Bundle Quality, Safety & Experience Committee 22 January 2019

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

1.0   OPENING BUSINESS AND EFFECTIVE GOVERNANCE

1.1   09:30 - QS19/1 Chair's Opening Remarks

1.2   09:31 - QS19/2 Declarations of Interest

1.3   09:32 - QS19/3 Apologies for Absence

1.4   09:33 - QS19/4 Minutes of Previous Meeting Held in Public on 29.11.18 for Accuracy, Matters Arising and Review of Summary Action Log

         QS19.4a Minutes QSE 29.11.18 Public V0.04.docx

         QS19.4b Summary Action Log QSE Public Live.docx

1.5   09:43 - QS19/5 Maternity Services in North Wales - Deloitte's Presentation and Final Update on the Commissioned Organisational Development (OD) Programme Miss Teresa Owen

Mr Mark Green to attend to deliver supporting presentation

Recommendations:
The Committee is requested to:
1. Note the update and progress to date and support the recommendations made by Deloitte in this final update presentation – which includes ongoing support from Deloitte on a 2 day/month basis for the remainder of 2019.
2. Acknowledge that cultural change of the scale required in the Women's Directorate will need Corporate OD support and that the ongoing OD plan will need some financial support and investment to ensure that the early signs of positive change are embedded and sustained.
3. Support that the risk register entry as noted previously is not de-escalated until the findings of the Internal Audit of the service is considered in Q4.

         QS19.5 Deloitte maternity services.docx

2.0   FOR DISCUSSION

2.1   10:13 - QS19/6 Health & Safety Update - Mrs Sue Green

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

         QS19.6a Health and Safety.docx

         QS19.6b Health and Safety Appendix 1 Final Internal audit report - Compliance with Legislation - Health and Safetyv1.pdf

2.2   10:33 - QS19/7 Health Protection Team (North Wales) 2018 Annual Report - Miss Teresa Owen

Recommendation:
The Committee is asked to note the contents of the report for information.

         QS19.7a Health Protection Team coversheet.docx

         QS19.7b Health Protection Team Annual Report 2018.docx

2.3   11:03 - QS19/8 Integrated Quality & Performance Report : Mr Mark Wilkinson

Recommendation:
The Committee is asked to note the report.

         QS19.8a IQPR coversheet.docx

         QS19.8b Integrated Quality Performance Report.pdf

2.4   11:48 - Comfort Break

3.0   FOR CONSENT

3.1   QS19/9 Policies , Procedures or Other Written Control Documents for Approval

3.1.1   12:03 - QS19/9.1 Policy for Section 5(2) for use in General and Community Hospitals

Recommendation:
The Committee is asked to approve the policy for implementation

         QS19.9.1a Section 5(2) Policy coversheet.docx

         QS19.9.1b Section 5(2) in General hospitals V8 FINAL.doc

         QS19.9.1c Section 5(2) Policy Appendix EQIA.doc

3.1.2   12:08 - QS19/9.2 Covert Administration of Medication Clinical Policy

Recommendation:
The Committee is asked to approve the Covert Administration of Medication Clinical Policy for use within BCUHB

         QS19.9.2a Covert Administration of Medication policy coversheet.doc

QS19.9.2bCovert Administration of Medication policy 07.01.2019 draft 6.doc

| 3.1.3 | 12:13 - QS19/9.3 BCUHB Restricted Antimicrobial Policy |

Recommendation:
The Committee is asked to approve the policy for implementation in BCUHB.

QS19.9.3a Restricted Antimicrobial Policy coversheet.docx

QS19.9.3b Restricted Antimicrobial Policy.docx

QS19.9.3c Restricted Antimicrobial Policy Appendix EQIA.doc

| 3.2 | 12:18 - QS19/10 Quality Safety Group Assurance Report - Meetings Held 13.12.18 and 9.1.19 : Mrs Gill Harris |

QS19.10 QSG Chair's report Dec and Jan meetings.doc

| 3.3 | 12:33 - QS19/11 Improvement Group (HASCAS & Ockenden) Chair's Assurance Report : Mrs Gill Harris |

Recommendation:
To note the progress of the HASCAS & Ockenden recommendations

QS19.11 HASCAS_Ockenden Review_progress report.docx

| 4.0 | 13:03 - FOR INFORMATION |
| 4.1 | QS19/12 Tissue and Organ Donation Report : Mr Adrian Thomas |

Recommendation:
The Committee is asked to note the activities of the BCU/NHS-BT Organ Donation Committee and to highlight the report to the Health Board.

QS19.12a Tissue Organ Donation coversheet_amended.docx

QS19.12b ODC Annual Plan.pdf

QS19.12c NHSBT Summary report.pdf

| 4.2 | QS19/13 Issues Discussed in Previous In Committee Session |

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

QS19.13 In Committee items reported in public.docx

| 4.3 | QS19/14 Documents Circulated to Members |

10.1.19 Briefing note regarding care commissioned from a Gwynedd nursing home
14.1.19 Arrangements for future meetings and agendas
15.1.19 Quality Safety Group notes 10.10.18

| 4.4 | QS19/15 Issues of Significance to inform the Chair's Assurance Report |
| 4.5 | QS19/16 Date of Next Meeting |

Tuesday 19.3.19 @ 9.30am

| 4.6 | QS19/17 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."

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

Quality, Safety & Experience (QSE) Committee

Minutes of the Meeting Held in Public on 29.11.18 in
The Boardroom, Carlton Court, St Asaph

Present:

Mrs Lucy Reid	Independent Member (Chair)
Mrs Jackie Hughes	Independent Member

In Attendance:

Mrs Deborah Carter (*part meeting*)	Associate Director Quality Assurance
Mrs Michelle Denwood (*part meeting*)	Associate Director of Safeguarding
Mrs Kate Dunn	Head of Corporate Affairs
Mr Steve Forsyth (*part meeting*)	Director of Nursing, Mental Health & Learning Disabilities
Mr David Jenkins	Independent Adviser
Mrs Gill Harris	Executive Director of Nursing & Midwifery
Dr Evan Moore (*part meeting*)	Executive Medical Director
Dr Jill Newman (*part meeting*)	Director of Performance
Miss Teresa Owen (*part meeting*)	Executive Director of Public Health
Mr Adrian Thomas	Executive Director of Therapies & Health Sciences
Mr Mark Thornton	Community Health Council Chair

Agenda Item Discussed	Action By
QS18/169 Chair's Opening Remarks **QS18/169.1** The Chair welcomed everyone to the meeting. She acknowledged that concerns had been raised over the length of the Committee meeting and that a range of pre-existing diary commitments precluded many of the Executives from staying for the whole meeting. However, she noted that the revised timing had been agreed at the previous meeting in September as a result in the change in frequency of the Committee meetings. The Chair raised concerns at the varied quality of the papers provided and that there was room to improve the level of detail that came to the Committee in order for it to be able to fulfil its assurance role. It was noted that a meeting to review and refresh the Committee cycle of business would be arranged between the Chair and Lead Executive, who would also have timely 1:1s in between Committee meetings.	GH
QS18/170 Declarations of Interest None raised.	
QS18/171 Apologies for Absence Apologies were received for Cllr Cheryl Carlisle, Mrs Lyn Meadows, Professor Michael Rees, Mrs Sue Green and Dr Melanie Maxwell.	

QS18/172 Minutes of Previous Meeting held in public on 25.9.18 for Accuracy, Matters Arising and Review of Summary Action Log **QS18/172.1** The minutes were agreed as an accurate record and updates to the summary action log were noted. **QS18/172.3** A matter arising was raised with regards to concerns raised by the Healthcare Professionals Forum Chair previously around primary coronary intervention. The Executive Medical Director confirmed there were improvement plans in place but members needed to be aware that this was not an issue specific to BCUHB. The Independent Members would wish to see the detailed figures but noted that consideration of the financial implications would in due course need to be undertaken by the Finance & Performance Committee or the Executive Management Group, however, the QSE Committee would need to be sighted on any quality or harm risks.	EM
QS18/173 Committee Terms of Reference **QS18/173.1** The Committee noted some further inaccuracies or areas for amendment namely: • Correction of title to Executive Director of Primary Care & Community Services; • That the Committee now met on a bimonthly basis not monthly; • To add the Director of Performance as formally in attendance; • To amend the reference to Staff Side to read Trade Union partners. **QS18/173.2 It was resolved that** the Committee recommend the highlighted amendments, plus those noted above, to the Board through the Chair's Assurance Report.	LR
QS18/174 Public Services Ombudsman Annual Letter 2017-18 **QS18/174.1** the Executive Director of Nursing & Midwifery presented the paper noting that the Ombudsman had identified a range of areas for improvement. She confirmed there was no requirement for the organisation to specifically respond to the letter. With regards to the findings of the two public interest reports it was noted that the Ombudsman was satisfied with the learning and had closed the cases. The Chair noted the concerns raised by the Ombudsman with regards to the overall handling of complaints and a conversation took place as to the level of confidence that these failures would not reoccur. The Executive Director of Midwifery assured the Committee that appropriate policies and procedures were in place but there was always room for improvement in terms of their robust implementation, and this linked to the ongoing 'SAFER' work. The Chair enquired whether the audits referred to within the report fed into the clinical audit programme and the Executive Director of Therapies & Health Science indicated he would need to specifically check this but confirmed that there were local RRAILS (Rapid Response to Acute Illness Learning Set) audits. A discussion around lessons learnt in terms of handover was held and the Associate Director of Quality Assurance confirmed that this aspect had been strengthened and outcomes had improved. The Chair enquired as to the outcome of the recommendation to review the complaint handling in one specific case and the Associate Director of Quality Assurance confirmed that transparency and oversight of	

concerns or serious incidents had been improved. The Executive Director of Nursing & Midwifery undertook to identify and circulate details of what actions had been taken in terms of the handling of this complaint. **QS18/174.2 It was resolved that** the Committee note the Annual Letter and the actions taken by the Health Board.	GH
QS18/175 Update on Infection Prevention & Control Across BCUHB **QS18/175.1** The Executive Director of Nursing & Midwifery presented the paper and highlighted that the high level indicators for Clostridium Difficile and MRSA remained off trajectory but there had been a significant reduction. Monitoring against the new national cleaning standards had reinforced the need to maintain the focus on infection control. There were positive elements to report in terms of improvements in antimicrobial prescribing and culture but there remained areas of concern including the need to develop a business case for a different model for the decontamination of medical devices. The Community Health Council (CHC) Chair reiterated his support for the Safe Clean Care (SCC) programme and that this approach would realise benefits in the longer term if the principles were persevered with. Members also reported they had noted improvements on site walkarounds in terms of culture and ownership. The Associate Director of Quality Assurance also reported that funding had been secured to make improvements within estates and environments that will support the delivery of SCC. **QS18/175.2 It was resolved that** the Committee: 1. Note current performance in relation to key infections, and how BCUHB benchmarks with other Welsh Health Boards and with England. 2. Note recent progress with key elements of the Safe Clean Care Campaign, and recent highlights including launch of the ward accreditation programme, and the successful autumn infection prevention conference. 3. Note the feedback from Welsh Government in relation to decontamination of medical devices following the decontamination survey. 4. Note the next steps continue improving cleanliness across BCUHB, and the work in progress to provide routine MRSA screening information.	
QS18/176 Pressure Ulcer Collaborative **QS18/176.1** The Associate Director of Quality Assurance presented the paper which provided an update to the Committee on the development of a standard approach to care with the aim of reducing tissue damage and pressure ulcers (PUs) for patients. She confirmed that there were two identified cohorts of wards from across the Health Board which had a higher level of PUs and they were being given additional support and guidance to make improvements and reduce harm by using their own data in their own environment. In response to a question it was confirmed that community areas were also involved in the collaborative. The Director of Performance suggested that reporting levels were likely to increase as a result of the launch of the collaborative and that there was also a national change in PU reporting requirements. The Chair enquired as to plans to engage with ambulance services and it was confirmed that the third cohort would involve the Wales Ambulance Services Trust.	

QS18/176.2 The Committee was also informed that improvement methodology for a falls collaborative was also being developed and falls prevention was a regular part of safety walkarounds. A written update on both collaboratives would be provided to the March 2019 Committee meeting but in the interim the Committee would also receive a brief update in January as part of the IQPR reporting process. **QS18/176.3 It was resolved that** the Committee support the Collaborative approach to reducing Hospital Acquired Pressure Ulcers (HAPU) with a plan to utilise this approach for reducing inpatient falls in April 2019.	GH
QS18/177 Mental Health & Learning Disabilities (MHLDS) Division : Update on Thematic Quality Improvement Plan *[Mr Steve Forsyth joined the meeting]* **QS18/177.1** The Director of Nursing (MHLDS) SF presented the paper and reminded the Committee of the quality improvement methodology known as TODAYiCAN which had been presented to the Board in August. A procurement process had culminated in the commissioning of a provider to deliver this programme of change which was now into its first 90 day cycle. It was reported that the focus was on making sustainable small changes which together would make a real difference. The Director of Nursing confirmed that a Project Lead and Champions had been identified for the next 12 months to ensure the methodology was cohesively rolled out. **QS18/177.2** The Executive Director of Nursing & Midwifery provided some feedback on the improvements in terms of culture in that there had been recent positive feedback from a Tawel Fan family member who had been involved in the recruitment process for staff within the Division. The Executive Director of Public Health made reference to a recent sports award event that she had attended with partners and that she had noted the normalisation of discussions around mental health. Other members had also noted positive aspects around how mental health issues were discussed and how individuals felt empowered. **QS18/177.3** The Chair welcomed the assurances around the methodology and looked forward to receiving details of actual outcomes in due course. It was agreed to provide an update to the Committee at the end of each 90 day cycle with the next report being scheduled for March 2019. **QS18/177.4** It was resolved that the Committee note the contents of the report	 SF
QS18/185 Integrated Quality & Performance Report *[Agenda item taken out of order at Chair's discretion]* **QS18/185.1** The Director of Performance presented the report and asked that the Committee be tolerant whilst the new format evolved and was sharpened as there was work yet to be done with section leads in terms of relevance and clarity of data and the ability to provide a good level of assurance. She also confirmed that many of the indicators were national but there were also opportunities for some local indicators, and that through discussion of the reports the Committee would need to consider if any indicators required escalation. It was also noted that the Mental Health Measure now came under the QSE Committee's scrutiny as part of the Timely	

Care indicators and that there was an ongoing discussion as to whether other mental health indicators should also move over alongside these.

QS18/185.2 The Director of Performance went on to draw members' attention to key points within the report. She highlighted that the most improved indicators related to infection prevention and control, and reflected the positive impact of the Safe Clean Care programme. She was also pleased to report that the Health Board had delivered on the smoking cessation quit rate target for the first time.

QS18/185.3 In terms of Never Events the Chair requested that future reports give further detail as to what was being done to ensure lessons were learnt. The Executive Director of Nursing & Midwifery stated that individual action plans for each Never Event were scrutinized at the Quality Safety Group (QSG) and she would work to find an appropriate mechanism to share the key elements of that conversation within QSE Committee papers. The point was also made of the need to be able to share meaningful detail of cases without breaking patient confidentiality. With regards to incidents it was noted that the rate of closure was of concern due to the large backlog which related to their sign off with Welsh Government. Officers described a range of reasons for the backlog including prioritisation issues and consistency of application and completion of DATIX fields. The Chair requested an exception report into this issue and officers would liaise to determine the most useful way to provide this. A discussion took place around the performance in terms of concerns being closed within 30 days and a conflict in terms of timeframes was noted where a concern was linked to an incident. Members asked that future reports give an indication of how far beyond the 30 day target cases were, and also which concerns were linked to incidents. This would be addressed in future reports.

QS18/185.4 Ward staffing levels remained of concern and the Executive Director of Nursing & Midwifery confirmed that the approach was being taken that in some areas where it was not possible to recruit nurses then Band 4 Healthcare Support Workers were being appointed with a progression plan to support them to enter into nurse training. This was not impacting on the agreed establishment and all opportunities to recruit to registered nurse vacancies and reduce turnover were being explored with Workforce & Organisational Development.

[Dr E Moore left the meeting]

QS18/185.5 The Director of Performance made reference to the challenges around delayed transfers of care from ITU which had two indicators pertaining to hours lost and discharge within four hours. It was noted that both indicators showed the most acute pressures were on the Wrexham site. It was then highlighted that the mortality rate within BCUHB had not changed significantly and was comparably amongst the best in Wales. With regards to Information Governance Training it was suggested that this indicator should be reviewed by the Information Governance & Informatics Committee and the Chair would make this recommendation in her assurance report to Board. It was reported that the backlog in clinical coding had been cleared. A conversation took place regarding the importance of coding to support good quality decisions and that the Committee would also wish to be assured as to the accuracy and depth of coding, not just the percentage. The Director of Performance would take

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these comments on board and consider alongside the externally validated quality reports undertaken on coding.

QS18/185.6 In relation to infection prevention it was reported that there had been measles outbreaks and there was a need to improve the uptake of the second dose in particular. It was confirmed this had been reported up through the Strategic Infection Prevention Group. A conversation took place regarding flu uptake amongst staff and the Committee were keen to see a more direct approach by BCU as an employer. With regards to GP practices it was confirmed that those with a higher uptake had been asked to share good practice through the cluster work.

QS18/185.7 With regards to the Mental Health Measure it was noted there had been slippage against the 28 day adult referral to assessment and assessment to treatment target, however, it was positive to record that the quality and accuracy of reporting had improved to allow appropriate targeting of areas. The area of most concern was in relation to Child and Adolescent Mental Health Services (CAMHS) and the Director of Performance indicated the organisation was in regular discussions with Welsh Government who were assured that the longest waiting patients were being treated first. An internal 'deep dive' would be undertaken during December and a tool had been agreed with the Delivery Unit which would inform a national piece of work early in 2019.   In addition the Committee noted that funding of £182,000 had been received in order to address the backlog. A conversation took place regarding support and services within primary and community care to avoid the need to refer young people into CAMHS services in the first place and the Executive Director of Public Health confirmed she was working closely with the Director of Mental Health & Learning Disabilities and lead clinicians.

[Mrs D Carter left the meeting]

QS18/185.8 In terms of the primary care measures it was noted that some further quality checks were being undertaken on the data as the NHS Statistics information was not wholly recognisable. Clarification was given on the two targets in that the first element related to a practice physically being open and the second related to the ability of a patient to actually consult with a healthcare professional.

QS18/185.9 It was resolved that the Committee:
- note the transitional nature of this report,
- to consider the level of assurance applicable to the content of chapters and
- assess whether any escalation to Board is required for indicators not currently within the Board KPIs.

[Dr J Newman left the meeting. The Committee broke for lunch]

QS18/184 Safeguarding and Protection of People at Risk of Harm Interim Report November 2018
[Agenda item taken out of order at Chair's discretion]
[Mrs Michelle Denwood joined the meeting]

QS18/184.1 The Associate Director of Safeguarding introduced the report and highlighted that safeguarding had had an initial risk score of 20. She reported that a number of improvement actions had now been implemented including there being a full complement of staff within the corporate safeguarding team, the development of the Best Interest Assessor role, implementation of training packages and the development and updating of key policies and procedures. She then went on to describe there had been a significant increase in the number of applications under the Deprivation of Liberty Safeguards (DoLS) and there were concerns over the Board's ability to discharge this function.

QS18/184.2 A conversation took place regarding the format of the report and that in order to provide assurance to the Committee, there needs to be sufficient detail included of the HASCAS and Ockenden recommendations to provide context around the actions and how that action would meet the recommendation. It was accepted however that the report still needed to be succinct and manageable. The Associate Director of Safeguarding would ensure that future reports would include this detail.

MD

[Miss Teresa Owen left the meeting]

QS18/184.3 In terms of the corporate safeguarding risk (CRR16) it was confirmed that the risk score had been reduced to 16 from 20 some time ago based on evidence of progress made. The Executive Director of Nursing & Midwifery stated that she was not recommending any further reduction until the outcomes of current work were known. The Committee were in agreement that there would always be an element of risk within this area of work and that the strength of controls and mitigation was key. In general members were content with the pace of progress and that real improvements were being made particularly around training and BIAs. Some specific comments were made on the controls and further actions in terms of rewording to become clearer and these would be reflected in the next update to CRR16. On a wider point it was noted that the Board was having a workshop in December around risk appetite.

MD

QS18/184.4 The Chair took the opportunity to seek a verbal update on recent safeguarding issues which had been reported in the media regarding a Local Authority run care home in Criccieth. The Associate Director of Safeguarding confirmed that allegations of harm had been shared with a multi-agency group and that assessments had been undertaken and historical information had been reviewed as part of a look-back exercise and which had not identified any matter of concern during the period of activity in question. The Executive Director of Nursing & Midwifery confirmed that the Local Authority were taking steps in terms of the potential failure to respond to needs of patients and partners had been assured that appropriate action was being taken by the care home to ensure the safeguarding of current residents. The Chair enquired as to the arrangements in place for the Health Board to receive updates from CSIW where relevant to services provided to its patients. It was agreed that this would be clarified.

GH

QS18/184.5| It was resolved that the Committee:
•Recognise the work undertaken within this period
•Support the continuation of the work as set out in the paper.
•Support the review of the Deprivation of Liberty Safeguarding Team based upon the organisational demand and challenges.

[*Mrs M Denwood left the meeting*]	
QS18/178 Corporate Risk & Assurance Framework **QS18/178.1** The Committee considered each risk in turn. • CRR02 Infection Prevention & Control – the Executive Director of Nursing & Midwifery recommended that the risk score remain unchanged as although progress was being made, the organisation was not yet on trajectory and there were concerns around e-coli. The 90 day plans were also not yet fully embedded within primary care. The Committee agreed that the current risk score was appropriate. • CRR03 Continuing Health Care – the Executive Director of Nursing & Midwifery recommended that the risk score remain unchanged as processes were not yet as strong and consistent as they could be and due to the shared risk and associated costs. Also taking into account the deep dive by the Finance & Performance Committee on the 28.11.18 the Committee agreed that the current risk score was appropriate. • CRR05 Learning from Patient Experience – the Executive Director of Nursing & Midwifery stated that opportunities were being taken up to reconfigure the corporate team following the departure of a key member of the team. She felt that good progress had been made in terms of systems however these needed to be consistently applied and embedded. The Committee noted the progress but had a general concern that the initial risk score had been set too low (in 2012) and it would not be appropriate to reduce the risk at this point in light of the recent Ombudsman's annual letter. It was noted that the risk score methodology is being discussed at the board workshop on the 20.12.18. • CRR13 Mental Health Services – the Committee requested further information to be sought from the Director of Mental Health & Learning Disabilities to explain the recommendation to decrease the score as members were not assured that there had been sufficient progress. • CRR16 Safeguarding – discussed as part of safeguarding report and the Committee were content with the level of current risk score. **QS18/178.2** The Community Health Council Chair referred to recent media coverage of a potential risk in terms of pharmaceutical supplies post-brexit and enquired where this was being managed within BCUHB. The Executive Director of Nursing & Midwifery would flag this with executive colleagues. **QS18/178.3** It was resolved that the Committee: 1. Note that CRR04 has been de-escalated to Tier 2; 2. Refer the relevant risks back to the risk owner for appropriate changes to be made before it can be referred to the Board.	AR GH
QS18/179 Special Measures: Review of expectations allocated to the QSE Committee **QS18/179.1** The Executive Director of Nursing & Midwifery presented the paper and confirmed that each of the expectations had previously undergone detailed scrutiny at the Special Measures Improvement Framework (SMIF) Task & Finish Group but the	

latest updates were now presented to the QSE Committee for review. She confirmed that once a status was agreed as 'green' by the SMIF then it came off the monitoring log and the SMIF would also review that the evidence in support of each expectation remained pertinent. Members queried the purpose of the paper and Mr D Jenkins advised it was for members to determine whether they were satisfied that they had seen sufficient evidence as a Committee to support the level of assurance that was recorded within the monitoring log. A conversation took place around the difficulty in ensuring that a meaningful and manageable level of detail was provided in such a paper to enable the Committee to come to a view as to whether the level of assurance was sufficient. Members also accepted there were various ways of defining a RAG status. A discussion ensued about whether QSE agendas should be more aligned to risks. It was noted that a review of the cycle of business was being scheduled with the Chair and Executive Director of Nursing & Midwifery and this discussion would be picked up at that point. **QS18/179.2 It was resolved that** the Committee: • Include within its Chair's Assurance Report a summary of the discussion • Share the Chair's Assurance Report with the Office of the Board Secretary, for submission of relevant information to the SMIF Task & Finish Group. *[Miss T Owen rejoined the meeting]*	
QS18/180 Quality Safety Group Assurance Report - Meeting Held 10.10.18 **QS18/180.1** In order to ensure a more timely circulation of QSG notes it was agreed that draft versions (approved by the QSG Chair) would be circulated in future. **QS18/180.2 It was resolved that** the Committee note the report.	DC
QS18/181 Improvement Group (HASCAS & Ockenden) Chair's Assurance Report **QS18/181.1** The Executive Director of Nursing & Midwifery highlighted that a tracker tool had been developed and the escalation framework refined. There was a meeting planned to look at the wider financial implications of responding to the recommendations. In terms of the Stakeholder Group it was noted that although the first meeting had been challenging there was a good level of engagement. **QS18/181.2 It was resolved that** the Committee note the report	
QS18/182 Listening and Learning from Experience **QS18/182.1** The Executive Director of Nursing & Midwifery presented the report. She advised the Committee that the patient experience function was being redefined to lock the expertise into operational business as opposed to being held corporately. Common themes were noted as the familiar topics of access and waiting times, and members' attention was drawn to a range of positive responses in terms of overall care provided by BCUHB. The report also set out food and nutrition as an aspect of	

care which tended to have a negative impact on the overall experience although it was difficult to triangulate the feedback directly to complaints or incidents. **QS18/182.2** The Chair indicated she found the layout of the report unhelpful in terms of the reader being able to easily pull out the improvements and what area they addressed. She also queried the interpretation of the table reporting the top 7 incidents for each site with regard to the categories specified. The CHC Chair added there was a lot of information and analysis within the report but it wasn't clear how this transferred into actions. A comment was also made that in terms of the percentages within the tables as it wasn't clear what the Board should actually be aiming for. Overall the Committee felt that the Listening & Learning report should be a key document but that consideration needed to be given to identify how best to present the information to the Committee to provide the assurance required. The Executive Director of Nursing & Midwifery would reflect and set up a small task group to take this forward ahead of the next report coming to the Committee in March. The Community Health Council Chair and Trade Union Independent Member volunteered to be a part of this group. **QS18/182.3 It was resolved that** the Committee note the report pending review by the operational team to on its format and content for future meetings.	GH
QS18/183 Healthcare Inspectorate Wales (HIW) Inspection Update Report **QS18/183.1** The Executive Director of Nursing & Midwifery presented the report and confirmed that there was a process in place to ensure that HIW actions were reported into the QSG. Associated action plans were subsequently signed off by the relevant area or division and by herself as the Executive Lead before final sign off by the Chief Executive. Overall the action plans were becoming more meaningful although it was the responsiveness and capacity of the teams that was key to their delivery. **QS18/183.2** A conversation took place regarding where actions were stated as "outstanding" and the Executive Director of Nursing & Midwifery defined this as being where she had not seen evidence that the actions were embedded and were making a difference. As such, QSG were unable to provide the necessary assurance. The Committee were supportive of the need for clear evidence and assurance before actions were closed down and on this basis could not take an adequate level of assurance from the report as provided. The Chair would write to the QSG to note this shared lack of assurance. **QS18/183.3 It was resolved that** the Committee note the content of the report but that it did not provide the required level of assurance, and this would be shared with the Quality Safety Group.	LR
QS18/186 Issues Discussed in Previous In Committee Session It was resolved that the Committee note the information in public.	
QS18/187 Documents Circulated to Members	

QS18/187.1 The Committee noted that the following information had been provided to members: 20.9.18 Briefing note on prescribing lessons learned from Gosport investigation 27.9.18 Copy of presentation slides from Cross Party Stroke meeting 16.10.18 Copy of presentation slides from Improvement Group (HASCAS & Ockenden) 18.10.18 Position statement from Executive Medical Director on paediatric cover 19.11.18 Copy of Quality Safety Group draft cycle of business	
QS18/188 Welsh Health Specialised Services Committee – Quality & Patient Safety Committee Chair's Report July 2018 **It was resolved that** the Committee note the information	
QS18/189 Issues of Significance to inform the Chair's Assurance Report To be agreed with Chair.	
QS18/190 Date of Next Meeting Tuesday 22nd January 2019 @ 9.30am in Carlton Court	
QS18/191 Exclusion of Press and Public It was resolved that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960.'	

BCUHB QUALITY, SAFETY& EXPERIENCE SUB COMMITTEE - Summary Action Log Public Version				
Officer/s	Minute Reference and summary of action agreed	Original Timescale	Latest Update Position	Revised Timescale
25th September 2018				
E Moore	**Primary Coronary Intervention** (item deferred from draft September agenda) Letter from Richard Cowell circulated to members on 26.7.18. Committee Chair requested verbal update at November meeting.	November	29.11.18 Update provided under matters arising.	Closed
29th November 2018				
G Harris	**QS18/169.1** Arrange meeting with Committee Chair to refresh and review the cycle of business	January	4.1.19 Meeting held	Closed
E Moore	**QS18/172.3** Arrange for IMs to receive further details including financial implications of proposals regarding primary coronary intervention.	December	Verbal update to be provided at January meeting.	January
L Reid	**QS18/173.2** Recommend amended terms of reference to the Board through Chair's assurance report	January	Completed	Closed
G Harris	**QS18/174.1** Circulate details of actions that had been taken in relation to the public interest report regarding complaints handling as detailed within the PSOW annual letter	December	Briefing note sent to Committee Chair 15.1.19.	
G Harris	**Q18/176.2** Ensure that the Committee received an update on the HAPU and Falls collaborative as part of the January IQPR report PLUS a written paper to the March meeting.	January March	Included within IQPR report for 22.1.19 meeting. Added to CoB and author aware.	Closed

S Forsyth	**QS18/177.3** Ensure that the Committee received a further update against TODAYiCAN at the end of the next 90 day cycle	March	Reflected within CoB and Division aware of the need for paper in March.	Closed
G Harris	**QS18/184.4** Clarify the arrangements for the Health Board to receive updates from CSIW where relevant to services provided to its patients.	January	CSIW will provide reports directly where services are provided by the HB. For shared or co services these are published via CSIW website and would be discussed through partnership working groups. Going forward this is being reviewed as part of the HIW merger.	Closed
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	
J Newman D Carter	**QS18/185.3** Arrange for exception report within IQPR on the backlog for sign-off of incidents	January	Included within IQPR report for 22.1.19 meeting.	Closed
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		
L Reid	**QS18/185.5** Recommend to the Board through Chair's report that the information governance training indicator within the IQPR should be allocated to the IGI Committee.	January	Included in Chair's report.	Closed
M Denwood	**QS18/184.2** Reflect on format of future safeguarding reports and how best to include appropriate level of detail around HASCAS and	January	Ongoing conversations between the Associate Director of Safeguarding and Associate Director of Quality Assurance, and Executive Director of Nursing & Midwifery.	

	Ockenden recommendations.			
A Roach	**QS18/178.1** Provide a briefing note on email to explain the recommendation to decrease the corporate risk register score (CRR13)	December		
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.	Update in March
D Carter	**QS18/180.1** Ensure that draft QSG notes are circulated once approved by the QSG Chair, to ensure more timely receipt by committee members.	December onwards	Arrangements in hand.	Closed
G Harris	**QS18/182.2** Set up small task group to review and refresh the listening and learning report format in light of Committee discussion.	January	Initial meeting being diarised.	
L Reid	**QS18/183.2** Write to the QSG to express concern at shared lack of assurance around the HIW inspection report and the need for clear evidence to allow actions to be closed down.	December		

Quality, Safety & Experience Committee 22.1.19	**GIG CYMRU NHS WALES** Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board *To improve health and provide excellent care*

Report Title:	Maternity Services in North Wales - Deloitte's Presentation and Final Update on the Commissioned Organisational Development (OD) Programme
Report Author:	Mr Mark Green – Director/Audit & Risk Advisor – Deloitte LLP
Responsible Director:	Miss Teresa Owen, Executive Director of Public Health
Public or In Committee	Public
Purpose of Report:	This presentation, prepared by the Deloitte OD Team, details the final update to the Health Board on the commissioned Organisational Development project within the Women's Directorate.
Approval / Scrutiny Route Prior to Presentation:	The Maternity Service was placed in Special Measures in May 2015 and de-escalated by Welsh Government (WG) in February 2018.

One of the elements that accounted for the service being placed in Special Measures was the historic and ongoing cultural and leadership issues identified specifically on the Ysbyty Glan Clwyd site. Whilst the service has been de-escalated from measures WG continues to seek assurances that the Organisational and Development plan to improve culture and leadership within maternity services in North Wales is ongoing and having a positive impact.

An external Organisational Development (OD) company was commissioned to support the Health Board's plan to improve the culture and the multidisciplinary team working within maternity services. The diagnostic phase of the programme commenced in July 2016 and a proposed OD Implementation plan, based on the diagnostic findings, was presented to the Executives of the Health Board in May 2017. Ten clear interventions were identified as a means to support the maternity unit in Ysbyty Glan Clwyd. The plan included local and externally commissioned OD elements. The commissioned element of the OD Implementation plan (Phase 2) followed a procurement process and the tender was awarded to a Deloitte OD Team. Phase 2 of the project commenced in February 2018 and extends to the end of November 2018.

To provide assurances to both WG and the Board, a monthly OD Monitoring Project Board, chaired by an Executive Lead who reports directly to the Executive Sponsor for the Project, has been established. Quarterly progress reports have been presented to the Quality and Safety Sub Committee of the Women's Board to maintain the assurance monitoring framework that supported the service whilst in measures.

As further assurances to the Committee and WG an Internal Audit Review of the service, based on the elements that led to the service being placed in Special Measures, will be undertaken in Q4 of 2018/19 and the findings will be presented to QSE Sub Committee as part of the BCUHB agreed Internal Audit Cycle Reporting Plan. |

Governance issues/risks:	The Presentation provides and update on; 1) The core activities of the OD Programme which includes; - Orientation & Engagement - YGC Service Leadership Team Development Programme - Work Plan Development - Development Programme for the Clinical Directors across North Wales. - Development Programme for the Women's Service Senior Leadership Team. 2) The Progress to date on the five work streams. 3) An update against the Outcome Measures for the OD Programme. 4) Assessed Risks and Key Impacts. *5)* Outlines the hand over arrangements and plan on conclusion of Phase 2 of the Project, and Deloitte's recommendations to sustain measurable progress going forward. Whilst this report confirms the conclusion of Phase 2 of the OD Project it is recognised that cultural change on this scale will take time and continued effort and support. To mitigate risk at this point a hand over plan for the Directorate with clear recommendations has been drafted by Deloitte to support a smooth transition of the programme on their exit. A Corporate Performance Dashboard and Accountability Framework has also been developed to support the ongoing monitoring of the overall project. The Transition and ongoing plan will continue to be monitored at the established monthly OD Board which will be Chaired by the Director of Midwifery & Women's Services going forward. However, the Directorate does not have the OD expertise to manage the Programme in isolation and this poses a risk to the ongoing Cultural and OD Improvement plan. In order to mitigate this risk and to avoid regression in the overall plan and reported progress to date the Directorate seeks continued support from the Corporate OD Team going forward. The Directorate also seeks support for the continued support from Deloitte on a 2 day/month basis for the remainder of 2019. This ongoing OD and Leadership Project is cited as a mitigation element against entry W056C on Tier 2 of the Risk Register and relates to – 'Unsafe Care Delivery Provision by an Obstetrics and Gynaecology team due to dysfunction within the team. Initial Score – 16, current score with mitigation – 12.
Financial Implications:	Of note the Deloitte Project has been fully funded by the Directorate. As noted previously Cultural Change on the scale required in the Women's Directorate will take time and investment from the Directorate and the Corporate OD Team going forward. This will have some ongoing finance implications. Over the past 2 years the Directorate has financially invested in other projects to support the overall OD Programme, which focus on promoting a positive multidisciplinary culture, through joint training, situational awareness and team working in all situation. One such initiative has been the introduction of PROMPT (**P**ractical **O**bstetric **M**ulti **P**rofessional **T**raining). The training is evidence based multi-professional package for obstetric emergencies and is associated with

	direct improvement in periantal outcomes and has been shown to improve knowledge, situational awareness, clinical skill and team working. Whilst some of the funding for this training has been sourced by WRP the Directorate has contributed to the overall implementation costs and will need to provide ongoing investment for such projects to support the overall OD plan and to comply with WG mandated programmes with the introduction of the revised Maternity Vision in December 2018. To note Deloitte has made several recommendations as part of their final Report which will also require funding to support the ongoing overall OD plan. A single tender waiver for ongoing support from the Deloitte Team in 2019 has been submitted and is awaiting final sign off by the Executive Director of Finance. The full cost implications have been submitted as part of the Women's Directorate IMTP Plan for the next 3 years.
Recommendations:	The Committee is requested to: 1. Note the update and progress to date and support the recommendations made by Deloitte in this final update presentation – which includes ongoing support from Deloitte on a 2 day/month basis for the remainder of 2019. 2. *Acknowledge that cultural change of the scale required in the Women's Directorate will need Corporate OD support and that the ongoing OD plan will need some financial support and investment to ensure that the early signs of positive change are embedded and sustained.* 3. Support that the risk register entry as noted previously is not de-escalated until the findings of the Internal Audit of the service is considered in Q4.

