Bundle Quality, Safety & Experience Committee 5 May 2020

1.1 09:30 - QS20/79 Chair's Opening Remarks

1.2 09:31 - QS20/80 Declarations of Interest

1.3 09:32 - QS20/81 Apologies for Absence

1.4 09:33 - QS20/82 Minutes of Previous Meeting Held in Public on the 17.03.20 for Accuracy, Matters Arising and review of Summary action

QS20.82 Minutes QSE 17.03.2020 Public draft v0.03.docx

QS20.82a Summary Action Log.docx

2 FOR DISCUSSION

2.1 09:48 - QS20/84 COVID-19 update - Mrs Gill Harris

The QSE Committee is asked to receive the verbal update

2.2 09:58 - QS20/85 Infection Prevention Report - Mrs Gill Harris

The QSE Committee is asked to note the Infection Prevention report.

QS20.85 Infection Prevention Report v2.docx

2.3 10:08 - QS20/86 Serious Untoward Incidents - Mrs Gill Harris

The QSE Committee is asked to receive the report for assurance and note the following;
• Changes of Welsh Government serious incident reporting requirements
• Implementation of the 'Make it Safe' process

QS20.86 Serious Untoward Incident Report v4.docx

2.4 10:18 - QS20/87 North Wales Vascular Services - Mrs Gill Harris / Dr David Fearnley

The QSE Committee is asked to receive the verbal update report

2.5 10:28 - QS20/88 Stroke Services update report - Mrs Gill Harris

The QSE committee is asked to note the report.

QS20.88 Stroke Care Update v3.docx

2.6 10:38 - QS20/89 Ophthalmology Report - Mrs Gill Harris

The QSE committee is asked to note:
1. The continuing challenge in reduction of backlog of patients waiting for outpatients and treatments, with limited improvement made in 2019/20
2. The opportunity presented through the digital pathway re-designs and development of the eye care business case
3. The impact of covid-19 on present service delivery
4. The work undertaken to establish pathways at this time to provide access to emergency and urgent eye care for patients and so mitigate the risk of harm due to sight loss.

QS20.89 Ophthalmology Report v3.docx

2.7 10:48 - QS20/90 Psychological Therapy Services - update report - Mrs Lesley Singleton

The QSE committee is asked to receive this report and regular updates on improvement work for scrutiny and assurance.

QS20.90a Psychological Therapies Report_Appendix 1.pdf

QS20.90 Psychological Therapies Report May 2020.docx

2.8 10:58 - QS20/91 BCUHB Obstetric Haemorrhage rates report and action plan - Mrs Fiona Giraud

The QSE Committee is asked to note the Directorate's current position regarding obstetric haemorrhage and the actions taken to mitigation the identified risks and improve performance.

QS20.91 Current Obstetric Haemorrhage Rates and Action Plan.docx

2.9 11:08 - QS20/92 Response to Healthcare Inspectorate Wales review of Maternity Services - Mrs Fiona Giraud

The QSE Committee is asked to note the update provided for assurance on the required actions in line with the HIW improvement plans, following a series of unannounced and announced inspections of Maternity Services in North Wales.

QS20.92 Response to HIW review of Maternity services.docx

QS20.92 Response to HIW review of maternity services_Appendix 1.pdf

2.10 11:18 - QS20/93 Maternity Framework for Maintaining Life Saving and Life Impacting Essential Services during the COVID 19 Pandemic - Ms Teresa Owen

The QSE Committee is asked to note the Directorate's compliance and service adaptation to specific guidance for Maternity Services in Wales in relation to Welsh Government's Framework for Maintaining Life Saving and Life Impacting Essential Services during the COVID-19 Pandemic and support the;
• Ring fencing and preservation of the Red and Green estate adaptations on all three DGHs and relocated services in the Communities.
• Preservation of the Midwifery and Obstetric Workforce in order to maintain essential services throughout the Pandemic.

QS20.93 Maternity Framework for Maintaining Life Saving and Life Impacting Essential Services during the COVID 19 Pandemic.docx

2.11 11:28 - QS20/94 Corporate Risk Assurance Framework - Mrs Gill Harris

The QSE Committee is asked to:
1) Consider the relevance of the current controls.
2) Review the actions in place and consider whether the risk scores remain appropriate for the presented risks.
3) Approve the proposed reduction in risk score of CRR28 – PPE (
4) Note, approve and recommend this extract of the Corporate Risk Register (CRR) to the Audit Committee and to gain assurance that the risks articulated herein are appropriately managed in line with the Health Board`s risk management strategy and best practice.

QS20.94 Corporate Risk Assurance Framework v2.docx

2.12 11:38 - QS20/95 Ward Accreditation update - Mrs Gill Harris

The QSE Committee is asked to note the ongoing Ward Accreditation process post Covid-19 Pandemic.

QS20.95 Ward Accreditation Paper v4.pdf

2.13 11:48 - QS20/96 Health & Safety Update Report - Mrs Sue Green

The QSE Committee is asked to note the procedural guidance for Health Board employees to follow on the death, or serious illness (including hospitalisation), following a positive test result for COVID-19.

QS20.96 Health & Safety Report v2.docx

2.14 11:58 - QS20/97 QSE Committee Annual Report - Mrs Gill Harris

The Committee is asked to approve the Annual Report for 2019-20

QS20.97a QSE Committee Annual Report front template.docx

QS20.97b QSE Committee Annual Report.docx

QS20.97c QSE Committee Annual Report Appendix 1 QSE ToR V5.0.pdf

QS20.97d QSE Committee Annual Report Appendix 2 QSE ToR V6.0.pdf

QS20.97e QSE Committee Annual Report Appendix 3 QSE CoB.pdf

4 FOR INFORMATION

4.4 12:08 - QS20/99 GMS Access standards - Dr Chris Stockport

The QSE Committee is asked to note the content of the report.

QS20.99 GMS Access Standards.docx

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Quality, Safety and Experience (QSE) Committee

Minutes of the Meeting Held in public on 17.03.20 in The Boardroom, Carlton Court, St Asaph

Present:

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

In Attendance:

Mrs Gill Harris	Executive Director of Nursing and Midwifery *(part of meeting)*
Miss Claire Brennan	Head of Office, Executive Director of Nursing and Midwifery

AGENDA ITEM DISCUSSED	ACTION BY
QS20/37 Chair's Opening Remarks **QS20/37.1** The Chair welcomed everyone to the meeting and confirmed that decision had been taken to reduce attendance and prioritise discussions within the agenda, to allow Executive officers and other senior leaders to fully focus on the response to the COVID 19 pandemic. **QS20/37.2** The Chair advised that all other relevant parties had been informed of this revised approach and WAO had confirmed they would not observe the meeting as previously planned.	
QS20/38 Declarations of Interest None were declared	
QS20/39 Apologies for Absence Received for Mr A Roach, Dr Chris Stockport	
QS20/40 Minutes of Previous Meeting Held in Public on the 28.1.20 for Accuracy, Matters Arising and review of Summary Action Log **QS20/40.1** The minutes were agreed as an accurate record. **QS20/40.2** The following discussions were noted regarding the summary action log. **QS20/40.2.1** Action QS19/102.2 – The Chair advised that a sustainability assessment is being undertaken across primary care practices and a heatmap had been requested within the primary care report. However, due to the fact that the information had not been shared with providers previously, it was agreed that a higher level of detail would be presented in the first instance. It was therefore agreed to keep this action open and	

the Chair will discuss with the Executive Director of Primary & Community Care at an appropriate time outside of the meeting. **QS20/40.2.2** The Chair will address the requirements of actions relating to performance reporting which were agreed to remain open. **QS20/40.2.3** QS180.4 page 7 enhanced care inpatient policy – submitted for approval LR to sign off **QS20/40.2.4** further to the update provided on the summary log, ongoing concerns were expressed by Independent Members and it was agreed that JH will discuss further with GH and TO and action QS19/012.2 therefore remains open.	**LR** **LR** **JH**
QS20/41 Action log from Joint Audit and QSE Committee The minutes were noted.	
QS20/42 Patient Story **QS20/42.1** standard item not reviewed due to prioritisation of agenda items in light of the COVID 19	
QS20/43 Quality/Safety Awards and Achievements **QS20/43.1** standard item not reviewed due to prioritisation of agenda items in light of the COVID 19	
QS20/44 Annual Plan Monitoring Report (APMR) **QS20/44.1** standard item not reviewed due to prioritisation of agenda items in light of the COVID 19	
QS20/45 Integrated Quality & Performance Report **QS20/45.1** standard item not reviewed due to prioritisation of agenda items in light of the COVID 19	
QS20/46 Exception Report on BCU response to audit report into postponed procedures **QS20/46.1** item deferred in light of COVID 19 pandemic planning	
QS20/47 Infection Prevention & Control Q3 2019-20 *Mrs G Harris in attendance for this item* **QS20/47.1** The Executive Director of Nursing and Midwifery advised that as part of the national work being undertaken a desk top review of lessons learned, will include an infection prevention & control perspective. This will be given priority focus following the COVID 19 position and further review of lessons learned in respect of issues relating to infection that were reported during the pandemic.	

QS20/47.2 An Independent Member referred to narrative within the report that '78% of infections are unavoidable' and requested more information on the number of avoidable infections. There have been discussions regarding the role of community and public health staff and how they can support work to reduce incidences of infection. **QS20/47.3** The Chair highlighted the difference in infection rates between sites with YGC reporting the highest number. Executive Director of Nursing and Midwifery explained how they are ensuring key metrics are in place, building on CHKS information and the need to share meaningful data to ensure site focus. **QS20/47.4** An Independent Member referred to the financial implications set out in the report and the Executive Director of Nursing and Midwifery acknowledged the need to ensure that cost pressures are aligned with priorities. **QS20/47.5** The Chair referred to the statement on page 9 of the report in relation to Ward 19 environment being difficult to clean and requested further information on this. The Executive Director of Nursing and Midwifery agreed to respond to this and provide more details on the specific issues. There was further discussion regarding ensuring issues that can be dealt with are addressed to ensure confidence in processes. The Executive Director of Nursing and Midwifery confirmed that approval for recruitment to domestic staff has been addressed through the Health Board's executive review process. **QS20/47.6** An Independent Member sought reassurance on how domestic cleaning standards will be maintained during the COVID-19 pandemic given pending pressures and additional risks faced from COVID-19. The Executive Director of Nursing and Midwifery advised there was guidance for reasonable IPC measures and agreed to provide a detailed response. **QS20/47.7 It was resolved that** the Committee receive the report and the feedback provided on the report would be actioned	**GH** **GH** **GH**
QS20/48 Ward Accreditation update **QS20/48.1** An Independent Member noted with concern that procurement processes were impacting on wards obtaining necessary resources such as labels which are required to meet the standards. A suggestion was made to circulate a request on internal communication systems for supplies that maybe surplus within other departments. **QS20/48.2** An Independent Member referred to the 82 wards having received their accreditation and queried what this equated to in terms of an overall percentage and whether this was in line with the trajectory. A query was also raised in respect of ensuring ward accreditation outputs are triangulated with other issues. The Executive Director of Nursing and Midwifery agreed to ensure future iterations of the report is split by site/area in the same way as the IPC report.	**GH**

QS20/48.3 It was resolved that the Committee receive the report and the feedback provided on the report would be actioned	
QS20/49 Serious Untoward Incidents **QS20/49.1** The Committee Chair welcomed the revised level of detail included within the report. **QS20/49.2** Members discussed the Never Event regarding an endoscopy appointment that was issued incorrectly to a patient who underwent the procedure unnecessarily and emphasised the need to ensure key learning is clear, supported by triangulation in the data / information between the performance and informatics teams. **QS20/49.3** The Executive Director of Nursing and Midwifery advised that a patient safety and incident reporting workstream will also be undertaking rapid reviews of any serious incidents as a result of COVID-19 pandemic and members stated that this should also include examples of what went well. Concern was raised as to whether incident reporting will be impacted as a result of COVID-19, however, it a number of COVID-19 related incident reports had already been received. **QS20/49.4 It was resolved that** the Committee receive the report and the feedback provided on the report would be actioned	
QS20/50 Monitoring of actions from Internal Audit report into WAST Handover at Emergency Departments **QS20/50.1** An Independent Member raised a query in relation to recommendation a) on page 4 regarding funding and asked for specific details regarding operational issues referred to in the paper between BCUHB and WAST. The Executive Director of Nursing and Midwifery agreed to provide further details in this regard. **QS20/50.2** An Independent Member queried whether the 'Tuag Adref' / Homeward Bound model in the West would be replicated in other areas. The Executive Director of Nursing and Midwifery advised that each area had identified models to support discharge which were in different stages of development and that discussions were ongoing across North Wales. **QS20/50.3** An Independent Member asked about progress of the Building Better Care programme to date. The Executive Director of Nursing and Midwifery confirmed that there had been some developments during this early stage of the longer term programme of improvement work for Unscheduled Care but acknowledged that the Health Board wasn't where it wanted to be and further work is continuing to deliver an improved position across North Wales. The Executive Director of Nursing and Midwifery also advised that a number of posts that had been implemented to support increased demand over winter pressures and consideration was being given to continue posts, such as progress chasers, where they were felt to be beneficial. **QS20/50.4 It was resolved that** the Committee receive the report and the feedback provided on the report would be actioned	GH

QS20/51 Mortality Reporting **QS20/51.1 The committee noted the report** and the update on proposed actions.	
QS20/52 Draft 2020-21 Clinical Audit Plan **QS20/52.1** It was agreed to defer this item to September as a result of the COVID-19 pandemic planning	
QS20/53 Draft Annual Quality Statement (AQS) 2019-20 **QS20/53.1** defer item and committee annual report pending all Wales advice	
QS20/54 Patient Experience Report Quarter 3 2019-20 **QS20/54.1** It was agreed to defer this item as a result of the COVID-19 pandemic planning	
QS20/55 Medicines Management Annual Report 2019*20 **QS20/55.1** It was agreed to defer this item as a result of the COVID-19 pandemic planning	
QS20/56 Psychological Therapies Update **QS20/56.1** The Committee received the update and Terms of Reference for the programme group. An Independent Member observed that the summary action plan was difficult to tie in with the recommendations of the report and it was agreed thaht this needs to be more explicit. The Chair also noted that that the Terms of Reference for the membership of the group needs to be refreshed due to changes in roles. The Committee received the update and feedback would be provided to the Interim Director of Mental Health and Learning Disabilities	LS
QS20/57 Thematic Review of Suicides **QS20/57.1** It was agreed to defer this item as a result of the COVID-19 pandemic planning	
QS20/58 Primary & Community Care Quality Assurance Report **QS20/58.1** It was agreed to defer this item as a result of the COVID-19 pandemic planning	
QS20/59 Quality Safety Group Assurance Report **QS20/59.1** It was agreed to defer this item as a result of the COVID-19 pandemic planning	

QS20/60 Primary Care CAMHS (Child Adolescent Mental Health Services) – Progress update against delivery Unit Recommendations **QS20/60.1** It was agreed to defer this item as a result of the COVID-19 pandemic planning	
QS20/61 Item Deferred Which item was this?	
QS20/62 Health & Safety Policy HS01 for Approval QS20/62.1 The committee approved the policy.	
QS20/63 Committee Annual Report 2019-20 **QS20/63.1** It was agreed to defer this item until advice had been received from Welsh Government	
QS20/64 Summary of business considered in private session	
QS20/65 Documents Circulated to Members It was noted that the following had been circulated: 27.01.2020 Psychological Therapies Review Report 18.02.2020 Annual Plan Progress Monitoring Report 02.03.2020 QSG January meeting notes 09.03.2020 Briefing note - Safeguarding Training Medical Staff in Emergency Departments	
QS20/66 Welsh Health Specialised Services Committee **QS20/66.1** It was agreed to defer this item as a result of the COVID-19 pandemic planning	
QS20/67 Issues of Significance to inform the Chair's Assurance Report	
QS20/68 COVID-19 Pandemic Planning update **QS20/68.1** The Executive Director of Nursing and Midwifery provided the Committee with an update on the planning work being undertaken to prepare for the expected increase in patient numbers. A Gold Command structure had been established with regular reporting in place. Workstreams had been set up to focus on key areas of planning including primary and community, workforce, clinical pathways and risk and governance. Regular reporting internally and externally had been agreed and a communications plan is being finalised. The workforce group is looking at redeploying staff across the Health Board to support critical areas.	

Members thanked the Executive Director of Nursing and Midwifery for the update and noted that a Board briefing was being arranged which will provide more detail of the plans. It was noted that the situation was changing rapidly and the plans would need to be adaptable to this.	
QS20/69 Healthcare Inspectorate Wales Inspection Reports **QS20/69.1** The reports were noted but discussion deferred due to the COVID-19 pandemic planning	
QS20/70 Date of Next Meeting Tuesday 05.05.20 @ 9.30am in Carlton Court, St Asaph.	
QS20/71 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**
21st May 2019				
D Carter	**QS19/70.2** Consider whether non-patient elements need separating from the CLIICH report in terms of category 'abuse of staff by patients', for next submission	Sept	24.9.19 discussions between teams ongoing as part of gap analysis. 30.10.19 The new Assistant Director of Service User Experience (who started with BCU in mid-October) is meeting with the Assistant Director of Health, Safety and Equality and will discuss how patient safety and staff safety incidents will be separated in the reports submitted to the committee, ensuring information to the committee is not lost and remains triangulated where appropriate. 19.11.19 The Chair confirmed she had met with the new Assistant Director for Patient Safety and this action would be addressed within the Patient Safety report in January. 28.1.20 The Committee were content that this action could be closed.	January Closed
~~E Moore~~ M Maxwell	**QS19/74.2** Reflect on comments regarding format and flow of mortality report including the need to ensure a single author/owner for next submission.	Sept	17.9.19 A revised format has been submitted and agreed at Quality Safety Group, and will inform the next report to Committee. 24.9.19 Committee agreed to re-open the action until next mortality report received. 12.11.19 Mortality report agendered for discussion at November Committee meeting. Members' feedback invited on format and flow.	~~Closed~~ ~~November~~ ~~January~~

			19.11.19 Further report requested for January. Meeting set up for January between QSE Chair and Office of Medical Director. 6.1.20 Meeting held and clarification/steer provided on how to improve and strengthen mortality reporting, with agreement the paper be deferred to the March meeting. 28.1.20 QSE Chair confirmed her expectation that the paper in March will be a plan of action as to how mortality will be addressed and reported. 04.03.20 A plan for the development of mortality reporting was submitted to the March meeting Update: item deferred	March
16th July 2019				
D Carter	**QS19/99.2** Include patient story re Welsh Language in the next Welsh Language monitoring report		13.9.19 As recommended by QSE, Head of Patient and Service User Experience for BCUHB has produced a Quality Assurance for Patient Stories Framework Sept 2019 to ensure that all Patient Stories are monitored. BCUHB has ensured adequate resources are in place to sustain the growth and development in capturing, monitoring and measuring quality improvements from patient stories. The Listening and Learning group will be the quality assurance measure to monitor reports and translate them into improvement work and celebrating best practice. The Listening and Learning Strategic forum for Patient and Service Experience' group (LLG) (LLE was stepped down for 6 months to review the function/purpose of the meetings and capture	~~Closed~~

			the correct attendees in alignment with QSE and QSG). The LLG will focus on outlining targets and reporting frameworks to link the connections between Patient & Service User feedback and service improvements. The LLG will be the quality assurance measure to monitor reports and translate them into improvement work and celebrating best practice. This includes Patient Stories. Patient Stories will be integrated into the Clinical Harm Dashboard along with all other feedback methods. Quality improvement actions will be captured, monitored and measured in triangulation with incidents and complaints. The one system approach strengthens the service improvement management. 24.9.19 Committee requested action be re-opened as response did not confirm if the patient story had been included into the Welsh Language monitoring report or not. 19.11.19 Noted that the qualitative report re Welsh Language came to QSE as part of the IQPR reporting process. Timeframe for next report to be confirmed and whether the patient story had been included. 28.1.20 The Committee were content that this action be closed.	November January Closed
C Stockport Lucy Reid	**QS19/102.2** Work to provide a heat map summary in future primary care reports	By next report (March)	Summary provided in the primary care report for March QSE 17.03.20 LR to discuss level of detail of practice sustainability information with CS	TBC following COVID-19

C Stockport	**QS19/102.4** Ensure that future reports include narrative on lessons learned from incidents	By next report (March)	Detail of how 'lessons learnt' are collated and shared with Primary Care colleagues is included in the report for March QSE To remain open as item was deferred	TBC following COVID-19
A Thomas	**QS19/112.3** Follow up query from the May QSG report as to whether the related patient safety alert had been closed at the time, even though a Medical Devices Safety Officer was not in post.	Sept	24.9.19 AT reported that there was a lack of clarity. The CHC Chair accepted that the information was difficult to unpick retrospectively but was assured that the intention to appoint a Medical Devices Safety Officer was still ongoing. Committee agreed to keep action open. 19.11.19 AT confirmed there was a robust system around medical devices and this was an operational issue that should back through QSG, however, the Chair reminded members that the action had originated from the report from QSG. AT would take this action away again. 20.1.20. AT has had confirmation from the DGM of NWMCS that the MDSO function will be assigned to a member of staff within the Medical Devices team by the end of June 2020. 28.1.20 The Committee were assured that day to day work continued whilst the nominated MDSO function was ongoing, and that tracking was undertaken via the Assistant Director Patient Experience. The Committee were content that the action be closed.	November January Closed
24th September 2019				
J Newman	**QS19/129.1** Revisit the briefing note (against action QS19/101.1) on mapping of indicators to reflect members' comments re appropriateness and mapping to SPPH	Oct	19.11.19 JN indicated that there was a list within the IQPR of annual plan issues that came through QSE. The Chair reiterated that the action relates to having the briefing note refreshed to give the Committee confidence that	

			it was monitoring the right annual plan elements. JN set out challenges in that whilst an overall action may be attributed to QSE there may be multiple milestones within that action which relate to another Committee – for example clinical coding. SG felt that an action shouldn't need to be deconstructed in order for it to be fully monitored. It was suggested that the Executive Director of Planning & Performance take the discussion through Exec Team. 28.1.20 The Chair of QSE has discussed this with the Executive Director of Planning and Performance. The committee with overall responsibility to scrutinise each Action in the operational plan will be added to the IQPR from the next report. This will reflect that some of the actions are being scrutinised through committees over than QSE.	January Closed
D Carter T Owen	**QS19/139.1** Ensure that next report from Women's Division includes detail of the reported clinical complex cases.		19.11.19 TO suggested that six months would be appropriate for next report.	TBC following COVID-19
19th November 2019				
J Newman	**QS19/164.1** Review the sequencing and reporting of APMR reports to committee to ensure as timely as possible.	January	28.1.20 Review took place immediately after the QSE meeting resulting in timetable for report completion being brought forward. Updates from Executives are now requested at month end to enable earlier sign off of the report by the Exec Team. The completed report is issued to all relevant secretaries of the Board Committees so as to enable the latest report to be included in next Committee meeting and for QSE members	Closed

			to receive reports relating to month end progress during the months that the committee does not meet.	
L Singleton	**QS19/165.3** Ensure that future MHLDS exception reports within IQPR provided an explanatory narrative where a major outlier was identified, together with timelines to address.	January	21.1.20 S Forsyth confirmed this has been taken on board and actioned. 28.1.20 The QSE Chair did not feel the narrative sufficiently set out the current position and asked that this action be reopened. 09.03.20 comments in relation to the IQPR have been acknowledged and work is underway with Head of Ops to improve narrative which will be completed for future reports.	TBC following COVID-19
J Newman Mark Wilkinson Lucy Reid	**QS19/165.5** Consider reviewing an existing performance team reporting schedule to include information for committee members as to what data goes where and when	January	28.1.20 Director of Performance confirmed this had been actioned and she would provide the necessary narrative to enable the action to be closed 28.1.20.The list of when each measure is reported and the committee reported to was circulated to members ahead of the January 2020 QSE meeting by the committee secretary 17.03.20 LR to discuss further with JN and MW	
D Fearnley	**QS19/171.2** Look at uptake against safeguarding training within various staff groups and provide a briefing note for circulation outside of the meeting.	January	19.1.20 Site Medical Directors have been asked to review safeguarding training for medical staff and report performance to the Executive Medical Director before end of January 2020. A briefing note will then be circulated to QSE members. 28.1.20 The Executive Medical Director confirmed this related to EDs and he would ensure the outstanding briefing note was circulated before the next meeting 09.03.20 Briefing note circulated	Closed

M Denwood	**QS19/171.3** Provide details of referrals by both area and referrer in future reports.	May 2020	Work in progress to complete action	TBC following COVID-19
M Denwood	**QS19/171.3** Work to ensure future reports are less numbers-focused and concentrate more on outcomes and learning.	May 2020	Work in progress to complete action	TBC following COVID-19
L Reid	**QS19/175.1** Send a letter of congratulations on Nursing Time award for Team of the Year to the MHDLS Division	December	20.1.20 Committee Chair has drafted correspondence 28.1.20 The QSE Chair confirmed this had been action. Point was raised that there were numerous other awards that could be recognised similarly. Noted that these were acknowledged directly at Executive level.	Closed
D Carter	**QS19/180.4** Arrange for amendments to be made to the Levels of Enhanced Care In-Patients Policy for submission for Chair's Action	December	21.1.20 revised policy received and will be submitted to Chair for approval 06.02.20 policy submitted to Chair for approval	Closed
D Carter	**QS19/182.1** Work to refresh the HASCAS / Ockenden reports to ensure more manageable	January	Refreshed report submitted for January meeting	Closed
28th January 2020				
L Singleton	**QS20/4.3** It was noted that a briefing note on suicides had been circulated to members, although the Chair expressed concern that it did not provide a thematic review of the cluster of suicides within the West and asked that this be re-provided for the March meeting.	March	Report submitted for discussion at March meeting	Closed
D Carter	**QS20/7.1** Circulate briefing note already prepared on awards and achievements.	February	Deferred until further notice during revised COVID-19 pandemic arrangements in place	TBC following COVID-19

