identified
Recommendation:	The Committee is asked to approve the Policy

<p>Health Board's Well-being Objectives (indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)</p>	<p>WFGA Sustainable Development Principle (Indicate how the paper/proposal has embedded and prioritised the sustainable development principle in its development. Describe how within the main body of the report or if not indicate the reasons for</p>
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		<i>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			
Special Measures Improvement Framework Theme/Expectation addressed by this paper			
Leadership and Governance			
Equality Impact Assessment			
See attached			

Disclosure:

*Betsi Cadwaladr University Health Board is the operational name of Betsi Cadwaladr University Local Health Board
Board/Committee Coversheet v10*

MM 01**BCU MEDICINES POLICY**

Author & Title	BCUHB MEDICINES POLICY Medicines Policy Task and Finish Group Editorial Group Medicines Governance Lead Pharmacist Medicines Management Nurses Associate Director of Nursing (Chapter 8 HCSWS)
Responsible dept / director:	Pharmacy & Medicines Management Clinical Division Dr Berwyn Owen, Chief Pharmacist
Approved by:	Quality and Safety Executive
Date approved:	18.3.19
Date activated (live):	XX
Documents to be read alongside this document:	<p>BCU Medicines Management Policies</p> <ul style="list-style-type: none"> • MM 03 Non-Medical Prescribing Protocol for Supplementary and Independent Prescribers Policy • MM05 Intrathecal chemotherapy policy • MM08 BCUHB Code of Practice for BCUHB staff with pharmaceutical companies (also providing guidance for General Practitioners and other independent health contractors • MM11 Guidance for Nurse Independent Practitioner (INP) V100 /V150 prescribers • MM 12 Procedure for the Management of Medication Administration Incidents and Near Misses including Management of Nursing / Midwifery Staff, or other Registered Healthcare Professionals • MM 15 Guidance for Administration and use of Emergency and Non-Emergency Oxygen in Adults In Acute and Community Hospitals • MM16 BCUHB Written Control Document for Guidance on the Transcription of Medicines • MM 21 BCUHB self administration guideline • MM31 BCUHB Policy for the prescribing, supply and administration of methotrexate for hospital inpatients • MM33 Guidelines for Community Staff on the removal of unwanted medication from a patient's home • MM PGD 01 Patient Group Directions -Procedure and Guidance for Authors and Users • Injectable Medicines Policy – awaiting ratification • Unlicensed Medicines Policy – awaiting ratification • Covert Administration of Medicines Clinical Protocol <p>Standard Operating Procedures</p> <ul style="list-style-type: none"> • Pharmacy Department's Clinical Trial Standard Operating Procedures PCT01 • Guidelines • Standard Operating Procedure BCUHB Safe

	discharge of all patients taking warfarin <ul style="list-style-type: none"> • BCUHB Critical Medicines Guide • SOP for destruction of CDs for authorised witnesses
	BCU Documents (non medicines management) <ul style="list-style-type: none"> • F03 BCUHB Local Anti Fraud, bribery and corruption Policy • WP6 BCUHB Code of Conduct (Disciplinary rules and standards of behaviour • NU01 Discharge Protocol • IMMS 04 Storage and handling of Vaccines Written Control Document • RES 03 BCUHB Cardiopulmonary Resuscitation (CPR) Policy • CSPM 01 Guidance for ensuring Safety and Quality of Chemotherapy Services • MD 17 Interventions not normally undertaken (INNU) • BCUHB Guideline for the in-patient management of adult patients addicted to opioids • ES 03 Waste Management Policy
	National Policies or Documents <ul style="list-style-type: none"> • All Wales Pharmacist Enabling Therapeutic Switch (PETS) Policy • AWMSG All Wales Multidisciplinary Medicines Reconciliation Policy • Codes of Conduct for Regulatory Bodies of all health professional • MARRS All Wales Policy for Medicines Administration, Recording, Review, Storage and Disposal (2015) • PSN 15 'The storage of medicines: Refrigerators 2015 • PSN 030, The safe storage of medicines: Cupboards 2016
Date of next review:	April 2022
Date EqIA completed:	April 2015

First operational:	12/2015 Replaces MM02– Medicines Code				
Previously reviewed:	12/ 2015	09/2018	04/2019		
Changes made yes/no:	YES (MM02)	YES (MM01)	YES		

N.B. Staff should be discouraged from printing this document. This is to avoid the risk of out of date printed versions of the document. The Intranet should be referred to for the current version of the document.

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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** are medicines that do not hold a UK or European marketing authorisation/ product licence. If a product holds a licence which is not valid in the UK it is not considered licensed in the UK and must be treated as an unlicensed product. See BCUHB Unlicensed Medicines Policy

- **Off label medicines** are licensed medicines used outside the terms of their marketing authorisation/ product licence.

- **Manufactured specials** are unlicensed medicines that have been specially prepared by the holder of a Manufacturers Specials Licence in response to or in anticipation of the order of a doctor/ prescriber to meet the specific needs of an individual patient. See BCUHB Unlicensed Medicines Policy

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:

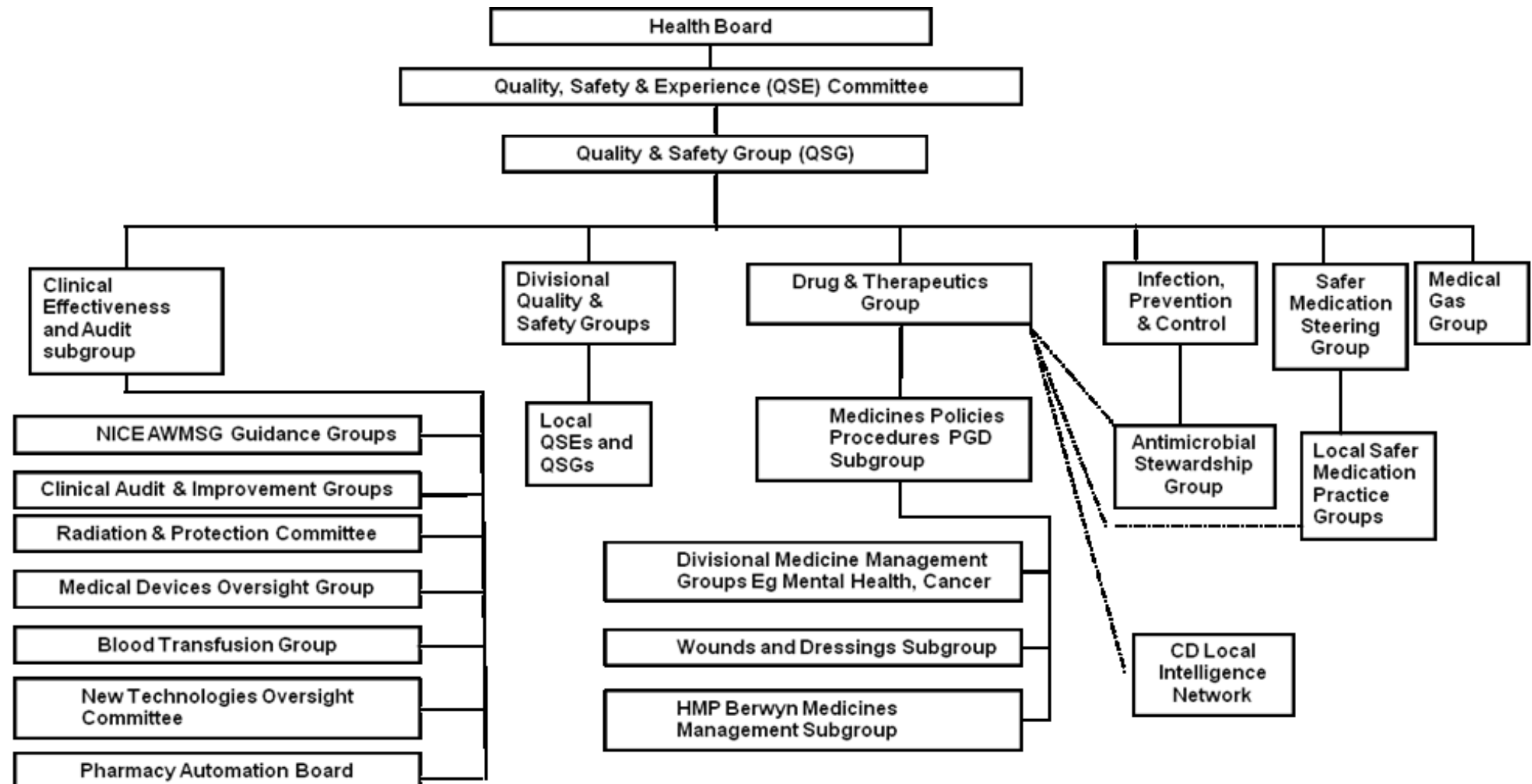
- Providing a safe, effective, efficient and secure system for medicine stocks held within pharmacy.
- Providing a safe, effective, efficient and secure system for medicine distribution.

- 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)

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 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.

NHS Indemnity covers negligent harm caused to patients when they receive an established treatment, whether or not in accordance with an agreed external guideline or protocol. This extends to a novel or unusual treatment (including unlicensed and off-label medicines) which, in the judgement of the health care professional, is appropriate for that particular patient. It also covers patients who participate in authorised clinical research. Therefore BCUHB will apply NHS Indemnity to prescribers in respect to negligence claims related to prescribing. It is essential that prescribers can demonstrate adherence to current legislation, best practice (such as MDT reviews) and the overarching BCUHB Medicines Policy.

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. chlorthalidopoxide, 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

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^o 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									
				OCTOBER		2018											
DATE →	22/10/18	22	23	24	25	26	27	28	29	30	31	1/11	2/11	3/11	4/11		
ROUTE →	TOP	MEDICINE (Approved Name)		SPECIAL INSTRUCTIONS		PRESCRIBER'S SIGNATURE		PHARMACIST SIGNATURE		DISCHARGE PRESCRIPTION							
		FENTANYL PATCH		EVERY 72 HOURS		A. Prescriber		P. Haymer									
SPECIFY TIME IF REQUIRED ↓	DOSE ↓ SIGN ↓ DOSE CHANGE ↓			Medicines Reconciliation (circle)		Bleep No.		SUPPLY		To be reviewed by GP		Continuous					
				Started () Continued () Dose Changed ()		1234											
Morning	✓ 12 micrograms																
Midday																	
Evening																	
Bedtime																	
																Limited Duration	
																days	
																Other instructions	

Another example is oral alendronic acid:

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 →	22/10/18	22	23	24	25	26	27	28	29	30	31	1/11	2/11	3/11	4/11		
ROUTE →	PO	MEDICINE (Approved Name)		SPECIAL INSTRUCTIONS		PRESCRIBER'S SIGNATURE		PHARMACIST SIGNATURE		DISCHARGE PRESCRIPTION							
		ALENDRONIC ACID		WEEKLY - TUES		A. Prescriber		P. Haymer									
SPECIFY TIME IF REQUIRED ↓	DOSE ↓ SIGN ↓ DOSE CHANGE ↓			Medicines Reconciliation (circle)		Bleep No.		SUPPLY		To be reviewed by GP		Continuous					
				Started () Continued () Dose Changed ()		1234											
Morning	0600 70mg																
Midday																	
Evening																	
Bedtime																	
																Limited Duration	
																days	
																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 BCU Unlicensed Medicines Policy

4.2.5 Off Label medicines

Prescribing a medicine outside of its marketing authorisation, either for indication or dose is described as 'off-label' use. Such use presents a higher risk than using a medicine in accordance with the marketing authorisation. It is therefore the responsibility of the prescriber to ensure the rationale for its use is appropriate and is clearly documented.

Prescribers must be satisfied that such use would better serve the patient's needs than an appropriately licensed alternative before prescribing a medicine off-label and should:

- be satisfied that there is a sufficient evidence base and/or experience of using the medicine to show its safety and efficacy
- take responsibility for prescribing the medicine and for overseeing the patient's care, including monitoring and follow-up
- record the medicine prescribed and, where common practice is not being followed, the reasons for prescribing this medicine. Prescribers may wish to record that they have discussed the issue with the patient

Transfer of responsibility for ongoing off-label medicine use to the patient's General Practitioner (GP) will depend upon the BRAG status of the medicine. BRAG status is assigned by the BCUHB Drugs and Therapeutics Group (DTG). The GP must be informed of the off label use before the prescribing responsibility is transferred, who must agree to accepting clinical and legal responsibility for the off-label prescribing. The hospital prescriber is responsible for continuing treatment if the GP will not accept responsibility for continuing care.

The same principles apply regarding patient information, patient consent and prescriber liability, as for unlicensed medicine use. BCUHB DTG is responsible for providing the governance and monitoring of both unlicensed and off-label medicines. See BCU Unlicensed Policy for further details.

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 →		23/7		MEDICINE (Approved Name)		SPECIAL INSTRUCTIONS		PRESCRIBER'S SIGNATURE		PHARMACIST	
ROUTE →		SC		NOVORAPID		WITH MEALS		A. DOCTOR		SUPPLY	
SPECIFY TIME IF REQUIRED ↓		DOSE ↓		SIGN ↓		Medicines Reconciliation (circle)		Bleep No. 1234			
		UNITS				Started Continued Dose Changed					
Morning		6									
Midday		6									
Evening		8									
Bedtime											

DATE →		23/7		MEDICINE (Approved Name)		SPECIAL INSTRUCTIONS		PRESCRIBER'S SIGNATURE		PHARMACIST	
ROUTE →		SC		LANTUS				A. DOCTOR		SUPPLY	
SPECIFY TIME IF REQUIRED ↓		DOSE ↓		SIGN ↓		Medicines Reconciliation (circle)		Bleep No. 1234			
		UNITS				Started Continued Dose Changed					
Morning											
Midday											
Evening											
Bedtime		16									

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 2m² 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 as 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[®]' 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 Administration of unlicensed and 'off-label' medicines

A registered nurse can administer an unlicensed medicine with the patient's consent against a prescription but not against a patient group direction (PGD). Medicines which are being used in an "off-label" manner can also be administered against a prescription. Off label medicines can also be administered under a PGD, if their use is exceptional, justified by best practice and the status of the product is clearly described.

When administering either unlicensed or 'off-label' medicines, the nurse must be satisfied that:

- There is sufficient information available to administer the medicine safely
- There is acceptable published evidence for the use of the medicine for the intended indication or a clear documented rationale

7.10 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.

7.11 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.

7.12 Covert administration

Refer to the Covert Administration of Medicines Guideline

7.13 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.

7.14 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.

7.15 Non-availability of medicines in hospitals

7.15.1 Non availability when pharmacy is closed

See chapter 5

7.15.2 Borrowing of Medicines

See chapter 5

7.16 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.

7.17 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.

7.18 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

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 Specification Medication	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/Omnicell) / 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	Standard Operating Procedure for Healthcare Support Workers/Assistants & to act as an independent 2nd Checker for the checking of Controlled Drugs stock levels	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	Standard operating procedure (SOP) and competence assessment for the administration of Low Molecular Weight Heparin (Clexane® (Enoxaparin Sodium)/ Fragmin® (Dalteparin)) by Health Care Support Workers in Community hospitals and Community Settings	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	Standard operating procedure (SOP) and competence assessment for the administration of medication of per rectum (e.g. suppositories, micro enemas) by Health Care Support Workers in Community hospitals and Community Settings	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)	Procedure for the preparation, observation, assessment and supervision of health care support worker to undertake the	Level 3 or above on the QCFW (2006), in addition to the specific skills. Completed

		administration of insulin for clinically stable named adults	competence assessment
Application of creams/ointments to patients delegated by registered practitioner	A CN CH	Standard operating procedure (SOP) and competence assessment for the application of creams/ointments to patients specified by registered practitioners by Health Care Support Workers in Community hospitals and Community Settings	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	<p>Standard operating procedure (SOP) and competence assessment for the administration of eye drops to patients specified by registered practitioners by Health Care Support Workers in Community hospitals and Community Settings</p> <p>Standard operating procedure (SOP) and competence assessment for the administration of nose drops to patients specified by registered practitioners by Health Care Support Workers in Community hospitals and Community Settings</p> <p>Standard operating procedure (SOP) and competence assessment for the administration of ear drops to patients specified by registered practitioners by Health Care Support Workers in Community hospitals and Community Settings.</p>	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)	Standard operating procedure (SOP) and competence assessment for the administration of transdermal patches to patients specified by registered practitioners by Health Care Support Workers in Community hospitals and Community Settings.	Level 3 or above on the QCFW (2006), in addition to the specific skills. Completed competence assessment
Administration of medicines by mouth,	CN (only)	Standard operating procedure (SOP) and	Level 3 or above on the QCFW

in liquid or solid dosage form (tablets including sub-lingual and capsules) only to patients specified by registered practitioner		competence assessment for the administration of medicines by mouth, in liquid or solid dosage form (tablets including sub-lingual and capsules) to patients specified by registered practitioners by Health Care Support Workers in Community hospitals and Community Settings	(2006), in addition to the specific skills. Completed competence assessment
Administration of medication via inhalers, spacers device specified by registered practitioner	CN (only)	Standard operating procedure (SOP) and competence assessment for the administration of medication by inhalation using a metered dose inhaler (MDI) to patients specified by registered practitioners by Health Care Support Workers in Community hospitals and Community Settings.	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 Standard operating procedure (SOP) and competence assessment for the administration of medication by inhalation using a nebulizer to patients specified by registered practitioners by Health Care Support Workers in Community hospitals and Community Settings.	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 specified medicines via Enteral tube route (NG, PEG) only to patients specified by registered practitioner.	CN (only)	SOP Administration of medication via Gastrostomy	Level 3 or above on the QCFW (2006), in addition to the specific skills. Completed competence assessment
Discontinue infusions delivered	CH CN	Standard operating procedure (SOP) and	

subcutaneously and remove syringe driver or infusion device		competence assessment for the removal and disposal of subcutaneous infusions by Health Care Support Workers in Community hospitals and Community Settings.	
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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 nd 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	Standard Operating Procedure for Healthcare Support Workers/Assistants & to act as an independent 2nd Checker for the administration of Controlled Drugs	Level 3 or equivalent or above on the CQFW (2006). In addition, completion of independent second check competency Completed competence assessment
2 nd 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 nd 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
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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, tramadol, pregabalin and gabapentin

Temazepam, midazolam, tramadol, pregabalin and gabapentin 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, pregabalin and gabapentin do not need 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 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, tramadol pregabalin and gabapentin

	CD Order	CD Storage	CD Records	Administration
Temazepam	YES	YES	YES	Two nurses
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)

Midazolam	YES	NO	NO	* Single nurse for buccal route and when nurse is familiar with the medication (Two nurses for IV route)
Pregabalin and gabapentin	YES	NO	NO	Single nurse

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
PATIENTS'S OWN CDs					
Sent from clinical area	Pharmacy	Pharmacist or registered pharmacy technician Denaturing Kit	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 Denaturing Kit	Pharmacist or registered technician	Pharmacy CD Destruction Register	The patient must consent to the destruction
Patient deceased	Pharmacy	Pharmacist or registered pharmacy technician Denaturing Kit	Pharmacist or registered technician	Pharmacy CD Destruction Register	Can be destroyed without the consent of patient's estate (or relatives)
WARD STOCK CDs					
Excess/unwanted or expired	Pharmacy	Pharmacist or registered pharmacy technician Denaturing Kit	Pharmacist or registered technician	Clinical area: CD Register Pharmacy: CD destruction Register	
WASTAGE					
Part doses drawn up on ward for individual patient e.g. when 5mg dose from 10mg ampoule	Clinical area	Registered nurse or midwife Empty into sharps bin	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 theatre for individual patient eg. 5mg dose from 10mg ampoule	Theatre	Registered: nurse, midwife or ODP Empty into sharps bin	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
WASTAGE					
Dose drawn up in a clinical area for individual patient but not given	In the clinical area	Registered nurse or midwife Empty into sharps bin	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 Empty into sharps bin	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 Empty into sharps bin	Registered nurse, midwife, doctor or pharmacist	Clinical area CD register	Details of amount discarded should show name of patient and reason for non-administration
PHARMACY					
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 (CDLO) 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 either be retained for destruction by the CDLO or it can be handed over to the Police on their request when making an arrest. Full details of the crime number and arresting officer should be made and the CDLO should be informed.

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 CPSPM01 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

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 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:

C34	Keep out of the reach of children	MS 35931	
14 Tablets	CLARITHROMYCIN 250mg		
	ONE to be taken TWICE a day.		
BATCH NO. A103 EXPIRY DATE 15 JUN 15	Take at intervals of approximately 12 hours. Complete the course unless otherwise directed.	Name: _____ Date: _____	
Pharmacy, Wrexham Maelor Hospital Tel: 01978 725959 1/1			

A8	Keep out of the reach of children	MS 35931	
100ml	AMOXYCILLIN SYRUP 250mg/5ml		
	Take ____ x 5ml spoonful(s) THREE times a day for ____ days.		
BATCH NO. A103 EXPIRY DATE 15 JUN 15	Take at regular intervals. Complete the prescribed course unless otherwise directed.	Name: _____ Date: _____	
SHAKE THE BOTTLE. STORE IN A REFRIGERATOR. Discard any remaining solution once course is complete.			
Pharmacy, Wrexham Maelor Hospital Tel: 01978 725959 1/1			

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 midwife
- Doctor
- Pharmacist or pharmacy technician
- Physiotherapist

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
Adults		
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
Procedures		
For urinary catheter insertion Flexible cystoscopy insertion (urology) Coil insertion (DSH)	Instillagel® (contains chlorhexidine check allergy status)	Once only prior to procedure
Local anaesthetic for topical application where there is no PGD in place	Ametop® / EMLA®	Once only prior to procedure
Analgesia If the patient has liver disease seek medical advice. Do not administer with other paracetamol containing products		
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 10% , 20% and 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>

Glucose 10% and 20% has been added to the Human Medicines Regulation list in line with the JBDS –IP Joint British Diabetes Societies for Inpatient care 'The Hospital Management of Hypoglycaemia in Adults with Diabetes Mellitus' 3rd edition April 2018

https://abcd.care/sites/abcd.care/files/resources/20180508_JBDS_HypoGuideline_Revised_v2.pdf

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: All stationery which could be used to obtain medicines fraudulently.

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°C to -23°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

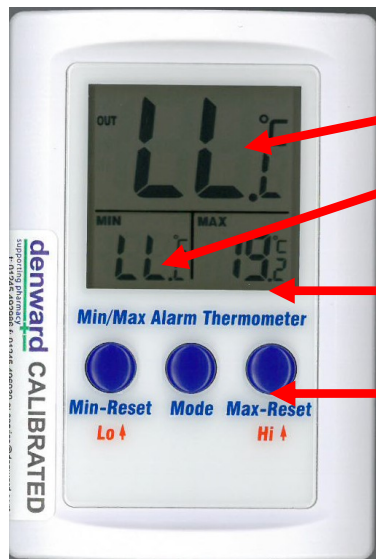
Ysbyty Wrexham Maelor 01978 726346

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 ⁰ c to -23 ⁰ 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



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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 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?	Medicines Policy MM01
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"> • Set out the operational responsibilities of all healthcare staff with regards to medicines management. • Describe the governance structure for medicines management • Provide guidance on the safe and secure use of medicines
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>BCU Medicines Management Policies</p> <ul style="list-style-type: none"> • MM 03 Non medical Prescribing Protocol for Supplementary and Independent Prescribers Policy • MM05 Intrathecal chemotherapy policy • MM08 BCUHB Code of Practice for BCUHB staff with pharmaceutical companies (also providing guidance for General Practitioners and other independent health contractors • MM11 Guidance for Nurse Independent Practitioner (INP) V100 /V150 prescribers • MM 12 Procedure for the Management of Medication Administration Incidents and Near Misses including Management of Nursing / Midwifery Staff, or other Registered Healthcare Professionals • MM 15 Guidance for Administration and use of Emergency and Non-Emergency Oxygen in Adults In Acute and Community Hospitals • MM16 BCUHB Written Control Document for Guidance on the Transcription of Medicines • MM 21 BUCHB self administration guideline • MM31 BCUHB Policy for the prescribing, supply and administration of methotrexate for hospital inpatients

- [MM33](#) Guidelines for Community Staff on the removal of unwanted medication from a patient's home
- [MM PGD 01](#) Patient Group Directions -Procedure and Guidance for Authors and Users
- Injectable Medicines Policy – currently a section in Medicines Code, has been removed as will become a stand alone Policy
- Unlicensed Medicines Policy – awaiting ratification
- [Covert Administration of Medicines Clinical Protocol](#)

Standard Operating Procedures

- Pharmacy Department's Clinical Trial Standard Operating Procedures [PCT01](#)
- Guidelines
- BCUHB [Critical Medicines Guide](#)
- [SOP for destruction of CDs for authorised witnesses](#)
- SOP for the Return of Controlled Drugs (CD's) from Community Hospitals to the Acute Site pharmacy department with transport

BCU Documents (non medicines management)

- [F03](#) BCUHB Local Anti Fraud, bribery and corruption Policy
- [WP6](#) BCUHB Code of Conduct (Disciplinary rules and standards of behaviour
- [NU01](#) Discharge Protocol
- [IMMS 04](#) Storage and handling of Vaccines Written Control Document
- [RES 03](#) BCUHB Cardiopulmonary Resuscitation (CPR) Policy
- [CSPM 01](#) Guidance for ensuring Safety and Quality of Chemotherapy Services
- [MD 17](#) Interventions not normally undertaken (INNU)
- [BCUHB Guideline for the in-patient management of adult patients addicted to opioids](#)
- [ES 03](#) Waste Management Policy

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?	<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?	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, <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 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"> • 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	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
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Part B:

Form 4 (i): Outcome Report

Organisation:	BETSI CADWALADR UNIVERSITY HEALTH BOARD		
1. What is being assessed? (Copy from Form 1)	Medicines Policy MM01		
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">• Set out the operational responsibilities of all healthcare staff with regards to medicines management.• Describe the governance structure for medicines management• Provide guidance on the safe and secure use of medicines		
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 & 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	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

you implement your document or proposal?	When will the EqIA be reviewed? (Usually the same date the policy is reviewed)	In 3 years
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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"> • Doctors, (consultants, junior and speciality doctors) • All pharmacy staff • Matrons, Community Matrons • Medical and Nursing Directors • Theatres • Paediatrics • Mental Health • HMP Berwyn • Primary Care • Resus Committee • Estates <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
Please Note: The Action Plan below forms an integral part of this Outcome Report		

Form 4 (ii): Action Plan

This template details any actions that are planned following the completion of 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:			

	Proposed Actions	Who is responsible for this action?	When will this be done by?
2. What changes are you proposing to make to your document or proposal as a result of the EqIA?			
3a. Where negative impacts on certain groups have been identified, what actions are you taking or are proposed to mitigate these impacts? Are these already in place?			
3b. Where negative impacts on certain groups have been identified, and you are proceeding without mitigating them, describe here why you believe this is justified.			
4. Provide details of any actions taken or planned to advance equality of opportunity as a result of this assessment.			

**Quality, Safety &
Experience Committee**
21.5.19

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To improve health and provide excellent care

Report Title:	Section 17 Leave of Absence Policy MHLD 0044
Report Author:	Wendy Lappin, Mental Health Act Manager
Responsible Director:	Mr Andy Roach, Director of Mental Health and Learning Disabilities Division
Public or In Committee	Public
Purpose of Report:	The S17 policy is a statute document in relation to the Mental Health Act 1983 as amended 2007. The Health Board must ensure that all staff who work with patients who are subject to the Mental Health Act are aware of their responsibilities and the associated legalities.
Approval / Scrutiny Route Prior to Presentation:	<p>MHLD Policy Implementation Group November 2018 MHLD Divisional Q-SEEL January 2019 MHLD Divisional Directors November 2018 Professional Advisory Group – Chairs Approval April 2019 Quality Safety Group (QSG) – May 2019</p> <p>The policy has been developed alongside the other health boards within Wales to ensure that there is a standard MHA policy for all health boards with minimal differences.</p>
Governance issues / risks:	<p>The policy provides guidance on the use of leave of absence and the procedure that must be followed when granting Section 17 leave to ensure that patients detained under the Mental Health Act do not go on leave without the correct legal framework being adhered to.</p> <p>The purpose of this policy is to ensure that leave arrangements under Section 17 comply with the Mental Health Act provisions.</p> <p>The policy informs Hospital staff how to manage and record Section 17 leave.</p>
Financial Implications:	S17 Leave is a requirement of the Mental Health Act there are no additional financial implications.
Recommendation:	The Committee are asked to approve this policy for ratification

Health Board's Well-being Objectives <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>	√	WFGA Sustainable Development Principle <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	√		
Special Measures Improvement Framework Theme/Expectation addressed by this paper Mental Health Leadership and Governance			
Equality Impact Assessment The EQIA was developed in August 2018 – copy attached.			

Disclosure:

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

Number here e.g. MHL D 0044

Mental Health & Learning Disabilities Section 17 Leave of Absence Policy

Date to be reviewed:	November 2021	No of pages:	17
Author(s):	Wendy Lappin	Author(s) title:	Mental Health Act Manager
Responsible dept / director:	Director of Mental Health & Learning Disabilities		
Approved by:	MHL D Policy Group 28 th November 2018 MHL D Q-SEEL 17 th January 2019 PAG – Chairs Assurance 30 th April 2019 QSG – 8 th May 2019		
Date approved:	Date approved		
Date activated (live):	January 2019 whilst progressing through Health Board Approval Process		

Date EQIA completed:	August 2018
Documents to be read alongside this policy:	MHL D 0025 – Ty Llywelyn Section 17 and Therapeutic Leave Policy relating to Patients detained under the MHA 1983(2007) MHL D AC008 – Missing Absconding Person Policy Code of Practice for Wales (revised 2016) Mental Health Act 1983 (as amended 2007)
Purpose of Issue/Description of current changes:	Policy has been updated in line with the Code of Practice for Wales

First operational:	3rd November 2008				
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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1. Introduction and Policy Statement

A patient currently liable to be detained in a Hospital or specified Hospital Unit can only leave that Hospital lawfully – even for a very short period – by being given leave of absence under Section 17 of the Mental Health Act (the Act).

Section 17 of the Act requires the Responsible Clinician (RC) to authorise personally any leave from Hospital of a patient detained under the Act.

Section 17 applies to patients who are detained under Sections 2, 3, 37 and 47 of the Act.

For patients on Restriction orders (i.e. Section 37/41) the Responsible Clinician must seek the agreement of the Ministry of Justice before granting leave under Section 17. The Responsible Clinician is also not able to grant leave of absence to patients detained under Section 35, 36 or 38 of the Act.

Sections 35 and 36 the remanding court must be in agreement with the leave, the Responsible Clinician would need to request in writing permission from the court prior to the leave being granted. For Section 38 no leave can be granted the court must be made aware in instances of emergency treatment.

Informal patients are not subject to Section 17 leave under the Mental Health Act. A patient who is not detained has the right to leave, other than those patients subject to authorisation under the Deprivation of Liberty Safeguards (DoLS). However, patients may be asked by staff to inform them when they want to leave the ward. In the case of children, safeguarding needs and the opinion of the person with parental responsibility should be taken into account.

2. Purpose of the Document

The purpose of this policy is to ensure that leave arrangements under Section 17 comply with the Mental Health Act provisions.

The policy informs Hospital staff how to manage and record Section 17 leave.

3. Scope

This policy is concerned with inpatients who are detained under the Mental Health Act 2007 within the facilities managed by Betsi Cadwaladr University Health Board.

The policy is concerned with Section 17 leave only. (17A or Supervised Community Treatment is addressed within a separate policy).

4. Aims and Objectives

This policy provides guidance on the use of leave of absence and the procedure that must be followed when granting Section 17 leave.

5. Roles and Responsibilities

The responsibilities of the Responsible Clinician and other professional staff involved with the patient's care remain the same whilst the patient is on leave, although it is exercised in a different way. The duty to provide after-care under Section 117 Aftercare provisions applies to patients who are on leave of absence, provided they qualify.

Ward Managers and the Nurse in Charge are responsible for the implementation of the policy.

5.1 Responsible Clinician

Only the patient's Responsible Clinician can grant leave of absence to a patient detained under the Act. Responsible Clinicians cannot delegate the decision to grant leave of absence to anyone else. In the absence of the usual Responsible Clinician, e.g. if they are on leave, permission can be granted only by the Approved Clinician who is, for the time being, acting as the patient's Responsible Clinician.

Responsible Clinicians may grant leave for specific occasions or for specific or indefinite periods of time. They may make leave subject to any conditions which they consider necessary in the interests of the patient or for the protection of other people.

The Responsible Clinician can authorise the Nurse in Charge of the ward to curtail leave at his or her discretion. In practice, this is likely to be leave granted for specific occasions or specific periods.

When a patient is transferred or a change of Responsible Clinician is made the new RC MUST review any previously granted leave and either agree for continuation by completing a new Section 17 leave form or recording that this has been revoked.

5.2 Nurse in Charge

The nurse in charge has the authority to curtail leave. Leave should only be curtailed where, in the opinion of the Nurse in Charge of the ward, there is a marked deterioration in the mental state of the patient. Where the nurse considers it necessary to curtail leave, a record must be made in the patient's case notes and the Responsible Clinician must be informed at the earliest opportunity.

5.3 Nursing staff

Nursing staff are responsible for escorting patients whilst using Section 17 leave if applicable. Following the leave the nursing staff are responsible for communication in relation to how the leave went and documentation appertaining to the leave process.

6. Procedure

The flowchart should be consulted (Appendix 1)

The Responsible Clinician should ensure that when considering and planning leave the criteria identified within the Code of Practice paragraph 27.7 should be adhered to.

Leave of absence granted for specified occasions may include:

- Outpatient appointments
- Attendance at weddings/funerals
- Shopping expeditions
- Home leave

Leave of absence granted for specified periods may include:

- Overnight leave at home
- Weekend leave
- Weeks leave

The Section 17 leave form must be completed and the dates of the leave specified. To include leave details, duration, frequency and number of escorts if required. The determination of the number of escorts will be by the Responsible Clinician following discussion with the Multi Disciplinary Team to include the consideration of risks identified in risk assessments.

NOTE: Leave with relatives is regarded as UNESCORTED Leave unless this is specified as custodial leave (please see section 10).

The form must be signed and dated by the Responsible Clinician or the covering Responsible Clinician.

On return from leave whether escorted or unescorted the nursing staff must complete a mental state examination and feedback in relation to the leave any further information from family may also be ascertained.