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

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

Special Measures Improvement Framework Theme/Expectation addressed by this paper

Maternity Services
Leadership and Governance

Equality Impact Assessment

A full EqIA has not been completed for this OD & Leadership project as it should not affect one group less or more favourably based on any protected characteristic.

| **Quality, Safety & Experience Committee**

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

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Report Title:	Health and Safety Update Report
Report Author:	Mrs Sue Green, Executive Director of Workforce and Organisational Development
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 approved by the Board at its meeting on 1st November 2018.
Approval / Scrutiny Route Prior to Presentation:	The Health and Safety Annual Report together with a position statement and proposed actions were considered by the Health Board in November 2018. In addition the Internal Audit Report regarding Health and Safety has been reviewed by both the Quality, Safety & Experience Committee and Audit Committee previously.
Governance issues / risks:	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. 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.
Financial Implications:	There are no direct financial implications from this report
Recommendation:	The Committee is asked to: 1. Note the position outlined in the report.

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

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

Special Measures Improvement Framework Theme/Expectation addressed by this paper

Engagement
Leadership & Governance

Equality Impact Assessment

Update paper – none required.

Health and Safety Update Report

1.	Purpose of report

This report provides an update on the actions approved by the Health Board at its meeting on 1st November 2018.

2.	Background and Context

2.1   Requirements

The Health and Safety at Work Act 1974 and the Management of Health and Safety at Work Regulations 1999 place a requirement on the Health Board to put in place arrangements to control health and safety risks.

As a minimum the following processes and procedures are required to meet the legal requirements:
    a. A written health and safety policy
    b. Assessments of risks to employees, patients, visitors, contractors, partners and any other people who could be affected by Health Board activities – and record the significant findings in writing. Any risk assessment should be suitable and sufficient
    c. Arrangements for effective planning, organisation, control, monitoring and review of preventative and protective measures that come from risk assessment
    d. Access to competent health and safety advice
    e. Providing employees with information about the risks in the workplace and how they are protected
    f. Instruction and training for employees in how to deal with the risks
    g. Ensuring there is adequate and appropriate supervision in place
    h. Consulting with employees about their risks at work and current preventative and protective measures

The legislation is enforced by the Health and Safety Executive (HSE) who have far reaching powers which include:
    i.   Access to work premises at any reasonable hour
    ii.   Freedom to interview staff, visitors, contractors or patients
    iii. Confiscation of equipment and applicable documents
    iv.   Take statements, photographs, measurements and samples
    v.   Issue notices (Improvement and Prohibition) requiring respectively improvements within a certain timeframe or stopping work until improvements are made also within a timeframe
    vi.   Initiating criminal court proceedings for alleged breaches of Health and Safety.

2.2   Current State and Progress Update

Executive Leadership

Accountability for Health and Safety has now moved to the Executive Director of Workforce & Organisational Development (OD) and the team is being integrated into the overall structure for Workforce and Organisational Development. A way forward re Security has been agreed between the Executive Director of Planning and Performance (accountable for estates) and the Executive Director of Workforce & OD and will be part of the Improvement Plan submitted to the Board in March.

The relevant responsibilities for Risk Management are also subject to review by the Executive Team and again, this should be agreed and in place by the end of February.

Capacity and Capability

Prior to transfer of accountability from the Chief Operating Officer to the Executive Director of Nursing in April 2018 the team comprised:

1 - Head of Health and Safety (band 8a)
1.6 - Health and Safety Managers (band 7)
0.8 – Violence & Aggression Manager (band 7)
3.0 – Safety Advisors (band 6)
0.8 – Administrative Assistant

At the point of transfer, the Head of Health and Safety left the organisation and since this time, one of the Health and Safety Managers has retired and the other has been absent due to sickness. An Interim Head of Health and Safety was engaged through an agency and was in post until the end of December.

The role of Head of Health and Safety was advertised prior to the agreement to transfer accountability from the Executive Director of Nursing & Midwifery to the Executive Director of Workforce &OD. Joint interviews were held and two suitable candidates identified. Following agreement with the Executive Director of Finance, both candidates have been appointed and have now started. The Interim Head of Health and Safety finished on 20th December 2018.

The position of Associate Director of Health, Safety and Equality has been advertised with a closing date of 9th January 2019. Interviews are set for 30th January 2019 and there is a level of confidence for a good appointment based on the calibre of applicants. This role will be responsible for the management and delivery of the following, both on a workforce and service provider/public basis:
- Health and Safety
- Occupational Health
- Equality and Human Rights

In recognising and exploiting the synergies between the work undertaken by these teams (and others within the WOD portfolio), the aim will be to ensure that the management of health and safety is better integrated and linked with benefits realisation e.g. time lost; recruitment and retention; confidence and reputation management etc.

2.3   Governance and Management System/Plan

Over the course of 2017/18, the arrangements in place within the Health Board were subject to a review by Internal Audit. The report titled Review of Corporate Legislative Compliance: Health & Safety at Work etc. Act 1974 was finalised in March 2018 and considered by the Audit Committee. This report is attached at Appendix 1.

The review, based on field work undertaken between July and December 2017 provided an overall opinion as follows:

> "The Board can take limited assurance that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with moderate impact on residual risk exposure until resolved."

The report contained 6 recommendations –

4 - High priority (poor key control design OR widespread non-compliance with key controls. PLUS significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement);

2 - Medium Priority (Minor weakness in control design OR limited non-compliance with established controls. PLUS some risk to achievement of a system objective

Since this report, whilst best efforts have been made to make progress against the recommendations, given the context described in 2.1 and 2.2 above, this has been extremely challenging. In addition, there has been the need to "react" to a number of significant issues e.g. health record storage; HSE inspections e.g. Abergele Hospital and risks identified following walk rounds or staff concerns e.g. Tegid Ward.

Having undertaken an initial review of the structures in place and the availability/visibility of critical information, the Executive Director of Workforce & OD advised the Board that she believed that the position had potentially deteriorated since the fieldwork was undertaken and as a result required significant focus over the next 2-3 months to take the following steps. Progress against each point is outlined below:

- Establish the structure outlined above – Structure in place and appointment of the Associate Director anticipated by the end of January with a start date before 1st April 2019. In addition, work is being undertaken to review the location and accommodation for some of the teams to better align them with Occupational Health Teams and improvement the environment.

- Review and recommend an effective governance and performance management structure to align with the overall accountability and assurance structure of the Health Board – the Terms of Reference for the existing Health and Safety Committee have been reviewed and are being amended to bring Health, Safety and Wellbeing together under one structure. A proposal is

being developed to re-establish this as a Health and Safety Group consistent with the Quality & Safety Group, reporting through to the Executive Team for performance management and this Committee for assurance. The draft Terms of Reference will be reviewed as part of the first meeting of the group being organised for February 2019 before being submitted for approval. In addition, the team is currently developing a "map" of the Health and Safety governance and partnership structures across the organisation to ensure a "Board to Ward" thread. This will be reviewed by the Health and Safety Group at its first meeting and proposals for improvement developed as a matter of urgency.

- Develop a 3 year Improvement plan with clear and time bound objectives for delivery within 2019/20 and each year following to be considered by the Board no later than March 2019 – The framework for a plan is being formulated with a view to this being further developed now that the Heads of Health and Safety are in post and in anticipation of involvement of the successful candidate for the role of Associate Director. It has been incorporated into the 3 year priorities within the Workforce Strategy and Workforce section of the draft 3 year plan to be considered by the Board of Directors in January 2019.

- Continue to build on the work undertaken by the Executive Director of Nursing and Assistant Director of Quality Assurance to develop a more effective relationship with the Health and Safety Executive to secure trust and confidence in the Health Board – A meeting was held with the Health and Safety Executive Inspector and further sessions are being planned with him as part of the development of the Improvement Plan. The emphasis needs to be on delivering on the Board's commitments and as such, these sessions will be programmed at a point when there is demonstrable and tangible progress against the steps outlined above.

4.	Assessment of risk and key impacts

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.

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.

The need to undertake a fundamental review has been expressed by the Health and Safety Executive and by the Health Board's Trade Union Partners in various settings over a period of time and as such being clear on the approach outlined in this report should start to improve confidence of these key regulators/stakeholders

5.	Conclusions / Next Steps

Good progress is being made against the actions set out to the Board and there is confidence that taking a more structured and systematic approach will result in an improvement in the position in terms of Health and Safety.

In delivering against the actions outlined above, the Board will also be delivering the recommendations set out within the Internal Audit Report.

Finally, the plans and progress described above have been discussed with Trade Union partners and there is overall support for the direction of travel.

6.	Recommendation

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

Betsi Cadwaladr University Health Board

Corporate Legislative Compliance: Health & Safety at Work etc. Act 1974

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BCU 2017/18

March 2018

NHS Wales Shared Services Partnership

Corporate Legislative Compliance: Health & Safety at Work etc. Act 1974
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Review reference:	BCU-1718-05
Report status:	Final Internal Audit Report
Fieldwork commencement:	6th July 2017
Fieldwork completion:	17th November 2017
Draft report issued:	23rd November 2017
Management response received:	15th & 29th January 2018
Final report issued:	2nd February 2018
Auditor/s:	Paul Stocker
	Dave Harries
Executive sign off:	Executive Director of Nursing & Midwifery
Distribution:	Director of Estates & Facilities
	Associate Director of Quality Assurance
	Head of Health & Safety
	Board Secretary
	Deputy Board Secretary
	Finance Director: Operational Finance
	Compliance & Assurance Manager
Committee:	Audit Committee

ACKNOWLEDGEMENT
NHS Wales Audit & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Disclaimer notice - Please note:

This audit report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Service Strategy and Terms of Reference, approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Shared Services Partnership – Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Betsi Cadwaladr University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

1.   Introduction and Background

The relevant lead Executive Director for the assignment is the Executive Director of Nursing and Midwifery.

The Health and Safety at Work Act 1974 etc places duty on every employer to ensure, as far as reasonably practicable, the health, safety and welfare at work of all its employees, and any other persons who may be affected by its activities.

The Health and Safety Executive (HSE) is the body responsible for the encouragement, regulation, and enforcement of workplace health, safety, and welfare in Wales, England, and Scotland.

The Health Board has a legal and moral duty to put in place suitable arrangements to manage health and safety within the organisation. A comprehensive risk assessment programme should be in place in order to identify, recognise, and mitigate risk as far as practically possible.

The Health Board has issued HS01 Health and Safety Policy which provides detailed instruction from roles and responsibilities through to undertaking risk assessments as well as detailing the Terms of Reference for the Strategic Health and Safety Committee.

In delivering and monitoring compliance with the Act, there is an established mechanism of performance review, through the following:

- Health and Safety Self-Assessment Performance Tool – a six monthly performance indicator undertaken by each Directorate/Area & Corporate Function to measure the level of compliance.

- Health and Safety Review - a planned visit conducted by the Corporate Health and Safety Advisers focusing on the outcome of the health and safety self- assessment performance tool.

- Local Inspections – carried out by each Department/Ward.

- Review of DATIX Incident Reports – By Directorates/Areas and Corporate Functions/Corporate Health & Safety.

2.   Scope and Objectives

The objective of this review was to ensure Policy is being complied with and the assurance is robust.

The scope of the review focused on the following areas:

- Governance arrangements – we reviewed the Terms of Reference of the Strategic Health and Safety Committee, ascertain compliance through reviewing agenda and minutes and then evaluated the escalation of relevant matters to the Board.

- Self-assessment tool – We reviewed overall compliance within the organisation and the completeness of returns as made. Working in partnership with a Health and Safety Advisor, we visited a sample of locations to corroborate the accuracy of the self-assessment and ascertain what actions are being taken to address any shortcomings.

- RIDDOR – Reviewed a sample of the most recent reports to the Health & Safety Executive, identifying the lessons learnt, completion of the Root Cause Analysis (RCA) and ascertained how this has been shared across the Health Board.

- Health and Safety Management Reviews – we reviewed the process followed by the Corporate team in undertaking reviews, reporting of the findings and following-up actions identified.

- Training – We reviewed the completion of the self- assessment tool in respect of this area, and identifying the training required and how this is delivered in-house.

We have not reviewed the terms of reference agenda or minutes pertaining to the Health & Safety Leads meeting.

3.   Associated Risks

The risks considered at the outset of this review are as follows:

- Failure to comply with Statutory requirements.

- Governance arrangements do not provide timely and robust assurance to the Accountable Officer and Board.

- Reporting assurances to the Board is based on inaccurate self-assessment data.

- Lessons learnt are not evident or shared across the Health Board.

- Training requirements are not based upon the findings of an up to date needs analysis.

OPINION AND KEY FINDINGS

4.   Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

The assurance rating and findings detailed within this report pre-date that transfer of executive responsibility to the Executive Director of Nursing and Midwifery.

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the Corporate Legislative Compliance: Health & Safety at Work etc. Act 1974 review is limited assurance.

RATING	INDICATOR	DEFINITION
Limited Assurance		The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters

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		require management attention with **moderate impact on residual risk** exposure until resolved.

The overall level of assurance that can be assigned to a review is dependent on the severity of the findings as applied against the specific review objectives and should therefore be considered in that context.

5.   Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
1	Governance Arrangements		✓		
2	Self-Assessment Tool		✓		
3	RIDDOR		✓		
4	Corporate Health & Safety Management Reviews			✓	
5	Training			✓	
6	Management Arrangements in place within Divisions and Areas		✓		

* The above ratings are not necessarily given equal weighting when generating the audit opinion.

Design of Systems/Controls

The findings from the review have highlighted no issues that are classified as weakness in the system control/design for Corporate Legislative Compliance: Health & Safety at Work etc. Act 1974.

Operation of System/Controls

The findings from the review have highlighted 6 issues that are classified as weakness in the operation of the designed system/control for Corporate Legislative Compliance: Health & Safety at Work etc. Act 1974.

6.   Summary of Audit Findings

The key findings are reported in the Management Action Plan.

Governance Arrangements

The Health Board has a Health & Safety Committee [which was renamed the Strategic Health & Safety Committee (SHSC) during 2016], with the Terms of Reference noting that it reports into Quality, Safety & Experience Committee and Executive Management Group.

We noted a published governance structure details a 'Health & Safety Committee' reporting through the Executive governance structure and not through the Health Board assurance structure.

We are unclear whether this meets the requirements set out in the *Safety Representatives and Safety Committees Regulations 1977 (as amended) and Health and Safety (Consultation with Employees) Regulations 1996 (as amended)* where we note under '*The conduct of health and safety committees – paragraph 96*' "*…..and arrangements should be made to ensure that the Board of Directors is kept informed generally of the work of the committee.*"

It is noted that the Terms of Reference (ToR) for this group was subject to review in February 2017; however we understand that the revised ToR have not been formally approved and this has been put back to the December 2017; the current ToR as included at the back of policy HS01 state that they were due for review in April 2017.

The ToR state that the committee was established to monitor the performance of the Health Board in respect of the management of health and safety. As part of this it will:

- '*Develop health and safety performance indicators through the self - assessment audit process.*'

- '*Submit the Committee's minutes and issues of significance to the Quality, Safety and Experience Committee for consideration as part of the Integrated Governance Committee through to Health Board.*'

On reviewing the minutes and agendas of the SHSC for the period December 2016 through to June 2017, we noted:

- The meeting was not quorate for the February; April and June 2017 meetings;

- Overall low attendance at meetings;

- Issues identified in respect of the returns of the Health & Safety Self-Assessments in December 2016, February 2017 and again in April 2017.

- Within the April 2017 minutes, poor self-assessment returns was recorded as an issue for escalation to the Quality Safety and Experience Committee (QSE). We reviewed the agenda and minutes of the QSE Committee [for meetings held between April and October 2017] to verify the escalation and also to identify the level of non-compliance - We were unable to identify any specific mention of this issue.

Self-Assessment Tool

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The review identified a number of issues in relation to the completion of the Self-assessment tool.

It is required to be completed bi-annually with the returns collated and reported to the Board. However it has suffered since its introduction with returns not being universally completed.

The six monthly returns which were due to be submitted to the Corporate Health & Safety Team by end of October 2017 at the very latest, show this trend continuing with only a third of expected submissions received.

Our review highlighted further issues, with differing interpretations, at which level these self-assessments should be undertaken and by whom.

For example, on some secondary care wards the Sister completes but at others the Matron.

For some Community Hospitals a single self-assessment would be made by the Matron for the entire Community Hospital, but for others the completion of this was undertaken remotely by a colleague with a background in Health & Safety with the assessment covering several Community Hospitals and the assessment being based in part on conversations with Heads of Service.

In addition the evidence to support the self-scoring assessment was not found to be consistently robust, with differing views on what constituted a satisfactory level of compliance across different wards/hospitals.

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR)

For those accidents and dangerous occurrences that are reportable under the provisions of RIDDOR, this information must be notified to the Health & Safety Department as soon as possible either by the electronic Incident Reporting System (Datix), e-mail or telephone so that they can report the incident to the Health & Safety Executive (HSE).

The Law requires RIDDOR reports to be sent to the HSE within 15 days of an injury.

On reviewing a sample of 14 incidents recorded for August 2017 [selected to allow three months for completion of the Root Cause Analysis] in Datix, all of which were initially identified as being RIDDOR, we noted the following:

- 3/14 were not reported to the HSE within the required timescale of 15 days;

- A further 2/14 had no date recorded in Datix to advise if or when it was reported to the HSE.

- No Root Cause Analysis was attached for the majority of the sample reviewed, despite evidence of email requests from the Corporate Health & Safety Team requesting them.

- Generic short responses provided in the Datix field which requires details of lessons learnt. In one case it simply stated "*always ensure staff safety*".

Corporate Health & Safety Management Reviews

The Corporate Health & Safety Department have had a number of staff changes to contend with in the past 12 months and are only recently getting back to a full complement of staff which has impacted on their ability to undertake reviews.

We noted that the corporate team reviews are not risk based and the findings of the reviews are not subject to follow-up.

However, from visits that we undertook to wards and departments across the Health Board, it is apparent that a programme of visits is underway with the majority of the wards/ departments we visited having had a review within the past few months.

Training

During the course of undertaking this review we were made aware from discussions with clinical staff and from comments on self-assessment documentation that there appears to be a need for training of staff on how to undertake the ward assessments and self-assessments.

It is recognised that in the current climate it is not always possible for wards to release staff to attend training, however maybe ways of delivering training locally could be considered.

Management arrangement within Divisions and Areas

We found that the Health and Safety management arrangements differed significantly between the Divisions and Areas.

Two of the three Areas, along with Mental Health, had in place Health and Safety/Risk/Quality and Safety/Governance managers/leads or equivalent, the supporting structures varied significantly.

- The leads identified within the Areas and Mental Health were working to out of date job descriptions pertaining to previously held roles within the CPG Structures.

- A lead identified for Secondary Care (Ysbyty Glan Clwyd) did not have accountability for Health and Safety clearly defined within their job descriptions.

7.   Summary of Recommendations

The audit findings, recommendations are detailed in Appendix A together with the management action plan and implementation timetable.

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	4	2	0	6

Corporate Legislative Compliance: Health & Safety at Work etc. Act 1974
Betsi Cadwaladr University Health Board

Final Internal Audit Report
Appendix A - Action Plan

Finding - ISS.1 – Governance Arrangements (Operating effectiveness)	Risk
From reviewing the minutes for meetings of the Strategic Health & Safety Committee (SHSC) we observed that overall attendance is patchy with three meetings in 2017 not quorate. The question of who is in attendance and who should be in attendance representing divisions within the Health Board has been the subject of minuted discussions at meetings. We are unsure whether the reporting lines of the Strategic Health and Safety Committee/Health and Safety Committee meet the *Safety Representatives and Safety Committees Regulations 1977 (as amended) and Health and Safety (Consultation with Employees) Regulations 1996 (as amended)*. In addition the Terms of Reference for the SHSC note that they were due for review in April 2017 and this is reflected in the minutes of the SHSC meeting on the 31st August 2017 which record that these are due back for the December 2017 meeting. The issue of the level of returns of self-assessment has been raised at meetings held in December 2016, February 2017 and again in April 2017, however minutes of the meetings do not show any evidence that this issue has been subject to any scrutiny or challenge within the meeting itself. The meeting of the 27th April 2017 details an issue *'not all completed Self-Assessment Performance Tool returns have been received'* under Issues of Significance for escalation to the Quality, Safety and Experience Committee – We have been unable to confirm that this issue has been escalated.	The Strategic Health & Safety Committee not fulfilling its Terms of Reference and therefore cannot be relied upon as part of the assurance process. Compliance with Regulations.
Recommendation	**Priority level**
Management review the governance; assurance; and reporting arrangements in respect of Health & Safety through to the Health Board.	**High**
Management Response	**Responsible Officer/ Deadline**

Governance, assurance and reporting arrangements to be reviewed by the Strategic Health & Safety committee and approved by the Quality, Safety and Experience Committee of the Board which receives assurance from this committee.	Director of Estates and Facilities / Associate Director Of Quality Assurance / 30.04.18
Finding - ISS. 2 – Self-Assessment Tool (Operating effectiveness)	**Risk**
The review identified a number of issues in relation to the completion of the Self-assessment tool which is required to be completed bi-annually with the returns collated and reported to the Board. However it has suffered since its introduction with returns not being universally completed. The six monthly returns which were due to be submitted to the Corporate Health & Safety Team by end of October 2017 at the very latest, show this trend continuing with only a third of expected submissions received. Our review highlighted further issues with differing interpretations of at which level these self-assessments should be undertaken and by whom. In addition the evidence to support the self-scoring assessment was not found to be consistently robust, with differing views on what constituted a satisfactory level of compliance across different wards/hospitals.	The information as provided is incomplete and inconsistent and does not provide the basis for accurate and reliable assurance and reporting.
Recommendation	**Priority level**
Self-Assessments should be completed in line with the requirements of the Health Board and the process of completing these should be standardised to ensure the reliability and integrity of the information that is being reported.	**High**
Management Response	**Responsible Officer/ Deadline**
The Strategic Health and Safety Committee to review process to ensure standardised, reliability and integrity of completed Self-Assessments. The Corporate Health and Safety Leads meeting to ensure Divisions/Areas/Corporate	Director of Estates and Facilities / Associate Director Of Quality Assurance / 30.04.18

functions clearly identify a health and safety lead or leads for their areas.	Head of Health & Safety -01/04/18
Finding - ISS.3 – RIDDOR (Operating effectiveness)	**Risk**
On reviewing a sample of 14 incidents recorded for August 2017 in Datix, all of which were initially identified as being RIDDOR, we noted the following issues: • 3/14 not reported to HSE within the required timescale of 15 days • 2/14 no date recorded in Datix to advise if or when reported to HSE. • No Root Cause Analysis attached for the majority of the sample reviewed, despite email requests from the Corporate Health & Safety Team. • Generic short responses provided in Datix field which requires the details of lessons learnt to be noted. In one case it simply said "always ensure staff safety".	Non-compliance with Statute.
Recommendation	**Priority level**
Incidents identified as being RIDDORs must be reported and managed in line with Health and Safety Legislative requirements.	**High**
Management Response	**Responsible Officer/ Deadline**
The Strategic Health and Safety Committee to monitor and review RIDDOR reporting and implement training programme for Datix Management / Root Cause Analysis.	Director of Estates and Facilities / Associate Director Of Quality Assurance / 30.04.18
Finding - ISS.4 – Training Provision (Operating effectiveness)	**Risk**
During the course of undertaking this review we were made aware from discussions with clinical staff and from comments on self-assessment documentation that there would appear to be a need for training for staff on how to undertake and complete the ward	Completion of returns are not consistent due to gaps in knowledge on

Corporate Legislative Compliance: Health & Safety at Work etc. Act 1974
Betsi Cadwaladr University Health Board

Final Internal Audit Report
Appendix A - Action Plan

assessments and self-assessments. It is however recognised that in the current climate it is not always possible for wards to release staff to attend training, however maybe ways of delivering training locally could be considered.	the part of those staff tasked with completing them.
Recommendation	**Priority level**
Consideration be given to delivering further training to staff responsible for completing generic ward assessments and the self-assessment audit tool.	**Medium**
Management Response	**Responsible Officer/ Deadline**
Refresher training to be identified and programme put in place.	Head of Health & Safety- 30.04.18

Finding - ISS.5 – Management Arrangements (Operating effectiveness)	**Risk**
Two of the three Areas, along with Mental Health, had in place Health and Safety/Risk/Quality and Safety/Governance managers/leads or equivalent, the supporting structures varied significantly. • The leads identified within the Areas and Mental Health were working to out of date job descriptions pertaining to previously held roles within the CPG Structures. • A lead identified for Secondary Care (Ysbyty Glan Clwyd) did not have accountability for Health and Safety clearly defined within their job descriptions.	Non- compliance with the requirements of Health & Safety Policy HS01.
Recommendation	**Priority level**
The Health Board reviews the Health and Safety management and governance arrangements across its entirety to ensure that it is embedded and delivers its statutory requirements.	**High**

Corporate Legislative Compliance: Health & Safety at Work etc. Act 1974
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Final Internal Audit Report
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Management Response	Responsible Officer/ Deadline
The Strategic Health and Safety Committee to review Health and Safety management and governance arrangements to provide embedded reporting structures to ensure delivery of statutory requirements.	Director of Estates and Facilities / Associate Director Of Quality Assurance / 30.04.18

Finding - ISS.6 – Corporate Health & Safety management reviews (Operating effectiveness)	Risk
Whilst the management reviews are undertaken we noted from our testing that these are not risk based and are not subject to follow-up. In addition we also noted that the self-assessment audit tool returns are not subject to scrutiny and follow-up by Corporate Health & Safety.	The current process does not target those areas identified as being of greatest risk.

Recommendation	Priority level
The rolling programme of Corporate Health & Safety management reviews are based on a formal risk assessed schedule driven by the self-assessment audit tool. With the reports subject to a formal reporting assurance forum e.g. Hospital Management Team/Area Management meeting.	**Medium**

Management Response	Responsible Officer/ Deadline
Corporate Health and Safety will use the out turn of the Self - Assessment Tool to inform the Departments work planning process. CHS have raised on a number of occasions the lack of responses from Divisions/Areas/ Corporate Functions which in turn undermines the CHS work plan. Failure to submit returns will be escalated through the Committee reporting structure.	Director of Estates and Facilities / Associate Director Of Quality Assurance / 31.04.18

Appendix B - Assurance opinion and action plan risk rating
Audit Assurance Ratings

Substantial assurance - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

Reasonable assurance - The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

Limited assurance - The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

No assurance - The Board can take **no assurance** that arrangements in place to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved.

Assurance not applicable is given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are **not appropriate** but which are relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

Quality, Safety & **Experience Committee** **22.1.19**	GIG CYMRU NHS WALES — Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board ***To improve health and provide excellent care***

Report Title:	Health Protection Team (North Wales) 2018 Annual Report
Report Author:	Dr Graham Brown Consultant in Communicable Disease Control (CCDC)
Responsible Director:	Miss Teresa Owen Executive Director Public Health
Public or In Committee	Public
Purpose of Report:	To provide assurance to the Health Board with respect to the work of the Health Protection Team, acting to protect and control the risk of communicable disease and other hazards to population health.
Approval / Scrutiny Route Prior to Presentation:	• Direct to Committee • Health Protection issues are discussed regularly at the Senior Leadership Team of the PH Directorate
Governance issues / risks:	Maintaining appropriate health protection arrangements for the UHB is a requirement for the UHB. This annual report provides an overview of recent activity.
Financial Implications:	No specific implications are detailed within the paper. However all outbreak type incidents are resource intense for the UHB, the Health Protection Team and Partners.
Recommendation:	The Committee is asked to note the contents of the report for information.

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

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

Special Measures Improvement Framework Theme/Expectation addressed by this paper

Leadership & Governance

Equality Impact Assessment

A full EqIA has not been completed in relation to this specific report. The health protection team is a universal service led by a Consultant in Communicable Disease Control, based with Public Health Wales. The Health Protection Team undertake EqIA's when required.

Health Protection Team (North Wales)
2018 Annual Report

Author: Dr Graham Brown, Consultant in Communicable Disease Control	

Date: January 2019	**Version:** 1

Publication/ Distribution:

- Betsi Cadwaladr University Health Board, Quality Safety and Experience Committee

Purpose and Summary of Document:

To provide assurance to Betsi Cadwaladr University Health Board Quality Safety and Experience committee with respect to the activity of the Health Protection Team.

1   Introduction

The Health Protection Team (HPT) is responsible for the surveillance, prevention and control of communicable diseases, vaccine preventable diseases, and non-communicable public health incidents such as those involving chemicals or the environment in Wales. It provides a local presence as part of the national health protection service that offers a 24/7 source of expert advice and support.

Consultants in Communicable Disease Control (CCDC) and Consultants in Health Protection are employed by Public Health Wales, but also authorised as Proper Officer by Local Authorities in Wales. This role allows them to discharge, on behalf of the Local Authorities, the statutory functions relating to communicable disease.

The Health Protection Team works closely with and reports regularly to the local Executive Director of Public Health (DPH).

1.1   Local health protection

The Health Protection Team is based in a number of offices across Wales. This enables the provision of a national level service with local support where required. Each Health Board area has a named consultant lead for health protection issues.

Staff based in north Wales are:

- Consultant in Communicable Disease Control (named consultant for Betsi Cadwaladr University Health Board) x1   (1.0 WTE)
- Consultant in Health Protection (named consultant for Powys Teaching Health Board) x1   (1.0 WTE)
- Health Protection Nurse x3   (2.8 WTE)
- Information analyst x1   (0.6 WTE)
- Administration officer x2   (1.8 WTE)

Co-located with the team is also a Specialist Immunisation Nurse (0.6 WTE) dedicated to supporting the Public Health Wales Vaccine Preventable Disease Programme.

1.2   National level service

The health protection service functions as a single, all-Wales team for responding to acute health protection issues. This All-Wales Acute Response

(AWARe) service provides additional resilience through a shared case and incident management system (TARIAN) that allows secure sharing of information between staff located in any of the offices in Wales, as well as with laboratories and local authorities.

2 Communicable disease

A full breakdown of cases notified to the Health Protection Team is listed in Appendix 1 and demonstrates the variety of issues that the team have responded to. Notable outbreaks & incidents are outlined below.

2.1 Hepatitis A

The outbreak that was declared in early 2017 continued to pose a number of challenges into early 2018. Microbiological data on the cases identified a number of different strains indicating that rather than a single outbreak, there were multiple smaller outbreaks of linked cases.
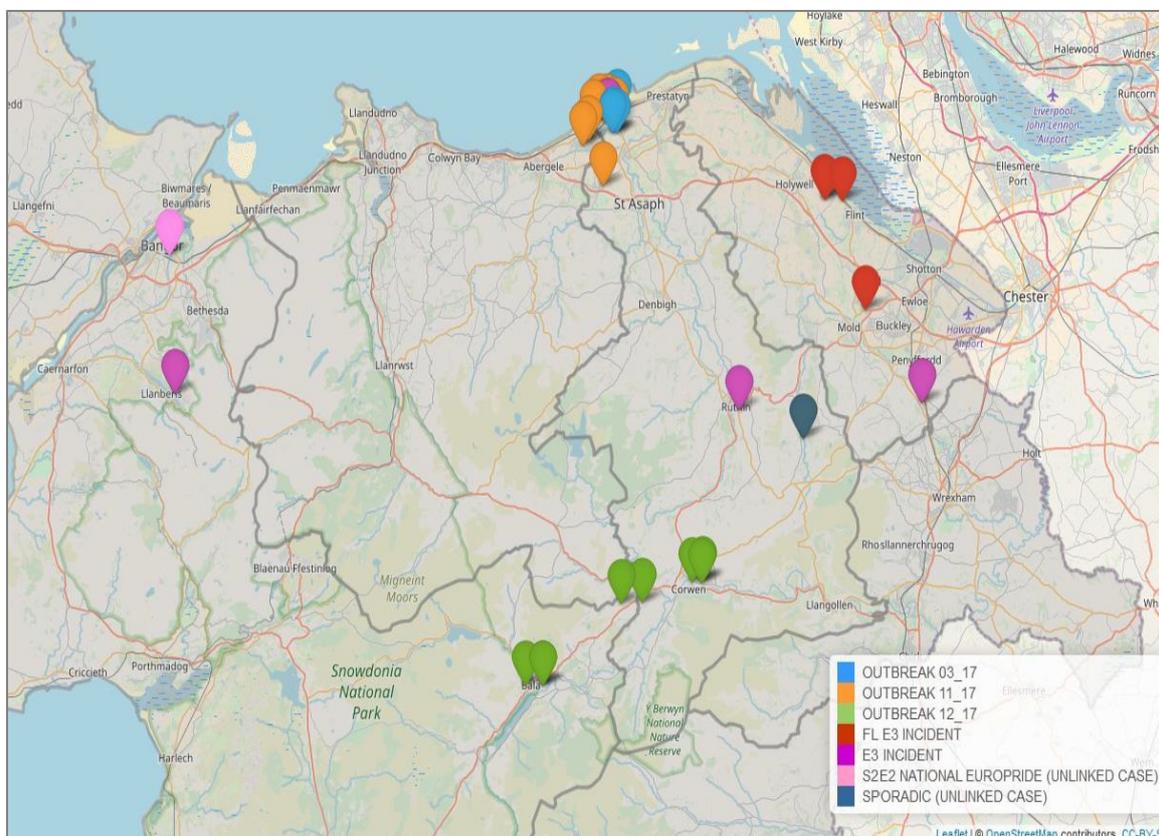

Figure 1: Hepatitis A strains, BCUHB area 2017-18

In each outbreak there was evidence of sustained person-to-person transmission, most often within the household setting. Identifying cases proved challenging as the infection is often mild in children.

As a result of a number of cases in school-aged children, vaccination was offered to pupils and staff of schools where cases were identified. Over the course of the outbreaks in excess of 1200 individuals were vaccinated through these sessions, which were coordinated and delivered by BCUHB staff with support from the HPT.

The source of infection in the index cases for these outbreaks has been difficult to establish. Many of the strains identified have been linked to foreign travel, however the cases had no relevant travel identified suggesting that another factor, e.g. low level contamination of food, may be a cause. As is routine practice, data from the outbreak continues to form part of ongoing epidemiological surveillance.

2.2 E coli O157

In June 2018 an outbreak of E coli O157 was declared in the Conwy area. In response to the cases a local nursery and childminder closed in order to identify further cases and prevent any transmission within these settings. Around 80 individuals were screened as a result, with officers from the local authority coordinating the response and working with the laboratory at Ysbyty Glan Clwyd to ensure positive cases were identified early and excluded as appropriate.

This outbreak demonstrated the importance of close working relationships between PHW, BCUHB, and the local authority. Early notification of the index case by the medical and infection prevention team at YGC facilitated a swift public health response that enabled ongoing risk to be managed in a timely way.

A total of 8 confirmed cases were associated with the outbreak.

2.3 Influenza

Last winter saw the most intense influenza activity in Wales for a number of years. In the BCUHB area a total of 9 influenza outbreaks were reported from care and residential home settings. Each of these outbreaks was managed in consultation with the home and local primary care provider(s).

The Health Protection Team established a dedicated flu service over the winter months in light of the severity of the flu season in order to meet the demand.

Support was also provided to BCUHB in the response to outbreaks of flu in secondary care, in particular on the Wrexham Maelor site.
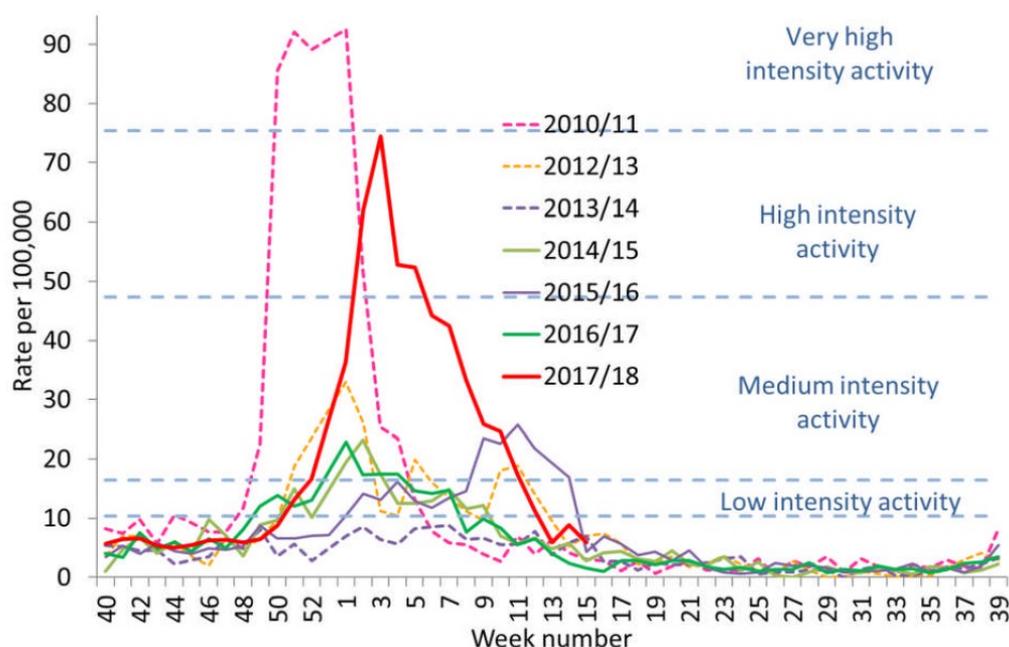
Figure 2: Public Health Wales sentinel GP weekly consultation rate for influenza-like-illness 2017/18

2.4   Tuberculosis

Over the last year the Health Protection Team has been working closely with the respiratory team in the Wrexham area to investigate a number of linked cases of TB. A total of 8 cases have been identified to have epidemiological links since 2012 (6 in the last year).