L Reid	**QS20/7.1** Discuss with the Health Board Chair the potential of sharing information on awards and achievements at Board meetings.	February	This has been discussed with the Chair as part of the Board development programme	Closed
Jill Newman	**QS20/8.1** Link APMR reports to other committees	March	09.03.20 The APMR has been amended to include an additional column to show which committee has responsibility for scrutinising which action	Closed
Jill Newman	**QS20/8.2** Amend reports to remove 'no update' and ensure accuracy in reporting	March	09.03.20 The narrative has been refined to ensure there is a distinction between 'no update being received from the sponsor', and 'no further progress on implementation of the action' to provide greater clarity.	Closed
Jill Newman Mark Wilkinson Lucy Reid	**QS20/9.1** ensure narrative in IQPR reports links to previous reporting	March	09.03.20 Retrospective lookback on a sample of reports commenced and will be completed for the May report 17.03.20 LR to discuss further with JN and MW	
T Owen Jackie Hughes	**QS20/9.5** Follow up maternity staffing issues to ensure transparency of reporting and sharing of information with Trade Union partners.	March	Compliance is reported at the annual WG Maternity Performance Board and submitted to HIW as part of their Review of Maternity Services. The current full Birth Rate Plus audit is being carried out by the Birth Rate Plus Consultancy Team and final report is awaited. The 2016/17 report has been shared with the local RCM Representative and a meeting is scheduled (in the next week) to explore/discuss the report further. Finalised report will be reported via the Women's Committee/Meeting Structure. The Head of Service meets with RCM Representatives regularly, and will brief all IMs as appropriate.	May

			17.03.20 JH to discuss ongoing concerns with TO and GH	
L Singleton	**QS20/9.6** Provide paper on psychological therapies update to next meeting including the terms of reference for the Psychological Therapies Programme Board.	March	Report submitted for the March meeting	Closed
J Newman	**QS20/9.7** Briefing note to be circulated In relation to postponed procedures which focused on the specified non-clinical reasons.	March	09.03.20 Included as additional slides in the IQPR for March 2020 17.03.20 LR to discuss further with JN and MW	May
Sue Green	**QS20/11.2** Provide an update on the exploration of a contracted solution for the Occupational Health Physician vacant post	March	Two Occupational Health Physicians (OHP) have expressed an interest for the OHP post within the Occupational Health and Wellbeing Department. Interviews are planned for early May 2020. It is anticipated the post will be filled by September 2020.	Closed
D Carter J Newman M Maxwell M Joyes	**QS20/12.3** Meet to discuss how more consistent data reporting could be achieved across various department from different software packages and systems.	May	Work in progress – further update to be provided	TBC following COVID-19
D Carter M Joyes	**QS20/12.4** incident reporting to be expanded to include the highest incident categories rather than just reporting on the top 3	March	SI report updated to include all themes – report submitted to March meeting	Closed
L Singleton	**QS20/13.2** Work to develop increased visibility around actual lessons learnt for the next routine report from the MHLDS Division.	May	09.03.20 Work is underway to include lessons learnt within May report	TBC following COVID-19
G Harris	**QS20/16.1** Provide action plan against the All-Wales Self-Assessment of Quality Governance Arrangements at next meeting	March	Deferred until further notice during revised COVID-19 pandemic arrangements in place	TBC following COVID-19
D Carter	**QS20/17.2** Continue to provide full inspections reports as part of HIW updates	March	Reports submitted for information at March meeting	Closed
L Singleton	**QS20/18.1** Refresh risk description for CRR13 Mental Health	February	Refreshed narrative will be presented at the Risk Management Group Meeting in May	May

S Green	**QS20/18.2** Provide target date for ID 3024 Non-Compliance of Fire Safety	February	17.02.20 Target risk date for ID 3024 Non-Compliance of Fire Safety has been set to 01/11/2020.	Closed
S Green	**QS20/18.2** Change "comprise" to "compromise" on ID 2956 Potential to comprise patient safety due to large backlog and lack of follow-up capacity	February	11.2.20 Workforce Optimisation Business Manager / Programme Manager contacted Datix support to enact this change. Completed. 17.02.20 Wording "comprise" has been amended to "compromise" on ID 2956	Closed
G Harris C Stockport	**QS20/18.3** Refresh risk description for ID 2950 Potential inability of Care Homes to provide safe quality care	February	The Risk Description ID 2950 has been de-escalated and reviewed in line with discussions at the previous meeting and the risk now states *…."The ability of the Health Board to respond proactively to support care homes when concerns are raised".*	Closed
L Meadows	**QS20/18.4** Raise issue of IMs input into H&S risks – via next IMs meeting	March	09.03.20 LM emphasising the importance of health and safety to IMs	Closed
L Reid	**QS20/20.4** Escalate quality, safety and strategic aspects of the General Medical Council Enhanced Monitoring of Medicine Training and Wrexham Maelor Hospital**,** to the Board through Chair's report.	March	This has been discussed with the Chair and a report has been requested for the March Board meeting.	Closed
G Harris	**QS20/21.1.1** Further amend and submit Review of Open Visiting Policy for Chair's action	February	09.03.20 Executive Director of Nursing seeking assurance that the Visitors Charter, appendix to the Open Visiting Policy, is being reviewed with wider stakeholders prior to Chairs Action. 02.04.20 The updated visitors' charter will be sent back to the CHC for further review following COVID restrictions.	May
G Harris	**QS20/21.2.2** Add W&OD colleagues' comments to Nurse Staffing Levels Policy and resubmit for approval under Chair's Action	February	WOD colleagues confirmed they had not previously commented on the policy during consultation period. Comments have now been	Closed

			received, added and forwarded 10/02/20 for policy final ratification	
M Maxwell	**QS20/21.3.1** Amend frequency of reporting within the clinical audit policy	February	Reporting amended quarterly to CAESG and annually to JAQS	Closed
K Dunn	**QS20/21.4.1** Arrange for discussion around submission of policies at next CBMG and invite Bethan Wassell.	March	5.5.20 Invitation sent to Bethan Wassell, and notification to CBMG secretariat to include on March agenda.	Closed
17th March 2020				
G Harris	**QS20/47.2** further details to be provided in relation to the number of 'unavoidable' infections	May	Avoidable infections are those whereby the infection should not have occurred. These may be in relation to health care, device care and/or exposure to an organism in the environment. Avoidable infections reduced over Q1 and Q2 with innovations and deep dive analysis. However it is expected to achieve a position where avoidable infections are minimal/zero and any occurrence is reported by exception. (e.g. 79 infections in January of which 61 (77%) were unavoidable, issues include contaminated blood cultures, catheter infections, relapse and attributable to another Trust.	Closed
G Harris	**QS20/27.5** provide further details on the difficulties in cleaning the environment on Ward 19 referred to within the report	May	Ward 19 experiences the most outbreaks of infection in the Health Board, and is the most difficult to terminally clean. It is not possible to HPV the ward due to ceiling voids and square footage. In addition the two rooms available are not en-suite and one is at the end of a bay. There is a toilet shared between 2 bays that opens out onto the reception area of the ward. Ward 19 is still waiting to move to Ward 2. During April 2020 whilst COVID 19 is occurring Ward 19 has had a further Norovirus outbreak.	Closed

G Harris	**QS20/27.6** Provide details on how domestic cleaning standards will be maintained during the COVID-19 pandemic given pending pressures and additional risks faced.	May	Cleaning continues in the same way as before due to the products used which destroy COVID 19 in the environment. As with all “periods of Increased Incidence (PPI)”, enhanced cleaning takes place in high activity areas whereby touch points, hand decontamination resources and waste are addressed three times a day rather than twice.	Closed
G Harris	**QS20/27.7** revise Ward Accreditation reports to ensure split by site / area	May	Report to May meeting addresses this requirement	
G Harris	**QS20/50.1** clarify details of operational issues between BCUHB and WAST referred to in the WAST handover at ED report.	May	A revised ‘dual pin’ handover procedure was implemented in July 2019 whereby both nursing and ambulance staff jointly enter a unique pin to release the vehicle within 15 minutes of arrival and immediately at handover. Since this process was implemented there has been a deterioration in the 15 minute ambulance handover performance for the Health Board and the effectiveness of this process is under review on an All Wales approach. This is being addressed through the Emergency Department Quality Delivery Framework (EDQDF), of which BCUHB are an early adopter, and ambulance handover improvement is one of the key priority areas.	
L Singleton	**QS20/56.1** Amend summary action plan for the psychological therapy services report to reflect the recommendations from the review	May	Report to May meeting addresses this requirement	
L Singleton	**QS20/56.1** Update the membership for the Terms of Reference for the psychological therapy services review group	May	Report to May meeting addresses this requirement	

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety & Experience Committee 05.05.2020
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Infection Prevention (IP) Report
Cyfarwyddwr Cyfrifol: Responsible Director:	Gill Harris - Deputy Chief Executive / Executive Director of Nursing and Midwifery
Awdur yr Adroddiad Report Author:	Amanda Miskell – Assistant Director of Nursing (ADN) – Infection Prevention
Craffu blaenorol: Prior Scrutiny:	Gill Harris - Deputy Chief Executive / Executive Director of Nursing and Midwifery
Atodiadau Appendices:	

Argymhelliad / Recommendation:

The Committee is asked to note the Infection Prevention report.

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

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

Sefyllfa / Situation:

The IP exception report will update the Health Board (HB) on the position of IP performance and any associated risks relating to IP.

For this report a summary on:

1. COVID 19 clusters and related staff illness
2. Key IP issues
3. 2019/20 IP performance

Cefndir / Background:

Infection Prevention performance and reporting is compulsory to the Board. This is in relation to the position of the Health Board in relation to our trajectories, quality improvement, avoiding harm and exception reporting.

Asesiad / Assessment & Analysis:

Strategy Implications
To have a zero tolerance to any avoidable infection (I) across the HB that is either Community Onset (CO) or Hospital Onset (HO) and Health Care Associated (HCAI). This programme is multifaceted and has a reliance on the wider clinical Multi-Disciplinary Team and other services, in particular Estates and Facilities.

For year ending 2019/20 BCUHB was in 3rd position for four of the six trajectory infections and 2nd for two in the Wales dashboard. It should be noted that BCUHB was given a 12% reduced trajectory for Clostridium difficile for 2019/20. 2019/2020 saw a decrease of 32% in Meticillin Resistant Staphylococcus Aureus (MRSA) blood stream infections and 1% in E.coli infections which are increasing elsewhere. Avoidable infections have also decreased over the year and on average 77% of infections are unavoidable. Some of those avoidables are not Health Board related infections with other causes being attributable to other Trusts and contaminated blood cultures.

Although we are currently in a period of exceptional activity in relation to IP and COVID 19 IP initiatives and normal activity continues. This includes training and everyday advice and support in relation to all the other respiratory, blood stream and gastro intestinal infections. 2020 saw an increase in meticillin sensitive staphylococcus aureus (MSSA), some associated with wounds but not necessarily health care related or surgical, the majority of these were seen in the West an increase of 27 from the year before which is being scrutinised . Klebsiella and Pseudomonas infections also increased in 2020. East saw the biggest increase in cases of Klebsiella, 21 cases on year before and the majority of these were related to urinary catheters. Many of these infections although related to urinary catheters are not Health Care Acquired (HCAIs). The work related to removing these unnecessary devices continues in the hospital settings, and an increase in Trail Without Catheter (TWOC) clinics and an increase in those awaiting Trans Urethral Resection of Prostate (TURP) will continue into 2020/21.

Ward 19 has not yet moved and during April, Ward 19 has also had a further outbreak of Norovirus. The ward cannot be terminally cleaned due to the roof void and square footage with HPV. There are no ensuite facilities and only two rooms, one of which is via a bay. The cohort of patients make it difficult to isolate and cohort and one of the accessible toilets is in the foyer area outside of the bays.

Key issue to report is the level of COVID positive patients and associated clusters. From 19th March Wales was confirmed as being in “sustained transmission”. This has altered the Personal Protective Equipment (PPE) use and the need to carry out further training including Fit Testing for FFP3s which has been challenging due to loss of supply and increase in demand.

Key clusters of infection have been seen more in community hospitals with increased prevalence in staff infections. Holywell hospital had cases on both wards. As visiting had already been restricted and there had been a symptomatic staff member, it is most likely that the index case was a member of staff. It is difficult to ascertain if the other staff affected acquired from staff or from patients as we cannot confirm the index case.

At Ruthin hospital, two patients were discharged from Ward 7 at YGC on 27th March, not symptomatic. They both later tested positive on 1st April and were both isolated. A member of staff also tested positive on 2nd April who would also have been infectious before being symptomatic. The other three side room patients and female bay and twenty other members of staff all tested positive over the next two weeks.

In both hospitals staff have started returning to work who were symptomatic.

Guidance on PPE was understood by staff at both sites, and the IP guidance to include the use of PPE and donning and doffing was circulated to the staff by the IP Team. In addition a member of the IPT delivered a donning and doffing session to the ward staff, visiting the ward and also providing Fit Testing. Video conferencing and telephone contact was made daily and via weekend IP on call. Q&A sessions also took place. PPE was always available to staff.

If a member of staff was the index case it is unlikely staff would have implemented the same precautions and PPE with each other and therefore it is possible that staff infected each other and patients before they were symptomatic and tested positive as with many infections.

Financial Implications

1. Staff absence for self-isolating, shielding and symptom management.
2. Fit Testing equipment and positive pressure hood orders for Fit Test failures.
3. Movement of Ward 19 at YGC.

Risk Analysis

Infection prevention is currently on the Risk Register and a PPE risk register has also been developed via the PPE steering Group chaired by The Executive Director of Nursing.

Legal and Compliance

Reporting to Incidents for any COVID 19 clusters and deaths confirmed on death certificates.
Reporting to HSE via RIDDOR for any dangerous occurrences relating to staff infections.

Impact Assessment

No impact applicable to this report.

Cyfarfod a dyddiad: Meeting and date:	**Quality, Safety and Experience Committee**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Serious Incident Report – March 2020 (V2)
Cyfarwyddwr Cyfrifol: Responsible Director:	Matthew Joyes, Acting Associate Director of Quality Assurance & Assistant Director of Patient Safety and Experience
Awdur yr Adroddiad Report Author:	Kath Clarke, Head of Patient Safety
Craffu blaenorol: Prior Scrutiny:	Review by the responsible director and executive director
Atodiadau Appendices:	Serious Incident Report – March 2020

Argymhelliad / Recommendation:

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

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

Sefyllfa / Situation:

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

Cefndir / Background:

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

Asesiad / Assessment & Analysis

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

Serious Incident Report
March 2020

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

1. INTRODUCTION

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

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

1.2 With effect from Monday 23rd March 2020, as part of interim COVID-19 contingency measures, only the following incidents need formally reporting to the Welsh Government under the serious incident framework (following a temporary revision to PTR requirements advised by the Deputy Chief Medical Officer):

- never events
- maternal deaths
- neonatal deaths
- in-patient suicides
- mental health homicides
- unexpected deaths where the death is related to healthcare service delivery/failures
- Human Tissue Authority incidents
- IR(ME)R reportable radiation incidents
- other incidents of severe avoidable harm caused by healthcare service delivery/failures

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

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

- Grade 0 - Concerns currently and commonly referred to as a 'no surprise' and/or where it is initially unclear whether a serious incident has occurred will be graded 0. Unless further information is received, the Welsh Government will automatically close the incident after 3 days and no further correspondence with the Welsh Government is required.
- Grade 1 - It is expected that a comprehensive investigation will need to be completed by the Health Board organisation within 2 calendar months. In order to close this incident the Welsh Government require confirmation that an appropriate investigation has been

undertaken, has been reported to an appropriate committee, an action plan developed and where relevant has identified any actions for wider learning and dissemination. A closure/update report form is completed and submitted for this purpose.

- Grade 2 - This will follow a similar process to the above. A comprehensive investigation is required, and in some cases the incident may be referred for independent external review by Health Inspectorate Wales (HIW) or another regulatory body. Grade 2 incidents will be subject to ongoing monitoring by Welsh Government and final agreement through its Patient Safety Committee that the incident has been investigated appropriately and thoroughly before closure. Examples of such incidents could include mental health homicides, maternal deaths, clusters of similar incidents and never events.

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

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

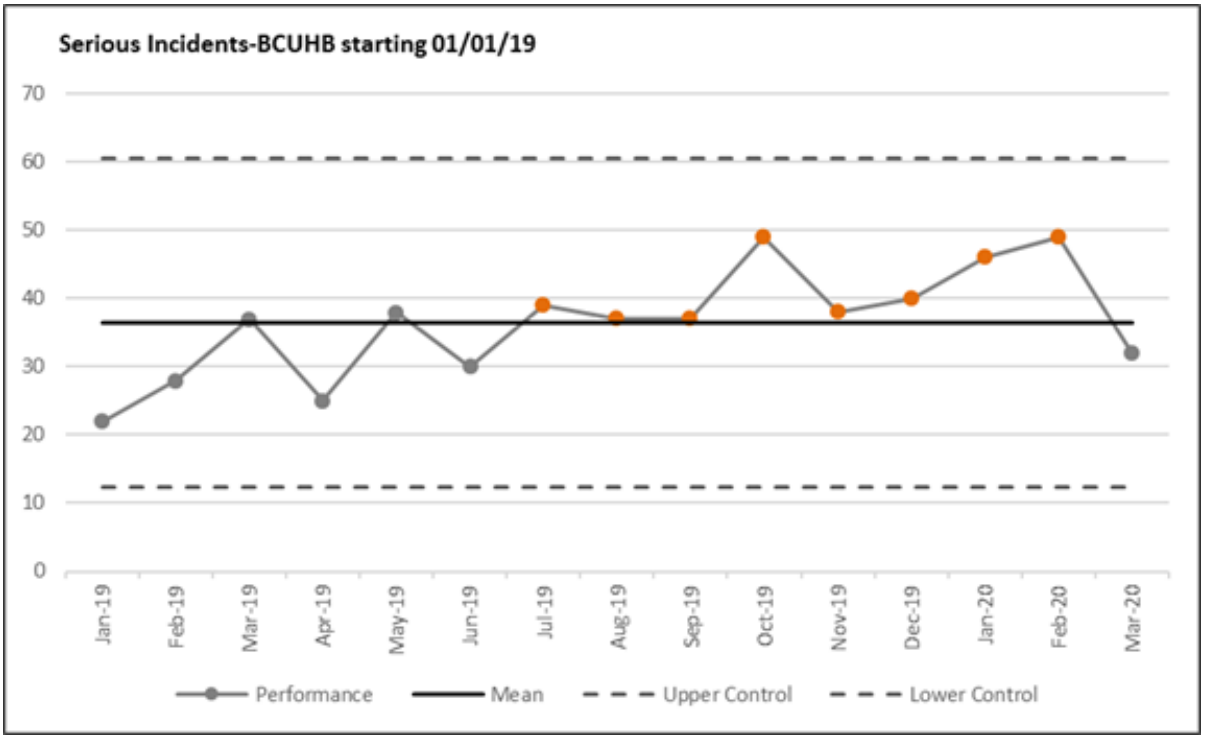
- A data point falling outside a process limit (upper or lower) indicates something unexpected has happened as 99% of data should fall within the process limits – the process limits are indicted by dotted grey lines.
- Two out of three data points falling near a process limit (upper or lower) represents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

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

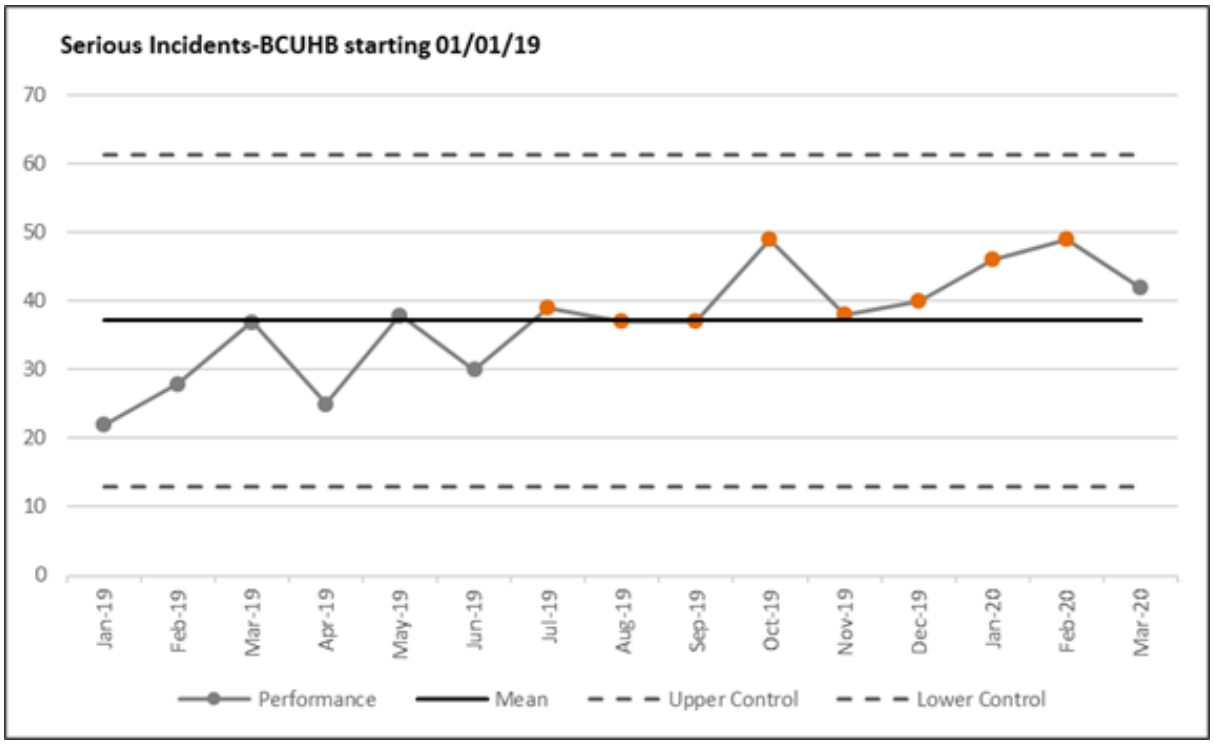
Variation			Assurance		
					
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling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

2. OVERALL SERIOUS INCIDENTS

2.1 During the time period under review, 32 serious incidents were reported compared to 38 in the comparable prior period.



2.2 The following chart shows an adjusted figure that reflects what the Health Board *would have reported* if the reporting criteria had remained the same:



2.3 The common categories of reported serious incident are as follows (this includes every category where four or more serious incidents have been recorded) – at the time of writing investigations are underway:

- Patient falls (which included the following categories: fall down steps; fall from a height, bed or chair; fall on level ground; tripped over an object). Nine incidents fitted into this category during the reporting period. During the period under review, Ysbyty Alltwen and Wrexham Maelor Hospital (different wards) reported the highest predominance of incidents. One incident was reported as catastrophic but this fall occurred in the patient's home and has been reported as the patient was open to mental health services (although reported as a fall rather than as unexpected death whilst under the care of a health professional.
- Unexpected death whilst under the care of a health professional – the significant predominance of these incidents are deaths reported by the Mental Health and Learning Disability Division who are required to report all unexpected deaths of patients open to services. This is regardless of whether the death was contributed to by healthcare services (as per the national Serious Incident Framework). During the period under review all deaths in the division occurred in community services and there is a largely even spread across localities. Four incidents fitted into this category during the reporting period and are subject to a Serious Incident Review if the rapid review identifies care and service delivery issues, or in all other cases a mortality review.

2.4 At the time of writing, 107 serious incidents remain open with Welsh Government of which 40 are overdue. Of these, the predominance of overdue incidents relate to Ysbyty Glan Clwyd (7), Central Area (8), and Corporate (5). All divisions have seen and continue to see a reduction in overdue incidents. A small number of incidents are overdue by twelve months (4) and these relate to matters subject to police investigation. A number (8) are overdue by 6-12 months and a slightly larger number (5) are overdue by 3-6 months. It is of note that West Area and Women's have only one overdue incident each.

2.5 The Patient Safety and Experience Department were planning a comprehensive review of the serious incident process (including incidents and safety alerts) and this will be conducted in co-production with divisions and other stakeholders. This work was due to commence in March 2020 but due to COVID 19 pandemic has been put on hold for the foreseeable future.

3. SPECIFIC SERIOUS INCIDENTS

3.1 The following serious incidents reported during the reporting period are being specifically highlighted for the attention of the Committee:

- 13 year old child found dead at home (likely suicide). The child was brought to Wrexham Maelor Hospital by Emergency Retrieval Service (EMRTS) but taken directly to mortuary rather than to the Emergency Department as stipulated in the Procedural Response to Unexpected Death in Childhood (PRUDiC) 2018 (Section 6).
- The patient attended the British Pregnancy Advisory Service for an early medical abortion (EMA). She was supplied mifepristone the same day and also took misoprostol. The client was alone at home following treatment. The client's parents were aware and tried to contact her but attempts were unsuccessful. Due to this the parents attended the client's home at and found her deceased. Duty of Candour is being followed by BPAS. Reported to WG as a sensitive issue but upgraded to serious incident. Investigation ongoing.

4. NEVER EVENTS

4.1 During the reporting period, one Never Event was reported. It was classified as being "wrong site surgery" and involved a steroid injection being administered into the wrong finger. The

patient was immediately informed, apology given and the correct finger then injected. Investigation nearly complete.

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

4.3 During the reporting period one Never Event was closed. The key learning points from these completed investigations are:

Incident Overview	Key Learning	Improvement Actions
A patient had a PiCC line inserted in to her right arm on the intensive care unit under aseptic technique, however, the locking and suturing clamp was not attached to the line. The line was sutured in place over the introducing cannula and an x-ray was taken to confirm position. It was later reported that the line was not flushing and the patient was cannulated in the left arm. The PiCC line was removed under aseptic conditions but when the line was pulled back, no catheter came out but the guidewire did. It was at this point that it was realised that the PiCC line had not been put in correctly (i.e. using LOCCSIP). The line was successfully removed by the interventional radiologist. Patient recovered with no ill effect.	Although a LocSSip had been introduced for the placement of PiCC lines it appeared that this was not followed within the ITU setting.	LocSSIp for PiCC line insertion re-introduced into ITU. The checklist is now situated with the PiCC line kit and this has been audited to check that this is in place. Anaesthetists discouraged from inserting PiCC lines unless there is NO alternative. Issue raised, discussed and agreed at Anaesthetic Medical Advisory Committee on 12/11/19. In addition a register of PiCC line insertions is now being kept and only consultants allow to insert when there is no alternative.