7. Restricted Patients

Where the courts of the Secretary of State have decided that a restricted patient is to be detained in a particular unit of a hospital, that patient will require the Secretary of State's permission to have leave of absence, to go to any other part of that hospital as well as outside the hospital. (CoPW 27,35)

Following Multi-Disciplinary Team (MDT) agreement and completion of risk assessment, the Responsible Clinician must apply to the Ministry of Justice for Escorted and or Unescorted leave with the completion of leave request form available on www.justice.gov.uk. Responsible Clinicians should submit any additional information they consider would assist the Secretary of State to reach a decision.

Written authorisation from the Ministry of Justice must accompany the Section 17 documentation and be stored in the patient's notes.

The Responsible Clinician should notify the Ministry of Justice if they need to suspend the leave of any restricted patients. Consideration will then be given as to whether to revoke or rescind the leave or allow the leave to continue.

For routine medical appointments of treatment the Secretary of State's permission will be required. It is accepted that there will be times of acute medical emergency where the patient requires emergency treatment. In these situations, the Responsible Clinician may use their discretion, having due regard to the emergency or urgency being presented and the management of any risks, to have the patient taken to hospital. The Secretary of State should be informed as soon as practicable that the patient has been taken to hospital, what risk management arrangements are in place, be kept informed of developments and notified when the patient has been returned to the secure hospital. (CoPW 27.37).

8. Short Term Leave

The Responsible Clinician may decide to authorise short-term leave, managed by other staff. If the patient is subject to restrictions the authority of the Secretary of State for Justice will also be required. As an example, the patient may be given leave for a shopping trip of two hours every week, with the decision on which particular two hours left to the discretion of the responsible nursing staff. The parameters within which this discretion may be exercised should be clearly set out by the Responsible Clinician to ensure the terms of the leave prescribed, cannot be interpreted differently by the staff managing the leave of absence.

9. Longer periods of Leave

Leave may be used to assess a patient's suitability for discharge from detention. The patient should be fully involved in the decision to grant leave and should be able to demonstrate that they will be able to cope outside of the hospital.

When considering whether to grant leave for more than seven consecutive days, or extending leave so that the total period is more than seven consecutive days, Responsible Clinicians should also consider whether the patient should go on to a Community Treatment Order (CTO) instead. This does not apply to restricted patients, or, in practice, to patients detained for assessment under Section 2 of the Act as they are not eligible to be placed on a CTO. (CoPW 27.8)

The option of using a CTO does not mean the Responsible Clinician cannot use longer-term leave if that is the more suitable option, but they will need to be able to show both options have been considered. Decisions should be fully documented in the patient's notes. CoPW 27.9)

Subject to patient consent, there should be detailed consultation with appropriate relatives and friends, including, where appropriate, independent advocacy and community services.

Where relatives/friends are to be involved in the patient's care, but the patient does not agree that they should be consulted, leave should not be granted.

It is essential carers, especially where the patient is residing with them while on leave, and professionals who support the patient while on leave should know who to contact if they feel consideration should be given to return of the patient before their leave is due to end.

10. Custodial Leave

Under the Mental Health Act a Responsible Clinician may direct that a patient remains 'in custody' while on leave of absence. Patients may be kept in the custody of any officer on the staff of the hospital or any person authorised in writing by the Hospital Managers.

Custodial Leave may be used in circumstances to allow patients to participate in escorted trips or to have compassionate home leave.

The code of practice 27.25 states while it may often be appropriate to authorise leave subject to the condition a patient is accompanied by a friend or relative, responsible clinicians should only specify that the patient is to be in the legal 'custody' of a friend or relative if it is appropriate for that person to be legally responsible and that the person understands and accepts the responsibilities of being the patient's legal custodian. In the case of children, it may be appropriate for the person with parental responsibility to be the legal custodian. Otherwise leave with friends or relatives is classed as unescorted.

If custodial leave is to be used the S17 leave form must be countersigned by a suitable person to sign on behalf of the Hospital Manager as specified under the MHLA Mental Health Act Scheme of Delegation.

11. Recording of Leave

The granting of leave and the conditions attached to it, should be clearly recorded in the patient's case notes. The prescribed leave should be recorded on the Section 17 leave form (Appendix 2) be duly signed by the patient and forwarded immediately to the Mental Health Act Office.

All expired section 17 leave authorisation forms should be clearly marked as no longer valid.

Copies of the authorisation of leave form should be given to the patient, any appropriate relatives or friend and any professionals in the community who may need to be informed.

The outcome of leave, whether or not it went well, benefits achieved and particular problems encountered or concerns raised should be recorded in the patient's case notes to inform future decision-making.

The leave will be updated and recorded on any relevant IT Patient Information Systems as used within the Health Board.

12. Conditions of leave

The Responsible Clinician can attach any conditions that are considered appropriate: for example, that the patient remains in the custody of any officer on the staff of the Hospital or of any person authorised in writing by the Hospital Managers for the duration of the leave, or that they reside at a particular address during the time they are on leave

Patients, who are sent for assessment to other hospitals, should be transferred under the provisions of section 17 leave. E.g transfer to Whiston Hospital.

Patients on section 17 leave from one hospital to a second hospital remain liable to be detained in the first hospital.

***EG:** a patient is placed in Tan Y Castell from Ablett for a short time under S17 leave, the current RC will remain the Responsible Clinician for the patient as the patient has not been transferred under Section 19 of the Act.*

Section 17 leave is not required to allow a patient to be transferred from one hospital to another, transfers should be enacted under Section 19 of the Act.

***EG:** A patient is within the Hergest Unit and needs to go to the Ablett Unit, this is a transfer of care and a transfer should be facilitated under Section 19 of the Act by completion of the internal transfer documentation.*

13. Care and Treatment whilst on leave

The responsibility held by the Responsible Clinician and the Nursing staff remain the same whilst the patient is on Section 17 leave.

Where it is necessary to administer treatment to a patient who is on Section 17 leave but the patient is not consenting under Part 4 of the Act, the Responsible Clinician should decide if it would be in the best interests of the patient's health or safety or for the protection of other persons for their Section 17 leave to be rescinded.

However the refusal of treatment may not on its own be sufficient grounds for such an action and a decision should take into consideration the guiding principles in (chapter 1 Code of Practice for Wales 2016), including the least restrictive care and treatment option and maximisation of independence should be given.

13.1 Physical Disorder

Occasionally, patients detained under the provisions of the Mental Health Act will be transferred under Section 17 to local Acute Hospital for the purpose of treating their physical disorders.

Section 17 leave is not required if the patient is detained within a psychiatric unit considered part of that hospital site, eg Heddfan to Wrexham Maelor. Section 17 leave will be required for off site treatment, eg Hergest to Ysbyty Glan Clwyd.

However the Responsible Clinician will be responsible for ensuring that the staff of the receiving Acute Hospital understand the specific implications and requirements of the Section of the Mental Health Act under which the patient is detained and of the implications of Section 17 leave. In particular, the explanation must include the following:

- That detention under the Mental Health Act provides no authority to proceed with most physical treatments without the patient's valid consent.
- That the responsibility for the patient's mental health treatment remains with the Responsible Clinician and that the patient continues to be detained by the Hospital Managers of the Psychiatric Service.
- The receiving Hospital should be provided with information which will allow them speedy access to psychiatric advice and support.
- A full explanation of any risk assessments undertaken and their outcome. A risk assessment which shows any risk of absconding or the possibility of self harm or harm to others should result in a robust assessment of whether psychiatric nursing support should be provided for the duration of the patient's stay.
- Following conclusion of the physical treatment the patient should not be discharged but returned to the care of the Psychiatric Service.

14. Extension of Section 17 Leave

Section 17 leave can be extended without the patient returning to hospital. This can only be authorised by the Responsible Clinician.

15. Rescinding of Section 17 Leave

The Responsible Clinician can rescind the leave of absence under Section 17 where it is considered necessary in the interests of the patient's health or safety or for the protection of other people.

The Responsible Clinician must carefully consider the reasons for rescinding Section 17 leave and the effect it may have on the patient's care and treatment.

If rescinding the Section 17 leave is considered necessary, the Responsible Clinician must record in writing the reasons for doing so and for this record to be included in the patient's case notes. The patient must be informed of the reasons.

The current Section 17 leave form must be struck through and cancelled clearly being evident, a copy must be forwarded to the Mental Health Act Office.

The nurse in charge has the discretion to end the leave if it is felt necessary, the reasons must be communicated to the Responsible Clinician and documented in the patient's case notes.

16. Absence without leave (S18)

Where detained patients on section 17 leave in the community are absent without leave, the duty nurse should be informed immediately who will contact the Responsible Clinician.

The Responsible Clinician will decide whether the patient should be returned to Hospital and agree with the duty nurse who should be informed and how the patient should be returned, e.g. by involving the Police or the Ambulance Service.

The procedures identified in the MHL D AC008 Missing Absconding Persons Policy should be followed.

17. Information to relevant individuals

The information leaflet (Appendix 4) will be provided to the patient, carer, family member or any other relevant person as necessary once Section 17 leave has been agreed. The contact details will be completed by the nursing staff prior to the leaflet being distributed.

A copy of the S17 leave form will be provided to the patient, carer, family member or any other relevant person as necessary and in line with General Data Protection Regulations (GDPR).

18. Monitoring, Escalation and Implementation Arrangements

Ward Managers will be made aware of the policy and will be responsible for ensuring that all staff follow the procedures when leave is granted.

Mental Health Act Administration staff will continue to deliver regular training updates to staff within BCUHB to ensure staff are compliant with leave of absence for detained patients.

Records of all periods of leave will be documented in the patient's case notes. Compliance with this policy will be monitored as an integral part of the divisional clinical governance systems and audited by the Matrons and reported through the Quality and Safety Experience Groups. (Appendix 3)

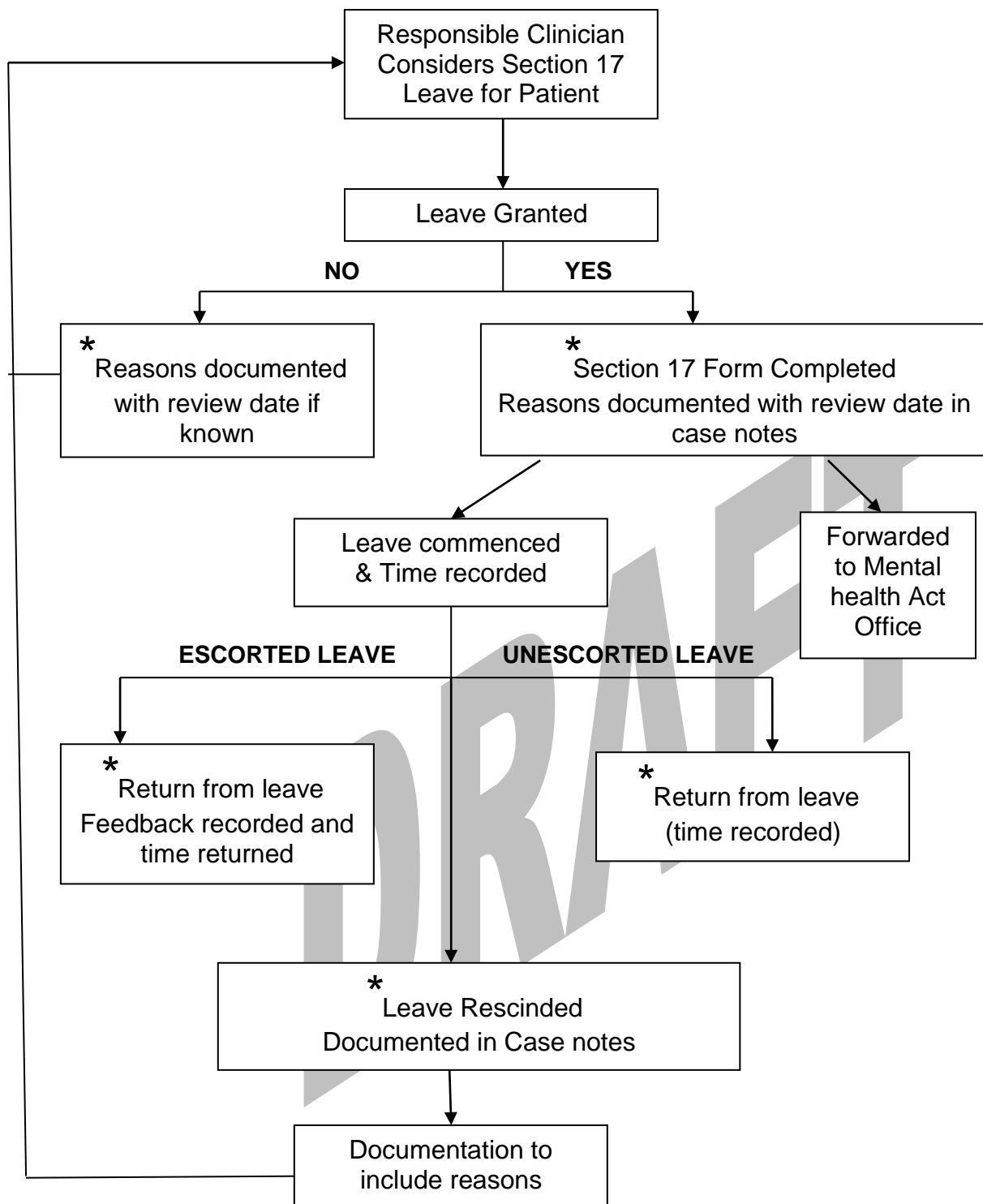
19. Reference to Legislation

Department of Health and Welsh Office, Mental Health Act revised Code of Practice for Wales 2016 ISBN 978-1-4734-7176-4

Jones R., 2016 Mental Health Act Manual 19th Edition. London: Sweet and Maxwell / ISBN 978-0-414-05748-7

Appendix 1

PROCEDURE



* Denotes for Audit purposes as per Audit Form Appendix 3

Appendix 2

PATIENT'S LEAVE OF ABSENCE
SECTION 17-MENTAL HEALTH ACT 1983

From: Dr _____
Responsible Clinician

Unit/Ward: _____

Section: _____

AFFIX ID LABEL HERE

Section 17 Leave of absence CANNOT be granted to patients detained under S37/41 unless the appropriate written permission has been obtained from either the Court or Ministry of Justice.

S37/41 Has authorisation for proposed leave been received from Ministry of Justice? YES / NO (please delete as appropriate)
If leave is for more than 7 consecutive days has a CTO been considered? YES / NO (please delete as appropriate)
Please document reasons in notes.

NB: LEAVE WITH RELATIVES IS REGARDED AS UNESCORTED LEAVE UNLESS CUSTODIAL AND AGREED BY HOSPITAL MANAGERS

Custodial leave: Yes/No **Signed on behalf of Hospital Managers:** Signature: _____ Date: _____

	LEAVE DETAILS	DURATION	FREQUENCY	ESCORTS
Within Hospital Perimeter				
Specified Location				
Unlimited Area/Specific Trips				
Overnight Leave				

This arrangement is authorised from _____ (date) to _____ (date)

Other conditions:

- Leave will only be allowed at the discretion of the Nurse in Charge of the ward at the time leave is to be taken.
- Patient may be subject to random drug or alcohol screening following leaves and/or pat down search upon return to the ward.

Signature – RC _____ Date _____

To be completed by the patient: I understand the terms and conditions of the above leave and that leave will only be allowed at the discretion of nursing staff.

Signature – PATIENT _____ Date _____

Witness – NURSE _____ (print and sign) Date _____

Copy to (please tick): Patient: ☐ GP: ☐ Keyworker: ☐ Relative/Friend (if appropriate): ☐ Other _____: ☐

Feedback regarding leave has been documented for the period above: YES / NO (please delete as appropriate)

Atodiad 2

ABSENOLDEB CLAF
ADRAN 17 - DEDDF IECHYD MEDDWL 1983

Gan : Dr _____
Clinigydd Cyfrifol

Uned / Ward: _____

Adran: _____

AFFIX ID LABEL HERE

Ni ellir caniatáu absenoldeb Adran 17 i gleifion sy'n cael eu cadw dan S37/41 oni bai bod y caniatad ysgrifenedig priodol wedi'i gael gan un ai y Lllys neu'r Weinyddiaeth Gyfiawnder.

S37 / 41 A gafwyd caniatâd ar gyfer absenoldeb arfaethedig gan y Weinyddiaeth Gyfiawnder? DO / NADDO (dileer fel sy'n briodol)

Os yw absenoldeb am fwy na 7 diwrnod yn olynol a oes CTO wedi cael ei ystyried? DO / NADDO (dileer fel sy'n briodol). Cofnodwch y rhesymau yn y nodiadau.

DS: MAE ABSENOLDEB GYDA PERTHNASAU YN CAEL EI YSTYRIED FEL ABSENOLDEB HEB GWMNI ONI BAI EI FOD YN WARCHODOL NEU WEDI'I GYTUNO ARNO GAN REOLWYR YR YSBYTY.

Absenoldeb gwarchodol: Ia / Na Llofnodwyd ar ran Rheolwyr yr Ysbyty: Llofnod: _____ Dyddiad: _____

	MANYLION ABSENOLDEB	YR	HYD	AMLLDER	HEBRYNGWYR
O fewn perimetr yr ysbyty					
Lleoliad penodol					
Ardal annherfynol / teithiau penodol					
Absenoldeb dros nos					

Cymeradwywyd y trefniant hwn o _____ (date) i _____ (date)

Amodau eraill:

- Caniateir absenoldeb yn ôl cyfarwyddyd y Nyrs Mewn Gofal y ward ar amser y cymerir yr absenoldeb.
- Efallai y bydd cleifion yn cael prawf sgrinio cyffuriau neu alcohol yn dilyn absenoldebau a/neu archwiliad wrth ddychwelyd i'r ward

Llofnod - RC _____ Dyddiad _____

I'w gwblhau gan y claf: Rwy'n deall amodau a thelerau'r absenoldeb uchod a bydd absenoldeb yn cael ei ganiatáu ar ddisgresiwn y staff
nyrsio yn unig.
Llofnod – CLAF _____ Dyddiad _____

Tyst – NYRS _____ (printiwch a llofnodwch) Dyddiad _____

Copi i (ticiwch): Claf: ☐ Meddyg Teulu: ☐ Gweithiwr allweddol: ☐ Perthynas/ffrind (os yw'n briodol): ☐ Arall _____: ☐

Mae adborth ar gyfer absenoldeb wedi'i gofnodi ar gyfer y cyfnod uchod: DO / NADDO (dileer fel sy'n briodol)

Appendix 3

Section 17 Leave for Patient Audit Form

Patient Name:

Reference No:

Section Status:

Date of Audit:

<u>SECTION 17 LEAVE GRANTED</u>					
YES			NO		
Type of leave granted and review date			Reasons and review date		
Noted in Case Notes	Yes	No	Noted in Case Notes	Yes	No
Section 17 Form completed	Yes	No			
<u>TYPE OF SECTION 17 LEAVE</u>					
ESCORTED LEAVE			UNESCORTED LEAVE		
Feedback recorded	Yes	No	Time returned from leave recorded	Yes	No
Time returned from leave recorded	Yes	No			
Additional Information			Additional Information		
Has leave been rescinded	Yes	No	Reasons documented in case notes	Yes	No

Appendix 4



Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

**TAFLEN WYBODAETH DEDDF IECHYD
MEDDWL, 1983 CYFNOD O'R YSBYTY DAN
ADRAN 17**

**MENTAL HEALTH ACT, 1983 SECTION 17
LEAVE INFORMATION LEAFLET**

Beth yw cyfnod o'r ysbyty dan Adran 17?

Mae Adran 17 yn gyfnod o'r ysbyty wedi'i drefnu sy'n rhan bwysig i baratoi'r defnyddiwr gwasanaeth ar gyfer cael ei ryddhau o'r ysbyty yn y pendraw. Bydd yn galluogi'r tîm gofal i ganfod sut mae'r defnyddiwr gwasanaeth yn datblygu, ac mae hefyd yn caniatáu ffordd o gadw mewn cysylltiad â ffrindiau a theulu, a mynychu pethau y tu allan i'r ysbyty.

Pryd y caniateir cyfnod o'r ysbyty dan Adran 17?

Bydd hyn yn wahanol ym mhob achos. Bydd yn ddibynnol ar nifer o wahanol bethau er enghraifft; effeithiau'r salwch a'r amgylchiadau, a manteision a'r risgiau y bydd y cyfnod o'r ysbyty yn eu hachosi.

Pwy sy'n gallu awdurdodi cyfnod o'r ysbyty?

Dim ond y meddyg sy'n gyfrifol am ofal y defnyddwyr gwasanaeth (a elwir yn y Clinigydd Cyfrifol neu RC) sy'n gallu awdurdodi cyfnod o'r ysbyty. Y meddyg ymgynghorol yw hwn fel arfer, ond gall fod yn feddyg arall os yw'r RC arferol i ffwrdd o'r gwaith.

Am ba mor hir y gellir caniatáu Adran 17?

Gellir ei roi am gyfnod penodol neu amhenodol. Pan fo cyfnod o'r ysbyty am fwy na 7 niwrnod yn cael ei roi, bydd y RC yn ystyried a fydd Gorchymyn Triniaeth Cymuned yn fwy addas.

I ble y gellir caniatáu Adran 17?

Bydd y RC yn cwblhau manylion y cyfnod o'r ysbyty yn ysgrifenedig megis y dyddiadau a'r amseroedd, ac unrhyw amodau sy'n berthnasol. Dylid trafod hyn â'r defnyddiwr gwasanaeth, y tîm gofal a'r teulu / gofawyr. Dylid rhoi copi o'r ffurflen cyfnod o'r ysbyty Adran 17 i'r defnyddiwr gwasanaeth ac unrhyw unigolyn arall sydd angen gwybod

What is Section 17 leave?

Section 17 is planned leave from hospital which is an important part in preparing the service user for eventual discharge from hospital. It will enable the care team from finding out how well the service user is progressing and it also allows means of keeping in touch with friends and family and attending to things outside of hospital.

When is Section 17 leave granted?

This will be different in each case. It will be dependent on a number of different things for example; the effects of illness and circumstances and the benefits and risks the leave will have.

Who can authorise leave?

Only the doctor in charge of the service users care (known as the Responsible Clinician or RC) can authorise leave. This is usually the consultant but may be another doctor if the usual RC is away.

How long can Section 17 be granted for?

It can be given for a specific or indefinite period. Where leave is given for more than 7 days the RC will consider if a Community Treatment Order will be more appropriate.

Where can Section 17 be granted to?

The RC will complete the details of the leave in writing such as the dates and times and any conditions that apply. This should be discussed with the service user, the care team and family / carers. A copy of the Section 17 leave form should be given to the service user and any other people who need to know about the leave for example the nearest relative.

am y cyfnod o'r ysbyty, er enghraifft perthynas agosaf.

A ellir atal Adran 17?

Efallai y bydd y RC wedi gadael cyfarwyddiadau i'r nyrs, na ddylid caniatáu cyfnod o'r ysbyty os yw'r defnyddiwr gwasanaeth yn sâl iawn, a bod risg os yw'r cyfnod o'r ysbyty yn cael ei ganiatáu. Bydd y RC wedi trafod y math hwn o sefyllfa pan fydd yn caniatáu'r cyfnod o'r ysbyty.

Amod o'r cyfnod o'r ysbyty yw bod y defnyddiwr gwasanaeth yn cael ei hebrwng gan aelod o staff, ac efallai y bydd oedi achlysurol i ddarparu nyrs sy'n hebrwng. Ni ddylai hyn ddigwydd yn aml iawn, ac mae'n well ei osgoi drwy gynllunio ymlaen llaw gyda'ch nyrs benodol.

A ellir ymestyn y cyfnod o'r ysbyty heb ddychwelyd i'r ysbyty?

Gellir, er hynny dim ond y RC all wneud hyn.

Pan rydych ar gyfnod o'r ysbyty dan Adran 17

Dylai defnyddwyr gwasanaeth bob amser geisio bod yn ôl ar y ward ar yr amser a gytunwyd arno, ac a nodwyd ar y ffurflen cyfnod o'r ysbyty dan Adran 17.

Os nad yw rhywun yn dychwelyd i'r ward, mae'r Ddeddf Iechyd Meddwl yn datgan bod yn rhaid i staff ysbyty ddod â'r unigolyn yn ôl i'r ysbyty, gyda chymorth eraill os oes angen.

Gwybodaeth i ofalwyr a pherthnasau

Dylai gofalwyr, perthnasau ac unigolion eraill yn y gymuned sydd angen gwybod am y cyfnod o'r ysbyty gael copi o'r awdurdodiad. Os yw'r cyfnod o'r ysbyty dan Adran 17 yn amlinellu bod yn rhaid i'r defnyddiwr gwasanaeth fod yng ngwarchodaeth gyfreithiol ffrind neu berthynas, bydd angen i'r unigolyn hwnnw ddeall y cyfrifoldeb a'i dderbyn.

Manylion cyswllt:

Cydlynnydd Gofal:.....

Ward.....

Tîm Crisis.....

Gwasanaeth IMHA.....

Can Section 17 be withheld?

The RC may have left instructions for the nurse that leave should not be given if the service user is particularly unwell and that there is a risk if the leave were to go ahead. The RC will have discussed this kind of situation when granting the leave.

It a condition of the leave is that that the service user is to be escorted by a staff member there may be an occasional delay in providing a nurse escort. This should not happen very often and is best avoided by planning ahead with your named nurse.

Can leave be extended without returning to hospital?

Yes however only the RC can do this.

Whilst out on Section 17 leave

Service users should always try to be back on the ward at the time agreed and stated on the Section 17 leave form.

If someone does not return to the ward the Mental Health Act provides that hospital staff must bring that person back to hospital with the help of others if necessary.

Information for carers and relatives

Carers, relatives and other people in the community who need to know about the leave should be given a copy of the authorisation. If the Section 17 leave specifies that the service user is to be in the legal custody of a friend or relative that person will need to both understand and accept the responsibility.

Contact details:

Care Coordinator:.....

Ward.....

Crisis Team

IMHA Service

Members of the Working Group:

Name	Title
Wendy Lappin	Mental Health Act Manager
Mark Couchman	Service Manager – Adult
Debby Land	County Manager Wrexham
Tracy Martland	AMHP/ Team Manager
Alison Parry	Matron Hergest Unit
Dr Anita Pierce	Consultant Psychiatrist / Clinical Director Central
Myfid Healy	AMHP Lead / Manager
Tracy Norcross	Modern Matron Ablett Unit

Engagement has taken place with:

Name	Title	Date Consulted
Gail Griffiths	Interim Deputy County Manager	January – September 2018
Mairead Fripps Jones	Deputy County Manager Flintshire	January – September 2018
Dawn Hunter	County Manager Denbighshire	January – September 2018
Becky Baker	County Manager Conwy	January – September 2018
Keith Saycell	Interim County Manager	January – September 2018
Jane Rowland	Modern Matron Heddfan	January – September 2018
Gaynor Kehoe	Head of Operations Central	January – September 2018
Fleur Evans	Head of Operations East	January – September 2018
Sam Watson	Head of Operations West	January – September 2018
Carole Evanson	Head of Operations County Wide	January – September 2018
Dr Masood Malik	Consultant Psychiatrist / Clinical Director East	January – September 2018
Fiona Hughes	Head of Nursing – West	January – September 2018
MHLD Division	Senior Staff and relevant persons	September 2018
Lisa Jones	Matron Ty Llywelyn	September 2018
Fiona Farquhar	Consultant Psychiatrist	October 2018



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WALES

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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.

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?	MH&LD Section 17 Leave of Absence Policy	
2.	Provide a brief description, including the aims and objectives of what you are assessing.	<p>A patient currently liable to be detained in a hospital or specified hospital unit can only leave that hospital lawfully – even for a very short period – by being given leave of absence under Section 17 of the Mental Health Act 1983.</p> <p>The policy aims to provide staff with sufficient guidance in order to ensure effective compliance with providing leave to detained patients in accordance with the Mental health Act and the Code of Practice for Wales 2016.</p> <p>The policy is required to ensure that staff are aware of their responsibilities for granting leave under the Act, aware of their responsibilities for documenting leave of absence and managing the risks that may be associated with this and to ensure that staff are aware of the procedures to follow when a patient is absent without leave (AWOL)</p>	
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?	MH&LD Policy Sub Group	
4.	Who is Involved in undertaking this EqIA? Include the names of all the people in your sub-group.	Name	Title/Role
		Wendy Lappin	Mental Health Act Manager
		Tracy Norcross	Matron Central – Ablett Unit
		Dr Anita Pierce	Consultant Psychiatrist / Clinical Director Central
		Myfid Healy	AMHP Lead / Manager
5.	Is the Policy related to, or influenced by, other Policies/areas of work?	<p>Mental Health Act 1983</p> <p>Code of Practice for Wales (Revised 2016)</p> <p>Welsh Language Act 2016</p> <p>Mental Health Wales Measure 2010</p> <p>MHLD 0025 – Ty Llywelyn Section 17 and Therapeutic Leave Policy relating to patients detained under the MHA 1983</p>	

		MHLD AC008 Missing Absconding Person Policy
6.	Who are the key Stakeholders i.e who will be affected by your document or proposals?	<p>Service Users, Registered Nursing Staff, Responsible Clinicians, Approved Clinicians, Mental Health Act Administrators and Assistants and other professionals working within Mental Health Services.</p> <p>Carers/Relatives of patients detained under certain sections of the Mental Health Act.</p>
7.	What might help/hinder the success of whatever you are doing, for example communication, training etc?	<p>Training for all Mental Health Staff</p> <p>Communication to staff</p> <p>Workflow chart.</p> <p>Cooperation of staff</p> <p>Time constraints</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, <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/a	N/a	The Mental Health Act relates to all patients suffering from a mental disorder who meet the criteria for detention, irrespective of age.
Disability	(+)	High Positive (+)	The proposed policy will apply to all patients detained regardless of disability. Persons who are disabled who are detained under the Mental Health Act would still be eligible for S17 leave at some point. Some patients with long term mental health problems may fall under the protection of disability equality law and this policy ensures consideration of their needs when assessing the risks for allowing S17 leave.
Gender Reassignment	N/a	N/a	This policy will apply regardless of whether patients have had gender reassignment or not.
Pregnancy & Maternity	N/a	N/a	This policy will apply regardless of whether patients are pregnant at the time of being detained. In relation to staff wards will have completed risk assessments in relation to staff who would be providing escorting duties for leaves.
Race / Ethnicity	N/a	N/a	The proposed policy will apply regardless of the race / ethnicity of patients or staff.
Religion or Belief	N/a	N/a	The proposed policy will apply regardless of the religion or belief of patients or staff.
Sex	N/a	N/a	The proposed policy will apply regardless of the sex of patients or staff.
Sexual Orientation	N/a	N/a	The proposed policy will apply regardless of the sexual orientation of the patients or staff.
Welsh Language	(+)	High Positive (+)	The information leaflet for the patients will be available in both English and Welsh. Welsh Language Act is a consideration and in instances where the patient is conversed with in a different language this will be a provision. Within the explanation of rights form this now details if the information has been given in the patients preferred language and will be reported on and advise staff of a patients preference.
Human Rights	(+)	High Positive (+)	The proposed policy promotes human rights in ensuring that all patients are detained lawfully and receive appropriate care in accordance with their needs.

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

<p>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:-</p> <ul style="list-style-type: none"> • 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 legal processes in relation to S17 leave are followed.
2. Describe here how your policy or proposal could better advance equality of opportunity (if relevant)	Following procedures advised and by providing a robust audit structure for ensuring the granting and recording of S17 leave is recorded adequately.
3. Describe here how your policy or proposal might be used to foster good relations between different groups (if relevant)	Better communication Joint Working between staff of the Health Board.

Part B:

Form 4 (i): Outcome Report

Organisation:	BETSI CADWALADR UNIVERSITY HEALTH BOARD
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1. What is being assessed?	MH&LD Section 17 Leave of Absence Policy
----------------------------	--

2. Brief Aims and Objectives:	<p>A patient currently liable to be detained in a hospital or specified hospital unit can only leave that hospital lawfully – even for a very short period – by being given leave of absence under Section 17 of the Mental Health Act 1983.</p> <p>The policy aims to provide staff with sufficient guidance in order to ensure effective compliance with providing leave to detained patients in accordance with the Mental health Act and the Code of Practice for Wales 2016.</p> <p>The policy is required to ensure that staff are aware of their responsibilities for granting leave under the Act, aware of their responsibilities for documenting leave of absence and managing the risks that may be associated with this and to ensure that staff are aware of the procedures to follow when a patient is absent without leave (AWOL)</p>
-------------------------------	--

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?	

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 type="checkbox"/>	Not applicable <input checked="" type="checkbox"/>
	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?	Section 17 forms are forwarded to the Mental Health Act Office. Records of all periods of leave will be documented in the patient's care notes. Compliance will be monitored as an integral part of the divisional clinical governance systems and audited by the Matrons and reported through the Q-SEEL groups.	
	Who is responsible?	Matrons	
	What information is being used?	An audit proforma has been developed to highlight Leave granted Yes/No and reasons. Time returned from leave and feedback, if leave is rescinded reasons why.	
	When will the EqIA be reviewed? (Usually the same date the policy is reviewed)	October 2021	

7. Where will your decision or policy be forwarded for approval?	MH& LD Policy Sub Group
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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 to be completed following consultation.
--	---

	Name	Title/Role
9. Name/role of person responsible for this Impact Assessment	Wendy Lappin Tracy Norcross Dr Anita Pierce Myfid Healy	Mental Health Act Manager Matron Central Area Ablett Unit Consultant Psychiatrist / Clinical Director Central AMHP lead / Manager
10. Name/role of person <u>approving</u> this Impact Assessment		
Please Note: The Action Plan below forms an integral part of this Outcome Report		

Form 4 (ii): Action Plan

This template details any actions that are planned following the completion of 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:			
2. What changes are you proposing to make (or have already made) to your document or proposal as a result of the EqlA?			
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?			

	Proposed Actions	Who is responsible for this action?	When will this be done by?
3b. Where negative impact(s) on certain groups have been identified, and you are proceeding without mitigating them, describe here why you believe this is justified.			
4. Provide details of any actions taken or planned to advance equality of opportunity as a result of this assessment.			

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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**Quality, Safety & Experience
Committee**
21.5.19

**GIG
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NHS
WALES**

 Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

To improve health and provide excellent care

Report Title:	Therapeutic Engagement and Observation Policy
Report Author:	Gaynor Kehoe, Head of Operations Central. Gareth Owen, Positive Interventions Clinical Lead
Responsible Director:	Mr Andy Roach, Director of Mental Health and Learning Disabilities Division
Public or In Committee	Public
Purpose of Report:	To seek approval to implement the policy
Approval / Scrutiny Route Prior to Presentation:	<p>MHLD Policy Implementation Group February 2019 MHLD Divisional Q-SEEL February 2019 MHLD Divisional Directors March 2019 Professional Advisory Group – Chairs Approval April 2019 Quality Safety Group (QSG) – May 2019</p> <p>This policy and procedure addresses the therapeutic engagement and observation of patients who are receiving care in wards and units provided by Betsi Cadwaladr University Health Board (BCUHB). It reflects contemporary guidance, terminology and definitions for practice issued by the National Institute for Health and Care Excellence (NICE 2015), which must be adopted across England and Wales.</p>
Governance issues / risks:	This policy will support the management of behaviours which challenge in clinical areas and ensure that BCUHB is compliant with national guidance and relevant legislation.
Financial Implications:	There are no additional financial implications.
Recommendation:	The QSE Committee are asked to approve this policy for implementation.