Many of the recent cases have complex social needs, including homelessness and substance misuse. Many of the needs of these individuals have required intense support and coordination that has put additional pressures on both BCUHB and the Health Protection Team. Identifying social networks in order to trace contacts of cases has also proved to be a challenge.

Due to the lengthy incubation period of TB and the social context of the cases to date it is likely that further cases will come to light as the investigations continue.

3   Environmental incidents

The NWHPT continue to serve as the point of contact for public health advice relating to environmental incidents in north Wales, working in conjunction with the environmental health protection team where required.

More information on the variety of incidents and work of the environmental health protection team can be found on the Public Health Wales website.[1]

4 Emergency planning

The Health Protection Team continues to remain actively engaged with the Local Resilience Forum (LRF) in order to fulfil statutory duties as a Category 1 responder.

This last year has seen a focus on planning for pandemic flu as this remains one of the highest rated risks for the LRF. A multi-agency exercise was held in November 2018 to test updated LRF plans and proved a useful focus for partners to review their own individual agency plans. Further work around planning for pandemic flu will continue this year.

The Health Protection Team have continued to engage in the planning for Wylfa Newydd from both a local and national perspective.

Ongoing support for induction of staff at HMP Berwyn continues on an ad-hoc basis.

5 Partnership working with BCUHB

The HPT continues to play an active role in a number of BCUHB groups including:

- Civil Contingencies Group
- Infection Prevention Sub-Group
- Strategic Immunisation Group
- Operational Immunisation Group
- Flu Planning & Performance Group
- Area Infection Prevention Groups

Support is also provided to local immuniser training in conjunction with BCUHB's Immunisation Coordinator.

6 Recommendations

The committee is requested to note the contents of the report for information.

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[1] Environmental Health Protection Team Annual Report:
http://www.wales.nhs.uk/sitesplus/888/page/87800

Appendix 1

Summary of notifications to the Health Protection Team for BCUHB area. Data are for Apr-Mar unless otherwise stated. Bold data are for last complete year.

Disease/syndrome	Notifications			
	2015/16	2016/17	2017/18	2018 (Apr-Dec)
Acute encephalitis	1	0	**1**	4
Botulism	2	0	**0**	0
Cryptosporidiosis	109	115	**97**	128
Dysentery	1	1	**2**	2
Food poisoning:				
Campylobacter	813	832	**826**	748
E Coli	11	22	**12**	24
Salmonella	89	77	**64**	81
Other (unknown)	12	13	**10**	8
Giardiasis	26	26	**18**	32
Hepatitis A	3	7	**33**	3
Hepatitis B:				
Acute	5	2	**0**	1
Chronic	33	34	**40**	19
Hepatitis C:				
Acute	0	1	**6**	7
Chronic	111	136	**107**	79
Hepatitis E	3	4	**13**	8
Invasive Group A Streptococcal disease	28	21	**25**	15
Legionellosis	3	3	**5**	3
Listeriosis	3	2	**2**	1
Lyme disease	16	21	**14**	17
Malaria	4	3	**2**	0
Measles	11	29	**25**	9
Meningitis (non-meningococcal)	18	21	**27**	14
Meningococcal disease:				
Meningitis	5	4	**6**	2

Septicaemia		9	13	**8**	1
Other			2	**1**	2
Mumps		134	90	**92**	106
Rubella		6	5	**0**	0
Scarlet fever		273	369	**465**	219
Tuberculosis		21	17	**17**	18
Whooping cough		118	83	**81**	37
Others not statutorily notifiable.					Laboratory confirmed
Influenza	A	108	76	**254**	91
	B	30	18	**264**	10

NB: Data are provisional and should not be used for official reporting purposes. Complete data can be found at:

http://www.wales.nhs.uk/sites3/page.cfm?orgid=457&pid=25726

Quality, Safety & Experience Committee 22.1.19	**GIG CYMRU NHS WALES** Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board *To improve health and provide excellent care*

Report Title:	Integrated Quality & Performance Report
Report Author:	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 and approved by the Director of Performance and signed off by the Executive Director of Planning and Performance.
Governance issues / risks:	Our report outlines the key performance and quality issues that are delegated to the Quality, Safety & Experience Committee. Caution should be applied when looking at graphs and tables containing data prior to November 2016. This was when WPAS was implemented at Ysbyty Glan Clwyd and therefore direct comparison should not be made between data pre and post go live. This month sees the second presentation of the report in the new format with all measures presented in Chapter form as per the Health Board version. The Summary of the report is now included as an Executive Summary within the report itself.
Financial Implications:	*N/A*
Recommendation:	The Committee is asked to note the report.

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

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

Special Measures Improvement Framework Theme/Expectation addressed by this paper
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.

Board/Committee Coversheet v10.0

November 2018

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

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

November 2018

Put patients first ● Work together ● Value and respect each other ● Learn and innovate ● Communicate openly and honestly

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

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:

| Measure Code | | National Target | Reporting Period | | Where BCU is rated among Welsh Health Boards | | Status compared to last month (See key below) | | Escalation Level as determined by the Board: Levels 0 to 4 |

| DFM 018 | Infection Prevention: Cumulative rate of laboratory confirmed **E.coli** cases per 100,000 population | Target <= 67 | Plan TBC | Sep-18 | 79.97 | Wales Benchmark | 2nd | Executive Lead | Gill Harris | Status | ⬇ | Months in Exception | 6+ | Escalation Level | |

Measure Description — Recovery Plan — Actual Performance — Named Responsible Executive Officer — Number of Months in exception

Status Key:

Achieved & Improved	⬆ (green)	Achieved but Worse	⬇ (green)	Achieved Static	➡ (green)
Not Achieved Static	⬅ (red)	Not Achived but Improved	⬆ (red)	Not Achieved Worse	⬇ (red)

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

November 2018

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

Where we are:
This is new format for the Integrated Quality and Performance Report (IQPR) for the Quality, Safety & Experience (QSE) Committee. The Committee is delegated by the Board to scrutinise the key indicators from the national delivery framework under the thematic chapter of quality. The Mental Health indicators have transferred from F&P committee to QSE for scrutiny as these indicators are quality based measures affecting patient experience and outcome.

The indicators within this chapter are presented individually at this time, however the intention is to triangulate information and provide a greater depth of understanding going forward. Work will be undertaken to develop improved exception reports with clear actions, expected outcomes and timelines for delivery. It is expected that thematic reports will be developed within the next 6months

What we are doing:
The HCAI measures are entering the next cycle of improvement , having demonstrated excellent clinical engagement and with a high number of clinical champions resulting in improved management of HCAI rates. The next cycle includes the focus on reducing urinary track infection with the launch of UTI Friday to improve catheter management.

Healthcare acquired pressure ulcers is a concern for the LHB and this together with in-patient falls is the focus on collaborative working. Work has demonstrated that the majority of pressure ulcers are acquired in the community rather than in hospital. In this report we include the revised national indicator for reporting of all pressure ulcers and the original indicator relating to grade 3 ulcers and above. The ward dashboard is being used to manage incidents of HAPU and falls and to learn from themes arising from both.

We have launched our winter influenza vaccination programme and are actively seeking to improve on the level of vaccinations achieved for at risk groups last year, despite the challenges arising from access to vaccines this year. Recruitment remains a concern . In this report we demonstrate the pipeline of staff being recruited to fill service vacancies.

It is noted that the draft national delivery framework for 2019-20 has been issued and this includes additional prevention, primary care and safety indicators. These are presently being mapped to Executive leads and will be included within the IMTP submissions in January 2019.

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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.

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Measure	Status		(Target)	Measure	Status		(Target)
Qualitative Reports x 4	Submitted	⬆	Submit	Falls Prevention (Reported as Serious Incidents)	11	⬇	>= 11
New Never Events	0	⬆	0	Antibacterial items per 1000 STAR PUs	274.72	⬇	Reduce
Incidents: % Assured within agreed timescales	25.00%	⬆	>= 90%	Total Antibacterial Items Prescribed	9.41%	⬆	Reduce
Concerns: % Replies within 30 days	25%	⬇	>= 75%	NSAIDS per 1000 STAR PUs	1,149	⬇	Reduce
Patient Safety Notices: Number Not Assured	4	⬅	1	Medication Errors reported as Serious Incidents	3	⬇	0
Patient Safety Alerts: Number Not Assured	0	➡	0	Information Governance Training	81%	⬆	>= 85%
Ward Staffing Levels	88.00%	⬆	100%	Episodes Clinically Coded within 1 month	90.40%	⬆	>= 95%
Ward Staffing Skill Mix	54.6%	⬆	60%	Number of H&CRW Studies	40	⬆	>= 40 (Q:
ITU DelayedTransfers of Care: % Hours Lost	7.81%	⬆	<= 5%	Number of Commercially Sponsored Studies	7	⬆	>= 6 (Q2
ITU Delyaed Transfers of Care: % Within 4 Hrs	49.10%	⬆	>= 95%	Number recruited to H&CRW studies	336	⬆	>= 1000 ((
Mortality: Crude Under 75 yoa	0.74%	⬆	<= 0.70%	Number recruited to Commercial studies	116	⬆	>= 50 (Q:
Mortality: Universal Mortality Reviews	90.70%	⬆	>= 95%				

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DFM 077	Evidence of advancing Equality throughout the organisation	Target Submit QRS	Plan Submit QRS	Oct-18	Yes	Wales Benchmark	N/A	Executive Lead	Sue Green	Status	➡	Months in Exception	N/A	Escalation Level	
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	Oct-18	Yes	Wales Benchmark	N/A	Executive Lead	Gill Harris	Status	➡	Months in Exception	N/A	Escalation Level	
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	Oct-18	Yes	Wales Benchmark	N/A	Executive Lead	Gill Harris	Status	➡	Months in Exception	N/A	Escalation Level	
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	Oct-18	Yes	Wales Benchmark	N/A	Executive Lead	Sue Green	Status	➡	Months in Exception	N/A	Escalation Level	

The Committee received an update on these qualitative measures in October 2018 after submission of the bi-annual reports. The next update will be after the March 2019 submissions, unless the Committee requests an update beforehand.

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DFM 023	Of the serious incidents due for assurance, the percentage which were assured within the agreed timescales	Target 90.0%	Plan 90%	Nov-18	25.00%	Wales Benchmark	7th	Executive Lead	Gill Harris	Status	⬆	Months in Exception	6+	Escalation Level

96 incidents were due a closure form for November, 25% (24) were submitted within timeframe.

Actions
- Incident Management Review meeting established weekly to review all serious incidents
- Focused work to resolve historic cases within Datix and identify learning – trajectories set for each area and managed to these
- Revised operational arrangements to maximise the opportunities for learning by ensuring local ownership and investigation

Outcomes
- Early review of serious incidents to ensure:
- Make safe actions taken
- Correct categorisation and level of investigation
- Opportunities for learning and dissemination of learning
- Improved monitoring of investigation process

Timeline for improvement:
The improvement of performance is linked to the wider work of the quality improvement strategy. Improvement will be progressive during 2019/20

Welsh Government Reportable Incidents

Welsh Government Closure Performance

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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%	Oct-18	74.90%	Wales Benchmark	7th	Executive Lead	Gill Harris	Status	⬆	Months in Exception	6+	Escalation Level

Where we are:

118 Concerns were received in October of those 30 (25%) received a response within 30 working days. At 95%, 6 month performance continues to be better than profile. All overdue complaints are required to submit a SBAR to the Director of Quality Assurance. Daily, weekly and monthly monitor of performance in place

What are we doing about it:

- The Corporate Team monitor performance as a local KPI and this is reported to the Corporate Concerns Management Team meeting.
- Discussions are ongoing and awareness raising so other areas are aware of the need to promptly forward complaints. All information to service users clear states the address that complaints are to be sent to.
- Revised deadlines and trajectories set; all overdue complaints are required to submit a SBAR to the Director of Quality Assurance for review to understand the issues preventing resolution. These issues are being discussed at the Quality and Safety Group (QSG)
- Daily, weekly and monthly monitor of performance in place
- New complaints being managed on an On the Spot (OTS) basis where appropriate and possible to the satisfaction of the complainant
- Patient Advice and Support Service (PASS) in place in Ysbyty Glan Clwyd

When we expect to be back on track:

The QSG will monitor improvement, it is expected that we will be back on track in line with revised deadlines and trajectories by January 2019.

30 Day Target - Concerns

Performance — Mean — Upper Control — Lower Control — Profile

% of Complaints closed within 6 calendar months (inc 30 day responses)

92% 87% 94% 92% 95%

Performance — Profile

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| DFM 022 | Number of Patient Safety Solutions Wales Alerts that were not assured within the agreed timescale | Target 0 | Plan 0 | Nov-18 | 0 | Wales Benchmark | 1st | Executive Lead | Evan Moore | Status | ➡ | Months in Exception | 6+ | Escalation Level | |
| LM 22B | Number of Patient Safety Solutions Wales Noticess that were not assured within the agreed timescale | Target 0 | Plan 0 | Nov-18 | 4 | Wales Benchmark | N/A | Executive Lead | Evan Moore | Status | ⬅ | Months in Exception | 6+ | Escalation Level | |

As of 30th November 2018, the Health Board is **100% compliant with Patient Safety Alerts** issued by the Welsh Government (WG).

To date 45 **Patient Safety Notices** have been issued by the WG and the BCUHB are 91% compliant with 41 alerts complete, **4 remain open**, details as follows:-

PSN030 The safe storage of medicines: Cupboards - compliance due 26/08/2018. Pending issue of a formal revision, Nursing Directors have been advised full compliance is expected for new builds and refurbishments. All other areas should be risk assessed with plans in place to mitigate risk. Discussed at Quality & Safety Group (QSG) on 12/09/18, and expected to be removed through the meeting in October 2018.

PSN034 Supporting the introduction of the National Safety Standards for Invasive Procedures (NatSIPs) – compliance due 28/09/2017A list of procedures has now been collated, and DGH sites are now providing LoCSSIP, published on the intranet to facilitate sharing. All three acute sites have to a degree completed a template collating evidence of their compliances for key themes, and linking this to LoCSSIP. To date all have prepared this for theatres, but reports from other procedural areas, such as endoscopy suites, re still awaited. Human Factors and Team training remains a challenge; while many can identify aspects in place, secondary care there is no systematic approach. Proposals have been made to the secondary care management team on how this might be addressed, and these were discussed at Secondary Care QSE on 19th September 2018.

PSN043 Supporting the introduction of the Tracheostomy Guidelines for Wales – compliance due 03/10/2018. Relevant to Intensive Care, Maxillo-Facial and Ear Nose & Throat (ENT) Surgeries, the notice and accompanying guidance have been distributed to the three Acute Hospital Management Teams for action.

PSN045 Resources to support safer modification of food and fluid – compliance due 01/04/2019. BCU are already compliant with this notice. However, for completeness copies of supporting evidence has been requested. Once this received, the author will report BCU as compliant.

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WG 201	Ward nurse staffing fill rate (%)		Target 100%	Plan	Nov-18	88.00%	Wales Benchmark	N/A	Executive Lead	Gill Harris	Status	↑	Months in Exception	6+	Escalation Level	
WG 202	Ward nurse staffing skill mix ratio (% Registered)		Target >= 60%	Plan	Nov-18	54.60%	Wales Benchmark	N/A	Executive Lead	Gill Harris	Status	↑	Months in Exception	6+	Escalation Level	

Actions
- Each acute site having completed a Recruitment and Retention action plan
- Representation at national recruitment events
- Continuous rolling advert on TRAC / NHS Jobs
- Safe Care now introduced across all 3 acute sites
- Health Care Assistant (HCA) Level 4s supported to undertake Fast Track into nursing course

Outcomes
- One candidate was recruited and appointed at the recent Birmingham Nursing Times event
- Staff deployed according to acuity per shift where necessary

Timelines
Vacancy situation unlikely to be resolved in next 6 months although recruitment is ongoing.

Ward Staffing Levels Fill Rate (Medical & Surgical Acute)

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

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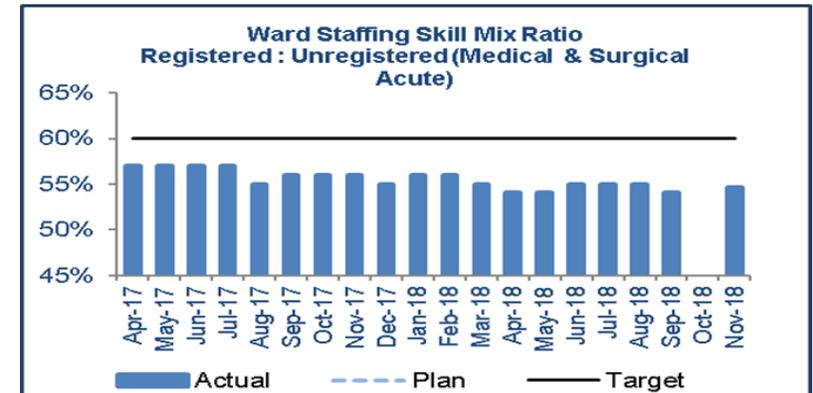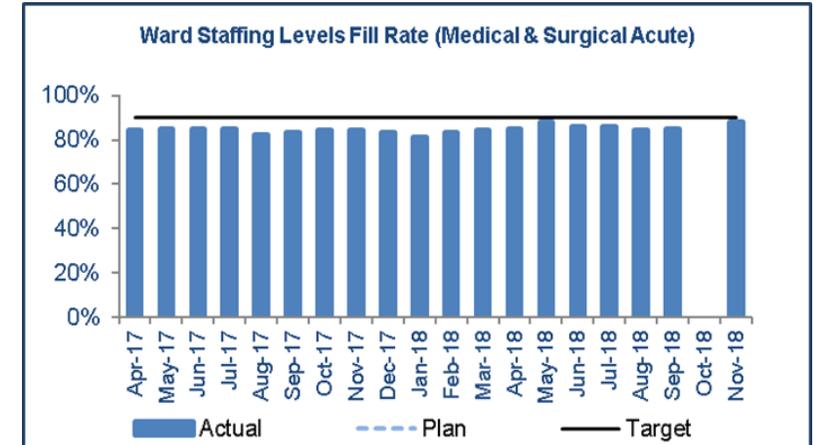
LM 131A	Delayed Transfers of Care (DToC): Critical Care - % hours lost due to ITU DToC	Target <= 5%	Plan <= 5%	Nov-18	7.81%	Wales Benchmark	N/A	Executive Lead	Gill Harris	Status ⬆	Months in Exception 6+	Escalation Level	
LM 131B	Delayed Transfers of Care (DToC): Critical Care - % Discharged within 4 Hours of patient being ready	Target >= 95%	Plan	Nov-18	49.10%	Wales Benchmark	N/A	Executive Lead	Gill Harris	Status ⬆	Months in Exception 6+	Escalation Level	

Measure	YG	YGC	WMH	BCU
% Hours lost due to DToC	2.94%	11.24%	9.54%	7.81%
% Discharges within 4 Hours of being ready	71.20%	35.50%	43.90%	49.10%

Where we are:
- Ysbyty Gwynedd (YG) have improved performance this month as a result of increased acuity on the unit (high incidence Level 3s in November) and also additional Level 2 capacity.
- Ysbyty Glan Clwyd (YGC) have deteriorated this month. flow within the site has posed a challenge and in particular it has been important to ensure that 1:1 support can be provided on the ward for some patients and that staff receiving patients from ITU have the required levels of skill to safely manage
- Wrexham Maelor Hospital (WMH) are demonstrating improved performance from previous month although they have discharged 7 patients directly home during November 2018.

Actions
- In the short term, over winter, YG have increased Level 2 capacity by 1 bed
- Performance shared at each site's Safety Huddle
- DToC prioritised to ensure ICU emergency bed is available

Outcomes and Timelines
Performance improved at YG and increased Level 2 capacity by 1 bed until end of March 2019
WMH increased Level 3 capacity by 1 bed until end of March 2019.
Increased focus on all three sites with view to increased performance

% of hours lost due to Intensive Care Unit delayed transfers

% of Intensive Care discharges within 4 hours of patient being ready

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| DFM 032 | Percentage of universal mortality reviews (UMRs) undertaken within 28 days of a death | Target >= 95% | Plan >= 95% | Nov-18 | 90.70% | Wales Benchmark | 3rd | Executive Lead | Evan Moore | Status | ↑ | Months in Exception | 6+ | Escalation Level | |

| DFM 033 | Crude mortality rate of patients under 75 years of age | Target Reduce | Plan < 0.70% | Nov-18 | 0.74% | Wales Benchmark | 2nd | Executive Lead | Evan Moore | Status | ↑ | Months in Exception | 6+ | Escalation Level | |

Actions
- Focus on improving Sepsis response with 60 minutes of a triple trigger
- Focus on Acute Kidney Injury (AKI) as area of work which requires further attention
- Improvements in mortality reviews

Outcomes
- Sepsis collaborative launched 5th November 2018, further events during January and April 2019
- AKI lead identified and data collection tool completed so we can target efforts for collaborative to be launched in 2019
- Focussed work on improving further mortality review process

Timelines
- Sepsis complete by end of 2019
- AKI collaborative- date for collaborative to be confirmed
- Ongoing work and will be supported further by introduction of the DATIX electronic system and introduction of the medical examiner during 2019.

Percentage of Universal Mortality Reviewes (UMRs) undertaken within 28 days of death

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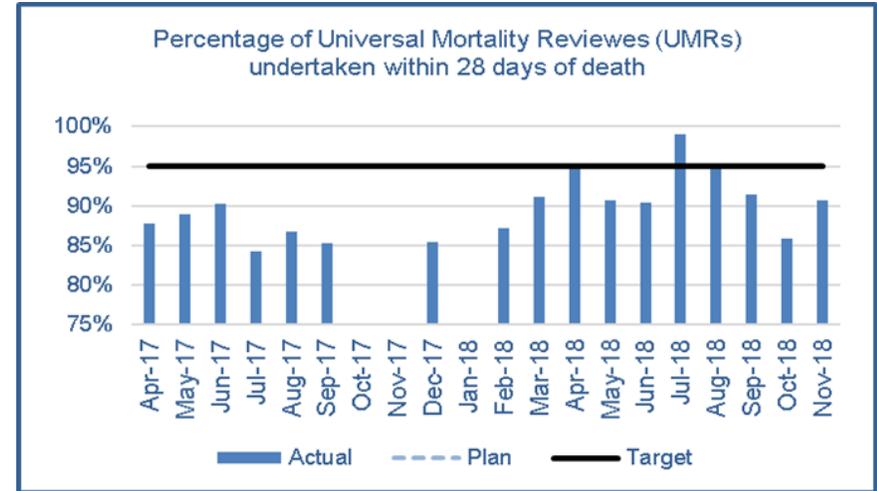
DFM 035	Percentage episodes clinically coded within 1 month of the episode end date	Target >= 95%	Plan >= 95%	Nov-18	90.40%	Wales Benchmark	5th	Executive Lead	Evan Moore	Status	↑	Months in Exception	6+	Escalation Level	
DFM 036	Percentage of clinical coding accuracy attained in the NWIS national clinical coding accuracy audit programme	Target Improve	Plan TBC	17/18	84.20%	Wales Benchmark	7th	Executive Lead	Evan Moore	Status	↓	Months in Exception	6+	Escalation Level	

Where we are
The Health Board is currently showing as having 95.8% activity coded in a rolling 12 months. The current coding backlog to reach the National Welsh Target is currently at 2,371 episodes. The position against the national target is up from 89.5% in October 2018 to 90.4% in November 2018.

When we expect to be back on track
Progress has slowed over the last few months, mainly due to sickness absence. Despite this the department has continued to reduce the backlog gradually getting nearer to the national target. It is anticipated that the coding completeness will be reaching Welsh Government target by the end of Quarter 3, 2018/19.

Coding Backlog Improvement Trajectory

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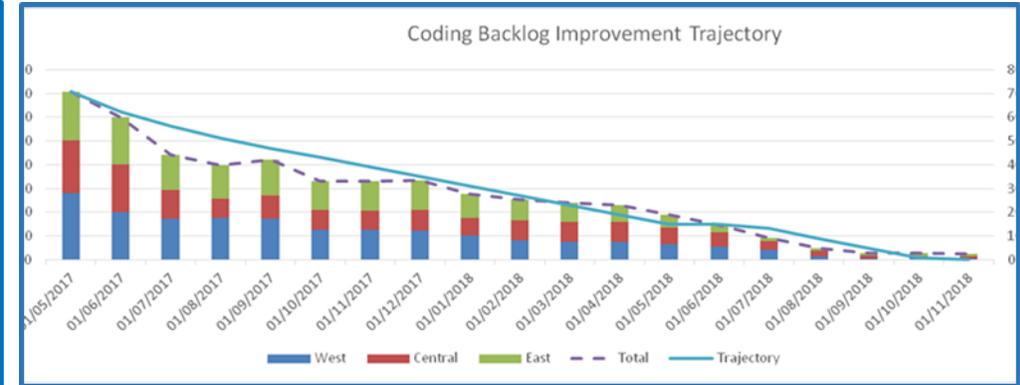
DFM 038	Number of Health & Care Research Wales clinical research portfolio studies (quarterly Year-To-Date figure)	Target >= 89	Plan >= 23	Qtr1 18/19	40	Wales Benchmark	3rd	Executive Lead	Evan Moore	Status	⬆	Months in Exception	6+	Escalation Level
DFM 039	Number of commercially sponsored studies (rolling 4 quarter sum)	Target >= 11	Plan >= 3	Qtr1 18/19	7	Wales Benchmark	3rd	Executive Lead	Evan Moore	Status	⬆	Months in Exception	6+	Escalation Level
DFM 040	Number of patients recruited into Health & Care Research Wales clinical research portfolio studies (quarterly Year-To-Date figure)	Target >= 2,016	Plan >= 505	Qtr1 18/19	336	Wales Benchmark	5th	Executive Lead	Evan Moore	Status	⬆	Months in Exception	6+	Escalation Level
DFM 041	Number of patients recruited into commercially sponsored studies (rolling 4 quarter sum)	Target >= 92	Plan >= 24	Qtr1 18/19	116	Wales Benchmark	1st	Executive Lead	Evan Moore	Status	⬆	Months in Exception	6+	Escalation Level

Where we are:
We are on target with 3 of the 4 indicators and are confident that these targets will be met at year end.

What we are doing about it:
Recruitment of patients into portfolio studies (DFM040) is below trajectory. This target represents an increase of 10% from our previous years' performance of the number of patients recruited into research studies.

Compliance is closely monitored so we can pro-actively manage performance against key indicators. We have a number of studies due to open to recruitment and are working to increase participant recruitment into studies. This increase has been realised in Quarter 2, and we continue to monitor proactively.

When we expect to be back on track:
All studies are being reviewed to ensure they are recruiting to target, and where they are not analysis and appropriate actions are being taken.

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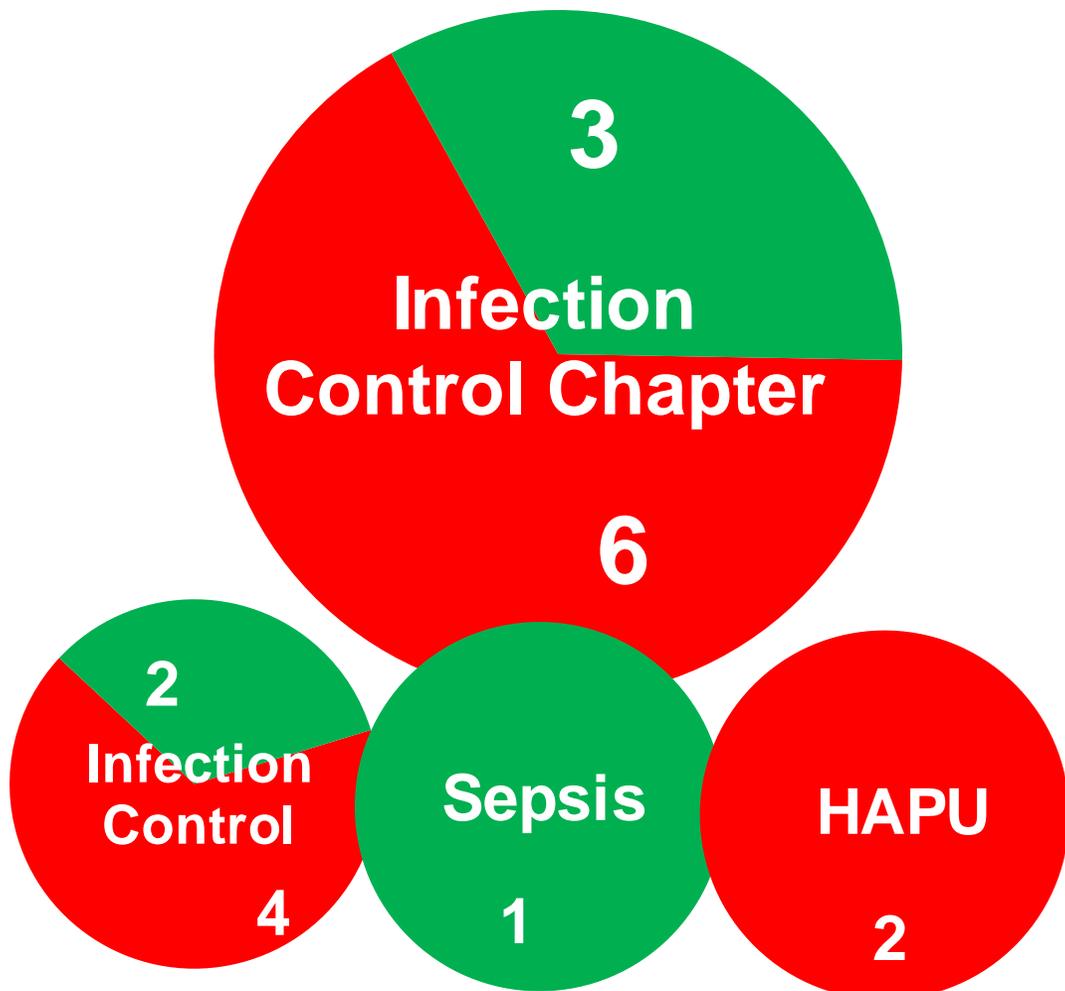
Measure	Status	(Target)
Infection Prevention: E.Coli	82.85 ↓	<= 67
Infection Prevention: C.Difficile	26.66 ↑	<= 26.00
Infection Prevention: S.Aureus	22.79 ↑	<= 20.00
Infection Prevention: MRSA	0 ↑	0
Infection Prevention: MSSA	14 ↓	<= 11
Healthcare Acquired Pressure Ulcers (HAPU) SI*	42 ↑	<= 21
Healthcare Acquired Pressure Ulcers (HAPU) All	491 ↓	TBC
Sepsis Six Bundle - Emergency Departments	48.15% ↓	100%
Sepsis Six Bundle- Inpatients	100% →	100%
Preventable Hospital Acquired Thrombosis (HAT)	0 →	0

*SI = Serious Incident

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DFM 020	The cumulative rate of laboratory confirmed C.difficile cases per 100,000 of the population	Target <= 26	Plan <= 26	Nov-18	26.66	Wales Benchmark	4th	Executive Lead	Gill Harris	Status	⬆	Months in Exception	6+	Escalation Level

Actions
- 3rd phase 90 Day plan of Safe Clean Care in Acute sector
- 2nd phase 90 Day plan in BCU-wide Community hospitals
- Prioritise Aseptic non-touch technique (ANTT)
- Nurses 'right-to-challenge' antibiotic prescribing
- Focus on UTI diagnosis & management following latest guidance

Outcomes
- Increased awareness of and reduction of infection rates in Primary, Secondary & Community Care
- Sharing of knowledge across Acute to Community
- Reduction in infections from invasive devices
- Reduction in unnecessary antibiotic prescribing
- Reduction in Gram negative bacteraemia

Timeline
Improved performance is expected during the 90 day phases and together with continued focus on 'right-to-challenge', adoption of ANTT methods across BCU & compliance with national guidance it is expected to achieve and sustain the reduction targets set for 2018/19 (as shown in header bar).

The monthly rate of laboratory confirmed C. difficile cases per 100,000 of the population

Actual - Total C. difficile/100,000 population
Target - Maximum rate of C. difficile/100,000 population to achieve reduction expectation
England benchmark - Actual rate of C. difficile/100,000 population

Benchmark Chart - Number of cases of C. difficile per 100,000 of the population - April to November 2018 (Rolling)

CWM TAF 19.6, CARDIFF 23.8, ANEURIN BEVAN 26.1, BCUHB 26.7, ABMU 39.9, HYWEL DDA 42.1

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| 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	Nov-18	22.79	Wales Benchmark	1st	Executive Lead	Gill Harris	Status	↓	Months in Exception	6+	Escalation Level

Actions:
- 3rd phase 90 Day plan of Safe Clean Care in Acute sector
- 2nd phase 90 Day plan in BCU-wide Community hospitals
- Prioritise Aseptic non-touch technique (ANTT) to reduce wound infection
- Nurses 'right-to-challenge' antibiotic prescribing
- Focus on UTI diagnosis & management following latest guidance

Outcomes:
- Increased awareness of and reduction of infection rates in Primary, Secondary & Community Care
- Sharing of knowledge across Acute to Community
- Reduction in St aureus infections from invasive devices
- Reduction in Gram negative bacteraemia

Timelines:
Improved performance is expected during the 90 day phases and together with continued focus on 'right-to-challenge', adoption of ANTT methods across BCU & compliance with National guidance it is expected to achieve and sustain the reduction targets set for 2018/19.

Number of Staphylococcus aureus bacteraemias across BCUHB: including in patient and non inpatient

BCUHB
Total weekly number of S. aureus bacteraemia - to 16th December 2018

Benchmark Chart - Number of cases of *S. aureus* bacteraemia per 100,000 of the population – April to November 2018 (Rolling)

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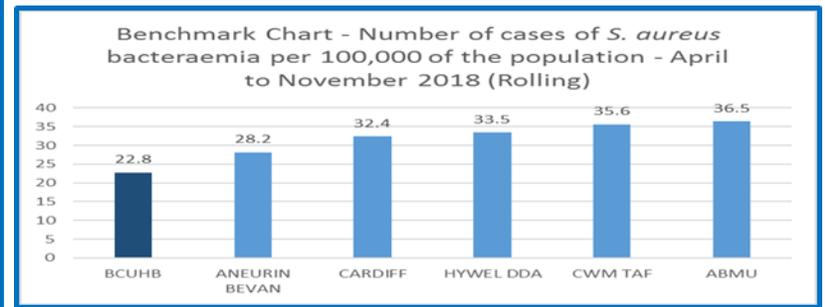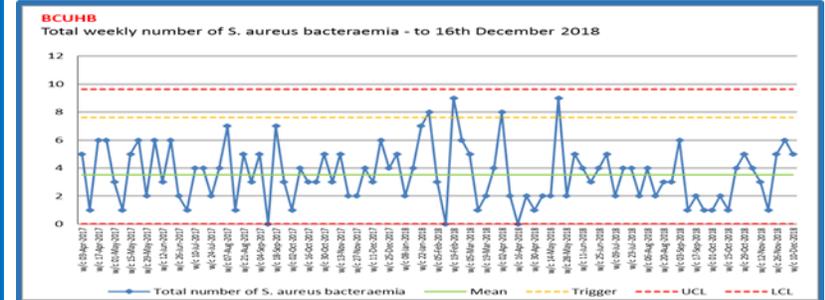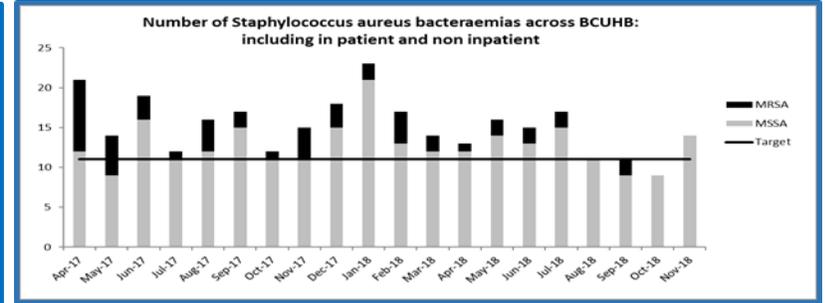
LM 019a	Number of laboratory confirmed cases of MRSA	Target 0	Plan 0	Nov-18	0	Wales Benchmark	N/A	Executive Lead	Gill Harris	Status	➡️	Months in Exception	6+	Escalation Level	

|														
LM 019b	Number of laboratory confirmed cases of MSSA	Target <= 11	Plan <= 11	Nov-18	14	Wales Benchmark	N/A	Executive Lead	Gill Harris	Status	⬇️	Months in Exception	6+	Escalation Level	

Actions:
- 3rd phase 90 Day plan of Safe Clean Care in Acute sector
- 2nd phase 90 Day plan in BCU-wide Community hospitals
- Prioritise Aseptic non-touch technique (ANTT)
- Focus on UTI diagnosis & management following latest guidance
- Executive review for HCA MRSA bacteraemia

Outcomes:
- Increased awareness of and reduction of infection rates in Primary, Secondary & Community Care
- Sharing of knowledge across Acute to Community
- Reduction in St aureus infections from invasive devices
- Reduction in Gram negative bacteraemia

Timelines:
Improved performance is expected during the 90 day phases and together with continued focus on 'right-to-challenge', adoption of ANTT methods across BCU & compliance with National guidance it is expected to achieve and sustain the reduction targets set for 2018/19.