4.4 The Committee will be aware of a Never Event at Ysbyty Glan Clwyd. The investigation for this was due for completion in mid-March 2020. The report was finalised in late April and has now been sent for independent review.

5. LEARNING FROM SI REVIEWS

4.1 The current serious incident process has been amended in response to Welsh Government changes to PTR and the current COVID 19 pandemic. The rapid review has been replaced

with a “Make it Safe” process. A “Make it Safe Review” must be completed by the service within 72 hours for all severe and catastrophic incidents and submitted to the Corporate Patient Safety and Experience Department via BCU.WelshGovernmentIncidents@wales.nhs.uk who will make a decision on whether the incident can be closed or whether a full serious incident review is needed. The decision will be communicated to the service within 24 hours. If the incident can be closed the Corporate Patient Safety and Experience Department will complete the Welsh Government closure form.

4.2 During the reporting period, 64 serious incident closure forms were submitted to Welsh Government. Following the process mentioned above, the responsible division submits a closure form summarising the investigation and action plan to the Assistant Director of Patient Safety and Experience who reviews (on behalf of the Executive Director of Nursing and Midwifery) along with the Head of Patient Safety before onward submission to Welsh Government. The following high-level themes have been identified from a review of these forms:

- 23 closure forms related to unexpected deaths in mental health or substance misuse services where the cause of death was not connected to healthcare services and have been subject to a mortality review;
- 4 closure forms identified issues with the completion, review and updating of pressure ulcer risk assessments, Maelor scores and care plans;
- 6 closure forms identified issues with the completion of falls risk assessments; although in total 23 closure falls for falls were submitted to Welsh Government during the reporting period.
- Accurate completion of assessment documentation was a recurrent theme throughout the closure forms reviewed for the time period.

6. CONCLUSION AND RECOMMENDATIONS

6.1 This report provides the Quality, Safety and Experience Committee with information and analysis on serious incidents and Never Events occurring in the last two months (since the Committee’s last meeting) although 14 months of overall trend data is included (section 2.1) to allow for period on period comparison in the last year. Longer-term thematic analysis is included in the quarterly Patient Safety Report.

6.2 The QSE Committee is asked to note the report.

6.3 The QSE Committee is also asked to note the changes of Welsh Government serious incidents reporting requirements

6.4 The QSE Committee is also asked to note the implementation of the Make it Safe process

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety & Experience Committee 05.05.2020
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Stroke Services update report
Cyfarwyddwr Cyfrifol: Responsible Director:	Mr Rob Smith, East Area Director
Awdur yr Adroddiad Report Author:	Dr. Walee Sayed Clinical Director Stroke Care, Medwyn Jones DGM medicine and Stroke Managerial Lead, Dr Jill Newman Director of Performance
Craffu blaenorol: Prior Scrutiny:	Stroke Leads
Atodiadau Appendices:	*None*

Argymhelliad / Recommendation:

The committee is asked to note the report.

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

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

Sefyllfa / Situation:

This document provides an update on the latest performance in relation to stroke services. The paper briefly describes the admissions to wards, facility to support Stroke rehabilitation and outpatient services during Covid-19.

Cefndir / Background:

Stroke services have seen incremental improvement across BCU over a number of years, however work in London and Manchester has shown the benefits that can be achieved for patient survival of a different care model being adopted. Work has been undertaken across North Wales to redesign the service model focussing on achievement of the recognised national standards outline through evidence based practice and included in the Stroke Sentinel National Audit Programme (SSNAP). This work culminated in the development of the Stroke services business case which was submitted to the Finance and Performance Committee in November 2019.

The paper reflects on the progress since the production of the business case, the performance of stroke services and the present situation in continuing to provide this essential service during the covid-19 pandemic.

Asesiad / Assessment & Analysis

Stroke services have seen incremental improvement across BCU over a number of years, however work in London and Manchester has shown the benefits that can be achieved for patient survival of a different care model being adopted. Work has been undertaken across North Wales to redesign the service model focussing on achievement of the recognised national standards outline through evidence based practice and included in the Stroke Sentinel National Audit Programme (SSNAP). This work culminated in the development of the Stroke services business case which was submitted to the Finance and Performance Committee in November 2019. This provides a 3-4 year programme of service transformation to deliver: a community based early supported discharge programme and integrated regionalised community based rehabilitation in-patient beds to facilitate the move to a Hyper-Acute Stroke Unit integrated with an acute stroke unit on one site (HASU/ASU model). Given the deficit position at the time the committee were not able to support the additional in-year investment and this business case was refined further and prioritised for year 1 investment in 2020-21.

Progress

Since November 2019 it has been possible to progress with elements of year one of the business case so as to ensure improvement continues. Specific achievements include:

a) The commissioning of a 7 day per week thrombectomy service via Walton Hospital for our population. Work is required internally to enable CT angiography reports to be available for timely transfer of patients at weekends and so fully utilise the service.
b) The recruitment of a rehabilitation assistant for each of the three sites to support patients making earlier recovery and discharge through increased therapy contact time while in the acute phase of their strokes
c) The provision of improved IT connectivity and equipment to enable consultants to review patients' clinical care from home so as to increase the speed of decision making for patients who represent in ED.
d) Implementation of action plans for improved thrombolysis following the DU review of thrombolysis across Wales.
e) The Health Board has also participated in the Cross Party working group on Stroke Care and received the outcome report in April 2020 which is currently with the Minister for Health for consideration. The recommendations within this report align closely with the principles contained in the BCU Stroke Services business case.

Latest Performance

The national reporting of stroke performance has been stood down during the Covid-19 pandemic, however local data collection is still required and Stroke is seen as an Essential Service which must continue to be delivered during the Pandemic.

Mortality – Mortality figures by site for the past three years have been published by SSNAP in March 2020. For England and Wales the mean crude mortality was 13.5% and the mean SMR was 1.05. YGC is an outlier. An action plan is in place to address this.

Heath Board	**Site**	**2017/18**	**2016/17**	**2015/16**
		Crude Mortality % (SMR)	**Crude Mortality % (SMR)**	**Crude Mortality % (SMR)**
BCUHB	Glan Clwyd	15 (1.38)	14 (1.11)	16 (1.16)
	Wrexham	15 (1.04)	15 (1.08)	14 (1.05)
	Ysbyty Gwynedd	15 (1.26)	16 (1.18)	16 (1.12)

The SSNAP Scores show gradual improvement in services meeting the required standards with the last 6 quarterly reporting periods shown below (note years are calendar years)

SSNAP scores	2018	2018	2019	2019	2019	2019
	P20	P21	P22	P23	P24	P25
YGC	C	B	C	C	B	B
Wrexham	D	C	D	C	C	B
YG	C	D	C	C	C	C

The March 2020 performance figures are not yet available for the YGC site. The combined performance of the YG and Wrexham sites shows there is still room for considerable improvement on the key performance indicators included in the Annual Delivery Framework:

Stroke performance –March 2020 (YG and WMH data only; no data available for YGC)
Access to the Acute Stroke Unit within 4hrs: 28/64 = 43.8%
Stroke Consultant review within 24hrs: 54/67 = 80.6%
Speech and Language therapy compliance with daily minutes: 37.9%
Follow-Up assessment at 6 months: 41.8% *
*Taken from latest SSNAP quarterly BCU results (October 2019 – December 2019) – patient centred results.

The Covid-19 pandemic has required adjustment in the current service provision while maintaining focus on providing stroke care as an essential service. It is also felt by the clinical teams that the volume of potential strokes attending EDs has declined during this period, although at this time data is not yet available to demonstrate whether this is a change in the volume of mimic strokes or confirmed strokes.

Ysbyty Gwynedd- Currently no site pressures affecting the stroke ward and admissions are lower– general assumption is reduction in stroke mimics and patients avoiding hospital.

Referrals/Clinics - TIA clinics are running on site with a minimum of a 20% reduction in attendance and Stroke Follow-up clinic are generally used for Telephone FUP
Covid-19 Pathway for positive Covid-19-19 stroke patients is to admit to the Covid-19 Positive Ward and Stroke consultants will provide in-reach service.

Within Ysbyty Gwynedd the stroke ward is currently part of the escalation plan for ITU SHOULD Covid-19 levels increase and so there is a risk of needing to relocate this ward and its gym space to be able to continue to provide acute and rehabilitation services.

Ysbyty Glan Clwyd-Ward 14 is now a mixed ward with 8 beds for stroke and patients remain on ward for acute phase and transferred to Llandudno for rehabilitation phase. The contingency plan will be to move stroke patients to Colwyn Bay if beds in Llandudno are required for Covid-19-19-19. Specialist support for rehabilitation has relocated to Llandudno. Again general admissions are down and there is ward capacity currently.

Referrals/Clinics – TIA clinics in place and will see urgent patients and attendance have dropped by approximately 50%. All clinics are done virtually where possible via telephone FUP's.
Covid-19 Pathway for positive Covid-19-19 stroke patients is to admit to the Covid-19 Positive Ward and Stroke consultants will provide in-reach service.

Ysbyty Maelor- Bersham ward remains the stroke ward but the current stroke rehabilitation on Onnen no longer exists as wards used for ITU expansion. A document has been created and sent to HMT for the provision of Stroke Rehabilitation but concerns remain regarding consistency of provision if patients are sent to different community hospitals. Therapies have agreed to provide as much specialist input as capacity will allow. Currently no site pressures affecting the ward and ASU admissions are lower.

Referrals/Clinics - TIA clinics are running on site with a reduction in attendance of approximately 50% and Stroke Follow UP clinics are generally used for Telephone FUP with patients.
Covid-19 Pathway for positive Covid-19 stroke patients is to admit to the Covid-19 Positive Ward and Stroke consultants will provide in-reach service.

Summary
In summary all 3 sites have seen a reduction in admissions and capacity is available on the wards currently. Further discussion required with Ysbyty Gwynedd regarding contingency plans for Stroke Patients if Covid-19 patients increase. TIA clinics remain in place and all site doing telephone follow ups. Scans and Swallow assessments remain in place on all 3 sites. The general view regarding outcomes is that patients are not coming to the hospital (stroke mimics or mild strokes) but difficult to quantify, however clinicians are concerned of issues post Covid-19

Recommendation
The committee are asked to note the content of the report.

Strategy Implications
The business case for stroke provides an excellent strategic fit with the learning from evidence-based practice, the care closer to home strategy and the cross-party working group recommendations to Welsh Government.
The immediate changes implemented to support the continuity of services and risks arising in the longer term due to covid-19 are reflected in the document.

Financial Implications
The financial implications are set out in the business case.

Risk Analysis
There is a risk at the present time that the reduction in patients presenting early with stroke symptoms may impact on longer term patient outcomes and rehabilitation requirements.

Legal and Compliance
None identified

Impact Assessment
The business case includes a full Equality Impact Assessment.

Board/Committee report template

Cyfarfod a dyddiad: **Meeting and date:**	Quality, Safety & Experience Committee 05.05.2020
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Ophthalmology Report
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Mrs Gill Harris, Executive Director of Nursing & Midwifery
Awdur yr Adroddiad **Report Author:**	Dr Jill Newman Director of Performance
Craffu blaenorol: **Prior Scrutiny:**	Eye Care Group Leads
Atodiadau **Appendices:**	*n/a*

Argymhelliad / Recommendation:

The committee are asked to note:

1. The continuing challenge in reduction of backlog of patients waiting for outpatients and treatments, with limited improvement made in 2019/20
2. The opportunity presented through the digital pathway re-designs and development of the eye care business case
3. The impact of covid-19 on present service delivery
4. The work undertaken to establish pathways at this time to provide access to emergency and urgent eye care for patients and so mitigate the risk of harm due to sight loss.

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

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

Sefyllfa / Situation:

This paper is intended to provide the committee with a brief overview on the progress in delivering improvements in the provision of eye care in North Wales and the current position in relation to delivery of eye care during Covid-19 aimed to minimise the risk of harm to patients.

Cefndir / Background:

The population in North Wales experiences delays to accessing secondary care services. It is recognized that these delays can result in harm for patients including the loss of vision. Eye Care measures were introduced to enable patients to be managed via a clinically determined risk stratified approach so as to reduce the risk of harm occurring while waiting.

The development of the Welsh Eye Care Service (WECs) has resulting in an extended range and increased volume of activities delivered in primary care and demonstrates the potential offered from multi-professional working.

The eye care transformation fund was used in 2019/20 to further increase this way of working , promoting a move towards shared care and revision of the three largest eye care pathways which culminated in the production of the eye care business case and the award of contract to 6 primary care ophthalmology and treatment centres, the development of an expansion and training of non-medical injectors for WetAMD and the referral refinement and aftercare of patients requiring cataract treatment to minimize visits to hospital.

The backlog of patients waiting in secondary care remains high and while the business case for eyes aims to address this, the impact of Covid-19 has meant that for routine patients, vulnerable and self-isolating patients and staff service reduction has been necessary based on a balance of risk and professional guidance.

The paper identifies the actions taken rapidly to provide new pathways for emergency and urgent care in North Wales with the aim of minimising further harm for patients during Covid-19. These have resulted in the development of the Primary Care Cluster Hubs for emergency eye care and the Primary Care ODTCs to support clinical data capture for patients in need of urgent eye care and so inform consultant decision-making.

Asesiad / Assessment & Analysis

The purpose of this paper is intended to provide the committee with a brief overview on the progress in delivering improvements in the provision of eye care in North Wales and the current position in relation to delivery of eye care during Covid-19 aimed to minimise the risk of harm to patients.

Population Health Need

The population demographics in North Wales means that there is an increasing incidence of chronic eye disease. Public Health Wales prevalence data 2015 – 2039 estimates by 2039 N Wales will see an increase of 5,020 people living with AMD; 3,370 people with Glaucoma and an increase of between 5,510 and 12,590 people with a Cataract.

The RNIB data below shows the population of each Borough within North Wales and the anticipated numbers of people living with sight loss by 2020.

RNIB information on Sight Loss for the Boroughs of North Wales 2019						
Area	Population Total	% population 65+	Number People living with sight loss	Number of people registered blind or partially sighted	% increase in people with sight loss by 2030	Estimated (Direct and indirect) cost of sight loss each year
Flintshire	155,155	21%	5,430	820	38%	£69,390,000
Wrexham	135,571	20%	4,700	660	37%	£60,230,000
Denbighshire	95,159	24%	3,790	227	32%	£48,900,000
Conwy	116,863	27%	5,520	321	26%	£71,630,000
Isle of Anglesey	69,794	26%	2,990	427	30%	£38,610,000
Gwynedd	123,742	23%	4,080	705	23%	£62,470,000

The RNIB has worked with Deloitte Access Economics to produce detailed analysis of the economic cost of sight loss in the UK. Based on the proportion of people living with sight loss in each area, the RNIB can estimate these costs for each local authority.

Current Service Provision

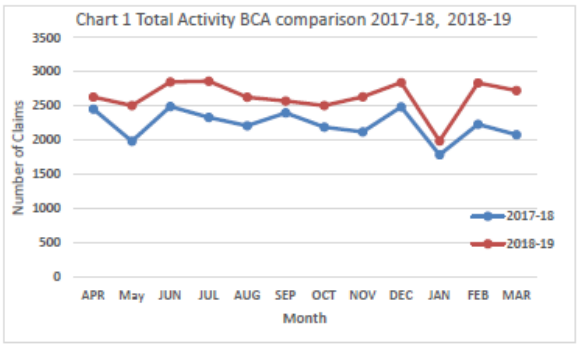
The eye care services in North Wales are provided in primary care via Optometry practices with a wide geographical base and relatively close to population centres and via the Hospital Eye Services (HES) on Ysbyty Gwynedd, Ysbyty Glan Clwyd and Wrexham Maelor Hospital sites. The Hospital Eye Service also operates through ophthalmology diagnostic and treatment centres at Colwyn Bay and Deeside Hospital and outreach clinics within community hospitals. Orthoptist and specialist eye care nurses work from within the Hospital Eye Services.

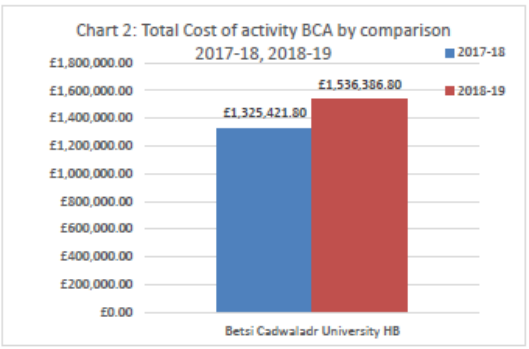
North Wales Eye Health Examination Wales (EHEW) Optometric Practices by Location

Welsh Eye Care Service (WECS)

The WECS service is delivered via EHEW accredited optometrists across North Wales. The service has expanded to provide clinical triage and signposting of referrals, post cataract review and aftercare, follow up review of long waiting patients. Data for 2019/20 is currently being finalised and is expected to show continuation of the expansion in the service delivered seen in the previous year as a result of the work undertaken to transform eye care across North Wales.

Chart 1 indicates that total activity for the Health Board has risen by **2084 (9%)** in 18-19 compared to the previous period of 17-18. Chart 2 shows that the cost of services have increased for by **£210,965 (14%)** during 18-19 compared to 17-18.





Hospital Eye Services

Within secondary care the waits for referral to treatment and the follow up waits are of significant concern and pose the greatest risk of sight loss. BCU lead the way in highlighting the need to adopt a risk based approach to the delivery of eye care resulting in the development of the national programme of work developing and implementing Eye Care Measures. This approach produces a risk stratification of patients waiting for secondary care review and treatment with a clinical due date identified so as to indicate where delays to the patient treatment may lead to harm. The patients are risk stratified into Health Risk Factors (HRF) 1-3 with HRF1 being the highest risk of harm.

During 2019-20 the health board have been actively working to implement the eye care measure programme of work which aims to minimise risk of harm through shared care for chronic condition management between primary care and secondary care, re-designing clinical pathways of care to optimise clinical time and access for treatment and digitise the integrated eye care service.

Measurement of eye care access times shows that the challenge is sizeable and while improvement has been made there is more to do. The table demonstrates improvement in all measures at the end of March 2020 compared to the March 2019 figures with achievement of the targets for ensuring 98% of patients have a HRF value and the volume of follow up patients more than 100% overdue there appointment. The work has seen an increase in the volume of patients classified as HRF1 with almost 84% of the hospital eye service waiting list in this highest risk category. This increase is expected and reflects that the majority of patients within the service are deemed to require Consultant led care. This level is higher than other health board in Wales. There is an intention to introduce Peer Review nationally to demonstrate consistency.

The aim of eye care measures is to ensure that 95% of patients waiting less than 25% beyond their clinical due date. BCUHB achieved this for just over 65% of our patients at the end of March 2020. This means than c10,000 remain waiting longer than this for their appointments and is the greatest area of concern which the Eye Care business case aims to address.

Eye Care delivery plan

BCU		Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Gap to target	change year to date	Percent of R1 on waiting list	12 month Percentage improvement
	Plan	30527	30020	29513	29006	28499	27992	27485	26978	26471	25964	25457	24950	24442				
Follow up waiting list - total number waiting	Actual	30527	29876	28968	29404	28985	28887	28386	28386	28232	28254	28262	28179	27885	-3443	2642		8.65
	Plan	8223	8086	7949	7812	7675	7538	7401	7264	7127	6990	6853	6716	6578				
Follow up waiting list - total number 100% overdue	Actual	8223	7589	7013	7207	7101	7065	7022	6715	6689	6699	6498	5985	5849	729	2374		28.87
	Plan	36887	36643	36399	36155	35911	35667	35423	35179	34935	34691	34447	34203	33962				
ECM Total number on list	Actual	36887	38705	37895	39156	38341	38670	38058	37379	37288	37309	37019	36022	35715	-1753	1172		3.18
	Plan	25909																
ECM total number of R1	Actual	25909	29519	29371	30383	29294	29666	29171	28886	28949	29637	29912	29991	29949		-4040	83.9	-15.6
	Plan	10723	10562	10401	10240	10079	9918	9757	9596	9435	9274	9113	8952	8792				
ECM total number R1 overdue more than 25%	Actual	10723	11310	10612	11215	10840	10837	10772	10324	10382	10771	10603	9792	10325	-1533	398		3.71
	Plan	87.80%	89.10%	90.40%	91.70%	93.00%	94.30%	95.60%	96.90%	98.20%	98%	98%	98%	98%				
%patients with HRF value	Actual	87.80%	96.73%	97.74%	98.77%	98.47%	99.11%	98.95%	98.92%	99.10%	98.93%	98.86%	98.58%	99.38%	1.4%	11.58%		13.19

The Eye Care Business Case is awaiting approval (interrupted due to the covid-19 incident) and addresses three main eye care pathways which are recognised as the main areas for risk of harm for patients:

- Glaucoma
- WetAMD
- Cataract.

While the business case process has been interrupted, work to support the implementation started through the eye care transformation fund in 2019/20 and this facilitated improvement work to progress within the three pathways and link to the national work on the digital eye care programme. The changes introduced are considerable, however many started to come to fruition late in 2019/20 and so the full benefits have yet to be realised or fully quantified. It must also be note that for some of the pathway changes there will be a time-lag while the multi-professional workforce development takes place. Therefore short term non-recurrent solutions will be needed during 2020-21 to support the transition to new ways of working.

<u>Glaucoma:</u>

The Health Boards glaucoma pathway has been agreed and is aligned to the national glaucoma pathway which aims to increase the care delivered in the community with consultant visits only required on average for every third appointment. A high proportion of the follow up backlog in

secondary care relates to glaucoma management and therefore it is important to create the additional capacity required by taking a multi-professional pathway approach.

Additionally, to enable further release of capacity in secondary care for glaucoma management, the re-designed cataract pathway forms an inter-dependant factor in successfully reducing the backlog of patients in need of consultant glaucoma care.
In January 2020, following a procurement process, 6 primary care ophthalmology diagnostic and treatment centres (ODTCs) were appointed to take this pathway forward. There is an important period of training required to support these practices to progress from referral refinement, to support shared care management of patients with stable glaucoma and ultimately with advanced training and independent provider status to provide glaucoma management on low-medium risk patients. This programme of work will take 2-3 years to fully embed. Training places have been secured via HEIW and consultant placements are essential for skill and relationship development.

This programme is heavily reliant on good IT systems and infrastructure to fully enable shared care of these patients. The award of the contract for digital eye care to OpenEyes was made nationally prior to Christmas 2019 and BCU are working with the national programme to improve connectivity enabling referral and image transfer between primary and secondary care as a bi-directional system. This programme of work is the largest clinical digital eye care programme in Wales, the full business case is currently with Welsh Government.

<u>WetAMD</u>
The transformation fund and BCU discretionary capital in 2019/20 enabled the opening of the second IVT suite in Abergele, supporting the development of a training hub for non-medical injectors and facilitating the running of parallel lists. 3 nurse (one from each acute site) are undertaking this training and so will expand service capacity. However the business case demonstrated that the demands on this service will continue to grow and identifies the importance of time–critical injections for these patients to reduce sight-loss.

<u>Cataract Surgery</u>
Good progress has been made during 2019/20 across all three hospital sites in re-designing with primary care the cataract pathway, enabling patients through optometry referral refinement be directed to a one-stop pre-operative assessment, biometry and consenting service prior to surgery and for follow up care to be provided in accredited optometry practices. This work needs to continue in 2020/21, optimising the productivity on the theatre lists and reducing the RTT backlog of surgical patients waiting for cataract removal. At the end of March 2020 1497 were waiting over 36 weeks on the referral to treatment pathway with c500 of these awaiting for surgery. This has increased during the covid-19 incidents due to the national and professional guidance on cessation of routine cataract surgery and so will require a recovery plan once it is safe to recommence surgery.

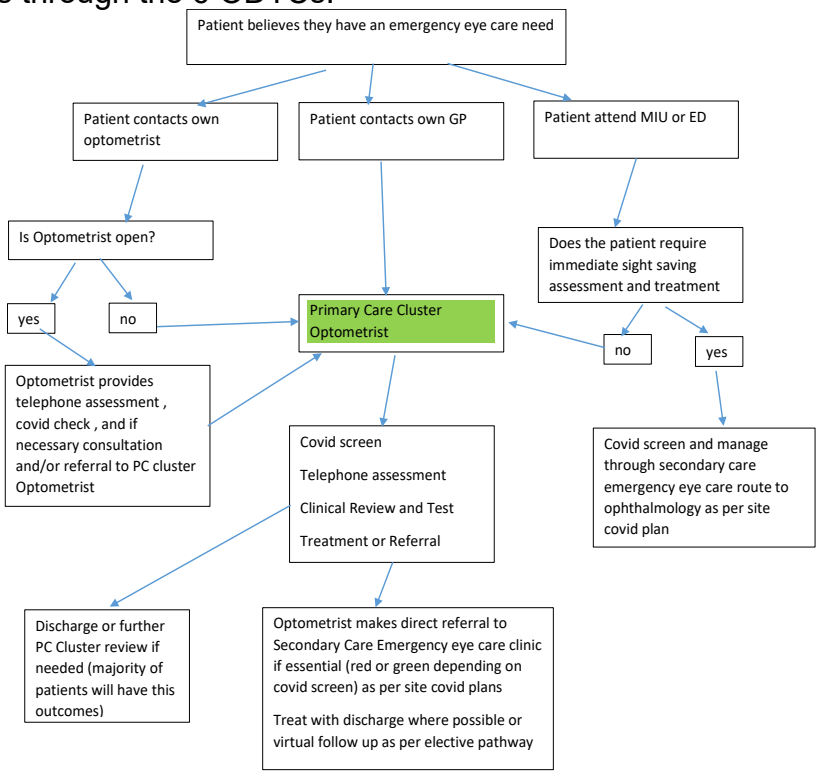
Covid-19 Impact on eye care services and mitigating actions.
The covid-19 pandemic poses a number of challenges for delivery of essential eye care services. These include:

- Balancing the risk of covid-19 infection with the risk of loss of sight for our population given that a proportion of our patients will be shielding or self-isolating in line with covid-19 advice.
- Ensuring the safety of our staff undertaking examinations and procedures on patients in close physical contact to the face
- Recognising that some patients due to covid-19 symptoms or positive diagnosis are unavailable for treatment or are naturally unwilling to attend appointments at this time.