Health Board's Well-being Objectives <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>	√	WFGA Sustainable Development Principle <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	√		
Special Measures Improvement Framework Theme/Expectation addressed by this paper http://www.wales.nhs.uk/sitesplus/861/page/81806			
Equality Impact Assessment The policy has been subject to an Equality Impact Assessment which had no impact on protected characteristics			

Disclosure:

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



MHLD AC002

THERAPEUTIC ENGAGEMENT AND OBSERVATION POLICY

Date to be reviewed:	December 2021	No of pages:	34
Author(s):	Gaynor Kehoe. Gareth Owen	Author(s) title:	Head of Operations and Service Delivery (Central). Clinical Nurse Specialist / Violence & Aggression Clinical Lead.
Responsible dept / director:	Director of the MHLD Division		
Approved by:	MHLD Policy Implementation Group 5 th February 2019 MHLD Q-SEEL 21 st February 2019 PAG – Chairs Assurance 30 th April 2019 QSG – 8 th May 2019		
Date approved:	This policy is approved as a draft document whilst it is progressing through the HB procedures.		
Date activated (live):	22 nd February 2019 as Draft		
Date EQIA completed:	February 2015 and December 2018		
Documents to be read alongside this policy:	See reference list in the policy on page 15 and cross referenced policies.		
Review	Purpose of Issue/Description of current changes: Review of an existing procedure to ensure a divisional wide approach to therapeutic observations with inpatient environments.		

First operational:	22 nd March 2015.			
Previously reviewed:	December 2018			
Changes made yes/no:	yes			

PROPRIETARY INFORMATION

Therapeutic Engagement and Observation Policy

10 KEY POLICY POINTS AND MUST DO'S.

1. Each patient admitted to an inpatient setting will have an individual, potentially fluctuating level of risk.
2. A key intervention in managing risk is the use of therapeutic engagement and observation. Therefore, all inpatients are subject to observation.
3. There are four intensities of observation, always described as set out below:
 - a. Low-level intermittent observation.
 - b. High-level intermittent observation.
 - c. Continuous observation.
 - d. Multi-professional continuous observation.
4. Observations must always be clearly documented on the appropriate recording forms (Appendices 5 – 8, pages 24 – 30 of policy).
5. An assessment of risk will underpin all decisions to change the intensity of observation (see section 4.5, page 11 of policy).
6. Clinical notes must include the rationale for an increase or decrease in intensity of observation level.
7. A handover which includes physical sight of patients will always occur between the incoming and outgoing shift.
8. Observations cover the 24 hour period. This includes times when patients may be sleeping or resting. The policy requires staff to enter bedrooms to check on the physical and mental well being of patients and to ensure there is no loss of vital signs.
9. Patients should be informed of the observations they are subject to and given a copy of the 'Patients and Carers information leaflet'.
10. All intensities of observation are an opportunity to engage with patients.

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1. Purpose of policy.

This policy and procedure addresses the therapeutic engagement and observation of patients who are receiving care in wards and units provided by Betsi Cadwaladr University Health Board (BCUHB). It reflects contemporary guidance, terminology and definitions for practice issued by the National Institute for Health and Care Excellence (NICE 2015), which must be adopted across England and Wales.

2. Definitions.

- Observation is an intervention that is used both for the short-term management of disturbed/violent behaviour and to prevent self-harm (National Institute for Health and Care Excellence, NICE 2015). This involves a two-way relationship, established between the patient and the member of staff, which is meaningful, grounded in trust, and therapeutic for the patient (NMC 2008). Observation also provides an opportunity to collaborate with the patient in managing their risks and to explore the key interventions required to manage those risks.

Observation relates to the 24-hour period. (**NB** observation, in this context, must not be confused with *physical observations* that are conducted when a patient is physically unwell, has been physically restrained or who is subject to rapid tranquillisation.)

Avoidable Deaths (2006) suggest that observation above general observation should be considered if any of the following warning signs are present and all must be considered in relation to each individual:

- History of previous suicide attempts, self-harm or attacks on others.
 - Hallucinations, particularly voices suggesting harm to self or others.
 - Paranoid ideas where the patient believes that other people pose a threat.
 - Thoughts or ideas that the patient has about harming themselves or others.
 - Past or current problems with drugs or alcohol.
 - Recent loss or significant life event.
 - Poor adherence to medication programmes or non-compliance with medication.
 - Marked changes in behaviour or medication.
 - Known risk factors.
 - Chronic physical health problems, especially in older people.
 - High levels of impulsivity.
 - High levels of hopelessness.
 - Significant levels of agitation.
 - When a person is unknown to services and is presenting for the first time in acute mental health crisis.
- Physical health issues must be considered too, because either alone, or in combination with mental health problems, they may indicate the need for increased observation. Some of the conditions that may present increased risks to the patient's well being are:
 - Coronary heart disease
 - Diabetes
 - Asthma
 - Blood pressure irregularities

- Mobility problems.
- Head injury.
- Side effects of medication.

- NICE NG10 (2015) has defined four types of observation. They should **never** be referred to as anything other than their full descriptions, listed below:

- a. **Low-level intermittent observation.**
- b. **High-level intermittent observations.**
- c. **Continuous observation.**
- d. **Multi-professional continuous observation.**

A full definition of the four types or intensities of observation which are based on NICE NG10 (2015) guidance can be found in Table 1 (page 6).

- All four types of observation can be applied to patients detained under the Mental Health Act 1983 without their consent, although such consent must always be sought. Even if the patient declines to consent, this procedure is applicable to them. They retain the right to ask for a review of the observation to which they are subject.
- All four types of observation may be applied to informal patients without their explicit permission, even though permission must always be sought. If the patient objects to the observation that they are placed on, the multidisciplinary team should consider the objection, patient safety is paramount in all decision making. Patients admitted informally to an inpatient facility who are assessed as lacking capacity may be treated under 'best interests' in the context of the Mental Capacity Act (2005). The appropriate assessment of capacity will need to be completed. They retain the right to ask for a review of the observation to which they are subject.
- Recovery and rehabilitation services will ordinarily work to a less intense level of observation than that described in this policy which can be found in **Appendix 1**.

Table I: The four types of observation

The following applies to all types of observation

- At least once a shift a member of staff should set aside dedicated time to engage positively with the patient to assess the current risks and mental state of the individual.
- Engaging with a person whilst carrying out observations can have a positive effect on levels of distress.
- Assessment, engagement and intervention should be used to recognise, prevent and therapeutically manage disturbed or violent behaviour; risk to self; risk of neglect and absconson.
- The type of observation must be recorded in full in the clinical notes.
- Observations cover the 24 hour period, which means going into patient's bedrooms when the person is sleeping/resting to check on their physical and mental well-being and to ensure there is no detrimental changes to vital signs.
- Patients on higher than low level intermittent observations should remain ward based and only leave the ward if escorted whilst having due regard for the patients legal rights.
- At times, it may be necessary to search the patient and their belongings whilst having due regard for the patients legal rights. BCUHB's MHL D 0013 - Searching Patients and their Property will be followed.
- In some circumstances it may be necessary to temporarily remove belongings that could be used to inflict harm, however, any decision to do so by the MDT/Nursing team should only be made where it is reasonable and proportionate to the harm being avoided.
- All observations will be recorded on the appropriate recording form (**Appendix 5.6.7.8**)

Multi-professional continuous observation

This observation is for patients assessed to be at the highest level of risk of harming themselves or others, who need to be supervised at close proximity, either at arm's length or within eyesight. Harm to self includes accidental and deliberate. On rare occasions more than one nurse may be necessary. Issues of privacy, dignity and consideration of gender in allocating staff, also environmental dangers need to be discussed and incorporated into the care plan. Observation will be maintained when using lavatory or bathroom facilities. Patients subject to this level of observation should not leave the ward.

Continuous observation

This observation is for patients assessed to be an immediate threat to themselves or others and need to be kept within eyesight or within arm's length of a dedicated one-to-one nurse. Observation will be maintained when using the lavatory or bathroom facilities. Patients subject to this level of observation should not leave the ward and immediate access to additional members of staff should be available if needed. When this level of observation is used, it must be clearly documented

High-level intermittent observations

This observation is appropriate when patients are assessed to be potentially, but not immediately at risk of suicide or potential risk to others. This means that the patient's location must be checked at specified intervals ranging from once every 15-30 minutes as agreed by the care team. Examples of this include patients with depression, but who have no immediate plans to harm themselves, or patients who have previously been at risk of harm to self or others, but who are in the process of recovery. Patients subject to high-level intermittent observation should not leave the ward environment without an appropriate escort, unless this is part of an agreed and documented care plan.

Low-level intermittent observation

This is the baseline level of observation in a specified psychiatric setting. The frequency of observation is once every 30-60 minutes.

3. Scope of policy

The policy is applicable to most wards and units across BCUHB. Forensic and rehabilitation services take an approach appropriate to the service user group as detailed in **Appendix 1 and 2**.

4. Principles

All intensities of observation are an opportunity to engage with patients and must not be regarded as just another task to be recorded.

Research demonstrates that risk of suicide is reduced when a patient is given the opportunity to talk about their distressing thoughts and concerns.

Use observation only after positive engagement with the patient has failed to dissipate the risk of violence or aggression.

The primary function of therapeutic observations is to maintain patient safety. However, the process of observing patients affords staff the opportunity to monitor and assess behaviour, symptoms, physical well being and interactions.

5. Policy Statement

- Every patient is subject to observation. Low-level intermittent observation is the minimal acceptable observation for all patients, which means the member of staff seeing the patient at least once an hour to ensure their physical and mental wellbeing is known. The location of all patients must be known to staff, but not all patients need to be kept within sight.
- Observation tasks should be undertaken by registered nurses, who may delegate to competent persons.
- The decision to increase or decrease the intensity of observation must be underpinned by a robust assessment of risk, for example the Dynamic Appraisal of Situational Aggression (DASA) chart.
- Explaining the purpose of observation to the patient is important. Their perspective on observation, their gender and that of the member of staff providing observations must always be taken into account. Furthermore, any relevant aspects of equality and diversity issues must be considered, including the protected characteristics **Age, Disability, Gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief / lack of belief, sex, sexual orientation** - when addressing the patient's needs for observation and engagement.
- The patient must be provided with information about why they are being observed, the aims of the observation and how long it is likely to be maintained. The observation must, where appropriate, be communicated (with the patient's approval) to the nearest relative, friend or carer. Full and summarised information sheets for patients, their advocates, families and carers and the public are provided at **Appendix 4**.
- All observations must follow the processes and recording requirements set out in this document.

- The privacy and dignity of patients must be considered and maximised. However, It will always be balanced against the need to need to maintain safety.
- All decisions about the type of observation to use must be based on key areas that help staff maintain relational security. They are: the whole care team, the other patients on the ward, the inside world of the patient and the connections the patient has with the outside world (Department of Health, *See, Think, Act*, 2010).

6.0 Duties

- **Director of Nursing / Assistant Director of Nursing / Heads of Operations.**
To ensure provision and distribution of a comprehensive, up to date policy, reflecting best practice, that is fit for purpose across all care groups.
- **Heads of Nursing / Service Managers.**
Heads of Nursing and Service Managers are responsible for the dissemination of this policy and procedure, to all their relevant staff. And for ensuring that all those staff are adequately trained in order that they understand it, comply with it, and implement it.
- **Matrons / Ward Managers**
Training on the use of this policy is essential for **all** staff working in inpatient units. Staff will undertake continuing personal development to maintain and enhance their patient engagement skills and associated observation skills. In addition, it is the responsibility of the ward manager to conduct informal training for all nursing staff (qualified and unqualified) on the ward in relation to observations and to ensure all staff are competent to carry out observations. Competency should also be discussed during supervision. Local induction of bank staff will include instruction on the therapeutic observation policy and they will be given a copy of the pocket book guide (**Appendix 3**).
- **Multi-disciplinary Team**
The patient's multidisciplinary team, normally the nursing staff, hold the responsibility for deciding on variations to observation. The ways in which such changes can be made, and by whom, are set out within this document.
- **Governance**
The Governance team coordinates the review of all serious untoward incidents across the Division. The serious Incident review reports include trends in incidents including trends related to the consistent implementation of the Therapeutic Engagement & Observation Policy. Such trends will be addressed to the policy authors and the Divisional Director and Assistant Director of Nursing and the Heads of Operation and Service delivery for appropriate action.

7.0 Procedure

7.1 Risk Assessment prior to admission

Thorough and careful risk assessment underpins the application of appropriate types of observation.

One of the main reasons for a person to be admitted to an inpatient setting is because their level of risks are deemed to have increased and it is no longer felt they can be offered safe care in a less restrictive setting.

It is therefore important that the referring team provides an accurate, up to date assessment of risk at the point of admission. The thorough risk assessment should detail the level and type of risk, in order that the receiving ward or unit can best assess the immediate level of observation necessary and ensure that the patient is admitted to the most suitable setting for their needs, their safety, the safety of other patients and staff.

7.2 Risk Assessment and observation on admission

- During the admission assessment and until the initial risk assessment is complete; the patient must be kept on continuous observation. This can be achieved by asking the patient to stay in the social area of the ward in the company of staff or by taking the patient to a quiet room with a member of staff.
- Inpatient team members must complete, as a minimum, a risk and mental health assessment within two hours of the patient's arrival on the ward.

7.3 Observation following the admission assessment

- Once a full mental health and risk assessment has been completed a decision can be reached about the appropriate type of observation. This decision will be made by the admitting nurse (with a discussion with a Doctor and other nursing colleagues where possible) with the decision being conveyed to the Nurse in Charge. The agreed observation will be implemented and recorded on the relevant 'observation recording form' and in the patient's clinical notes. A pocket guide for staff is provided at **Appendix 3**.
- For the 24 hours following admission, the patient should remain ward based regardless of the type of observation they are subject to. This is to enable a detailed risk assessment to be undertaken and in order that the ward staff can start to establish a relationship with the patient.
- The rationale for the level of therapeutic observations will be recorded in the patients' clinical notes.

7.4 Carrying out observation

- Nurses - and other staff - undertaking observation must:
 - ∴ Be fully aware of the observation policy and procedure.
 - ∴ Work to use the time positively with the patient.
 - ∴ Ensure they are fully briefed about the patient's history, background, specific risk factors, particular needs and any relevant equality and diversity issues i.e. **Age, Disability, Gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief/lack of belief, sex, sexual orientation.**
 - ∴ Be familiar with how to access interpreting services if required.
 - ∴ Be familiar with the ward, the ward policy for emergency procedures and potential risks in the environment.
 - ∴ Be approachable, listen to the patient, know when self-disclosure and the therapeutic use of silence are appropriate and be able to convey to the patient a sense of their being cared about and for.

- The nurse in charge of each shift will provide clear and unambiguous instruction, management and leadership to others in the allocation of observation duties and ensure that those duties are carried out.
- A handover of observations will occur between the incoming shift and outgoing shift and recorded on the appropriate observation form. This will involve both nurses walking around the ward together, conversing with patients, checking on their physical and mental well-being and ensuring all patients who should be on the ward are physically present.
- Therapeutic observations cover the 24 hour period. At night, staff must continue the agreed type of observation. This will require entering bedrooms to ensure that patients are safe and not in emotional distress - and checking that they are not experiencing, or have not experienced, any physical distress, loss of vital signs or collapse.
- Registered nurses are accountable for all areas of their practice, including delegation, the carrying out and recording of observation activities. They must abide by the Nursing and Midwifery Council's Code: Standards of conduct, performance and ethics for nurses and midwives.
- The least intrusive method of observation appropriate to the levels of risk must always be adopted so that due sensitivity is given to a patient's safety, dignity and privacy whilst maintaining the safety of those around them.
- When carrying out higher than low level intermittent therapeutic observations it is important that staff also observe and record the patient's presentation and location.
- All decisions about the specific type of observation must take into account:
 - ∴ The current assessment of risk
 - ∴ The patient's current mental state including thoughts, feelings, behavior.
 - ∴ Any prescribed medications and their effects.
 - ∴ As far as possible, the patient's own view.
- The rationale as to what type of observation the patient is in receipt of must always be recorded in the patient's notes.
- An individual staff member must not undertake a period of multi professional continuous observations or continuous observation for longer than one hour. Good practice suggests that an individual member of staff must not undertake high level intermittent observations for longer than two hours. The nurse in charge is responsible for ensuring that the number of patients that any individual staff member is required to intermittently observe does not jeopardise the safety of any of those patients.
- Staff members must be aware of and sensitive to the fact that patients sometimes find observation provocative, and that it can lead to feelings of isolation and even dehumanisation, and may increase levels of agitation and aggression.
- Where possible, the handover from one nurse or staff member to another should involve the patient so that they are aware of what is being said about them.

7.5 Reviewing types of observation:

- **Guiding Principles**

Any changes in the intensity of observation must be based on an up-to-date risk and mental health assessment which is fully documented in the clinical notes detailing the rationale for the alteration in observation.

When making decisions about decreasing observation intensity, or increasing above low level intermittent observation, it will be clearly documented in the clinical notes when the observation will be reviewed and by whom.

Whilst it is good practice to ensure that all members of the multidisciplinary team and the patient are involved in any decision making process about the patient's care and observation, it is recognised that this may not always be possible.

Observation must be discussed with the patient and always reflected in the clinical notes.

Changing the intensity of observation must be dependant on the patient's requirements for care and safety, and not based on the availability of the full multidisciplinary team to make decisions.

Observations will be reviewed by the nursing team on a shift-by-shift basis.

Any request made by the patient, their carer or relative, about increasing or decreasing the intensity of observation must be considered in line with current assessment of risk.

Prior to decreasing multi professional continuous observation and continuous observation a formal MDT review must occur.

7.6 Who can change the type of observation?

- **Increasing levels of observation**

The following may increase the patient's levels of observation:

- Any qualified nurse in conjunction with the Nurse-in-Charge
- The multidisciplinary team when reviewing care

If observations are increased above high level intermittent observation then these observations should remain in place until a full review MDT review can occur.

- **Decreasing observations**

Decreasing continuous and multi-professional continuous observation

Patients who are placed on continuous and multi professional continuous observation are people deemed to be at the highest risk. Therefore, reduction in the intensity of observation levels must follow a formal process to ensure that a team decision is made which is based on a current mental health and risk assessment whilst taking into account the views of the patient and carers.

The objective of the decision reached is always to provide safe care whilst treating the patient in the least restrictive environment.

Patients subject to multi professional continuous observation or continuous observation will be reviewed as a minimum once every 24 hours.

In working hours – Full MDT Review

This clinical discussion will wherever possible include:

- .. Ward Manager / Most Senior Nurse available in the unit.
- .. Nurse-in-Charge.
- .. Other members of the multi-disciplinary team, one of which should be a doctor.
- .. Views of patient
- .. Views of the carer (where appropriate)

The Clinical team will agree and document in advance, the changes in risk and mental health presentation needing to be demonstrated before levels of observation can be reduced.

If the observations are to be reduced following this discussion, this will be documented in the patient's clinical notes with clear rationale for the decision and the team and patient informed.

If the patient is to remain on multi professional continuous observation or continuous observation this will remain in place for a 24 hour period until a further MDT review can take place.

If a patient is placed on multi professional continuous observation or continuous observation during an out of hours period they **should not be decreased until a Full MDT Review** can occur on the next working day (see 11.6) - for example, a patient is assessed as at risk and requiring multi professional continuous observation or continuous observation on a Saturday afternoon, the patient will remain on these increased levels of observation until a Full MDT Review can occur on the first working day.

Out-of-hours – Weekend / Bank Holidays

If the Nurse-in-Charge thinks the criteria to reduce the observation has been met as previously agreed by the MDT review (see 11.6), then prior to any reduction in therapeutic observations an additional review will occur involving:

- .. Nurse-in-Charge
- .. The other nurses on shift
- .. Senior qualified nurse on duty within the unit

If felt necessary by the Nurse-in-Charge, the decision will be discussed with the Duty Doctor.

If the observations are to be reduced following this discussion this will be documented in the patient's notes with clear rationale for the decision, and the team and patient informed.

- **Decreasing High-level Intermittent Observations**

In working hours (Monday to Friday 0900 – 1700) In order to decrease high-level intermittent observations a clinical discussion must take place and include:

- Ward Manager (when on duty).
- Nurse-in-charge.
- Other nurses/MDT member on duty.
- View of the patient.
- View of the carer (where appropriate).

If the observations are to be reduced following this discussion, this will be documented in the patient's notes with clear rationale for the decision, and the team and patient informed.

Out-of-hours In order to decrease high level intermittent observations a clinical discussion must take place and include:

- Nurse-in-Charge
- The other nurses on shift.
- Senior qualified nurse on duty within the unit.

If the observations are to be reduced following this discussion this will be documented in the patient's clinical notes with clear rationale for the decision, and the team and patient informed.

7.7 Who should be informed of the change?

- The patient must be informed about the change of observation and the reason explained. They must also be given a copy of their new care plan, which reflects the amended observation. Information for patients, their advocates, families and carers and the public is provided at **Appendix 4**.
- All staff on duty and all members of the next on-coming shift. The patient's psychiatrist should also be informed as soon as possible, if they were not part of the decision making process. The doctor on-call should be informed, if the risks are such that this is warranted.
- The Ward Manager (when on duty).
- Matron (when on duty).

7.8 Recording observation

- In order to ensure the observation procedure is completed and to allow for staff to monitor patients, clear timely and accurate recording of observations is imperative.
- It is the responsibility of the nurse-in-charge to allocate members of staff to the observation of patients, ensuring that staff are familiar with those patients, are

aware of this policy/procedure and have a copy of the pocket book guide for staff and understand the recording processes.

- The recording of observation will be completed on the appropriate observation recording form, for the type of observation the patient is subject to. The necessary forms, with instructions, for recording the level of observation can be found at **Appendices 5, 6, 7 and 8**. The following standards will apply to the recording of all observation levels:
 - ∴ Carrying out observation, provides an opportunity to therapeutically engage with the patient(s), and recording is part of that engagement and should not, therefore, be conducted in a mechanistic way.
 - ∴ Patients' names entered in full.
 - ∴ Each recording entry must be legible.
 - ∴ The name, role and the signature of the nurse implementing the observation must be written clearly on the form.
 - ∴ Nurses responsible for the observation of a patient(s), must ensure that a detailed handover is given to the nurse who takes over the observation from them.
 - ∴ If a nurse has any concerns about the observation of patients then they must bring those concerns to the nurse in charge, without delay.

8.0 Development, consultation and ratification

This policy has been consulted upon with a range of stakeholders including the Director and assistant Director of Mental Health Nursing, Divisional Heads of Nursing, Heads of Operation and service delivery, Service Managers, Matrons, Consultants, Safeguarding lead, Business managers, Specialist Nurse Practitioners. Consultant Nurse, Service users and carers and other clinical staff working in inpatient areas. This policy will be ratified by MHL Divisional Policy and Procedure Group.

9.0 Equality Impact Assessment (EQUIA)

This policy has been subject to an equality impact assessment.

10.0 Monitoring Compliance

- 10.1 Good practice requires regular and frequent audits of compliance with this policy. These will be undertaken by Matrons and Ward Managers in collaboration with their service Manager. As a minimum these audits will be on an annual basis and utilise the audit form provided in **Appendix 9**.
- 10.2 The audits will ensure that all staff in inpatient settings have received training on the implementation of the policy and procedure.
- 10.3 The audits will monitor compliance with all practice elements of the policy and that the appropriate observation recording sheets have been completed and that details of observation and engagement are recorded in the patient's care plans and notes.
- 10.4 This policy will be reviewed on an annual basis to ensure that any audit findings, trends or lessons revealed through Serious Incident reports and their associated action plans are addressed. Reviews will also take account of changes in national standards, policies and guidance

11.0 Dissemination and Implementation of policy

This policy will be uploaded to BCUHB's intranet page; clinical staff will be alerted to the issue, reissue and review of versions of this policy.

12.0 References:

'Avoidable Deaths' Five year report of the national confidential inquiry into suicide and homicide by people with mental illness (2006) University of Manchester.

Bowers L, Flood C, Brennan G & Allan T (2008) *A replication study of the City nurse intervention: reducing conflict and containment on three acute psychiatric wards* Journal of Psychiatric and Mental Health Nursing **15**, 737-742.

Department of Health, January 2010: "See, Think, Act – your guide to relational security"

National Institute for Health and Care Excellence (2005) *Violence: the short-term management of disturbed/violent behaviour in inpatient psychiatric settings and emergency departments*. Clinical Guideline 25. London: NICE.

National Institute for Health and Clinical Excellence (2005a) *Violence: managing disturbed/violent behaviour. Understanding NICE guidance – information for patients, their advocates, families and carers, and the public*. London: NICE.

National Institute for Health and Care Excellence (2015) *Violence and Aggression: the short-term management in mental health, health and community settings*. NG10. London: NICE

Nursing and Midwifery Council (2008) *The Code: Standards of conduct, performance and ethics for nurses and midwives*. London: NMC.

Office of the Childrens Commissioner (2007) "*Pushed in to the shadows-young people's experience of adult mental health facilities*". London.

Savage v South Essex Partnerships NHS Trust – (January 2009) The

Stationery Office (2005) *The Mental Capacity Act*. London: TSO

13. Cross referenced policies:

- MHLD AC008 Missing / Absconding patient policy.
- MHLD 0013 Searching patient and their property policy.
- MHLD 0004a Rapid tranquillisation policy.
- MH02 protocol for the exceptional admission of children under the age of 18 years to an acute psychiatric inpatient unit.
- MHLD 0001 Acute Care Operating Framework.
- MM17 Guidelines in the management of delirium / acutely disturbed or violent behaviour in vulnerable / older adults.
- Violence and Aggression (V&A) policy- Proactive reduction and therapeutic management of behaviours which challenge.

14. Acknowledgements

Sussex Partnership NHS Foundation Trust

Appendix 1 - Therapeutic Engagement and Observation Policy in Betsi Cadwaladr University Health Board Recovery and Rehabilitation Service

Wykes and Holloway (2000) define the rehabilitation and recovery client group as:

“People with severe and long term mental illnesses who have both active symptomology and impaired social functioning as a result of their mental illness”. Typically, the contemporary pathway into rehabilitation services involves many years of illness and disability (Craig 2006 p4), and every effort will have been made in secondary services to treat and support them in other settings, including the community. This presents very different opportunities for assessment of risk from acute services, as people referred to these units are very well known to mental health services and generally are considered to have achieved a level of stability within which there are clear treatment opportunities to support ongoing recovery. Fostering self management and choice is central to the care offered within the service, however staff should still be mindful of and regularly review, risk status and risk management plans.

The primary objective within these services is to promote self care and to maximise the opportunities for service users to feel in more control of their lives. To this end where staff enable and support service users to take the opportunity to become more accountable for their movements both within and beyond the unit, they must do so safely, recognising that the service user is still under BCUHB's care.

BCUHB's Therapeutic Engagement and Observation Policy is predicated on the notion that a service user is at a significant risk to themselves by virtue of the acute nature of their illness and in this regard the policy naturally expects that nursing staff will need to closely observe service users at the very least every hour. As mentioned above service users at this stage in their recovery are working towards independence and as such need to take back responsibility for their own safety.

The Policy

Decisions to adopt a lower level of observation than that described within BCUHB's Therapeutic Engagement and Observation Policy can only be made where a robust risk assessment has been made and can be evidenced. The adoption of lower levels of observation must be the subject of an ongoing and dynamic process of continually assessing risk both in terms of risk to self and risk to others.

The minimum acceptable lower level of observation will be to ensure that a service user has been observed at least one time per staff working shift and that during that contact an assessment of their mental state has been established to support the current observation levels in the care plan or to prompt an immediate review.

In many cases the staff will be required to observe the service user more than once per shift. The observation time period in use for every service user will be clearly stated in their care plan.

The observation levels described in the care plan will be reviewed regularly in line with the service user's mental state and changing circumstances. The risk to self and/or others will be reviewed on an ongoing basis and evidenced by clearly documented risk management plans.

References

1) Wykes, T and Holloway F, (2000) community rehabilitation: past failures and future prospects. International review of psychiatry, 12, 197-205.

2) Craig, T ch1 pg 4in what is Psychiatric rehabilitation Wykes T and Holloway F 2005.

Appendix 2 - Observation in Ty Llywelyn (medium secure unit).

As a standard, all patients on the Medium secure Unit will be on intermittent observations.

On the assessment ward and the rehabilitation wards all patients will be observed hourly and on the intensive care ward patients will be observed every 30 minutes.

Minimum standard observations of hourly and 30 minutes will be carried out by the allocated security nurse for each shift.

Appendix 3 – Pocket Book Guide

High-level Intermittent Observation	Continuous Observation	Multi-professional Observation	Continuous Observation	
<p>Intermittent High-level Observation:</p> <p>This means that the patient's location must be checked at specified intervals ranging from 15-30 minutes as agreed by the care team. Intermittent High-level Observation is appropriate when a patient is judged to be potentially, but not immediately at risk.</p> <p>It may be necessary for the multi-disciplinary team to alter the routine pattern of recording observations at specified times. Alteration to the recording pattern will not increase the agreed interval period.</p> <p>For example, where high-level intermittent observations are agreed at 10 minute intervals, the patient must be observed at least every 10 minutes. This could mean a patient being checked at 5 minutes, then after 7 minutes, then after 10 minutes, but never more than every 10 minutes.</p> <p>It may be necessary to search the patient and their belongings. BCUHB's Search Policy must be followed.</p> <p>Observations are recorded on the High-level Intermittent Observation form.</p> <p>Patients subject to high-level intermittent observation should not generally leave the</p>	<p>Continuous Observation:</p> <p>This is for those patients who present an immediate risk of harm themselves or others, or be especially vulnerable in another way.</p> <p>The patient must be kept within sight or within arms length at all times, by day and by night Including when they are using lavatory or bathroom facilities.</p> <p>Any implements that could be used to cause harm will be removed.</p> <p>It may be necessary to search the patient and their belongings whilst having due regard for the patient's legal and human rights. BCUHB's Search Policy must be followed.</p> <p>Observations are recorded on the Continuous Observation form.</p>	<p>Multi-professional Observation:</p> <p>This is for patients judged to be at the highest risk of harming themselves or others. Harm to self includes accidental and deliberate.</p> <p>Issues of privacy, dignity and consideration of gender in allocating staff need to be discussed and incorporated into the care plan. Environmental dangers must also be considered.</p> <p>Observations must be maintained within arm's length or eyesight including when the patient is using lavatory or bathroom facilities.</p> <p>It may be necessary to search the patient and their belongings whilst having due regard for the patient's legal and human rights. It may be necessary to temporarily remove personal belongings that could be used to inflict harm. BCUHB's Search Policy must be followed.</p> <p>Observations are recorded on the Multi-professional Continuous Observation form.</p>	<p>Continuous Observation:</p>	<p>Therapeutic Engagement & Observation</p> <p>This pocket book guide must be read in conjunction with BCUHB's Observation Policy</p>

Therapeutic Observation	Why is there a need for observation?	At a Glance Reminder: applicable to all types of observation	Low-level Intermittent Observation
<p>This brief outline is designed to ensure that all staff at all times are clear about the importance of therapeutic observation. The full policy can be found on BCUHB intranet.</p> <p>NICE defined four types of observation</p> <ul style="list-style-type: none"> .. Low-level Intermittent .. High-level Intermittent .. Continuous Observation .. Multi-professional Continuous Observation <p>All types of observation are an opportunity to engage with patients.</p> <p>Observations should be undertaken by registered nurses, who may delegate to competent persons.</p> <p>It is the duty of the Nurse-in-Charge to provide clear and unambiguous instruction in the allocation of the observations and ensure those duties are carried out appropriately.</p>	<p>Keeping patients safe is an absolute priority.</p> <p>Observation should be considered if any of the following warning signs are present. All must be considered in relation to each individual:</p> <ul style="list-style-type: none"> .. A history of previous suicide attempts, self-harm or violence or aggression towards others .. Hallucinations, particularly voices suggesting harm to self or others .. Paranoid ideas where the patient believes that other people pose a threat .. Thoughts or ideas that the patient has about harming themselves or others .. Past or current problems with drugs and/or alcohol .. Recent loss or significant life event .. Poor adherence to medication .. Chronic physical health problems .. High levels of impulsivity .. High levels of hopelessness .. High levels of distress and agitation 	<ul style="list-style-type: none"> .. Always clearly document observations on the appropriate recording form. .. A detailed risk assessment must underpin all decisions to alter the type of observation. .. Clinical notes must include the rationale for an increase and decrease in observation. .. A handover which includes actually seeing patients will occur between the incoming and outgoing shift. .. All observations cover the 24 hour period which will require entering the bedroom to ensure the patient is mentally settled and not experiencing any physical distress or loss of vital signs. .. Patients should be informed of the observations they are subject to and given a copy of the 'Patients and Carers information leaflet.' 	<p>Low-level Intermittent is the minimum acceptable observation for all in-patients.</p> <p>Low-level Intermittent covers the 24 hour period.</p> <p>The location of all patients should be known to staff, but not all patients need to be kept within sight. All observations need to be recorded hourly.</p> <p>The observation is recorded on the Low-level Intermittent form.</p> <p>At least once a shift a Nurse must set aside dedicated time to engage positively and collaboratively with the patient and to assess the current risks and mental state of the individual. The assessment must always include an evaluation of the current risks, patient's mood, thoughts and behaviours. This must be recorded in full in the clinical notes.</p> <p>To ensure patient safety and best practice a formal process of review must be followed when reducing intensity of observation.</p>

Appendix 4 – Information for Patients, relatives and carers

Equality and Diversity

Your perspectives on engagement and observation, your gender and the member of staff providing the increased engagement and observation, must always be taken into account and the purpose of observation explained to you. When planning the needs for observation and engagement, any relevant aspects of equality and diversity issues should be considered, including Age, Disability, Gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief / lack of belief, sex, sexual orientation. You should be provided with information about why you are under observation, the aims of the observation and how long it is likely to be maintained; the aims and level of observation should, where appropriate, be communicated, with your approval, to the nearest relative, friend or carer.