Number of MRSA reported cases in month (zero tolerance of MRSA, therefore target = 0)

Number of MSSA reported cases in month

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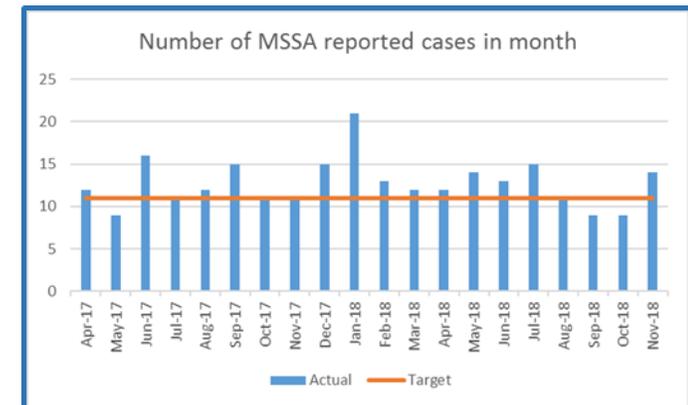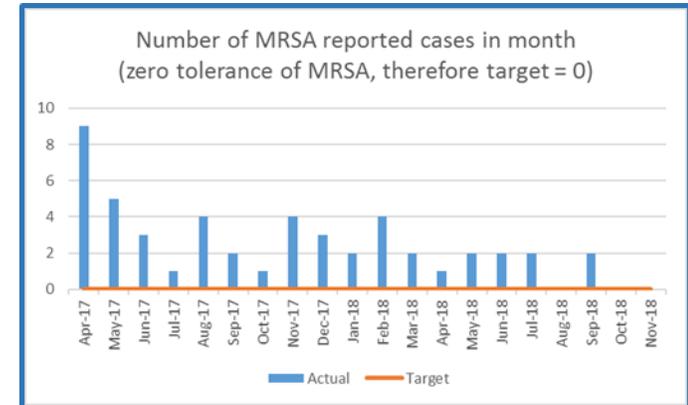
DFM 026	Number of Grade 3, 4 & Unstageable healthcare (hospital or community) acquired pressure ulcers (HAPU) reported as Serious Incidents	Target Reduce	Plan 35	Oct-18	42	Wales Benchmark	7th	Executive Lead	Gill Harris	Status	⬆	Months in Exception	6+	Escalation Level	
DFM 026b	Total number of Healthcare Acquired Pressure Ulcers Reported in Month	Target TBC	Plan TBC	Nov-18	491	Wales Benchmark	7th	Executive Lead	Gill Harris	Status	⬆	Months in Exception	6+	Escalation Level	

Actions
- Pressure Ulcer Collaborative Phase 2 commenced in December 2018
- All areas now provided with access to own level data
- Work has commenced to review the data recording of Pressure Ulcers

Outcomes
- Aim is to focus on areas of highest occurrence to identify improvement potentials
- Aim to use own data to start to focus on problem areas
- Clarity of data recording is essential for understanding what improvements are being made

Timelines
- New guidance issued by Welsh Government requires process change which are being urgently assessed.
- Data being collated for improvement sessions in January 2019. Data cleansing January & February 2019
- Further timelines to be determined

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

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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	Nov-18	100%	Wales Benchmark	1st	Executive Lead	Evan Moore	Status	➡	Months in Exception	N/A	Escalation Level	N/A
DFM 014	Percentage of patients who presented to the Emergency Department with a positive sepsis screening who have received all elements of the 'Sepsis Six' first hour care bundle within one hour of positive screening	Target Improve	Plan TBC	Nov-18	48.15%	Wales Benchmark	2nd	Executive Lead	Evan Moore	Status	⬇	Months in Exception	6+	Escalation Level	

Within BCUHB we launched the Sepsis collaborative on November 5th 2018 to focus primarily on treating sepsis in emergency departments with the introduction of DRIPS* meetings. Progress is being made on setting up plans and DRIPS* meetings are in the process or have already gone live.

*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. **D**iscuss Data and results from the previous week
2. **R**eview all sepsis forms.
3. **D**evelop an action plan around issues requiring **I**mprovement
4. **P**lot the dots: plot results on a run chart to be displayed in public areas
5. **S**hare and celebrate: share the success of the work staff have undertaken and acknowledge improvement.

Sepsis Six - Inpatients

Sepsis Six in ED

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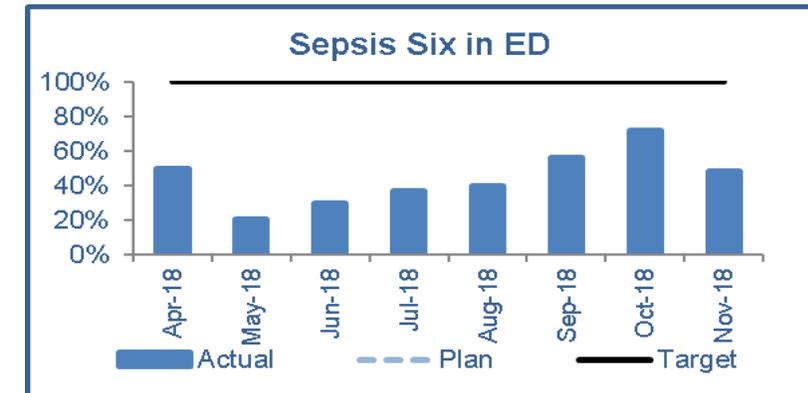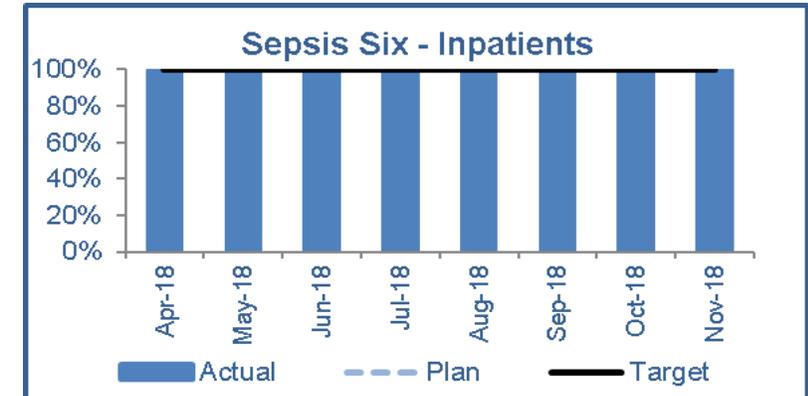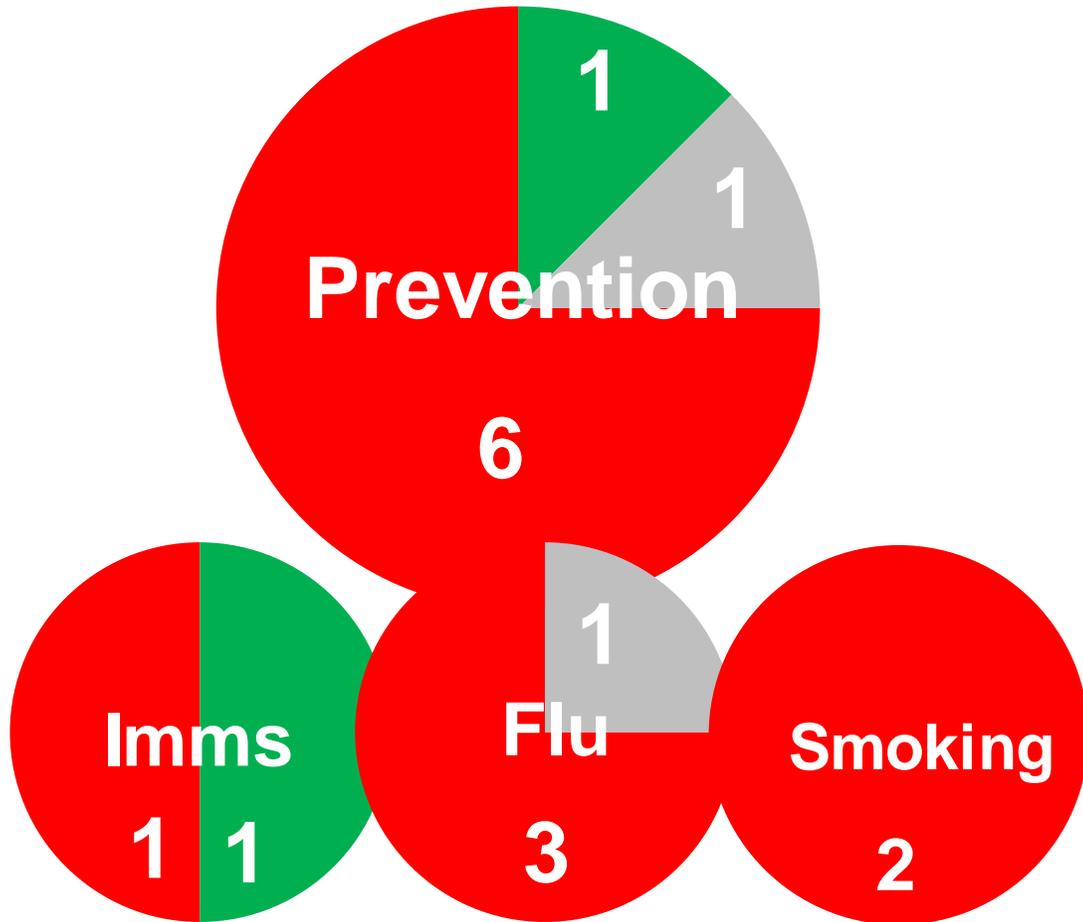
Measure	Status	(Target)
Immunisation: 3 doses of 6 in 1	95.00% ⬇	>= 95%
Immunisation: 2 doses of MMR	90.70% ⬇	>= 95%
Flu Vaccination: Under 65's at Risk Group	43.80% ⬆	>= 55%
Flu Vaccination: Over 65's	68.00% ⬆	>= 75%
Flu Vaccination: Pregnancy	N/A N/A	>= 75%
Flu Vaccination: Healthcare Workforce	48.00% ⬆	>= 60%
Smoking Cessation: % Service Use	3.63% ⬆	>= 5%
Smoking Cessation: Validated as Quit	38.80% ⬇	>= 40%

Prevention
1 1
6

Imms
1 1

Flu
1
3

Smoking
2

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DFM 005a	% uptake of influenza vaccine in Under 65's at risk	Target >= 55%	Plan >= 53%	Nov-18	43.80%	Wales Benchmark	N/A	Executive Lead	Teresa Owen	Status	⬆	Months in Exception	6+	Escalation Level	
DFM 005b	% Uptake of influenza vaccine in Over 65's	Target >= 75%	Plan >= 72%	Nov-18	68.00%	Wales Benchmark	1st	Executive Lead	Teresa Owen	Status	⬆	Months in Exception	6+	Escalation Level	
DFM 005c	% uptake of the influenza vaccine in pregnant women	Target >= 75%	Plan >= 75%	Nov-18	N/A	Wales Benchmark	N/A	Executive Lead	Teresa Owen	Status	N/A	Months in Exception	N/A	Escalation Level	N/A

Actions
- The BCUHB Flu Plan is being implemented across North Wales
- Data circulated to GP practices and Cluster Leads to raise awareness about differences in uptake and to ensure the data being submitted is accurate.
- Long stay inpatients in BCUHB are being offered the Flu vaccine.

Outcomes
Increase in uptake of flu vaccinations

Timelines
Although BCU is the best performing Health Board in Wales with regards the Flu Vaccination campaign, the target rate will not be achieved but we are aspiring to vaccinate as many as possible over the next 12 weeks.

% aged under 65 at risk

Legend: Abertawe Bro Morgannwg, Aneurin Bevan, Betsi Cadwaladr, Cardiff & Vale, Cwm Taf, Hywel Dda, Powys

% aged 65 and older

Legend: Abertawe Bro Morgannwg, Aneurin Bevan, Betsi Cadwaladr, Cardiff & Vale, Cwm Taf, Hywel Dda, Powys

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| DFM 006 | % estimated smoking population treated by smoking cessation services; year to date | Target >= 5.0% | Plan >= 3.5% | Qtr2 18/19 | 3.63% | Wales Benchmark | 2nd | Executive Lead | Teresa Owen | Status | ↑ | Months in Exception | 6+ | Escalation Level | |

| DFM 007 | % smokers treated by NHS smoking cessation CO-validated as successful; year to date | Target >= 40% | Plan >= 31.5% | Qtr2 18/19 | 38.78% | Wales Benchmark | 7th | Executive Lead | Teresa Owen | Status | ↓ | Months in Exception | 6+ | Escalation Level | |

Although we have not achieved the target rate for either of the smoking cessation measures, we have surpassed the planned rate for Quarter 2 of 2018/19 on both measures. It is expected that performance will continue to improve and that we will achieve the target rate for both measures by the end of Quarter 4 2018/19.

% estimated smoking population treated by smoking cessation services; year to date

% smokers treated by NHS smoking cessation CO-validated as successful; year to date

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LM 074A	% of assessment by the LPMHSS undertaken within 28 days of the date of referral: Adult	**Target >= 80%**	**Plan**	**Nov-18**	**66.20%**	**Wales Benchmark**	na	**Executive Lead**	Andy Roach	**Status**	⬇	**Months in Exception** 6+	**Escalation Level**
LM 075A	% of therapeutic interventions started within 28 days following an assessment by LPMHSS: Adult	**Target >= 80%**	**Plan**	**Nov-18**	**71.70%**	**Wales Benchmark**	na	**Executive Lead**	Andy Roach	**Status**	⬇	**Months in Exception** 6+	**Escalation Level**

Where we are: The Mental Health & Learning Disabilities (MHLD) validated performance for November 2018 is currently below target and non-compliant for the percentage of assessments carried out within 28 days of referral and interventions carried out within 28 days of assessment.

What are we doing about it:
- 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
- Longest waiters seen first
- Diverted Senior Management time to support Primary Care in West & East
- Timely weekly reporting direct to teams to ensure they are fully sighted and up to date with the current position
- MHM Lead(s) supporting allocated area to increase focus, and specific issues
- Regular and timely data cleansing & validation
- Additional & diverted Senior Manager support and clinical activity
- Weekly monitoring of referral activity by Measure Leads to inform the team(s) of those patients who may breach the 28 day target
- Close monitoring of performance and highlight reports are completed
- Recruitment to STR workers is progressing.
- Developed and implemented local action plans to improve targets.

When we expect to be back on track: The Division is expecting to meet the targets for Part 1 by end of January 2019 and will aim to maintain this performance.

% of assessment by the LPMHSS undertaken within 28 days of referral - Adult Services

% of therapeutic interventions started within 28 days following an assessment - Adult Mental Health Services

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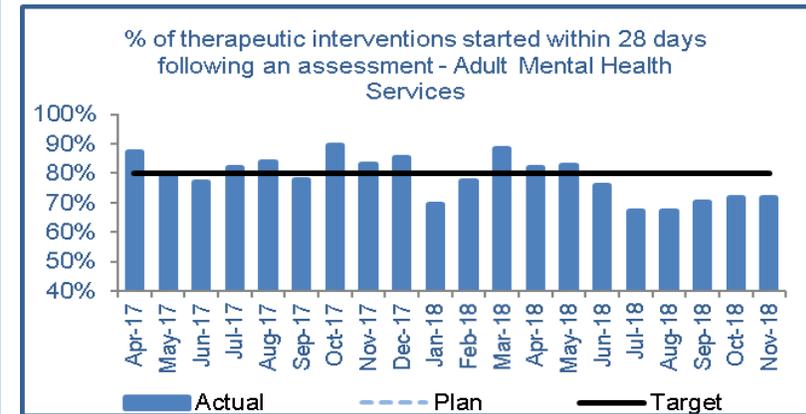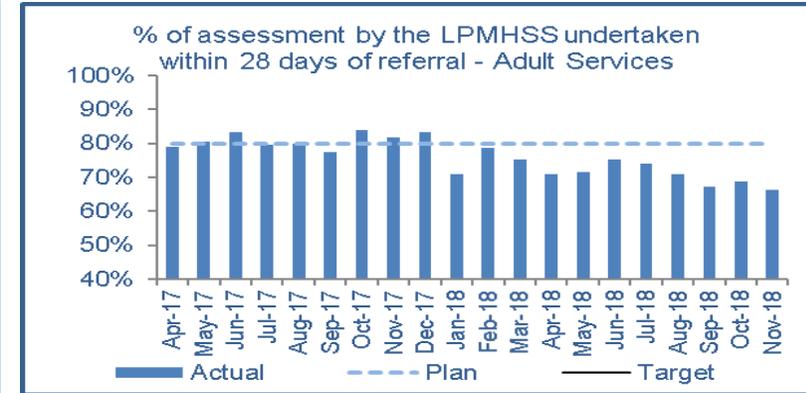
| LM 074B | % of assessment by the LPMHSS undertaken within 28 days of the date of referral: CAMHS | Target >= 80% | Plan | Nov-18 | 72.00% | Wales Benchmark | na | Executive Lead | Andy Roach | Status | ↑ | Months in Exception | 6+ | Escalation Level | |
| LM 075B | % of therapeutic interventions started within 28 days following an assessment by LPMHSS: CAMHS | Target >= 80% | Plan | Nov-18 | 39.40% | Wales Benchmark | na | Executive Lead | Andy Roach | Status | ↓ | Months in Exception | 6+ | Escalation Level | |

Where we are: In November 2018, **72%** of children were assessed within 28 days of referral and **39.4%** of children started therapeutic interventions within 28 days of being assessed. The rate of children being assessed within 28 days of referral has increased for the last two consecutive months.

What we are doing about it: Specific actions in the East Area to meet targets include the establishment of two separate Clinical Task & Finish Groups for Assessment and Therapy to focus wholly on the backlog, As the assessment backlog is addressed it has increased the therapy waiting list this means that predominately only urgent cases are addressed within the 28 days until the therapy backlog is addressed.
Task & Finish Groups to recruit bank and agency staff and substantive staff to undertake additional hours from within the current budgets within Children's Services.
Weekly demand and capacity meetings being held.
Additional funding has been secured from WG for Psychological Therapies to improve provision of therapeutic interventions across the region. Feedback awaited on additional funding for Crisis Services.
West are experiencing recruitment issues and a significant increase in referrals in October, agency staff to be recruited to increase capacity.
Bid submitted to Welsh Government (WG) for increased resources to reduce the waiting list.

When we expect to be back on track: Based on current demand and current/known future capacity the forecasts for each team are as follows: West: Assessment targets to be maintained, Therapy targets will be met in March 2019 Central: Assessment targets and Therapy targets will require additional investment in year to be met East: Assessment targets were met in October 2018, Therapy targets will be met in March 2019. Forecasts assume no significant increases in demand or reduction in capacity.

% of assessment by the LPMHSS undertaken within 28 days of referral - Child Adolescent Mental Health Services

% of therapeutic interventions started within 28 days following an assessment - Child and Adolescent Mental Health Services

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| DFM 085 | % of LHB residents (all ages) to have a valid CTP completed at the end of each month | Target >= 90% | Plan 89.7% | Nov-18 | 89.20% | Wales Benchmark | 5th | Executive Lead | Andy Roach | Status | ↑ | Months in Exception | 6+ | Escalation Level | |

Where we are:
The Mental Health Measure for Adults requires all relevant patients in receipt of Secondary Care services to have a valid Care and Treatment Plan (CTP). The Mental Health & Learning Disability (MHLD) at **89.2%** are not compliant with the 90% Welsh Government target.

What are we doing about it:
- 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

When we expect to be back on track:
We expect outcome from validation of data quality to be known by end of January 2019 and thereafter we will produce a trajectory for sustained improvement.

% of LHB residents (all ages) to have a valid CTP completed at the end of each month

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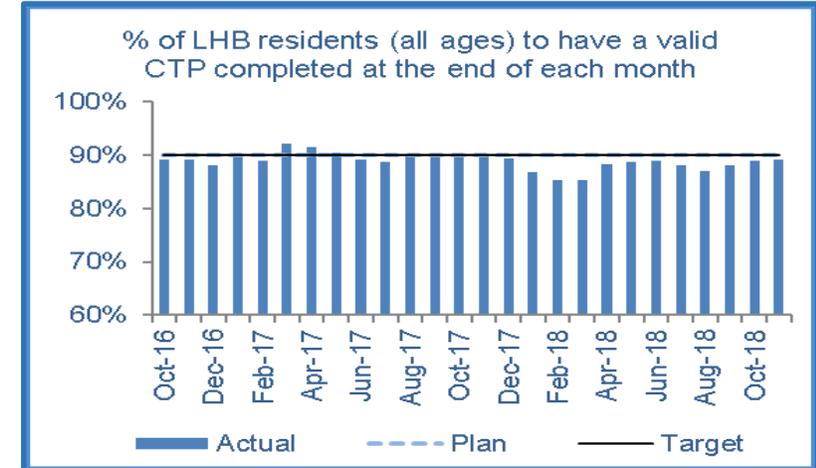
DFM 082	Number of mental health calls to the 'CALL' helpline	Target Improve	Plan Improve	Qtr2 18/19	230.50	Wales Benchmark	2nd	Executive Lead	Andy Roach	Status	⬇	Months in Exception	6+	Escalation Level	
DFM 083	Number of calls relating to dementia to the 'Dementia' helpline	Target Improve	Plan Improve	Qtr2 18/19	61.00	Wales Benchmark	1st	Executive Lead	Andy Roach	Status	⬇	Months in Exception	6+	Escalation Level	
DFM 084	Number of calls relating to drugs and alcohol to the 'DAN 24/7' helpline	Target Improve	Plan Improve	Qtr2 18/19	7.00	Wales Benchmark	1st	Executive Lead	Andy Roach	Status	⬇	Months in Exception	6+	Escalation Level	

Although the rate of calls to the CALL helpline have slightly reduced this quarter overall the helpline numbers for Quarter 2 (1,605) are only 48 less than the previous quarter. Subsets of these figures demonstrate that Conwy and Denbighshire are responsible for the highest use for this service and clinical subsets of the data demonstrate anxiety as the highest reason for contacting the service. The rate for calls to the dementia helpline has also reduced this quarter. Typically numbers for this service are significantly lower than those for the CALL and DAN24/7 helplines and this is replicated across Wales.

Total calls to the Dementia helpline for Wales in Quarter 2 are 97, of which BCUHB reported 27. DAN 24/7 has seen an uplift in call numbers this quarter with a total of 425 calls compared to 320 in the previous quarter. There are a number of areas within the subset information that are to be investigated in Quarter 3 to establish cause. Most notably, is that across all three helplines Conwy is reporting high numbers that are disproportionate to their population rates. Early indications are that Bala, postcode area LL21 may be being counted in all three subsets as this postcode area crosses all three county boundaries. In addition as the health board now has more than 2 years of data from the helplines, analysis will be done to establish any seasonality within the data and further benchmarking against other parts of Wales.

BCUHB are in discussions with Welsh Government to consider revision of the parameters of the KPI for all three helplines. At present contacts via the website are not included within the submissions and therefore do not reflect a comprehensive picture of the uptake of the service resources. The website provides information and interactive support and care for patients, families and carers. For both the Dementia and DAN helplines the contact sessions via the web far exceeded the volume of telephone contacts made and for the CALL helpline figures were around 12% lower than the number of calls.

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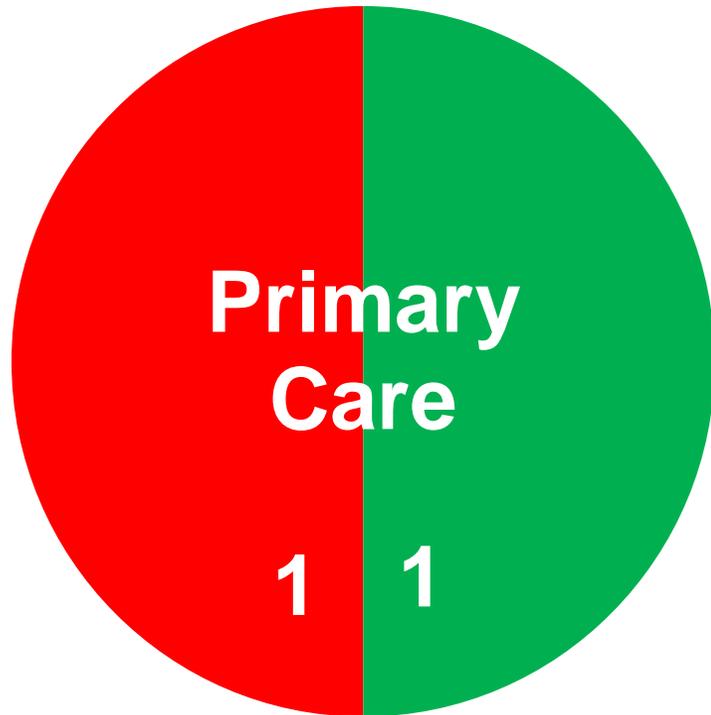
Measure	Status	(Target)
% GP practices open during daily core hours	**92.45%** ⬆	>= 91%
% GP practices open between 17:00 and 18:30	**66.04%** ⬇	>= 99%

Primary Care

1 1

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.

	Measure	Target	Plan	Qtr		Wales	Executive	Lead	Status	Months in Exception		Escalation Level	
DFM 053	% GP practices open during daily core hours or within 1 hour of daily core hours	Target Improvement	Plan 91.0%	Qtr2 18/19	**87.9%**	Wales Benchmark		Executive Lead	Chris Stockport	Status ⬆	Months in Exception		Escalation Level
DFM 054	% GP practices offering appts between 17:00 and 18:30 at least two days a week	Target Improvement	Plan 99.0%	Qtr2 18/19	**95.40%**	Wales Benchmark		Executive Lead	Chris Stockport	Status ⬆	Months in Exception		Escalation Level

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

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

Further information on our performance can be found online at:
- Our website   www.pbc.cymru.nhs.uk
                       www.bcu.wales.nhs.uk
- Stats Wales   www.statswales.wales.gov.uk

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

follow @bcuhb

http://www.facebook.com/bcuhealthboard

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Quality, Safety & Experience Committee **22.1.19**	GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board ***To improve health and provide excellent care***

Report Title:	Policy for Section 5(2) for use in General and Community Hospitals
Report Author:	Wendy Lappin, Mental Health Act Manager
Responsible Director:	Andy Roach, Director of Mental Health and Learning Disabilities
Public or In Committee	Public
Purpose of Report:	Section 5(2) allows a doctor (in charge of a patients treatment) to detain an inpatient for a maximum of up to 72 hours in order for an assessment of their mental health under the Mental Health Act.
Approval / Scrutiny Route Prior to Presentation:	MHLD Policy Implementation Group MHLD Divisional Q-SEEL MHLD Divisional Directors PAG
Governance issues / risks:	The policy is required to minimise the number of Section 5(2) detentions that are done within the general hospital inadequately and therefore make the detention illegal.
Financial Implications:	None
Recommendation:	The Committee is asked to approve the policy for implementation

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

5.To improve the safety and quality of all services	√	5.Considering impact on all well-being goals together and on other bodies	√
6.To respect people and their dignity	√		
7.To listen to people and learn from their experiences	√		
Special Measures Improvement Framework Theme/Expectation addressed by this paper Leadership & Governance Mental Health			
Equality Impact Assessment Attached. To be reviewed October 2020			

Board/Committee Coversheet v10.0

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

MHLD 0046

Betsi Cadwaladr University Health Board Policy for Section 5(2) for use in General and Community Hospitals

Date to be reviewed:	June 2021	No of pages:	25
Author(s):	Wendy Lappin	Author(s) title:	Mental Health Act Manager
Responsible dept / director:	Mental Health and Learning Disabilities Division Andy Roach		
Approved by:	MH&LDS Policy and Procedure Group Programme Advisory Group QSG QSE		
Date approved:			
Date activated (live):	Date becomes live		

Date EQIA completed:	June 2018
Documents to be read alongside this policy:	Mental Health Act 1983 (as amended 2007) Mental Health Act Code of Practice for Wales (Revised 2016) Mental Health Act Scheme of Delegation MHLD AC008 Missing absconding Persons Policy MPO1 – Procedure for missing persons from BCUHB premises – Emergency Department and General Wards
Purpose of Issue/Description of current changes: Section 5(2) allows a doctor (in charge of a patients treatment) to detain an inpatient for a maximum of up to 72 hours in order for an assessment of their mental health under the Mental Health Act. The policy has been updated in line with the Code of Practice revisions and in collaboration with Liaison and Acute Hospital Management to ensure the policy is enacted correctly.	

First operational:	3rd November 2008				
Previously reviewed:	31st March 2009	date	date	Date	date
Changes made yes/no:	Yes/no	Yes/no	Yes/no	Yes/no	Yes/no

PROPRIETARY INFORMATION

Contents Page

Appendix 1a

FLOWCHART (ACUTE HOSPITALS)

Do you have concerns about the patient's behaviour?

Yes

No
Continue normal procedures

Are you the Doctor in charge of the patient's care as per section 7.1.1
(this cannot be a SPR, SHO and must be a Consultant Physician/Surgeon)

No

Ask the doctor in charge to see the patient

Yes

Are there concerns that the patient is exhibiting signs of mental disorder

Yes

Unsure

No
Continue normal procedures

Contact the local Liaison Psychiatric Team

If the patient lacks capacity and has no Mental Health needs consideration may need to be given to Best Interest Decision or DOLS and follow due process

Is the patient stating they are going to leave

Yes

No

Ask the patient if they would stay and wait for a Mental Health Assessment

No

Yes

Is it felt that there would be a risk to the patient's health and/or safety or a risk to others if they left

No

Yes

Await arrival of Liaison Service or follow their advice

Assessment for Section 2 or 3 may be undertaken

Responsible Doctor to Apply Section 5(2) following the procedure in Appendix 2 and contact Liaison Service

Appendix 1b

FLOWCHART (COMMUNITY HOSPITALS)

Do you have concerns about the patient's behaviour?

Yes

No
Continue normal procedures

Are you the Doctor in charge of the patient's care as per section 7.1.1
(this cannot be a SPR, SHO and must be a Consultant Physician/Surgeon)

No

Ask the doctor in charge to see the patient

Yes

Are there concerns that the patient is exhibiting signs of mental disorder

No
Continue normal procedures

Yes

Unsure

Within hours Contact your area MHA office or local CMHT. Out of hours contact duty nurse at local psychiatric unit for contact information of AMHP

If the patient lacks capacity and has no Mental Health needs consideration may need to be given to Best Interest Decision or DOLS and follow due process

Is the patient stating they are going to leave

Yes

No

Ask the patient if they would stay and wait for a Mental Health Assessment

No

Yes

Is it felt that there would be a risk to the patient's health and/or safety or a risk to others if they left

Await arrival of AMHP and assessing doctor

No

Yes

Assessment for Section 2 or 3 may be undertaken

Responsible Doctor to Apply Section 5(2) following the procedure in Appendix 2 and contact MHA Office, CMHT or Duty Nurse

1.   Glossary of Terms

AC	Approved Clinician – A mental health professional approved by the Welsh Ministers to act as an appropriate clinician for the purposes of the Act. In practice, Health Boards take these decisions on behalf of the Welsh Ministers.
Form HO12	Statutory Welsh Form to be completed by a Doctor when implementing Section 5(2)
Hospital Managers	The Health Board is defined as the 'Hospital Managers' for the purposes of the Mental Health Act. This role is delegated to staff, who are named within the Mental Health Scheme of Delegation, who receive Mental Health Act paperwork on their behalf. **For the purpose of this document these are Mental Health Senior Managers or Duty Nurse for out of hours and interim periods**.
Mental Capacity Act 2005	An Act of Parliament that governs decision making on behalf of people who lack capacity, both where they lose capacity t some point in their lives and where the incapacitating condition has been present since birth.
Responsible Doctor/ Registered Medical Practitioners	A medical professional who is in charge of a patient's treatment. For the purpose of this document this cannot be a Specialist Registrar or Senior House Officer. If nominated as a deputy this will be a Consultant, Physician/Surgeon.
Section 5(2)	Enables a doctor (in charge of a patients treatment) to detain an inpatient for a maximum of up to 72 hours to prevent the patient from discharging himself before there is time to arrange an application under S2 or S3 under the Mental Health Act.
Section 2	Compulsory admission of a patient to hospital for assessment and for detention up to 28 days
Section 3	Compulsory admission of a patient to hospital for treatment and detention for up to six months.
Out of Hours	Any time between 17:00 hours and 09:00 hours. Any timer period between 17:00 Friday to 09:00 Monday
Within Hours	Office working hours 09:00 to 17:00 Monday to Friday are classed as within hours.

The terms "holding power" and "detention" are often deployed as interchangeable and informal terms as a substitute for the correct legal term "detention". No harm or criticism will arise from using the terminology "holding power" in general language.

2.   Introduction and Policy Statement

Section 5(2) is the power under the Mental Health Act, 1983 (MHA) that allows a Responsible Doctor or Approved Clinician to detain an in-patient who is expressing a wish to and/or trying to leave hospital and is suspected to be suffering from a mental disorder. The power enables detention for a maximum period of up to 72 hours in order to make arrangements for an assessment for detention under Section 2 or Section 3 of the MHA. **It is not good practice to allow a 5(2) section to lapse once enacted.**

This power can only be used to detain patients who have already been admitted to a hospital as an inpatient (informal admission), it cannot be used for patients physically present but not yet admitted to hospital eg outpatients, visitors, ED.

Section 5(2) should only be used if; at the time it is not practicable or safe to take the steps necessary to make an application for Section 2 or 3 detention under the Mental Health Act. It should not be used as an alternative to making an application, even if it is thought that the patient will only need to be detained for 72 hours or less.

Section 5(2) cannot be used for patients who are currently under any other section of the Mental Health Act ie Sections 2, 3, 4, 37, 38, 37/41, 48/49 and 47/49. Section 5(2) may only be used for patients under an informal status.

Patients who are transferred from the prison for medical attention are not under the Mental Health Act but would be classed as a prisoner under restraint receiving hospital care. Prison Officer escorts will be in situ at all times therefore alleviating the need to place the prisoner on a section to stop them from leaving the hospital.

Prisoners detained under the Mental Health Act on Hospital Transfers 48/49 or 47/49 or under the restrictions of the Ministry of Justice 37/41 would not be subject to Section 5(2) any admissions would be managed under S17 leave arrangements and escorts would be in place.

The use by staff of common law powers to detain and control patients in emergency situations whilst awaiting the presence of a doctor who has the power to act is also allowable under the European Convention of Human Rights. However such power should only be used as a "safety net" to cover situations were it not possible to immediately invoke the statutory powers. To be consistent with ECHR, common law powers should not be used an alternative to the powers contained in the Mental Health Act. (1-089 Mental Health Act Manual).

3.   Purpose of the Document

This policy has been developed to guide staff on the implementation and management of section 5(2) doctors holding power in accordance with the Mental Health Act 1983 as amended by MHA 2007. This guidance has been developed in line with the Mental Health Act 1983 Code of Practice for Wales 2016 (Code of Practice).

When implemented S5(2) authorises the detention of the patient in the hospital for a maximum of 72 hours so the patient can be assessed with a view to an application for detention under the Mental Health Act being made.

4.   Scope

This policy applies to all Registered Medical Practitioners in charge of patients care in the general and community hospital settings within the Health Board. Responsibility for use of this section lies with the Consultant in charge of the patient's care and cannot be deputised. In the case of absence a nominated person will be in charge of the patient's care, for the purposes of BCUHB this will be the Consultant on Call.

The policy does not apply to patients seen in the Emergency Department (ED) and Outpatient Departments (OPD) or those subject to a Community Treatment Order (CTO).

The Psychiatric Liaison Service must be the first point of contact for any concerns staff may have whether this be on a general ward or for a patient in ED within the general hospitals (Ysbyty Gwynedd, Glan Clwyd or Wrexham Maelor).

5.   Aims and Objectives

The aims of the policy are to:

* Ensure staff are aware of their individual and collective responsibilities when considering and assessing individuals before implementing S5(2) power of detention.
* Provide clear guidance to staff in relation to their legal responsibilities under the Mental Health Act 1983.
* Ensure that statutory requirements under the Mental Health Act 1983 are met.
* To facilitate the development of good practice.

Practitioners should have due regard to the Mental Health Act Code of Practice generally and specifically to the guiding principles when they are considering the use of Section 5(2) doctors powers of detention. This would ensure that considerations are given as to whether the objectives can be met in a less restrictive way.

6.   Nature of the power

A section 5(2) on inpatients authorises the detention of an informal patient for up to 72 hours by the Registered Medical Practitioner or nominated person in the case of absence.

The period of detention begins once form HO12 (Appendix 3) is completed and received by Hospital Managers or an authorised person on their behalf who will complete the Receipt of Mental Health Act Documents form (Appendix 6).   In practice this will usually be the Nurse–In-Charge of the local psychiatric inpatient unit.

Within hours the Mental Health Act Office will ensure the appropriate person accepts the documents, out of hours the nurse in charge of the local psychiatric inpatient unit will accept the paperwork.