- Recognising that some of our workforce are unavailable due to self-isolating, or covid-19 symptoms or diagnosis to provide treatment at this time.
- Recognising the need to be agile in providing care in the current uncertain environment and therefore providing an immediate response while planning for re-activation and recovery of eye care services over the next few months and into next year.

National guidance, including the framework developed by Moorfields eye hospital is being used to determine which areas and thresholds for intervention can proceed at this time. All routine outpatient and cataract appointments have been postponed until it is safe to proceed.

The eye care group has worked positively and quickly to take account of all the professional and national guidance in relation to managing eye care at this time. This has resulted in the development of both an emergency eye care and an urgent eye care pathway, both of which have been supported through the covid-19 clinical advisory group of the health board and are being implemented. These pathways aim to mitigate the risk of harm occurring to patients during the covid-19 pandemic.
The full papers and project plan are lengthy and so for brevity the pathways are presented together with the detail on the location of the primary care practice cluster hubs and the process of management of Glaucoma pathways through the 6 ODTCs.



Note: domicillary service note currently available. PC optometry hub will work on a telephone assessment process and review in practice essential cases , referring to secondary care emergency cases which need HES treatments.

Eye problems?

ıave an eye problem then it may well be your regular Opticians is not contactable.

is a list of Health Board supported Optometry Practice Hubs where you will receiv
and assessment; and examination if required. **This is a free service**.

phone your nearest Hub:

Cluster Area West:

• Specsavers	Caernarfon	01286 685820
• Barnet Pepper	Caernarfon	01286 672717
• Eleanor Davies	Dolgellau	01341 423773
• M W Williams	Bangor	01248 354949

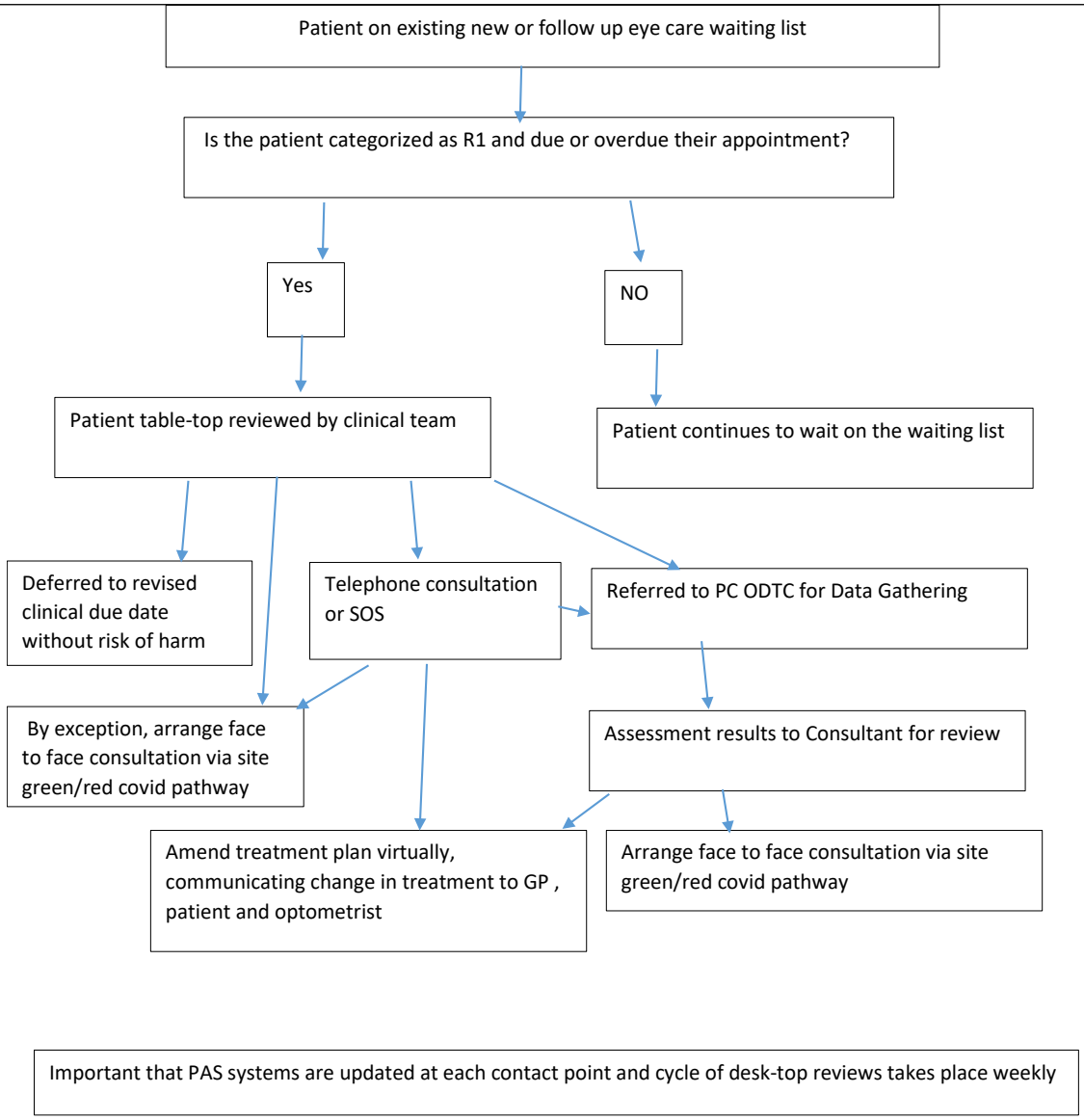
Cluster Area Central:

• Specsavers	Llandudno	01492 877077
• ASDA	Llandudno	01492 864320
• Saunders & Schwarz	Llanrwst	01492 640682
• Specsavers	Rhyl	01745 343200
• Saunders & Schwarz	Denbigh	01745 812767

Cluster Area East:

• Specsavers	Flint	01352 792710
• Specsavers	Broughton	01244 509959
• Schwarz Sons	Holywell	01352 714888
• Specsavers	Mold	01352 705090
• Specsavers	Wrexham	01978 261485
• i.Matters	Wrexham	01978 291653

correct as of 20/04/2020. Up to date list can be found at www.eyecare.wales.nhs.uk



Agreed pathway: Glaucoma Time Critical Review: Data Capture in Community

These patients are **most at risk** of time critical sight loss who are **least at risk** of COVID-19.

a) To enable immediate management decisions
b) To inform the post COVID era urgency of appointment

Step1 Table-top review of notes will allow patients to be selected by Consultant onto this pathway. Consultants will retain final discretion, but patients *may* include (guidance not protocol):

- Most overdue follow-up Glaucoma/OHT patients
- Most unstable Glaucoma patients
- Patients with recent medication change
- Patients due for or having had recent IOP controlling surgery
- New/Pending patient who has have newly commenced treatment despite no assessment by Ophthalmologist and now requires a follow up IOP check

Step2 Lists of designated patients split between and sent to nearest Primary Care ODTC's (PC ODTC), every Friday. The PC ODTC's then contact the patients to advise of the process, booking in appropriately asking COVID symptom questions to ensure their sites remain Green.

Step3 Patient attends the PC ODTC and goes through agreed protocols of social distancing and sterilisation. Optometrist takes agreed measurements, which **at this point** are:

- Visual Acuities (Vas) (Right & Left (R&L)
- Intraocular Pressure (IOP) R&L
- Patients will be asked if they are compliant with drops and if any side effects noted. If any problems these will be noted in the "comments" section of the report form.

Step4 These quantitative results are then returned to the requesting hospital/Consultant via fax and then posted every Friday. (The service will move to digital feedback when a solution arises.) The results reported back to include patient identifiers; VA's R&L and IOPs R&L where attendance occurred; or Did Not Attend arranged appointment or Refused Offered Appointment where no attendance occurred. Any IOP of 35mmHg or more will result in urgent referral (fax if working hours Mon-Fri; phone call if outside that is deemed appropriate based on presentation.)

Step5 The results are viewed by the Ophthalmology teams to consider:

- Change in medication management? (To be actioned via a letter to GP)
- Change in Red/Green rating / Consider Target Date of next appointment

Area	PC ODTC	Fax	Email
WEST	Specsavers, Caernarfon	01286 685822	dyfan.jones@specsavers.com
	Barnett Pepper, Caernarfon	01286 672726	bethan@barnetpepprer.co.uk
CENTRAL	Specsavers, Llandudno	01492 877555	charlotte.jones1@specsavers.com
EAST	Specsavers, Broughton	01244 504588	Kelly.gibson@specsavers.com
	Schwarz Opticians, Wrexham	01978 316778	alistair@schwarzopticians.co.uk
	Jane Smellie, Wrexham	01978261098	wrexham@smellieopticians.co.uk

<u>Mitigation of risk of harm during the covid-19 pandemic</u>

In order to mitigate the risk of harm during covid-19 pandemic the above pathways are key. It will always be necessary for clinicians to balance any potential harm from deterioration or loss of sight with the risk of covid-19 infection for our patients, especially as many of the patients we treat are elderly and may well be shielding or self-isolating at this time. It is also important to ensure staff are protected from risk of harm due to infection at this time.

The actions being taken to mitigate the risk of harm due to sight-loss are in line with professional guidance and include:

1. Consistent pathway for emergency eye care with majority of patients directed to community based services for the management of their condition and avoidance of footfall onto an acute site
2. Green and Red pathways identified on acute sites for emergency eye care conditions which need immediate sight-saving treatment by the Hospital eye service
3. Improved communication pathways between primary and secondary care for management of emergency eye care.

4. Cancelled appointments table top reviewed by secondary care consultants to determine alternative routes for consultation and treatment based on clinical risk , with outcomes including defer for 12 weeks with no increased risk, telephone consultation, data collection by primary care optometrists and results feedback to inform treatment decisions, face-to face consultation.
5. Same weekly process of table top review for HRF1 patients due to be booked with risk stratification into green-safe to defer appointment for 12 weeks, amber needs to be reviewed in 4-12 weeks, red needs to be reviewed within 4 weeks to mitigate against risk of harm.
6. WetAMD clinics moved to one stop diagnostic and injection clinics to reduce footfall and time spent in department. Green covid-19 pathway created on each site with red areas and routes identified for patients with covid-19 symptoms.
7. PPE provided to PC cluster hubs and PC ODTCs to protect staff working in these environments.

Recommendations

The Quality, Safety & Experience committee are asked to note:

5. The continuing challenge in reduction of backlog of patients waiting for outpatients and treatments, with limited improvement made in 2019/20
6. The opportunity presented through the digital pathway re-designs and development of the eye care business case
7. The impact of covid-19 on present service delivery
8. The work undertaken to establish pathways at this time to provide access to emergency and urgent eye care for patients and so mitigate the risk of harm due to sight loss.

Strategy Implications

The business case for eyes provides an excellent strategic fit with the development of digitally-enabled multi-professional pathways of care,supporting prudent health care principles and care closer to home.

The immediate pathway changes align to national advice and recommendations in providing essential eye care services for patients during the Covid-19 pandemic. These changes aim to mitigate the risk of harm from sight-loss while balancing with the risk to our staff and patients from covid-19 infection.

Financial Implications

The financial implications are set out in the business case.

There are financial implications of the immediate pathway changes during Covid-19 and these are being worked through as part of the Covid-19 costs and resource recently been made available for eye care from the Outpatient Transformation fund.

Risk Analysis

Loss of and/or deterioration of sight arising from both the current waits and the covid-19 pandemic both present significant risks which while mitigated through the actions being taken will not be eliminated while backlogs within the pathways continue to exist.

Legal and Compliance
Extension of the Primary Care ODTC contracts forms part of the business case and is being addressed by Executives to support good governance during the Covid-19 pandemic.

Impact Assessment
The programme plan for the implementation of the emergency and urgent care pathways during the pandemic has a Quality Impact Assessment completed and a data protection impact assessment. The business case has had an EquIA included.

PSYCHOLOGICAL THERAPIES REVIEW IN NORTH WALES

Facilitated by TogetherBetter Collaborative Consultancy

February - August 2019

Reviewers & Report Authors

Anna Lewis

Dr Alison Beck

Dr Amanda Clark

Extract taken of recommendations from main report:

Chapter Seven

Our Recommendations

1. Focus first on engaging staff

Staff engagement trumps all other measures for predicting the quality of organisational outcomes. Bring together a cross-specialty group of people, chosen for their passion and expertise in psychologically-informed care, who represent a diverse cross section of the multidisciplinary workforce. Give them dedicated time, a specific brief, the freedom to act and some independent facilitation. Sponsor the work at Board level. Plan from the outset to embed an appreciative style of collaboration, building upon existing work around strategy implementation. Make the primary goal to build trust. Consider if a reverse mentoring initiative between this group and the Divisional leadership team would be valuable.

2. Co-create a vision for psychologically-informed approaches

Come together as a diverse group of stakeholders to explore why this matters to you. Bring the conversation into the heart of the organisation's narrative. What do you mean by 'psychologically-informed care' across the board – from mental health and learning disabilities to cancer to long term conditions? How can it help you to achieve your BCUHB vision? What needs to change in your system and your culture to make this a reality? Clarify the role and accountability of the Psychological Therapies Management Committee and consider if it is constituted and functioning effectively to deliver against that role. Create safe space to explore the particular inter-professional challenges within the mental health field. Co-produce the vision with your partners as well as people who have recent experience, and set out how the voice of lived experience will be embedded in

service delivery. Consider if there are better ways to work together with the third sector, pooling respective strengths to grow community resilience.

Align it with a vision for the relationship that BCUHB wishes to have with its employees – a psychologically safe, values-driven employer of choice, which enables people to thrive.

3. Design and equip pathways of care that are fit for purpose by:

a. addressing the legacy waits in East Adult Mental Health

Design and resource a specific non-recurrent solution for the backlog, which addresses any outstanding cultural change as well as direct clinical capacity. Simultaneously ensure the service is designed to cope with today's work today, participating fully in the work around stepped care described below.

b. making stepped care a reality

Look across the whole system, both horizontally and vertically, to work towards the right care in the right place at the right time. This can't happen in specialist psychological therapies services alone. It requires better collaboration across team, area and organisational boundaries – a strategic approach. The current fragmented system design means there is insufficient capacity at Tier 1 to intervene early and pull demand away from specialist services. Be willing to redesign tiers or services, and to allocate resources differently, to ensure capacity and expertise is aligned for timely access. Make the links with other sources of feedback, such as the Joint Thematic Review of CMHTs and Delivery Unit reviews. Consider operational improvements such as standard operating procedures, step up and step down protocols, information sharing, joint capacity management, supervision and training across tiers, outcome measurement. This may need to look slightly different in different areas, but tackling unwarranted variation in access to and quality of care must be a priority to end the postcode lottery. This is a very big challenge for some specialties, so make effective use of pilot approaches to establish proof of concept through iterative change cycles.

c. tackling inequality of access

Service users experience wide variation in access that is unwarranted. They may be disadvantaged in receiving timely evidence-based interventions as a result of where they live, what co-existing needs they may have, how they communicate, whether they are marginalised. While much of this variation can be explained, much less can be justified. There is a known data deficit here, so the first task is to understand what can be achieved to improve your understanding of the specific issues around unequal access.

d. looking at out of county repatriation potential

Local people are leaving their homes and their roots in order to access specialist care out of county, as a result of gaps in local pathways. There is significant potential for psychologically-oriented solutions to make a transformative contribution to the repatriation of people with complex and long term needs. Clinical Psychologists have a unique skills set to offer to these challenges, but lack of capacity and opportunity are barriers to improvement.

4. Devise a strategic workforce plan and phase its implementation, with clear resource commitments at each stage.

Specialities which have made clear progress in embedding psychological approaches across their services have done so by ensuring that workforce design complements a well-informed service vision and strategy. They pull in the same direction. Capacity building requires specialist time and expertise to be allocated to multidisciplinary training, supervision, team consultation and service development. It also requires multidisciplinary role design to be centred around therapeutic outcomes. It is important that additional investment, which is inevitably needed, is not simply ploughed into doing more of the same, but that it considers the development needs of the multidisciplinary workforce as a whole.

Specific actions might include:

- Gaining a clearer understanding of population need alongside existing workforce and capacity design. What do we need and where?
- Developing a clear career pathway for clinicians who specialise in psychological therapies. This might include development of a more diverse skill mix, cross-speciality opportunities for continued professional development, a leadership development offer for Clinical Psychologists, and opportunities for advanced practice (e.g. specialisation; approved clinician role). This should include practitioners who work within primary care (Tier 1).
- Designing a skills escalator, which describes the psychological toolkit that every clinician will have, from support worker through to consultant psychologist and psychiatrist.
- Reviewing the role design of care co-ordinators, to ensure every clinician has the opportunity to practise in therapeutically oriented ways.
- Designing a workforce training plan that serves the needs of the vision and strategy.
- Ensuring that the conditions for psychologically-informed practice are designed into the workforce and what is asked of it. This includes management practices and behaviours that nurture psychological safety and trust.

5. **Undertake specific work to strengthen team-based interdisciplinary working, in line with the evidence base.**

Specialties that are able to demonstrate clear evidence of psychologically-informed care have created the conditions for effective interdisciplinary working to happen. Where this is not the case, it is vital for it to happen. This is unlikely to be a 'one size fits all' solution, as different teams have different starting points, but a common approach to define what you do to nurture team-based working could make a valuable contribution.

6. **Pay attention to the enablers of change:**
    a. **take urgent action to tackle the gaping intelligence deficits in services**

Recognise the scale of risk that is associated with the current paucity of intelligence-driven decision-making, both in terms of quality, safety and effectiveness, as well as less tangible aspects such as transparency and trust. What can you do while you wait for an all-Wales electronic solution?

    b. **strengthen the governance and assurance flows from team to area to Division to Psychological Therapies Management Committee**

The fragmentation apparent in existing arrangements is a significant barrier to progress. The need for more effective multidisciplinary join-up is essential for both quality and culture. This should include clarity as to the leadership of the psychological therapies agenda in the organisation, as well as optimal operational management arrangements to nurture interdisciplinary working.

    c. **make effective use of recognised quality improvement methodology to test ideas and engage staff. Use pilots; avoid 'big bangs' and initiative overload**

Organisations that have a consistent approach to continuous quality improvement are able to accelerate progress, by building capacity and capability for improvement into daily work. The change agenda facing NHS services across the UK calls for a co-ordinated and tactical approach that focusses effort where it is most needed, in ways which appeal to the intrinsic motivation of staff to improve care. We strongly urge you to consider how your wide-ranging strategic implementation programme might embrace quality improvement methodology at its heart.

Cyfarfod a dyddiad: **Meeting and date:**	Quality, Safety & Experience Committee 05.05.2020
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Update on Psychological Therapies
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Lesley Singleton Interim MHLD Director/Director of Partnerships
Awdur yr Adroddiad **Report Author:**	Lesley Singleton Interim MHLD Director/Director of Partnerships
Craffu blaenorol: **Prior Scrutiny:**	Interim MHLD Director
Atodiadau **Appendices:**	Appendix 1 – Psychological Therapies Recommendations aligned to work programme

Argymhelliad / Recommendation:

The committee is asked to receive this report and regular updates on improvement work for scrutiny and assurance.

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

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

Sefyllfa / Situation:

Within Wales, despite improvement work an increase in demand for psychological therapies, together with low levels of specialist resource and a lack of NHS architecture and infrastructure to support workable stepped care pathways, means people are still waiting too long for treatment. There are areas of North Wales where waits are reasonable and compliant with Welsh Government Targets. However, there remain areas of concern such as Wrexham which continue to skew regional reporting due to a backlog of legacy waits.

The BCUHB MHLD external review has now concluded, and within the MHLD Division a workshop in February 2020 and a new programme board developed to take 5 specific improvement workstreams forward. The lines of accountability will be update reports and any issues/concerns will be escalated to the Health Board QSE.

Cefndir / Background:

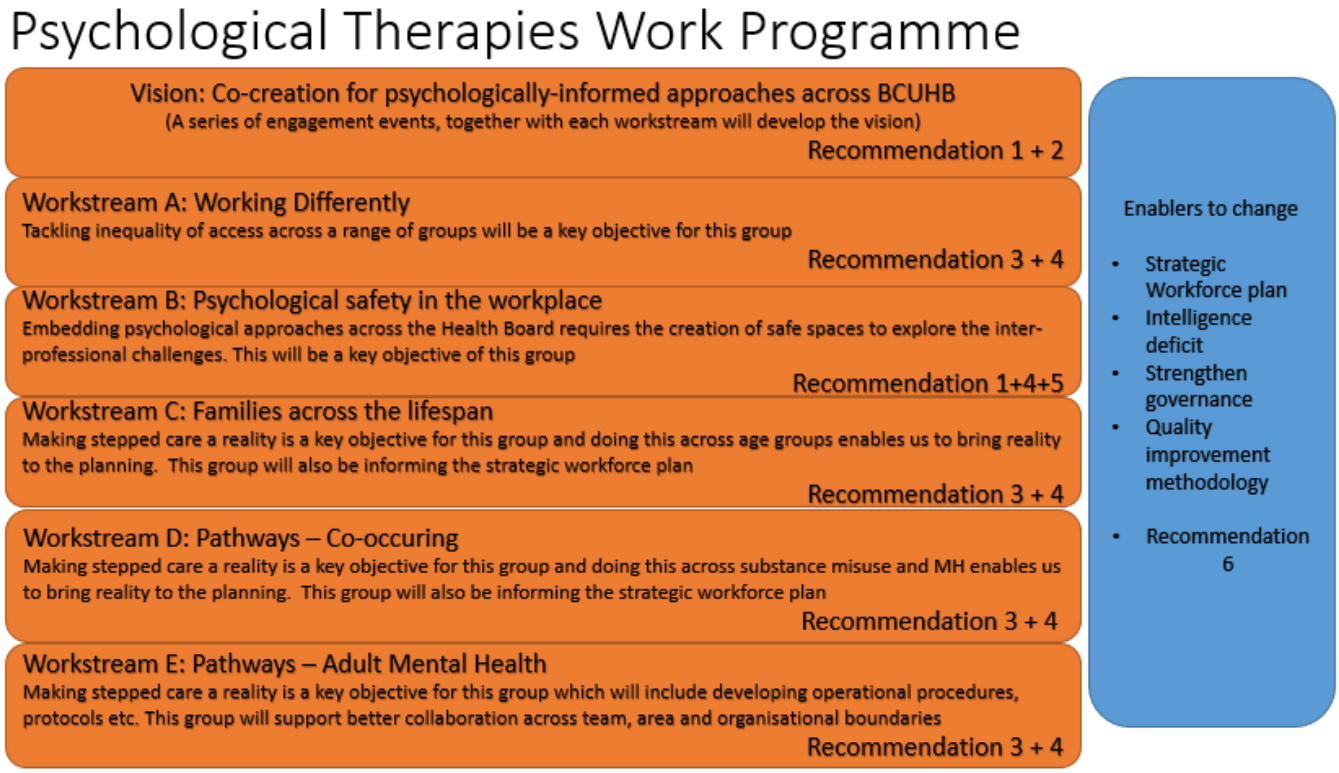
National Welsh NHS guidance and standards have been developed over the last 5 years to guide evidence based service improvements and provision across Wales. The All Wales Psychological Therapies Committee (NPTMC) together with Public Health Wales developed the National Psychological Therapies Plan 2018 and Matrics Cymru 2017, which recommend a stepped care model for Wales across multidisciplinary services. System wide challenges to improvement in access across Wales are identified in the All Wales 2019 survey, and for North Wales also reflected in the 2019 BCUHB MHLD commissioned external review of Psychological Therapies.

In North Wales there remain considerable challenges to increasing access across multidisciplinary stepped care services, and in the wider aim of psychologically informed care across all health care. In many areas there is an over reliance on specialist staff, with lower step and earlier access to other parts of the system not readily available. Where particularly prevalent, this has led to longer legacy secondary care specialist waiting lists (eg. Wrexham Adult Mental Health).

To encourage improvements in access across Wales, Welsh Government piloted national 26 week Psychological Therapy Targets for Secondary Care Specialist Mental Health Services in 2018 and in April 2019 these became statutory reportable Targets across Wales. This has increased the visibility of secondary care specialist waits.

Asesiad / Assessment & Analysis

Further update from QS20/56.1 Minutes of 17th March 2020, detailing the 5 workstreams and how they assign to the recommendations noted in the Psychological Therapies Review report set out below.