Keeping you informed

If your observation is increased or decreased, you should be given information about why this has happened, the aim of the change, and how long the observation is likely to last. Where possible you will be involved in the decision making process. Where it's possible, you must be involved in the handover between staff at the end of observation shifts so you know what is being said about you. More information about observation is available from members of staff.

References

National Institute for Health and Care Excellence (2015) *Violence and Aggression: the short-term management in mental health, health and community settings*. NG10. London: NICE

National Institute for Health and Care Excellence (2005a) *Violence: managing disturbed/violent behaviour. Understanding NICE guidance – information for patients, their advocates, families and carers, and the public*. London: NICE.



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University Health Board

Therapeutic Engagement & Observation

December
2018

Information for
Patients, Relatives and
Carers

INTERVENTION

The National Institute for Health and Clinical Excellence, or NICE, is the independent organisation responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health.

NICE issued the Clinical Guideline NG10 in May 2015, which contains instructions about how NHS organisations must implement the observation of mental health patients admitted to hospital. Information about observation for patients, drawn from NICE is set out below.

What is Observation?

Observation is the welfare check carried out by staff on the ward. There are a number of reasons why a person could be on an increased intensity of observation. These include keeping vulnerable patients safe; to help prevent a person from harming themselves or others or because someone is physically unwell. All types of

observation are a positive opportunity to talk to you and engage you in activities.

Deciding which observation is needed

You must be observed using the least intrusive observation possible. A balance must be struck between your dignity and privacy and the safety of yourself and those around you.

Decisions about your observation must take into account your current risks and mental health needs, your history and any medication you are on.

As far as possible your views must also be taken into account. As soon as possible, your psychiatrist or the doctor on call will be told of any decisions

about increasing your intensity of observation, and decisions together with the reasons for using observation above the general observation will be written in your notes. Your observation will be reviewed by staff at least every shift.

Types of Observation

There are four types of observation depending on the assessed level of risk.

Low-level Intermittent: This is the minimal observation for all people admitted to hospital. Staff will check on your whereabouts every 30 minutes to an hour but they don't have to be able to see you all the time. At least once during their shift, a nurse will check on how you are. This is the most common type of observation.

High-level Intermittent Observation: This observation is used when staff are concerned about your level of risk, either to yourself or to others. Staff will check on where you are at specified intervals between 15 and 30 minutes. As far as possible, this must be done without disturbing you whilst respecting your privacy and dignity. At least once during their shift, a nurse will check on how you are. If you are subject to intermittent observation, you will generally not be able to leave the ward environment without appropriate escort, unless this is part of your agreed and documented care plan.

Continuous Observation: This observation will be used if there's a risk you could try to hurt yourself or another person at any time. Staff must keep you within eyesight or within arms length at all times. This includes when you are using lavatory and bathroom facilities. If necessary, anything that you could use to harm yourself or others will be removed. Staff may need to search you and your belongings, though they must do this in a sensitive way and must keep your legal and human rights in mind. At least once during their shift, a nurse will check on how you are.

Multi-professional Continuous Observation: This observation means that more than one member of staff will stay close to you. This includes when you are using lavatory and bathroom facilities. This observation will be

used if you're likely to hurt yourself or another person if you get the chance. If necessary, anything that you could use to harm yourself or others will be removed. As far as possible your privacy and dignity must be respected. You must be asked your opinions on different aspects of being under this type of observation (for example, would you prefer to be observed by staff of the same sex as yourself). At least once during their shift, a nurse will check on how you are.

What you can expect from staff

You can expect that nurses and other staff involved in your observation will have been briefed on your previous history, and must know about any particular needs you have or areas where particular care should be taken. They will try to engage positively with you, listen to what you're saying, and value you as a person. To ensure patient safety and best practice a formal process of review must be followed when reducing the intensity of observation.

Appendix 5 –Low-level Intermittent Observation Form: 30minutes – 1 hour. Instructions for Use

Enter the date, enter each patient's full name, enter name of the allocated nurse for each period and insert initials on completion

Enter patient's activity, utilising these codes: **1.1 = one-to-one time**; **✓ = safe/present**; **E = out with escort**; **O = out unescorted**; **S = asleep**; **A = AWOL**; **C = Conversation with patient**

Once you have completed your allocated time you must handover your observations to the next allocated member of staff

Low-level intermittent observations continue at night, which will require entering the bedroom to ensure the patient is mentally settled and not experiencing any physical distress or loss of vital signs.

Low-level intermittent observations forms must be retained on the ward for ease of access – as per record keeping policy

All types of observation are an opportunity to engage with patients

Date:

Ward:

Name of Nurse Observing (PRINT)																									
Both nurses to sign when carrying out shift-to-shift observation handover																									
Full name of patient (PRINT)	07.00	08.00	09.00	10.00	11.00	12.00	13.00	14.00	15.00	16.00	17.00	18.00	19.00	20.00	21.00	22.00	23.00	24.00	01.00	02.00	03.00	04.00	05.00	06.00	
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19																									
Observation Nurse's initials																									

Appendix 6 – High-level Intermittent observation recording form

Appropriate when a patient is assessed to be potentially, but not immediately at risk. High-level Intermittent Observation:

- This means that the **patient's location must be checked** at specified intervals ranging from 15 – 30 minutes
- The care team must agree the maximum interval time of the intermittent observation, for example every 10 minutes which is then recorded on the intermittent observation form and in more detail in the clinical notes.

A separate recording form must be used for each patient subject to High-level intermittent observation

- Enter patient's full name and the date
- Enter the exact time the high-level intermittent observation occurred using the 24 hour clock
- Allocated nurse to enter their name and job title, and to sign at the end of the observation period – and indicating in the comments column to whom the observations have been handed over to
- Enter comments on location, engagement, risks, mental state and activity during observed period.
- High-level intermittent observations will continue at night, which requires entering the patient's bedroom to ensure that the patient is mentally settled and not experiencing any physical distress or loss of vital signs
- File recording form in the patient's notes
- When handing over the observations, both nurses must sign the form

Patient's full name (PRINT):	Date:	Room number
Frequency of intermittent observations (i.e. maximum time between checks)		

[illegible]

HIGH-LEVEL INTERMITTENT OBSERVATION: RECORDING FORM – PAGE 2 OF 2

Patient's full name (PRINT):	Date:
Frequency of high-level intermittent observation	Room number

Observations are an opportunity to engage with patients

[illegible]



Appendix 7- Continuous Observation Recording Form

For patients who could make an immediate attempt to harm themselves or others, or be especially vulnerable in another way.

Instructions for the use of this form

- .. A separate recording form must be used for each patient subject to continuous observation
- .. Allocated nurse enters their name and job title and their signature at the end of the observation period
- .. Enter details of the patient's behaviour, activity etc in the comments column at hourly intervals
- .. File this recording form in the patient's notes
- .. It is very important that you actively engage with the patient whilst they are on within continuous observation.
- .. When handing over the observations, both nurses must sign the form

Patient's full name:	Room Number:	Date
-----------------------------	---------------------	-------------

Time	Name of Nurse Observing + job title (PRINT)	Comment on location, engagement, risks, mental state, behaviour and activity during observed period.	Signature of Nurse Observing
00.00			
01.00			
02.00			
03.00			
04.00			
05.00			
06.00			
07.00			
08.00			



Patients Name		Room Number	Date
09.00			
10.00			
11.00			
12.00			
13.00			
14.00			
15.00			
16.00			
17.00			
18.00			
19.00			
20.00			
21.00			
22.00			
23.00			



Appendix 8 –Multi-professional Continuous Observation: Recording Form

For patients assessed to be at an **immediate risk** of harming themselves or others. Harm to self includes accidental and deliberate.

Instructions for the use of this form

- A separate recording form must be used for each patient subject to multi-professional continuous observation.
- Allocated nurse enters their name and job title and their signature at the end of the observation period
- Enter details of the patient's behaviour, activity etc in the comments column at hourly intervals
- File this recording form in the patient's notes
- It is very important that you actively engage with the patient whilst they are on multi-professional continuous observation.
- When handing over the observations, both nurses must sign the form

Patient's full name:	Room Number:	Date
-----------------------------	---------------------	-------------

Time	Name of Nurse Observing + job title (PRINT)	Comment on location, engagement, risks, mental state, behaviour and activity during observed period.	Signature of Nurse Observing
00.00			
01.00			
02.00			
03.00			
04.00			
05.00			
06.00			
07.00			
08.00			



Patients Name		Room Number	Date
09.00			
10.00			
11.00			
12.00			
13.00			
14.00			
15.00			
16.00			
17.00			
18.00			
19.00			
20.00			
21.00			
22.00			
23.00			



Appendix 9 - Therapeutic Observation Audit Form

This audit form is to be used once every six months. It is the responsibility of the Modern Matron to complete the audit, but this duty can be delegated to a Ward Manager.

1.	Has the Nurse-in-Charge provided clear and unambiguous instruction in the allocation of therapeutic observations?	Yes	No
2.	<p>Choose two staff on duty, one qualified and one unqualified</p> <p>Staff member 1 - qualified</p> <p>Is the member of staff able to explain the purpose of the therapeutic observation policy?</p> <p>Is the member of staff able to explain their duties under the therapeutic observation policy</p> <p>Staff member 2 - unqualified</p> <p>Is the member of staff able to explain the purpose of the therapeutic observation policy?</p> <p>Is the member of staff able to explain their duties under the therapeutic observation policy</p>	<p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p>	<p>No</p> <p>No</p> <p>No</p> <p>No</p>
3.	<p>Observation recording forms</p> <p>Are the Therapeutic Observation forms completed in line with policy?</p> <p>General Observation form</p> <p>Intermittent observation form</p> <p>Within Eyesight Observation form</p> <p>Within Arms length Observation form</p>	<p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p>	<p>No</p> <p>No</p> <p>No</p> <p>No</p>
4.	<p>Select two sets of notes of patients who have been under varying types of observation.</p> <p>Check if changing levels of therapeutic observation are recorded.</p> <p>Check to see if the rationale for alteration in observation is recorded.</p> <p>Set of notes 1</p> <p>Set of notes 2</p>	<p>Yes</p> <p>Yes</p>	<p>No</p> <p>No</p>



Consultation has taken place with:

Consulted with	Deputy ACOS (nursing and operational) all Locality Managers Acute Care Consultants Director of Mental Health and Learning Disability Divisional Head of Nursing Matrons who distributed to their own inpatient teams and community teams. Nurse Consultant (OPMH) Business Managers Safeguarding Lead Service User and carer group. Centre for Aggression management – Specialist Nurse practitioners. Operations managers. Head of programmes.	January 2015
Consulted with:	Acute care teams East, West, Central. OPMH teams East, West, Central. CMHT's East, West, Central. Regional Specialist Services. Divisional Directors.	November 2018.



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EQUALITY IMPACT ASSESSMENT FORMS

PARTS A and B: SCREENING AND OUTCOME REPORT

Introduction:

These forms have been designed to enable you to record, and provide evidence of how you have considered the needs of all people (including service users, their carers and our staff) who may be affected by what you are writing or proposing, whether this is:

- a policy, protocol, guideline or other written control document;
- a strategy or other planning document e.g. your annual operating plan;
- any change to the way we deliver services e.g. a service review;
- a decision that is related to any of the above e.g. commissioning a new service or decommissioning an existing service.

This is not optional: Equality Impact Assessment is a specific legal requirement on public sector organisations under equalities legislation and failure to comply could result in a legal challenge to a decision or strategy. More importantly, equality impact assessment helps to inform better decision-making and policy development leading to improved services for patients. **This form should not be completed by an individual alone, but should form part of a working group approach.**

The Forms:

You must complete:

- **Part A** – this is the Initial Screening that is always undertaken and consists of Forms 1 to 3; these forms are designed to enable you to make an initial assessment of the potential impact of what you are doing, and decide whether or not you will need to proceed to a Full Impact Assessment (Part C);

AND

- **Part B** – this is the Outcome Report and Action Plan (Form 4) you will need to complete whether or not you proceed to a Full Impact Assessment;

Together, these forms will help to provide evidence of your Impact Assessment and how you have shown “due regard” to the duties.

You may also need to complete Part C (see separate Form) – if parts A and B indicate you need to undertake a Full Impact Assessment. This enables you to fully consider all the evidence that is available (including engagement with the people affected by your document or proposals) to tell you whether your document or proposal will affect people differently. It also gives you the opportunity to consider what changes you may need to make to eliminate or mitigate any adverse or negative impact you have identified.

Remember that these forms may be subject to external scrutiny e.g. under a Freedom of Information request.

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.

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?	Mental Health and Learning Disabilities Division. Therapeutic Engagement and Observation Policy. .	
2.	Provide a brief description, including the aims and objectives of what you are assessing.	This policy and procedure, addresses the therapeutic engagement and observation of patients who are receiving care in wards and units provided by Betsi Cadwaladr University Health Board (BCUHB) It reflects contemporary guidance, terminology and definitions for practice issued by the National Institute for Health and Clinical Excellence (NICE 2015), which must be adopted across England and Wales. The aims and objectives of the policy are to keep patients safe, to explain how to manage and record observations, to describe the different intensities of observation, increasing and decreasing observation intensity and how to provide information to patients and staff. The policy adheres to NICE guidance.	
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?	MHLD Division Director of Mental Health and Divisional Head of Nursing	
4.	Who is Involved in undertaking this EqIA? Include the names of all the people in your sub-group.	Name	Title/Role
		Gaynor Kehoe	Head of Operations and Service Delivery,
5.	Is the Policy related to, or influenced by, other Policies/areas of work?	<p>'Avoidable Deaths' Five year report of the national confidential inquiry into suicide and homicide by people with mental illness (2006) University of Manchester.</p> <p>Bowers L, Flood C, Brennan G & Allan T (2008) A replication study of the City nurse intervention: reducing conflict and containment on three acute psychiatric wards Journal of Psychiatric and Mental Health Nursing 15, 737-742.</p> <p>Nursing and Midwifery Council (2008) The Code: Standards of conduct,</p>	

		<p>performance and ethics for nurses and midwives. London: NMC.</p> <p>Office of the Childrens Commissioner (2007) “Pushed in to the shadows-young people’s experience of adult mental health facilities”. London.</p> <p>National Institute for Health and Clinical Excellence (2005) Violence: the short-term management of disturbed/violent behaviour in inpatient psychiatric settings and emergency departments. Clinical Guideline 25. London: NICE.</p> <p>Savage v South Essex Partnerships NHS Trust – (January 2009) The Stationery Office (2005) The Mental Capacity Act. London: TSO</p> <p>National Institute for Health and Clinical Excellence (2005a) Violence: managing disturbed/violent behaviour. Understanding NICE guidance – information for patients, their advocates, families and carers, and the public. London: NICE.</p> <p>Department of Health, January 2010: “See, Think, Act – your guide to relational security.</p> <p>(AWOL) policy Induction policy Policy and procedure for clinical risk assessment and management. Prevention and management of violence and violence policy Rapid tranquillisation policy Acute Care Operating Framework Search Policy and procedure Acute care Handover Guidelines Under 18 policy</p>
6.	Who are the key Stakeholders i.e who will be affected by your document or proposals?	<p>Patients and carers</p> <p>Inpatient staff</p> <p>Community teams</p> <p>Acute Care Staff.</p> <p>Senior managers</p> <p>Consultants.</p> <p>Junior Doctors. .</p>
7.	What might help/hinder the success of whatever you are doing, for example communication, training etc?	<p>Compliance from all professionals involved.</p> <p>Training to all staff</p> <p>Policy launch</p> <p>Communication.</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, <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	(-)	High positive (+)	The policy relates to all inpatient settings - acute care, older persons, rehabilitation, forensic services. There is no discrimination against age. .
Disability	(N/a)	No impact/Not applicable (N/a)	Disability discrimination act 1995. The policy does not affect disabled and non disabled people any differently.
Gender Reassignment	(N/a)	No impact/Not applicable (N/a)	The Equality Act 2010 which includes Gender reassignment equality act 2010
Pregnancy & Maternity	(N/a)	No impact/Not applicable (N/a)	The equality Act 2010
Race / Ethnicity	(N/a)	No impact/Not applicable (N/a)	Human Rights Act 1998
Religion or Belief	(N/a)	No impact/Not applicable (N/a)	
Sex	(N/a)	No impact/Not applicable (N/a)	The policy treats men and women the same.
Sexual Orientation	(N/a)	No impact/Not applicable (N/a)	The policy does not differentiate between sexual orientation.
Welsh Language	(N/a)	No impact/Not applicable (N/a)	Distribution list for Consultation included welsh speakers.
Human Rights	(N)	No impact/Not applicable (N/a)	Human Rights Act 1998

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

<p>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:-</p> <ul style="list-style-type: none"> • Eliminate unlawful discrimination, harassment and victimisation; • Advance equality of opportunity; and • Foster good relations between different groups 	
1. Describe here (if relevant) how you are ensuring your policy or proposal does not unlawfully discriminate, harass or victimise	The policy is written for all staff who work within the inpatient settings in mental health and it is aimed at all patients who are admitted into these wards and units.
2. Describe here how your policy or proposal could better advance equality of opportunity (if relevant)	Not relevant
3. Describe here how your policy or proposal might be used to foster good relations between different groups (if relevant)	MDT working and collaborative decision making. Improved service user and carer involvement.



Part B:

Form 4 (i): Outcome Report

Organisation:	BETSI CADWALADR UNIVERSITY HEALTH BOARD
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1. What is being assessed?	Mental Health and Learning Disabilities Division. Observation and Therapeutic Engagement Policy.
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2. Brief Aims and Objectives:	This policy and procedure, addresses the therapeutic engagement and observation of patients who are receiving care in wards and units provided by Betsi Cadwaladr University Health Board (BCUHB) It reflects contemporary guidance, terminology and definitions for practice issued by the National Institute for Health and Clinical Excellence (NICE 2015), which must be adopted across England and Wales. The aims and objectives of the policy are to keep patients safe, to explain how to manage and record observations, to describe the different intensities of observation, increasing and decreasing observation intensity and how to provide information to patients and staff. The policy adheres to NICE guidance.
-------------------------------	--

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 checked="" type="checkbox"/>	No <input type="checkbox"/>

4. Did the assessment	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
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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?	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?		
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"/>	Not applicable <input type="checkbox"/>
	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?	The policy is monitored through the MHLd policy implementation group.	
	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? verbal feedback from the operational group and evidence / data on admissions out of area, DTOC's, out of hours admissions.	
	When will the EqIA be reviewed? (Usually the same date the policy is reviewed)	The EQIA will be reviewed in line with the policy in December 2021	

7. Where will your decision or policy be forwarded for approval?	MHLd statutory compliance committee
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8. Describe here what engagement you have undertaken with stakeholders including staff and	Acute care forums. operational meetings.
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service users to help inform the assessment	local operational meetings.
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	Name	Title/Role
9. Name/role of person responsible for this Impact Assessment	Gaynor Kehoe	Head of Operations and Service Delivery (Central)
10. Name/role of person <u>approving</u> this Impact Assessment	Divisional policy and procedure Group	All Disciplines represented.
Please Note: The Action Plan below forms an integral part of this Outcome Report		

Form 4 (ii): Action Plan

This template details any actions that are planned following the completion of EqIA including those aimed at reducing or eliminating the effects of potential or actual negative impact identified.

	Proposed Actions	Who is responsible for this action?	When will this be done by?
1. If the assessment indicates significant potential negative impact such that you cannot proceed, please give reasons and any alternative action(s) agreed:	N/A		
2. What changes are you proposing to make (or have already made) to your document or proposal as a result of the EqIA?	None		

	Proposed Actions	Who is responsible for this action?	When will this be done by?
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		
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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**Quality Safety &
Experience Committee**

21.5.19


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University Health Board

To improve health and provide excellent care

Report Title:	Progress report of Recommendations arising from HASCAS independent investigation and Ockenden governance review
Report Author:	Miss Claire Brennan, Head of Office
Responsible Director:	Mrs Deborah Carter, Acting Executive Director of Nursing & Midwifery
Public or In Committee	Public
Purpose of Report:	The paper provides the progress updates as at the end of Q4 against the recommendations arising from both the HASCAS independent investigation and the Ockenden governance review
Approval / Scrutiny Route Prior to Presentation:	HASCAS & Ockenden Improvement Group
Governance issues / risks:	Additional resources required have been identified for a number of recommendations to progress the work identified to deliver improvements and address the recommendations.
Financial Implications:	A paper will be submitted to Executive Team setting out the additional resources and any related costings, including any additional workforce requirements, for their approval.
Recommendation:	To note the progress against the recommendations to date

Health Board's Well-being Objectives <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>	√	WFGA Sustainable Development Principle <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	√		
Special Measures Improvement Framework Theme/Expectation addressed by this paper			
Governance & Leadership Mental Health Services			
Equality Impact Assessment			
Not required			

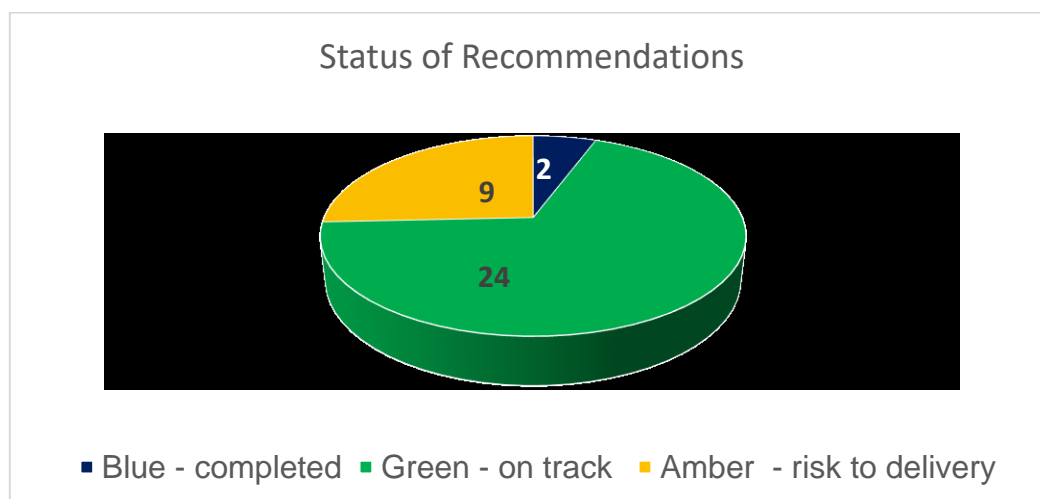
Disclosure:

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

HASCAS & Ockenden Recommendations status

Progress for all HASCAS & Ockenden recommendations is well underway; the status of the total 35 recommendations is detailed below;

- 24 are reporting green as on track to achieve delivery, some of these recommendations are almost due to complete and any that are proposed for closure will be formally reviewed at the Improvement Group meeting on 28th May and shared with Stakeholder Group members;
- 9 are reporting amber, where work is progressing but some additional focus or support is required to address some challenges that is impacting on timely progress;
- 2 recommendations have been completed; these are relation to;
 - *Ockenden 14: Board Development and prescribed disengagement.* Health Board members participated in a dementia friendly awareness session which was delivered on 10th January 2019. Further dementia awareness sessions will be delivered to senior management and wider staff teams going forward.
 - *Recruitment of the second Consultant Nurse for Dementia* – recruitment process completed and the successful candidate is due to commence in the role on 17th June 2019.



- HASCAS Recommendation 9 was previously reporting as red, regarding the safe management of patient records, due to the impact of the embargo on destruction of casenotes as a result of the 'infected blood inquiry'. However, the update received this month has confirmed it is now reporting as amber with a more positive overall position due to a number of actions being progressed. An issue has been escalated in relation to delays being experienced on the TRAC recruitment system, which is impeding progress and has been escalated to senior workforce staff.
- HASCAS Recommendation 13 regarding Restrictive Practice Guidance has now completed all relevant actions to meet the recommendation, these are in respect of training; policy implementation; and reporting of incidents of restraint. The Director of Nursing for Mental Health & Learning Disability as operational lead, is therefore proposing that Recommendation 13 now be closed. This will be formally reviewed and signed off at the next Improvement Group meeting on 28th May as

well as Stakeholder Group review. However, it was emphasised by the Director of Nursing Mental Health, at the Improvement Group meeting in March, that whilst the actions to deliver the recommendation have been completed, the PICSS and Psychology teams continue to work to deliver and sustain improvements being made to ensure the preventative approach continues to be embedded into the culture of the organisation with ongoing monitoring of agreed measures.

- In respect of this Recommendation 13, the Stakeholder Group meeting on 30th April received a presentation on the establishment of the Positive Interventions Clinical Support Services (PICSS) Team and the progress made by the team, which also meets the requirements this Recommendation 13. This work focuses on a proactive and preventative approach to managing behaviours that challenge, with an emphasis on restrictive practice being the last resort and embedding this into the culture of staff and teams across the Health Board.

Improvement Group

- The Improvement Group, which is held bi-monthly, has now met 4 times since its inception in August 2018 and is well attended by core members as well as operational leads and or executive lead for each Recommendation to provide progress update reports.
- In addition to the bi-monthly Improvement Group meetings, additional one to one meetings have been established between the operational lead and the Acting Executive Director of Nursing, for a deep dive into the progress and issues of each recommendation and to identify any areas that are not progressing at the anticipated pace and agree required actions and any support to address barriers.

Stakeholder Group

- The Stakeholder Group, which is required to meet quarterly, has now met 4 times since its inception in October 2018. Contact has been made by operational leads with Stakeholder members for the recommendations where they had expressed an interest to support and the majority of Stakeholder members are now actively engaged with the work of the relevant groups. Operational leads have formally acknowledged the valuable contribution that stakeholders are making in supporting the progress of actions.
- The Stakeholder Group has received presentation at previous meetings to highlight the work being undertaken to progress actions in the following areas;
 - End of Life Care;
 - Dementia Care in Emergency Departments;
 - Restrictive Practice Guidance
 - Neurological conditions (pathways)
- A work programme has been developed and it has been agreed to receive a presentation on Estates and anti-ligature work at the next Stakeholder Group meeting in July.

HASCAS & Ockenden Recommendations – update report for QSE Committee meeting 21st May 2019

Recommendation	Current position	Progress update	Risks
<p>HASCAS 1: Integrated Care Pathways 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>	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"> • Scoping Exercise: Recognising the significant work that has been undertaken within BCUHB and the North Wales Regional Partnership Board (MWRPB) to date, a strategy mapping exercise has been completed that identifies all the existing work programmes that relate to integrated care pathways for older people. A thematic analysis has also been conducted to look at the themes relating to older persons care pathways, this has helped inform the priorities that BCUHB need to focus upon in reviewing services and taking forward HASCAS/Ockenden recommendations. As such, the improvement lead is meeting with senior nurses from all three Emergency Departments, SAU and AMU across BCUHB to examine older persons experience and pathways; including end of life care. Discussions are also being held with the Nurse Director of Secondary Care with meetings planned for the forthcoming month. To note, 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. • Service Gap Analysis: A meeting has taken place with the Director of Primary Care and Associate Director of Quality Assurance to agree a way forward for the development of an older persons’ service gap analysis through the support and engagement of Area Directors. A presentation on the methodology, aims and objectives will be delivered on the 22nd of May 2019. • Implementation Plan: In March, an implementation plan was developed to capture progress and actions required against this recommendation. The plan identifies the clinical and practice deficits highlighted by both HASCAS & Ockenden reports, the desired outcomes, actions, governance arrangements and evidence. Updating the report requires a whole system approach as the ambition of the action plans has resource implications for all service areas. All agreed work-streams would also require the support of evidence based practice, stakeholder engagement and consideration upon spread and sustainability issues • Logic Models: In April, a meeting took place between the Older Persons Programme Manager and Senior Health Planning Manager for BCUHB. Logic models were designed for the benefit of capturing the implementation programmes (above) with clearly defined outcomes, measurable outputs and activities required. Performance Lead for BCUHB is in the process of providing support to help determine outcomes and output indicators so that evidence of improvement can be captured succinctly. The implementation plan has therefore been subsumed and translated into the logic model, which will be presented for executive approval at the end of May 2019. • A drafted pathway ‘Meeting the Physical Health Needs of People Admitted to an Older Person Mental Health Ward’ (January 2019) is being developed which aims to integrate the clinical pathways between physical health and OPMH. • An improvement programme of work is in development with support from consultant psychiatry and medical staff to review and revise the clinical pathways between Emergency Department and Care of the Elderly (COTE). Outcome measures are being developed in line with the drafted pathway above in order to help measure service change. The Improvement plan will also be shared with the OPMH Quality and Workforce Group for support, spread and sustainability. 	<p>Timescale to achieve review of a broad range of services</p> <ul style="list-style-type: none"> - Joint and clear action plan including milestones and timelines to be developed. Progress regularly reported to Improvement Group <p>Workforce capacity and resource for transformation (reducing duplication / conflicting agendas)</p> <ul style="list-style-type: none"> - Ensure joint responsibility of translating strategy into action via an improvement sub-group and map out all forums/groups involved. <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"> - Design a set of agreed principles in partnership along with quality and safety standards to inform the model of care and strategy

HASCAS & Ockenden Recommendations – update report for QSE Committee meeting 21st May 2019

Recommendation	Current position	Progress update	Risks
		<ul style="list-style-type: none"> • Advanced Nurse Practitioners (ANP): To support the above development; clinical teams from Care of the Elderly Services and OPMH have met to determine the service changes required to further support further OPMH patients. This has resulted in the identification and support for further ward based clinical sessions for physical assessment by appointing ANPs to assess the physical health needs of older persons on mental health wards and the development of an integrated pathway for rapid response. These ANP posts are now being advertised. • Stakeholder Engagement The work programmes mentioned above have individually engaged with wider stakeholders and the findings of this care pathways high-level initial review, will be presented for consultation on an ongoing basis to help inform the design and service improvement models. To note, the review engagement to date has identified care outcomes as being central to an integrated service model and care pathways. The three main care pathways under development at present include: <ul style="list-style-type: none"> – OPMH pathway between OPMH and Secondary Care; as noted above and is currently under consultation, awaiting responses by end of May 2019. – End of Life Pathway; meeting arranged between Improvement Lead and Head of Nursing for Palliative Care in May 2019. – ED, AMU, SAU pathways under early discussions; meeting between Improvement Lead and Head of Nursing for ED arranged for May 2019 	
<p>Ockenden 1: Integrated Service Model for Older People and those with Dementia 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> <p><i>There will be the need for extensive multi-agency working between BCUHB and a range of partners with continuing oversight by the BCUHB Board and Welsh Government as this work progresses.</i></p>		<ul style="list-style-type: none"> • The integrated service review of older persons needs to be scoped out in partnership with support from the NWRPB with stakeholder engagement. Work has progressed in relation to the Improvement Lead having met with our stakeholders to discuss the model for presentation and wider consultation. • A representative of the North Wales Social Care and Wellbeing Service Improvement Collaborative will be attending our working group meeting in May to update on the partnership approach to the North Wales Dementia Strategy and how older person's services may be addressed. • Meetings have been arranged at director level to discuss the opportunities for BCUHB to work with the NWRPB in terms of the older persons work streams and how we may successfully update QSE with consideration to some operational challenges. • An older persons' service gap analysis will also be undertaken across all regions in North Wales in partnership with local authorities, this will help inform the future direction. This service gap analysis aims to identify the issues and deficits that are causing fragmented care pathways and access to services for older people. Following the completion of the gap analysis, we will develop a single action plan that consolidates all other existing work streams and strategies that supports the future vision of an integrated service model for older people. • An OPMH Improvement Hub is also in early planning development with the Improvement Lead working with Foundations of Nursing and University colleagues with benchmarking against service improvement hubs in England. • It is important to note that BCUHB's response to the HASCAS and Ockenden recommendations and all clinical actions will support wider strategic programmes for older people such as the North Wales Regional Plan (Area Plan) and Integrated Care Fund revenue plan. This recommendation will therefore be subsumed into wider work streams under the NWRPB and North Wales Social Care and Wellbeing Services Improvement Collaborative, particularly dovetailing with the Dementia Strategy. • A logic model has been developed to this extent, which includes assessing the governance processes that underpin older persons' services, and identifying improvement plans to make governance of older persons' services a sustainable key part of everyday practice. 	

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Recommendation	Current position	Progress update	Risks
<p>HASCAS 2 : Dementia Strategy Operational Lead: Chris Lynes, Area Nurse Director (West)</p> <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>Ockenden 8: Dementia Strategy</p> <p><i>The dementia strategy should be developed to work across all relevant clinical services across BCUHB not just within the MH&LD division. The dementia strategy should incorporate care across home, primary care and secondary care.</i></p>	On track to deliver	<ul style="list-style-type: none"> The North Wales Regional Partnership Board have agreed to develop an integrated North Wales Dementia Strategy for the 6 Local Authorities and BCUHB setting out joint aims and objectives. This work is being led by project support from the Regional Collaborative Team and BCUHB Director of Partnerships (MH&LD). Meetings have been arranged at director level to discuss the opportunities for BCUHB to work with the Regional Partnership Board in terms of the older persons work streams and how we may successfully update QSE with consideration to some operational challenges. The BCUHB dementia strategic action plan that has been developed (2018-2020) also requires further work to consider costings which will be undertaken through a newly developed BCUHB Dementia Strategy Group and this will feed into the wider North Wales strategy. Work has begun to scope out the range of ICF programmes across BCUHB with partner organisations that will be overseen by the Dementia Strategy Group and the Dementia Improvement Lead. An implementation plan has also been devised to address the practice and clinical deficits as highlighted in the HASCAS/Ockenden reports, stipulating the activities required. Three task and finish groups are in the process of being established to this effect to address 1) Audit Processes 2) A Dementia Therapies Plan and 3) Implementing the wider action plans listed (awaiting allocation of representatives). A logic model has been constructed to capture the above and is awaiting support from BCUHB's Improvement Lead in order to develop outcome and output indicators. The logic model will be shared at the next Improvement Group in May for executive approval. HASCAS Recommendation 2 and Ockenden Recommendation 8 have been consolidated and within the logic model which includes the following main actions: <p>Action 1. Clear Governance 'Ward to Board' 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"> BCUHB are in the process of establishing a third sector partner's group with Alzheimer's Society and the Carers Trust to shadow all BCUHB's Dementia transformation work. A task and finish group is in the process of being established in response to BCUHB's Dementia Audit Plan (2018-2020) to undertake audits and all future reporting from 'ward to board'. BCUHB have launched a 'dementia feedback toolkit' for service users. This will be developed further by involving community services and expecting services to undertake their own performance management arrangements to report directly to Area Directors. The work streams under BCUHB's Dementia Friendly Organisation Plan will also be included within the audit process. The HASCAS/Ockenden working group are also reviewing the process of gathering self-service feedback in order to have in place one single point of data to help with ward to board reporting. <p>Action 2. Evidence based policies and clinical standards. Action identified for a BCUHB wide systematic approach in reviewing all current policies relating to older people and those with Dementia (dovetails with Ockenden recommendation 12 and Ockenden recommendation 3).</p> <ul style="list-style-type: none"> Review of clinical policies is to be undertaken, which will be led by the Dementia Consultant Nurse upon their commencement in June. 	<p>Timescales pose a rise to delivery in respect of achieving such a broad range of service reviews.</p> <ul style="list-style-type: none"> Joint and clear action plans including milestones and timelines will be developed through logic models and KPIs with progress regularly reported to Improvement Group <p>Workforce capacity and resource for transformation (reducing duplication / conflicting agendas).</p> <ul style="list-style-type: none"> Ensure joint responsibility of translating strategy into action via an improvement 'working group' and map out all forums/groups involved. <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"> Design a set of agreed principles in partnership along with quality and safety standards to inform the model of care and strategy.