Efforts should be made by the doctor and nursing staff to persuade and encourage those patients who are at risk of harm to self or others and attempting to leave, to return to, or remain on the ward area. In many cases this will often be the best way to resolve the situation in accordance with the MP01 – Procedure for missing persons from BCUHB premises-Emergency Department and general wards.

Treatment in relation to the individual's mental health cannot be given against the patient's consent under section 5(2).

6.1   Renewal of Section 5(2)

Section 5(2) **cannot** be renewed, it ends at the expiry of the 72 hour period. **It is not good practice for a Section 5(2) to lapse**, any lapses will be monitored and followed up as per section 15.

Though section 5(2) cannot be renewed its subsequent reuse can be considered upon the patients reversion to informal status should circumstances arise; however repeated use of section 5(2) would tend to indicate that the patient has been inadequately assessed or managed and should not arise.

6.2   Absconsion

A patient detained under section 5(2) who absconds cannot be retaken/returned under the section 5(2) if they remain AWOL beyond the 72 hour period as the section will have lapsed.

7   Roles and Responsibilities

7.1   Registered Medical Practitioner

Where the patient was admitted for physical disorder with no previous psychiatric history or treatment, **only the Registered Medical Practitioner in charge of the patient's care may authorise the detention**. They cannot nominate Specialist Registrars or Senior House Officers as a deputy. Therefore, in all circumstance this will be undertaken by the nominated person**.**

In the case of absence the nominated person will be in charge of the patient's care, for the purposes of BCUHB this will be the Consultant on Call or Surgeon in charge of the Patient's care.

The identity of the person in charge of a patient's medical treatment at any time will depend on the particular circumstances. However, a professional who is treating the patient under the direction of another professional should not be considered to be in charge. (CoPW 18.5)

Where a patient is receiving treatment for both a physical and a mental disorder, the Psychiatrist or Approved Clinician in charge of the patient's treatment for the mental disorder is the preferred person to use the power in Section 5(2). (CoPW 18.6)

The Registered Medical Practitioner must be fully aware of the diverse needs of the patient when considering detention and must take them into account at all times. They must ensure that every effort is made to ensure the patient fully understands what is happening to them in a language and format which they are able to understand, this will include sensory and cognitive abilities and physical impairment. Where necessary, an interpreter should be obtained.

Within <u>General/Acute Hospitals</u> the Registered Medical Practitioner should consult with the Mental Health Liaison Department for their area. Advice should always be sought from the Liaison Service who will attend as soon as possible and give advice.

The Psychiatric Liaison Team are contactable via:

East: 01978 726842 – bleep 5545
Central: 01745 585484 – bleep 6636
West: 01248 384384 – long range bleep Psychiatric Liaison

Within hours the Registered Medical Practitioner should consult with the Liaison Psychiatrist prior to the use of section 5(2).

Out of hours if the above is not practicable, then a Senior Psychiatrist should be consulted with.

Within <u>Community Hospitals</u> within hours the local CMHT should be contacted for contact details of Approved Mental Health Professionals (AMHPs) and medics to complete an assessment under Section 2 or 3 following a Section 5(2) or the local Mental Health Act Office.

Out of hours contact details for AMHPs and Medics can be obtained from the local duty nurse of the area psychiatric unit.

The Mental Health Act Offices and the duty Nurses can be contacted on the numbers below:

Area	MHA Office	Duty Nurse (request the duty nurse for psychiatric unit is bleeped)
East	01978 726834	01978 726800
Central	01745 445645	01745 585484
West	01248 384630	01248 384091

The Registered Medical Practitioner must complete a written record of the assessment (Statutory Form HO12 Appendix 3). As well as the completion of the statutory documentation, doctors must make a record of the assessment including the start time of the section in the patient's clinical notes.

A full Mental Health Act Assessment must be requested after the use of section 5(2).

7.2 Liaison

The Liaison Psychiatric Team **where practicable** will make the on call Psychiatrist aware of the situation and along with the nurse in charge of the local psychiatric unit assist in arranging further Mental Health Act Assessments out of hours.

The Liaison Psychiatric Team will attend the ward **as practicable** and provide advice and guidance to staff.

(Community hospitals are covered by the local CMHT for the area). Contact should be made with the local CMHT who will assist in locating the appropriate psychiatrist for an assessment to be made, communication with the Mental Health Act Office for the area will also be instigated, out of hours the local psychiatric unit duty nurse can be contacted for information.

7.3 Psychiatrists

On Call Psychiatrists must provide advice to the Registered Medical Practitioner and the Liaison Team

If the Section 5(2) is applied out of hours the on call Psychiatrist will advise the instigation of a Mental Health Act Assessment.

7.4 Mental Health Act Office

Within normal working hours the Mental Health Act Administrator will ensure the Section paperwork is completed sufficiently and arrange for acceptance by the Hospital Managers.

The Mental Health Act Administrator will contact Clinicians and an Approved Mental Health Professional (AMHP) for further assessment under the Mental Health Act.

7.5   Nurse-In-Charge of Local Psychiatric Unit

Out of hours, the nurse in charge of the local psychiatric unit must accept the section 5(2) for the section to be in place on the form (Appendix 6).

The nurse in charge will contact a Psychiatrist and an Approved Mental Health Professional (AMHP) to instigate a Mental Health Act Assessment for detention under Section 2 or 3 of the Mental health Act if this has not already been started by Liaison (see 7.2).

The nurse in charge will ensure that all section paperwork is delivered to the Mental Health Act Office.

8.   Procedure

The flowchart should be consulted (Appendix 1a or 1b) and The Procedure Summary (Appendix 2) guides the completion of a Section 5(2).

If it is felt a patient who is asking to leave has a mental disorder and will be a risk to self or others the Registered Medical Practitioner can invoke the power to detain the patient for a period of 72 hours, however consideration should also be given to whether the use of the Mental Capacity Act 2005 (MCA) would be more appropriate. Chapter 13 of the Code of Practice and paragraph 13.38 summaries the availability of the Act and of DOLS for treatment of a mental disorder.

The power can also be used if it is felt that the patient needs assessing for a Section 2 or Section 3 and is stating that they are going to leave and are a risk to self or others.

Patients who are in hospital by virtue of a Deprivation of Liberty authorisation under the Mental Capacity Act 2005 (MCA) may be detained under section 5(2). It does not matter whether the patient was originally admitted for treatment primarily for either a mental disorder or a physical condition (CoPW 18.10).

Contact must be made with the Liaison Psychiatry Service for advice and access to the Liaison Psychiatrist or a Psychiatrist on call.

Nurse in charge of the psychiatric unit to be informed out of hours.

Information to be provided to the patient regarding the actions and completion of form HO12.

The completed paperwork to be delivered via secure means (not via the hospital post) to the Nurse in Charge of the local psychiatric inpatient unit who will complete the acceptance form (Appendix 6). Within hours the Mental Health Act office should be contacted.

Although section 5(2) can last up to a maximum of 72 hours, the assessment process must be put in place once the HO12 is completed.

The Nurse in charge or the Mental Health Act Administrator will contact clinicians and an AMHP to further assess for detention under Section 2 or 3. (see 7.5)

All documentation to be delivered to the Mental Health Act Office by the Nurse in Charge.

9.   Information for patients

The person detained on section 5(2) should be given MHA Patient Information Leaflet 4 by the Nurse in Charge of the ward / Liaison Nurse which explains their legal rights. Information must be given to the patient verbally and in writing (As soon as possible / within 24 hours).

Leaflet 4 (Section 5(2) information can be found via the link:
http://www.wales.nhs.uk/sites3/page.cfm?orgid=816&pid=33957

There are no rights of appeal by either the patient or the nearest relative to the Hospital Manager or the Mental Health Review Tribunal.

10.   Section 18 Absent without Leave (AWOL)

A patient detained under section 5(2) who leave the hospital is AWOL and can be retaken but only within the 72 hour period.

11.   Ending of Section 5(2)

Section 5(2) detention lasts for a maximum of 72 hours and cannot be renewed.

Detention under section 5(2) will end if:

- The result of the assessment is a decision not to make an application under section 2 or section 3.
- An application under section 2 or section 3 is made.
- After the expiry of 72 hours (**it is not good practice to allow S5(2) to lapse**).
- The patient is discharged for clinical reasons before an assessment can be undertaken (for example if a patient needs transferring to another hospital or custody…see point 13)
- The doctor considers the presentation of the patient has changed and the patient is in agreement to stay informally. Form HO17 would be required to be completed to end the section. (**note**: this would be a rare event the use of S5(2) should instigate an assessment immediately for section 2 or 3).

The patient should be informed once they are no longer held under section 5(2) and advised of the reasons why. If this is because section 2 or 3 was not applied the patient should be informed that if they wish to leave hospital they are no longer under a section of the Mental Health Act which prevents this.

12. Further assessment for Section 2 or Section 3

The purpose of the 5(2) assessment is for the possibility for admission under either a section 2 or 3 of the Mental Health Act.

Good practice requires that the assessment takes place at the earliest opportunity once section 5(2) begins.

It should not be assumed that patients detained under section 5(2) on a Friday evening or at weekends can safely be left until Monday. An assessment should be completed as soon as possible by a S12 (2) approved doctor, ideally with previous knowledge of the patient and an AMHP.

13. Medical Treatment of Patients

The rules in Part 4 of the Act do not apply to patients detained under section 5(2) and as such there is no power under the Act to treat a patient without their consent for their mental disorder.

Medical treatment always implies that it is given with consent. MCA 2005 can only be used if it is deemed that a patient lacks capacity to consent to their care and treatment. The professional responsible for giving that specific treatment will need to assess to prove that the patient lacks capacity in relation to the material decision, at a specific time, to make the decision for themselves. It is important for the decision maker to determine if the patient has an attorney (donee) for a Lasting Power of Attorney for Health and Welfare as that person is the decision maker in place of the patient. It is also important to determine if the patient has in place an Advanced Decision ("Living Will" that might be contrary to the proposed treatment.

14. Transfer to other hospitals

Patients detained under section 5(2) cannot be transferred to another hospital under section 19, because they are not detained by virtue of an application made under Part 2 of the Act. This includes transfer between hospitals managed by the same hospital managers.

A patient who is subject to section 5(2) of the Act but needs to go to another hospital urgently for treatment, security or other exceptional reasons, can only be taken there if they consent to the transfer. If the patient lacks capacity to consent to the transfer, any transfer must be carried out in accordance with the Mental Capacity Act.

If following transfer the patient tries to leave the receiving hospital, a new situation will have arisen. In this circumstance, the receiving hospital may need to use section 5(2) to provide authority to detain the patient in that hospital.

15. Monitoring

Each time a Section 5(2) is used the Nurse in Charge of the local psychiatric unit will complete the receipt of mental health act documents form (Appendix 6) which must

be stapled to the Section 5(2) form HO12. This form will be sent to the Mental Health Act Office and a copy placed in the patient's notes.

The forms will be checked by the Mental Health Act Office for irregularities which will be followed up with the ward/Doctor concerned.

The Mental Health Act Manager will provide a quarterly report covering the use of section 5(2), appropriateness of use, speed of assessments and outcomes to the Mental Health Act Committee.

All lapses of Section 5(2) will be monitored and investigated to ascertain the reasons for the lapse and reported through the Mental Health Act Committee. Any areas of concern will be escalated to the appropriate manager to address with the relevant staff member.

16. Training

Mental Health Act Awareness and Intermediate Training is available for staff who have contact with the Mental Health Act and patients who subsequently need to be detained.

Levels and competencies are detailed below:

Level	Method	Update	For whom	Comments
Level 1 – Awareness	Workbook	Once only	Registered staff should complete the workbook.	See below
Level 2 – Intermediate	Session	Every 3 years	Band 7 level Ward sisters. Consultant and senior medical staff.	To attend Level 2 staff must already have current competency at Level 1 via completion of the workbook.

17. Reference to Legislation

All staff will work within the Mental Health Act 1983 and in accordance with the Code of Practice for Wales 2016, Mental Capacity Act 2005, and Human Rights Act 1998.

Mental Health Act 1983 - www.legislation.gov.uk/ukpga/1983/20/contents
Mental Capacity Act 2005 - www.legislation.gov.uk/ukpga/2005/9/schedule/7
Mental Health Review Tribunal for Wales - www.justice.gov.uk/tribunals/mental-health
Human Rights Act 1998 - www.legislation.gov.uk/ukpga/1998/42/contents

Appendix 2

<u>Section 5(2) Procedure Summary</u>

1. Ensure that you are the doctor in charge of the patient's treatment under the terms of the Mental Health Act see point 7.1.1.
2. Contact Liaison Service to inform and seek advice (General Hospitals only).

- Assess and personally examine the patient.

  Note: Psychiatrists will not undertake 5(2) assessments in general hospitals as they are not the treating doctor.

- If you decide to hold the patient under section 5(2), complete form HO12 **legibly,** as follows:

  Note: The forms must be <u>written</u> – no patient labels are to be used.

1. Provide the **full and correct address** of the hospital in which the patient is to be detained under section 5(2).

2. Enter your **full** name

3. Declare by deleting **(a) or (b),** your status for the purpose of Section 5(2)

4. Enter the patient's full name

5. Give **full reasons why informal treatment is no longer appropriate. Support this with evidence**:

   1. Suggesting the presence of a mental disorder
   2. Suggesting that the patient was at risk
   3. That the patient would no longer remain on the ward informally
   4. That there is a need for a further assessment under the Act

6. State the **exact time** when you furnished the report to the Hospital Managers. In BCUHB this means hand deliver or fax to the Mental Health Act Office (normal working hours) or Duty staff/Nurse in Charge of the Psychiatric units (outside of normal working hours). This is the start time of the Section 5(2). **Do not use the Health Boards Internal Mail system!**

7. Make sure that you sign and date the completed Form HO12

8. Record your actions.

9. Patient to be given information leaflet regarding their rights.

10. Confirm with Liaison or Inform the Nurse in Charge of the Psychiatric Unit or the Mental Health Act Office to instigate a Mental Health Act Assessment. If part of a community hospital contact can also be through local CMHT within hours.

Form HO 12

Regulation 4(1)(g)

Mental Health Act 1983 section 5(2) - report on hospital in-patient

PART 1

(To be completed by the registered medical practitioner or approved clinician in charge of the treatment of the patient under section 5(2) or any person nominated under section 5(3))

To the managers of

(name and address of hospital)

(full name) **I am**

and I am

Delete (a) or (b) as appropriate

(delete the phrase which does not apply)

(a) the registered medical practitioner/the approved clinician (who is not a registered medical practitioner)

OR

(b) a registered medical practitioner/an approved clinician who is the nominee of the registered medical practitioner or the approved clinician

in charge of the treatment of

(full name of patient)

who is an in-patient in this hospital and not at present liable to be detained under the Mental Health Act 1983.

It appears to me that an application ought to be made under Part 2 of the Act for this patient's admission to hospital for the following reasons

(the full reasons why informal treatment is no longer appropriate must be given)

Please turn over

Form HO 12 (Cont'd)

Delete the phrase which does not apply

I am furnishing this report by:

consigning it to the hospital managers' internal mail system today

(time)   at   [   ]

delivering it (or having it delivered) by hand to a person authorised by the hospital managers to receive it.

Signed: ....

Date: ....

PART 2

To be completed on behalf of the hospital managers

This report was:

(delete the phrase which does not apply)   furnished to the hospital managers through their internal mail system

delivered to me in person as someone authorised by the hospital managers

(time and date)   to receive this report at [   ] on [   ]

Signed: .... on behalf of the hospital managers

Name: ....

Date: ....

Appendix 4 Example of completed S5(2)

Regulation 4(1)(g)

Mental Health Act 1983 section 5(2) – report on hospital in-patient

PART 1

(To be completed by registered medical practitioner or approved clinician in charge of the treatment of the patient under section 5(2) or any person nominated under section 5(3))

To the managers of

(name and address of hospital)

> **Ysbyty Gwynedd**
>
> **BANGOR**
>
> **Gwynedd LL57 2PW**

Other addresses would be
Glan Clwyd Hospital
Bodelwyddan
Denbighshire
LL18 5UJ

Wrexham Maelor Hospital
Croesnewydd Road
Wrexham
LL13 7TD

For Community Hospitals the full hospital address needs to be written acceptance will be by the area MHA office or Psychiatric Unit Duty Staff.

Full name

I am   **Christian Name, Surname**

and I am

Delete (a) or (b) as appropriate

Delete the phrase which does not apply

(a)   the registered medical practitioner/the approved clinician (who is not a registered medical practitioner)

OR

(b)   a registered medical practitioner/an approved clinician   who is the nominee of the registered medical practitioner or approved clinician

in charge of the treatment of

(full name of patient)

> **Full (not abbreviated)** Christian Name, Middle Names, Surname

Who is an in-patient in this hospital and not at present liable to be detained under the Mental Health Act 1983

It appears to me that an application ought to be made under Part 2 of the Act for this patient's admission to hospital for the following reasons

(the full reasons why informal treatment is no longer appropriate must be given)

> *Give Reasons why the detention is needed ie describe patient's behaviour, is the patient threatening other patients/staff, is the patient a danger to self or others, is the patient trying to leave hospital, risks, further assessment needed, be clear on why informal treatment is no longer an option.*

Delete the phrase which does not apply

I am furnishing this report by:

NOTE: BCUHB do not use internal mail systems for original section papers (see section 8)

Consigning it to the hospital managers' internal mail system today.

(time)   at   **20:30   (Time S5(2) put on)**

delivering it (or having it delivered) by hand to a person authorised by the hospital managers to receive it.

Signed: ………Your Signature…………………………………………….

Date: …………Ensure correct date ………………………………………

PART 2

To be completed by Hospital Managers ONLY - The Mental Health Act Office will ensure the correct person signs as this must be a nominated person within the MHLD scheme of delegation.

(delete the phrase which does not apply) (time and date)

To be completed on behalf of the hospital managers

This report was:

Furnished to the hospital manages through their internal mail system

Delivered to me in person as someone authorised by the hospital manager to receive this report at [   ] on [   ]

Signed: ……………………………….. on behalf of the hospital managers

Name: …………………………………………………

Date: ………………………………………………..

Appendix 5

<u>**CHECKLIST FOR SECTION 5(2)**</u>

1 x FORM HO12 REQUIRED

_____

<u>**APPLICATION IN RESPECT OF PATIENT ALREADY IN HOSPITAL**</u>

1 The form must be correctly address to the appropriate hospital (Eg: Ysbyty Gwynedd, Glan Clwyd or Wrexham Maelor)

2 **<u>Full</u>** correct name of the Doctor

3 **<u>Full</u>** forename(s), surname of patient

4 The form must be signed by the registered medical practitioner in charge of the patient's treatment, or his nominee.

5 The doctor must give sufficient reasons why informal treatment is no longer appropriate. Full description of the patient's mental state and possible reluctance to stay in hospital.

6 Correctly signed, dated and time*

<u>*ERRORS WHICH CANNOT BE RECTIFIED</u>

<u>**PROCEED TO COMPLETE 'RECORD OF ACCEPTANCE'**</u>

Appendix 6

MENTAL HEALTH ACT 1983
RECEIPT OF MENTAL HEALTH ACT DOCUMENTS

This form must be completed by the Duty Nurse in Charge of the Unit for any patient admitted under the following Sections –

Section 5(4) …………………………………………
Section 5(2) ………………………………..……
Section 4   …………………………….…….……
Section 2   ………………………………………
Section 3   …………………………….…………
Section 17E (CTO recall – CP5) ………………..
Section 17F (CTO revocation – CP7) ……………

_____

PATIENTS NAME: _____

As the Duty Nurse in Charge of the Unit, I have received the section papers for the above named patient on behalf of the Hospital Managers of Betsi Cadwaladr University Local Health Board – (Insert Names of Unit below)

_____

Date and time of section (if already an inpatient) **OR** date and time of admission into hospital under section: *(Time is when patient is sectioned/arrives in unit, **NOT** when paperwork is checked by Duty Nurse)*

Date: __ __ / __ __ / __ __ __ __   **Time:** _____

Was Patient admitted from England: *Yes / No*

I have checked the papers with the checklist attached (**Appendix 2, 3, 4 or 5 as appropriate**).

The following errors need to be amended:

....
....
....

REPORT BY AMHP (REQUIRED UNDER 'CODE OF PRACTICE 14.87')

FORM RECEIVED: **YES** ☐ †   **NO** ☐ †

Senior Nurse Full Name: _____

Designation: _____   Signature: _____

This form and the Section Papers must be forwarded to the
*Mental Health Act Office **AS SOON AS POSSIBLE***

Paper copies of this document should be kept to a minimum and checks made with the electronic version to ensure the version to hand is the most recent.

Form HO 17

Regulation 7

Mental Health Act 1983 section 23 - discharge by the responsible clinician or the hospital managers

I/We* order the discharge of

(full name of patient and their address)

(state section) from liability to detention under _____ of the Mental Health Act 1983

(date and time) on _____ at _____

*(*delete as appropriate)* The patient will/will not* be remaining in hospital.

Signed: .... the Responsible Clinician

Name: ....

Date: ....

OR

Signed: .... a Hospital Manager

Name: ....

Signed: .... a Hospital Manager

Name: ....

Signed: .... a Hospital Manager

Name: ....

Date: ....

*(*delete as appropriate)*

Document number here :   Version: 0.7   Page 23 of 25
Paper copies of this document should be kept to a minimum and checks made with the electronic
version to ensure the version to hand is the most recent.

Members of the Working Group:

Name	Title
Wendy Lappin	Mental Health Act Manager
Dr Tania Bugelli	Liaison Consultant Psychiatrist
Karl Jones	Psychiatric Liaison Team Manager
Manon Gwilym	Clinical Law and Ethics Legal Advisor
Simon Allen	Service Manager Forensic and Rehab
Sian Cartwright	Psychiatric Liaison Team Manager
Gareth Ellis	Approved Mental Health Professional
Delyth Williams	Head of Nursing and Clinical Services Scheduled Care General Surgery
Julie Williams	Senior Nurse, Clinical Governance, Quality and Safeguarding Acute Medicine
Lyn Roberts	Matron Emergency Department

Engagement has taken place with:

Name	Title	Date Consulted
	Programme Advisory Group	October 2018
Dr Alberto Salmouraghi	Medical Director	March 2018
David Kaged	Solicitor (L&RS Solicitors)	January 2018
Consent and Capacity Group Meeting	Group Meeting	January 2018
Mairead Fripps-Jones	Deputy County Manager	December 2017
Anne St Paul	Team Leader Ynys Mon	November 2017
Karen Danby	Deputy Team Manager	November 2017
Ruth Millward	Matron Emergency Department	November 2017
Janette Hamilton	Lead Nurse, Clinical Governance, Medicine	November 2017
Andrew McGregor	North Wales Police	November 2017
Matt Morgan	Approved Mental Health Professional	November 2017
Mark Pye	Matron General Surgery	November 2017
Dr Stuart Porter	Consultant Psychiatrist	November 2017
Alex Fryer	Modern Matron LD	November 2017
Christopher Pearson	Safeguarding Specialist Practitioner	November 2017
Gaynor Kehoe	Clinical Network Manager – Central	November 2017
Fleur Evans	Clinical Network Manager – East	November 2017
Sam Watson	Clinical Network Manager – West	November 2017
Dr Ben Thomas	Consultant Nephrologist	November 2017
Marie Murphy	Mental Health Act Administrator	November 2017
Carole Evanson	Clinical Network Manager – County Wide	November 2017
Jayne Gregory	Matron ED	November 2017
Kelly Jones	Acute Matron, Wrexham	November 2017
Beverly Evans	DOLS Coordinator, Safeguarding	November 2017
Lyn Maclean	Liaison Practitioner Ablett	November 2017
Sian Parry	Liaison Mental Health Team Manager East	November 2017
Mandy Jones	Interim Director of Nursing MH&LD	November 2017
Gillian Roberts	Matron Medical Research and Development	November 2017
Tracey Harris	Clinical Governance Lead, East Nursing Midwifery	November 2017
Nichaela Jones	Interim Lead Nurse LD	November 2017
Karen Sutton	LD ECRS Inpatient Service Manager	November 2017
Dr Samuel Sanjoy	CT3 Psychiatry	November 2017

Rema		
Alison Ryan	Project Manager LD	November 2017
Jayne Sterriker	Ward Manager	November 2017
Sian Hughes-Jones	Head of Nursing Medicine, Acute Medicine	November 2017
Eleri Evans	Care of the Elderly Matron, Medicine	November 2017
Gordon Kennedy	County Manager	November 2017
Mark Jones	Approved Mental Health Professional	November 2017
Dr Anita Pierce	Consultant Psychiatrist	November 2017
Elizabeth Bond	Head of Pharmacy	November 2017
Simon Meadowcroft	Acute Liaison Nurse LD	November 2017
Dr Martin Jones	Consultant Psychiatrist	November 2017
Adrian Parry	Social Worker	November 2017
Dr Masood Malik	Consultant Psychiatrist	November 2017
Debbie Macmaster	Mental Health Liaison Deputy Manager – Heddfan	November 2017
Debby Land	County Manager	November 2017
Gail Griffiths	Interim Deputy County Manager	November 2017
Gill Strong	CMHT Manager	November 2017
Hayley Spridgeon	Staff Nurse	November 2017
Jane Rowland	Modern Matron Heddfan	November 2017
Joanne Kendrick	Team Manager Heddfan	November 2017
June Lovell	Service Manager Pwll Glas	November 2017
Karen McCormack	Home Treatment Team Manager	November 2017
Lisa Wright	Older Persons Service Manager – Heddfan	November 2017
Llinos prydderch	Nurse Manager Wrexham Maelor	November 2017

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 <u>must complete</u>:

- **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);

  <u>AND</u>
- **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 <u>may also need to complete</u> **Part C** (see separate Form) – if parts A and B indicate you need to undertake a Full Impact Assessment. This enables you to fully consider all the evidence that is available (including engagement with the people affected by your document or proposals) to tell you whether your document or proposal will affect people differently. It also gives you the opportunity to consider what changes you may need to make to eliminate or mitigate any adverse or negative impact you have identified.

Remember that these forms may be subject to external scrutiny e.g. under a Freedom of Information request.

To enter text, click on the grey box in the part of the form you are completing. Help text will appear in the status bar at the foot of the page. Some boxes have drop-down lists from which you can select options. Others may simply be a box to answer a question. Once completed, the EqIA Forms should accompany your document or proposal when it is submitted to the appropriate body for approval.

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?	Section 5(2) Doctors Holding Power in General and Community Hospitals
2.	Provide a brief description, including the aims and objectives of what you are assessing.	Section 5(2) allows a doctor (in charge of a patient's treatment) to detain an inpatient for a maximum of up to 72 hours in order for their assessment under the Mental Health Act. The aim of the policy is to ensure doctors are aware of their individual and collective responsibilities when considering implementing holding powers. To provide clear guidance to staff in relation to their legal responsibilities under the Mental Health Act 1983 as amended by the MHA 2007. Ensure that statutory requirements under the Mental Health Act 1983 are met. Practitioners should have due regard to the Mental Health Act Code of Practice generally and specifically to the Guiding Principles when they are considering the use of Doctors holding powers. This would ensure that considerations are given as to whether the objectives can be met in a less restrictive way.
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?	Professional Advisory Group

		Name	Title/Role
4.	Who is Involved in undertaking this EqIA? Include the names of all the people in your sub-group.	Wendy Lappin	Mental Health Act Manager
		All Wales Policy Group Members	Mental Health Act Managers

5.	Is the Policy related to, or influenced by, other Policies/areas of work?	Mental Health Act 1983 Code of Practice for Wales (Revised 2016) Welsh Language Act 2016 Mental Health Wales Measure 2010 Deprivation of Liberty Safeguards 2007 Equality Act 2010

6.	Who are the key Stakeholders i.e who will be affected by your document or proposals?	Service Users, Nursing Staff, Responsible Clinicians, Approved Clinicians, Mental Health Act Administrators and Assistants, Approved Mental Health Professionals, Qualified Nursing staff and other professionals working within mental health services.
7.	What might help/hinder the success of whatever you are doing, for example communication, training etc?	Training for all Mental Health Staff Communication to staff Workflow chart and examples Cooperation of staff Time constraints

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 (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 and this policy relates to all patients suffering from a mental disorder who meet the criteria for detention, irrespective of age.
Disability	(N)	Neutral	The proposed policy will apply to all patients detained regardless of disability, as the policy is reference to the scrutiny of the documents completed by staff rather than the processes. All documents will have been completed in conjunction with consideration of the Mental Health Act, Mental Capacity Act, DoLS and the Mental Health Wales Measure.
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. In relation to staff there are no changes to be made in relation to information given to patients. Wards will have completed risk assessments in relation to staff.
Race / Ethnicity	(N)	Neutral	This policy may involve those from different race or ethnicity, discrimination will be eliminated through the understanding of cultural values and communication needs will be met by where possible providing leaflets in alternative languages. Translators are also available as required.
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 (+)	Information leaflets for the patients are available in both English and Welsh. Within the explanation of rights this now details if the information has been given in the patients preferred language and will be reported on. Welsh Language Act is a consideration.
Human Rights	(+)	High Positive (+)	The proposed policy promotes human rights in ensuring that all patients are provided with information about their detention or stay within the hospital. Information leaflets are also available in easy read formats.

Guidance on completing Form 2: For each of the characteristics listed, and considering the aims and objectives you detailed in Q2 on Form 1, you need to consider whether your document or proposal likely to affect people differently, and if so, will this be in a positive or negative way? For example, you need to decide:

- will it affect men and women differently?
- will it affect disabled and non-disabled people differently?
- will it affect people in different age groups differently? - and so on covering all the protected characteristics.

Use the table below to indicate the scale of any impact identified. The factors used to determine an overall assessment for each characteristic should include consideration of scale and proportionality as well as potential impact.

Table A

High negative	Note: It is important to understand that we will be required to demonstrate what we have considered and/or done in order to mitigate or eliminate any negative impact on protected groups identified within the assessment. Details should be recorded in sections 3a/3b in the Action Plan in Form 4.
Medium negative	
Low negative	
Neutral	
Low positive	
Medium positive	
High positive	
No impact/Not applicable	

Form 3: Assessing Impact Against the General Equality Duty

As a public sector organisation, we are bound by the three elements of the "General Duty". This means that we need to consider whether (if relevant) the policy or proposal will affect our ability to:- • Eliminate unlawful discrimination, harassment and victimisation; • Advance equality of opportunity; and • Foster good relations between different groups	
1. Describe here (if relevant) how you are ensuring your policy or proposal does not unlawfully discriminate, harass or victimise	This policy aligns with legislative requirements. All relevant persons are required to comply with this document and must demonstrate sensitivity and competence in relation to the nine protect characteristics as defined in the Equality Act 2010. It will be the responsibility of each person enacting this policy to ensure that it is implements fairly and equitably with dignity and respect.
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)	Better communication Joint Working between staff of the Health Board.

Part B:

Form 4 (i): Outcome Report

Organisation:	BETSI CADWALADR UNIVERSITY HEALTH BOARD

1. What is being assessed?	Section 5(2) Doctors Holding Power in General and Community Hospitals.

2. Brief Aims and Objectives:	Section 5(2) allows a doctor (in charge of a patient's treatment) to detain an inpatient for a maximum of up to 72 hours in order for their assessment under the Mental Health Act. The aim of the policy is to ensure doctors are aware of their individual and collective responsibilities when considering implementing holding powers. To provide clear guidance to staff in relation to their legal responsibilities under the Mental Health Act 1983 as amended by the MHA 2007. Ensure that statutory requirements under the Mental Health Act 1983 are met. Practitioners should have due regard to the Mental Health Act Code of Practice generally and specifically to the Guiding Principles when they are considering the use of Doctors holding powers. This would ensure that considerations are given as to whether the objectives can be met in a less restrictive way.

		Yes	No
3a. Could the impact of your decision/policy be discriminatory under equality legislation?		☐	☒
3b. Could any of the protected groups be negatively affected?		☐	☒
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?		☐	☒

4. Did the assessment of potential impact on Form 2, coupled with your answers to the 3 questions above indicate that you need to proceed to a Full Impact Assessment?	Yes ☐	No ☒
	Record Reasons for Decision i.e. what did the assessment of scale on Form 2 indicate in terms of positive and negative impact for each characteristic?	

5. If you answered 'no' above, are there any issues to be addressed e.g. mitigating any identified minor negative impact?	Yes ☐	No ☐	Not applicable ☒

6. Are monitoring arrangements in place so that you can measure what actually happens after you implement your document or proposal?	Yes ☒	No ☐
	How is it being monitored?	The policy will be monitored through the Mental Health and Learning Disabilities Policy group for changes and submitted to the appropriate group for ratification. Data is collected in relation to the number of Section 5(2) and for how long the section is applied for this is communicated to the Mental Health Act Committee on a quarterly basis.
	Who is responsible?	BCUHB
	What information is being used?	How long a section lasts, which area is using Section 5(2), what the outcomes of the Section 5(2) is.
	When will the EqIA be reviewed? (Usually the same date the policy is reviewed)	June 2021

7. Where will your decision or policy be forwarded for approval?	MH& LD Policies Group

8. Describe here what engagement you have undertaken with stakeholders including staff and	The Policy was circulated for comments. The policy was written by the Mental Health Act Manager for BCUHB with involvement of a working

	service users to help inform the assessment	group.

	Name	Title/Role
9. Name/role of person responsible for this Impact Assessment	Wendy Lappin All Wales Policy Group	Mental Health Act Manager Mental Health Act Managers
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 EqIA including those aimed at reducing or eliminating the effects of potential or actual negative impact identified.

	Proposed Actions	Who is responsible for this action?	When will this be done by?
1. If the assessment indicates significant potential negative impact such that you cannot proceed, please give reasons and any alternative action(s) agreed:			
2. What changes are you proposing to make (or have already made) to your document or proposal as a result of the EqIA?			
3a. Where negative impact(s) on certain groups have been identified, what actions are you taking or are proposed to mitigate these impacts? Are these already in place?			

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

Report Title:	Covert Administration of Medication Clinical Policy
Report Author:	Ann Jones, Clinical Pharmacist - Psychiatry
Responsible Director:	Dr A Salmoiraghi, Medical Director, Mental Health & Learning Disabilities Division Dr B Owen, Director of the Pharmacy & Medicines Management Division
Public or In Committee	Public
Purpose of Report:	Final approval needed
Approval / Scrutiny Route Prior to Presentation:	Mental Health & Learning Disabilities Medicines Management Group Review – July 2018 BCUHB Medicines Policies, Procedures and PGD subgroup - July 2018 & October 2018 BCUHB Drug & Therapeutics group – July 2018 BCUHB QSG December 2018
Governance issues / risks:	Update of existing policy – none identified
Financial Implications:	Update of existing policy – none identified
Recommendation:	The Committee is asked to approve the Covert Administration of Medication Clinical Policy for use within BCUHB

Health Board's Well-being Objectives *(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)*	√	WFGA Sustainable Development Principle *(Indicate how the paper/proposal has embedded and prioritised the sustainable development principle in its development. Describe how within the main body of the report or if not indicate the reasons for this.)*	√
1.To improve physical, emotional and mental health and well-being for all	√	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 –	√	4.Putting resources into preventing	√

individuals, families, carers, communities - to achieve their own well-being		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 This was completed and submitted to the BCUHB Medicines Policies, Procedures and PGD subgroup			

Draft 6

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Number here e.g. …01…
Covert Administration of Medication
Clinical Policy

Date to be reviewed:	2019	**No of pages:**	No. of pages = 22
Author(s):	Ann Jones	**Author(s) title:**	Clinical Pharmacist Psychiatry
Responsible dept / director:	Dr A Salmoiraghi, Medical Director, Mental Health & Learning Disabilities Division Dr B Owen, Director of the Pharmacy & Medicines Management Division		
Approved by:	Mental Health & Learning Disabilities Medicines Management Group Review – July 2018 BCUHB Medicines Policies, Procedures and PGD subgroup - July 2018 & October 2018 BCUHB Drug & Therapeutics group – July 2018 BCUHB Quality & Safety group – Dec 2018		
Date approved:			
	Consent and Capacity Strategic Working Group		
Date endorsed:	Review endorsed:		
Date activated (live):	Date becomes live		

Staff should ensure they follow this procedure, with any deviation being risk assessed and escalated through their CPG/ Corporate Function escalation process.

Documents to be read alongside this document:	- Mental Capacity Act – Code of Practice - Mental Health Act – Code of Practice - BCUHB Medicines Code - Consent to Examination or Treatment - Royal College of Psychiatrists: Statement on Covert Administration of Medicines 2004 - NMC Statement: Covert Administration of Medicines – disguising medicine in food and drink - NMC Standards for Medicines Management - UKCC Position Statement on the Covert Administration of Medicines: Disguising medicine in food and drink - Case Law (AGvBMBC[2016])
Review	**Purpose of Issue/Description of current changes:** Reviewed on behalf of the Mental Health & Learning Disabilities Medicines Management Group June 2016 & 2017. Refer to guidance from UKMI Q&A What legal and pharmaceutical issues should be considered when administering medicines covertly?

First operational:	Date the procedure/ was first operational: Nov. 2011				
Previously reviewed:	June 2016	date	date	date	date
Changes made yes/no:	no	Yes/no	Yes/no	Yes/no	Yes/no

PROPRIETARY INFORMATION

DRAFT

Contents Page

1. Health Board Statement

1.1 The Health Board recognises that it is important to respect the autonomy of individuals who receive treatment. Patient care will be delivered without discrimination – regardless of gender / transgender, race, disability, sexual orientation, age, religion / belief or cultural practice.