Update on Programme Board Membership:

Marian Wyn Jones	Chair/Special Advisor to BCUHB
Lesley Singleton	Interim Director of MHLD / Director of Partnerships
Dr Dawn Henderson	Head Of Amh Clinical Psychology & Psychological Services
Dr Alberto Salmoiraghi	Medical Director
Steve Forsyth	Director of Nursing
Carole Evanson	Head Of Operations & Service Delivery, Regional Specialist Services
Sara Hammond-Rowley	Consultant Clinical Psychologist
Lee Hogan	Consultant Clinical Psychologist
David Oakley	Psychologist
Alan Dowey	Clinical Psychologist
Llinos Edwards	Service Improvement Programme Manager
Patrick Roberts	Communications Lead
Nicola Stubbins	Director of Social Care (Denbighshire)
Sue Green / Peter Bonam	WOD Lead
Joanna Garrigan	Finance Lead
Tom Regan	Head of Nursing MHLD (Central)
Marilyn Wells	Regional CAMHS Clinical Lead
Rob Callow	Head of Engagement
Adrian Thomas / Gareth Evans	Therapies
TBC	Programme Lead
Faith Kay	Secretary & Lead Programme Administrator

Cyfarfod a dyddiad: **Meeting and date:**	Quality, Safety & Experience Committee 05.05.2020
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Briefing Report on BCUHB's Current Obstetric Haemorrhage Rates and Action Plan
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Teresa Owen, Executive Director of Public Health
Awdur yr Adroddiad **Report Author:**	Hemant Maraj MRCOG, DFSRH, MSc (Med Ed), North Wales Clinical Lead for Women's Services
Craffu blaenorol: **Prior Scrutiny:**	Women's Committee Structure
Atodiadau **Appendices:**	Appendix 1: MEMO - Syntometrine first line uterotonic for 3rd stage of Labour

Argymhelliad / Recommendation:

The Committee is asked to note the Directorate's current position regarding obstetric haemorrhage and the actions taken to mitigation the identified risks and improve performance.

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

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

Sefyllfa / Situation:

BCUHB is currently seen as an outliner with the highest Post-Partum Haemorrhage (PPH) rates in Wales. The following briefing offers an action plan to address the performance and reduce unintentional harm.

Cefndir/Background:

The enclosed briefing confirms the Women's Directorate local response to PPH.

Asesiad/Assessment & Analysis

The table below offers the current obstetric haemorrhage rates across Wales. BCUHB is highlighted in yellow, and is currently an outliner in Wales, with the highest rate overall. (Representative data accurate as from April 2020).

Health Board	Maternities	Number of women >= 2500ml PPH	>= 2500ml PPH per 1000 maternities	Number of women >= 1500ml PPH	>= 1500ml PPH per 1000 maternities
All Wales	28,711	146	5.1	1,005	35.0
BCU	6,015	48	8.0	259	43.1
HD	3,081	5	1.6	84	27.3
SB	4,045	18	4.4	127	31.4
C&V	5,246	23	4.4	167	31.8
CTM	4,457	19	4.3	142	31.9
AB	5,655	33	5.8	224	39.6
P	212	0	0.0	2	9.4

Currently BCUHB has no maternity electronic informatics system however, ongoing work for a National system in Wales to capture all data accurately is currently being considered. BCUHB therefore will prioritise a retrospective review of all Postpartum Haemorrhage (PPHs) > 2500mls. The rates of PPH rate >2500mls appears to have decreased over the last 3 years in the East Area although an increasing trend has been seen in Central and West Area.

Primary medical management of 3rd stage of Labour has been extensively considered across all our practice sites, regarding the primary uterotonic and the standard practice. Previous action plans were based on a risk assessment for every woman in labour and Syntometrine recommended as first line if there are any risk factors for PPH. That did not produce the required effect and we have now enacted a change in clinical practice. A position statement has been circulated to all sites (Appendix 1), stating the change of 1st line drug to Syntometrine in all birth settings in BCUHB. Syntometrine as the first line prophylactic uterotonic will be used for all vaginal deliveries, including operative vaginal deliveries, unless contraindicated.

The anaesthetic view is that the use of intravenous Oxytocin 5 IU (International Unit) is used as the first line prophylactic uterotonic for Caesarean deliveries. The recommended practice for Caesarean deliveries is 5 IU Oxytocin and if necessary followed by a Syntocinon infusion, then Ergometrine if no contraindication. We now consider IM injections in deltoid for better absorption in women with a raised BMI.

Tranexamic acid is also used when PPH reaches 1000mls as per Obs Cymru (Obstetric Bleeding Strategy for Wales) protocol. Royal College of Obstetrics & Gynaecology (RCOG) Greentop guidance states that “clinicians should consider the use of intravenous tranexamic acid (0.5–1.0 g), in addition to oxytocin, at caesarean section to reduce blood loss in women at increased risk of PPH”. Tranexamic

acid should therefore be considered prophylactically at caesarean section to reduce blood loss in women at increased risk of PPH.

We also observe an association of PPH with prolonged 2nd stage of labour. It has been agreed that management of 2nd stage of labour should be 1 hour for passive descent and 1 hour of active pushing. Medical review is required following this. A medical review should be considered if no progress after 1 hour of passive descent.

Concerns regarding the accuracy of local MRI reporting for morbidly adherent placenta have been raised locally, and the current pathway agreed as follows: Women with a history of previous caesarean section seen to have an anterior low-lying placenta should be specifically screened for placenta accreta spectrum. Ultrasound and MRI have similar diagnostic value in detecting placenta accreta spectrum when performed by experts. The fetal medicine unit accepts referrals for ultrasound diagnosis of placenta accreta spectrum. MRI may assist perioperative planning – ideally referred via fetal medicine service.

Prospective review of any PPH >2500mls will all trigger a 72 hour review and root cause analysis.

Management of Risk and Mitigation
A local action plan has been developed to address and mitigate the risks associated with high obstetric haemorrhage rates as seen below:

ACTION	BY WHOM	TIMEFRAME
Obs Cymru Champions to validate 2019 data, PPH >2500mls and >1500mls	Obs Cymru Champions	March 2020
Review and audit of data of PPH >2500mls from the last 3 years. Clinical Directors to identify leads.	Identified audit Leads	June 2020
HM to produce a position statement to be circulated to all sites, stating the change of 1st line drug to Syntometrine; also to be rolled out in MLU.	HM	Completed 20/4/20
As part of the job planning exercises, Clinical Directors to look at feasibility of having a dedicated named consultant for elective CS lists.	Clinical Directors	24.04.20
Management of prolonged first and second stage of labour to be discussed with teams via the Labour ward forums	Labour ward leads	13-3-20
MAA/HM to contact Radiologist Clinical Director in relation pathway to access to MRI for morbidly adherent placenta and consideration of tertiary reporting	MAA/HM	24.04.20

The plan will be formally reviewed on the 24th April 2020 and actions updated.

In conclusion, the service has and will continue to adapt its response to the PPH rates in the ultimate interest of Women's safety throughout pregnancy, birth and the postnatal period.

Recommendation
The Committee is requested to receive the Directorate's response to its outlier status and be assured that the service is taking appropriate steps to reduce and monitor the rate of obstetric haemorrhage and actions to reduce the potential of avoidable harm in such circumstances.

Strategy Implications
The Services actions as detailed in the attached briefing reflects the steps taken to reduce obstetric haemorrhage rates whilst highlighting the current position and the prospective reviews required.

Financial Implications
Any and all financial implications have been considered as part of the Women's Directorates' planning and improvement strategy.

Risk Analysis
Please see enclosed briefing that highlights the clinical service risk and the mitigating actions to be taken.

Legal and Compliance
No legal advice required at present.

Impact Assessment
An EqIA will be considered following the proposed reviews if any changes in services are likely to affect the quality, safety or equality aspects of women's care delivery.

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

MEMORANDUM:

TO: Women's Directorate Clinical Staff

FROM: Hemant Maraj, North Wales Clinical Lead Women's Directorate

DATE: 20th April 2020

SUBJECT: Change in Practice - First Line Prophylactic Uterotonic for the Third Stage of Labour

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Please note the BCUHB change in clinical practice - Syntometrine (not syntocinon) is now the first line prophylactic uterotonic for the third stage of labour.

The enclosed SBAR details the assessment by the multidisciplinary team to assess the PPH rate within BCU and a consensus decision was made regarding medical management of the 3rd stage of labour which should be implemented with immediate effect:

- We will now use Syntometrine as the first line prophylactic uterotonic for all vaginal deliveries, including operative vaginal deliveries, unless contraindicated by risk assessment and **not for use with women with hypertension or severe cardiac conditions or severe vascular disease.**
- We will use intravenous Oxytocin 5 IU as the first line prophylactic uterotonic for Caesarean deliveries.

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

Situation

BCUHB is as an outlier for postpartum haemorrhage (PPH) – particularly PPHs of more than 2500ml.

PPH rates in BCUHB – data from Obs Cymru 2019:

Health Board	Maternities	Number of women >= 2500ml PPH	>= 2500ml PPH per 1000 maternities	Number of women >= 1500ml PPH	>= 1500ml PPH per 1000 maternities	Primary uterotonic
All Wales	28,711	146	5.1	1,005	35.0	varied
BCU	6,015	48	8.0	259	43.1	Syntocinon
HD	3,081	5	1.6	84	27.3	Syntometrine
SB	4,045	18	4.4	127	31.4	Syntometrine
C&V	5,246	23	4.4	167	31.8	Syntometrine
CTM	4,457	19	4.3	142	31.9	Syntometrine
AB	5,655	33	5.8	224	39.6	Syntocinon
P	212	0	0.0	2	9.4	?

BCU data set for 2019:

BCU Information services	6,224	53	8.5	214	34.4
BCU 2019 Birth Stats	6224	56	9.0	225	36.2

Background

BCU has been using Syntocinon as a prophylactic uterotonic since publication of NICE Clinical guideline [CG190] - Intrapartum care for healthy women and babies - Published December 2014.

“For active management, administer 10 IU of oxytocin by intramuscular injection with the birth of the anterior shoulder or immediately after the birth of the baby and before the cord is clamped and cut. Use oxytocin as it is associated with fewer side effects than oxytocin plus ergometrine.”

RCOG's Green-top Guideline No. 52 - Prevention and Management of Postpartum Haemorrhage – December 2016:

"A meta-analysis addressed prophylactic ergometrine–oxytocin versus oxytocin for the third stage of labour. This review indicated that ergometrine–oxytocin (Syntometrine®), oxytocin 5 iu and oxytocin 10 iu have similar efficacy in preventing PPH in excess of 1000 ml. Using the definition of PPH as blood loss of at least 500 ml, ergometrine–oxytocin was associated with a small reduction in the risk of PPH (Syntometrine® versus oxytocin any dose; OR 0.82, 95% CI 0.71–0.95). There were major differences between ergometrine–oxytocin and oxytocin alone in the adverse effects of nausea and vomiting, and elevation of blood pressure, with ergometrine–oxytocin carrying a five-fold increased risk (OR 4.92, 95% CI 4.03–6.00). Thus, the advantage of a reduction in the risk of minor PPH needs to be weighed against the adverse effects associated with the use of ergometrine–oxytocin."

Assessment

A multidisciplinary team across BCU involving the North Wales Clinic Lead, Director of Midwifery, Clinical directors, Labour ward obstetric leads, Obstetric anaesthetists, Labour ward lead midwives, Obs Cymru leads, Matrons, risk management team, was convened to address BCU's PPH rate.

Various action plans are ongoing. One aspect discussed was changing the primary uterotonic for the 3rd stage of labour from Syntocinon to Syntometrine.

Syntocinon has a better side effect profile. However, across Wales, Health Boards using Syntocinon have a higher rate of PPH. The patient safety profile of using Syntocinon as a prophylactic uterotonic is unacceptable based on current rates on PPH.

Previous attempts to mitigate this risk have not shown sufficient improvement in PPH rates. Currently, a risk assessment is undertaken for every woman in labour and Syntometrine is recommended as first line if there are any risk factors for PPH.

Recommendation

A consensus decision for BCU was made regarding medical management of the 3rd stage of labour:

- We will now use Syntometrine as the first line prophylactic uterotonic for all vaginal deliveries, including operative vaginal deliveries, unless contraindicated.
- We will use intravenous Oxytocin 5 IU for as the first line prophylactic uterotonic for Caesarean deliveries.

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety & Experience Committee 05.05.2020
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Health Inspectorate Wales (HIW) – Review of Maternity Services Briefing in Response to HIW's Recommendations Following Unannounced and Announced Visits to Maternity Services within BCUHB between June and December 2019 and January 2020.
Cyfarwyddwr Cyfrifol: Responsible Director:	Teresa Owen, Executive Director of Public Health
Awdur yr Adroddiad Report Author:	Maureen Wolfe, Women's Lead for Governance and Risk and Maria Atkin, General Manager and Business Lead, Women's Directorate
Craffu blaenorol: Prior Scrutiny:	Women's Committee Structure
Atodiadau Appendices:	Appendix 1 - HIW Progress Tracker for Maternity Services

Argymhelliad/Recommendation:

The Committee is asked to note the Directorate's assurances in providing an update on the required actions in line with the HIW improvement plans following a series of unannounced and announced inspections of Maternity Services in North Wales. The Committee is also reminded that specific board members will be interviewed as part of the HIW national review of Maternity Services once resumed. Please note that due to the current COVID-19 situation, HIW have reached a decision to stop routine inspections although this will resume as soon as is practicable. In the meantime, desk-based work is continuing and HIW will publish an interim update on Phase One of their National Maternity Service Review shortly.

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

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

Sefyllfa / Situation:

The Women's Directorate would like to provide the Committee with a progress update on the HIW National Review of Maternity Services in Wales and the Directorate's performance and response to the inspections undertaken as part of the review.

Cefndir/Background:

The enclosed briefing confirms the Women's Directorate local response to HIW's specific guidance for maternity service in BCUHB.

Asesiad/Assessment & Analysis

1) Introduction

Phase 1 of the HIW review was completed between June and December 2019 and comprised of unannounced inspections of Maternity Services at each of the three acute units across North Wales. Following each unannounced inspection, immediate verbal feedback was given by the inspection team, detailing areas for immediate improvement, good practice and other suggested improvements. The findings were also confirmed in a written letter to the Health Board, requesting submission of actions taken against immediate improvements within a seven-day timeframe and against an improvement plan by a specified date. The Health Board was also given the opportunity to comment upon the factual accuracy of each report prior to it being finalised and published on the HIW website. All inspection reports can be viewed via the link https://hiw.org.uk/national-review-maternity-services

2) Women's Directorate Response

Immediate assurances highlighted following the unannounced inspections include:

Ysbyty Glan Clwyd *(16th – 18th September 2019)*

1. Checking of neonatal resuscitaires should be recorded/performed daily
2. Medication to be stored safely and securely
3. The administration of PROPESS (for induction of labour) should be in line with NICE guidance

Action plan submitted to and accepted by HIW. All actions completed.

Ysbyty Gwynedd *(25th – 27th November 2019)*

No immediate actions identified

Ysbyty Wrexham Maelor *(7th – 9th January 2020)*

1. Checking of neonatal resuscitaires should be recorded/performed daily.

Action plan submitted to and accepted by HIW. All actions completed.

Phase 2 commenced in January 2020 and initially involved announced inspections of all Freestanding Midwifery Led Units (FMU) in Wales. Tywyn, Bryn Beryl and Dolgellau FMUs were inspected between 21st and 22nd of January 2020.

Immediate assurances raised:

1. Checking of neonatal resuscitaires should be recorded/performed daily
2. Audits to be completed in line with the Health Board's Policy
3. FMUs need to comply with IPC standards
4. Regular testing of emergency alarms to be undertaken
5. SOP required for consistent processes in all FMUs
6. Appropriate governance arrangements are to be put in place in all FMUs.

Action plan submitted to and accepted by HIW. All actions completed.

2.1) Current Position Statement

From the cumulative inspections, 117 actions were included in the improvement plans for all areas inspected and as of 20 April 2020, ***10 remain open on the HIW Tracker (Appendix 1).***

Plans to interview key personnel within the Health Board regarding the quality, safety and governance of Maternity Services were also due to take place in February 2020, but have been postponed due to the current COVID 19 situation.

HIW requested the submission of evidence for assurance against four multifaceted questions in preparation for the Governance phase of the National Review and the relevant responses and associated documents were provided by the Directorate in February 2020:

- BCU self-assessment against the Kirkup Report and the RCOG Report re Maternity Services in Cwm Taf
- The staff engagement process during the self-assessment undertaken
- Additional staff training identified and how it as implemented
- Action taken following feedback from women and their families
- Staff rotas for 3 months and how staffing is monitored
- Incident and concerns review processes
- Health Board links into national audit-MBRRACE, EBC and identified reporters
- Directorate QSE Sub group agendas
- Quality reports
- Whistleblowing policy
- Escalation process of identified risks
- Directorate exception reports to Corporate QSE
- How concerns raised by staff are addressed.

The review will conclude with the publication of a national service report in summer 2020.

In conclusion, the service has and will continue to work towards the ten remaining actions in progress. The Committee is reminded that specific board members will be interviewed as part of the HIW national review of Maternity Services once resumed. However, due to the current COVID-19 situation, HIW have reached a decision to stop routine inspections although this will resume as soon as is practicable. In the meantime, desk-based work is continuing and HIW will publish an interim update on their completed work in Phase One of the National Review shortly.

Strategy Implications

The services actions as detailed in the attached briefing, reflects HIW's recommendations following unannounced and announced inspections of Maternity Services at each of the three acute units across North Wales between June and December 2019, and of the Home from Home facilities in January 2020.

Financial Implications
Any and all financial implications have been considered as part of the Women's Directorates planning processes. The pending review of community midwifery led services may have financial implications dependent upon the proposed models of care, premises required and the approved option following full consultation.

Risk Analysis
The closure of the birthing room in Tywyn following an announced aspect of the three Home from Home Units in the West Health Economy has been added to the Directorate Risk Register ID3065, Tier 4, current score 8. A HIW Tracker is in place to monitor all open risks and the Directorate Governance Lead updates the improvement plans and Tracker on a monthly basis. The progression of the improvement plans is monitored at the Directorate's QSE Sub Group and Service Board on a monthly basis.

Legal and Compliance
The Committee will be kept up to date with regards to the outcome of Phase 2 of the national review and the final outcome of the Community Midwifery Services Review. The final HIW National Maternity Report will also be shared with the Committee when published.

Impact Assessment
An impact assessment will be completed as part of the review of Community Midwifery Led Services which is part of the Women's response to the HIW recommendations and previously agreed Three Year Service Plan.

Line Ref	Imp Plan Ref	Imp Plan Code	Date of Inspection	Directorate	Area	Speciality	Status	H& C Standards	Ward / Unit	Report /Immediate Action letter	HIW Recommendation	BCUHB Management Response	Imp Date	No. Revisions	Rev. Imp Date	Actual Imp. Date	Status Updates	Owner	Planned Follow up Review	Actual Follow up Review
18	HIW-IP-002	IA	Jan-18	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	Implemented		Llifon / Labour Ward / Midwife Led Unit	Immediate Assurance Plan	Patient attended assessment unit stating "thought waters had broken" - examined by Dr who (it is alleged) stated loudly "this woman needs potty training" - patient discharged home - within 48 hours returned and was found to be in early labout & on antibiotics due to an infection.	1. The patient was contacted by the Matron for Obstetrics and Gynaecology in Ysbyty Gwynedd on the 7th February, 2018 and the incident was discussed in detail. Matron Gardner apologised unreservedly for the way the patient had been spoken to by the identified member of the medical team and for the lack of dignity and respect that she had experienced. I can confirm that whilst the patient did not want to meet or take this further the family wanted assurance that the matter would be addressed with the doctor in question. Assurances were given at the time that the matter would be dealt with appropriately and the patients thanked the Matron for contacting her to allow her concerns to be heard and addressed. 2. The doctor in question was identified by the Medical Clinical Lead, Dr Bolton and spoken to on the 7th February, 2018. The doctor in question admitted it was a phrase she would have used, intending it as a light hearted comment. 3. The doctor has since been supported to reflect on this incident. Dr Bolton has discussed with the doctor how best vaginal leakage in late pregnancy could be explained in lay terms and that would not cause offence. I have been assured that the doctor has learnt from this valuable feedback and will not use such terminology again.	14/03/2018				Action progressed as per BCU Management Response. This is an older action and has since been closed from a corporate perspective	Fiona Giraud		
45	HIW-IP-004	IP	Jan-18	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	Implemented	4.1	Llifon / Labour Ward / Midwife Led Unit	Improvement Plan	It would be beneficial to some parents if the health board could explore the development of a bereavement midwife	Job Description for the post of a Bereavement Midwife for the Women's Directorate in BCUHB is in the process of being developed. 01.06.18 - Job Description for a bereavement Specialist midwife developed and sent for Job Matching on the 24th May 2018. 3/9/18 The job is currently on TRAC and will be advertised in the next few days once the full authorisation has been completed. 04/12/18 Bereavement Midwife commenced in post on 18/11/18. Clinical Supervisors of Midwives (CSfM) also support the maternity voices meetings and disseminate feedback from women to midwives supporting improvements in service provision and staff awareness of the needs of BCUHB women. CSfM also support the Band 7 midwives with their clinical leadership skills, ensuring a supportive and open culture for both staff and women.	01/07/2018		01/09/2018		Action progressed as per BCU Management Response. This is an older action and has since been closed from a corporate perspective	Head of Women's Inpatient and Outpatient Services		
46	HIW-IP-004	IP	Jan-18	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	Implemented	4.1	Llifon / Labour Ward / Midwife Led Unit	Improvement Plan	It would be beneficial to some parents if the health board could explore the development of a bereavement midwife	Aim is to recruit to a full time Bereavement Midwife post by July 2018. 01.06.18 - Following job matching post to be advertised. 3/9/18 The job is currently on TRAC and will be advertised in the next few days once the full authorisation has been completed. 04/12/18 Bereavement Midwife commenced in post on 18/11/18	02/07/2018		01/09/2018		Action progressed as per BCU Management Response. This is an older action and has since been closed from a corporate perspective	Head of Women's Inpatient and Outpatient Services		
47	HIW-IP-004	IP	Jan-18	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	Implemented	4.1	Llifon / Labour Ward / Midwife Led Unit	Improvement Plan	Angel Room (the bereavement room) would benefit from some redecoration	Meeting held with SANDS Local Representatives on the 26.3.18 to discuss re-decoration of the Angel Room.	01/03/2018				Action progressed as per BCU Management Response. This is an older action and has since been closed from a corporate perspective	Head of Women's Inpatient and Outpatient Services		
48	HIW-IP-004	IP	Jan-18	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	Implemented	4.1	Llifon / Labour Ward / Midwife Led Unit	Improvement Plan	Angel Room (the bereavement room) would benefit from some redecoration	Plan to re-decorate in the next 3 months in partnership with the local SANDS Groups Dec 18 - redecorating in progress	01/07/2018		01/09/2018		Action progressed as per BCU Management Response. This is an older action and has since been closed from a corporate perspective	Head of Women's Inpatient and Outpatient Services		
49	HIW-IP-004	IP	Jan-18	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	Implemented	6.3	Llifon / Labour Ward / Midwife Led Unit	Improvement Plan	The health board needs to explore why staff feel that they would not always be adequately supported if they were involved in an incident	Clinical Supervisors of Midwifery to explore with staff what levels of support would be beneficial	01/04/2018				Action progressed as per BCU Management Response. This is an older action and has since been closed from a corporate perspective	Clinical Supervisor of Midwives		
50	HIW-IP-004	IP	Jan-18	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	Implemented	6.3	Llifon / Labour Ward / Midwife Led Unit	Improvement Plan	The health board needs to explore why staff feel that they would not always be adequately supported if they were involved in an incident	Unit meetings held bi monthly to include opportunity for staff to highlight any concerns, and post incident support they need going forward. Meeting dates issued 12 months in advance.	01/03/2018				Action progressed as per BCU Management Response. This is an older action and has since been closed from a corporate perspective	Inpatient Matrons		
51	HIW-IP-004	IP	Jan-18	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	Implemented	6.3	Llifon / Labour Ward / Midwife Led Unit	Improvement Plan	The health board needs to explore why staff feel that they would not always be adequately supported if they were involved in an incident	Open door policy adopted by all managers within the unit and staff aware that they can access this support and guidance at any time. Reiterated at all site meetings in March 2018 and during Staff Drop In Sessions	01/03/2018				Action progressed as per BCU Management Response. This is an older action and has since been closed from a corporate perspective	Inpatient Matrons		
52	HIW-IP-004	IP	Jan-18	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	Implemented	6.3	Llifon / Labour Ward / Midwife Led Unit	Improvement Plan	The health board needs to explore why staff feel that they would not always be adequately supported if they were involved in an incident	Lessons learned are cascaded to all staff in a timely manner following all incidents.	01/03/2018				Action progressed as per BCU Management Response. This is an older action and has since been closed from a corporate perspective	Inpatient Matrons		
53	HIW-IP-004	IP	Jan-18	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	Implemented	6.3	Llifon / Labour Ward / Midwife Led Unit	Improvement Plan	The health board needs to explore why staff feel that they would not always be adequately supported if they were involved in an incident	Clinical Supervisor for Midwives (CSfM) always available to support staff in an open and confidential manner offering support and guidance, as part of their role	01/03/2018				Action progressed as per BCU Management Response. This is an older action and has since been closed from a corporate perspective	Clinical Supervisor of Midwives		
54	HIW-IP-004	IP	Jan-18	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	Implemented	6.3	Llifon / Labour Ward / Midwife Led Unit	Improvement Plan	The health board needs to explore why staff feel that they would not always be adequately supported if they were involved in an incident	All midwives receive 4hrs mandatory contact with CSfM – on an annual basis which includes 2hrs group supervision and 2hrs for local learning to inform practice	01/03/2018				Action progressed as per BCU Management Response. This is an older action and has since been closed from a corporate perspective	Clinical Supervisor of Midwives		
55	HIW-IP-004	IP	Jan-18	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	Implemented	6.3	Llifon / Labour Ward / Midwife Led Unit	Improvement Plan	The ward managers need to ensure that the Putting Things Right information is made available to patients in a timely manner	Putting things right information is made available to all patients in the booking information given out by the community midwife during the antenatal period, to ensure that patients receive the information in a timely manner	01/04/2018				Action progressed as per BCU Management Response. This is an older action and has since been closed from a corporate perspective	Women's Directorate Inpatient and Outpatient Matrons		
56	HIW-IP-004	IP	Jan-18	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	Implemented	6.3	Llifon / Labour Ward / Midwife Led Unit	Improvement Plan	The ward managers need to ensure that the Putting Things Right information is made available to patients in a timely manner	PTR Leaflets are displayed and available in all Inpatient Areas.	01/03/2018				Action progressed as per BCU Management Response. This is an older action and has since been closed from a corporate perspective	Women's Inpatient Ward Managers		
57	HIW-IP-004	IP	Jan-18	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	Implemented	6.3	Llifon / Labour Ward / Midwife Led Unit	Improvement Plan	The PSAG board in Labour Ward needs to be covered or moved to maintain patient confidentiality	All PSAG Boards are now located in non-public areas	01/02/2018				Action progressed as per BCU Management Response. This is an older action and has since been closed from a corporate perspective	Inpatient Matrons		
58	HIW-IP-004	IP	Jan-18	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	Implemented	2.1	Llifon / Labour Ward / Midwife Led Unit	Improvement Plan	The health board needs to explore the timely access to scanning for patients with foetal growth concerns	Discussions with Shared Services that manage USS provision and capacity in the Health Board have commenced and will continue to work through solutions. 01.06.18 - A further meeting is arranged for June with the Head of Radiology and site leads to determine the options for increasing the current capacity in scanning. Dec 18 - Ongoing meetings are being held between the Women's Directorate and Radiology. Women's are reviewing scan requests made to ensure all are essential to try and free up any potential capacity. Radiography are also developing a business case to employ more sonographers. This is a Helath Board and All Wales wide issue. The risk will remain open on the Directorate's Risk Register but the tracker for this service issue will formally be closed and submitted for formal closure via the Coporate Office.	01/09/2018				Action progressed as per BCU Management Response. This is an older action and has since been closed from a corporate perspective	General Manager		