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Recommendation	Current position	Progress update	Risks
		<p>Action 3: Sustained culture around Dementia. 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"> The BCUHB 'Dementia Friendly Organisation Action Plan' applies evidenced based practice such as the 'King's Fund National Quality Standards' for the Dementia supportive and enabling environments. The action plan is scheduled for completion by end of Q4 2018-19 – further upscaling to be shared across all BCUHB pan wide services to ensure implementation is consistent within both primary and secondary care, such as the mental health liaison service within general hospitals. The 29 recommendations from the Royal College of Psychiatrists National Audit of Dementia in general hospitals is pivotal within 'BCUHB's Dementia Friendly Organisational Plan' and we will continue to adopt the principles of the 'John's Campaign' in all work streams to this effect. In agreement with Bradford University, BCUHB has innovated the use of dementia care mapping as a measure of cultural change and published this work in an international peer reviewed social research journal. <p>Action 4. Over reliance on antipsychotic medication. 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"> BCUHB's response to 'Dementia Therapies Action Plan' has been drafted with further work ongoing in relation to obtaining stakeholder engagement and a gap analysis to inform the costed action plan. This dovetails with the work of HASCAS recommendation 10 to reduce the use of antipsychotic medication A task and finish group is in the process of being established. <p>Action 5. Independent Oversight 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"> The Executive Director of Nursing for BCUHB has confirmed that the stakeholders and audit groups can provide independent oversight for the programmes of work listed. In addition, Welsh Government have also appointed an All Wales Dementia Allied Health Practitioner Consultant post who will give advice and support to health boards and local authorities to enable the delivery of person-centred care and drive forward service improvements. This post forms part of the All Wales Dementia Action Plan. <p>Action 6. Capacity & Capability of the Workforce 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"> BCUHB will continue to train staff as 'dementia friends' champions and actively run sessions to support this. There are 10 dementia friendly communities across North Wales this needs to be up scaled; there are a further 9 dementia friendly communities which are working through the foundation criteria to become accredited by the Alzheimer's society. Dementia friends' sessions will also be included in all mandatory dementia training across BCUHB. BCUHB will have representation in every dementia supportive community project group. A project plan will be developed to outline the above ambitions with clear measurable outcomes, timescales and a governance structure. 	

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Recommendation	Current position	Progress update	Risks
		<p>Action 7. Accessing Information 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"> • Referrals are now routinely made to the Carers Trust for any individual with a diagnosis of dementia, from BCUHB's memory clinics. • A scoping exercise will be taken forward via the HASCAS/Ockenden working group to review all current BCUHB information ensuring that present and future public information is compliant with 'Accessible Communication' standards as per action 8 of the Welsh Government Audiology Framework for Action • Dementia Helpline has been launched across BCUHB providing 24hr advice, information and support. <p>Action 8. Dementia Strategy To develop an achievable strategy for older people with Dementia making it a relevant part of everyday care and clinical practice of people with Dementia, across all services. (dovetails with Ockenden recommendations 8 & 12 and HASCAS recommendation 2).</p> <ul style="list-style-type: none"> • BCUHB Dementia Strategic Action Plan 2018-2020 developed is yet to be costed. • Monitoring the above action plan and developing sound governance arrangements around its delivery plays a key part of the HASCAS/Ockenden work group. A plan will be developed in the next few months to this effect. • The Action Plan will also be reviewed and measured against the WAG (2018) Dementia Action Plan for Wales. • A BCUHB Clinical Dementia Strategy Work Group is in the process of being established by a dementia improvement lead, which intends to provide input into the wider regional 'Area Plan' by supporting the development of the Regional Partnership Board Dementia Strategy for North Wales. <p>Action 9. Regional approach to Dementia To subsume this implementation plan and develop alongside the North Wales Social Care and Wellbeing Service Improvement Collaborative.</p> <ul style="list-style-type: none"> • Ensure that all work programmes within this implementation plan compliments and does not duplicate any Integrated Care Funding (ICF) programmes that are currently providing transformational work across BCUHB. • In addition, this implementation plan will work alongside our partnership programmes: <ul style="list-style-type: none"> - BCUHB's <i>Together for Mental Health Strategy</i> - The North Wales Social Care and Community Health Workforce Strategy (RPB, 2018) - North Wales Population Assessment: Older People and Dementia. - North Wales 'Area Plan'. • A representative of the North Wales Social Care and Wellbeing Service Improvement Collaborative will be attending the working group meeting in May to update on the partnership approach to the North Wales Dementia Strategy. • BCUHB are also in the process of responding to the North Wales Social Care and Wellbeing Service Improvement Collaborative online consultation regarding the Dementia Strategy for North Wales. 	

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Recommendation	Current position	Progress update	Risks
<p>HASCAS 3: Care Homes and Service Integration Operational Lead: Reena Cartmell Associate Director of Nursing</p> <p><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></p>	On track to deliver	<ul style="list-style-type: none"> • 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"> - Implementing the newly developed "Quality Services: Delivering What Matters" (RPB, 2018) alongside the BCUHB Quality Monitoring Tools for North Wales Care Homes and drafted Quality Assurance Framework for Care Homes. - Review implementation of the "Care Homes for Older People: North Wales Market Shaping Position" (2018) and action plans. - Monitor the delivery of recommendations created by "Care Closer to Home Work Programme: Integrated Medium Term Plan for 2019/22 – financial and workforce strategy". - Develop a delivery plan to fully implement the "Quality Assurance Framework for Care Homes" developed by the CHC Corporate Team. - Care Home event held between Care Home Managers and BCUHB clinical ward staff to discuss ways to improve relations, safe discharges and celebrating successes in older person's care. This will also help inform a gap analysis for clinical pathway future development (dovetails with HASCAS recommendation 1). Action plans are being developed following this meeting. - Include Care Home providers within the design of a North Wales Training Programme to make ESR modules accessible (dovetails with Ockenden recommendations 12 & 14). - CIW/HiW Review (November 2018) into Support for North Wales Care Homes Action Plan is being developed, Area Directors are co-ordinating a response to the HIW / CIW action plan by end of April to prioritise any outstanding and close off any completed actions. • Another key requirement for improvement under HASCAS Recommendation 3 is the improved communication and integration of the independent care home sector and BCUHB services. A series of 4 hour 'getting to know you' events were held with care homes and clinical health board staff on 3 dates in March 2019 across West, Central and East areas. BCUHB hosted the event with a world café approach to generate ideas on how to improve our working partnerships for patient centred care. • The events were supported by the CEO of Care Forum Wales. The report following the above events, presents many great opportunities to strengthen partnership working between BCUHB and our valuable care homes, and in doing so, improve the quality of our services to the older person and those with a diagnosis of Dementia. We have asked that Area Directors look upon the recommendations provided and consider how they may develop these proposals further (both immediately and long term). Responses are expected in preparation for the next working group meeting to be held in May. We also intend on providing feedback to all partners who attended the events, and the programme manager for this work stream will coordinate all responses and action plans. The report was shared with Care Inspectorate Wales in March 2019. • A presentation will be delivered to the East partnership forum to raise awareness on the HASCAS and Ockenden work streams mentioned above, particularly the outcome of the care home event. This partnership forum provides an opportunity to move action plans forward and the presentation will be offered to central and west regions in the near future. 	<p>Timescales pose a rise to delivery in respect of achieving such a broad range of service reviews.</p> <ul style="list-style-type: none"> - Joint and clear action plans including milestones and timelines will be developed through logic models and KPIs with progress regularly reported to Improvement Group <p>Workforce capacity and resource for transformation (reducing duplication / conflicting agendas).</p> <ul style="list-style-type: none"> - Ensure joint responsibility of translating strategy into action via an improvement 'working group' and map out all forums/groups involved. <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"> - Design a set of agreed principles in partnership along with quality and safety standards to inform the model of care and strategy.

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Recommendation	Current position	Progress update	Risks
		<ul style="list-style-type: none"> BCUHB are supporting the 1,000 Lives National Care Home Programme – Quality Improvement Awards with 2 care homes in North Wales identified to pilot the scheme. A logic model has been drafted to reflect the above programmes of work above and will be shared with the Improvement Group at the end of May 2019 for executive approval. 	
<p>Ockenden 12: Older Persons Long Term Clinical Strategy Operational Lead: Reena Cartmell Associate Director of Nursing</p> <p><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></p>	On track to deliver	<ul style="list-style-type: none"> The Older Persons Long Term Clinical Strategy is fully dependant on the delivery of actions as set out in the HASCAS and Ockenden Reports. Recognising all elements of the report findings and recommendations, a draft plan has been developed working closely with Stakeholder engagement. Further work is required to build on the drafted document and this will be followed by wider consultation. Work has commenced on shaping the long term clinical strategy by setting out the desired principles, regulatory requirements, Tawel Fan legacy and baseline data. Merging HASCAS 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 persons' rights based culture for clinical standards of care. Three task and finish groups are currently being established to co-ordinate programs of work. The partnership event outcome will also be key to shaping future delivery of services along with further engagement opportunities across all clinical BCUHB services to help set the direction of travel. The BCUHB dementia strategy / action plan will underpin this work. A comprehensive training programme is being developed for BCUHB staff in relation to older persons care and Dementia with support from Bangor and Glyndwr Universities. Engagement with the Care Home independent sector following the care home events held in March will also help to inform the clinical services strategy in relation to the review and redesign of services in partnership. The Dementia Nurse Consultant commencing in June will be embarking on the review of clinical standards and uniformity working to the Executive Deputy Director of Nursing, with a focus on leadership, education, research and clinical practice to support the long term clinical strategy. 	<p>Timescales pose a rise to delivery in respect of achieving such a broad range of service reviews.</p> <ul style="list-style-type: none"> Joint and clear action plans including milestones and timelines will be developed through logic models and KPIs with progress regularly reported to Improvement Group <p>Workforce capacity and resource for transformation (reducing duplication / conflicting agendas).</p> <ul style="list-style-type: none"> Ensure joint responsibility of translating strategy into action via an improvement 'working group' and map out all forums/groups involved. <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"> Design a set of agreed principles in partnership along with quality and safety standards to inform the model of care and strategy.
<p>HASCAS 4 Safeguarding Training Operational Lead: Michelle Denwood, Associate Director Safeguarding</p> <p><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></p> <p><i>BCUHB will engage with all prior safeguarding course attendees to ensure that they are in receipt of the correct and updated guidance. The responsibility for this will be overseen by the relevant BCUHB Executive Director with responsibility placed on all clinical service managers from all of the clinical divisions within the organisation</i></p> <p><i>BCUHB has not been able to ensure staff attend safeguarding training sessions in the numbers required.</i></p>	Risk to delivery needs attention	<ul style="list-style-type: none"> A Scoping activity was undertaken to determine key areas for revision of existing training packages. Once completed, all existing Safeguarding Training packages were refreshed and updated in line with current legislation. The Social Services, and Well Being Act Wales and the Mental Capacity Act are now fully reflected. The impact of this activity has been recognised as the Ask and Act Training for VAWDASV (Domestic Abuse) which was developed by the Corporate Safeguarding Team and been accepted as a National Training package for Wales. Pending publication of the National Adult at Risk procedures, steps have been taken to ensure that all staff are kept up to date with the correct and updated guidance. To support this, the Corporate Safeguarding Team has implemented a monthly Bulletin which highlights national, and regional current policies, procedures and guidance The Safeguarding Bulletin also highlights a 'Learning' theme once a quarter and these Bulletins specifically emphasise education, legislation and policy & procedure updates. The Safeguarding homepage of the Safeguarding Reporting Framework, a Safeguarding Training Task group and has been established with clear Terms of Reference that include delivery of this HASCAS recommendation. 	

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Recommendation	Current position	Progress update	Risks
<p><i>there are multiple factors involved which will require a detailed and timed action plan with external oversight.</i></p>		<ul style="list-style-type: none"> • Training Reports are undertaken and areas of low compliance within Safeguarding Training are identified and scrutinised. Underperforming areas are reported via the Safeguarding Reporting Framework and into Area / Secondary Care / Divisional governance forums. Senior Managers / Directors within the Health Board are responsible for ensuring that training compliance within their areas is appropriate. <p>Continued progress, which is outside the scope of the recommendation</p> <ul style="list-style-type: none"> • A Training Needs Analysis (TNA) is due to be undertaken which sets out the Safeguarding Training requirements across the Health Board. The TNA will reference the intercollegiate document for adults and children. Once complete this will drive and inform the training strategy and programme for 2019-20. • ESR does not currently permit the monitoring of Level 3 Safeguarding Training and VAWDASV which affects the accuracy of compliance reporting for Safeguarding. The Corporate Safeguarding Team remain engaged to support amendments to ESR and identification of activities to ensure that training compliance is accurate. 	
<p>HASCAS 5 Safeguarding Informatics and Documentation Operational Lead: Michelle Denwood, Associate Director Safeguarding</p> <p><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></p> <ul style="list-style-type: none"> • <i>The use of the dividers to be re-iterated in safeguarding training, briefings, and other communication activities and a key annual audit activity;</i> • <i>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;</i> • <i>Team and ward managers to continue to include safeguarding documentation in team meetings and safety briefs.</i> <p><i>BCUHB will reconsider how clinical teams should record safeguarding information and the quality of the information provided.</i></p>	On track to deliver	<ul style="list-style-type: none"> • The Health Records department has worked alongside the Associate Director of Safeguarding to support the review and amendment of the safe storage of safeguarding information in clinical records in line with the Social Services & Well-Being Wales Act and GDPR. • Good Record Keeping (GRK) training that has been delivered incorporates a sign off element for safeguarding to ensure that records are correct. • Initial scoping work was undertaken to review the approach for the transition to digitalisation system from paper records. • Health Records Service have completed actions with the following deliverables: <ol style="list-style-type: none"> (i) Good Record Keeping Training explicitly includes a section on filing safeguarding information; (ii) Communications cascaded on Things You Need To Know (TYNTK) to remind staff of the importance of appropriately filing 'safeguarding' information; (iii) Supplier of the safeguarding divider (for the casenote folders) are updating to include full list of documents provided by the Safeguarding lead. • The GRK Training and communications from the action above are being used to strengthen the HR1 Policy for appropriate filing of safeguarding information – this is being prepared in line with a full review of HR1 in light of GDPR. Email has been sent to Mental Health colleagues to ascertain their use of the safeguarding divider, remind them of their responsibilities in its use, and ask for assurance of appropriate use • In order to assure progress in this area, internal audit are scheduled to undertake a records management audit and a review of the implementation of safeguarding documentation. This has been included within the planned works for 2019-20. • Level 3 Record management training is now included within the Safeguarding Training portfolio. This package incorporates the safe storage of safeguarding information. • When areas / departments identify high levels of safeguarding activity, a review of record management takes place where cases are discussed and supervision and support is provided. • The Safeguarding Bulletin highlights is 'Learning' themed once a quarter and these Bulletins specifically highlight education, legislation and policy and procedure updates. • The monthly Safeguarding Bulletins provide reference, advice and guidance relating to records management and remains a key activity of dissemination of information by Teams and Ward managers. 	<p>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.</p>

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Recommendation	Current position	Progress update	Risks
		<p>Continued progress, which is outside the scope of the recommendation.</p> <ul style="list-style-type: none"> • Work has been undertaken to triangulate Datix Reporting and Referral Data, with further work to be undertaken to ensure that the two systems interface seamlessly, and the process is more robust. • An Annual Safeguarding Report for 2018-19 has been produced for ratification at QSE which includes a specific section on BCUHB Adult at Risk referrals that enables the identification of trends and the consolidation of information to assist with understanding any areas which are under-performing. • The Lead Practitioner multi agency pilot is underway and will be implemented across BCUHB and all six Local Authorities, supported by the NW Safeguarding Board. • 70 BCUHB staff across MHL D have been identified to undertake the training. Six training dates are scheduled for April and May and the Lead Practitioner role will 'go live' following this. A six-month evaluation is planned, which will determine the next steps. • The next steps in the development of the Safeguarding Communication Strategy is to develop a Safeguarding presence on the staff App to ensure engagement with practitioners. • Safeguarding are working collaboratively with Corporate Communications to develop a Safeguarding web presence once the new Web is live in July 2019. 	
<p>HASCAS 6 Safeguarding Policies & Procedures 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"> • <i>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</i> • <i>Agree a priority list and activity timeframe to review documents within the parameters of corporate safeguarding</i> • <i>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;</i> • <i>Agree a governance structure and reporting framework for all safeguarding policies, procedures and SOPs;</i> • <i>Update and maintain the Safeguarding Policy webpage;</i> 	On track to deliver	<ul style="list-style-type: none"> • Good progress has been made in the management and control of Safeguarding policies. All policies and procedures within the Safeguarding remit have been identified and a register has been implemented which will manage version control and the publishing of policies in a timely and accurate way. • To ensure the governance structure is in place and in accordance with organisational procedure the Safeguarding Business Manager is linking in with the Board Secretary and the Policy on Policies (PoP) and their work on developing a central repository as part of this process. • A priority list has been identified with a full review of Phase 1 completed. The following procedures and guidance were requested for approval at QSG following ratification at the Safeguarding Governance and Performance Group on 31 January 2019. <ul style="list-style-type: none"> – The Adult at Risk Procedure – ratified for publication and builds on the guidance issued by Welsh Government. (HASCAS 8.3) – Safeguarding Supervision Procedure – BCUHB Supervision – Female Genital Mutilation (FGM) Standard Operating Procedure – Best Interest Meeting Guidance – Deprivation of Liberties (DoLS) • In addition, to the above policies, the following processes were approved at Safeguarding Governance and Performance Group in January 2019 and subsequently implemented: <ul style="list-style-type: none"> – Procedural Response to Unexpected Death in Childhood (PRUDIC) which is published in line with National guidance. – Safeguarding Team, Area Domestic Abuse Workplace Safety Group, Terms of Reference (ToR) – Safeguarding Supervision Procedure – Safeguarding Only Supervision • Full engagement takes place across the organisation and with participation at the North Wales Safeguarding Adult Training Sub Group, this ensures internal and external expertise is captured. 	

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Recommendation	Current position	Progress update	Risks
<ul style="list-style-type: none"> Continue to actively participate in the Policy and Procedure sub group of the Regional Safeguarding Boards 			
<p>HASCAS 7: Tracking of Adults at Risk across North Wales 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"> BCUHB in conjunction with the North Wales Safeguarding Adult Board established a Task and Finish Group to ensure shared learning with regards to documentation and communication. This Task and Finish Group has now been disbanded due to completion as agreed by the North Wales Safeguarding Adult Board. One of the outcomes was to support the implementation of the Lead Practitioner Pilot in BCUHB. Work has been undertaken to triangulate reporting / referral data against the Datix reporting to ensure that the systems are cross referenced. <p>Continued progress, which is outside the scope of the recommendation.</p> <ul style="list-style-type: none"> The development of the Lead Practitioner role continues and will retain oversight of the Patient Pathway. It is being implemented in MHLA as a pilot. The Adult at Risk Procedure has been written and ratified at Safeguarding Governance and Performance Group on 31 January 2019 and subsequently to QSG. The development of supporting report templates, aide memoirs for strategy meetings and case conferences will be consulted upon and implemented A Safeguarding Performance Dashboard is now published which includes consolidated data reports on Adult at Risk which triangulates data by area and by organisation. This Performance Dashboard then feeds into the Safeguarding Reporting Framework for scrutiny and review. 	
<p>HASCAS 8: Evaluation of Revised Safeguarding Structures / Ockenden 6: Safeguarding Structures Operational Lead: Michelle Denwood, Associate Director of Safeguarding</p> <p><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></p>	Risk to delivery needs attention	<ul style="list-style-type: none"> The safeguarding structure has recently received approval from Establishment Control. Full implementation is now urgent as the Ockenden recommendation from Welsh Government instructed that the implementation of the structure should be completed by March 2019 and this is now overdue. Appointments have been made to Best Interest Assessors (BIA) within the organisational change policy. Full implementation requires completion of a specialist course to achieve the qualification and application of the role. Implementation of the Named Doctor Adults at Risk remains outstanding and however positive discussions have taken place with the Office of the Medical Director to pursue this post with pace. A full review of the DoLS service is required and is captured within Recommendation 12 	<p>The current structure of the Safeguarding Team does not allow it to operate an out of hours/on call service.</p> <ul style="list-style-type: none"> Support from Director of Nursing to establish a structure and revised working pattern and on-call system to strengthen service provision.
<p>HASCAS 12 Deprivation of Liberties Operational Lead: Michelle Denwood, Associate Director of Safeguarding</p> <p><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></p>	On track to deliver	<ul style="list-style-type: none"> A review of the current DoLS service and structure remains active as the demand, complexity and challenging nature of this specialist service requires a sound infrastructure to meet the needs of the client group and organisation. The date of completion for start of the consultation is June 2019. Much activity has been undertaken around the Deprivation of Liberties (DoLS) provision. This includes the appointment of five Best Interest Assessors (BIA). There are six posts available, so currently one vacancy. All of whom have completed Level 7 specialist training to support them in their role. An agreed governance and training programme for DoLS signatories has been developed which incorporates the role of signatories to be transferred to the office of the Executive Nurse Director. This has resulted in an increase in named signatories training has been provided with a list of names for 40 potential signatories. This 	<p>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.</p> <p>The current resource cannot maintain the demand, high risk and complexity of cases.</p>

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Ockenden 9: Deprivation of Liberties <i>BCUHB will complete a review of the 2017-18 DoLS work plan</i>		requires a formal register to establish the active and available numbers of trained signatories available for the organisation. <ul style="list-style-type: none"> This activity incorporates a governance and training framework which is the first in Wales. A quality assurance framework will be developed to ensure quality and standards are in line with legislation. It has now been confirmed that accountability for the Mental Capacity Act (MCA) remains with the Office of the Medical Director however this requires further assurance activity. The Associate Director of Safeguarding has engaged on an individual level with the HASCAS Stakeholders allocated to the Safeguarding recommendation with a view to understanding their expectations and specific areas of interest. Work is being undertaken on this to ensure that engagement is meaningful and productive. An example is that one of the Stakeholder members is participating in the interviews for the Senior Management positions within Corporate Safeguarding. 	
HASCAS 9: Clinical Records Operational Lead: Dylan Williams, Chief Information Officer <i>Restructure and redesign of paper records archiving and retrieval systems</i>	At risk of delivery needs attention Progressed from Red to Amber	<ul style="list-style-type: none"> To strengthen the checks to prevent co-mingling made by the ATHR teams, prior to release through the centralisation of a new ATHR service. Preparing for delivery of this new service has progressed well with the majority of SOPs completed in readiness for GoLive, procedures written to include checks for co-mingling by the trained team using new software to remove and a process for logging the issue and informing the responsible team that misfiled. Recruitment is expected to be complete by the end of May 2019 and location being prepared. Aiming to GoLive with new service July. JD/PS for the 8b <i>Deputy Head of Health Records</i> has been reviewed following agreement to fund within Informatics and is being progressed via the recruitment process and is anticipated that this post will be in place by July. Additional project management resource required to support the Deputy Head of Health Records post is outstanding but being presented alongside all project management requirements to enable actions to deliver the HASCAS & Ockenden recommendations. Therefore the action to '<i>Baseline - storage, processes, management arrangements & standards compliance, for all types of patient records</i>' and '<i>Present business case for PAN- BCUHB compliance with legislation and standards in patient records management</i>' currently remains on hold with a view to progress in July. As soon as the work can be commenced, Mental Health Services will be the priority area. The action to ensure a clear portfolio responsibility for the management of all patient records is complete as it is now confirmed that this is within the remit of the Executive Medical Director. Timescale to explore clinical audit, including co-mingling checks, extended to September. 	Recruitment to posts that have been funded are experiencing significant delays in TRAC. This is being followed up daily and has been escalated with senior workforce staff Confirmation of funding for the Project Manager is required for support to progress baselining.
HASCAS 10: Prescribing and Monitoring of Anti-psychotic medication Operational Lead: Berwyn Owen, Chief Pharmacist A) <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> B) <i>BCUHB will continue to work with care homes across North Wales to provide practical clinical advice,</i>	Risk to delivery, needs attention	Ai) The BCUHB MM010 guidance has been audited across all OPMH dementia wards in March 2019 with full report on the results pending. http://howis.wales.nhs.uk/sitesplus/861/document/416663 Aii) A CAIR (checklist for antipsychotic initiation and review form) has been developed and distributed to all OPMH and CMHT teams across MH&LD division in October 2018. Reminders and communications to ward staff has improved implementation across OPMH dementia wards. Work is ongoing to continue to implement the use of the CAIR form and highlight best practice, particularly in care homes. The CAIR form and a letter has also been circulated to GPs and practice pharmacists.	Lack of pharmacy staff to deliver training for safe use of antipsychotic and support review <ul style="list-style-type: none"> Resource requirement to support implementation of recommendations. Paper to be submitted to executive team. Community pharmacist uptake of the NES for care homes has been minimal so far. Care homes not trained to deliver care that reduces need for antipsychotics

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<i>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>		<ul style="list-style-type: none"> Aiii) An All Wales audit is to be undertaken 2019-20 in primary care to identify the number of people with dementia who are prescribed antipsychotics. This will be captured and benchmarked across Wales using Auditplus software on GP systems. Despite feedback to All Wales Medicines Steering Group (AWMSG) it does not capture non-drug interventions around de-escalation. Bi) A proforma is in development to report on the use of anti-psychotics and length of treatment which is being progressed through the care home subgroup of primary care pharmacists and will identify support and intervention required for care homes. Bii) A community pharmacy care homes National Enhanced Service (NES) is in place to monitor antipsychotic use in care homes and increase the number of pharmacies signed up to the NES Biii) Discuss with the Associate Director of Nursing regarding use of an Adverse Drug Reaction (ADRe profile) for use within care homes which has demonstrated a significant reduction in falls in Swansea to align with work ongoing for Recommendation 3. 	<ul style="list-style-type: none"> MDT bid in place to support this (links to recommendation 2) GP audit is not mandatory although they are being strongly recommended to support this.
HASCAS 11: Evidence Based Practice Operational Lead: Dawn Sharp, Deputy Board Secretary <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 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>	On track to delivery	<ul style="list-style-type: none"> This recommendation dovetails with Ockenden 3 (see below). A review of the overarching policy on policies has been undertaken and the new policy adopted and launched. This sets out new ratification processes. A new intranet page has been established and documentation will be migrated onto it as each document is reviewed and updated. The new policy on policies and intranet site advises users that local hard copies of documents should not be retained. Further sessions have been held with Governance Leads and most recently the NW managed clinical services group to discuss the new policy and the review and transfer of documents to the new webpage. A series of individual meetings continue to take place with each Lead to agree transfer of documentation, communication plan for key staff and removal of old links. Staff have been reminded that all clinical policies should be developed using a person centred approach. Existing Policies are being reviewed to ensure that the evidence-base in relation to the older adult and/or those with dementia is specified and if necessary separate clinical policies and procedures will be developed with input from experts. A Project Initiation Document (PID) has been drafted and a detailed GANTT chart is being populated to ensure there are clear timelines documented as each cohort of policies and other written control documents are agreed for transfer by the relevant leads. Following agreement at the last HASCAS & Ockenden Improvement Group meeting, discussions have taken place with the Communications Team regarding use of the Staff App to host the new Intranet page. This will be possible if the page is moved to the Internet. As a consequence the Group took a decision at the last meeting to defer the transfer of all documentation to the new site to avoid having to reload all documentation to the new external website. The new website is expected to 'go live' in July 2019. Leads are being advised of the change in direction that all policies and other WCDs will be hosted on the external website. As a result of this a desktop exercise will be undertaken to review documentation against the new standards in terms of Welsh Language translation. 	

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Ockenden 2a: Quality Impact Assessment 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"> An update to HASCAS/Ockenden Improvement Group in January confirmed that a system is in place for Quality Impact Assessment (QIA) of savings schemes. Progress will be measured from samples of completed QIAs and a record of outcomes. Monitoring will also take place as part of the internal audit programme 2019/20. The audit is timetabled for Q1-2 in the draft IA plan for next year which was approved by the Audit Committee on 14th March 2019. 	
Ockenden 2b: Integrated Reporting Operational Lead: Dawn Sharp, Deputy Board Secretary <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"> Revised integrated reporting arrangements have been agreed in principle and are being tested over the next six months to ensure that they provide a more robust and effective accountability mechanism. The outcome from the first health economy reviews was circulated to divisions at the beginning of March 2019 and a feedback session with divisions was held at the end of March to review and learn from the process. Accountability Review meetings have now been set for June 2019. The revised Accountability Framework is to be presented to Audit Committee on 30th May 2019. 	
Ockenden 3: Policy Review 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 clinical practice as a 'work around solution' to lack of access to policies and guidance electronically.</i> <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>	On track to delivery	<ul style="list-style-type: none"> This recommendation dovetails with HASCAS Recommendation 11 (above) and will be progressed in tandem with the other recommendations in the report relating to corporate governance. Under the sponsorship of the Executive Director of Nursing and Midwifery, and with the Deputy Board Secretary acting as the operational lead, a programme of work commenced in July 2017 to review existing arrangements for the creation, cascade, access and storage of policies, guidance documents, protocols, and other written control documents. The breadth, volume and complexity of the work was recognised and it was agreed that in order to progress the work successfully, governance/policy leads would need to be identified in each Directorate. This was achieved in Autumn 2017 and an initial training session was held with the leads in November 2017 to outline the requirements to review all policies and procedures both clinical and non-clinical within their remit and bring them up to date, or confirm that they remained extant. In doing so leads were asked to identify current locations of all policies to be removed both, in paper copy or online, on the Health Board's intranet pages. In relation of BCU wide clinical policies the Corporate Nursing Team have undertaken a clinical policies mapping exercise to determine the location and current status of all clinical policies. These clinical policies have been risk assessed in terms of prioritising those that require urgent review under the direction of the Executive Clinical Directors. In line with the existing policy on policies the Quality, Safety and Experience Committee of the Board must approve clinical policies. From August 2018 an additional step has been added to the ratification and approval process with all new or refreshed clinical policies being scrutinised by the Quality and Safety Group to ensure they are fit for purpose and are evidence based. 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. This will be hosted on the new external website at the point the new website goes 'live' which will enable staff to access the page via the Staff App. 	<p>Clinical staff not being aware of the transfer of key policies to the new site</p> <ul style="list-style-type: none"> Targeted communication plan for each transfer to be agreed with the leads. Redirect system to be in place (from existing location) where possible <p>Resources to review policies and bring them up to date (across the wider organisation)</p> <ul style="list-style-type: none"> Meetings continue to take place with leads to agree the programme of transfer of documentation to the new site and to prepare communication plans and identify any issues

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Ockenden 10: Reviewing external reviews Operational Lead: Dawn Sharp, Deputy Board Secretary <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> <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>	On track to delivery	<ul style="list-style-type: none"> Following the review undertaken by the Corporate Nursing Team to strengthen assurances, the BCU/HIW management plan introduced to provide additional assurance processes continues to be implemented. All open/outstanding actions arising from these inspection reports continue to be monitored/managed on a monthly basis by the Quality and Safety Group. It was agreed at the Improvement Group meeting held on 29th January that a period of time is required for embedding this work and as a result this action should continue to remain open to ensure ongoing monitoring. 	
Ockenden 14: Board Development Operational Lead: Dawn Sharp, Deputy Board Secretary <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>	Delivered	<ul style="list-style-type: none"> The Executive Director of Nursing and Midwifery determined that this ambition would be best met by the full Board participating within a dementia friendly awareness session which was delivered on 10th January 2019. At the Improvement Group meeting held on 29th January it was agreed for this Recommendation to be closed as the action has been completed for Board members, however, the Executive Director of workforce & OD agreed to take forward an action to consider how to incorporate dementia awareness sessions into the Health Board's induction programme. A dementia friendly awareness session for senior managers as members of the Executive Management Group, who have not already received the training at the Board session, is also being arranged. 	
HASCAS 13: Restrictive Practice Guidance Operational Lead: Steve Forsyth Director of Nursing MH&LD <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>	On track to deliver	<ul style="list-style-type: none"> The Task & Finish Group for Recommendation 13, led by the Director of Nursing for Mental Health & Learning Disabilities, is well established with agreed Terms of Reference that ensure focus on the objectives to respond to and provide assurance in response to Recommendation 13. The group has progressed all actions, which are now all completed and awaiting sign off from the Stakeholder and Improvement Groups to close this Recommendation. 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"> i) 'Proactive Reduction & Therapeutic Management of Behaviours which Challenge' is a new policy written to address the requirement to take all reasonable precautions to minimise incidence of behaviours which challenge services, in line with statutory and mandatory directives. This focuses on proactive approaches to prevent challenging behaviours from occurring along with therapeutic management techniques. ii) 'Physical Restraint Guidelines' have been amended to comply with newly published national guidelines and provides guidance on the safe use of physical restraint as a last resort when all other options have been exhausted The two policies are based on the most up-to-date evidence based practice and are written to ensure compliance with national guidance such as NICE guidelines NG10, the Mental Health Act 1983 Code of Practice for Wales and the All Wales NHS Violence and Aggression Training Passport and Information Scheme. 	<ul style="list-style-type: none"> 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 D Positive Interventions Clinical Support Service (PICSS) where appropriate. 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 D professionals for the most appropriate and least restrictive environment.