1.2 Information will be presented to all patients, and carers in a way in which they can understand it.

2. Introduction

2.1 This clinical policy has been developed to support staff in making a decision as to when it is appropriate to administer medication covertly, that is disguising medication in food or drink and giving it to a patient who is unaware they are receiving it.

2.2 Covert administration of medication without informed consent may be regarded as deception. However there is a difference between patients whose refusal to taking medication should be respected (as they are capable of making an informed decision) and those who lack capacity.

2.3 Giving medicines covertly is only likely to be necessary or appropriate when patients / actively refuse medication and who (1) are judged not to have the mental capacity to understand the consequences of their refusal and the medication is clinically necessary, or (2) if they do not have the capacity to make a decision to refuse medication and are unable to take the medication when administered openly. For considerations under the Mental Health Act please see Section 10.

2.4 Several further crucial considerations apply with regards to covert administration and this clinical protocol seeks to address them in detail.

2.5 The Mental Capacity Act 2005 (MCA) provides a statutory framework to empower and protect vulnerable people who are not able to make their own decisions and this clinical protocol encompasses the latest recommendations.

3. Purpose

3.1 This clinical policy seeks to deliver guidance to ensure that when medication is given covertly the decision has been properly considered and recorded; thorough consultations have been made and that the practice is transparent and open to public scrutiny and audit.

3.2 The deceptive nature of this practice should not be confused with the administration of medicines against someone's will, which in itself may not be deceptive, but may be unlawful.

3.3   The Nursing Midwifery Council (NMC) recognises that this is a complex issue that has provoked widespread concern. It involves the fundamental principles of patient and client autonomy and consent to treatment, which are set out in existing legislation, namely the Mental Capacity Act 2005;   HRAct 1998, MCA 2005, DoLs 2008, MHA 2007,   and HSCWb(Wales) Act.

4. Scope

4.1   This clinical protocol provides information for registered healthcare professionals / professionals allied to medicine working (or contracted to work) at the Betsi Cadwaladr University Health Board. It provides a framework and should not supersede clinical judgement or override regulatory body guidance.

4.2   Administration of covert medication applies for treatment of **either physical and / or mental disorder**.

4.3   This clinical policy is not intended to apply to participants of clinical trials or other research.

4.4   An adult is classed as aged 16 years old for the purpose of this policy.

4.5   For specific advice relating to children and young people under 16 years of age see section 12.

5. Capacity to Consent

5.1   Every adult is presumed to have capacity to consent or refuse treatment including medication and it is for those that believe a person not to be capable to prove the fact.

5.2   The decision to consent to treatment involves receiving adequate information about the proposed treatment, having the capacity to assess and understand the nature of the treatment, and being able to make a free choice without undue pressure or coercion.

5.3   Ensure that the five principles of the MCA have been fully considered:
- A person must be assumed to have capacity unless it is established that they lack capacity.
- A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
- A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
- An act done or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in their best interests.
- Before the act is done, or the decision made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action

(For the purposes of the MCA in order to determine what is in a person's best interests, the determination **must not** be made merely on the basis of the person's age or appearance or their condition, or an aspect of their behaviour, which might lead others to make unjustified assumptions about what might be in their best interests).

5.4 If a patient is suspected of lacking capacity, they should be individually assessed. This assessment should be subject to continuous review. To decide whether the patient has the capacity or not to consent to receiving medication, two tests of the MCA need to be considered (PC and NC v City of York Council [2013]):

- Can the patient make a decision for himself/herself in relation to the matter? All practicable and appropriate support should be given to help the patient.
- If not, is this because of a temporary or permanent impairment or disturbance affecting the functioning of the mind or brain?

If the patient fails on any of these two tests, then s/he lacks mental capacity to consent.

5.5 Undertaking the assessment is primarily a matter for the medical prescriber, but all multidisciplinary healthcare practitioners have a responsibility to participate in discussions.

5.6 Where a patient is not capable of making a decision about medical treatment, consent can be given / refused by an Attorney under a Lasting Power of Attorney (Health & Welfare) that the patient executed whilst competent or by a Deputy appointed by the Court of Protection (Refer to the MCA 2005 – Code of Practice for further guidance).

5.7   In frail elderly patients who are unable to consent to medication, repeated restraint and injection of treatment (with attendant risk to life and physical health) may be more degrading and inhuman than the covert administration of medication. However, proper documentation and clearly defined processes need to be adhered to.

6. Refusal of Treatment

6.1   An adult patient with capacity has the right to refuse treatment, even if that refusal may adversely affect their health or shorten their life. An unwise decision must be respected. No one else can give consent on behalf of an competent adult.

6.2   Any refusal of treatment must be documented in the patient's healthcare record Consider reasons why the patient may be refusing treatment and whether further investigations are necessary e.g. problem with swallowing, unpleasant nature of the medication or experiencing underlying infection or delirium.

6.3   Discussions should be regularly conducted (and documented in the patient's health   care record) with the patient to try and gain consent over time. Refer to Appendix 6 for BCUHB guidance on what to do when a patient refuses medication.

6.4   An exception to the above is patients who are competent refusing to consent to treatment who are detained under the MHA (refer to section 8).

7. How and when to use Covert Medication

7.1   Alternative approaches should be tried where a patient initially refuses essential medication, before resorting to covert administration. Ensure that a medication review takes place and **only prescribe those deemed essential**.

- try to administer essential medicines a short time later when the patient may be more compliant (or another nurse could approach the patient)
- ask the Pharmacist if the medicine/s is/are available in another form e.g. liquid may be more palatable and easily taken; some tablets can be crushed or are available in dispersible form, a medication patch may be more suitable.
- consider alternative medicines / formulations with reduced administration frequency

7.2 Continuing regular attempts are made to encourage the patient to take their medication overtly.

7.3   The patient's mental capacity to consent to or refuse treatment is formally assessed in accordance with the Health Board's Consent to Treatment or Examination Policy

7.4   If the patient is assessed to have mental capacity then his/her wishes must be respected. However, there should be a review as to whether the patient has been given adequate information as to the nature, purpose, associated risks and alternatives to the medication.

7.5   If the patient is assessed as lacking mental capacity to consent or withhold consent, the BCUHB 'Assessment of Mental Capacity and Best Interest Decision Form' should be completed and retained in the patient 's healthcare record. If the covert. medication is to allow a procedure to occur e.g. Pre-Medication for a surgical procedure then this should be incorporated in the Best Interests decision by the decision maker undertaking the procedure. This decision would then be shared with the Multidisciplinary team meeting to determine if the planned procedure should go ahead

Link to BCUHB Assessment of Mental Capacity and Best Interests Decision form:
http://howis.wales.nhs.uk/sitesplus/documents/861/mca_decision_form_0811.pdf

7.6 The implication of continued medication refusal and the alternatives available including administering medication covertly are discussed with any donee named in a Lasting Power of Attorney (Health & Welfare). An informed decision will need to be made by the named donee. If the Covert Medication is part of a procedure that is likely to require Covert Medication e.g. Pre-Med the this should be incorporated in a Best Interest Decision

7.7   If a **valid** and **applicable** Advance Decision exists this should be followed.

7.8   Where the patient is detained and **lacks capacity** under the Mental Health Act, the Approved Clinician considers appropriate use of powers under the legislation to

administer essential medication by the least restrictive means for the treatment of the mental disorder. This could be covertly or by IM or IV routes, with or without restraint as deemed appropriate.

7.9 Appropriate members of the multi-disciplinary team (MDT) (to include at least the Consultant or nominated deputy, the Named Nurse, the Pharmacist, a relative / carer LPA or Independent Mental Capacity Advocate (IMCA) if appropriate) should meet to discuss covert medication administration. To avoid delays hold discussions with key MDT members before a meeting to ensure their views are included in the decision if they cannot attend. The purpose of this meeting is to decide whether covert administration of medication is in the patient's best interests or not.

7.10 As part of this discussion:
- medication is reviewed to reduce to **essential medicines only**
- alternative routes of administration, different formulations and dose changes are discussed with the Pharmacist and these should be documented for each medication, including the risks and benefits of administration in an altered form.
- the Pharmacist checks suitability of prescribed medicines for adding to food or fluids, to ensure that medication will not be altered or become unsafe. Specialist advice can be obtained from local Medicines Information Centres.

7.11 If a decision is made to covertly administer medicines complete the form in Appendix B (Covert Administration of Medication Authorisation Form) and attach a copy of the form to the Drug Administration Record. Add a sticker to the front of the Drug Administration Record to highlight that the patient is receiving medication covertly (Contact the ward pharmacist to obtain a supply of the stickers):

*"This patient receives **medication covertly**, please ensure appropriate formulations are used"*

Medicines are covertly administered in food or fluids as agreed following consultation and under close supervision. Record the administration of medication on the Drug Administration Record and on the Covert Administration of Medicines Record Form Appendix D. Continuing and regular attempts are made to encourage the patient to take medication overtly and attempts and outcomes are recorded.

7.12 The covert administration must be supervised by the registered nurse administering the medication. If the patient is taking medication in food or drink then delegated supervision by a health care support worker is acceptable, but must continue until all the medication has been taken. A note should be made in the patient's healthcare record of successful (or otherwise) completion of the administration.

Consideration should be given to the use of separate crockery for the administration of covert medication. It should be different in design to routine crockery used on the ward, in order for nursing staff to ensure that it is only used for patients having medication covertly. If this crockery is left unattended on the ward it should immediately be returned to the nursing station.

7.13 The Consultant is informed if covert medicine administration fails, e.g. by food or fluid refusal at the earliest opportunity. The registered nurse administering the medicine covertly records the outcome using the '4 – refused' code if the administration fails on the patient's medicine administration chart. A further multi-disciplinary team meeting is reconvened, urgently if necessary.

7.14 If the covert administration of medication in the patient's food or drink makes the patient resistant to eating or drinking, then consideration should be given to ceasing the practice immediately as the significance of harm caused by diminished hydration and/or nutrition may be greater than the harm caused by not receiving essential medication orally. In such circumstances non-oral routes of administration should be considered. Further discussion will be required in a MDT meeting.

7.15 In order to be transparent and provide an audit trail, any patient receiving medication covertly should have a care plan in place detailing why covert administration is necessary; why the patient is non-concordant with medication; ways in which concordance could be improved; how often the covert administration plan should be reviewed by the MDT (usually weekly) and following changes to the patient's medication and medical condition.

7.16 A regular review of the covert administration of medication should be undertaken at intervals decided by the multi-disciplinary team in consultation with the main carer/nearest relative or LPA attorney for Health and Welfare, using the form attached in Appendix C (Covert Administration of Medication Review Form).

7.17 If the patient is transferred to another medical/care setting then arrangements must be made to communicate the covert administration care plan to the ward manager/ care manager. However, it will be the responsibility of the ward manager/care provider to complete a capacity assessment and follow the best interest process to agree a new covert administration care plan.

8. Extreme situations

8.1 In extreme situations (such as putting self and/or others at risk due to their behaviour), a patient that lacks mental capacity who is not compliant may have an immediate need for a specifically prescribed medication. When circumstances prevent the privilege of an impromptu MDT meeting with carer input, the nurse may after discussions with the immediate team including the doctor and pharmacist, administer the initial dose under the Mental Capacity Act 2005 where the patient is incapable of consenting. (Out of hours, contact the on-call doctor and pharmacist).

8.2 The situation would then be reviewed within the following 24 hours with a view to seeking compliance or following the established procedure. The decision, action to be taken and names of all parties concerned must be documented in the care plan, together with a review date.

9. Medication considerations

9.1 The doctor and pharmacist must always agree to any alterations to standard medication administration practice, to ensure patient safety.

9.2 If it is decided that medication is to be given in food/drink, a pharmacist must be consulted about what type of preparation should be used to ensure appropriate delivery of treatment. Specialist advice is available from local Medicines Information Centres.

9.3 If a prescriber intends to direct tablets to be crushed or capsules to be open then they should be aware of Section 4.8 of the BCUHB Medicines Code/Policy. Any method of administration which is outside the product licence of that medication is unlicensed, and can only be authorised by an approved prescriber who may be liable if harm ensues. This should also be reviewed by the pharmacist.

9.4 The prescriber must document any authorisation to administer a medication by an unlicensed method, having first considered the patient's safety, the requirement for that particular medication and alternative treatment or means of administration.

9.5 Wherever possible, a suitable licensed liquid or soluble, dispersible or 'melt' formulation should be used. Crushing tablets or opening capsules should only be undertaken when another formulation is unavailable, and with the consent of the prescriber since both actions alter the licensed status of the medicine and may affect the clinical efficacy or safety of the medicine. Dose adjustment may be necessary. Particular danger is possible if slow-release or enteric-coated tablets are crushed, as this may change the way the medication is absorbed.

9.6 Any instructions regarding how to administer the medicine(s) should be clearly annotated on the patient medication record / prescription chart to aid nurse administration and the instructions conveyed verbally to the relevant nurse. In addition the recommendations must be documented in the healthcare record.

9.7 Any medical, cultural or religious dietary requirements should be complied with (e.g. gluten-free for patients with coeliac disease, avoidance of animal gelatin for vegetarian, Jewish or Muslim patients).

9.8 Where necessary medicines should be mixed with a small amount of food or liquid rather than in a whole drink or portion of food. Patients receiving medication administered in food or drink must not be left until the medication has been consumed. The nurse administering medication must remain with the patient until the medication is consumed.

10. Considerations under the Mental Health Act

10.1 Patients who are refusing treatment related to a mental disorder should be assessed with a view as to whether this should be dealt with under Part IV of the MHA 1983.

10.2 The principles of consent continue to apply to any medication for conditions not

related to the mental disorder for which they had been detained. The assessment of their capacity to consent or refuse such medication therefore remains important. However in relation to medication for the mental disorder for which the patient has been detained, medication can be given against a patient's wishes during the first 3 months of treatment, whilst detained under the Act (Section 3) for treatment then may continue where discussed with and authorised by a Second Opinion Appointed Doctor.

10.3 Although, any advanced refusal made by the patient regarding refusal to treatment relating to their mental disorder would be invalid under the terms of the Act, (except Electro Convulsive Therapy (ECT) in certain circumstances – please refer to the MHA Code of Practice Chapters 23 & 24) clinicians should, where practicable, try to comply with the patient's wishes as expressed in an advance refusal and consider whether it is possible to use a different form of treatment not refused by the advance refusal.

10.4 Ongoing efforts should be made to obtain the patient's consent and administer the medicines openly.

10.5 In certain situations additional advice may need to be sought from the Responsible Clinician / Mental Health Pharmacist.

11. Considerations under the Human Rights Act

11.1 Article 2 *'Everyone's right to life shall be protected by law'*

Where covert medication enables the provision of **effective and essential medication** to someone who would otherwise reject it, this article might be used to justify such a practice. Clearly no treatment can be given covertly that is not specifically indicated for the treatment of illness or alleviation of distress (although such treatment may, sometimes, shorten life as a secondary result of their administration). Administration of treatments whose purpose is to shorten life is illegal.

11.2 Article 3 *'No one shall be subject to torture or inhuman or degrading treatment or punishment'*

In an incapacitated individual, repeated restraint and injection of treatment (with attendant risk to life as well) may be more degrading and inhuman than to administer covertly.

11.3 Article 5 *'Everyone has the right to liberty and security of person'*

To justify the invasion of privacy which covert medication entails, it must be clear that this invasion is justified by the need for effective treatment. This also apples to Article 8

11.4 Article 6 *'Everyone is entitled to a fair and public hearing within a reasonable period of time by an independent and impartial tribunal established by law'*

It is essential that, if medication is administered covertly this is done following discussion and with clear clinical records, so that a fair and public hearing may be obtained when required.

12. Considerations for children and young people

12.1 It **cannot** be assumed that children are unable to give consent. It is important that both legal and professional principles governing consent are applied equally to all whatever the health care setting but with the following significant restrictions

12.2 Children under 16 – are generally presumed to lack capacity, to consent or refuse treatment, including medication. The right to do so remains with the parents or those with parental responsibility, unless the child is considered to have significant understanding and intelligence (Gillick competence[1]) to make his or her own mind about it.

12.3 Children 16 -17 years old are presumed to be able to consent for themselves. In exceptional circumstances, it may be necessary to seek an order from the Court if a young person without capacity refuses care and treatment or refuses to stay in hospital for care and treatment which is in their best interests. Urgent advice should be sought from a senior clinician and legal services department in this situation.

12.4 The covert administration of medicines is only considered to be necessary or appropriate in the case of children and young people who are either mentally or physically disabled or too young to comprehend and therefore are judged not to have the capacity to understand the consequences of their refusal of medication.

12.5 Please also refer to section 7 bullet points 11-16 and section 9 regarding the legal requirements in recording covert administration of medication. Delegation of administration of covert medication to a parent should be dealt with in a similar manner as that of monitoring a HCSW (unless there are actual or suspected safeguarding concerns).

13. Audit

Divisions will be responsible for maintaining registers of medication practice with regard to the covert administration of medicines.

Divisions will ideally take on the overall responsibility of auditing the process in the near future to ensure compliance with this clinical protocol.

Audit reports will form part of the Health Board's assurance framework and will be used for the patient safety performance management assessment process.

14. Monitoring

Divisions should produce and submit an Annual Report of Covert Medication to the BCUHB Board to demonstrate compliance with this clinical protocol and maintain standards of safe clinical practice.

[1] A child under the age of 16, who **has capacity** and has been assessed as **Gillick competent** (i.e. has sufficient maturity and intelligence to be capable of understanding the treatment and making a decision based on the information provided) is able to give their consent to treatment

15. References

Case Law (AgvBMBC [2016])

Position statement: Covert administration of medicines-disguising medicine in food and drink, NMC 2006

The Mental Capacity Act 2005, BMA Guidance for Health professionals, March 2007

Code of Professional Conduct, NMC 2002

DOH (1999) Mental Health Act 1983 Code of Practice

British Medical Association and Law Society. 'Assessment of Mental Capacity: Guidance for Doctors and Lawyers'. London: BMJ 2004

General Medical Council, Consent: patients and doctors making decisions together 2008

Covert administration of medicines, The Pharmaceutical Journal, Volume 270, No 7230, Jan 2003

Royal College of Psychiatrists: Statement on covert administration of medicines 2004

UKMI Q&A What legal and pharmaceutical issues should be considered when administering medicines covertly? Prepared 23/02/2017   www.sps.nhs.uk

Appendix A

COVERT ADMINISTRATION OF MEDICATION – DECISION TREE

Remember to:
- Have regard to the Mental Capacity Act – Code of Practice
- Permit and encourage the person to participate on the decision making process
- Take account of all relevant circumstances
- Your decision must not be motivated by a desire to bring about the person's death

---

Always presume mental capacity of patient (however see section relating to children)

↓

Does the patient's refusal of medication raise concerns or doubts about their capacity to make a decision?

YES → Please complete the Health Board's "Assessment of Mental Capacity & Best Interests Decision Form" or adhere to practice

The completion of the form establishes that the patient lacks capacity

NO → Patient has the right to refuse medication even if it is considered unwise. No further action taken under the Mental Capacity Act 2005. **

NO (from form) → Patient has the right to refuse medication...

YES → Is there a relevant, valid and applicable Advance Decision, Lasting Power of Attorney (Health & Welfare), or, Court Appointed Deputy?

NO → MDT arranged involving people close to the patient (spouse, partner, family, friends, carer, advocate) in the decision-making process regarding best interests and least restrictive legal principles

YES → Act in accordance with the Advance Decision (consider alternative treatments), or decision of the Attorney(s) / Court Appointed Deputy.

YES → Best Interest Decision for the medication to be given covertly. Covert medication deemed appropriate.

NO → Covert medication deemed inappropriate. Use other provisions under the Mental Capacity Act or Mental Health Act 1983 (if applicable)

↓

Complete Covert Medication Authorisation Form (Appendix B). Use covert medication and review as appropriate.

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* If deputy is thought not to be acting in the patients best interests an Application to the Court of Protection should be made.

** If patient is detained under the Mental Health act consider treatment under s58 or s63.

Appendix B

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

Covert Administration of Medication Authorisation Form

Surname	
First name	
Hospital / Ward	
NHS/Hospital no.	----------/------
Date of birth	_____/_____/_____

STATEMENT OF HEALTH CARE PROFESSIONAL

On behalf of the Multi Disciplinary Team treating the patient; I confirm that:-

☐ I have completed the BCUHB 'Assessment of Mental Capacity and Best Interests Decision Form' on behalf of the patient named above and I am of an opinion that the patient lacks the mental capacity to consent to the administration of medication. Following discussion with the multidisciplinary team a decision has been made to administer medication covertly.

Or

☐ An extreme situation has occurred (putting self and/or others at risk due to their behaviour), and it is believed the patient lacks mental capacity to comply to the specifically prescribed medication (This decision and name of all parties involved must be must be documented clearly in the patient's healthcare record).

This circumstance has prevented the privilege of an MDT meeting with care input. After discussions with the immediate team, the initial dose of medication will be administered under the Mental Capacity Act 2005 and a review of the situation will take place within 24 hours with a view to seek compliance.
The Health Boards "Assessment of Mental Capacity and Best Interest's Decision Form will also be completed at the earliest opportunity and a review date set.

Signature……*Dr* …….Name PRINT)…………………….………Date_____/_____/_____
Job title………………………………….Contact Details…………………..…………………………..……
GMC No……………………..……………

Signature……*Nurse*………….Name (PRINT)…………………….………Date_____/_____/_____
Job title…………………………………….Contact Details…………………..…………………………..……
NMC Pin No. ……………………..…………

Signature……*Pharmacist*…….Name (PRINT)…………………….………Date_____/_____/_____
Job title…………………………………….Contact Details…………………..…………………………..……
GPHC No………………………..…………….

Please attach a copy of this form to the patient medication record

Appendix B cont:

Surname	
First name	
Hospital / Ward	
NHS/Hospital no.	_____/_____
Date of birth	_____/_____/_____

Covert Administration of Medication Authorisation Form Continued

Date…………………………...

All medication prescribed:	Covert Yes / NO	Details of how to give the medication covertly to be verified by a clinical pharmacist State reason if NOT to be given covertly
Date:		Date
Completed by:		Pharmacist check

Review Covert Medication Administration Within 7 Days, review date =

Appendix C

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

Covert Administration of Medication Review Form

Surname	
First name	
Hospital / Ward	
NHS/Hospital no.	_____/_____
Date of birth	_____/_____/_____

REVIEW OF ADMINISTRATION OF COVERT MEDICATION (weekly initially, no longer than a month if required as a longer term measure)

How is covert medication administration given?…………………………………………..
………………………………………………………………………………………………………
………………………………………………………………………………………………………
……………………………………………………………………………………………

Was medication accepted covertly? Did patient refuse?
………………………………………………………………………………………………………
………………………………………………………………………………………………………
……………………………………………………………………………………………

Proposed changes to course of treatment agreed following MDT review, including Doctor or nominated deputy, Name Nurse and Pharmacist………………………………….………………
………………………………………………………………………………………………………
……………………………………………………………………………………………

☐   The MDT has reviewed the patient's "Assessment of Mental Capacity and Best Interests Decision Form" dated **_____/_____/_____** to administer medicines covertly and confirm that the form is still valid and applicable to the initial situation.

Signature……*Dr* …….Name PRINT)…………………….………Date_____/_____/_____
Job title……………….…………………Contact Details………………..…………………..……
GMC No…………………..……………

Signature……*Nurse*………….Name (PRINT)…………………….……Date_____/_____/_____
Job title……………….…………………Contact Details……………..……………………….……
NMC Pin No. ……………………..…………

Signature……*Pharmacist*…….Name (PRINT)…………………..……….Date_____/_____/_____
Job title……………….…………………Contact Details……………..……………………….……
GPHC No…………………..……………….

Date review completed   _____/_____/_____

Date of next review   _____/_____/_____ (Complete a new form for each review)

To be retained in the patient's healthcare record

Appendix D

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

**Covert Administration of Medication
Record Form**

Date Policy Implemented:.................
Valid until:..

Surname	
First name	
Hospital / Ward	
NHS/Hospital no.	----------/------
Date of birth	
MHA status	

The registered nurse administering medication, on each occasion, to sign:
1: medication given covertly as per protocol
2: medication taken willingly by patient
3: unable to administer medication – document why

Date	Time	Enter code 1 or 2 or 3	Signature in full

Appendix E
How to seek a court declaration

C1.   If you need to obtain legal advice or apply for a court ruling in relation to a complex covert medication issue you should contact your divisional Concerns team (contact details listed below)

C2.   Out of office hours, you should contact the Senior Manager on-call, who will contact one of the Health Board's Solicitors on your behalf.

C3.   You should ensure that you have all the relevant information about the case to hand so that you can brief the Solicitor appropriately. You should also keep a clear written record of any legal advice you have been given.

C4.   Where a decision is made to apply to a court the lead clinician should, as soon as possible, inform the patient and his or her representative of the decision and of his or her right to be represented at the hearing. The patient's solicitor should be informed immediately and, if practicable, should have a proper opportunity to take instructions and apply for legal aid where necessary.

C5.   There may be occasions when the situation may be so urgent, and the consequences so desperate, that it is impracticable to attempt to comply with these guidelines. Where delay may itself cause serious damage to the patient's health, or put their life at risk, then rigid compliance with these guidelines would be inappropriate. Further legal advice could be sought if the situation allows. In these cases it is essential to provide adequate documentation and reasons for cause of action undertaken. Any deviation from the MCA Code of Practice and the reasons for this must also be clearly recorded.

C6.   The Court of Protection deals with serious decisions affecting personal welfare matters, including healthcare, which were previously dealt with by the High Court. Case involving:

❖ cases where there is doubt or dispute about whether a particular treatment will be in a person's best interests (includes cases involving ethical dilemmas in untested areas) should be referred to the Court for approval. The Court can be asked to make a decision in case where there are doubts about the patient's capacity and also about the validity or applicability of an advance decision to refuse treatment.

Please contact:-

Head of Investigations and Redress
Concerns Team
Ysbyty Gwynedd
Penrhosgarnedd
Bangor
Gwynedd LL57 2PW

Telephone: East – 01978 725543   Central – 01248 385337   West – 01248 384194
Email: ConcernsTeam.bcu@wales.nhs.uk

Appendix F

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Link to the BCUHB Assessment of Mental Capacity
And Best Interests Decision form:

http://howis.wales.nhs.uk/sitesplus/documents/861/mca_decision_form_0811.pdf

Appendix G

What to Do When a Patient "Refuses" Medication

STEP ONE	STEP TWO

STEP ONE

Does the Patient Have Capacity?
(Mental Capacity Act 2005)

A person must be assumed to have capacity unless it is established that they lack capacity.
A person is not to be treated as unable to make a decision unless all practicable steps to help them to do so have been taken without success.
A person is not to be treated as unable to make a decision merely because they make an unwise decision.

Do you consider the person able to...?

Understand the information relevant to the decision made?

Retain the information for long enough to make this choice or an effective decision?

Use or weight that information as part of the decision-making process?

Communicate – verbally or non-verbally

Yes to All 4 Questions: Has Capacity

No to ANY Question: Lacks Capacity

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STEP TWO

Has Capacity		Lacks Capacity	
STOP: Is this a Critical Medication?		**STOP: Is this a Critical Medication?**	
Yes	**No**	**Yes**	**No**

Has Capacity – Yes:
Doctor to be informed to discuss this with the patient

If all risks and benefits are explained to patient, and they still refuse, please document as "Patient Refuses"

Has Capacity – No:
Is the patient refusing because of a clinical reason?
E.g. refusing analgesia as no pain, or refusing laxative due to loose stools

If No:
Document as "Patient Refuses"

If Yes:
Document on chart
And Kardex as "Other Reason"

Lacks Capacity – Yes:
Have you tried to get support from family or friends to help patient take their medications?

Doctor to be informed immediately to decide about further action

Have you considered alternative routes of administration that the patient would tolerate better?

If still struggling gain SENIOR input re covert medication BELOW

Lacks Capacity – No:
Is there a clinical reason that the medication is currently not needed? If so document on chart
E.g. refusing analgesia as no pain, or refusing laxative due to loose stools

Have you tried to get support from family or friends to help patient take their medications?

Normal day team doctor to review at first available opportunity

⚠️ **What is a Critical Medication?** ⚠️

- Antimicrobials
- Antiepileptics
- Opioids
- Insulin
- Anticoagulants
- Parkinson's meds

If in doubt, refer to the
Quick Reference Guide - Critical medication
If any concern, discuss with pharmacy or doctor

- Has a best interest meeting been held with the MDT team including a family member or patient advocate?
- Has a plan been made how to administer medicines?
  - Discuss with Pharmacist
- Is regular review undertaken to assess continued need for covert administration?

Members of the 2017 working group:

Dr S Bhattacharyya	Consultant psychiatrist OPMH
Elizabeth Bond	Head of pharmacy, MHLD division
Bev Evans	Corporate safeguarding team and BCUHB DoLS lead
Dr M James	Associate specialist OPMH and liaison psychiatry
Ann Jones	Lead mental health pharmacist BCUH East
Hayley Jones	Medicines management nurse BCUHB East
Martin McSpadden	Paediatric and neonatal services manager
Chris Pearson	Corporate Safeguarding Team All Wales AC & S12(2) Dr and BCUHB DoLS Manager
Katherine White	Medicines management nurse BCUHB East
Rebekah Roshan	Lead MHLD nurse, BCUHB East

Consultation has taken place with stakeholders listed below:

Dr C Abbott	Consultant geriatrician
Dr S Abraham	Consultant geriatrician
Dr S Bhattacharyya	Consultant psychiatrist OPMH
Dr F Farquhar	Consultant psychiatrist LDS
Dr P Gore-Rees	Consultant psychiatrist CAMHS
Dr M James	Associate Specialist OPMH & liaison psychiatry
Prof P Lepping	Consultant psychiatrist
Dr Q Mirza	Consultant psychiatrist OPMH
Dr A Salmoiraghi	Consultant psychiatrist and clinical director, MHLD division
Dr A White	Consultant geriatrician
Hayley Jones	Medicines management nurse BCUHB East
Martin McSpadden	Paediatrics and neonatal services manager
Sean Page	Consultant nurse
Rebekah Roshan	Lead MHLD nurse, BCUHB East
Jane Rowland	Modern matron, Heddfan unit, WMH
Mike Shone	Interim matron OPMH BCUHB East
Rowenna Spencer	Memory clinic nurse BCUHB East
Katherine White	Medicines management nurse BCUHB East
Liz Bond	Head of pharmacy, MHLD division
Gill Boothman	Prescribing support pharmacist Llandudno
Teresa Bushell	Prescribing support pharmacy technician, Llandudno
Suzanne Cotter	Lead pharmacist paediatrics, BCUHB East
Iain Dawson	Lead pharmacist mental health, BCUHB Central
Judith Green	Medicines lead pharmacist, BCUHB East

Consultation list continued:

Louise Howard-Baker	Assistant director of pharmacy, BCUHB East
Sue Lord	Pharmacy hospital operations manager, BCUHB East
Berwyn Owen	Chief pharmacist, BCUHB
Karen Pritchard	Lead pharmacist patient safety, BCUHB East
Siân E Roberts	Lead pharmacist mental health, BCUHB West
Elaine Sturman	Lead pharmacist surgery, BCUHB East
Janet Thomas	Patient safety pharmacist, BCUHB East
Bev Evans	Corporate safeguarding team and BCUB DoLS lead
Amanda Lewis	Interim associate director safeguarding (adults)
Eleri Lloyd-Burns	Head of safeguarding (nursing)
Chris Pearson	Corporate Safeguarding Team All Wales AC & S12(2) Dr and BCUHB DoLS Manager

**Quality, Safety &
Experience Committee**

22.1.19

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

To improve health and provide excellent care

Report Title:	BCUHB Restricted Antimicrobial Policy
Report Author:	Charlotte Makanga, Consultant antimicrobial Pharmacist
Responsible Director:	Gill Harris, Executive Director of Nursing, Midwifery and Patient Services
Public or In Committee	Public
Purpose of Report:	Approve the use of the Restricted Antimicrobial Policy in BCUHB
Approval / Scrutiny Route Prior to Presentation:	Consultation All Consultants in BCUHB via email September 2018 Antimicrobial Stewardship Group July 2018 Policy and Procedures Drug and Therapeutics Group Quality & Safety Group
Governance issues / risks:	This policy will be reviewed at regular intervals and all changes to availability of antimicrobials to clinical areas. There is still the BCUHB wide issue of a lack of microbiologists, this may affect the impact of the policy
Financial Implications:	The restrictive policy is to be implemented to ensure antimicrobials are used appropriately and their use is safeguarded to stop the overuse and limit or slow down the development of antimicrobial resistance. The issues of antimicrobial resistance are serious and will have higher financial implication both now and in the future through more expensive, less effective antimicrobials, longer hospital stays and the use of multiple antimicrobials and for a longer duration.
Recommendation:	The Committee is asked to approve the policy for implementation in BCUHB.

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

Board/Committee Coversheet v10.0

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

RESTRICTED ANTIMICROBIAL POLICY

Date to be reviewed:	Date here	No of pages:	6
Author(s):	Charlotte Makanga	Author(s) title:	Consultant Antimicrobial Pharmacist
Responsible dept / director:	BCUHB Antimicrobial Steering Group Director: Executive Director of Nursing, Midwifery and Patient Services		
Approved by:	Infection Prevention Sub-Group Drug and Therapeutics Sub Group		
Date approved:			
Date activated (live):			

DRAFT

Date EQIA completed:	18.12.18
Documents to be read alongside this policy:	BCU Antimicrobial Prescribing Policy MM10 BCU Medicines Policy MM01
Purpose of Issue/Description of current changes: The purpose of this policy is to restrict antimicrobials and their prescribing within BCUHB. All antimicrobials prescribed must adhere to this policy and therefore will support antimicrobial stewardship, reduce unnecessary antimicrobial prescribing and therefore reduce harm.	

First operational:	Date the policy was first operational				
Previously reviewed:	N/A	date	date	date	date
Changes made yes/no:	N/A	Yes/no	Yes/no	Yes/no	Yes/no

1. Introduction and Policy Statement

The restriction, prudent and appropriate use of antimicrobials is imperative to safeguard antibiotics for use in the future in the Health Board. This policy must be strictly adhered in order to maintain the patency and effectiveness of antimicrobials.

All antimicrobials prescribed must also adhere to the prescribing policy as set out in MM10.

This policy only applies to BCUHB formulary antimicrobials.

Non Formulary Antimicrobials: Any antimicrobials not on formulary require a formulary application process or an IPFR request by the consultant wishing to prescribe.

Formulary Antimicrobials: Antimicrobials are restricted due to safety issues e.g. risk of infection with *Clostridium difficle* or concerns regarding resistance.

2. Purpose of the Document

The purpose of this policy is to restrict certain antibiotics to ensure the patients of BCUHB receive safe, appropriate antibiotics only when needed. This will reduce unnecessary prescribing and reduce harm.

3. Scope

This is for all prescribers in BCUHB who wish to prescribe antibiotics and sets out those antimicrobials that have further restrictions for prescribing placed upon them, before they can be given.

4. Aims and Objectives

Aim: To ensure antimicrobials are used in an appropriate and prudent way to ensure patients are not exposed to unnecessary treatment.

Objectives:
1. Restrict and preserve certain antimicrobials for use only when recommended by microbiologists.
2. Ensure antimicrobials are used only for clear indications and have a clear review/stop date.
3. Empowering all healthcare professionals to take an active role in antimicrobial stewardship.

5. Roles and Responsibilities

Prescribing a restricted antimicrobial without consultation with microbiology (or speciality consultant for certain restricted antimicrobials) may lead to delayed treatment while pharmacy ascertains whether approval has been given. It is the responsibility of the prescriber to contact microbiology. It is important for the prescriber to document on any medication chart or prescription that microbiology approval has been obtained to reduce delay.

The consultant microbiologist can be reached during working hours (8:30 – 5PM) Monday to Friday, to discuss alternative treatment options if required.

Out of hours, restricted antibiotics may be initiated if no other alternative. The consultant microbiologist **must** be contacted the next working day to approve the prescription.

Ysbyty Gwynedd   01248 384384 ext: 4656
Ysbyty Glan Clwyd 01745 44 8790 ext: 2949
Wrecsam Maelor   01978 725861

6. Monitoring, Escalation and Implementation Arrangements

6.1 All the stock of antimicrobials in clinical areas will reflect this policy. Stock will be removed or reduced in accordance to the policy.

6.2 All areas will be monitored for their compliance and issues will be escalated via either the area management or hospital management teams.

7. Restriction Categories

There are 3 categories of restricted antimicrobials in BCUHB outlined as follows:

1. Restricted antimicrobials requiring approval by a consultant microbiologist
2. Specific use antimicrobials reserved for specialty use, specific indications or consultant microbiologist approval.
3. All other antimicrobials prescribed in accordance with Microguide®.

For up to date antimicrobial prescribing guidelines please refer to Microguide® available on the intranet at: http://howis.wales.nhs.uk/sitesplus/861/page/54498 or a free to download app.

7.1 Restricted antibiotics requiring approval by a consultant microbiologist

7.1.1 Some antimicrobials are classified as restricted and pharmacy will only dispense these antimicrobials after consultant microbiologist approval (table 1). These antimicrobials are marked as RMA (Restricted Microbiology Approval) on Microguide®.

7.1.2 Prescribers planning to prescribe an antimicrobial from this list must contact the consultant microbiologist prior to prescribing treatment.