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59	HIW-IP-004	IP	Jan-18	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services		2.1	Llifon / Labour Ward / Midwife Led Unit	Improvement Plan	The health board needs to explore the timely access to scanning for patients with foetal growth concerns	Further meeting scheduled with the Head of Shared Services in April 2018. 01.06.18 - A further meeting is arranged for June with the Head of Radiology and site leads to determine the options for increasing the current capacity in scanning. Sep 18 - Work is on going with reagrds to addressing the shortfall in scanning capacity across BCU. Radiology is submitting a Business Case for addditional resources. A further meeting has been arranged for 6th Sept. Dec 18 - Ongoing meetings are being held between the Women's Directorate and Radiology. Women's are reviewing scan requests made to ensure all are essential to try and free up any potential capacity. Radiography are also developing a business case to employ more sonographers. This is a Helath Board and All Wales wide issue. The risk will remain open on the Directorate's Risk Register but the tracker for this service issue will formally be closed and submitted for formal closure via the Coporate Office.	01/04/2018		01/09/2018		Action progressed as per BCU Management Response. This is an older action and has since been closed from a corporate perspective	General Manager		
60	HIW-IP-004	IP	Jan-18	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services		2.1	Llifon / Labour Ward / Midwife Led Unit	Improvement Plan	The health board needs to explore the timely access to scanning for patients with foetal growth concerns	USS capacity is highlighted on the Women's Directorate risk register as an open risk for services to manage and support demand and capacity. 01.06.18 - A further meeting is arranged for June with the Head of Radiology and site leads to determine the options for increasing the current capacity in scanning. Sep 18 - Work is on going with reagrds to addressing the shortfall in scanning capacity across BCU. Radiology is submitting a Business Case for addditional resources. A further meeting has been arranged for 6th Sept.	01/05/2018		01/09/2018		Action progressed as per BCU Management Response. This is an older action and has since been closed from a corporate perspective	General Manager		
61	HIW-IP-004	IP	Jan-18	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services		2.1	Llifon / Labour Ward / Midwife Led Unit	Improvement Plan	The health board needs to ensure clinical staff only have access to current policies	An icon to Access all Written Control Documents has been placed on IT desk-tops on all departmental computers in clinical areas	01/02/2018				Action progressed as per BCU Management Response. This is an older action and has since been closed from a corporate perspective	Inpatient Matrons		
62	HIW-IP-004	IP	Jan-18	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services		2.1	Llifon / Labour Ward / Midwife Led Unit	Improvement Plan	The health board needs to ensure clinical staff only have access to current policies	How to Access Health Board Policies has been included in the ward safety briefings for a 2 week period in February 2018	01/02/2018				Action progressed as per BCU Management Response. This is an older action and has since been closed from a corporate perspective	Ward Managers / Shift Leaders		
63	HIW-IP-004	IP	Jan-18	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services		2.1	Llifon / Labour Ward / Midwife Led Unit	Improvement Plan	The health board needs to ensure clinical staff only have access to current policies	Clinical Supervisors for Midwives are also reminding midwives of how to access policies during their clinical supervision updates.	01/02/2018				Action progressed as per BCU Management Response. This is an older action and has since been closed from a corporate perspective	Clinical Supervisors of Midwives		
64	HIW-IP-004	IP	Jan-18	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services		2.1	Llifon / Labour Ward / Midwife Led Unit	Improvement Plan	The health board needs to ensure clinical staff only have access to current policies	Work is progressing pan BCUHB to ensure that all duplicate or out of date policies are removed from the Intranet Dec 18 - A direct link to Women's policies has been added to the intranet policies and documents home page. Clinical Supervisor for Midwives are performing a snapshot audit of the ease of which staff can access the Women's policy page. The admin support person for the Women's Directorate Written Control Document Group ensures all old policies are removed at the same time that a new policy is uploaded.	01/09/2018				Action progressed as per BCU Management Response. This is an older action and has since been closed from a corporate perspective	Transforming Care Team		
65	HIW-IP-004	IP	Jan-18	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services		2.6	Llifon / Labour Ward / Midwife Led Unit	Improvement Plan	The ward manager needs to ensure that the medicine refrigerator is locked, the door kept closed when not is use and fridge temperature readings are recorded daily	All fridges have locks and daily checks are conducted to ensure temperatures are recorded	01/02/2018				Action progressed as per BCU Management Response. This is an older action and has since been closed from a corporate perspective	Ward Managers		
66	HIW-IP-004	IP	Jan-18	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services		2.6	Llifon / Labour Ward / Midwife Led Unit	Improvement Plan	The ward manager needs to ensure that the medicine refrigerator is locked, the door kept closed when not is use and fridge temperature readings are recorded daily	A new system has been introduced to ensure all daily checks required are highlighted in the one file for ease of access and signed off by the shift leader on that day – this is then checked for compliance by the ward managers.	01/02/2018				Action progressed as per BCU Management Response. This is an older action and has since been closed from a corporate perspective	Shift Leaders / Ward Managers		
67	HIW-IP-004	IP	Jan-18	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services		2.6	Llifon / Labour Ward / Midwife Led Unit	Improvement Plan	The ward manager needs to ensure that the medicine refrigerator is locked, the door kept closed when not is use and fridge temperature readings are recorded daily	Safe storage of medication and daily checking of the medicines fridge temperature has been included on the Matron's daily intentional rounding and quality assurance form (Version 11 February 2018).	01/02/2018				Action progressed as per BCU Management Response. This is an older action and has since been closed from a corporate perspective	Inpatient Matrons		
68	HIW-IP-004	IP	Jan-18	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services		2.6	Llifon / Labour Ward / Midwife Led Unit	Improvement Plan	The ward manager needs to ensure that the medicine refrigerator is locked, the door kept closed when not is use and fridge temperature readings are recorded daily	The quality assurance form is completed on a monthly basis by the matron and compliance reported together with any themes and trends to the Women's Quality, Safety and Experience Group on a monthly basis.	01/02/2018				Action progressed as per BCU Management Response. This is an older action and has since been closed from a corporate perspective	Inpatient Matrons		
69	HIW-IP-004	IP	Jan-18	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services		2.9	Llifon / Labour Ward / Midwife Led Unit	Improvement Plan	The resuscitaires need to have daily cleaning and checking schedules in place	Checks are completed daily	01/02/2018				Action progressed as per BCU Management Response. This is an older action and has since been closed from a corporate perspective	Ward Manager / Shift Leader		
70	HIW-IP-004	IP	Jan-18	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services		2.9	Llifon / Labour Ward / Midwife Led Unit	Improvement Plan	The resuscitaires need to have daily cleaning and checking schedules in place	Daily checking of the resusitaires on the Delivery Suites, Midwifery led units and maternity wards are included on the Matron's daily intentional rounding and quality assurance form (version 11 February 2018).	01/02/2018				Action progressed as per BCU Management Response. This is an older action and has since been closed from a corporate perspective	Inpatient Matrons		
71	HIW-IP-004	IP	Jan-18	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services		2.9	Llifon / Labour Ward / Midwife Led Unit	Improvement Plan	The resuscitaires need to have daily cleaning and checking schedules in place	The quality assurance form is completed on a monthly basis by the Matrons and the compliance reported together with any themes and trends to the Women's Quality, Safety and Experience Group on a monthly basis	01/02/2018				Action progressed as per BCU Management Response. This is an older action and has since been closed from a corporate perspective	Inpatient Matrons		
210	HIW-IA-003	IA	Sep-19	Secondary Care	Central Glan Clwyd Hospital	Midwifery & Women's Services		2.1 2.9	Celyn Ward / Midwifery Led Unit/ Labour Ward / Traige Assessment Area / Operating Theatre	Immediate Assurance Plan	The health board must provide HIW with details of the action it will take to ensure that checks of the neo-natal resuscitaires are carried out on a daily basis and in line with their policy.	1. Staff have been reminded that daily checks of neonatal resuscitaires will be the minimum expected standard. This has been communicated to all staff via safety briefings for a minimum of two weeks and will continue to be communicated at every opportunity. Shift co-ordinators will monitor compliance on a daily basis. The Matron, as an extra measure, will also monitor compliance during a daily walk about on the unit. Any concerns identified will be addressed immediately with the staff member. 2. The Matron will audit compliance of daily checks by completing a weekly audit, and will take every opportunity to remind staff of the lessons learned following the unannounced inspection. Any concerns identified will be addressed immediately with the member of staff and an action log will be completed. 3. The learning from this unannounced inspection has been communicated and will continue to be communicated at all interdepartmental meetings within the unit.	01/10/2019				Commenced as per BCU Management response and is subject to ongoing review and audits: Daily checks of neonatal resuscitaires continues to be the minimum expected standard. Matron continues to monitor compliance thorugh daily walkabout. Compliance has been 100% since September, until 30.12.2019 when one check was missed. This has resulted in a further immediate assurance and is captured in the immediate assurance plan received 10.01.2020 - safety briefings have been circulated and staff have been updated following the inspection. Weekly quality assurance audits also take place by the Matron and any issues identified are addressed immediately with staff and the team	Director of Midwidery & Womens Services, Maternity		
211	HIW-IA-003	IA	Sep-19	Secondary Care	Central Glan Clwyd Hospital	Midwifery & Women's Services		2.1 2.6	Celyn Ward / Midwifery Led Unit/ Labour Ward / Traige Assessment Area / Operating Theatre	Immediate Assurane Plan	The health board must ensure that medication is stored safely and securely at all times.	1. staff have been reminded that full compliance with the BCUHB standards of medication storage will be expected. This has been communicated to all staff via safety briefings for a minimum of two weeks and will continue to be communicated at every opportunity 2. Shift co-ordinators will monitor compliance throughout each day. The Matron, as an extra measure, will also monitor compliance during a daily walk about on the unit. Any concerns identified will be addressed immediately with the staff member 3. The Matron will audit compliance against the standards by completing a weekly audit, and will take every opportunity to remind staff of the lessons learned following the unannounced inspection. Any concerns identified will be addressed immediately and documented in an action log 4. The BCUHB Medicines Policy MM01, highlighting the safe storage of medication has been re-circulated to all staff 5. The learning from this unannounced inspection has been, and will continue to be communicated at all interdepartmental meetings within the unit. 6. The Women's Directorate will embark upon a medicines management improvement programme utilising improvement methodologies to meet the required standards. The leads will work with local pharmacy leads and the BCUHB Medicines Management Collaborative utilising a data collection tool to monitor compliance against the standards inclusive of medicine storage 7. All wards within the health board will be part of the BCUHB audit programme, which will assess compliance with medicine management standards by the end of 2019.	01/10/2019				1. Full compliance with the BCUHB standards of medication storage continues to be the expected standard against this action. Shift co-ordinators monitor compliance against this action throughout each shift. Any concerns identified are addressed immediately with the staff member concerned. 2. The Matron audits compliance against the standards during a weekly Quality Assurance audit. 3. A named Matron has been identified to lead on a medicine management improvement programme for the Directorate and has developed an action plan, which was presented at the October meeting of the Safer Medicines Committee, which the Matron attends on a monthly basis. 4. The Matron also attends the health Board Medicines Management Collaborative, where the monthly Directorate audits are reviewed. No further concerns have been identified to date and medication has been stored appropriately. Women's audits are reviewed at the previously detailed health board meetings and all updates with regards to medicines management are fed back to Directorate via the named Matron. Any new information and learning is disseminated to staff in all clinical areas via the Inpatient and Outpatient Matrons.	Director of Midwidery & Womens Services, Maternity		

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212	HIW-IA-003	IA	Sep-19	Secondary Care	Central Glan Clwyd Hospital	Midwifery & Women's Services		2.6 3.1	Celyn Ward / Midwifery Led Unit/ Labour Ward / Traige Assessment Area / Operating Theatre	Immediate Assurance Plan	The health board must ensure that the administration of PROPESS is in line with the health board's policy and NICE guidelines	1. The Clinical Director and Labour Ward Lead at YGC fed back the learning to the clinical team with regards to the need for obstetric review of the patient before repeat prostaglandin administration and caution regarding use of repeated Propess 2. The North Wales Clinical Lead and Director of Midwifery and Women's Services shared the learning from the unannounced inspection with clinical teams across North Wales, at their monthly staff drop in sessions. 3. feedback following the unannounced inspection was also shared at Women's Quality, Safety & Experience Sub Group on 20/09/19 for wider learning. The North Wales Clinical Lead and Director of Midwifery and Women's Services, also attended all clinical areas to re iterate the learning and the required standard of practice for prostaglandin management, seeking assurances from all departments within the Directorate 4. The North Wales Clinical Lead shared a memo with all staff advising on the practice of IOL. This included a section on "What is expected if labour has not started or ARM is not possible after one cycle of Propess® treatment?"This highlighted the need for senior obstetric review and outlined the various options available to the women 5. The Women's Induction of Labour (IOL) Written Control Document (WCD) update had previously been deferred pending an update from NICE in 2020. The Directorate however decided to have an interim update of the WCD. Two identified Consultant Obstetricians (labour ward leads) will amend the current WCD to mandate obstetric review of the patient before repeat prostaglandin administration. The WCD will be revised and reviewed within the Women's Governance Framework, for agreement and ratification at QSE Sub Group and Board meetings by the end of October 2019 6. The learning from this unannounced inspection has been and will continue to be, communicated at any given opportunity and at all interdepartmental meetings within the Directorate 7. BCUHB will register as a stakeholder for the NICE Clinical Guideline, in order to review and provide early feedback on it 8. A named Obstetrician will implement an updated IOL Integrated Care Pathway (ICP). The ICP will support the learning from the inspection and include the need for obstetric review before further intervention after an initial Propess 9. To further support the counselling of women, the IOL leaflet will be updated. This will be performed by the Consultant Midwife and a named Consultant Obstetrician, and will be required to be translated into Welsh for our service users, which may delay the publication process 10. The policy, patient information leaflets and ICP have been completed, ratified and uploaded onto the Women's Intranet policies page.	01/10/2019				1, 2, 3, 4 and 6 are complete as per "BCUHB Response". 5. The WCD has been updated and agreed by the Women's Quality, Safety & Experience sup-group and is on the agenda for Women's Board and the health board Drugs & Therapeutics Group for January 2020. The WCD will also be added to the health board Medicines Management Group agenda in February 2020 7. Awaiting further update 8. The revised Integrated Care Pathway (ICP) was agreed at the Women's Quality, Safety & Experience sup-group in December 2019 and will be ratified at Women's Board in January 2020. 9. The Induction of Labour (IOL) patient information leaflet is on the agenda for Women's Quality, Safety & Experience sup-group and Women's Board meetings for January 2020 and once agreed will be sent for translated and printed for women and their families.	Director of Midwifery & Womens Services, Maternity		
213	HIW-IP-011	IP	Sep-19	Secondary Care	Central Glan Clwyd Hospital	Midwifery & Women's Services		1.1	Celyn Ward / Midwifery Led Unit/ Labour Ward / Traige Assessment Area / Operating Theatre	Improvement Plan	The health board must ensure that health promotion is readily available throughout the unit	1. The Directorate has worked in partnership with Public Health to secure the relevant information for display in the clinical areas for women and their families. 2. Ward managers and housekeepers will review and update the information displayed on a monthly basis. 3. White boards advising women of who is caring for them on each shift have been introduced. 4. The boards will be updated by the shift coordinator at the start of each shift and reviewed by the Matron on her daily walkabout the unit.	01/10/2019				These actions were completed at the time, in September 2019 and are subject to ongoing review and audits.	Fiona Giraud		
214	HIW-IP-011	IP	Sep-19	Secondary Care	Central Glan Clwyd Hospital	Midwifery & Women's Services		1.1	Celyn Ward / Midwifery Led Unit/ Labour Ward / Traige Assessment Area / Operating Theatre	Improvement Plan	The health board must ensure that the process of handover is reviewed.	1. The record of attendance logs at handover are now completed daily 2. Monthly monitoring of this introduction is performed via spot-checks led by the labour ward leads 3. Patient specific information is not retained or recorded at handover, to avoid Information Governance breaches and compliance with the Department of Health Records Management Code of Practice, Addendum 1. 4. All care planning discussions are recorded in the hospital records and in individualised hand held notes.	01/10/2019				These actions were completed at the time, in September 2019 and are subject to ongoing review and audits.	Fiona Giraud		
215	HIW-IP-011	IP	Sep-19	Secondary Care	Central Glan Clwyd Hospital	Midwifery & Women's Services		1.1	Celyn Ward / Midwifery Led Unit/ Labour Ward / Traige Assessment Area / Operating Theatre	Improvement Plan	The health board must ensure that patients and families are made aware of the Community Health Council (CHC) for advocacy and support.	The contact details for the Community Health Council is displayed and available in all clinical areas.	01/10/2019				These actions were completed at the time, in September 2019 and are subject to ongoing review and audits.	Fiona Giraud		
216	HIW-IP-011	IP	Sep-19	Secondary Care	Central Glan Clwyd Hospital	Midwifery & Women's Services		2.1 2.4	Celyn Ward / Midwifery Led Unit/ Labour Ward / Traige Assessment Area / Operating Theatre	Improvement Plan	The health board must ensure that organisation of utility rooms within the unit is maintained to high standards.	All clinical areas have been de-cluttered by the ward managers, and spot checks are undertaken as part of the Matron's daily walk about.	01/10/2019				These actions were completed at the time, in September 2019 and are subject to ongoing review and audits.	Fiona Giraud		
217	HIW-IP-011	IP	Sep-19	Secondary Care	Central Glan Clwyd Hospital	Midwifery & Women's Services		2.1 2.4	Celyn Ward / Midwifery Led Unit/ Labour Ward / Traige Assessment Area / Operating Theatre	Improvement Plan	The health board must ensure that doors to unauthorised access rooms are securely closed to maintain safety.	1. A memo was circulated to all staff following the unannounced inspection, to remind them of the need to keep all doors closed to avoid unauthorised access and maintain security and safety on the unit. The senior leads per shift, on a continuous basis, monitor compliance against this action. 2. Security requirements on the unit are communicated clearly at the twice-daily handovers and should any security issues arise, there are local and health board policies to support escalation of any identified concerns.	01/10/2019				These actions were completed at the time, in September 2019 and are subject to ongoing review and audits.	Fiona Giraud		
218	HIW-IP-011	IP	Sep-19	Secondary Care	Central Glan Clwyd Hospital	Midwifery & Women's Services		2.1 2.9	Celyn Ward / Midwifery Led Unit/ Labour Ward / Traige Assessment Area / Operating Theatre	Improvement Plan	The health board must ensure that regular checks are conducted on all resuscitation trollies throughout the unit.	1. Daily checks of neonatal resuscitaires continues be the minimum expected standard. 2. The Matron monitors compliance against this action as part of daily walk about on the unit and any issues identified are addressed immediately with the staff member concerned. Compliance has improved and continues to be 100% since the inspection in September 2019 3. The Matron completes a weekly Quality Assurance audit inclusive of daily equipment checks. Any issues identified are addressed immediately with the member of staff or relevant team. 4. The Senior Management Team also monitor compliance against this action during their regular walk about on the unit.	01/10/2019				These actions were completed at the time, in September 2019. In addition, it has been confirmed in January 2019 that 100% compliance has been achieved and maintained with daily checks since inspection until recently in a further HIW Inspection of Wrexham Maternity in January 2020 where non-compliance with checks has been confirmed by HIW; one check on 30.12.2019 was missed	Fiona Giraud		
219	HIW-IP-011	IP	Sep-19	Secondary Care	Central Glan Clwyd Hospital	Midwifery & Women's Services		2.1 2.4	Celyn Ward / Midwifery Led Unit/ Labour Ward / Traige Assessment Area / Operating Theatre	Improvement Plan	The health board must ensure that hand washing posters to be displayed.	Hand washing technique posters were in place above all hand washing sinks prior to the inspection in September 2019 2. Posters in place.	01/10/2019					Fiona Giraud		
220	HIW-IP-011	IP	Sep-19	Secondary Care	Central Glan Clwyd Hospital	Midwifery & Women's Services		2.1 2.4	Celyn Ward / Midwifery Led Unit/ Labour Ward / Traige Assessment Area / Operating Theatre	Improvement Plan	The health board must ensure that tap on the birthing pool is replaced.	1. The team have completed further inspections of all birthing pools and no stains could be identified, and no maintenance issues have been required for the birthing pool taps.	01/10/2019				These actions were completed at the time, in September 2019 and are subject to ongoing review and audits.	Fiona Giraud		
221	HIW-IP-011	IP	Sep-19	Secondary Care	Central Glan Clwyd Hospital	Midwifery & Women's Services		2.1 2.4	Celyn Ward / Midwifery Led Unit/ Labour Ward / Traige Assessment Area / Operating Theatre	Improvement Plan	The health board must ensure that all cleaning schedules are appropriately completed	1. A review of all cleaning schedules has been undertaken and those not required, removed 2. All remaining cleaning schedules are completed weekly, as per health board requirements and this is also audited as part of the ward accreditation metrics process.	01/10/2019				These actions were completed at the time, in September 2019 and are subject to ongoing review and audits.	Fiona Giraud		
222	HIW-IP-011	IP	Sep-19	Secondary Care	Central Glan Clwyd Hospital	Midwifery & Women's Services		2.5 2.6	Celyn Ward / Midwifery Led Unit/ Labour Ward / Traige Assessment Area / Operating Theatre	Improvement Plan	The health board must ensure that fluid balance charts are completed following commencement of intravenous fluid administration	1. The completion of fluid balance charts is managed by the Quality Improvement programme (QIP) for the maternity unit 2. Fluid balance charts are audited as part of the ward accreditation process and the Matron's weekly Quality Assurance audit. Where any omissions are identified, it is addressed directly with the member of staff to avoid a recurrence. 3. An improvement has been noted in the monthly audit results and the end date for the QIP is 31 December 2019, however, monthly audits will be continued throughout 2020. 4. The Clinical Supervisors for Midwives discuss documentation standards during their presentation on the monthly mandatory training days and these sessions are open to both midwifery and medical staff	01/10/2019				These actions were completed at the time, in September 2019 and are subject to ongoing review and audits. In addition, it has been confirmed in January 2020 that the Quality Improvement Programme is ongoing and the monthly audits undertaken by the Ward Manager/Matron, are showing an improvement in compliance. Continued work is required and therefore the programme will be extended until 31st March 2020.	Fiona Giraud		
223	HIW-IP-011	IP	Sep-19	Secondary Care	Central Glan Clwyd Hospital	Midwifery & Women's Services		2.6	Celyn Ward / Midwifery Led Unit/ Labour Ward / Traige Assessment Area / Operating Theatre	Improvement Plan	The health board must ensure that medication is stored appropriately and securely at all times	1. Full compliance with the BCUHB standards of medication storage continues to be the expected standard against this action. Shift co-ordinators monitor compliance against this action throughout each shift. Any concerns identified are addressed immediately with the staff member concerned 2. The Matron audits compliance against the standards during a weekly Quality Assurance audit. 3. A named Matron has been identified to lead on a medicine management improvement programme for the Directorate and has developed an action plan, which was presented at the October meeting of the Safer Medicines Committee, which the Matron attends on a monthly basis. 4. The Matron also attends the health Board Medicines Management Collaborative, where the monthly Directorate audits are reviewed.	01/10/2019				These actions were completed at the time, in September 2019 and are subject to ongoing review and audits. In addition, it has been confirmed in January 2020 that no further concerns have been identified to date and medication has been stored appropriately. Women's audits are reviewed at the previously detailed health board meetings and all updates with regards to medicines management are fed back to the Directorate via the named Matron. Any new information and learning is disseminated to staff in all clinical areas via the Inpatient and Outpatient Matrons.	Fiona Giraud		