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		<ul style="list-style-type: none"> The policies have been produced following consultation with service-user representative groups and emphasise the importance of delivering compassionate, safe, dignified and respectful care and encourages practitioners to co-work with the patient and carers in the formulation of person centred care plans Both policies have been reviewed via the Health Board's Professional Advisory Group (PAG) and Quality Safety Group (QSG) in January and are to be submitted for final approval to the Quality Safety & Experience (QSE) Committee in March. A benchmarking exercise has been completed for all areas against policy implementation and a further review will be undertaken to ascertain how the new policies and changes have been embedded. Work undertaken to prioritise a restrictive intervention reduction strategy across the Health Board. A benchmarking exercise has been conducted to identify areas where staff are involved with Restrictive Practice Intervention. Ratified policies have been uploaded onto the intranet and proactive corporate training launched to ensure that BCUHB adopts a proactive approach commensurate with the recommendations in national guidelines and ensure staff are supported in proactively managing behaviours that challenge (and reduce the need for restraint). This training programme is being delivered with the support of specialists from MHL D before the corporate training team assume full responsibility. Specialist PICSS reduction leads identified in all divisions and leads will develop a plan to raise awareness to prepare for organisational readiness. Training programme for PICSS leads in MHL D has been rolled out with organisational readiness being routed through Recommendation 13 task & finish group, Nurse Directors, Health & Safety, Governance teams task & finish group and Quality Safety Group. Work is now complete in ensuring that all incidents of restraint are recorded across BCUHB. Datix has been developed to include a specific field for recording physical restraint incidents and a training programme developed to support staff in its use. An increase in data capturing on Datix has been used to develop and inform the baseline data on RPI and benchmark against RPI policy. 	
HASCAS 14: Care Advance Directives Operational Lead: Dr Melanie Maxwell, Associate Medical Director <i>BCUHB will conduct an audit to establish how many patients and their families have advance directive documentation within their clinical records together with care plans in relation to choice and preference about end of life care</i>	On track to deliver	<ul style="list-style-type: none"> Monitoring process commenced November 2018 and is ongoing to continue to capture data on End of Life paperwork for inpatient deaths, this includes 'What Matters', future care plans, ACP, treatment escalation plans, care decisions, DNACPR etc. This will provide baseline data for improvement work and also enable the identification of patients for more in-depth review. An end of life case note review for inpatient notes was held on 18th April with clinical staff from palliative care and mental health teams, based on the 5 priorities of care for the dying person. A date for further data collection is currently being identified to complete this review. A meeting is being arranged to review progress with End of Life recommendations and identify any gaps and further improvement work. Discussions held with stakeholder group member who will attend the meeting which has been arranged to discuss the findings of the case note review and determine what further actions are required to support delivery of the recommendations. 	Staff are unable to commit to additional data collection in a timely way.
HASCAS 15: End of Life Care Environment 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"> The EOL / OPMH pathway has been developed alongside a standard operating procedure (SOP), an MDT / relatives joint risk assessment and a dedicated training module. The draft SOP was presented to Stakeholder Group in January 2019 for input and minor amendments made from stakeholder feedback The SOP includes real time audit of the process. The low number of deaths on an OPMH ward makes this realistic. The SOP identifies when DATIX is to be used. 	Staff not being released for training. <ul style="list-style-type: none"> Training is mandated on OPMH wards for Registered Nurses.

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		<ul style="list-style-type: none"> Relative rooms have been developed on each OPMH 'organic' ward. Bespoke end of life care training programme developed for all older person Registered Nurses commenced 6th December 2018. Ongoing evaluation underway. Work in relation to End of Life Care has been presented to a number of group / committees across BCUHB and identified some minor changes to the SOP and a gap in knowledge to access community stores at weekends Agreement received for the recruitment of a dementia specialist Admiral Nurse to provide expert practical, clinical and emotional support to families living with dementia. This is being progressed in partnership with St Kentigerns' Hospice for End of Life care and will be joint funded by MH&LD / Area and the Hospice for 2 years. 	
<p>Ockenden 2c Workforce Development Operational Lead: Sue Green, Executive Director of Workforce & Organisational Development</p> <p><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&LD and specifically OPMH with recruitment and retention expertise across medical, nursing and support services going forward. The MH&LD will need to utilise this support to creatively explore different ways of working and new and effective ways of recruiting and retaining staff. There will need to be efficient, timely and effective recruitment processes in place at all times to support MH&LD going forward.</i></p>	Risk to delivery, needs attention	<ul style="list-style-type: none"> MHLD Division has recently been successful in the appointment of MHLD nursing students who will become eligible for registration and employment in September 2019 through the central recruitment campaign. Work continues to allocate students to preferences were possible into the available band 5 vacancies across the MHLD Division. This process will continue as the summer months progress An Improvement Lead Programme Manager and four TODAY ICAN Change Facilitators commenced in roles within the MH&LD division and are working to support each of the triumvirate teams.. In February 2019 the first cohort of Learning Disability HCSWs attended and participated in a dedicated HCSW forum to receive news, updates and a chance to reflect on the importance of their role in delivering quality patient care. Tier 5 / 6 restructuring has been signed off by Divisional Directors, consultation process has now closed and themes are being developed from feedback. Following approval of the Workforce strategy by BCUHB Health Board meeting in March 2019, organisational workforce objectives and actions have been established to deliver within year 1. Divisional workforce objectives and actions are to be developed in Q1. The Quality & Workforce for acute care group has a 3 year delivery plan and is currently reviewing the evidence base for the acute care model for mental health in North Wales. This will include consideration of Psychiatric Intensive Care Unit (PICU) provision and supporting s136 activity through a psychiatric decisions unit to provide an alternative to the use of police detention. 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 that were considered important to those involved in directly delivering MH services in the community. The work to redesign MH services is now being progressed through the implementation of the Together for MH in North Wales strategy and new models of care that are being developed through Quality & Workforce Groups. A continued focus remains on engaging frontline staff and operational managers in training to develop skills and processes that are required to understand service demand and capacity, in order to improve flow within the CMHTs. Work continues to build on current learning and will be used to support further improvements in the delivery of care within the current system and also the work of our Quality & Workforce Group to redesign services. The MH&LD division has completed an establishment review using all Wales MH tools and benchmark analysis. Revised substantive clinical leadership and management structure is now in place within the MH&LD division with dedicated project management support in place to 	

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		<p>enable triumvirates to engage with the Quality Improvement Governance Plan and produce Divisional Action Plans.</p> <ul style="list-style-type: none"> A programme of training was delivered in October 2018 for area triumvirates which included all participants undertaking psychometric profiling. MHLD Managers committed to recognising the achievements of staff and submitted award nominations for CNO awards, Nursing Times, NHS, BCUQI, and NHS Wales 	
<p>Ockenden 4a: Staff Engagement Operational Lead: Sue Green, Executive Director of Workforce & Organisational Development</p> <p><i>The BCUHB board and the MH&LD divisional senior management team is recommended first to ask front line staff 'what does the term 'staff engagement' mean to you, 'what would effective staff engagement look like for you?' and then to develop a system of bespoke meaningful and sustained staff engagement first across mental health and specifically older persons mental health. The Board may then wish to consider how effective their engagement is with staff across BCUHB and decide whether a new Board approach is required to staff engagement across the whole of BCUHB</i></p>	On track to delivery	<ul style="list-style-type: none"> Listening leads have been recruited and trained across the MH&LD division, who are the link co-ordinator between staff and senior managers and discuss the concerns and issues of staff directly with the Director of MH&LD. Triumvirates continue to meet monthly with Listening Leads and supported by TIC and OD to encourage more staff to engage in Ward to Board dialogue Using the TODAY ICAN methodology, MH&LD staff are continually encouraged and empowered to make small changes, which collectively have a huge impact on patient care and experience. Care has been taken to ensure that the Division are introduced to the impact that some of the smaller initiatives have had on patients and the quality of care that they have received as well as some of the divisional wide service developments. The first 'BeProud' Pioneer Programme commenced in March, teams from the following areas attended: <ul style="list-style-type: none"> Carreg Fawr Rehabilitation Unit, Bryn Y Neuadd Hospital Complex Needs Services Bryn Y Neuadd Hospital Hydref Ward, Older person's mental health services, Heddfan Unit, Wrexham Ogwen Ward, Unscheduled Care, Ysbyty Gwynedd Conwy Ward, Unscheduled Care, Ysbyty Gwynedd Intensive Care Unit, Ysbyty Wrexham Maelor Emergency Department, Ysbyty Wrexham Maelor Care of the Elderly Ward 2 Ysbyty Glan Clwyd Emergency Department, Ysbyty Glan Clwyd Pharmacy Department Ysbyty Glan Clwyd Action plans to improve staff engagement and drive change continue to be developed within the Pioneer teams. The teams are being supported on a regular basis through contact with their sponsor who is a senior manager within their service. To further improve staff engagement, the "Be Proud Pioneer Programme" is now being rolled out with priority teams identified and the MHLD service have gained 6 places on the very first cohort, which is due to start in March 2019 and will receive regular mentoring and support from OD representatives. Using an evidence based cultural diagnostic tool to help improve and measure levels of staff engagement across the organisation, the Pioneers will be able to work with senior managers to make changes. This tool will enable Organisational Development to support individual teams to help build levels of engagement and ultimately improve both team effectiveness and organisational performance. A Mental Health Nurses celebration event was held on 21st February to thank and recognise the hard work and commitment of our MHLD nurses. 100 years of Learning Disability Nursing was celebrated during an event held on St David's Day In February 2019 the first cohort of Learning Disability HCSWs participated in a dedicated HCSW forum which provided protected time for HCSW's to receive news, 	<p>IT issues identified which prevents the Be Proud survey reaching BCUHB staff.</p> <ul style="list-style-type: none"> Go Engage investigating a workaround. Team level surveys will not be affected as manual entries can be made in the 4 interim period

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Recommendation	Current position	Progress update	Risks
		<p>updates and a chance to reflect on the importance of their role in delivering quality patient care.</p> <ul style="list-style-type: none"> • Site visits have been undertaken by divisional directors to ensure visibility and engagement on an individual basis. • Lessons learnt sessions have been held with stakeholders • In October 2018 a conference was held to introduce the TODAY change methodology, which was opened by the CNO and BCUHB Executive Director of Nursing. Feedback from the event has been overwhelmingly positive • The TODAYiCAN programme was officially launched on 20th December 2018 at an event attended by 130 staff which included the TODAYiCAN masterclass. This event spearheaded the approach to mainstream this new way of approaching change across the wider MH&LD workforce. A further event took place in April 2019 which was equally well subscribed. • A staff engagement event was held at the start of 2019 focused on themes from the staff survey. • TODAYiCAN team are utilising the newly developed BCUHB staff app to promote staff achievements, training events, new ideas and promotional material. • Caniad and TODAYiCAN team are using Big Chat forums to create Patient and Carers views on “Always events” These will be embedded within the Quality Strategy • A communications hub has been established on the BCUHB website and intranet to provide further information on TODAYiCAN and the underpinning methodology. • The first <i>Byddwch Yn Falch / Be Proud</i> organisational engagement survey has been launched, analysis of the data and feedback will take place in early June 2019 	
<p>Ockenden 4b & 4c: Staff Surveys Operational Lead: Sue Green, Executive Director of Workforce & 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>	on track to deliver	<ul style="list-style-type: none"> • The NHS Wales Staff Survey is currently under review in terms of its content, administration and execution. The Cabinet Secretary has been clear of the expectation that staff locally need to be involved in driving the change and improvements required to improve experiences at work. NHS Wales has historically facilitated pan-organisational surveys bi-annually which have been contracted out to organisations who have provided pan-NHS Wales and organisational reports. There has also been access to the results database to allow more localised interrogation of the data, but this has not allowed organisations to drill down fully to team and departmental level in a meaningful way. • Following a decision by the Welsh Partnership Forum in November 2018, in line with Welsh Government strategies, the national Staff Survey Project Group has been charged with implementing approaches which develop and build an “in-house” ongoing sustainable approach to measuring colleague experiences. The new approach will help develop the NHS Wales culture so that colleagues regularly give and receive feedback. The first workshop to gather views across the NHS community was held on the 11th February 2019. • The MHL D Division have created an Improvement Plan in response to the NHS Wales Staff Survey 2018. The Organisational Improvement Plan along with all Divisional Improvement Plans submitted to the Board in March 2019. • The Board approved the Staff Survey Organisational Improvement Plan along with Divisional Improvement Plans in March 2019, these will be monitored through the Workforce Improvement Group chaired by the Executive Director Workforce & Organisational Development • The Board approved the Staff Engagement Strategy in August 2016. The strategy identified key activities and achievements required to successfully realise the 	

HASCAS & Ockenden Recommendations – update report for QSE Committee meeting 21st May 2019

Recommendation	Current position	Progress update	Risks
		<p>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.</p> <ul style="list-style-type: none"> 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"> a simple way to understand the science behind staff engagement in terms of cause and effect Clear practical recommendations to improve staff engagement Regular trend analysis – not a once a year/two years snapshot in time. Ability to act quickly on data, 2 week turnaround from close of survey to presentation of results Organisational and team level diagnosis of culture 	
<p>Ockenden 4d: Clinical Engagement Operational Lead: Sue Green, Executive Director of Workforce & 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>	On track to deliver	<ul style="list-style-type: none"> The second BCUHB Medical and Dental Conference held in partnership with the Welsh NHS Confederation and BMA Wales took place on 7th March 2019 to support clinical engagement. The conference included attendance and presentations from senior executive managers from each organisation and included discussion about how to engage with Medical and Dental staff better to deliver for our patients. Following on from feedback, a 3rd Medical and Dental Conference is to be scheduled for September / October 2019 and to be held in partnership with the Welsh NHS Confederation and BMA Wales. Clinical Leads are invited to attend engagement meetings twice a year Ad-hoc 3D engagement events have been held across the organisation with medical staff Similar themes have arisen from all of the above events. All actions are to be compiled into one action plan The first 3 cohorts of the Leading for Transformation senior leadership programme have commenced with a further two due to start in May and June 2019. A Ward Manager Development Programme for 2019 has been developed to support Ward Managers in their day to day roles as managers and leaders. This bespoke programme is designed to develop management and leadership skills and competencies to enable individuals to build effective capability within their roles as clinical leaders. It provides practical skills and tools which will enable the Ward Managers to manage and lead their team effectively to enable improved patient outcomes. The programme fits within the NHS Healthcare Leadership Model ensuring all elements of the model are achieved. The programme enables individuals to develop an understanding of the complexities of healthcare across boundaries, particularly focusing on the relationship between primary and secondary care. A Transformation Group has been set up with the five national priority specialties (ophthalmology, orthopaedics, dermatology, urology and ENT) supported by a number of workstreams addressing improvements by site to reduce variation and reduce follow up backlog. Change management arrangements and resources will be identified to accelerate the pace of delivery for long-term outpatient transformation. 	

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Recommendation	Current position	Progress update	Risks
<p>Ockenden 13: Culture Change Operational Lead: Sue Green, Executive Director of Workforce & Organisational Development</p> <p><i>There will need to be sustained, visible (in clinical areas), stable leadership within MH&LD division over a longer period of time to ensure that the culture within mental health and specifically OPMH continues to develop in a positive way.</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&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"> Dementia friendly awareness session held with Health Board members on 10th January 2019 led by a Consultant Nurse (Dementia) and a Service User National Champion. Further training programme being developed to roll out dementia friends' awareness session. A Safeguarding Induction package has also been developed for delivery at Board level by end May 2019 In line with the BCUHB Dementia Strategy, the three Emergency Departments, outpatients department, COTE and orthopaedic teams are involved in the 'Dementia Friendly Hospital' accreditation programme as part of our strategic partnership with the Alzheimer's society. Within this programme it is acknowledged that any visit to hospital can be distressing for a person affected by dementia as alongside any anxiety is the diminished ability to fully make sense of what is happening and why. Ysbyty Gwynedd is the first acute hospital in Wales to be accredited 'Dementia Friendly' by the Alzheimer's society. The emphasis on the Dementia Friends initiative from the Alzheimer's society will continue to be embedded in these departments and there is an expectation that all staff become dementia friends. TODAY ICAN team have completed "train the trainer" delivered by Prof B Dolan on 14th January 2019. A delivery plan has been developed to roll out further staff training in more localised areas to increase awareness and knowledge of Quality Improvement methodology. As part of the Quality Improvement and Governance Programme (QIGP), a Quality Improvement Strategy will be developed through an established collaborative task & finish group in consultation with staff, partners and people with lived experience of using our services which will continue to meet monthly to ensure the production of an MHL D Quality Strategy. The 10 themes of the QIGP have been fully mapped out for actions which are reviewed in 90 day cycle meetings. The next meeting is in June. The strategy will assure our stakeholders of our continued determination to focus on delivering high quality patient care and challenging ourselves to achieve the highest of standards. It is aimed to launch the strategy in July. The Health Board is strengthening its offer of skilled level dementia training for clinical staff. Current training is aligned to the 'Good Work' framework and we are developing our modules further by placing additional emphasis on the important role of the carer. To support this work is underway with TIDE, an involvement network for carers of people living with dementia, hosted by the Life Story Network CIC. Its mission is to be the voice, friend and future of all carers and former carers of people with dementia. TIDE is supporting 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. 	
<p>Ockenden 5: Partnership Working 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"> Meetings have been held with Chief Officers of the Community Voluntary Councils (CVCs) to discuss the development of the overall strategic approach to relationships with the third sector. Engagement sessions with CVC third sector forums are underway to consider partnership issues with workshops being held over the next two months to seek further input from the sector. One to one meetings are being held with stakeholders who have expressed an interest in this area of work, to shape the key issues being developed. As a result of this feedback, further emphasis to be given to the Health Board's role in supporting Local Authorities to provide Information, Advice and Assistance (under the Social Services and Well-being Act), signposting people to community support, and reviewing access to advocacy services across the range of services 	<p>Complexity of the Health Board presents challenges in developing a fully embedded approach</p> <ul style="list-style-type: none"> Develop a set of principles to be adopted across the Health Board <p>Partnership approaches differ across the 6 counties</p> <ul style="list-style-type: none"> Ensure corporate arrangements are supportive of and link closely with county based arrangements <p>Objectives need review and refresh to reflect the wider strategic approach</p>

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Recommendation	Current position	Progress update	Risks
		<ul style="list-style-type: none"> 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. Discussions are taking place with the Executive Team to progress the recommendations This dovetails with the work ongoing for HASCAS recommendation 3 in relation to integrated care pathways 	<ul style="list-style-type: none"> Include wider strategic development within objectives
<p>Ockenden 7: Concerns Management 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 actual everyday experience of families, service users and service user representatives who try to make complaints to BCUHB as an organisation. Service user representatives also raised the reluctance of families and service users to complain and the fear they have of complaining.</i></p>	Risk to delivery needs attention	<ul style="list-style-type: none"> Work continues to progress to respond to the actions identified to better manage concerns in a timely and effective manner. Revised trajectories have been set to deliver real time management of complaints and incidents by the end of June 2019, which continue to be monitored via weekly incident review meetings. The number of open and overdue incidents has decreased by 989 from 6,130 in October 2018 to 5,143 in May 2019. There has also been a decrease in the number of open Welsh Government closure forms from 611 in January 2019 to 311 as at 8th May 2019. A bilingual online complaints form is now live on the BCUHB internet since January 2019 for which activity is being monitored. A draft patient experience strategy has been shared with the Community Health Council for comment. PTR1a procedure for staff has been developed and will be presented to Quality Safety Group in June. A revised Putting Things Right (PTR) 1 policy will be presented to the May QSE Committee for ratification. Standard Operating Procedure for writing a complaint response has been implemented within the corporate concerns team. Recruitment process is being progressed for the appointment of Patient Advice & Liaison Service (PALS) officers. A progress update on work to date against this recommendation was presented to the Stakeholder Group meeting on 30th April 2019. 	<p>Capacity within divisions to prioritise investigation and report writing for Concerns (against operational priorities)</p> <ul style="list-style-type: none"> Trajectories developed by division to deliver required deadlines by week commencing June 17th; No WG incidents overdue by end of June 2019 No complaints graded as 1 or 2 overdue No more than 15 complaints 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 <p>Quality of historic information to support robust learning</p> <ul style="list-style-type: none"> 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
<p>Ockenden 11: Estates OPMH Operational Lead: Rod Taylor, Director of Estates & 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 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>		<ul style="list-style-type: none"> A multi Directorate/Divisional working group that includes Operational Estates, Estate Development and Mental Health and Learning Disabilities is been established with agreed Terms of Reference. A site-by-site schedule (inventory) of outstanding repairs and maintenance work for MH&LD buildings has been completed. Work is progressing through Operational Estates to complete any outstanding jobs and the schedule is updated monthly to monitor progress. A detailed inventory of previous External Audits and Inspections by HIW & CHC relating to MH&LD OPMH facilities has been prepared and all outstanding actions are completed. Funding of £200,000 has been identified in the 2019/20 discretionary capital programme to address additional repairs and to commence the assessment of a Safe Healing Environment. Procurement and planning will now be undertaken for this work to support Workstream 2. A multi Directorate / Divisional working group comprising membership from Operational Estates, Estate Development and Mental Health and Learning 	<p>Project management capacity</p> <ul style="list-style-type: none"> Paper to go to executive team for review of resources required <p>Capital and Revenue funding to undertake identified works</p> <ul style="list-style-type: none"> Revenue funding bids have been included within Estates and Facilities budget cost pressures for 2019/20

HASCAS & Ockenden Recommendations – update report for QSE Committee meeting 21st May 2019

Recommendation	Current position	Progress update	Risks
<p><i>The estates inventory should include for each area an audit based on the work for Enhancing the Healing Environment.</i></p>		<p>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:</p> <p>Workstream 1</p> <ul style="list-style-type: none"> • <u>Develop the site by site schedule (inventory) of outstanding repairs and maintenance work and the implementation of actions to address these.</u> A site-by-site schedule (inventory) of outstanding repairs and maintenance work for MH&LD buildings has been completed. Work is progressing through Operational Estates to complete outstanding jobs by the end of March 2019 and the schedule is updated monthly to monitor progress which is reported to the HASCAS & Ockenden Improvement Group. • <u>Review recent and previous external audits and inspections (HIW & CHC) relating to MH&LD OPMH facilities to determine outstanding actions.</u> A detailed inventory of previous HIW & CHC audits and inspections relating to MH&LD OPMH facilities has been prepared and all outstanding actions have now been completed. • <u>This baseline assessment will establish the level of resources required both in regards to revenue and capital funding to address the programme of work required.</u> Funding for discretionary capital for 2019/20 has been identified within the Health Boards 2019/20 Discretionary Capital programme. Planning and procurement will be undertaken to progress this work. <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&LD buildings.</p> <p>Workstream 2 – this will commence in April 2019</p> <ol style="list-style-type: none"> <u>Develop the Enhancing the Healing Environment (EHE) assessment across all wards within MH&LD OPMH facilities.</u> <u>Determine the scope of work and resources required at each facility.</u> <p>King's Fund dementia environment audits will occur across 2019 as part of the broader dementia friendly hospitals programme.</p>	

Quality, Safety & Experience Committee	 GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board
21.5.19	<i>To improve health and provide excellent care</i>

Report Title:	Continuing NHS Healthcare (CHC) Quarterly Report
Report Author:	Marianne Walmsley – Interim Head of CHC & Commissioning Sian Kelbrick – Interim Head of CHC & Performance Katherine Titchen – Head of Commissioning for CHC
Responsible Director:	Dr Chris Stockport – Executive Director of Primary & Community Services
Public or In Committee	Public
Purpose of Report:	Quarterly CHC Position Report is provided to the Committee to provide an update and detailed analysis on CHC activity and process
Approval / Scrutiny Route Prior to Presentation:	For consideration - Quarterly reporting requirements are supported by the Wales Audit Office (WAO) in their 2013 ¹ and 2015 ² reports. Compliance is also required by the Welsh Government Public Accounts Committee and CHC National Leads Group
Governance issues / risks:	Key risks for the Health Board within this quarter <ul style="list-style-type: none"> • Imminent closure of the all wales retrospective project • Challenges remain in managing cases within prescribed timescales and there is an ongoing risk of breaches. Actions to mitigate risks have been implemented and cases are managed in chronological order wherever possible. • Fragility of care home sector
Financial Implications:	<ul style="list-style-type: none"> • Possible financial risk to the HB with possible delays in the Retrospective process due to closure of project.
Recommendation:	The Committee is asked to - <ul style="list-style-type: none"> • Note issues identified in this report • Note the development of Corporate CHC Team and Functions • Note the current position of the Health Board on the processing of retrospective claims; • Note the review of national policy and delivery systems that may include a review of the role of the National Complex Care Board; • Note the Health Board position on the current WG mandated performance measures, and the work underway which aims to

¹ Wales Audit Office: Implementation of the National Framework for Continuing NHS Healthcare (2013)

² Wales Audit Office: Continuing NHS Healthcare – Follow Up Report (2015)

	embed CHC performance within the wider outcomes frameworks in future years. • Note the immediate priorities for the CHC department
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Health Board's Well-being Objectives <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>	√	WFGA Sustainable Development Principle <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			
Special Measures Improvement Framework Theme/Expectation addressed by this paper			
Leadership and Governance Strategic and service planning			
Equality Impact Assessment			
Not required for update paper			

Disclosure:

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

Continuing NHS Healthcare Quarterly Report

1. Purpose

The *Continuing NHS Healthcare National Framework for Implementation in Wales (2014)*¹ is the Welsh Government (WG) policy document for the management of Continuing NHS Healthcare (CHC). This is supported by a National Performance Framework specific to CHC, a key requirement of which is that a formal quarterly CHC Position Report is provided to HB Boards for consideration. For additional scrutiny and detailed analysis, consideration is provided at the appropriate Board level Committee or Group. Quarterly reporting requirements have been supported by the Wales Audit Office (WAO) in their 2013² and 2015³ Reports and compliance is required by the Welsh Government Public Accounts Committee and CHC National Leads Group.

2. Background and Context

Continuing NHS Healthcare (CHC) is a term used to describe a package of care fully funded by the NHS where it has been determined the individual's primary need for care is a health need. CHC is not a term mentioned in statute. Instead, it is a policy construct which has been developed to support the identification of individuals whose level of need indicates their package of care should be funded by the NHS. The revised CHC National Framework (2014) remains the extant policy guidance. Prescribed CHC Performance and Governance and Accountability Frameworks were issued by the WG and this Report ensures compliance with these national components. In context, it is important to note there is a growing demand for both CHC and Funded Nursing Care (FNC) services, linked to the demographic profile of an increasingly older population over the coming decade.

3. Scrutiny

CHC has been subject, as referenced, to two Wales Audit Office (WAO) Reports, most recently the 2015 CHC 'Follow Up' Report which sought to establish progress in implementing recommendations set out in the 2013 Report. The Reports focus primarily on the extent to which HBs have implemented and comply with the 2014 National Framework and the management of Retrospective Reviews of CHC eligibility. The Public Accounts Committee (PAC) considered the WAO Reports in

¹ Continuing NHS Healthcare the National Framework for Implementation in Wales (2014)

² Wales Audit Office: Implementation of the National Framework for Continuing NHS Healthcare (2013)

³ Wales Audit Office: Continuing NHS Healthcare – Follow Up Report (2015)

2015 and issued a further set of recommendations which are subject to ongoing monitoring. Performance is also considered as part of the National CHC Leads work programme.

4. Performance Framework

As noted, WG issued a Performance Framework, specific to CHC, the key components of which are:

- Identification of a lead Executive Director in each HB with responsibility for CHC
- Identification of a named senior officer in each local authority with the lead for CHC and the interface with social care
- National annual self-assessment exercise of compliance with the 2014 National Framework, using a tool developed by WAO
- Annual sample audits⁴ process, dip sampling a number of current and retrospective CHC case files to capture compliance with the CHC National Framework;
- Initially, WG planned to conduct a 'customer satisfaction' survey for all individuals undergoing the assessment and CHC eligibility decision making process. This action has now been revised, with the need to capture user feedback forming part of national and local scoping work
- Compliance with a quarterly report specific to CHC. This paper ensures BCUHB compliance with this requirement.

5. Review of the 2014 National Continuing NHS Healthcare Framework

The WG provided a commitment to undertake review of the 2014 National Framework within 3 years of its implementation. A Task and Finish Group was established by the WG in 2017 at which Health Boards, Local Authorities and the Public Services Ombudsman for Wales were represented. The National Complex Care Board agreed principles supporting the current Framework are sound and a fundamental re-write was not required. Scope has focussed on clarifying, refining and adding to the existing Framework which is due out for consultation imminently.

6. Audit Cycle

As outlined in the National Performance Framework, each HB is responsible for completing an annual self-assessment audit and developing an action plan to address key areas. BCU HB self-assessment and action plans were submitted to

⁴ The baseline audits were undertaken in late 2014 and repeated in 2015 and 2016. Individual feedback was provided to each HB, with anonymised summary findings shared across HBs and with WG. The findings have been generally positive across Wales, with some excellent examples of good practice and well documented evidence and rationales for decision making.

the WG for scrutiny in January 2018 and there have been subsequent ongoing actions to build on achievements to deliver a high quality CHC service. The next formal cycle of self-assessment is underway. Feedback from the sample audit undertaken by senior WG officers in February 2018 was generally positive with examples of exemplary practice and areas of learning for consideration. The HB awaits details relating to the next cycle of WG audit. What has been notable is the resilience and dedication of staff across all areas of the CHC service to ensure the best outcomes for patients.

7. Retrospective Continuing Healthcare Reviews

The HB, via Corporate CHC team, manages applications for retrospective reviews of CHC eligibility, which are a high profile focus for the Public Accounts Committee and Welsh Government (WG). These reviews are in respect of individuals who have contributed financially to care fees but who now believe their care should have been funded solely by the NHS with CHC funding. The WG directed all Health Boards to adopt the nationally prescribed process to manage retrospective applications and BCU HB has fully implemented these procedures, which provide the necessary level of scrutiny for cases and assurance a robust governance structure is in place (further details are available in *'Continuing NHS Healthcare the National Framework for Implementation in Wales (2014)' Section 6: Retrospective Claims for Reimbursement*). This section of the report will focus on retrospective reviews including performance, activity and the strategic interface with WG.

Phase 1 - The national project hosted by Powys Teaching Health Board (PTHB) launched in June 2011 to review 2454 claims received by Health Boards across Wales. These cases were in response to a cut-off date announced by the WG in December 2009. BCU HB transferred 368 cases to the project some of which were subsequently closed. All claims have been reviewed and this phase is now complete. The financial value of BCU HB settlements is £3,329,607.

Phase 2 - Due to a backlog of cases in HB's, CEO's agreed to transfer further cases to the project during 2014/15; 941 were transferred with 350 of these from BCU HB however a residual number remained the responsibility of the HB to review. Value of BCU HB settlements to date is £5,047,143.

Phase 3 - WG advertised a cut-off date relating to the claim period 1st April 2003 to 31st July 2013 in May 2014. 250 cases were received from BCU HB and the project was responsible for reviewing the majority of these. Value of BCU HB settlements to date is £1,163, 649.

Phase 4 - to date - £838, 822;

Phase 5 - to date - £280,672;

Phase 6 - to date - £8,074

Phase 7 – to date - £2,365;

Ad hoc cases - to date £80,667

The WG announced further deadlines for new applications and the process for considering a retrospective review is as follows:

- the claim period to be considered will be no longer than 12 months from the date of application
- If the claim period is after a MDT / IRP decision of no eligibility, the period to be reviewed may go back to the date of the decision as long as it is no longer than 12 months
- If the claim period is prior to a MDT / IRP decision, no longer than a 12 month period will be reviewed

All new cases are Phase 7 and categorised by annual date. The total value to date, of BCU HB settlements across all Phases is £10,750,972

Further detail by Phase and Key Stages is provided in **Tables 1** and **2** below.

Table 1

Phase	For Claim Applications Submitted	Limits of Claim Periods to be Reviewed		Target Review Timescale
		Powys	HBs	
Phase 1	Up to 15/08/2010	01/04/1996 - 15/08/2010	N/A	-
Phase 2	16/08/2010 - 30/04/2014	01/04/2003 - 31/07/2014	01/04/2003 >	30/06/2014
Phase 3	01/05/2014 - 31/07/2014	01/04/2003 - 31/07/2014	01/04/2003 >	2 Years
Phase 4	01/08/2014 - 31/10/2015	N/A	01/08/2013 >	1 Year
Phase 5	01/11/2015 - 30/09/2016	N/A	01/10/2014 >	6 Months
Phase 6	01/10/2016 - 30/09/2017	N/A	01/10/2015 >	6 Months
Phase 7	Annual dates ¹ April to 31 March	N/A	01/11/2016 >	6 Months

Table 2

Status	Definition
Received	Application submitted but not yet activated i.e. awaiting legal authority & evidence of payments to proceed
Activated	All evidence received & verified
Reviewed	Reviewed & peer reviewed to point of draft recommendation
Completed	Reimbursement made or 'no eligibility' ratified
Closed	Case closed or withdrawn with no review having taken place

WG requires assurance in terms of performance and activity without being overly demanding in terms of reporting requirements and data is monitored via a national IT system which BCU HB has fully implemented, reporting to WG on a monthly basis. Management of applications should be considered as part of core HB business and reported to HB Boards via quarterly reports. This report fulfils that reporting requirement. Data reported includes:

- Performance & Activity

- Retrospective numbers by Phase & Status
- Assessment of compliance with WG timescales
- Reviews finished and reimbursements made
- Claim eligibility (conversion) & costs reimbursement
- Finance department performance
- Staffing position
- Key risks & mitigating actions

Summary of current HB position by Phase / Status is available at **Table 3** below

Status					
Phase	Received	Activated	Reviewed	Completed	Closed
2	0	0	0	11	2
2 - Alive	0	0	3	6	16
3	0	0	0	1	5
3 - Alive	0	1	7	6	17
4	0	2	5	44	54
5	0	8	9	19	27
6	0	20	3	2	23
7 - 17/18	0	8	1	0	4
7 - 18/19	12	7	2	1	3
7 - 19/20	0	0	0	0	0
7 - 20/21	0	0	0	0	0
7 - 21/22	0	0	0	0	0
Total All Phases	12	46	30	90	151

The number of cases reviewed as at time of report is **30**. There is a gap between cases reviewed and completed. This is expected as cases reviewed are then taken through claimant comments and / or negotiation and ratification by Independent Chair and / or Independent Review Panel. Pathways for the **90** completed cases to date are:

- Full Eligibility – 16
- Partial Eligibility – 54
- No Eligibility – 20

Summary of Breached Review dates is available at **Table 4** below

Review Dates Breached				Review Dates Not Breached		
Phase	Review Completed	Review Not Completed	Total Breached	Review Completed	Review Not Completed	Total Not Breached
2	11	2	13	0	0	0
2 - Alive	8	5	13	0	0	0
3	0	0	0	1	0	1
3 - Alive	5	4	9	8	2	10
4	37	8	45	13	0	13
5	27	10	37	0	1	1
6	5	21	26	1	2	3
7 - 17/18	1	5	6	0	3	3
7 - 18/19	2	1	3	1	6	7
7 - 19/20	0	0	0	0	0	0

7 - 20/21	0	0	0	0	0	0
7 - 21/22	0	0	0	0	0	0
Total All Phases	96	56	152	24	14	38

Table 5 provides details of residual BCU HB activity

BCUHB Residual Activity			
Phase	Received	Activated	Timescale for Review
P2&P2Alive	0	0	2 Years
P3&P3Alive	0	1	2 Years
P4	0	2	1 Year
P5	0	8	6 Months
P6	0	20	6 Months
P7 – 17/18	0	8	6 Months
P7 – 18/19	12	7	6 Months
Total	12	46	

The Health Boards performance regarding completion of retrospective reviews – Since 1st September 2018 – 19 cases reviewed & 9 cases completed

BCU HB has adopted the amended process as directed by the WG and applies the 'NHS Continuing Healthcare Checklist November 2012 (Revised) (Department of Health 2012)' to applications. There are five key performance areas:

- Overall performance against target timescales, balancing review of older cases while mitigating the risk of additional breaches for phases that are more recent and timescales for review are 6 months. This has been acknowledged by the WG as being a challenge.
- Month on month performance including component performance
 - i. Nurse Reviewers' performance
 - ii. Chronologists' performance
- Performance of the HB reimbursing cases within 30 days of receiving indemnity letter from the claimant.