7.1.3 If treatment with an antimicrobial listed in table 1 is started out of hours the initial doses may be dispensed and consultant microbiologist approval sought at the earliest opportunity the next working day.

7.1.4   The microbiology approval must be documented in the patient's medical notes and the medication chart by the prescriber. This must done by circling the Micro Advice in the *Compliant to guidelines* box. The name of the microbiologist must be clearly documented in the medical notes.

7.1.5   Prescribing a restricted antimicrobial without consultation with microbiology may lead to delayed treatment while pharmacy ascertains whether approval has been given. It is important to document on any medication chart or prescription that microbiology approval has been obtained to reduce delay.

7.2 Specific use antimicrobials reserved for specialty use, specific indications or consultant microbiologist approval.

7.2.1   This applies to antimicrobials prescribed for non Microguide® Indications by specialist consultants e.g. respiratory.

7.2.2   Antimicrobials classified in this group can only be prescribed by the designated specialties for conditions other than those listed in Microguide® e.g. *Pneumocystis jiroveci* (PCP) pneumonia (table 2). These medicines are also marked as RMA (Restricted Microbiology Approval) or RCA (Restricted Consultant Approval) depending on who has approved the antimicrobial on Microguide®.

7.2.3   Prescribing of these antimicrobials outside of these specialties or indications must only occur following approval from the patient's consultant or the consultant microbiologist.

7.2.4   If treatment is started out of hours the initial doses may be dispensed and administered. Consultant microbiologist or specialist approval must be sought at the earliest opportunity the next working day.

7.2.5   The antimicrobial approval must be documented in the patient's medical notes and the medication chart. This must done by circling the Micro Advice in the *Compliant to guidelines* box. The name of the microbiologist or specialist consultant must be clearly documented in the medical notes.

7.2.6   Prescribing a restricted antimicrobial without consultation with microbiology or specialty consultant may lead to delayed treatment while pharmacy ascertains whether approval has been given. It is important to document on any medication chart or prescription that microbiology approval has been obtained to reduce delay.

7.3   All other antimicrobials being used in accordance with Microguide®.

7.3.1 This applies to all other antimicrobials that are being prescribed.

7.3.2 They must be prescribed in accordance with Microguide and clearly documented as per the antimicrobial prescribing policy.

Table 1: Restricted antibiotics requiring approval by a consultant microbiologist

Antimicrobial	Reasoning
Aztreonam	Not on Microguide®.
Daptomycin	Formulary antimicrobial for use on recommendation by consultant microbiologist
Carbapenems: Ertapenem, Imipenem	
Fidaxomicin	For treatment of *Clostridium difficile* infection as per Microguide®
Linezolid	Formulary antimicrobial for use on recommendation by consultant microbiologist
Tigecycline	

Table 2: Specific use antimicrobials reserved for speciality use, specific indications or consultant microbiologist approval for conditions other than those listed in Microguide® e.g. *Pneumocystis jiroveci* (PCP) pneumonia

Antimicrobial	Restriction details/consultant specialty
Amikacin	Paediatrics
Azithromycin	Consultant Speciality GUM ,COPD, bronchiectasis prophylaxis
Ceftriaxone	GUM, Respiratory, Paediatrics, Care of the Elderly in community hospitals, and as per Microguide®
Cefotaxime, Ceftazidime, Cefalexin, Cefuroxime	As per Microguide® only, outside of this by consultant microbiologist recommendation only
Chloramphenicol	As per Microguide® only, outside of this by consultant microbiologist recommendation only
Co-amoxiclav	As per Microguide® only, outside of this by consultant microbiologist recommendation only
Colistin	Respiratory consultant, Paediatrics and outside of this by consultant microbiologist recommendation only
Co-trimoxazole	*Pneumocystis jiroveci* (PCP) pneumonia or as per Microguide® only, outside of this by consultant microbiologist recommendation only
Clindamycin	As per Microguide® only, outside of this by consultant microbiologist recommendation only
Fosfomycin	As per Microguide® only, outside of this by consultant microbiologist recommendation only
Meropenem	Paediatrics and as per Microguide® only, outside of this by consultant microbiologist recommendation only
Pivmecillinam	As per Microguide® only, outside of this by

Paper copies of this document should be kept to a minimum and checks made with the electronic version to ensure the version to hand is the most recent.

	consultant microbiologist recommendation only
Quinolones: Ciprofloxacin, Levofloxacin, Moxifloxacin, Ofloxacin	Renal consultants, GUM, Paediatrics, As per Microguide® only, respiratory, outside of this by consultant microbiologist recommendation only
Rifampicin	Respiratory, dermatology or cardiology consultant, outside of this by consultant microbiologist recommendation only
Teicoplanin	Paediatrics and as per Microguide® only, outside of this by consultant microbiologist recommendation only
Tobramycin	Respiratory consultant, paediatrics and outside of this by consultant microbiologist recommendation only
Sodium fusidate (Fusidic acid)	Dermatology consultant, outside of this by consultant microbiologist recommendation only. **(Must always be prescribed with a second anti-staphylococcal antibiotic to prevent resistance developing during therapy).**

This table should be completed and added at the end of the document:

Members of the Working Group:

Name	Title
Charlotte Makanga	Consultant Antimicrobial Pharmacist
Kailey Sassi-Jones	Antimicrobial Pharmacist
Rebecca Hetherington	Antimicrobial Pharmacist
Aled Hughes	Antimicrobial Pharmacist
Amir Khalifa	Antimicrobial Pharmacist
Pauline Roberts	Antimicrobial Pharmacist
Suhail Sarwar	Antimicrobial Pharmacist
Stuart D'Arcy	Consultant Microbiologist
Milada Tavodova	Consultant Microbiologist
Azhar Iqbal	Consultant Microbiologist
Deepannita Bhattacharjee	Consultant Microbiologist
Samanthi Welikumbura	Consultant Microbiologist

Engagement has taken place with:

Name	Title	Date Consulted
All Members of ASG		July 2018
All Consultants in BCUHB		September 2018

EQUALITY IMPACT ASSESSMENT FORMS
PARTS A and B: SCREENING AND OUTCOME REPORT

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

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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Betsi Cadwaladr
University Health Board

Part A
Form 1: Preparation

1.	What are you assessing i.e. what is the title of the document you are writing or the service review you are undertaking?	**Restricted Antimicrobial Policy MM TBC**
2.	Provide a brief description, including the aims and objectives of what you are assessing.	The purpose of the restricted antimicrobial policy is to set out a clinical governance framework to promote the safe and prudent prescribing use of antimicrobials The policy applies to all areas within BCU where antimicrobials are used, i.e. secondary care, community hospitals, managed practices, mental health and HMP Berwyn. Policy Aim: To ensure antimicrobials are used in an appropriate and prudent way to ensure patients are not exposed to unnecessary treatment. Policy Objectives: • Restrict and preserve certain antimicrobials for use only when recommended by microbiologists. • Ensure antimicrobials are used only for clear indications and have a clear review/stop date. • Empowering all healthcare professionals to take an active role in antimicrobial stewardship.
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?	• BCU Antimicrobial Prescribing Policy MM10 • BCU Medicines Policy MM01

5.	Who are the key Stakeholders i.e. who will be affected by your document or proposals?	Registered and non registered healthcare staff involved in the safe and prudent use of antimicrobials. Whilst the policy is aimed at staff, the purpose is to ensure patients receive antimicrobials 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. This will provide good antimicrobial stewardship and safeguard antimicrobial for future generations.
6.	What might help/hinder the success of whatever you are doing, for example communication, training etc?	Communication of Policy changes to all key stakeholders

Form 2: Considering the potential impact of your document, proposals etc in relation to equality and human rights

Characteristic or other factor to be considered	Potential Impact by Group. Is it:-		Please detail here, for each characteristic listed on the left:- (1) any Reports, Statistics, Websites, links etc. that are relevant to your document/proposal and have been used to inform your assessment; and/or (2) any information gained during engagement with service users or staff; and/or other information that has informed your assessment of Potential Impact.
	Positive (+) Negative (-) Neutral (**N**) No Impact/Not applicable (**N/a**)	High Medium or Low	
Age	N	N/A	To ensure antimicrobials are used in an appropriate and prudent way to ensure patients are not exposed to unnecessary treatment.
Disability	Neutral	N/A	
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.
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	Antimicrobial prescribing resources such as the Start Smart then Focus poster available in Welsh
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:- • 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 prudent use of antimicrobials. This will ensure antimicrobials are used in an appropriate and prudent way to ensure patients are not exposed to unnecessary treatment.
2. Describe here how your policy or proposal could better advance equality of opportunity (if relevant)	N/A
3. Describe here how your policy or proposal might be used to foster good relations between different groups (if relevant)	N/A

Part B:

Form 4 (i): Outcome Report

Organisation:	BETSI CADWALADR UNIVERSITY HEALTH BOARD

1. What is being assessed? (Copy from Form 1)	**Restricted Antimicrobial Policy MMTBC**

2. Brief Aims and Objectives: (Copy from Form 1)	The purpose of the restricted antimicrobial policy is to set out a clinical governance framework to promote the safe and prudent prescribing use of antimicrobials The policy applies to all areas within BCU where antimicrobials are used, i.e. secondary care, community hospitals, managed practices, mental health and HMP Berwyn. Policy Aim: To ensure antimicrobials are used in an appropriate and prudent way to ensure patients are not exposed to unnecessary treatment. Policy Objectives: - Restrict and preserve certain antimicrobials for use only when recommended by microbiologists. - Ensure antimicrobials are used only for clear indications and have a clear review/stop date. - Empowering all healthcare professionals to take an active role in antimicrobial stewardship.

3a. Could the impact of your decision/policy be discriminatory under equality legislation?	Yes	No	X
3b. Could any of the protected groups be negatively affected?	Yes	No	X
3c. Is your decision or policy of high significance?	Yes	No	X

4. Did the decision	Yes	No	X

scoring on Form 3, coupled with your answers to the 3 questions above indicate that you need to proceed to a Full Impact Assessment?	Record here the reason(s) for your decision i.e. what did Forms 2 & 3 indicate in terms of positive and negative impact for each characteristic? Overall there appears to be a neutral impact on the characteristics and health inequalities as a result of this Policy.		
5. If you answered 'no' above, are there any issues to be addressed e.g. mitigating any identified minor negative impact?	Yes [ ]		X
	Record Details: 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.		
6. Are monitoring arrangements in place so that you can measure what actually happens after you implement your document or proposal?	Yes X		No [ ]
	How is it being monitored?	Via the incident reporting system Datix.	
	Who is responsible?	Division where incident occurred	
	What information is being used?	E.g. will you be using existing reports/data or do you need to gather your own information? Existing incident reporting data	
	When will the EqIA be reviewed? (Usually the same date the policy is reviewed)	In 3 years	

7. Where will your decision or policy be forwarded for approval?	QSE

8. Describe here what engagement you have	The Policy content has undergone extensive consultation.

undertaken with stakeholders including staff and service users to help inform the assessment	Email Consultation to: • Antimicrobial Stewardship Group Members • All Consultants in BCUHB

9. Names of all parties involved in undertaking this Equality Impact Assessment:	Name	Title/Role
	Charlotte Makanga	Consultant Antimicrobial Pharmacist
	Judith Green	Lead Pharmacist Medicine (East)
Please Note: The Action Plan below forms an integral part of this Outcome Report		

Form 4 (ii): Action Plan

This template details any actions that are planned following the completion of EqIA including those aimed at reducing or eliminating the effects of potential or actual negative impact identified.

	Proposed Actions	Who is responsible for this action?	When will this be done by?
1. If the assessment indicates significant potential negative impact such that you cannot proceed, please give reasons and any alternative action(s) agreed:			
2. What changes are you proposing to make to your document or proposal as a result of the EqIA?			

	Proposed Actions	Who is responsible for this action?	When will this be done by?
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 (QSE) Committee **22.1.19**	*To improve health and provide excellent care*
	Advisory Group Chair's Report

Name of Advisory Group:	Quality and Safety Group

Meeting dates:	13th December 2018 & 9th January 2019

Name of Chair:	Mrs Gill Harris, Executive Director of Nursing and Midwifery

Responsible Director:	Mrs Gill Harris, Executive Director of Nursing and Midwifery

Summary of key items discussed:	**Safe Storage of Medicines** Following feedback from the collaborative work it was recognised that there was an Improving picture but further work is needed and ongoing. Chair suggested escalating to the QSE Committee as a positive example of lessons learned, (details included in the December minutes). The chair also thanked the teams across the sites for their work to support this. **Point of care testing** The report was presented following an update from a previous meeting which detailed the gap analysis exercise conducted across BCUHB (secondary care), there has been some slippage from the timescales listed in the original plan, the training and competency assessment is underway and anticipated completion dates have been added for any outstanding areas. It has been identified that additional staffing is needed for which the posts have been agreed, and recruitment planned for next year. There was acknowledgment of the gaps in primary care, and Chair asked for this to be further described to understand any risks. Chair asked for a risk assessment to be conducted in areas and acute sites to bring timescales forward for training, and to use the train the trainer principal. Report did not give the necessary assurance and support for the training programme as needed. Issues have been identified with the ability to release staff to attend the sessions.

	Ward Kitchens/Environmental inspections Concern was raised following the annual inspections from the Local Authority being undertaken, a review of the ward kitchens was conducted, which showed indicative results with some having a food hygiene score of 1. Group were informed that failure to act on the findings of this audit report means that the HB would not be complying with Food safety legislation and could have significant effect on the food hygiene scores, to mitigate this risk decisions need to be taken about the management of food at a ward level. Findings and recommendations were discussed which included removing all food from the ward kitchens (yoghurts/sandwiches etc). *Group accepted the report and the recommendation for centralisation of the system with options for access to food during out of hour's i.e. snack boxes. Further updates to be provided.* **EMS Site – Mechanical Infrastructure – Rod Taylor** Following recent Mechanical and Engineering surveys and onsite inspections at Wrexham Maelor Hospital it has been identified that the existing pipework of both Domestic Hot Water & Heating suppling services to the EMS site is of an age where there is a significant risk of failing. These risks have the potential to impact on key clinical services which operate from the EMS part of the Wrexham Maelor site. Work has now commenced on developing Business Continuity Plans for critical services lead by the Hospital Director and Director of Estates and Facilities and a full update would be provided to the meeting in February.
Key advice / feedback for the QSE:	A further paper to include options for Ward Kitchens/ EHO inspections was produced and presented to QSG in January and the group accepted the recommendations. Group asked for an additional paper for Point of Care testing to include how we are going to mitigate risks, benefit of additional staff, support to cascade the training and support needed , it will also include recommendations on how to take the training forward. **This will be presented at the February meeting and feedback provided to QSE.** There is a delay in ophthalmology outpatient appointments. A review group has been established to review the current workload and establish how to creating further capacity. There was no immediate solution but this was being closely monitored and mitigations are in place. A report regarding the Wrexham EMS Infrastructure detailing areas

	of mitigation would be presented to the February meeting.
Special Measures Improvement Framework Theme/Expectation addressed	Leadership and Governance
Planned business for the next meeting:	To be determined from cycle of business
Date of next meeting:	Wednesday 13th February 2019

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

Advisory Group Chair's Assurance Report Template V4.0 June 2016

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To improve health and provide excellent care

Report Title:	HASCAS independent investigation and Ockenden governance review: progress report
Report Author:	Mrs Deborah Carter, Associate Director Quality Assurance
Responsible Director:	Mrs Gill Harris, Executive Director of Nursing & Midwifery
Public or In Committee	Public
Purpose of Report:	The paper provides the progress updates as at the end of Q3 against the recommendations arising from both the HASCAS independent investigation and the Ockenden governance review
Approval / Scrutiny Route Prior to Presentation:	The Improvement Group and Stakeholder Group meetings review, monitor and scrutinise the work and progress of the recommendations
Governance issues / risks:	Work is underway to identify any additional resources required to progress the work identified to deliver improvements and address the recommendations.
Financial Implications:	A paper will be submitted to Executive Team setting out the additional resources and any related costings, including any additional workforce requirements, for their approval.
Recommendation:	To note the progress of the HASCAS & Ockenden recommendations

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

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

Special Measures Improvement Framework Theme/Expectation addressed by this paper

Mental Health
Leadership and Governance

Equality Impact Assessment

Board/Committee Coversheet v10.0

HASCAS Investigation and Ockenden Governance Review Progress Report as at January 2019

Background

In the autumn and winter of 2013 a series of events occurred which brought issues of concern regarding care on Tawel Fan Ward to the attention of senior staff within the Health Board. This led to the ward being closed in December 2013.

In January 2014, Donna Ockenden was commissioned by the Health Board to conduct an external investigation into the concerns raised and her report was published in May 2015.
http://www.wales.nhs.uk/sitesplus/documents/861/tawel_fan_ward_ockenden_internet.pdf

In August 2015 the Health Board commissioned an Independent Investigation to be undertaken by HASCAS Consultancy Limited into the care and treatment which had been provided on Tawel Fan Ward. The outcome of the Independent Investigation was the provision of three separate outputs which included:

- A thematic "Lessons for Learning" report
- Detailed Individual Patient reports to support the Putting Things Right process
- Individual Staff reports to support employment processes

The conclusions and findings of the thematic lessons for learning report were published in the '*Independent Investigation into the Care and Treatment provided on Tawel Fan Ward: A Lessons for Learning Report* 'on the 3rd May 2018 and included 15 recommendations. The full report and executive summary can be found via the following links:-

http://www.wales.nhs.uk/sitesplus/861/page/75258/
http://www.wales.nhs.uk/sitesplus/861/page/94107

Alongside the HASCAS investigation, a governance review was commissioned by the Health Board which was undertaken by Donna Ockenden. This review focussed on the governance arrangements relating to the care of patients on Tawel Fan Ward prior to its closure and current governance arrangements in older people's mental health services within the Health Board. The findings of the Ockenden Governance Review were received at the public Board meeting on 12th July 2018.
http://www.wales.nhs.uk/sitesplus/861/page/75258

On the 12th July at its public Board meeting, the Health Board considered a paper which contained the initial response to the HASCAS report and approved the governance and reporting arrangements which would oversee the implementation of the recommendations from the HASCAS report and the Ockenden Governance review. At this meeting the Health Board also approved the establishment and terms of reference for an Improvement Group to respond to the recommendations arising from both HASCAS and Ockenden reports as well as a Stakeholder Group to strengthen and guide the work of the Improvement Group.

Both the Improvement Group and the Stakeholder Group have now been established with membership agreed and confirmed in line with the respective terms of reference for both groups (attached at Appendix 1).

The inaugural meeting of the Improvement Group was held on 16th August 2018, and chaired by the Executive Director of Nursing & Midwifery, where the Group received status and progress updates from each of the operational leads who had been given delegated responsibility for specific recommendations. This included developing metrics and achieving milestones where these had been set in the reports as well as agreeing ones for where they had not. The leads also described progress towards achieving the outcomes of the recommendations. The second meeting of the Improvement Group was held on 23rd October and meetings are scheduled bimonthly throughout 2019 where progress reports are presented by each operational lead as well as monthly highlight reports submitted to the Executive Director of Nursing & Midwifery and an internal tracker tool developed for performance monitoring purposes.

The Stakeholder Group, which is a subgroup of the Improvement Group, has confirmed 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 6 Tawel Fan family members. The first meeting of the stakeholder group was held on Monday 8th October and was conducted in the form of a workshop, facilitated by the Associate Director of Quality Assurance and the Director of Partnerships for Mental Health & Learning Disabilities. The workshop aimed to engage with the members to:

- Establish Group Values
- Agree required outcomes
- Consider a 12 month forward view in the form of a work programme
- Establish individual areas of interest and intent to support

The group also reviewed the terms of reference for the group in order to consider their role in respect of scrutiny, advice, support, challenge and endorsement of the work being undertaken to deliver the required improvements. Members of the psychology service were also in attendance at the meeting to offer support to members if required.

The Stakeholder Group is required to meet quarterly, however, at the request of the members at the first meeting, an additional meeting was scheduled within 6 weeks, due to discussions around the amount of work and pace of progress, within a schedule of meetings being held on a quarterly basis. This second meeting was subsequently held on 19th November and enabled discussion and review of a proposed cycle of business for the work of each recommendation. Stakeholder Group members have also put themselves forward as members of any task and finish groups that have been established for specific recommendations, where they hold a particular interest and wish to contribute and support ensuring the views of stakeholders are incorporated into this important programme of work. Meeting dates have been scheduled quarterly throughout 2019.

On 1st November 2018, the Health Board received a paper providing an update against the recommendations of both the HASCAS and Ockenden recommendations as well

as confirmation of the establishment of both the Improvement Group and Stakeholder Group. The update presented by the Executive Director of Nursing & Midwifery reported positive progress following establishment of both the Improvement Group and Stakeholder Group. A piece of work was now being undertaken to review overall costs and required resources with the support of workforce and finance teams for consideration by the Executive Team.

Early positive feedback had been received from third sector representatives who had attended the first Stakeholder Group event and assurance was provided that the Health Board has been reviewing and strengthening its approach to partnership working and relationships with local authorities were also being maintained.   In particular, the membership of the Regional Partnership Board has been strengthened and an event was held in January 2019 to share strategic issues and identify principles for improved collaboration. Further work is also underway to build further on relationships with the sector, with discussions taking place with third sector leaders and through the Health Board's Stakeholder Reference Group. This work is taking place alongside the development of the Health Board's three year plan and identification of priorities for 2019 onwards.

All recommendations from both the HASCAS and the Ockenden reports have been mapped together to ensure the necessary actions identified are embedded across the organisation and are not dealt with in isolation.

Table 1 below summarises the recommendations from both reports and sets out the blended governance and oversight arrangements.

This report provides updates against the recommendations as at the end of quarter 3, December 2018 and further progress updates will be reported to future board meetings no less than quarterly.

Table 1

HASCAS	Ockenden	Executive Sponsor	Operational Lead	Oversight Group
1. Care Pathway and Service Redesign	**1**.Review and redesign service model for older people and those with Dementia **12**. Older Persons Strategy	Executive Director of Strategy	Deputy Director of Nursing	Older Persons Group / Regional Partnership Board.
2. Dementia Strategy	**8**. Dementia Strategy	Executive Director of Nursing & Midwifery	Area Director for Clinical Services (West)	Dementia Clinical Network Group
3. Care Homes and Service Integration		Executive Director of Nursing & Midwifery	Deputy Director of Nursing	Older Persons Group / Regional Partnership Board
4. Safeguarding Training		Executive Director of Nursing & Midwifery	Assistant Director Safeguarding	Corporate Safeguarding Group
5. Safeguarding Informatics and Documentation		Executive Director of Nursing & Midwifery	Assistant Director Safeguarding	Corporate Safeguarding Group
6. Safeguarding Policies and Procedures		Executive Director of Nursing & Midwifery	Assistant Director Safeguarding	Corporate Safeguarding Group
7. Tracking of Adults at Risk across North Wales		Executive Director of Nursing & Midwifery	Assistant Director Safeguarding	Corporate Safeguarding Group

HASCAS	Ockenden	Executive Sponsor	Operational Lead	Oversight Group
8. Evaluation of Revised Safeguarding Structures	**6**. Safeguarding structures	Executive Director of Nursing & Midwifery	Assistant Director Safeguarding	Corporate Safeguarding Group
9. Clinical Records		Executive Medical Director	Chief Information Officer	Health Records Group
10. Prescribing and Monitoring of Anti-Psychotic Medication		Executive Medical Director	Chief Pharmacist	Safer Medication Group
11. Evidence Based Practice	**2a.** Quality impact assessment **2b.** Integrated reporting **3**. Policy review **10.** Reviewing external reviews **14.** Board development	Executive Director of Nursing & Midwifery	Deputy Board Secretary	Quality and Safety Group
12. Deprivation of Liberties	**9.** Deprivation of Liberties	Executive Director of Nursing & Midwifery	Assistant Director, Safeguarding	Corporate Safeguarding Group
13. Restrictive Practice Guidance		Executive Director of Workforce & OD	Director of Nursing (Mental Health)	Quality and Safety Group (Corporate)
14. Care Advance Directives		Executive Medical Director	Senior Associate Medical Director	Palliative Care Group

HASCAS	Ockenden	Executive Sponsor	Operational Lead	Oversight Group
15. End of Life Care Environments		Executive Medical Director	Senior Associate Medical Director	Palliative Care Group
	2c. Workforce development **4a.** Staff engagement **4b. & 4c.** Staff surveys **4d.** Clinical engagement **13.** Culture change	Executive Director Workforce and Organisational Development	Head of Organisational and Employee Development	Workforce Senior Leadership Team / Staff Engagement Group
	2d. Consultant Nurse in Dementia	Executive Director of Nursing & Midwifery	Director of Nursing Mental Health	N/A
	5. Partnership working	Director Mental Health and Learning Disability	Director of Partnership Mental Health and Learning Disability	Together for Mental Health Partnership Board
	7. Concerns management	Executive Director of Nursing & Midwifery	Associate Director Quality Assurance	Quality and Safety Group
	11. Estates Older Persons Mental Health (OPMH)	Executive Director of Finance	Director of Estates and Facilities	Task Group

Recommendations updates

The following updates are provided against each of the recommendations in order of the sequence of the mapping described in Table 1:

HASCAS 1:   Care Pathway & Service Redesign
HASCAS 3:   Care Homes and Service Integration
Ockenden 1:   Review & Redesign service model for older people and those with dementia [progress update required by end of Sept]
Ockenden 12: Older Persons Strategy

Three emerging themes have been identified for the above recommendations:
i) <u>Organisational culture</u>; including corporate & clinical governance and stakeholder relationships
ii) <u>Strategy & planning</u>; care pathways, service redesign for Older Persons Mental Health (OPMH) and care homes & service integration
iii) <u>Organisational learning</u>; including knowledge & skills, training & development and information management

Work has progressed to identify the interdependencies of the older person strategy alongside recommendations 2, 3 and 5 and a programme and scoping exercise has now been completed that includes the identification of all existing strategies currently in place. This initial scoping exercise has helped inform the Health Board's HASCAS & Ockenden delivery plan, the objective of which is to support the overarching integrated pathways for older persons and those with dementia. This will ensure that there is a focus on clinical redesign and integration, education and the integration with the care home sector.

An exercise has also been completed to scope out all interlinking Older Persons forums and groups to ensure consultation and engagement take place across the organisation.   The Quality Safety Group meeting in January received an update on the end of life care pathway for Older Persons Mental Health and approved the draft Standard Operating Procedures presented to the group 'End of Life Care for the Person with Dementia under the care of In-patient Mental Health Services', ('*One chance to get it right*').

Extensive work has been undertaken within BCUHB and the North Wales Regional Partnership Board in relation to care services across North Wales for the older person. In February 2019, a partnership event will be held, which will identify and review the significant work underway in both health and social care services, in addition to the care provider sector. This work will inform a gap analysis to aid the future delivery plan.

Joint working has also commenced with the Older Persons Commissioner for Wales' office and support gained to help advise on future delivery plans.

A North Wales training programme for 'Care of the Older Person and those with Dementia' has been developed in specific relation to knowledge and skills around the care of the elderly. This involves a basic module to be made mandatory to be accessible to all health and social care staff, care providers and families and will

ensure consistent delivery of training material for all services that deliver care to the older person. Furthermore, an advanced programme will be developed with Glyndwr and Bangor universities, for postgraduates.

A North Wales wide joint clinical event for BCUHB and Care Home staff will be held in the beginning of Quarter 4, for ward staff and care home managers, to capture shared experiences and learning; encourage team building; and most importantly improve relationships and communication across all acute, community and care home settings. Furthermore, this will help identify the work needed to improve clinical pathways for integration and the future development of a long term clinical strategy.

A 'Pledge of Principles' has been developed by a small partnership working group to raise awareness around the good practice principles of cross-sector working, which aim to refresh and raise awareness about the care philosophy that underpins staff culture and effective ways of working in true collaboration.

A delivery plan on the Health Boards support into North Wales Care Homes has been developed following the HIW report and a meeting is scheduled for January 2019 to discuss the implementation and outcomes to help inform the future delivery plan and long term clinical strategy.

Risks and Issues
- A joint and clear action plan with milestones and timelines is in place to mitigate risk to delivery of outcomes, particularly given the review of a broad range of services across the Health Board within required timescale.
- An agreed partnership approach will be taken when reviewing services to ensure validation of data between NHS reporting and local authorities.
- Joint responsibility will be undertaken in ensuring translation of strategy into action in response to workforce capacity and resource for transformation to avoid duplication and conflicting agendas.
- An agreed set of principles will be developed in partnership together with quality and safety standards to inform the model of care and strategy to ensure sustainability and differing standards of quality & safety of services across multiagency providers and commissioners of care.

HASCAS 2 & Ockenden 2: Dementia Strategy

The Health Board's Dementia strategy was co-launched in February 2018 by the Executive Director of Nursing & Midwifery and the Regional Director for Alzheimer's Cymru. The strategy emphasises the importance of how best to support individuals within their environments, whether this be at home or within a healthcare setting. A draft high level action plan has been developed and is being reviewed including the financial details required around some of the delivery areas. The Health Board will be working within the framework of working towards becoming a dementia friendly organisation in line with the Alzheimer Society's dementia friendly communities programme. The three District General Hospitals, Emergency Departments, main Out-Patient Departments, Older Person's Mental Health services and Learning Disability services have project leads and action plans in place for this work. In December 2018 Ysbyty Gwynedd become the first acute hospital site in Wales to achieve Dementia Friendly status.

A task and finish group responding to Recommendation 2 has been established and terms of reference agreed. The remit of this group is to support the development of the action plan and monitor the delivery of the priorities and objectives defined within the HASCAS report. The first two meetings have taken place in November and December 2018, with project support identified to progress the action plan.

HASCAS 13: Restrictive Practice Guidance

Relevant guidance has been reviewed by the operational lead and the Improvement Group have acknowledged that there was more recent and up to date NICE guidance (NG10, 2015) than that referred to in part 2 of Recommendation 13 (RCP, March 2007). This has been considered alongside the updated Mental Health Code of Practice and quality standards on how to support and assess people with dementia and how to manage behaviours which challenge.

The Task & Finish Group for Recommendation 13 has been very well represented from all areas of the Health Board and output from the group has enabled us to deliver a number of complex issues at pace. Terms of Reference for Recommendation 13 Task & Finish Group have been refreshed and revisited to ensure focus on the HASCAS recommendation and provide assurance, that all older adults and those with dementia, receive lawful and safe interventions in relation to restrictive practice management across all care and treatment settings within BCUHB.

The Health Board Area Directors and Secondary Care Nurse Directors have undertaken a scoping exercise for restraint training and reviewed the scoping of restraint reporting. The Health Board's Restrictive Physical Intervention (RPI) policy has been ratified at the Policy Approval Group and Quality, Safety & Executive committee.

A benchmarking exercise has been undertaken across all areas against the policy implementation and the outcomes of this will be presented to Quality & Safety Group in January 2019.

A Proactive Reduction & Therapeutic Management of Behaviours which Challenge Policy has also been developed to support the delivery of Recommendation 13 and monitoring actions are in place to ensure it is achieved.

The requirement for a project management post has been submitted to lead on education, training and embedding positive management of behaviours to support the current programme of all Wales training passport modules A-C.

Identified processes are in place for patients within acute physical healthcare settings and who are distressed, due to a deterioration in mental health issues / symptomology, who will be assessed by liaison psychiatry and supported by MH&LD violence & aggression team.

Reporting of restraint incidents is being uniformed across the organisation utilising Datix as the reporting mechanism, training is being delivered to compliment a consistent approach of reporting, across the Health Board.

Ockenden 2d: Consultant Nurse in Dementia

The additional Consultant Nurse with a special interest in Dementia post has been advertised and interviews are scheduled for the 15th January 2019. The aim is to have a representative of the Stakeholder Group as part of the panel. Recruitment to this post is an essential step in response to the recommendations.

The Health Board are also working with Bangor University to review other roles including Advanced Nurse Practitioners to support people in their own homes.

HASCAS 4: Safeguarding Training
HASCAS 5: Safeguarding Informatics and Documentation
HASCAS 6: Safeguarding Policies & Procedures
HASCAS 7: Tracking of Adults at Risk across North Wales
HASCAS 8: Evaluation of Revised Safeguarding Structures
Ockenden 6: Safeguarding Structures
HASCAS 12 & Ockenden 9: Deprivation of Liberties

Following a scoping exercise across the whole of the safeguarding portfolio over the last 2 years, a thematic report and action plan including benchmarking are now in place. A further review has been undertaken of the Safeguarding Governance & Performance Group including membership to ensure the Terms of Reference enable the delivery and accountability of the HASCAS and Ockenden recommendations. A safeguarding dashboard has been developed and implemented and safeguarding has been included within the ward dashboards. Going forward a safeguarding communication strategy will be developed.

A scoping exercise has been undertaken of safeguarding policies and procedures and a matrix has been developed for monitoring, updating and implementation.

A Standard Operating Procedure (SOP) has been developed for adults at risk documentation, to support engagement, decision making and internal reporting and escalation. A revised and improved adult at risk reporting tool and database has been implemented.

Appointments have been made to several posts including Safeguarding Practice Development Lead, Safeguarding Data Analyst and a Business Manager.

All training packages have been reviewed and updated in line with legislation. A scoping exercise has been completed on training activity which has identified key areas of focus and the implementation of revised training packages and training methods.

A review has commenced of the Deprivation of Liberty (DoLs) service to identify and address the gaps in the service and ensure effective and efficient service delivery. Following the review, a position paper regarding the DoLs service and proposed requirements for the DoLs service and team will be presented at the Quality and Safety Group March 2019. A training package and governance framework has been developed for DoLs signatories this is to provide a monitoring framework of support, guidance and governance and to address the low numbers of signatories, relevant

staff are being identified for training, with a target of a minimum of 6 staff to be trained each month.

A new safeguarding web page has been developed with an implementation date of 21st January 2019 following which an external internet page will be developed for the public.

HASCAS 5: Safeguarding Informatics & Documentation
HASCAS 9: Clinical Records

Work has commenced in respect of training and communication in the use of safeguarding dividers within the clinical record and identified the need for a Standard Operating Procedure to be developed that will provide guidelines on filing and storing of safeguarding information to ensure consistency across all specialities. GRK training will be revised to include a section on filing of safeguarding information and uptake will be monitored by the Electronic Staff Record (ESR).

Significant work has commenced on the transfer of management of the Mental Health patient records within the same portfolio as acute patient records, under the Health Records service. The scope of this work has been expanded by the Executive Team of the Health Board in response to this and other regulatory recommendations (e.g. ICO Audit) to review the management arrangement for ensuring good record keeping across all patient record types including *Mental Health (inc. CAHMS, Drug and Alcohol services); Radiology, Audiology, Posture & Mobility Service (formerly ALAC), Sexual Health, Speech and Language Therapy, Community Hospitals, Child Health, Podiatry, Emergency Department, Physiotherapy, Occupational Health, Acute Records, Oncology, Midwifery, Genetics, Diabetics, Primary Prisoner Clinical Record*, all of which are now under the portfolio of the Executive Medical Director.

The 'Patient Records Transformation Programme' is being established with the Executive Medical Director as the Executive Lead and SRO, and will focus on 4 key areas of work; *ATHR under GDPR*, *Infected Blood Inquiry*, *Retention of Oncology Information within the Acute Record*, and the Project for this piece of work *'Management of BCU Patient Records'*

Phase 1 of this specific project will initially aim to deliver the following objectives of the overall programme to ensure:
- Objective 4: A baseline is in place that maps out the storage, processes, management arrangements and standards compliance, for all types of patient records, by (date).
- Objective 5: To present the recommendations and funding requirements to work towards PAN-BCUHB compliance with legislation and standards in patient records management across all case note types.

In order to progress this project which will meet the recommendations in both the HASCAS and Ockenden reports, and to ensure sustainability in mitigating against future risks, resource requirements to deliver this Programme have been identified and will be submitted for executive approval. Recognising that there will be many demands on limited resources; the Chief Information Officer is seeking to prioritise areas of

informatics funding to secure the senior 8b post required, however, funding for the Band 7 Project Manager will require additional funding.

HASCAS 10: Prescribing & Monitoring of Anti-Psychotic medication

The Health Board has recently updated guidance on prescribing antipsychotic medication in the presence of a dementia diagnosis (MM17) which will be subject following implementation, to a full audit within 12 months of the HASCAS report publication.

A medicines reconciliation audit was undertaken in Wrexham on the completion of an accurate drug history, within 24 hours of admission. This demonstrated that 24 hour targets are not consistently being met due to lack of pharmacy staffing on the OPMH wards, this can result in errors and omissions and the potential for patient harm. An improvement plan has therefore been developed which for the use of anti-psychotic medication, will mean that patients with a diagnosis of dementia will have 3 monthly reviews of any antipsychotic medication in use upon discharge.

A CAIR (checklist for antipsychotic initiation and review) chart has been prepared and distributed to all OPMH and CMHT teams across the MHLD Division (October 2018). Work is ongoing to continue to implement the use of the CAIR antipsychotic form and highlight best practice, particularly in care homes. The CAIR form and a letter has also been circulated to GPs and practice pharmacists for information.

Key to this work is the consistent availability of pharmacists or technicians on the wards and in CMHTs or memory clinics to support and embed change. This is being scoped and will be presented through the improvement group.

Monitoring

At present the pharmacy department is reviewing the capacity to support OPMH and care homes to deliver medicines optimisation in line with national recommendations and will report this back through the Improvement Group.