Line Ref	Imp Plan Ref	Imp Plan Code	Date of Inspection	Directorate	Area	Speciality	Status	H& C Standards	Ward / Unit	Report /Immediate Action letter	HIW Recommendation	BCUHB Management Response	Imp Date	No. Revisions	Rev. Imp Date	Actual Imp. Date	Status Updates	Owner	Planned Follow up Review	Actual Follow up Review
224	HIW-IP-011	IP	Sep-19	Secondary Care	Central Glan Clwyd Hospital	Midwifery & Women's Services	Completed	2.6	Celyn Ward / Midwifery Led Unit/ Labour Ward / Traige Assessment Area / Operating Theatre	Improvement Plan	The health board must ensure that induction of labour medication prescribing is reviewed.	1. A lessons learned position statement was circulated on 26 September 2019 to all clinical areas on the required standards of practice of prostaglandin administration (see separate document). 2. The revision of the Integrated Care Pathway (ICP) has been completed and is out for consultation until 9 December 2019 and will be ratified at the Women's Board meeting in January 2020. 3. The Induction of Labour (IOL) patient information leaflet, aligned to the Pathway and Policy, is being updated and translated. 4. The current Written Controlled Document (WCD) states 'If, 24 hours following the insertion, labour is not established or the woman is not suitable for ARM, the middle grade doctor should be informed and the case discussed with the LW consultant'. The review of this WCD has been extended to March 2020, pending the release of the new NICE IOL guidance for its inclusion. This has been made explicit on the current WCD, on the Directorate intranet policies page. 5. The North Wales Clinical Lead has been given assurance by the Clinical Directors across North Wales that clinical practice now reflects the required standard of practice for prostaglandin administration. Continued assurance has been requested on a monthly basis following the inspection	01/10/2019				Actions 1 & 5 were completed at the time, in September 2019. Action 2 is complete as at January 2020 2. The revised Integrated Care Pathway (ICP) was agreed at the Women's Quality, Safety & Experience Sub-Group in December 2019 and will be ratified at Women's Board in January 2020 3. The Induction of Labour (IOL) patient information leaflet is on the agenda for Women's Quality, Safety & Experience Sub-Group and the Women's Service Board meeting in January 2020 and once agreed will be sent for translated and printed for women and their families 4. The WCD has been updated and agreed by the Women's Quality, Safety & Experience Sub-Group and is on the agenda for Women's Services Board and the Health Board Drugs & Therapeutics Group in January 2020. The WCD will also be added to the Health Board Medicines Management Group agenda in February 2020	Fiona Giraud		
225	HIW-IP-011	IP	Sep-19	Secondary Care	Central Glan Clwyd Hospital	Midwifery & Women's Services	Implemented	2.6	Celyn Ward / Midwifery Led Unit/ Labour Ward / Traige Assessment Area / Operating Theatre	Improvement Plan	The health board must ensure that regular medication rounds are considered.	1. Medication rounds have been reconsidered following the unannounced inspection and re-trialled. 2. The management team agreed that all ward managers should have the autonomy to introduce either a full medicine round or midwife led medicine rounds for women in their care. 3. To support continuity of care and carer (Welsh Government's Maternity Five Year Strategy), the unit has adopted the individualised medication giving approach. This approach and compliance is monitored against the health board's medicine management standards and is audited as part of ward accreditation.	01/10/2019				These actions were completed at the time, in September 2019 and are subject to ongoing review and audits.	Fiona Giraud		
226	HIW-IP-011	IP	Sep-19	Secondary Care	Central Glan Clwyd Hospital	Midwifery & Women's Services	Implemented	1.1 2.5	Celyn Ward / Midwifery Led Unit/ Labour Ward / Traige Assessment Area / Operating Theatre	Improvement Plan	The health board must ensure that breast feeding support is reviewed and that visibility is increased throughout the unit.	1. All midwives receive annual breast feeding training and are available on an individualised basis to support women in their care. 2. The appointed Infant Feeding Co-ordinators are available to support staff across North Wales for more complex advice. 3. A business case has been developed to secure funding for extra breast feeding support across North Wales.	01/10/2019				These actions were completed at the time, in September 2019 and are subject to ongoing review and audits.	Fiona Giraud		
227	HIW-IP-011	IP	Sep-19	Secondary Care	Central Glan Clwyd Hospital	Midwifery & Women's Services	Implemented	3.5	Celyn Ward / Midwifery Led Unit/ Labour Ward / Traige Assessment Area / Operating Theatre	Improvement Plan	The health board must ensure that patient records are secured securely at all times.	1. All case note trolleys have been fitted with digital locks and all filing cabinets now have locks and keys. 2. All staff are aware that case notes need to be returned to a locked storage facility when not in use.	01/10/2019				These actions were completed at the time, in September 2019 and are subject to ongoing review and audits.	Fiona Giraud		
228	HIW-IP-011	IP	Sep-19	Secondary Care	Central Glan Clwyd Hospital	Midwifery & Women's Services	In Progress	3.4	Celyn Ward / Midwifery Led Unit/ Labour Ward / Traige Assessment Area / Operating Theatre	Improvement Plan	The health board must ensure that policies and procedures are reviewed and updated within appropriate timescales	1. The Written Control Document Group has an action plan available that details all policies and guidelines that have been developed within the Women's Directorate, inclusive of revision dates. All policy/guideline authors are approached when policy review is required to perform the necessary review and are prompted in a timely manner. 2. Since the unannounced inspection, all authors of outstanding policies have been asked to submit their updated versions for ratification in January 2020. This is part of wider work we are undertaking as a Health Board to update all of our policies. 3. The Director of Midwifery and Women's Services and North Wales Clinical Lead are monitoring the progress made at monthly Senior Management Team meetings. 4. A process map of Written Control Documents/Policies is also being undertaken to improve the efficiency of this process. The Maternity & Neonatal Network in Wales are leading on this improvement.	01/03/2020				A memo from the Director of Midwifery & Women's Services and the North Wales Clinical Lead was circulated in December 2019 to all staff, detailing the need for WCD authors to comply with the required timeframes for updates. Agreement was reached at the Women's Quality, Safety & Experience Sub-Group, that a list of policies, authors and due dates are to be shared with the site triumvirate leadership teams, to enforce and support lines of accountability in reviewing WCD. WCD expiry dates have been extended to March 2020 to ensure staff are fully aware that the WCD on the intranet remain live for their support.	Fiona Giraud		
229	HIW-IP-011	IP	Sep-19	Secondary Care	Central Glan Clwyd Hospital	Midwifery & Women's Services	Implemented	3.4	Celyn Ward / Midwifery Led Unit/ Labour Ward / Traige Assessment Area / Operating Theatre	Improvement Plan	The health board must ensure that data entry is reviewed to ensure consistency.	The Directorate is working in partnership with the informatics department to triangulate data collected prior to entering it onto the maternity dashboard for accuracy purposes.	01/10/2019				These actions were completed at the time, in September 2019 and are subject to ongoing review and audits.	Fiona Giraud		
230	HIW-IP-011	IP	Sep-19	Secondary Care	Central Glan Clwyd Hospital	Midwifery & Women's Services	Implemented	3.5	Celyn Ward / Midwifery Led Unit/ Labour Ward / Traige Assessment Area / Operating Theatre	Improvement Plan	The health board must ensure that patient records are fully reflective of the care and treatment provided to patients and in line with standards of professional record keeping.	1. Clinical Supervisors for Midwives discuss documentation standards which includes the care and treatment provided to women, during their presentations on mandatory training days. These sessions are delivered every two years alternating with enhanced communication sessions as part of an agreed Training Needs Analysis for the Directorate. These sessions are open to both midwifery and medical staff 2. The Clinical Supervisors for Midwives also provide monthly notes audit sessions for staff, where they can review sets of notes and learn directly from any good/poor practice identified during the session. The audit results are also fed back at Group Supervision sessions, which each midwife is mandated to attend annually. The results are also presented to Women's QSE sub group annually. 3. Each midwife is required to audit two sets of their own records from the previous year to discuss at a Group Supervision session annually. 4. The Clinical Supervisors for Midwives also support documentation sessions for medical staff on their induction programme and highlight the need to include the care and treatment provided to women within their medical documentation. 5. Stamps have been re-ordered for all staff to use alongside their signature when documenting an entry in a woman's notes.	01/10/2019				These actions were completed at the time, in September 2019 and are subject to ongoing review and audits.	Fiona Giraud		
231	HIW-IP-011	IP	Sep-19	Secondary Care	Central Glan Clwyd Hospital	Midwifery & Women's Services	Implemented	3.4	Celyn Ward / Midwifery Led Unit/ Labour Ward / Traige Assessment Area / Operating Theatre	Improvement Plan	The health board must ensure that data collection methods of the birth register statistics is reviewed	1. To ensure the accuracy of the birth statistics, the monthly data collected by the Labour ward Clinical Lead Midwife is triangulated with that collected by the Governance Team and the Informatics Department. 2. Adverse Clinical Events forms are completed for each delivery and the data is collected and analysed by the Governance Team. The monthly birth statistics are then checked against the Governance Team data and also against the information collected on the Maternity Outcome e-form by Informatics.	01/10/2019				These actions were completed at the time, in September 2019, and are subject to ongoing review and audits.	Fiona Giraud		
232	HIW-IP-011	IP	Sep-19	Secondary Care	Central Glan Clwyd Hospital	Midwifery & Women's Services	Implemented	3.3	Celyn Ward / Midwifery Led Unit/ Labour Ward / Traige Assessment Area / Operating Theatre	Improvement Plan	The health board must ensure that follow on work from audits is reviewed to ensure learning and service improvements take place.	It has been agreed that all audit findings are discussed at the Women's QSE sub-group. Results of the audit and required improvement plans are referred to the relevant forums for development and monitoring. The Forums will then be required to provide updates on their improvement plans on a quarterly basis to Women's QSE sub-group to ensure improvements are implemented and embedded into service and care provision.	01/10/2019				These actions were completed at the time, in September 2019, and are subject to ongoing review and audits.	Fiona Giraud		
233	HIW-IP-011	IP	Sep-19	Secondary Care	Central Glan Clwyd Hospital	Midwifery & Women's Services	Implemented	3.3	Celyn Ward / Midwifery Led Unit/ Labour Ward / Traige Assessment Area / Operating Theatre	Improvement Plan	The health board must ensure that management empowerment and leadership support is reviewed to enable career progression.	1. The Directorate offers professional development for all staff. 2. Staff are encouraged to liaise with their line managers to identify areas in which they feel they need to professionally develop during their annual appraisal. 3. Shadowing opportunities are available to staff at all levels of leadership within the Directorate and nationally. 4. Secondment opportunities within the health board, local authorities and nationally, are also encouraged and supported by the Directorate. 5. Staff are actively encouraged to join policy development groups and to support audit by linking with the relevant audit leads. 6. Clinical midwives are also given some designated responsibility for linking with other services i.e. bereavement and maternity voices. 7. Newly appointed staff in leadership positions are supported in their role and in the skill of appropriate delegation. 8. Staff also support strategic development within the health board and lead at a national level.	01/10/2019				These actions were completed at the time, in September 2019 and are subject to ongoing review and audits.	Fiona Giraud		
234	HIW-IP-011	IP	Sep-19	Secondary Care	Central Glan Clwyd Hospital	Midwifery & Women's Services	Implemented	7.1	Celyn Ward / Midwifery Led Unit/ Labour Ward / Traige Assessment Area / Operating Theatre	Improvement Plan	The health board must ensure that the medical rota is reviewed.	1. An independent review of medical rotas has been completed, as part of the health board's medical workforce strategy. Immediate solutions have been supported by the health board. 2. Medium to long-term options will be discussed with executive colleagues on 2 December 2019.	01/10/2019				These actions were completed at the time, in September 2019 and are subject to ongoing review and audits.	Fiona Giraud		
304	HIW-IP-015	IP	Nov-19	Secondary Care	West Yabyty Gwynedd	Midwifery & Women's Services	Implemented			Improvement Plan	The health board must ensure that resource and availability of perinatal support is reviewed.	The Directorate is working in partnership with the Perinatal Mental Health Service to ensure that all relevant information and support is available to all women.	31/11/2019				This work has commenced and is ongoing. Progress will be monitored by the service and a follow up date has been set to review progress	Fiona Giraud	31/03/2020	
305	HIW-IP-015	IP	Nov-19	Secondary Care	West Yabyty Gwynedd	Midwifery & Women's Services	Implemented			Improvement Plan	The health board must ensure that resource and availability of perinatal support is reviewed.	The Perinatal Mental Health Service is located on the Glan Clwyd Hospital site. North Wales has a full complement of Perinatal Mental Health practitioners and therefore all six Counties have a named professional.	31/11/2019				This action was completed immediately following the inspection. No follow up review required	Fiona Giraud		

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306	HIW-IP-015	IP	Nov-19	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	In Progress			Improvement Plan	The health board must ensure that resource and availability of perinatal support is reviewed.	The Perinatal Mental Health Service has a robust training programme for 2020 which commenced in January. The training includes 'Training the trainer' for *Infant and Health Visiting Perinatal Mental Health* . The Women's Professional Development Midwife attended the training in January 2020, with a plan to identify midwife champions in all clinical areas and cascade this specialist knowledge. 2. Champions not yet appointed.	01/04/2020					Fiona Giraud		
307	HIW-IP-015	IP	Nov-19	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	Implemented	3.5		Improvement Plan	The health board must ensure that discussions regarding birth choices take place and are documented accordingly.	All pregnant women are given a copy of the Betsi Cadwaladr University Health Board Birth Choices Leaflet to facilitate discussion regarding options for birth.	31/11/2019				This action was completed immediately following the inspection. No follow up review required	Fiona Giraud		
308	HIW-IP-015	IP	Nov-19	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	Implemented			Improvement Plan	The health board must ensure that discussions regarding birth choices take place and are documented accordingly.	All staff have been reminded to document Birth Choice discussions within the Hand Held Notes. This will be monitored at the Clinical Supervisors for Midwives monthly notes audit.	31/11/2019				This action was completed immediately following the inspection. Follow up date has been set to review compliance	Fiona Giraud	31/05/2020	
309	HIW-IP-015	IP	Nov-19	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	Implemented			Improvement Plan	The health board must ensure that discussions regarding birth choices take place and are documented accordingly.	Birth Choice Clinics commenced within the maternity unit in Ysbyty Gwynedd in January 2020. Feedback from women on this service introduction will be collated and presented to the Women's Quality Safety and Experience (QSE) sub group on a quarterly basis. This will then feed up to the Board through the Corporate Quality safety Group (QSG).	31/11/2019				This work has commenced and is ongoing. Progress will be monitored by the service and a follow up date has been set to review progress	Fiona Giraud	31/03/2020	
310	HIW-IP-015	IP	Nov-19	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	Implemented	1.1		Improvement Plan	The health board must ensure that patients and families are made aware of the Community Health Council (CHC) for advocacy and support	The contact details for the Community Health Council are displayed and available in all clinical areas. This compliance is monitored on the Matron daily walkabout on the unit.	31/11/2019				Compliance is to be monitored by the service via daily walkabouts	Fiona Giraud		
311	HIW-IP-015	IP	Nov-19	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	Implemented	2.1		Improvement Plan	The health board must ensure that hand sanitiser gels are available for use	Fully operational hand sanitiser-dispensing pumps available at every bed space and throughout the unit. Compliance with this will be checked by the housekeeper and Health Care Support Worker on a daily basis.	31/11/2019				Compliance is to be monitored by the service via daily checks by the Housekeeper and Health care Support Worker	Fiona Giraud		
312	HIW-IP-015	IP	Nov-19	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	Implemented	1.1		Improvement Plan	The health board must ensure that breast feeding support is reviewed and that visibility is increased throughout the unit.	All midwives receive an annual update on breast-feeding and are available to support women on an individual basis when required. There is also a dedicated page on the Health Board's website	31/11/2019				This action was completed immediately following the inspection. No follow up review required	Fiona Giraud		
313	HIW-IP-015	IP	Nov-19	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	Implemented			Improvement Plan	The health board must ensure that breast feeding support is reviewed and that visibility is increased throughout the unit.	The Infant Feeding Co-ordinator is available to support staff to provide care to women and babies presenting with cases that are more complex.	31/11/2019				This action was completed immediately following the inspection. No follow up review required	Fiona Giraud		
314	HIW-IP-015	IP	Nov-19	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	Implemented			Improvement Plan	The health board must ensure that breast feeding support is reviewed and that visibility is increased throughout the unit.	A business case has been developed with options of how we can improve and further support breast-feeding support workers as part of a Quality Improvement Project. Awaiting a response from Finance	31/11/2019				Progress will be reported through usual governance route. Follow up date set to review	Fiona Giraud	01/05/2020	
315	HIW-IP-015	IP	Nov-19	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	Implemented			Improvement Plan	The health board must ensure that breast feeding support is reviewed and that visibility is increased throughout the unit.	Pending approval from Finance the Directorate will be recruiting in March and staff will commence in May 2020	01/05/2020				Progress will be reported through usual governance route. Follow up date set to review	Fiona Giraud	01/05/2020	
316	HIW-IP-015	IP	Nov-19	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	Implemented	3.4		Improvement Plan	The health board must ensure that policies and procedures are reviewed and updated within appropriate timescales	The Women's Written Control Document Group has an action plan that lists all policies and guidelines developed, which includes revision dates.	31/11/2019				Progress will be reported through usual governance route.	Fiona Giraud		
317	HIW-IP-015	IP	Nov-19	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	Implemented			Improvement Plan	The health board must ensure that policies and procedures are reviewed and updated within appropriate timescales	All policy/guideline authors are approached by the appropriate Forums within Women's Services when policy review is required.	31/11/2019				Progress will be reported through usual governance route. No follow up required	Fiona Giraud		
318	HIW-IP-015	IP	Nov-19	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	In Progress			Improvement Plan	The health board must ensure that policies and procedures are reviewed and updated within appropriate timescales	Authors of all outstanding policies are regularly reminded to submit their updated versions to the relevant governance group for approval in a timely manner. A tracker has been developed to support the monitoring of this action	31/05/2020				In progress as per BCUHB Management Response	Fiona Giraud		
319	HIW-IP-015	IP	Nov-19	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	Implemented			Improvement Plan	The health board must ensure that policies and procedures are reviewed and updated within appropriate timescales	A memo from the Director of Midwifery & Women's Services and the North Wales Clinical Lead was circulated in December 2019 to all staff, detailing the need for WCD authors to comply with the required timeframes for updates	31/11/2019				This action was completed immediately following the inspection. No follow up review required	Fiona Giraud		
320	HIW-IP-015	IP	Nov-19	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	Implemented			Improvement Plan	The health board must ensure that policies and procedures are reviewed and updated within appropriate timescales	Agreement was reached at the Women's Quality, Safety & Experience Sub-Group (QSE), that a list of policies, authors and due dates should be shared with the site triumvirate leadership teams, to enforce and support lines of accountability	31/11/2019				Progress will be reported through usual governance route.	Fiona Giraud		
321	HIW-IP-015	IP	Nov-19	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	In Progress			Improvement Plan	The health board must ensure that policies and procedures are reviewed and updated within appropriate timescales	Written Control Document expiry dates have been extended to March 2020 to ensure staff are fully aware that the Written Controlled Documents on the intranet remain live for their support	31/03/2020				In progress as per BCUHB Management Response	Fiona Giraud		
322	HIW-IP-015	IP	Nov-19	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	Implemented			Improvement Plan	The health board must ensure that policies and procedures are reviewed and updated within appropriate timescales	The Health Board have developed a formal route for written control documents to ensure that any policies approaching their expiry date, are reviewed and updated in a timely and appropriate manner	31/03/2020				The Health Board request that all policies developed are ratified by the Corporate Quality & Safety Group moving forward. No follow up review date required	Fiona Giraud		
323	HIW-IP-015	IP	Nov-19	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	Implemented			Improvement Plan	The health board must ensure that policies and procedures are reviewed and updated within appropriate timescales	The Director of Midwifery and Women's Services and North Wales Clinical Lead are monitoring the progress made at monthly Senior Management Team meetings.	31/11/2019				Progress will be reported through usual governance route.	Fiona Giraud		
324	HIW-IP-015	IP	Nov-19	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	Implemented			Improvement Plan	The health board must ensure that policies and procedures are reviewed and updated within appropriate timescales	Bi-weekly meetings have been arranged for the Chairs of the Women's Directorate Forums, the Governance lead and the Director of Midwifery to monitor progress and performance against the Written Controlled Document action plan	31/11/2019				Progress will be reported through usual governance route.	Fiona Giraud		
325	HIW-IP-015	IP	Nov-19	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	Implemented			Improvement Plan	The health board must ensure that policies and procedures are reviewed and updated within appropriate timescales	A Written Controlled Documents progress report is reviewed at the Women's QSE Sub-Group on a quarterly basis	31/11/2019				Progress will be reported through usual governance route.	Fiona Giraud		
326	HIW-IP-015	IP	Nov-19	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	Implemented	3.5		Improvement Plan	The health board must ensure that patient records are fully reflective of the care and treatment provided to patients and in line with standards of professional record keeping	Clinical Supervisors for Midwives discuss documentation standards, which includes the care and treatment provided to women, during their presentations on mandatory training days. These sessions are delivered every two years alternating with enhanced communication sessions as part of an agreed Training Needs Analysis for the Directorate. These sessions are open to both midwifery and medical staff.	31/11/2019				As per BCUHB Management Response, sessions are delivered every two years	Fiona Giraud		
327	HIW-IP-015	IP	Nov-19	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	Implemented			Improvement Plan	The health board must ensure that patient records are fully reflective of the care and treatment provided to patients and in line with standards of professional record keeping	The Clinical Supervisors for Midwives also provide monthly notes audit sessions for staff, where they can review sets of notes and learn directly from any good/poor practice identified during the session. The audit results are also fed back at Group Supervision sessions, which each midwife is mandated to attend annually. The results are also presented to Women's QSE sub group annually	31/11/2019				As per BCUHB Management Response, monthly audit note sessions take place with staff and progress reported via governance route. No follow up review required	Fiona Giraud		
328	HIW-IP-015	IP	Nov-19	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	Implemented			Improvement Plan	The health board must ensure that patient records are fully reflective of the care and treatment provided to patients and in line with standards of professional record keeping	Each midwife is required to audit two sets of their own records from the previous year to discuss at a group Supervision session on an annual basis	31/11/2019				As per BCUHB Management Response, audit takes place on an annual basis and is monitored by the service. No follow up review required	Fiona Giraud		
329	HIW-IP-015	IP	Nov-19	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	Implemented			Improvement Plan	The health board must ensure that patient records are fully reflective of the care and treatment provided to patients and in line with standards of professional record keeping	The Clinical Supervisors for Midwives also support documentation sessions for medical staff on their induction programme and highlight the need to include the care and treatment provided to women within their medical documentation	31/11/2019				As per BCUHB Management Response, audit takes place on an annual basis and is monitored by the service. No follow up review required	Fiona Giraud		
330	HIW-IP-015	IP	Nov-19	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	Implemented			Improvement Plan	The health board must ensure that patient records are fully reflective of the care and treatment provided to patients and in line with standards of professional record keeping	Stamps have been re-ordered for all staff to use alongside their signature when documenting an entry in a woman's notes	31/11/2019				This action was completed immediately following the inspection. No follow up review required	Fiona Giraud		
331	HIW-IP-015	IP	Nov-19	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	Implemented	Governance, Leadership and Accountability		Improvement Plan	The health board must ensure that CTG training is reviewed to cover the introduction of new processes	All new documentation is made available for staff consultation prior to implementation	31/11/2019				This action is already in place and is to be monitored by the service. No follow up review required	Fiona Giraud		
332	HIW-IP-015	IP	Nov-19	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	Implemented			Improvement Plan	The health board must ensure that CTG training is reviewed to cover the introduction of new processes	Clinical Supervisors for Midwives also post information with regards to the introduction of new documentation on the midwifery hub	31/11/2019				This action is already in place and is to be monitored by the service. No follow up review required	Fiona Giraud		
333	HIW-IP-015	IP	Nov-19	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	Implemented			Improvement Plan	The health board must ensure that CTG training is reviewed to cover the introduction of new processes	All midwives and obstetricians are required to complete six hours of face-to-face CTG training per annum. Training sessions include interpretation of a CTG using the antenatal and intrapartum CTG stickers implemented across the Women's Directorate	31/11/2019				Follow up review date set to check compliance.	Fiona Giraud	31/05/2020	
334	HIW-IP-015	IP	Nov-19	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	In Progress			Improvement Plan	The health board must ensure that CTG training is reviewed to cover the introduction of new processes	Midwifery CTG champions have been identified in each maternity unit. Midwifery CTG champions are in the process of completing a training programme that includes attending an RCOG study day and working with other CTG national champions. Following completion of the training, the champions will be responsible for delivering the training to midwives and obstetricians within the Directorate. 2. Training postponed due to COVID -19.	01/04/2020				This action is in progress with the service. As at January 2020, training has commenced and remains in progress until April 2020	Fiona Giraud		
335	HIW-IP-015	IP	Nov-19	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	Implemented	7.1		Improvement Plan	The health board must ensure that medical work plans are reviewed to ensure adequate medical cover is in place at all times	An external independent review of medical rotas has been completed, as part of the health board's medical workforce review strategy	31/11/2019				As per BCUHB Management Response, this has been completed and subject to governance. Follow up review date set to ensure implementation	Fiona Giraud	30/04/2020	
336	HIW-IP-015	IP	Nov-19	Secondary Care	West Ysbyty Gwynedd	Midwifery & Women's Services	In Progress			Improvement Plan	The health board must ensure that medical work plans are reviewed to ensure adequate medical cover is in place at all times	An independent review of job plans is scheduled for 7 February 2020. 2. Job planning commenced but now on hold due to COVID -19. Consultant of the day in place Monday to Thursday and some Fridays.	01/04/2020				This action is in progress with the service	Fiona Giraud		
337	HIW-IP-017	IP	Jan-20	Secondary Care	East Wrexham Maelor	Midwifery & Women's Services	Implemented	3.2		Improvement Plan	The health board must ensure that smoking cessation health promotion is readily available throughout the unit	The Women's Directorate has worked in partnership with Public Health to secure the relevant information for display in the clinical areas for women and their families. Smoking cessation information is now displayed in all clinical areas. The importance of Health Promotion for women has been highlighted to all staff within the maternity unit.	31/01/2020				This action is already in place and is to be monitored by the service. No follow up review required	Fiona Giraud		
338	HIW-IP-017	IP	Jan-20	Secondary Care	East Wrexham Maelor	Midwifery & Women's Services	Implemented			Improvement Plan	The health board must ensure that smoking cessation health promotion is readily available throughout the unit	The local Public Health Team has agreed to review all available patient information on a six monthly basis and will forward any new posters/information to the Matron for display in all ward areas	31/07/2020				**Update required**	Fiona Giraud		
339	HIW-IP-017	IP	Jan-20	Secondary Care	East Wrexham Maelor	Midwifery & Women's Services	Implemented			Improvement Plan	The health board must ensure that smoking cessation health promotion is readily available throughout the unit	The Ward Manager will review the information displayed on a monthly basis and will display all new information on a six monthly basis as forwarded by the Public Health Team. This will be monitored at the site monthly accountability meetings, as part of the Women's Directorate Assurance Framework.	31/07/2020				This action is already in place and is to be monitored by the service. No follow up review required	Fiona Giraud		
340	HIW-IP-017	IP	Jan-20	Secondary Care	East Wrexham Maelor	Midwifery & Women's Services	In Progress	3.2		Improvement Plan	The health board must ensure that directions are reviewed to enable easy access to the unit from all entrances.	The Women's Directorate has liaised with the Director of Estates and Facilities and has been advised that the Wrexham Hospital Management Team is currently reviewing signage on the Wrexham Maelor Site which will include Maternity Services. Costed options are being prepared for submission for capital funding and / or from charitable funds in 2020/21.	31/05/2020				**Update required**	Fiona Giraud		
341	HIW-IP-017	IP	Jan-20	Secondary Care	East Wrexham Maelor	Midwifery & Women's Services	Implemented	2.1 3.1		Improvement Plan	The health board must ensure that all staff caring for patients within the birthing pools are appropriately trained and this is documented accordingly.	Lead midwives have been identified to deliver pool evacuation training. The Leads have had training from the Manual Handling Department to ensure the safety of staff during this skills drill	31/01/2020				Mandatory Training has been revised during COVID 19 and face to face training has been suspended. Pool evacuation training will be revisited following COVID 19 to ensure all staff have completed their training.	Fiona Giraud		