Challenges remain in managing cases within prescribed timescales and there is an ongoing risk of breaches. Actions to mitigate risks have been implemented and cases are always managed in chronological order wherever possible.

BCU HB has implemented the national Independent Review Panel with access to Independent Chairs for panels and ratification of cases.

Closure of the All Wales Retrospective CHC Reviews Project

The All Wales Retrospective CHC Reviews Project that was hosted by Powys (Teaching) Health Board, is now set to close. This was originally established in 2011

to manage, on behalf of NHS Wales the 2,500 Phase 2 and Phase 3 applications for retrospective reviews. CEO's have received regular updates in terms of closure plans for the project which has now been agreed for 30 April 2019 and closure plans are now being progressed. Work will cease on current cases on 31 March 2019 with the following four weeks being used to close down the Project.

It had originally been anticipated all cases would be reviewed to the point of recommendation when the project closes at the end of April, however it has been confirmed incomplete cases will be returned to Health Boards for ongoing management of the process. This will have an impact related to resources and capacity.

Health Boards have been provided with a projected forecast of the residual number of cases which will be returned and require reviews, facilitation of claimant negotiation meetings and potential Independent Review Panels. This will have an impact on activity with existing HB cases. A series of SBARs has been developed which consider the main risks / issues associated with transfer of cases back into BCU HB and make recommendations for actions to mitigate. Key areas are:

- Capacity / staffing - assessment to ensure risk of breaches to current cases are mitigated and cases transferred back into BCU HB are reviewed / completed in a timely manner
- Securing adequate, appropriate storage facilities to allow screening of the 130 archive boxes of health and social care records due to be returned to the HB
- Securing alternative office space for staff to manage cases in a timely manner.

A detailed breakdown of cases being transferred to BCU HB is provided in **Table 6** however the number of cases to review will decrease as Clinical Advisors in the Project will continue reviewing cases until 31 March. Exact figures for cases not reviewed will be known four weeks before closure of the Project.

Table 6

	Phase 2	Phase 3
Number of cases transferred to Project	350	213
Closed	43	42
Activated by Project	307	171
Reviewed by Project	307	144
Completed by Project	297	111
Residual to be reviewed by BCU HB	0	27
Residual for Completion by BCU HB	10	60
Potential mediation meetings	0	49
Potential IRP's to be arranged by BCU HB	4	51

The Corporate CHC Team and IT department are working closely with the Project to facilitate seamless transfer of electronic files being returned to BCU HB. It is anticipated these will start to be transferred from 7 March in four tranches.

From mid to end March the Project will start transferring the 130 archive boxes of records to BCU HB. It is anticipated 30 boxes will need to be easily accessible for 'active' cases. The remaining 100 will contain completed cases. Records will require screening to ensure contents are compatible with tracking information and categorised as

- required immediately
- future retrieval / disposal
- returned to source
- disposal

Independent Chairs have previously been managed by the Project and the HB awaits confirmation as to who will take over management in its absence. The Project will write out to all claimants where cases are being transferred to the HB and it is anticipated this will generate enquiries.

CHC Training

The WG emphasise that training programmes need to ensure the lessons from retrospective reviews are used as learning opportunities. In order to facilitate compliance with WG requirements the corporate team is developing a strategy to deliver a sustainable regional CHC training programme, in partnership with the North Wales Local Authorities. To date however training and progress have been impacted upon by resource and capacity. Firm links are in place with Bangor and Glyndwr Universities where training sessions are delivered to Nursing and District Nursing students during the last quarter.

8. CHC Commissioning and associated joint work streams update February 2019.

Commissioning in Continuing Healthcare is both at individual and strategic levels.

At an individual level CHC commissioners are being supported to ensure compliance with the CHC legal framework for eligibility for fully health funded care. Objectives of the service and service support are around reduction of variation of implementation of the framework with clarity of the individual care planning to meet assessed needs in a no more no less CHC framework principle, clear details of how the needs are to be met and by what outcomes will be measured as this essentially provides the individualized service specification for that individual's care contractually.

Structures to support consistent implementation of the CHC framework include the software case management package Broad care. This is now fully operational in all

areas except children's complex care and will be the sole used case management system from the 1st of April giving administrative duties efficiencies in areas. Reporting and performance management falls out of this software package and a dashboard is in development to support this. From both the dashboard, local area variations of the dashboard and bespoke report generating requests from Broadcare comes the facility to have an evidenced based service improvement facility. This will have a knock on effect of identifying issues up and downstream from the CHC service in a whole systems improvement support in pathways associated with CHC service users.

Strategically the individual commissioners are being supported by wider strategic commissioning using a co design, regional Partnership forum through the Regional Commissioning Board. Aligning to the Partnership principles core commissioning boundaries are being clarified which will provide a business platform on which more creative commissioning can be sought. For instance the establishment of Care Home specifications, preplacement agreement (basic contract) and fee methodology across the region being standardised within a framework gives market stability and clarity reducing the variation and risk in individually commissioned services for each patient and cost stability for the Health Board. Following the need for enhanced services above framework core can be investigated and evidence based.

Service co-design across the health and social care system in Partnership.

Transformation work both with partners and within the Health Board are ongoing supporting issue resolution such as access to domiciliary care in Gwynedd and Anglesey and wider underpinning of the structures required to support more creative future commissioning. A clear example of this is the work being done around a regional framework for core service specifications in care homes, domiciliary care services and extra living facilities. Alongside specifications are agreements around fee rates and contracts to form the business platform and clarity on which to build wider creative commissioning.

Engagement with stakeholder partners including the internal links between area teams and corporate teams in BCU is key in coordinated co design fully utilising the Regional Commissioning Board arm of the Regional Partnership Board. Work stream priorities are being negotiated through the Partnership Board currently for 19/20 and horizon planning. Along with national and BCUHB priorities this will provide the basis for the 2019/2020 onwards commissioning strategy for CHC

Current work streams

- Partnership regional commissioning Board
- Care Home Group
- Domiciliary Care Group
- Inflationary uplifts

- Extra Care Group
- Enablers
- PRG
- Corporate/ PMO
- Sub project enablers
- Medicines management
- Community Equipment
- Broadcare
- Integrated partnership
- Older Person's Mental Health OPMH
- Conduit between corporate/ partnership board and areas

9. Quality Assurance for Commissioned Services

The HB through the Corporate CHC team has developed a number of key initiatives for implementation which provide the necessary level of scrutiny for commissioned services and ensure quality of care delivery. This section of the report will focus on Quality and provide updates on both the operational management and scrutiny of commissioned services, as well as strategic developments in progress.

Quality Aims and Objectives

The Health Board (HB) aims to commission services which improve the health and wellbeing of all patients for whom it commissions care. The HB will do this by securing sustainable health care which enables patients to receive modern, responsive, high quality yet cost effective care.

CHC for General and Older People with Mental Health is now part of the Executive Director of Primary & Community Services portfolio. The operational duties of CHC including the financial responsibility sits under the Area operational teams, with the strategic, governance, quality & performance being part of the Corporate CHC team under the Executive Director of Primary & Community Services.

The Corporate CHC team has a responsibility to drive and support commissioned services to deliver sustained quality care. In order to ensure its success the following key objectives have been set, to ensure -

- Commissioned services are safe, personal, effective and continuously improving
- Robust quality mechanisms are in place so standards of patient care are clearly described and effectively demonstrated
- Quality outcomes are proactively monitored and triangulated
- Appropriate action is taken if the quality of a commissioned service is found to be compromised

The Corporate CHC Team will:

- Establish a robust governance structure to monitor quality and safety including the analysis of personalised care, effectiveness and safety.
- Ensure the development of a North Wales wide Standard Operating Procedure for commissioned services. Working jointly with Local Authorities to ensure the standard implementation
- Implement a system for Patient and family/carer feedback to inform the Quality agenda & the Assessment and CHC decision-making process.
- Utilise data from feedback and concerns appropriately to detect early indicators of concern
- Collaborate with Care Inspectorate Wales (CIW) and Local Authorities to ensure triangulation of intelligence
- Support care providers as appropriate, to innovate in order to continuously improve and meet future challenges.

Quality developments

To ensure a driver for the delivery of quality and safe care within commissioned services, the Corporate CHC team have been delivering on a number of initiatives which include a Quality Assurance Framework, Service Specification and CHC Fees Methodology.

Quality Assurance Framework

The Quality Assurance Framework has been developed and presented within QSG and circulated to operational area teams for implementation. This sets out key deliverables to be monitored and implemented in ensuring the delivery of safe quality services by commissioned care providers. The delivery of the framework will be the central part of both the Corporate and Area teams approach and an essential component in delivering key quality initiatives.

Intelligence and Data Analysis

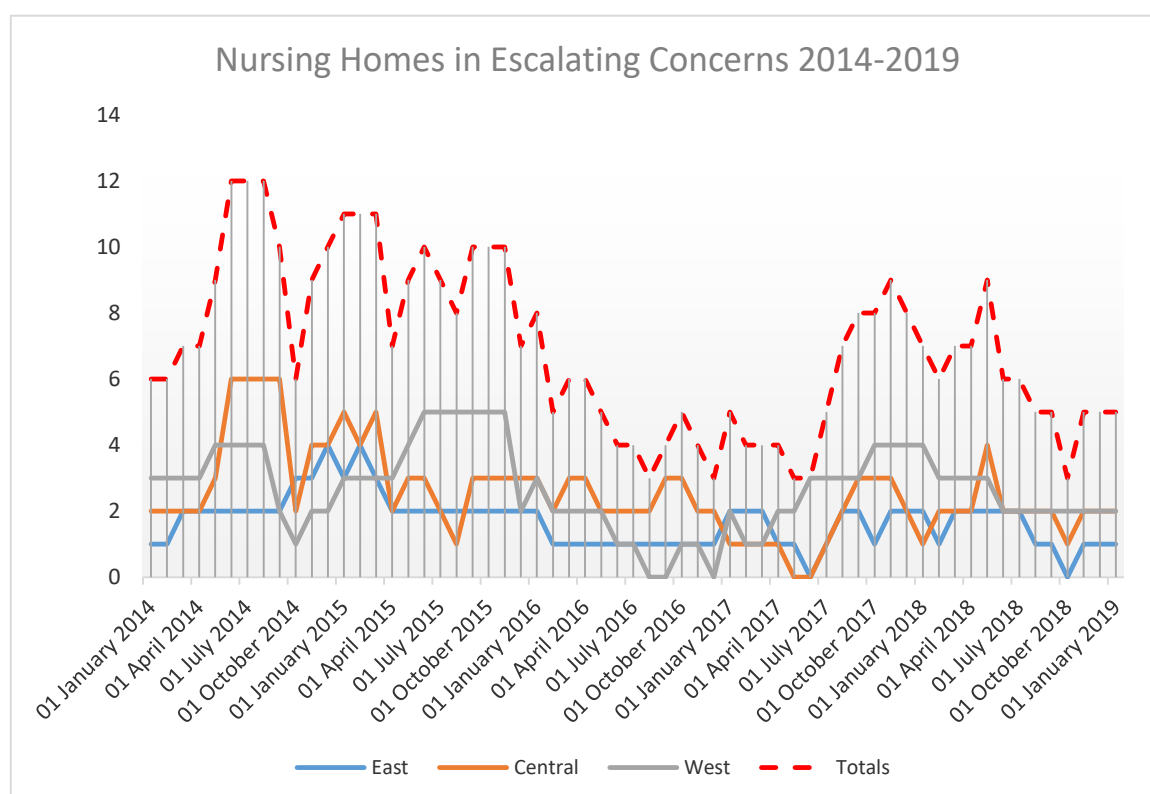
The Corporate CHC team collate intelligence with reference to commissioned services relating to quality standards, concerns, training and development. The quality and concerns elements are recorded within the monthly RAG report, which is shared with relevant officers both within the HB and Local Authorities.

The most recent RAG report (Jan 2019) identified that in relation to nursing homes there are 58 with no or minimal concerns; 5 with accumulating issues and concerns and 5 with escalating/serious concerns as seen in **Table 7** below

Table 7

Internal BCU Concerns Levels	Total Nursing Homes – 68 → (East 21 / Central 32 / West 16)
Level 1 (No / minimal issues)	58↑
Level 2 (Accumulating issues & concerns)	5↓
Level 3 (Serious concerns)	5→

The graph in **Table 8** below provides details in relation to Escalating Concerns inclusive of the period 2014 to the most recent RAG report.

Table 8

Homes under Level 3 Concern

The homes at Level 3 are all under the formal Escalating Concerns process. This is a multi-agency process to monitor and discuss serious concerns following Welsh Government statutory guidance.

Common themes in relation to Escalating Concerns:

- Registered Nurse staffing levels are a significant issue currently across a large number of nursing homes across North Wales. Homes are finding it difficult to recruit and retain registered nurses, so there is, in some homes, a high reliance

on agency usage. This has a negative impact on both finance and quality of care.

- The Fundamentals of Care key themes consistently identified include Medicines Management, nutrition and tissue viability. The PDNT within the Areas work closely with Specialist Nurses, Therapists and Medicines Management to develop, training and support within the homes .
- A failure to translate theory into practice evidenced by inadequate care planning and implementation. The PDNT have spent significant time within the homes under Escalating Concerns providing advice with regards to documentation, care planning and recommended risk assessments.

Current actions to mitigate risks

- Regular monitoring of staffing levels within the homes; support and advice with regards accessing agencies in addition to recruitment and retention.
- Provision of in-house, comprehensive clinical skills training by PDNT, Support in facilitation of evidence based practice
- Quality monitoring assessment based on the Fundamentals of Care; provision of ongoing support, education and training in accordance with the quality monitoring outcome and results
- Proactive meetings with Local Authorities to share intelligence and discuss the care (nursing) home agenda/key themes.
- Regular monitoring via joint risk assessment, corrective or developmental action plan led by the Escalating Concerns process.

Training

An annual training programme is planned and arranged through the PDNT within the Areas, and disseminated to the Nursing Homes in January. Attendance is monitored by the CHC Corporate team. The following graphs at **Tables 9, 10 and 11** provide details of training arranged and numbers attended September 2018 – January 2019. It should be noted that less training events are offered during the Christmas period. This is based on previous trends of poor attendance at the sessions, however if a home requests training the team will arrange and provide the training. There has also been a PDN vacancy in the West, for the later part of the year.

Table 9

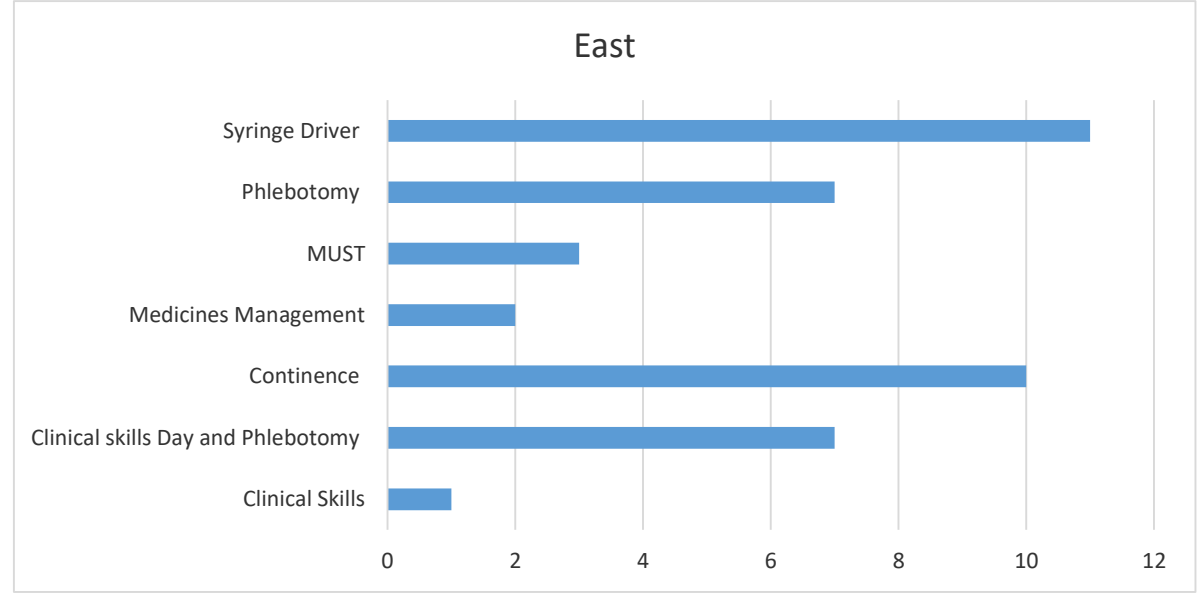


Table 10

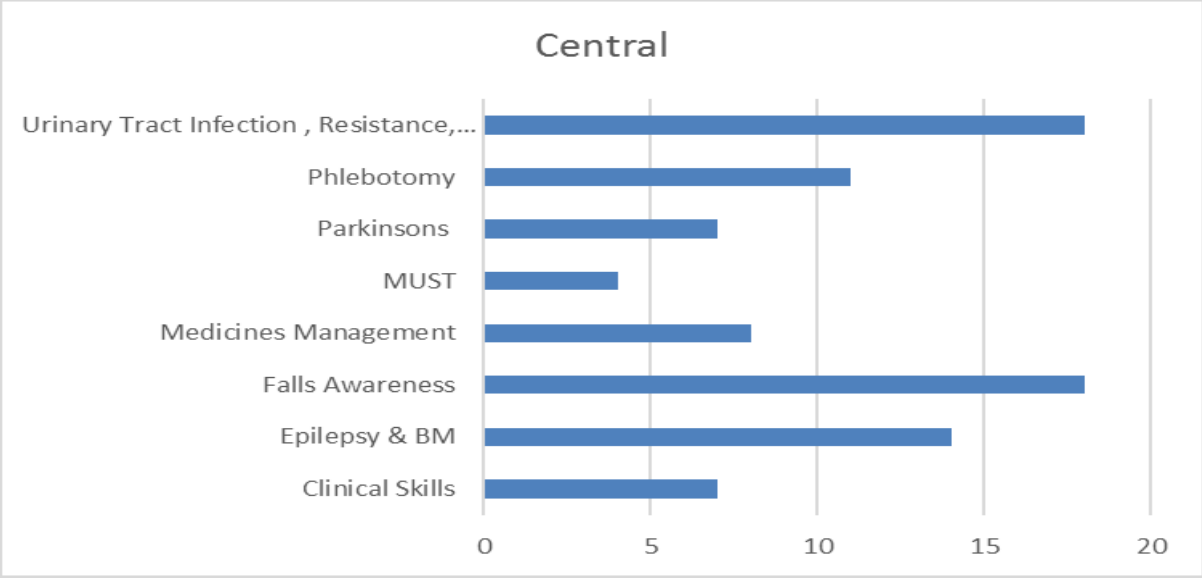
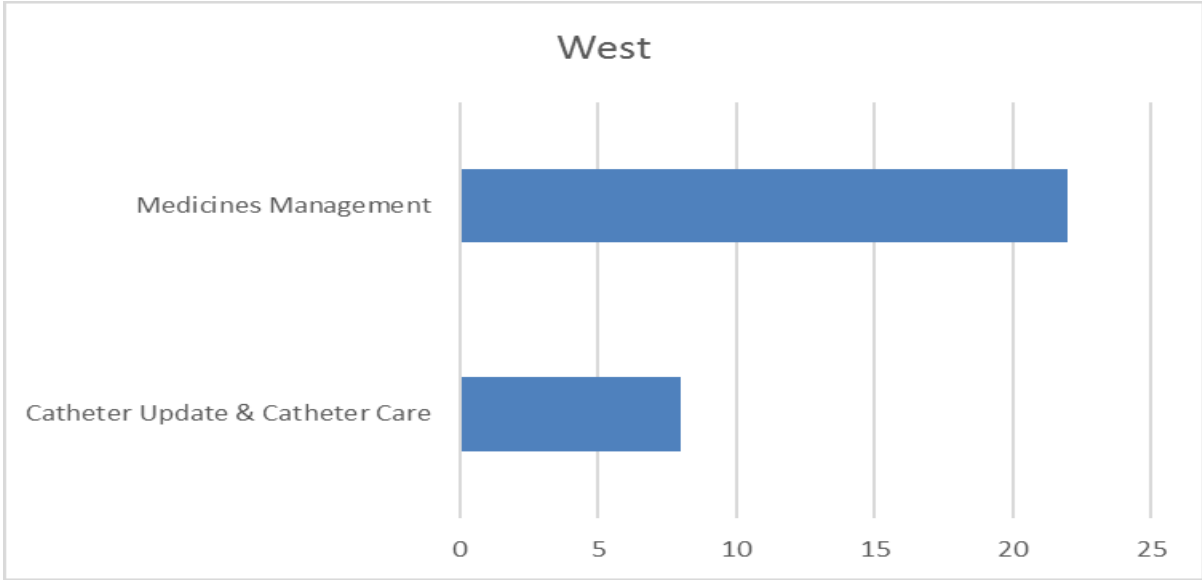


Table 11



Quality Monitoring audits are undertaken in all nursing homes by the PDNT. The CHC. The graph at **Table 12** provides details of the number of audits undertaken in 2018 and the results.

Table 12

Number of QMT scores done		Totals	West	Central	East
QMT 's Completed		45	6	23	16
NEW QMT 's Completed		19	7	10	2
Total QMT undertaken		64	13	33	18
Old QMT Average Percentage		93%	94%	93%	93%
New QMT Average Percentage		88%	87%	95%	83%
0-49% Red Old		0	0	0	0
0-49% Red New		0	0	0	0
50-89% Amber Old		10	1	6	3
50-89% Amber New		7	4	2	1
89-100%Green Old		36	5	17	14
89-100%Green New		10	2	7	1

Joint Quality Monitoring process

The team have been working jointly with the Local Authorities to develop a joint monitoring process to care homes. This will ensure a coordinated approach to monitoring thus relieving pressure of different visits to the homes as well as a triangulation of key intelligence. Joint monitoring is working effectively within the majority of areas . Joint visits are undertaken with agreement from the provider, separate action plans are then provided following the monitoring visit .

Joint Escalating concerns process

To ensure standardisation and the mitigation of risks the team have worked closely with the Local Authorities to develop a standard policy and approach to the management of quality and Escalating Concerns within our commissioned services. This has been widely circulated and a workshop planned in march to discuss the implementation and review.

Care Plans

One of the key issues from undertaking monitoring within the homes is the amount of conflicting advice the homes have been getting from different commissioners regarding what a person centred care plan should look like. To support the homes the team have developed a Person Centred Care Plan template, jointly with and approved by CIW and other partners. This has been circulated as best practice recommendation to all nursing homes across north Wales to provide them with advice and guidance as well as BCUHB resources such as, Risk Assessments, policies, procedures and examples of care plans.

CHC service specification for basic CHC in Nursing homes

A service specification regarding older people living in care homes receiving a basic CHC care package has been developed. This provides a detailed description of standards of quality & safety required for implementation by nursing homes. This is currently being consulted on with both the Local Authorities and the Nursing home sector across north Wales. Once implemented within the Health Board the specification will also form part of the North Wales Joint Health & Social Care suite of service specifications for commissioned services.

CIW/ HIW review into Health service provision into care homes

The CHC service has been working with Care Inspectorate Wales (CIW), Health Inspectorate Wales (HIW), the Older People's Commissioner for Wales and Care Forum Wales as part of the Advisory Group on the Review of Health Care Support within Care Homes in North Wales. The work stream focussed on key areas and themes identified during an initial scoping exercise for future CIW inspections and HIW lines of enquiry.

Between August and November 2017 a questionnaire was sent out by CIW to all registered older adult residential and nursing homes across the BCUHB footprint (over 200 homes). The main purpose of the survey was to determine what services care homes are able to access, quality of services accessed, reasons services weren't accessed (accessibility, timeliness, effectiveness); service gaps and the relationship which care homes have with the HB

The outcome of this was developed into a report which was published and placed on the CIW website. In response the HB were tasked to develop an action plan for implementation, which has been approved in the QSG. CHC corporate team are now meeting with Area teams to ensure a position statement on the actions, ensure implementation and provide support as needed.

CHC Standard Operational Procedure

A draft Commissioning Standard Operational procedure has been developed and is currently out for consultation. This has circulated to all Area teams, the MH&LDS Division as well as the Heads of Adults services in local Authorities.

The purpose of the Procedure is to provide assurance to the WG and HB that there is a robust governance structure in place to deliver fair, consistent and equitable application of the national framework across North Wales. In brief, with oversight by the Corporate CHC Team, the Procedure aims to streamline and strengthen the Assessment and CHC Eligibility Decision-Making process and further strengthen partnership arrangements.

The first formal consultation event has been held with the Local Authorities with positive outcomes. Further key work streams are planned to develop a joint Dispute Policy, section 117 Framework and Joint Funding process.

Enhanced Observation Policy

The Corporate CHC team have reviewed the Health Board's Enhanced Observation policy to make it relevant to the Nursing home sector. This was positively piloted in the East Area and now being implemented across the Areas .

Legal Library Support Service

Over the last eight months, the Corporate CHC Team implemented an innovative system through which support and advice can be provided to operational CHC teams across the HB in relation to complex cases that involve contentious health, commissioning and legal issues. A 'legal library' was developed to provide healthcare practitioners with a mechanism to apply sound legal principles into practice. The library offers a quick reference guide to the most up to date legal and healthcare issues along with a set of legally tested case examples. A set of robust measures are also being developed to:

- Demonstrate progress towards outcomes
- Identify areas which require attention and opportunities for learning
- Support continuous improvement of the CHC service

This innovative system also acts as an interface between the HB CHC service and Welsh Health Legal Services, as and when required. A number of performance measures achieved to date include; dispute resolution, cost avoidance, lessons learnt and empowering and educating staff.

Older Persons Agenda

The team are supporting the BCUHB Older Persons Agenda by developing a delivery plan that supports the overarching integrated pathways for older persons and those with dementia, focusing upon clinical service redesign, education and the integration with the care home sector. The objectives have been established against the Ockenden and HASCAS (2018) Independent Reports and work is overseen by the integrated Improvement Group, chaired by the Executive Director of Nursing and Midwifery. Significant progress has been made since the commencement of this programme in October 2018. An initial scoping exercise of all relating older persons work, both locally and nationally, was completed along with identifying improvements achieved to date in practice and a gap analysis. A BCUHB delivery plan has been developed to concentrate primarily on Ockenden Recommendation 1 and 12 and HASCAS Recommendation 1 and 3. A long-term clinical strategy is envisaged to encompass a regional training programme in partnership to address various educational needs across all settings in relation to the care of the older person, with university support. Setting clinical standards and developing strong clinical governance will also play a key part in the formulation of the pathways.

Three clinical events are planned to ensure the integration and partnership working between Care home sector and HB professionals. These are planned for March 2019 .

Whilst the work-stream for the older persons agenda is broad in nature and applies to all health and social care settings, including third sector and care provider services, the progression of the work plan will be supported by a partnership approach, underpinned by the overarching transformational plan for North Wales.

Conclusion and Recommendations

In order to continue with the improved Governance and Performance of CHC the centralised corporate CHC team reporting to the Executive Director for Primary & Community provides assurance to the HB of ongoing compliance with the National Governance & Performance Framework. Other functions include retrospective reviews , training, Quality Assurance in Commissioned Care and Commissioning Support.

WG issued a revised CHC National Framework in 2014. This Framework reflected Recommendations made by both the Wales Audit Office and Public Accounts Committee, who continue to monitor implementation, with the most recent report issued by PAC in March 2015 including a further series of recommendations.

As part of the separate CHC Performance Framework required by WG, Boards are required to receive a quarterly report on CHC, and this paper fulfils that requirement. It informs the Board of developments and current issues relevant to CHC, both nationally and locally.

The implementation of CHC across the BCUHB footprint has gathered pace and as the service embeds robust processes and systems, with greater alignment of operational staff within respective Areas, the focus of the department will be shifted towards developing and implementing a commissioning strategy for CHC, developing quality assurance processes and ensuring the standardisation of delivery of the framework across the HB.

Committee members are asked to:

- **Note** any national changes and local issues identified in this report
- **Note** the current position of the Health Board on the processing of retrospective applications;
- **Note** the review of national policy and delivery systems that may include a review of the role of the National Complex Care Board;
- **Note** the Health Board position on the current WG mandated performance measures, and the work underway which aims to embed CHC performance within the wider outcomes frameworks in future years.
- **Note** the immediate priorities for the CHC department

Appendix 1

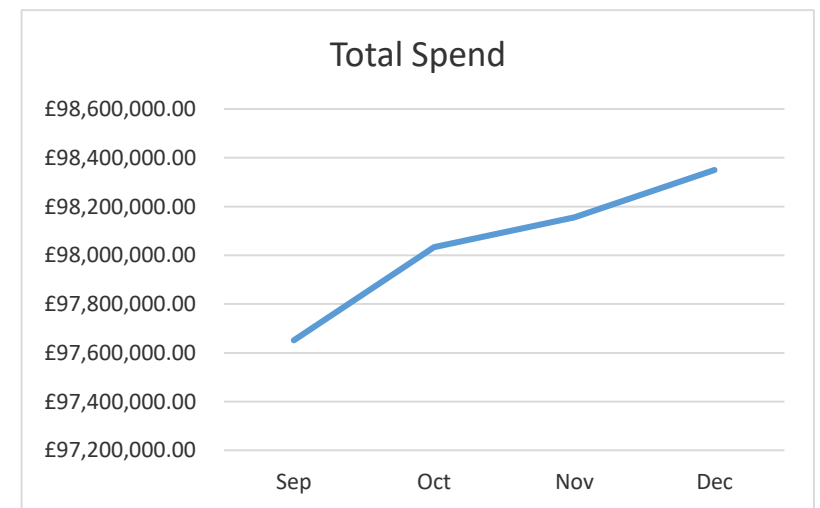
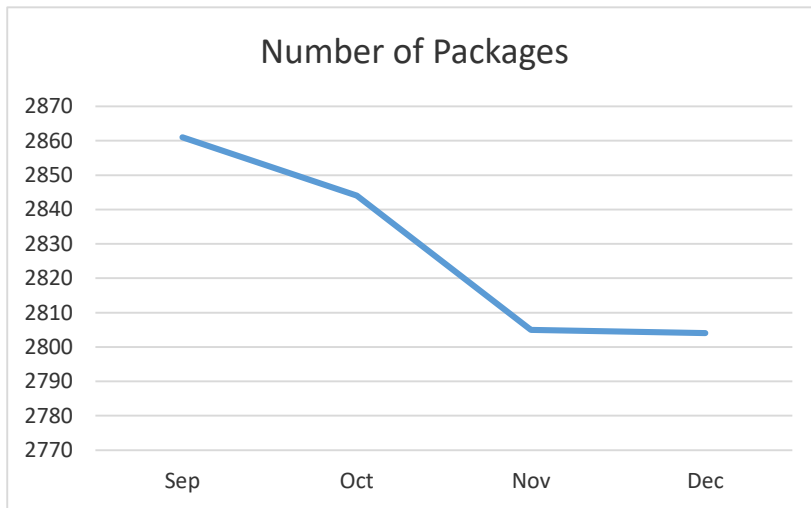
Performance Position against current measures

Measure						
	SEP			OCT		
	Patient No's	Spend	%	Patient No's	Spend	%
		£000's			£000's	
Number of current CHC packages delivered by category and by proportion of total HB CHC spend						
General Nursing	655	£25,286,945	32.46%	648	£25,326,817	32.30%
Elderley Mentally Ill Nursing Home	348	£15,827,432	20.31%	343	£16,114,083	20.55%
Community Based/Home Care Support	147	£5,923,364	7.60%	143	£6,291,392	8.02%
Adult Palliative Care	43	£1,729,921	2.22%	34	£1,642,703	2.10%
Respite	4	£33,713	0.04%	4	£39,013	0.05%
Children	26	£1,191,783	1.53%	27	£1,192,580	1.52%
Learning Disability	121	£18,005,298	23.11%	119	£17,978,335	22.93%
Adult Mental Health	35	£3,161,321	4.06%	33	£3,029,844	3.86%
Funded Nursing Care	881	£6,750,380	8.66%	888	£6,784,530	8.65%
Total	2,260	£77,910,157		2,239	£78,399,297	
Total number of CHC numbers and spend for CHC packages delivered:	Patient No's	Spend		Patient No's	Spend	
(a) in a registered setting		£000's			£000's	
CHC	1185	£62,186,227		1160	£62,283,042	
FNC	881	£6,750,380		888	£6,784,530	
JF	303	£10,886,860		301	£10,909,959	
Total	2,369	£79,823,467		2,349	£79,977,531	
(b) in the community						
CHC	194	£8,973,550		191	£9,331,725	
FNC	0	£0		0	£0	
JF	298	£8,854,759		304	£8,724,188	
Total	492	£17,828,309		495	£18,055,913	
	2861	£97,651,776		2,844	£98,033,444	

Percentage of case reviews undertaken at						
(a) 3 months						
East PCSM		100%			100%	
East OPMH		100%			100%	
Central PCSM		60%			71%	
Central OPMH		46%			100%	
West PCSM		100%			100%	
West OPMH		66%			66%	
AMHLD		94%			97%	
Childrens						
Average						
(b) twelve months						
East PCSM		100%			100%	
East OPMH		100%			100%	
Central PCSM		94%			97%	
Central OPMH		100%			100%	
West PCSM		100%			100%	
West OPMH		82%			90%	
AMHLD		98%			90%	
Childrens						
Average		96%			97%	
Performance re completion of retrospective reviews						
Number of identified priority staff who have received update training on the new Framework						

	Patient No's	Spend	%	Patient No's	Spend	%
Number of current CHC packages delivered by category and by proportion of total HB CHC spend		£000's			£000's	
General Nursing	615	£24,888,955	31.77%	603	£24,841,677	31.65%
Elderley Mentally Ill Nursing Home	345	£16,136,719	20.60%	336	£16,069,408	20.48%
Community Based/Home Care Support	136	£6,285,449	8.02%	137	£6,338,553	8.08%
Adult Palliative Care	28	£1,550,647	1.98%	28	£1,546,327	1.97%
Respite	4	£40,733	0.05%	4	£64,013	0.08%
Children	27	£1,185,370	1.51%	26	£1,137,312	1.45%
Learning Disability	121	£18,428,104	23.53%	122	£18,590,042	23.69%
Adult Mental Health	33	£3,050,960	3.89%	34	£3,091,315	3.94%
Funded Nursing Care	891	£6,765,891	8.64%	903	£6,802,603	8.67%
Total	2,200	£78,332,828		2,193	£78,481,250	
Total number of CHC numbers and spend for CHC packages delivered:	Patient No's	Spend		Patient No's	Spend	
(a) in a registered setting		£000's			£000's	
CHC	1125	£62,255,962		1105	£62,229,378	
FNC	891	£6,765,891		903	£6,802,603	
JF	307	£10,893,221		311	£10,922,260	
Total	2,323	£79,915,074		2,319	£79,954,241	
(b) in the community						
CHC	184	£9,310,975		185	£9,449,269	
FNC	0	£0		0	£0	
JF	298	£8,929,855		300	£8,946,844	
Total	482	£18,240,830		485	£18,396,113	
	2,805	£98,155,904		2,804	£98,350,354	

Percentage of case reviews undertaken at						
(a) 3 months						
East PCSM		100%			100%	
East OPMH		100%			100%	
Central PCSM		67%			50%	
Central OPMH		38%			29%	
West PCSM		100%			100%	
West OPMH		89%			100%	
AMHLD		75%			99%	
Childrens						
Average						
(b) twelve months						
East PCSM		100%			100%	
East OPMH		100%			100%	
Central PCSM		96%			100%	
Central OPMH		100%			100%	
West PCSM		100%			100%	
West OPMH		92%			50%	
AMHLD		85%			95%	
Childrens						
Average		96%			92%	
Performance re completion of retrospective reviews						
Number of identified priority staff who have received update training on the new Framework						



Quality, Safety & Experience Committee	 <div style="display: inline-block; vertical-align: middle;"> GIG CYMRU NHS WALES </div> <div style="display: inline-block; vertical-align: middle; margin-left: 10px;"> Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board </div>
21.5.19	<i>To improve health and provide excellent care</i>

Report Title:	Annual Quality Statement 2018/2019
Report Author:	Mrs Diane Read, Quality Improvement Team Mr Andrew Rogers, Head of Communications
Responsible Director:	Mrs Deborah Carter, Interim Executive Director of Nursing and Midwifery
Public or In Committee	Public
Purpose of Report:	<p>The attached draft Annual Quality Statement (AQS) is presented to the Committee for approval on the 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 where available is for year-end quality measures that have been presented to the Committee previously.</p> <p>The AQS has been developed following submissions from across the Health Board.</p>
Approval / Scrutiny Route Prior to Presentation:	The AQS has been presented to other groups for further feedback during the draft phase.
Governance issues / risks:	The AQS document highlights good practice that has taken place across the Health Board and identifies areas where further improvement work is required.
Financial Implications:	None identified at the point in time
Recommendation:	<p>The Committee are asked to:</p> <ol style="list-style-type: none"> 1. Approve the AQS. 2. Note that the final formatting will take place following approval in preparation for publication on 31st May 2019.