Care homes are not currently reporting on the use of anti-psychotics and length of treatment. In order to address this, a care home proforma is in development and will be progressed through the care home subgroup of the primary care pharmacists group. This will enable care homes which need support to be identified and targeted for intervention. In addition an all wales audit is being carried out in 2019 – 20 to identify the number of people with dementia who are prescribed antipsychotics.

The MHLD lead pharmacist for the Health Board will work with the Nurse Consultant in Dementia to ensure that training includes relevant information around psychotropic medication for frontline staff. A business case is being prepared to support a MDT project initiative. The anti-psychotic initiation and review (CAIR) chart will be used for people within the division and then rolled out across secondary care and community settings.

Also in line with the WG recommendations on antipsychotic prescribing, a project is being set up to trial the use of an ADRe (Adverse Drug Reaction profile) for use within

care homes / OPMH wards. This will aim to improve the documentation of care, side effects and monitoring, relevant to the use of all psychotropic drug usage. This has been implemented in Swansea where there was a notable reduction in falls as a result of the project.

Audit
Information is published annually in relation to the use of antipsychotics in care homes, benchmarked against NICE guidance and Welsh targets for patients with a diagnosis of dementia and this data was collected in primary care in 2017. The WG national audit of antipsychotic use in primary care is under consultation and is expected to deliver this recommendation once the audit implemented.

A community pharmacy care homes National Enhanced Services (NES) is in place to monitor antipsychotic use in care homes, to which only 5 pharmacies are currently signed up. Further work is ongoing to ensure all pharmacies that supply BCUHB care homes are signed up to the NES.

An audit of 'antipsychotics prescribing' including non-drug measures used to prevent behaviours that challenge is being planned jointly with the Consultant dementia nurse for February 2019 in line with HASCAS recommendations, and the National primary care audit on prescribing of antipsychotics in dementia is being planned for 2018-19 .

Implementation

A business case has is being prepared to fully support implementation and recommendations to increase pharmacy support to MHLD in order to support the full HASCAS recommendations including Recommendation 10.

HASCAS 11: Evidence Based Practice
Ockenden 2a: Quality Impact assessment
Ockenden 2b: Integrated reporting
Ockenden 3: Policy review
Ockenden 10: Reviewing external reviews
Ockenden 14: Board Development

The Board in September 2018 adopted revised arrangements for Board and Committee meeting arrangements to respond to the findings and recommendations of the Deloitte report into financial governance, the Wales Audit Office Structured Assessment for 2017, and the advice of the Specialist Adviser to the Board.

http://www.wales.nhs.uk/sitesplus/documents/861/Agenda%20bundle%20Board%20Public%206.9.18%20V2.0.pdf

The revised arrangements are intended to further improve and strengthen the effectiveness of the Governance Arrangements of the Board and its Committees, ensuring greater oversight and challenge in key areas by Independent Members and the ability for Executives to have an increased focus on turnaround and operational productivity. The revised arrangements seek to ensure appropriate time between meetings for follow up actions to be taken forward, whilst maintaining the ability to provide timely financial and performance reports to the Board and its Committees.

Failings in the health and social care systems in the past have highlighted the on-going need for greater focus on the impact on quality when considering cost improvement or efficiency related changes. A system is in place for Quality Impact Assessment (QIA) of savings schemes and progress will be measured from samples of completed QIAs and a record of outcomes and as part of the internal audit programme 2019/20. No changes, schemes, or indeed overall financial plans, will be approved without first having received appropriate assurances that the impact of the proposed changes on quality have been appropriately assessed and are, in the worst case neutral but at best are aiming for an improvement in quality. With an increased focus on cost containment and improving efficiency managers have been tasked with ensuring that any projects or schemes to help achieve this aim have due regard for the impact on service provision.

The Board has also sought to strengthen its decision making with a clear focus on quality and affordability and had revised its coversheet template to expressly include a requirement to document financial implications of any proposals. In addition, the Terms of Reference of the Finance and Performance Committee of the Board have been modified in this respect.

Following changes in the Executive portfolios and weaknesses identified in the effectiveness of the performance and accountability framework, the arrangements in place have been subject to detailed review. A revised framework has been considered by the Executive Management Team and was subsequently discussed at a Board Workshop in autumn 2018. The key principles set out in the revised framework include supporting the organization in delivering:

a) The strategy set out by the Board through the IMTP or Operational plan
b) Operational ownership of the key organizational priorities across services and at each level in the organization
c) Clarity of expectations as to level of performance expected within resources allocated to services
d) Decision-making based on visible performance information triangulated across key indicators
e) Opportunity for accountable officers to discuss support needed to achieve expected levels of performance
f) Opportunity for accountable officers to discuss support needed to achieve expected levels of performance
g) Challenge to accountable officers through a holding to account mechanism for areas where performance falls below expectations.
h) Clarity as to outcomes and consequences of poor performance through clear escalation process

Revised 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.

Work has been underway for some months to review the Health Board's arrangements for managing BCU wide policies, procedures and other written control documents

(WCDs). Part of this has involved the review of the Policy on Policies together with a new intranet page. The revised policy and intranet page were launched in September 2018.

Numerous sessions have been held between October and December to ensure Directorate Governance Leads are fully conversant with the new policy and the transfer arrangements to the new intranet location. In order to avoid any confusion or risk, staff, particularly clinical staff not being able to access documents quickly (from their former locations) transition arrangements are in place. One to one meetings with the Leads have been taking place to confirm which documents can move across to the new site and from what date and to agree dedicated communication plans for various cohorts of policies in terms of the key target audience. Access to the documents from the old location will remain active for an initial period but these links will be withdrawn over time and substituted with redirection notices. Staff feedback on the new arrangements has been encouraged (agreement in terms of the timeline for transition leading to final arrangements will be agreed by the end of April 2019).

The new Policy on Policies appends a new template which also includes a table showing the approval route for various types of document. 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. Authors of Policies, Procedures and other WCDs have also been reminded of the need to undertake an Equality Impact Assessment on all Health Board wide Policies and Procedures to ensure that decisions do not discriminate against people based on any protected characteristic. Environmental Impact Assessments also need to be undertaken where appropriate.

In relation of BCU wide clinical policies the Corporate Nursing Team have undertaken a clinical policies mapping exercise to determine the location and current status of all clinical policies. These clinical policies have been risk assessed in terms of prioritising those that require urgent review under the direction of the Executive Clinical Directors. In line with the existing policy on policies the Quality, Safety and Experience Committee of the Board must approve clinical policies. From August 2018 an additional step has been added to the ratification and approval process with all new or refreshed clinical polices being scrutinised by the Quality and Safety Group to ensure they are fit for purpose and are evidence based. In addition to this a BCU wide mapping exercise has been undertaken to assist Leads in identifying all linkages to existing intranet documentation supported by the Compliance Officer.

Reviewing External Reviews – Work has been undertaken to strengthen assurances around external reports produced in respect of the Health Board. The Corporate Nursing Team have undertaken a review of all HIW inspections from July 2017 to July 2018 to identify findings, recommendations and actions which were applicable to older people and specifically the care of older people with mental health concerns. All open/outstanding actions arising from these inspection reports continue to be monitored/managed on a monthly basis by the Quality and Safety Group. In addition to the review as detailed above, it should be noted that a BCUHB/HIW Management plan was ratified at the June 2018 Quality and Safety Group and has been circulated

to all Leads. This Management Plan has introduced the following additional assurance processes:

- Members of the Corporate Nursing Team complete regular post HIW inspection walkabouts (approximately six months post inspection) to review both closed and open/outstanding actions to identify areas of good practice, if actions/recommendations have been sustained and to offer support where required for open/outstanding actions;
- The Corporate Nursing Team hold regular meetings with Governance/Local Leads to progress action plans and review both open and outstanding actions to provide support where required, share learning and celebrate success.
- The Corporate Nursing Team to work with Governance Local Leads post inspection to ensure SMART action plans are developed in response to HIW inspection findings/recommendations.
- Pan BCUHB level actions (identified during local HIW inspections) are taken to the Quality and Safety Group for review and to identify/allocate a Lead.
- Thematic Analysis of HIW findings from 2015 to date has been undertaken by the Informatics Team to inform future improvement plans/learning.

The actions as outlined continue to be implemented in accordance with the agreed HIW Management Plan which can be accessed via the following link.
http://howis.wales.nhs.uk/sitesplus/861/page/74145

In addition to this the Office of the Board Secretary has established a database to capture all externally commissioned/produced reports such as the Delivery Unit, Royal Colleges, Commissioners etc. to ensure such reports are centrally logged and a lead officer identified. Further work is being undertaken to improve the system for recording external reports to ensure logging, cascade and follow up are automated as far as possible. Discussions have taken place with the All Wales Board Secretaries Group to share best practice. Resources in this area have also been strengthened with the assignment of a Compliance and Assurance Manager. These improvements will ensure that the system logging those reports is robust. This system has recently been expanded to capture applicable recommendations originating from National Assembly Wales (NAW) Committee Business. The relevant Committees are as follows:
- Children, Young People and Education Committee
- Climate Change, Environment and Rural Affairs Committee
- Committee for the Scrutiny of the First Minister
- Constitutional and Legislative Affairs Committee
- Culture, Welsh Language and Communications Committee
- Economy, Infrastructure and Skills Committee
- Equality, Local Government and Communities Committee
- External Affairs and Additional Legislation Committee
- Finance Committee
- Health Social Care and Sport Committee
- Petitions Committee
- Public Accounts Committee

NAW Committee business (agendas and minutes) is monitored by the Compliance and Assurance Manager. Items of note (Inquiries, Petitions, Reports, Recommendations, and Consultations) are logged and reviewed by the Office of the Board Secretary Senior Management Team. Where applicable, items are added to the TeamMate electronic monitoring system and reported via the Audit Committee.

In relation to Board Development, the Executive Director of Nursing and Midwifery has given consideration to Ockenden Recommendation 14 and has determined that this ambition will best be met by the full Board undertaking dementia training which will be delivered on 10.1.19 to be led by the Consultant Nurse (Dementia) and a Service User National Champion.

HASCAS 14: Care Advance Directives
HASCAS 15: End of Life Care Environments

Work is underway to embed and roll out Advanced Care Planning. Clarification has been sought with HASCAS that the ongoing work is for planning, not directives, as cited in the report.

In relation to Treatment Escalation Plans (TEPs) and DNACPR, significant progress has been made with increasing numbers of end of life conversations taking place within community and hospital settings. Communication with families is being encouraged to share decision making and identify common goals. Learning from the initial pilot of TEPs implementation in the community will inform further roll out.

The National Audit for Care at the End of Life (NACEL) The National Audit for Care at the End of Life (NACEL) was carried out nationally in 2018, and in BCUHB was led by the Performance Directorate. The North Wales Department for Specialist Palliative Care contributed to the data collection and the full audit of organisational data for end of life care in hospital settings, was submitted by the Performance Directorate; results awaited early 2019. The National Audit of Dementia (NAD), both audits have been added to the National Clinical Audit & Outcome Review Plan (NCAORP) Welsh Government programme of mandatory projects for 2018/19.is currently underway being led by Dr Andrew Shuler (Consultant in Palliative Medicine) and the National Audit of Dementia (NAD), both audits have been added to the National Clinical Audit & Outcome Review Plan (NCAORP) Welsh Government programme of mandatory projects for 2018/19.

In respect of End of Life Care environments, a task and finish group has been established and has met to determine the actions required. These have been developed further into a SOP to support delivery of high quality end of life care on Older Person's Mental Health Wards (OPMH) and training has commenced for Older Persons Mental Health (OPMH) nurses in respect of this guidance and SOP to improve the end of life care environment on OPMH wards. In addition a process is in place to monitor paperwork for inpatient deaths for patients receiving palliative & end of life care. This has been developed by the North Wales Department for Specialist Palliative Care to ensure a full complement of nursing staff are trained in this area and know how to access additional support from palliative care services. Staff training commenced in early December 2018 and a further six study days are being held

monthly (January – June 2019), in addition to staff from OPMH wards being able to access further training on a regular basis.

A dementia care pathway has been developed with the Alzheimer's Society.

Ockenden 2c: Workforce Development
Ockenden 4a: Staff engagement
Ockenden 4b & 4c Staff surveys
Ockenden 4d: Clinical engagement
Ockenden 13: Culture change

A draft Workforce Strategy is in place which details workforce improvements aligned to organisational priorities. Work has progressed in the following areas:
- The Team Survey element of the Go Engage tool which has been rebranded for the organisation as 'ByddwchYnFalch / BeProud' is being deployed to support the Older People care Pathway as a priority. Teams will commence training in engagement improvement work in March 2019, each team will produce a team level 6 month improvement plan supported by the Organisational Development Team.
- NHS Wales Staff Survey intelligence is being used to drill down into priority areas in order to develop meaningful team/department level improvement plans to support improved engagement, staff workplace experience and culture.

Ockenden 5: Partnership working

The Health Board recognise the importance of working effectively at a strategic level with the voluntary sector and wide range of multi-agency partners and is set out within the mental health strategy. Different ways of partnership working are being considered to develop, provide and sustain services to older people and those older people with mental health needs and dementia and a strategy implementation structure is in place. Local implementation teams are established with the third sector and including wider partner representation Engagement sessions have been held with third sector providers to develop themes and reports to ensure clear alignment to achievement of outcomes and objectives.

All mental health third sector contracts / grants for 2016/17 will be reviewed to inform strategy development in line with the dementia plan and the Health Board's *living healthy, staying well strategy* in relation to older people and older people with mental health needs. This will ensure a more diverse range of delivery models and fully implemented effective contract management arrangements.

A commissioning framework will be completed via the mental health commissioning group with a commissioning plan developed setting out clear intentions. A commissioning lead will be appointed within the agreed mental health structure.

Ockenden 7: Concerns Management

Work is progressing to improve the thematic analysis for management of concerns and the timescales for responses. Progress has been made with a 50% reduction in the total number of open complaints achieved with many legacy complaints now dealt

with, and improved responses, in real time. Reductions are also reported in the number of major and catastrophic incidents and the number of complaints that are open beyond 3 months.

Improvement plans have been developed for all elements of the service and task and finish groups have been established to drive improvement work. These will focus on:

- Staff training (including roles and responsibilities)
- Putting Things Right Management including Redress
- Data Analysis to include lessons learned and sharing
- Communication with and about patients including timeliness of responses, depth of investigations and letter writing
- Review of all policies and guidance to support the principles of good complaint and incident management

Work is ongoing to rollout the PASS (Patient Advocacy and Support Service) which has been piloted at Ysbyty Glan Clwyd to support increased local resolution of complaints in near or real time.

The roll out of an electronic form to support complainants to register and submit concerns has been commenced in January 2019.

A review of the Patient Experience real time data feedback is underway the results of which will be used to shape the way the service is offered.

Dashboards are in development to be used at a ward and department level which will include a broad range of patient experience measures including real time feedback, complaints and harms reported from incidents.

A revised process for claims has been completed and ratified at Quality & Safety Group. This process will be audited in March.

Ockenden 11: Estates – Older Persons Mental Health

A multi-directorate / professional task and finish group has been established with agreed terms of reference and membership which includes Operational Estates, Estate Development and Mental Health and Learning Disabilities to deliver the following work streams for initially Older Persons Mental Health Facilities and thereafter all ward areas within inpatient facilities.

Scoping exercise has been competed for work stream 1 to develop a site by site schedule (Inventory) of outstanding repairs and actions required from recent and previous external HIW and CHC audits and inspections relating to MH&LD OPMH facilities. Work is progressing to reduce the number of outstanding repairs required.

Work Stream 2 will develop the Kings Fund *Enhancing the Healing Environment* (EHE) assessment across all wards within MH&LD OPMH facilities to determine the scope of work and resources required at each facility.

Work Stream 3 will develop the Kings Fund *Enhancing the Healing Environment* (EHE) assessment across all remaining wards to determine the level of resources required. Scoping work has commenced on identifying outstanding repairs from within operational estates work management systems. Work has also commenced on identifying outstanding works and actions contained within previous and current HIW and CHC audits and inspections and a detailed schedule of work is being developed.

Project management capacity and availability of revenue and capital requirements are identified as required resources to support the delivery of the three work streams.

Appendix 1

Improvement Group (HASCAS and Ockenden)

Terms of Reference

1.1 The Health Board will establish under the direction of the Executive Director of Nursing and Midwifery an Improvement Group to oversee the implementation of the recommendations arising from the HASCAS Thematic Report a Lessons for Learning Report and the Ockenden Governance Review to be published July 2018.

1.2 The Improvement Group are responsible for ensuring that there is a clear plan to address the recommendations and will provide leadership, governance and scrutiny of the implementation of the recommendations adopting an improvement methodology to sustain change.

1.3 The Improvement Group will, on behalf of the Health Board, maintain a robust grip and oversight of the improvement work required. The Improvement Group will take decisions and make arrangements which need to be effected to respond to the recommendations and the Executive Director of Nursing and Midwifery will report on progress directly to the Quality, Safety & Experience Committee of the Health Board to provide assurance on progress, no less than 3 times a year.

1.4 It remains the responsibility of the Health Board to scrutinise the findings and recommendations of the HASCAS Lessons for Learning Report and the Ockenden Governance Review. When the recommendations have been implemented and improvements have been made to the satisfaction of the Quality, Safety, Experience Committee, the Improvement Group will be stood down.

Remit

1.7 The Improvement Group in respect of its actions, provision of advice and assurance is authorised by the Board to;
- Ensure there is a clear plan to address the recommendations
- Scrutinise, challenge and seek assurance on the actions identified to effectively deliver the recommendations;
- Hold programme leads to account for the successful implementation of actions in response to the recommendations;
- Agree and monitor metrics in order to identify improvements and track progress against these;
- Agree direct actions to address any under-performance including the mitigation of risk;
- Provide assurance to the Board via Quality, Safety and Experience Committee of the progress being made, escalating as appropriate.

Improvement Group Structure

1.8   The Improvement Group governance and reporting structure is set out below:
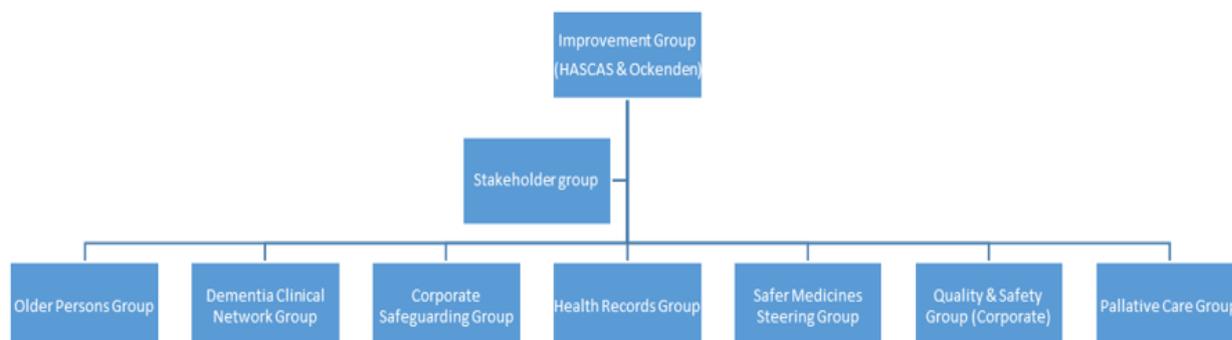
Membership

Membership of the Improvement Group shall comprise of the following;

> Executive Director of Nursing & Midwifery (Chair)
> Executive Medical Director (Vice Chair)
> Associate Director of Quality Assurance (Chair of Stakeholders Group)
> Associate Board Member (Director of Social Services)
> Executive Director of Workforce and Organisational development
> Nurse Director Mental Health & Learning Disability
> Medical Lead Older Persons
> Named Doctor Adult Safeguarding
>
> In attendance:
> Welsh Government Advisor
> Operational Leads for addressing the recommendations.
>
> The Chair will have the discretion to invite additional members to the meeting if it becomes apparent that this is appropriate and necessary to fulfil the purpose of the group e.g. finance
>
> Nominated deputies will be permitted

Meetings

<u>Quorum</u>

1.9   At least four members including one executive director must be present to ensure the quorum of the Improvement Group.

<u>Frequency of meetings</u>

1.10   Meetings shall be held no less than bi monthly or otherwise as the Chair of the Group deems necessary.

<u>Agendas and Papers</u>

1.11   The Improvement Group will be supported administratively by the office of the Executive Director of Nursing and Midwifery, whose duties in this respect will include;

- Chairing
- Dedicated secretariat
- Programme Manager
- Producing and collating assurance reports to the Quality, Safety and Experience Committee
- Maintaining oversight and monitoring progress on the implementation of the recommendations and work progress of the sub groups
- Arrangement of meetings

Reporting and Assurance Arrangements

1.12   The Improvement Group is accountable to the Quality, Safety & Experience Committee for its performance in exercising the functions as set out in these Terms of Reference.

1.13   The Improvement Group shall recognise the interdependencies of wider improvement work within the organisation, especially as it relates to dementia care and older person services.

1.14   The Improvement Group will:

- Provide an assurance report after each meeting normally bi monthly, outlining progress to date, a summary of the business discussed, key assurances provided, key risks identified including mitigating actions and milestones, matters which require escalating to the Quality, Safety & Experience Committee and planned business for the next meeting.

- Ensure appropriate escalation arrangements are in place to alert the Quality, Safety & Experience Committee to any urgent / critical matters that may compromise patient care and affect the operation and/or reputation of the Health Board.

- Embed the Health Board's vision, standards, priorities and requirements, e.g. equality and human rights, through the conduct of its business.

1.15 The Improvement Group has delegated authority from the Board and Quality, Safety & Experience Committee to exercise its functions as set out within these Terms of Reference.

Date Terms of Reference Approved:………………………………………….

Review date: August 2019

Stakeholders Group

Terms of Reference

The Health Board recognises the importance of Stakeholder engagement and wishes to establish a Stakeholder Group to strengthen and guide the work of the Improvement Group (HASCAS and Ockenden).

Remit

The group will provide scrutiny, advice, support, challenge and endorsement of the work being undertaken to deliver the necessary improvements across all areas affected by the recommendations from the HASCAS Thematic Review and the Ockenden Governance Review when published in July 2018.

The Stakeholder Group will provide a forum to facilitate full engagement and activate debate amongst stakeholders from across the communities served by the Health Board. Their aim will be to reach and present, wherever possible, a cohesive and balanced stakeholder perspective to inform the Improvement Group's decision-making in relation to implementing the recommendations arising from the HASCAS Thematic Review and the Ockenden Governance Review.

Membership

Membership of the Stakeholder Group shall comprise of the following;

Associate Director of Quality Assurance (Chair)
Director of Mental Health and Learning Disabilities (Vice Chair)
Representative of North Wales Local Authorities
Representative of Community Health Council
Representative of Bangor University
Representative of the Community Voluntary Councils
Representative of North Wales Police
Representative of Tawel Fan families (x5)
Representative of service user families and carers
Representative of Care Forum Wales.

The Chair will have the discretion to invite additional members to the meeting if it becomes apparent that this is appropriate and necessary to fulfil the purpose of the group.

Meetings

Quorum

1.16 At least one Health Board management member and three stakeholder members must be present to ensure the quorum of the Stakeholder Group.

Frequency of meetings

1.17 Meetings shall be held no less than quarterly and otherwise as the Chair of the stakeholder Group deems necessary.

Agendas and Papers

1.18 The Stakeholder Group will be supported administratively by the office of the Executive Director of Nursing and Midwifery, through the Associate Director for Quality Assurance whose duties in this respect will include;

- Chairing
- Dedicated secretariat
- Arrangement of meetings
- Ensure strong links to communities
- Facilitate effective reporting to the Improvement Group thereby enabling the Quality, Safety and Experience Committee to gain assurance that the business of the Stakeholder Group accords with the governance and operating framework set.

Reporting and Assurance Arrangements

1.19 The Stakeholder Group is accountable to the Improvement Group (HASCAS and Ockenden) for its performance in exercising the functions as set out in these Terms of Reference.

1.20 The Stakeholder Group shall recognise the interdependencies of wider improvement work within the organisation especially in older person and dementia services.

1.21 The Stakeholder Group will:

- Report formally after each meeting on the activities of the Group outlining progress to date and key recommendations and advice made to the Improvement Group.

- Embed the Health Board's vision, standards, priorities and requirements, e.g. equality and human rights, through the conduct of its business.

The Stakeholder Group has delegated authority from the Improvement Group to exercise its functions as set out within these Terms of Reference. Through its Chair and members it shall work closely with the Improvement Group to co-ordinate the sharing of information and good governance ensuring that its outputs are aligned with the Health Board's strategic goals.

Date Terms of Reference Approved:………………………………………….

Review date: August 2019

Quality, Safety & Experience Committee

22.1.19

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

To improve health and provide excellent care

Report Title:	Tissue and Organ Donation
Report Author:	Dr David Southern, Clinical Lead for Organ Donation
Responsible Director:	Mr Adrian Thomas, Executive Director of Therapies & Health Sciences
Public or In Committee	Public
Purpose of Report:	To report on the work of the Organ Donation Committee within BCUHB
Approval / Scrutiny Route Prior to Presentation:	Organ Donation Committee and Quality & Safety Group
Governance issues / risks:	None. The report is of ongoing work overseen by NHS-BT (Blood & Transplant)
Financial Implications:	None. The activity is underwritten by NHS-BT
Recommendation:	The Committee is asked to note the activities of the BCU / NHS-BT Organ Donation Committee and to highlight the report to the Health Board.

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

5.To improve the safety and quality of all services		5.Considering impact on all well-being goals together and on other bodies	
6.To respect people and their dignity			
7.To listen to people and learn from their experiences			
Special Measures Improvement Framework Theme/Expectation addressed by this paper Leadership and Governance			
Equality Impact Assessment Not necessary for governance report of this nature.			

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

Board/Committee Coversheet v10.0

Health Board : Insert Name

Key Achievements 2018 - 2019

1	Performed neonatal organ retrieval
2	Completion of YGC organ donation memorial
3	Ran "Organ Donation Simulation Course"
4	Promotion of donation by advertisement on lift wraps in all three hospitals
5	Link-nurse organ donation study day October 26 2018
6	Organ donation memorial service at St Asaph Cathedral

Missed Opportunities and Opportunities to Develop Practice 2018 - 2019

1	Reduce pre-approach to families
2	Develop a neonatal organ donation pathway
3	One "Organ Donation Simulation Course" was cancelled by blizzards
4	
5	

Key Strategic and Performance Priorities 2019 - 2020

1	Develop education programme for schools
2	Routine use of Cardiac Output monitoring for potential donors
3	Report of ODC activity to Trust Board
4	Good performance in NHSBT audit cycle
5	Increased media profile of organ donation in north Wales

Please submit with NHS Blood and Transplant Actual and Potential Deceased Organ Donation Summary Report :
April - Sept
April - March

Taking Organ Transplantation to 2020 Theme	Key Action Plan – 2019/20	Responsible Individual	Measurable Outcome	Target Date	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Comments (Optional)
Action by society and individuals will mean that the UK's organ donation record is amongst the best in the world and people donate when and if they can	**Organ Donation Promotion, Public Engagement & Education**		**Aim for consent rate above 80%**						
	Develop education programme for schools	CLODs/SNODs	Visit at least one school in each area of BCU	Dec-19					
	Transplantation Community Liaison Group	Abi Roberts	Biannual meeting	31.12.19					
	Contribute to all-Wales reports on organ donation	CLODs/SNODs	Inclusion of performance data in National report	Annually					
	Report activities of ODC to BCU Trust Board	CLODs	Attendance at Trust executive meeting	Jan-19					
Action by NHS hospitals and staff will mean that the NHS routinely provides excellent care in support of organ donation and every effort is made to ensure that each donor can give as many organs as possible	**Hospital Engagement**		**Aim for 26 deceased donors PMP**						
	Promote early identification and referral of potential organ donors	All staff	PDA Data	ongoing					
	Promote education of staff involved with management of potential donors	SNODs/CLODs	Two organ donation simulation days per annum	Dec-31					
	Ensure SNOD present in all PD approaches	All ITU Consultants	Potential Donor Audit	Monthly report					
Action by NHS hospitals and staff will mean that more organs are usable and surgeons are better supported to transplant organs safely into the most appropriate recipient	**Donation Process**		**Aim to transplant 5% more of the organs offered from consented, actual donors**						
	Optimise organ donors wiith use of cardiac output monitoring	CLODs	Equip YG/YGC/WMH with cardiac output monitors	30.6.19					
	DCD withdrawal in theatre	All ITU Consultants	PDA Data	Monthly report					
	Good performance in NHS BT potential donor audit	All staff	NHS BT audit						
Action by NHSBT and Commissioners means that better support systems and processes will be in place to enable more donations and transplant operations to happen	**Supporting NHSBT and Transplant Activity within Wales**		**Aim for a deceased donor transplant rate of 74 PMP**						
	Regional colloborative to lead local improvement in organ donation, retrieval and transplant practices and in local peomotion of	NHSBT	PDA data/National data	ongoing					
	Representation form NWODCM to BCU Clinical Legal & Ethical Group	CLODs	CLEG membership	ongoing					

Actual and Potential Deceased Organ Donation 1 April 2017 - 31 March 2018

NHS

Blood and Transplant

Betsi Cadwaladr University Health Board

Taking Organ Transplantation to 2020

In 2017/18, from 19 consented donors the Health Board facilitated 13 actual solid organ donors resulting in 28 patients receiving a life-saving or life-changing transplant.

In addition to the 13 proceeding donors there were 6 additional consented donors that did not proceed.

Best quality of care in organ donation

Referral of potential deceased organ donors

Goal: Every patient who meets the referral criteria should be identified and referred to NHS Blood and Transplant's Organ Donation Service

Aim: There should be no purple on the chart

Aim: The Health Board (marked with a cross) should fall within Bronze, Silver, or Gold
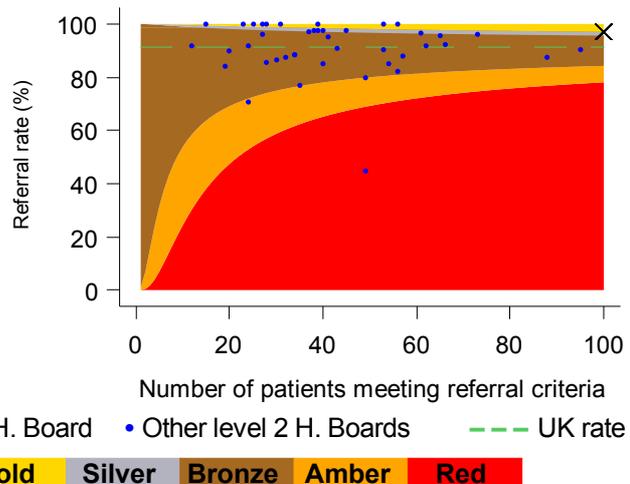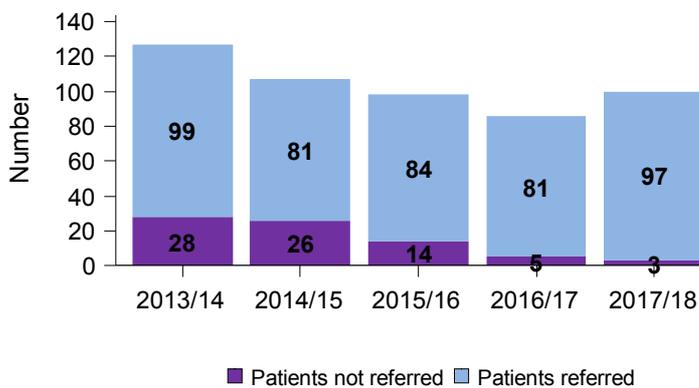
The Health Board referred 97 potential organ donors during 2017/18. There were 3 occasions where potential organ donors were not referred.

When compared with UK performance, the Health Board was good (silver) for referral of potential organ donors to NHS Blood and Transplant.

Presence of Specialist Nurse for Organ Donation

NHS

Goal: A Specialist Nurse for Organ Donation (SNOD) should be present during every organ donation discussion with families

Aim: There should be no purple on the chart

Aim: The Health Board (marked with a cross) should fall within Bronze, Silver, or Gold
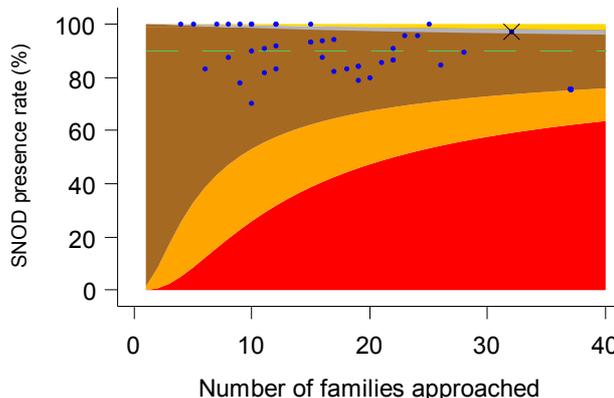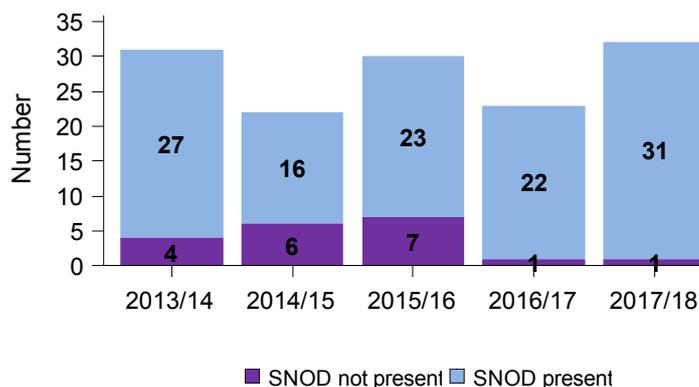
A SNOD was present for 31 organ donation discussions with families during 2017/18. There was 1 occasion where a SNOD was not present.

When compared with UK performance, the Health Board was good (silver) for SNOD presence when approaching families to discuss organ donation.

Why it matters

• If suitable patients are not referred, the patient's decision to be an organ donor is not honoured or the family does not get the chance to support organ donation.

• The consent rate in the UK is much higher when a SNOD is present.

• The number of patients receiving a life-saving or life-changing solid organ transplant in the UK is increasing but patients are still dying while waiting.

Regional donors, transplants, waiting list, and NHS Organ Donor Register (ODR) data

	Wales*	UK
1 April 2017 - 31 March 2018		
Deceased donors	74	1,574
Transplants from deceased donors	139	4,012
Deaths on the transplant list	16	426
As at 31 March 2018		
Active transplant list	234	6,045
Number of NHS ODR opt-in registrations (% registered)**	1,233,995 (40%)	24,941,804 (38%)

*Regions have been defined as per former Strategic Health Authorities
** % registered based on population of 3.1 million, based on ONS 2011 census data

Further information

Further information on potential donors after brain death (DBD) and potential donors after circulatory death (DCD) at the Health Board are shown below, including a UK comparison.

**Key numbers, rates and comparison with UK data,
1 April 2017 - 31 March 2018**

	DBD H. Board	DBD UK	DCD H. Board	DCD UK	Deceased donors H. Board	Deceased donors UK
Patients meeting organ donation referral criteria[1]	24	1954	77	6281	100	7978
Referred to Organ Donation Service	24	1929	74	5615	97	7302
Referral rate %	**G** 100%	99%	**S** 96%	89%	**S** 97%	92%
Neurological death tested	22	1676				
Testing rate %	**B** 92%	86%				
Eligible donors[2]	18	1582	45	4456	63	6038
Family approached	18	1471	14	1858	32	3329
Family approached and SNOD present	18	1394	13	1591	31	2985
% of approaches where SNOD present	**G** 100%	95%	**B** 93%	86%	**S** 97%	90%
Consent ascertained	13	1066	8	1115	21	2181
Consent rate %	**B** 72%	72%	**B** 57%	60%	**B** 66%	66%
Actual donors (PDA data)	10	955	3	613	13	1568
% of consented donors that became actual donors	77%	90%	38%	55%	62%	72%

[1] DBD - A patient with suspected neurological death
DCD - A patient in whom imminent death is anticipated, ie a patient receiving assisted ventilation, a clinical decision to withdraw treatment has been made and death is anticipated within 4 hours

[2] DBD - Death confirmed by neurological tests and no absolute contraindications to solid organ donation
DCD - Imminent death anticipated and treatment withdrawn with no absolute contraindications to solid organ donation

Note that a patient that meets both the referral criteria for DBD and DCD organ donation is featured in both the DBD and DCD data but will only be counted once in the deceased donors total

Gold	Silver	Bronze	Amber	Red

For further information, including definitions, see the latest Potential Donor Audit report at
www.odt.nhs.uk/statistics-and-reports/potential-donor-audit/

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

Report Title:	Summary of In Committee business to be reported in public
Report Author:	Mrs Kate Dunn, Head of Corporate Affairs
Responsible Director:	Mrs Gill Harris, 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:	The issues listed below were considered by the Committee at its private in committee meeting on 29.11.18 • Deloitte's Final Report on a Commissioned Organisational Development (OD) Programme for Maternity Services in North Wales
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 *(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)*	√	**WFGA Sustainable Development Principle** *(Indicate how the paper/proposal has embedded and prioritised the sustainable development principle in its development. Describe how within the main body of the report or if not indicate the reasons for this.)*	√
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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.

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