Health Board's Well-being Objectives <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>	√	WFGA Sustainable Development Principle <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	√		
Special Measures Improvement Framework Theme/Expectation addressed by this paper Leadership and Governance Equality Impact Assessment 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



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Annual Quality Statement

1 April 2018 - 31 March 2019



Health Improvement,
Health Inequalities



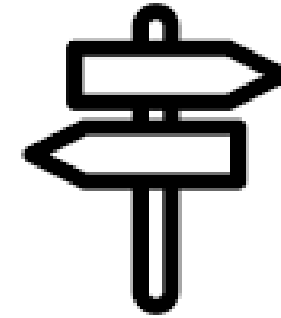
Care Closer to Home



Excellent Hospital
Care

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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 Standards¹ 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.

¹ Published by the Welsh Government on the 1st April 2015. For further information about the standards please use the following link:
http://www.wales.nhs.uk/sitesplus/documents/1064/24729_Health%20Standards%20Framework_2015_E1.pdf

Introduction and Welcome

The purpose of our Board is to govern the organisation effectively. We aim to build confidence in the quality and safety of the care that we provide. For more information about BCUHB Board Members, please find us on our Website www.bcu.wales.nhs.uk



Statement from Mr Gary Doherty, Chief Executive & Mr Mark Polin, Chairman

It is our pleasure to introduce the Annual Quality Statement for Betsi Cadwaladr University Health Board for the year ended 31st March 2019. Throughout this document, you will see examples of where our staff have delivered improvements in quality, safety, research and learning, all of which go to support a better experience for those people who access our service. We are extremely proud of our staff and grateful for their hard work and would like to offer our thanks to every one of them for the contribution they make to improve the quality of care across BCUHB. There has been so much good work over the last 12 months, with for example GP Out of Hours Services moving out of Special Measures (joining maternity services, which was de-escalated the year before) and a range of other quality improvements, particularly reductions in our rates of infection and substantial reductions in ambulance delays. However, we remain in Special Measures due to concerns in a number of areas of service delivery, governance, finance and performance. We are very clear on the improvements that need to be made at pace and the further work required to tackle the range of challenges facing the Health Board. During 2018/19 we strengthened our approach to service planning and have put much more focus on developing our Annual Plan for 2019/20 and our 3 Year Forward Look. We have confidence in the willingness and commitment of all staff within the organisation to strive to overcome the challenges faced by the Health Board, in order to deliver success that translates into better performance and outcomes for patients.

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.

This report and supporting documents can be made available in other languages or formats on request from the Corporate Communications Team:

Email: bcuhbpressdesk@wales.nhs.uk

Telephone: 01248 384776

Address: Communications Team
Block 5
Carlton Court
St. Asaph Business Park
St. Asaph
LL17 0JG

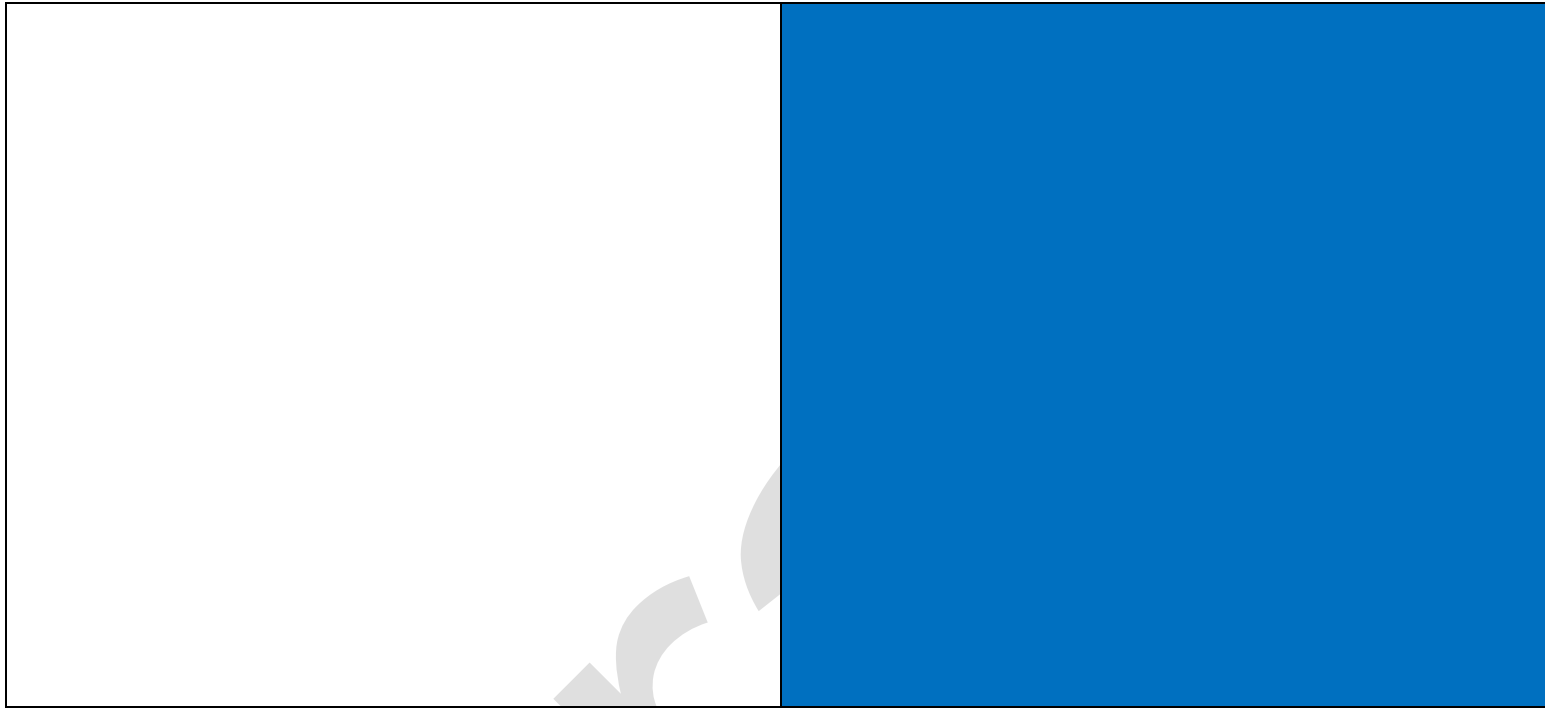
There are many opportunities to get involved and share your ideas about how we can improve health in North Wales.

We are keen to hear from you, whether as a member of the public, patient or carer, or if you have a compliment or a suggestion.

**It is your local health 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

BETSI CADWALADR UHB

POPULATION

696,300

North Wales has an increasing and aging population. The population is expected to increase to 734,700 by 2036; the percentage of the population aged 85 years and over is expected to increase by 154% between 2011 and 2036.



DEPRIVATION

Around 12% of the population in BCUHB live in the most deprived fifth in Wales. The Health Board has some of the most deprived areas in Wales, particularly along the North Wales coastline.

OLDER PEOPLE

15% of households in BCUHB are occupied by one person aged 65 years and over, which is just above the average for Wales (14%). Conwy has the highest percentage of one person households with people aged 65 years and over (17.1%). Isle of Anglesey, Gwynedd and Denbighshire are also higher than the BCUHB average.

FALLS

1 in 3 will suffer a fall each year. Only 1 in 3 will return to former levels of independence and 1 in 3 will end up moving into long term care. Yet many falls are preventable.



CHILDREN & YOUNG PEOPLE

Almost a quarter of children and young people under the age of 20 live in poverty in Wales. Across BCUHB this ranges from 18% in Gwynedd to 25% in Denbighshire.

LIFE

EXPECTANCY

82.5
YEARS

BCUHB



78.8
YEARS

...but the difference in life expectancy between the most and the least deprived is 8.8 years for men, and 6.2 years for women. The gap in **healthy** life expectancy is between 13 and 14 years for both sexes in BCUHB.

BEHAVIOURS AFFECTING HEALTH



	BCUHB (%)	Wales (%)
Smoking	19	19
Use e-cigarettes	6	7
Drinking above guidelines	18	19
Physical activity	52	53
Fruit & vegetable consumption	22	24
Overweight/Obese	57	60
Follow 0/1 healthy behaviours	10	10

CANCER

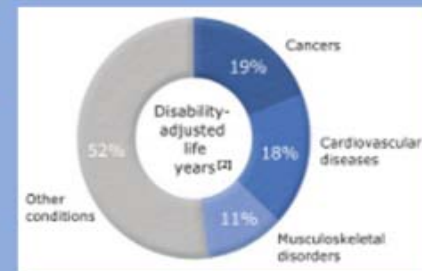
40%

4 in 10 cancers are preventable



BURDEN OF DISEASE

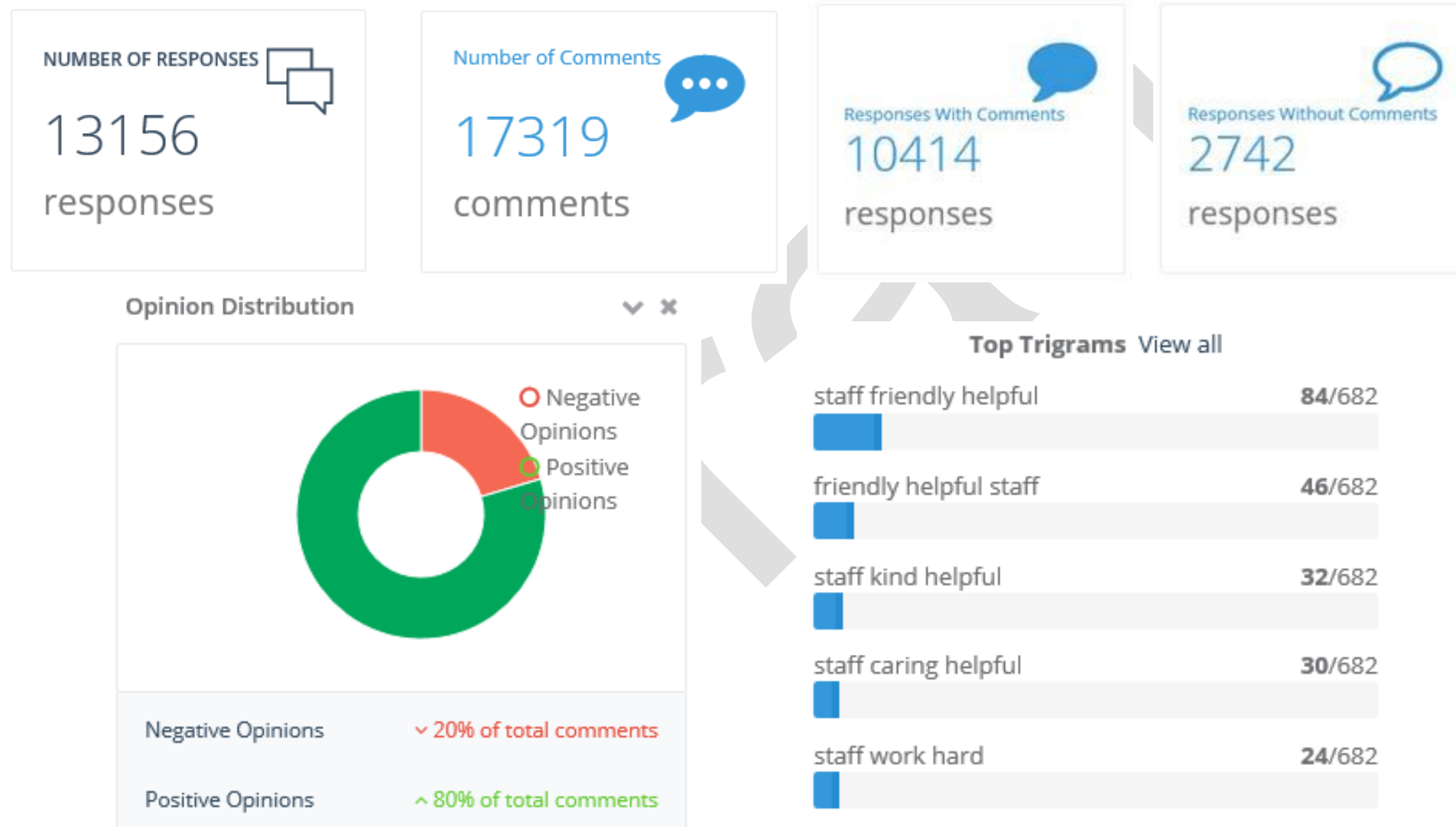
This chart shows the greatest cause of disease burden in Wales, as measured by the Disability Adjusted Life Years (DALY). Other conditions includes mental health problems.



Produced by Claire Jones,
BCU Public Health Team, April 2019



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"> We will implement the Learning from Death's Policy across the Health Board. 	<p>Crude mortality remains unchanged.</p> <p>Over the last year we have focussed on sepsis, developing improvements in practice for Health Board wide spread that will affect our crude mortality for the positive. Learning from Deaths policy, has led to pilots of a new mortality review tool in two of our Emergency Departments to check for sustainability before Health Board implementation as an IT based solution.</p>	<p>This will remain a key priority for the coming year.</p> <p>The coming year will see the mortality review tool implemented across the Health Board as learning tool to improve our care and practices.</p>
<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"> Continued development of the ward level dashboard to increase staff access to accurate information for improvement. 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 	<p>The ward dashboard has continued to be an essential part of our improvements and is accessed with an average of over 6000 reports run from the system, with the new version due to be launched in the summer 2019 this will enhance the abilities for the user to triangulate data for improvement.</p> <p>The Healthcare Acquired Pressure Ulcers (HAPU) collaboraitve is a group of wards</p>	<p>Harm free care focus of HAPU and Falls will remain the priority for the coming year as outline in the Quality Improvement Strategy 2017 to 2020 for the Health Board.</p>

What we said last year...	What we did ...	What we will do this year (2019/2020)...
<ul style="list-style-type: none"> We will implement the improvements across the Health Board for Hospital Acquired Thrombosis. 	<p>whose focus is on improvements to help reduce the incidents of pressure ulcers.</p> <p>The falls collaborative due to commence in June 2019 will follow the same approach as the HAPU collaborative with a new set of wards and will build on the already established improvements as the incident of inpatient falls reported as serious has reduced in the past year 2017/18 data for the year end was 76 incidents, data to the end of February 2018 is 11 incidents of inpatient falls reported as serious incidents.</p>	
<p>Achieve the highest level of reliability in clinical care by Strengthening our clinical pathways.</p> <ul style="list-style-type: none"> Continue to focus on clinical pathways in line with national guidance, results of national audits and findings from mortality reviews. 	<p>Implementation of Sepsis treatment pathway in all Emergency Departments following results of audits.</p>	<p>Acute Kidney Injury clinical pathway to be developed.</p>
<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>	<p>All acute and community wards have a standard Ward welcome/information board located near the entrance to the wards. This enable to wards to display their patient safety and patient experience information.</p>	<p>The ward accreditation programme will continue and will be embedded into the routine working of the Health Board. The standards by which the wards are assessed against will be reviewed and</p>

What we said last year...	What we did ...	What we will do this year (2019/2020)...
<ul style="list-style-type: none"> • Patient feedback via Viewpoint to be evaluated and used locally for improvement. Viewpoint data displayed on ward information Boards outside ward entrances • Introduce a Patient Advisory and Support Service to manage (in a timely manner) local resolutions 	<p>As part of the Ward Accreditation programme all wards are assessed for using their patient experience information for improvements to demonstrate the ward learning from patient feedback.</p> <p>The patient Advisory and Support Service is in the process of being implemented across all 3 acute hospitals and will be in place by Summer 2019.</p>	<p>enhanced annually so the standards will improve across all wards.</p>
<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"> • Continue to promote the use of information for improvements and develop the Community dashboard further. 	<p>The Community dashboard development continues this includes the development of the District Nurse dashboard all with the focus being for improvement.</p>	<p>This will continue going forward for the coming year.</p>

Progress against our strategic priorities

Improving Health and Reducing Health Inequalities	Care Closer to Home	Excellent Hospital Care
<ul style="list-style-type: none"> • We achieved the Platinum Health at Work standard, recognising our commitment to staff and population well-being and our overall social responsibility. • We introduced the “Let’s Get North Wales Moving” collaboration with partners. • The tier three Weight Management Service was implemented. • The “Help me Quit for Baby” smoking cessation support approach was embedded in Community Midwife Teams. • The hospital based smoking cessation service commenced. • An alcohol licensing framework was established. • The 'Made in North Wales' network developed an approach to social prescribing and an asset-based approach to well-being. 	<ul style="list-style-type: none"> • The new healthcare centre at Flint opened, delivering a range of services and fulfilling commitments previously made by the Board to the local population. • The redevelopment of Corwen Health Centre was completed, an important milestone in care provision for the local rural community. • Recent developments such as Llangollen Health Centre, Canolfan Goffa Ffestiniog and the new wing of Tywyn Hospital now provide a range of services providing benefits for the whole community. • More advanced practitioner nursing, physiotherapy, audiology and pharmacy roles were introduced in primary care settings. • Primary care clusters developed a range of innovative services, such as Advanced Nurse Practitioner roles in care homes, family practitioner and specialist diabetes care. 	<ul style="list-style-type: none"> • The new Sub-Regional Neonatal Intensive Care Centre was opened at Ysbyty Glan Clwyd. • The vascular centre development at Ysbyty Glan Clwyd progressed, with full implementation due in April 2019. • The major refurbishment programme for Ysbyty Glan Clwyd has been completed, bringing major improvements to the environment for patients and staff.

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

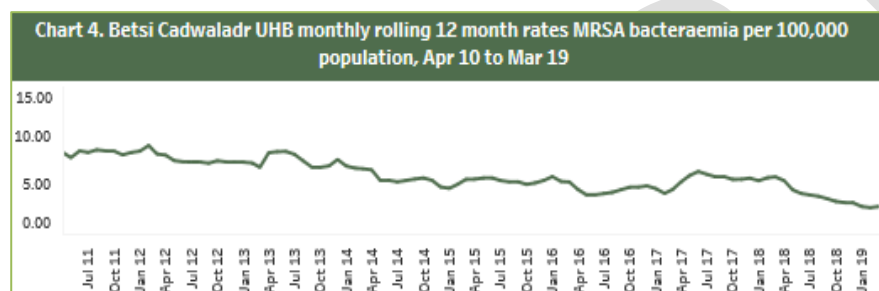
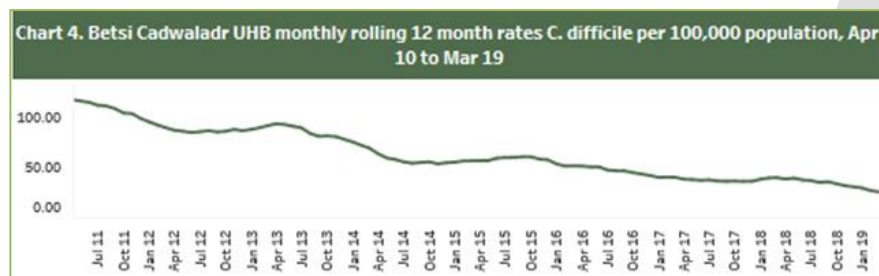
The removal of asbestos from the original Radiology Department in Ysbyty Glan Clwyd is complete. This has taken a number of years to do and involved the temporary relocation and closure of x-ray and scanning rooms, offices and corridors. Our staff, however, have worked both creatively and tirelessly 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.



Safe, Clean Care



There has been significant and focused improvement work relating to infection prevention as part of the Safe Clean Care campaign for the past year. This has seen a massive improvement made in relation to MRSA bacteraemia with 63% fewer cases this year (Incidents reported to end of February 2019 were 19). In addition, the Health Board has achieved the national reduction expectation target for Clostridium Difficile Infection (National Target is less than 26.00 incidents we have achieved below this as 24.6 incidents). Leading into next year we will be focussing in on gram-negative bacteraemia and work programmes in primary and community care to improve E-coli, klebsiella and pseudomonas.

Providing high quality, critical care

The Safeguarding Team is responsible for engaging staff across the organisation to ensure that excellent safeguarding practice is embedded and vulnerable adults, young people and children are protected which includes Adults at Risk, and Children at Risk. Significant achievements this year include:

- The development of a revised, robust reporting process for Adults at Risk.
- Participation in the All Wales Safeguarding Maturity Matrix (Children and Adults) and the development of a BCUHB improvement plan to ensure consistent and standardised quality outcomes for children and adults.
- The delivery of a 'Tell me your story' week in partnership with the Alzheimer's Society where people living with Dementia and their carers provided feedback about their experiences.
- The launch of refreshed communications to support the Safeguarding agenda, including a new intranet homepage and monthly Safeguarding Bulletin.



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 system for people who experience a mental health crisis.



Ward Accreditation

In July 2018, we began the exciting process of developing our new Accreditation Programme for all inpatient Wards/Units across BCUHB.

We are the first Health Board in Wales to have this robust assessment and support programme which follows on from the success of the Safe Clean Care campaign in 2018.

The Accreditation programme is an opportunity for the Health Board to implement a set of standards to frame our quality, safety and patient care agenda. A total of 35 wards have had an unannounced accreditation visit and have been assessed and awarded a score.



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.

North Wales Community Health Council (NWCHC)

The North Wales Community Health Council (NWHC) is the independent health watchdog for North Wales. It represents the interests of patients and the public who use our health services.

The NWCHC monitors and scrutinises our health services to improve the patient experience; one of the many ways the NWCHC does this is by visiting health premises. All visits are undertaken by NWCHC volunteer members.

During the year, NWCHC members visited all of our main hospitals, as well as our community hospitals, Emergency Departments and Mental Health Units. There has been more than 300 visits to sites during the period. As part of this exercise the NWCHC surveyed issues such as Food and Nutrition, Cleanliness, Dignity and Care and the Environment. NWCHC members also spoke to patients, their relatives and carers about all aspects of their experiences of health care.

The NWCHC has also looked closely at issues such as Catheter Care, Delayed Transfers of Care and MP-mri scans and has used patient experience feedback from hospital visits to champion the causes of patients.

This year, the NWCHC has been visiting many of the North Wales GP practices. We look forward to working with the NWCHC and GP practices in response to the NWCHC findings.

Our Transforming Care team continues to work collaboratively with the NWCHC and this has been successful in ensuring a greater scrutiny of our standards and practices and enabling Equality Diversity and Human Rights and Welsh Language considerations to be considered as part of the NWCHC's monitoring activity.

NWCHC reports now form part of our Ward Accreditation Programme and we look forward to working with the NWCHC to develop this programme into other service areas.

To find out more about the work of the NWCHC please contact:

- Email – admin@waleschc.org.uk
- Telephone – 01248 679284 (ext 3)
- Website – www.communityhealthcouncils.org.uk
- Write to – NWCHC, Unit 11, Chestnut Court, Parc Menai, Bangor LL57 4FH



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.



Building Better Care

In October 2018, the health board launched the Building Better Care Improvement programme which is focussed on the 3 main areas of Demand, Flow and Discharge. The work on the Demand aspect looks at how we can prevent patients attending our emergency departments by signposting them to alternative healthcare support either in the community or within alternatives such as minor injury units across North Wales. This is also focussed on reducing ambulance Demand with the introduction of our Single Integrated Clinical Assessment and Triage (SICAT) service where a team of doctors intercept ambulance calls and provide advice and support to avoid unnecessary ambulance journeys.

We are also improving the way that patients access our emergency care, are managed within our emergency departments and how admitted patients travel through our hospitals with our Flow programme ensuring that, for patients in hospital, every day counts.

Lastly, we are reviewing the way that we Discharge patients to aim to get all patients home first rather than needing additional support in our community hospitals and supporting them to recover in their own homes and how we prepare patients for Discharge on admission to hospital.

By focussing on these areas, we hope to improve timely care for our patients with fewer delays to their care and treatment and a better experience within our hospitals and to feel supported once they are well enough to go home.



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.

Supporting patients with dementia

Ysbyty Gwynedd became the first acute hospital in Wales to receive official recognition of working to become dementia friendly. The hospital has been recognised by the Alzheimer's Society as part of its work to recognise organisations and individuals supporting awareness around dementia. More than 300 members of staff are now 'Dementia Friends' at Ysbyty Gwynedd, which is only the second acute hospital in the UK to receive this recognition from the Alzheimer's Society.

The dementia team became volunteers for the Alzheimer's Society in 2015 and have since carried out a range of activities and 'dementia friends' training sessions to help staff understand more about dementia and how it affects patients and their families.



Improving the way we communicate



Wrexham Maelor Hospital's Children's Service is the first NHS organisation to be granted Makaton Friendly status in Wales.

More than 20 staff in the hospital have been trained so far including doctors, nurses and our staff that work out in the community. Makaton is a simplified system of sign language, which aids those who have communication difficulties.

Staff at the hospital have been undertaking training and also creating resources and new signage for the departments.

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.

Equality: Fairness, Rights and Responsibilities

At BCUHB our vision is to create a healthier North Wales, that maximises opportunities for everyone to realise their full potential, and helps towards reducing health inequalities. Our purpose is to improve the health of the population, which means that, over time, there will be a better quality and length of life across the whole population of North Wales.

Some of our key equality achievements in 2018/19:

- We have supported the implementation of the Health Board's ten-year strategy 'Living Healthier, Staying Well' (LHSW) and its underpinning principle to promote equality and rights in everything we do.
- We have strengthened the accountability, governance and performance management of our equality work.
- We have provided equality and human rights advice to Programme Groups implementing the LHSW strategy and strengthened scrutiny of equality impact assessment (EqIA) in regards to service change driven by the implementation of LHSW.
- We have continued to build organisational understanding and capacity in advancing equality and human rights through our training programmes.
- We have delivered mandatory equality and human rights training and increased compliance in the last 12 months to 85% across BCUHB, and training has also been delivered to 19 GP and dentist practices.
- We have worked to increase employment opportunities for people from protected characteristic groups; and driven forward initiatives supporting people from protected characteristic groups in work.
- We have increased our 'Top 100 Employer' status in the Stonewall Workplace Equality Index 2019, improving our ranking significantly to 37th overall across the UK out of 445 organisations taking part.
- We have held rainbow flag-raising ceremonies at each District General Hospital site in celebration of International Day Against Homophobia, Biphobia and Transphobia (IDAHoBiT) in May.
- We have co-produced a film with stakeholders designed to improve awareness amongst front-line staff of the issues faced by LGBT+ service users.
- We have maintained ongoing public engagement through our Equality Stakeholder Group (ESG) and expanded our membership.

More details about the work we do to promote and support equality can be found in our Annual Equality Report 2018 – 2019.



Concerns and Incidents

As a Health Board, we strive to provide safe, high quality care and treatment to all, but sometimes things can go wrong and we let our patients down. If this happens we respond to the concern (complaint, claim & serious incident) raised in line with the 'Putting Things Right' Regulations (PTR).

Concerns 2018/19

In 2018/19, the Health Board recorded 3,003 concerns that were resolved as 'on the spot' in addition the newly introduced PALs service recorded and resolved 452 'on the spot' concerns.

The top subject for contacting the Health Board regarding an 'on the spot' concern related to access, appointment, admission, transfer & discharge with (38%) 1,143 concerns raised. Of the 1,143 concerns relating to access, appointment, admission, transfer & discharge, (40%) 462 were in regards to unacceptable waiting time, (12%) 136 were recorded as date of admission cannot be given to patient.

The Health Board formal concerns, 1,408 formal concerns were received in 2018/19, this is a decrease of 1% on the previous year. The top subject for making a formal complaint to the Health Board was in relation to treatment, procedure with (28%) 395 formal complaints followed by consent, confidentiality or communication with (22%) 314 complaints recorded on the Datix system.

Of the 395 formal complaints received in regarding treatment, procedure, (25%) 99 were in relation to wrong diagnosis. Of the 314 formal concerns received in relation to consent, confidentiality or communication; well over half of the concern received (57%) 179 were in regards to communication with the patient (other than consent issues).

Incidents 2018/19

A total of 32,458 incidents were recorded onto the Datix System, of these 24,384 (75%) were patient safety incidents. Of the 32,458 incidents reported in 2018/19, Central region reported (35%) 11,284; East region reported (32%) 10,511 & West region reported (33%) 10,663.

The most reported incidents for 2018/19 can be found in the below table.

<i>Most Reported Incidents by Region 2018/19</i>	BCUHB Central	BCUHB East	BCUHB West	Total
Pressure sore / decubitus ulcer	1961	2010	1675	5646
Slips, trips, falls and collisions	1917	1553	1620	5090

These incidents continue to be the most reported year on year; the Health Board has taken steps to improve on the reporting of the above incidents.

Pressure Ulcers

The Health Board has been focusing on improving Pressure Ulcer reporting and root cause analysis as well as establishing the most prevalent areas in which pressure damage occurs. In November 2018, the Health Board launched a Pressure Ulcer Collaborative focusing on areas of highest prevalence. This team approach to harm reduction is using improvement methodology to support improvement and culture change. The aim is to develop a Health Board standard approach to care in relation to pressure areas.

Slips, trips, falls and collisions

Falls are reported via Datix and monitored via the Harms Dashboard. All falls are investigated as incidents with falls resulting in harm or death being subject to a serious incident review.

Building on the collaborative programme of work, reduction in falls will be supported with this methodology. The next stage of the Harms dashboard will see the launching of ward level dashboards which were live from 1st January 2019 and will enable local teams to continue to review their harm data but also provide additional functionality. Using data for Improvement sessions will commence in January and will be focused on ward and area teams using their own data to address areas of harm and risk to focus on reduction plans.

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

We will continue to focus on providing safe, effective and companionate care and services, by building on the success of our campaign style approach to Health Board wide improvement as seen with the Safe Clean Care programme and the collaborative approach to quality improvement. We will review our current Quality Improvement Strategy and prepare for our next Quality Improvement Strategy for 2020 onwards. Our preparation will include engaging with our staff, our partners in care delivery and with you our users of our care and services.

Quality, Safety & Experience Committee		Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board
21.5.19	To improve health and provide excellent care	

Report Title:	Summary of In Committee business to be reported in public
Report Author:	Mrs Kate Dunn, Head of Corporate Affairs
Responsible Director:	Mrs Deborah Carter, Interim Executive Director of Nursing & Midwifery
Public or In Committee	Public
Purpose of Report:	Standing Order 6.5.3 requires the Board to formally report any decisions taken in private session to the next meeting of the Board in public session. This principle is also applied to Committee meetings.
Approval / Scrutiny Route Prior to Presentation:	<p>The issues listed below were considered by the Committee at its private in committee meeting on 19.3.19</p> <ul style="list-style-type: none"> • Update on endoscopy services • Report on cases being managed under the ‘Dealing with Unreasonable Behaviour’ procedure • Executive briefings
Governance issues / risks:	None identified
Financial Implications:	None identified
Recommendation:	The Committee is asked to note the information in public.

Health Board’s Well-being Objectives <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>	✓	WFGA Sustainable Development Principle <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	✓		
Special Measures Improvement Framework Theme/Expectation addressed by this paper			
Governance			
Equality Impact Assessment			
No equality impact assessment is considered necessary for this paper.			

Disclosure:

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