Line Ref	Imp Plan Ref	Imp Plan Code	Date of Inspection	Directorate	Area	Speciality	Status	H& C Standards	Ward / Unit	Report /Immediate Action letter	HIW Recommendation	BCUHB Management Response	Imp Date	No. Revisions	Rev. Imp Date	Actual Imp. Date	Status Updates	Owner	Planned Follow up Review	Actual Follow up Review
342	HIW-IP-017	IP	Jan-20	Secondary Care	East Wrexham Maelor	Midwifery & Women's Services	In Progress			Improvement Plan	The health board must ensure that all staff caring for patients within the birthing pools are appropriately trained and this is documented accordingly.	All core staff have been trained and the remaining staff will have completed their training by the end of March 2020. 2. Training has been suspended due to COVID-19.	31/03/2020				Mandatory Training has been revised during COVID 19 and face to face training has been suspended. Pool evacuation training will be revisited following COVID 19 to ensure all staff have completed their training.	Fiona Giraud		
343	HIW-IP-017	IP	Jan-20	Secondary Care	East Wrexham Maelor	Midwifery & Women's Services	In Progress			Improvement Plan	The health board must ensure that all staff caring for patients within the birthing pools are appropriately trained and this is documented accordingly.	A register of all staff trained is completed by the Lead Midwives. The compliance with pool evacuation training has been added to the Directorate's Mandatory Training database for North Wales for monitoring and auditing purposes.	31/01/2020				Mandatory Training has been revised during COVID 19 and face to face training has been suspended. Pool evacuation training will be revisited following COVID 19 to ensure all staff have completed their training.	Fiona Giraud		
344	HIW-IP-017	IP	Jan-20	Secondary Care	East Wrexham Maelor	Midwifery & Women's Services	In Progress	2.1 3.1		Improvement Plan	The health board must ensure that anaesthetic cover is reviewed to maintain continuity of care	At present there are three on-call tiers from 08:30 until 21:30 daily. After 21:30 there are two tiers to cover Obstetrics and ICU, with the consultant on-call covering theatres from home. Withdrawal of the third tier overnight was a Deanery directive following a visit in 2012. There were further discussions with the Deanery about this level of cover in 2013/14. Work is ongoing in anaesthetics to increase the service to three tiers to support continuity of care. 2. Discussions ongoing with the Deanery.	31/05/2020					Fiona Giraud		
345	HIW-IP-017	IP	Jan-20	Secondary Care	East Wrexham Maelor	Midwifery & Women's Services	Implemented	3.1		Improvement Plan	The health board must ensure that policies and procedures are reviewed and updated within appropriate timescales.	The Women's Written Control Document Group has an action plan that lists all policies and guidelines developed, which includes revision dates.	31/01/2020				This action is already in place and is to be monitored by the service. No follow up review required	Fiona Giraud		
346	HIW-IP-017	IP	Jan-20	Secondary Care	East Wrexham Maelor	Midwifery & Women's Services	Implemented			Improvement Plan	The health board must ensure that policies and procedures are reviewed and updated within appropriate timescales.	All policy/guideline authors are approached by the appropriate Forums within Women's Services when policy review is required.	31/01/2020				This action is already in place and is to be monitored by the service. No follow up review required	Fiona Giraud		
347	HIW-IP-017	IP	Jan-20	Secondary Care	East Wrexham Maelor	Midwifery & Women's Services	Implemented			Improvement Plan	The health board must ensure that policies and procedures are reviewed and updated within appropriate timescales.	Authors of all outstanding policies are regularly reminded to submit their updated versions to the relevant governance group for approval in a timely manner. A tracker has been developed to support the monitoring of this action.	31/01/2020				This action is already in place and is to be monitored by the service. No follow up review required	Fiona Giraud		
348	HIW-IP-017	IP	Jan-20	Secondary Care	East Wrexham Maelor	Midwifery & Women's Services	Implemented			Improvement Plan	The health board must ensure that policies and procedures are reviewed and updated within appropriate timescales.	A memo from the Director of Midwifery & Women's Services and the North Wales Clinical Lead was circulated in December 2019 to all staff, detailing the need for WCD authors to comply with the required timeframes for updates.	31/01/2020				This action is already in place and is to be monitored by the service. No follow up review required	Fiona Giraud		
349	HIW-IP-017	IP	Jan-20	Secondary Care	East Wrexham Maelor	Midwifery & Women's Services	Implemented			Improvement Plan	The health board must ensure that policies and procedures are reviewed and updated within appropriate timescales.	Agreement was reached at the Women's Quality, Safety & Experience Sub-Group (QSE), that a list of policies, authors and due dates should be shared with the site triumvirate leadership teams, to enforce and support lines of accountability.	31/01/2020				This action is already in place and is to be monitored by the service. No follow up review required	Fiona Giraud		
350	HIW-IP-017	IP	Jan-20	Secondary Care	East Wrexham Maelor	Midwifery & Women's Services	Implemented			Improvement Plan	The health board must ensure that policies and procedures are reviewed and updated within appropriate timescales.	Written Control Document expiry dates have been extended to March 2020 to ensure staff are fully aware that the Written Controlled Documents on the intranet remain live for their support.	31/01/2020				This action is already in place and is to be monitored by the service. No follow up review required	Fiona Giraud		
351	HIW-IP-017	IP	Jan-20	Secondary Care	East Wrexham Maelor	Midwifery & Women's Services	Implemented			Improvement Plan	The health board must ensure that policies and procedures are reviewed and updated within appropriate timescales.	The health board has developed a formal route for written control documents to ensure that any policies approaching their expiry date, are reviewed and updated in a timely and appropriate manner.	31/01/2020				This action is already in place and is to be monitored by the service. No follow up review required	Fiona Giraud		
352	HIW-IP-017	IP	Jan-20	Secondary Care	East Wrexham Maelor	Midwifery & Women's Services	Implemented			Improvement Plan	The health board must ensure that policies and procedures are reviewed and updated within appropriate timescales.	The Director of Midwifery and Women's Services and North Wales Clinical Lead are monitoring the progress made at monthly Senior Management Team meetings.	31/01/2020				This action is already in place and is to be monitored by the service. No follow up review required	Fiona Giraud		
353	HIW-IP-017	IP	Jan-20	Secondary Care	East Wrexham Maelor	Midwifery & Women's Services	Implemented			Improvement Plan	The health board must ensure that policies and procedures are reviewed and updated within appropriate timescales.	Monthly meetings have been arranged for the Chairs of the Women's Directorate Forums, the Governance Lead and the Director of Midwifery to monitor progress and performance against the Written Controlled Document action plan.	31/01/2020				This action is already in place and is to be monitored by the service. No follow up review required	Fiona Giraud		
354	HIW-IP-017	IP	Jan-20	Secondary Care	East Wrexham Maelor	Midwifery & Women's Services	Implemented			Improvement Plan	The health board must ensure that policies and procedures are reviewed and updated within appropriate timescales.	The health board requires that all policies developed are ratified by the Corporate Quality & Safety Group. The Women's Directorate are compliant with this request and all new WCD are on the agenda for Corporate Quality & Safety Group meetings.	31/01/2020				This action is already in place and is to be monitored by the service. No follow up review required	Fiona Giraud		
355	HIW-IP-017	IP	Jan-20	Secondary Care	East Wrexham Maelor	Midwifery & Women's Services	Implemented	3.1 7.1		Improvement Plan	The health board must ensure that core healthcare support worker allocation is reviewed to maintain safe practice and competence based learning.	As part of each new starter's induction programme, staff including healthcare support workers are allocated to work in all clinical areas, ensuring skills are developed to meet the requirement of the role. This will ensure all staff access competence based learning and will maintain safe practice.	31/01/2020				This action is already in place and is to be monitored by the service. No follow up review required	Fiona Giraud		
356	HIW-IP-017	IP	Jan-20	Secondary Care	East Wrexham Maelor	Midwifery & Women's Services	Implemented			Improvement Plan	The health board must ensure that core healthcare support worker allocation is reviewed to maintain safe practice and competence based learning.	At each Personal Annual Development Review (PADR), training needs are discussed and where development areas are highlighted, the line manager will work with the healthcare support worker to ensure any additional competency based learning is accessed	31/01/2020				This action is already in place and is to be monitored by the service. No follow up review required	Fiona Giraud		
357	HIW-IP-017	IP	Jan-20	Secondary Care	East Wrexham Maelor	Midwifery & Women's Services	In Progress	3.1 7.1		Improvement Plan	The health board must ensure that medical work plans are reviewed to ensure adequate medical cover is in place at all times.	An external Consultancy Team is working with the Women's Directorate to review individual job plans and to support a team job planning exercise. The final report and recommendations will be presented to the health board in April 2020. 2. Commenced but now suspended due to COVID-19.	30/04/2020		?		This work will be finalised following COVID 19	Fiona Giraud		
358	HIW-IP-017	IP	Jan-20	Secondary Care	East Wrexham Maelor	Midwifery & Women's Services	Implemented	3.1 7.1		Improvement Plan	The health board must ensure that further senior leadership, development and coaching is available for progression in current roles	The Directorate offers professional development for all staff.	31/01/2020				This action is already in place and is to be monitored by the service. No follow up review required	Fiona Giraud		
359	HIW-IP-017	IP	Jan-20	Secondary Care	East Wrexham Maelor	Midwifery & Women's Services	Implemented			Improvement Plan	The health board must ensure that further senior leadership, development and coaching is available for progression in current roles	Staff are encouraged to liaise with their line managers to identify areas in which they feel they need to professionally develop during their annual appraisal.	31/01/2020				This action is already in place and is to be monitored by the service. No follow up review required	Fiona Giraud		
360	HIW-IP-017	IP	Jan-20	Secondary Care	East Wrexham Maelor	Midwifery & Women's Services	Implemented			Improvement Plan	The health board must ensure that further senior leadership, development and coaching is available for progression in current roles	Shadowing opportunities are available to staff at all levels of leadership within the Directorate and nationally.	31/01/2020				This action is already in place and is to be monitored by the service. No follow up review required	Fiona Giraud		
361	HIW-IP-017	IP	Jan-20	Secondary Care	East Wrexham Maelor	Midwifery & Women's Services	Implemented			Improvement Plan	The health board must ensure that further senior leadership, development and coaching is available for progression in current roles	Secondment opportunities within the health board, local authorities and nationally, are also encouraged and supported by the Directorate.	31/01/2020				This action is already in place and is to be monitored by the service. No follow up review required	Fiona Giraud		
362	HIW-IP-017	IP	Jan-20	Secondary Care	East Wrexham Maelor	Midwifery & Women's Services	Implemented			Improvement Plan	The health board must ensure that further senior leadership, development and coaching is available for progression in current roles	Staff are actively encouraged to join policy development groups and to support audit by linking with the relevant audit leads.	31/01/2020				This action is already in place and is to be monitored by the service. No follow up review required	Fiona Giraud		
363	HIW-IP-017	IP	Jan-20	Secondary Care	East Wrexham Maelor	Midwifery & Women's Services	Implemented			Improvement Plan	The health board must ensure that further senior leadership, development and coaching is available for progression in current roles	Clinical midwives are also given some designated responsibility for linking with other services i.e. bereavement and maternity voices.	31/01/2020				This action is already in place and is to be monitored by the service. No follow up review required	Fiona Giraud		
364	HIW-IP-017	IP	Jan-20	Secondary Care	East Wrexham Maelor	Midwifery & Women's Services	Implemented			Improvement Plan	The health board must ensure that further senior leadership, development and coaching is available for progression in current roles	Coaching is available to midwives via the Clinical Supervisors for Midwives, who have been trained to coach staff.	31/01/2020				This action is already in place and is to be monitored by the service. No follow up review required	Fiona Giraud		
365	HIW-IP-017	IP	Jan-20	Secondary Care	East Wrexham Maelor	Midwifery & Women's Services	Implemented			Improvement Plan	The health board must ensure that further senior leadership, development and coaching is available for progression in current roles	Coaching has been arranged for members of the North Wales Senior Leadership Team, who have highlighted this as an area for further development. The Coaching has been facilitated via an external agency working with the Directorate.	31/01/2020				This action is already in place and is to be monitored by the service. No follow up review required	Fiona Giraud		
366	HIW-IP-017	IP	Jan-20	Secondary Care	East Wrexham Maelor	Midwifery & Women's Services	Implemented	3.1 7.1		Improvement Plan	The health board must ensure that succession planning is reviewed for the roles with limited resource and staff coverage such as PROMPT Trainer.	There are PROMPT Faculties in each Maternity Unit and Community Area, who can lead and deliver the required PROMPT sessions within the health board in the absence of the PROMPT Lead. The Faculty approach ensures appropriate leads are available for all PROMPT sessions, and supports robust succession planning.	31/01/2020				This action is already in place and is to be monitored by the service. No follow up review required	Fiona Giraud		
367	HIW-IP-017	IP	Jan-20	Secondary Care	East Wrexham Maelor	Midwifery & Women's Services	Implemented			Improvement Plan	The health board must ensure that succession planning is reviewed for the roles with limited resource and staff coverage such as PROMPT Trainer.	Succession planning is being considered for specific roles within the Governance Team and is part of a priority in the Directorate Workforce three-year plan.	31/01/2020				This action is already in place and is to be monitored by the service. No follow up review required	Fiona Giraud		

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety & Experience Committee 05.05.2020
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Maternity Framework for Maintaining Life Saving and Life Impacting Essential Services during the COVID 19 Pandemic
Cyfarwyddwr Cyfrifol: Responsible Director:	Teresa Owen, Executive Director of Public Health
Awdur yr Adroddiad Report Author:	Fiona Giraud, Director of Midwifery and Women's Services
Craffu blaenorol: Prior Scrutiny:	Women's Committee Structure
Atodiadau Appendices:	One Appendix – Maternity Services Business Continuity COVID 19- Community Midwifery and Maternity Services Temporary Relocation Plan

Argymhelliad/Recommendation:

The Committee is asked to note the Directorate's compliance and service adaptation to specific guidance for Maternity Services in Wales in relation to Welsh Government's Framework for Maintaining Life Saving and Life Impacting Essential Services during the COVID-19 Pandemic and support the;

- Ring fencing and preservation of the Red and Green estate adaptations on all three DGHs and relocated services in the Communities.
- Preservation of the Midwifery and Obstetric Workforce in order to maintain essential services throughout the Pandemic.

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

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

Sefyllfa / Situation:

The Welsh Government's (WG) planning response system has declared that Maternity Services are essential services which must continue during the COVID-19 pandemic and define this amongst other services as lifesaving or life impacting. Guidance for these essential services has been published and Health Board compliance will be monitored.

Cefndir/Background:

The enclosed briefing confirms the Women's Directorate local response to Welsh Government's specific guidance for maternity service during the pandemic.

Asesiad/Assessment & Analysis

1) Introduction

The COVID-19 outbreak and associated healthcare demands represent a significant challenge to services. It is imperative to continue to provide high quality care to our most at risk patients and manage services proactively to reduce demand when the crisis is over. Welsh Government has called on Heath Boards to employ their guidance on strategies during this period.

The strategy to mitigate the effect of the virus on large numbers of 'at risk' members of the population includes social distancing, separation and 'shielding' for up to 12 weeks. The 'at risk' population includes pregnant women. In North Wales we'll have up to 6,000 women within this category at any one point of the outbreak.

The Welsh Government planning response system has established a group that will determine some key principles, identifying essential services, and provide a focal and co-ordinating point for the development of plans or protocols to deliver these essential services during the COVID-19 outbreak. WHO advise that countries should identify essential services that will be prioritised in their efforts to maintain continuity of service delivery. Services related to reproductive health, including care during pregnancy, childbirth and care of vulnerable populations, such as young infants are classified by WHO as high priority categories.

In response Welsh Government has declared that Maternity and Neonatal Services, are essential services which must continue during the COVID-19 pandemic and defined these services as lifesaving and life impacting i.e. where harm would be significant and irreversible, without urgent or emergency intervention. Guidance for these essential services has been published on the Welsh Government COVID pages. Specific Guidance for Maternity Services includes – 'Access to Maternity Services for antenatal, intrapartum and postnatal care, which includes provision of community service on a risk assessed basis, underpinned by The Royal College of Obstetrics and Gynaecology (RCOG) guidance. Welsh Government will be monitoring how essential services are being maintained during the COVID-19 outbreak and gaining assurances that Health Boards are delivering consistent essential services.

2) Women's Directorate Response

The Women's Directorate can confirm that the service is working with the Welsh Government guidance for essential services and specifically for maternity services based on RCOG advice.
The Directorate continues to provide:

- Miscarriage and Termination Services (for congenital abnormalities)
- Early Pregnancy Assessment Units per DGH Site
- Antenatal Screening and USS Services
- Midwifery Led and Consultant Led Antenatal Care
- 24hr Maternity Assessment Service per DGH Site
- Obstetric and Midwifery Led Care Inpatient Services per DGH Site
- Midwifery Led Clinic and Obstetric Intrapartum Care per DGH Site.
- Postnatal Acute and Community Services
- Newborn Hearing and Blood Spot Screening

The RCOG guidance is provided as a resource for UK Healthcare professionals based on a combination of available evidence, good practice and expert advice, but it is recognised that this is very much an evolving situation and that the guidance is a living document that is continually being updated as new information becomes available.

The priorities of the guidance and of the local service are to:

- Maintain high quality care for women throughout the pandemic.
- Reduce the transmissions of COVID-19 to pregnant women.
- Provide safe care to pregnant women with suspected/confirmed COVD-19

In response to these prioritised the service has adapted some of its acute and community services to meet the essential service requirements as follows:

2.1) Community Services

Midwifery Led Bookings and Antenatal Clinics have been adapted within the Communities to be able to see women safely. Some clinics still operate out of GP practices, whilst some of our community Midwifery Hubs, that are located in community hospitals, have been relocated as the sites become COVID receiving sites. (Appendix 1)

These relocations were risk based decisions and provide Community Midwifery teams with community bases where they can see women during their antenatal and postnatal period safely.
As a consequence of the Bryn Beryl and Dolgellau Hospital relocations the Intrapartum 'Home from Home' service on both sites has been temporarily suspended as has the home birth service. Women are advised in light of current staffing challenges and in response to the Welsh Ambulance Service Trust's letter to Health Boards noting their reduced capacity to be able to respond to emergency transfers from community birth setting during the pandemic, that the Health Board is not able to actively support Home Births in the current climate. Consequently Women are advised of the birth options available to them and that the three Alongside Midwifery Led Units are available as positive alternatives during the pandemic.

The provision of Obstetric led Antenatal Clinics and Ultrasound Screening has also been temporarily reorganised during the outbreak to ensure safe business continuity.

2.2) Acute Services

In order to reflect the service priorities during this outbreak maternity services on all three DGHs have been re-organised to be able to manage normal activity and the safe care and segregation of women and their babies who may be suspected or COVID positive. The maternity estate on each DGH has been designated into 'Green' and 'Red' Areas. Women are screened prior admission into the acute areas and streamed appropriately into the red and green inpatient areas. The designated areas care for women from early pregnancy through to the postnatal period and the three labour wards are also designated into 'Green' and 'Red' Areas. This temporary re-organisation is monitored closely and Women's feedback is actively captured to inform any modifications or improvements required throughout the outbreak.

2.3) Screening

All antenatal screening, as per Antenatal Screening Wales (ASW) Protocols and RCOG guidance, is prioritised. Newborn screening for hearing is also maintained as a priority and is undertaken before the newborn is discharged from hospital. Women who pursue a home birth during the pandemic, are made aware of all the risks as detailed previously and are supported by the service in full knowledge of any limitations, and are informed that newborn screening for hearing for births outside of the DGHs may be delayed by 9 months for the duration of the pandemic.

3) Management of Risk and Mitigation

Robust Clinical Pathways, based on the latest RCOG guidance, have been developed and are constantly updated as new evidence is presented. These are presented and ultimately approved by the Executive Lead C19 Clinical Pathway Group.

Pathways also include the introduction of a clinical 24hr telephone triaging system, operation from all three Acute Assessment Units. This system supports COVID screening, appropriate sign posting and advice to women. This introduction has been well evaluated by both women, staff and referring partners.

Triaging women booked to attend antenatal clinics, follow ups and reviews by medical colleagues has also changed practice positively and ensures that all face to face consultations, if not replaced by any other means, are clinically appropriate.

Monitoring of all temporary changes in response to the COVID 19 outbreak is managed by regular planning meetings, and the Directorate's compliance with the Welsh Government essential guidance for maternity services reported weekly to the Maternity and Neonatal Network. A contemporaneous risk log is also maintained and reviewed weekly.

4) Workforce

Impact of the COVID-19 outbreak and the related staff isolation guidance on service continuity is monitored daily, and appropriate re-deployment of staff to maintain essential services within the Acute and across communities in North Wales is constantly under review. Between 7-10% of the Workforce is currently absent due to COVID-19 restrictions.

The RCOG has expressed concerns about the redeployment of staff away from Maternity Services during the outbreak. As acknowledged by the RCOG protection of Midwifery and Obstetric staffing to remain within and manage services is a priority in order to maintain this, as classified, essential service.

5) Communication

Information for Women in relation to COVID-19 is being managed and updated regularly on the Service's Facebook page, supported by the Health Board's Communication Team, and via Maternity Voices and the Afterthoughts Forums in partnership with the Active Birth Movement.

Communication Hubs have been set up on each maternity unit on the three DGH sites and virtually for the community teams to ensure that the most up to date evidence and guidance is held at an accessible central source.

To support staff wellbeing weekly Staff Drop-in Sessions and walkabouts by Senior Leads have been re-instated.

6) Conclusions

In conclusion the service has and will continue to adapt its response to this evolving situation in the ultimate interest of Women's safety throughout pregnancy, birth and the postnatal period.

7) Recommendation

The Committee is requested to acknowledge the Directorate's compliance with Welsh Government's essential guidance for maternity services during the COVID-19 pandemic, and the temporary changes/adaptations made to local services to reflect these requirements and support the;

- Ring fencing and preservation of the Red and Green estate adaptations on all three DGHs and relocated services in the Communities.
- Preservation of the Midwifery and Obstetric Workforce in order to maintain essential services throughout the Pandemic.

References:

- RCOG (2020) – Coronavirus (COVID-19) Infection In Pregnancy - Information for Healthcare professionals (V7)
- Welsh Government (2020) – Framework for maintaining Life Saving and Life Impacting Essential Services during the COVID-19 Pandemic – Welsh Government

Strategy Implications

The Services actions as detailed in the attached briefing reflects Welsh Government's Framework for Maintaining Life Saving and Life Impacting Essential Services during the COVID-19 Pandemic, and the specific guidance for maternity services.

Financial Implications

Any and all financial implications have been considered as part of the Women's COVID-19 planning preparations. Contracting for the relocation of services and purchasing of equipment to support temporary changes have been appropriately managed in line with the COVID-19 Financial Governance and Accountability Instruction.

Risk Analysis

The Planning and Temporary changes to services have all been risk assessed, entered onto the Women's Risk Register and recorded contemporaneously on a Risk Log which is reviewed on a weekly basis.

Legal and Compliance

Planning and Legal Advice has been secured for all relocation solutions and agreement as part of the Women's COVID-19 Emergency Planning process.

Impact Assessment

An EqIA and QIA has been completed for the emergency changes made as part of the Service's COVID-19 planning strategy.

Appendix 1

MATERNITY SERVICES BUSINESS CONTINUITY
COVID 19- COMMUNITY MIDWIFERY AND MATERNITY SERVICES TEMPORARY RELOCATION PLAN
APRIL 2020

WEST	COVID SITE PLAN	MIDWIFERY/MATERNITY SERVICE POSITION	RE-LOCATION	DATE OF MOVE
Tywyn Hospital	Green Site	Continue services on Site	NO	
Dolgellau Hospital	Red Site	Services to be relocated	**Dolfeurig Centre Dolgellau LL40 1EL 01341 423031**	**9/4/20**
Bryn Beryl Hospital Pwllheli	Red Site	Service to be relocated	**Ysgol Glan Y Mor LL53 5NU**	**16/4/20**
Alltwen Hospital Porthmadog	Red Site	Service to be relocated	**Ysgol Eifionnydd LL49 9HS**	**21/4/20**
YPS Holyhead	Red Site	Service to be relocated	**Holyhead Leisure Centre LL65 2YE**	**11/4/20**
Cefni Hosptial Llangenfi	Red Site	Service to be relocated	**Plas Arthur Leisure Centre LL77 7QX**	**11/4/20**
Hafan Iechyd Caernarfon	Red OOH Weekends	Service to be relocated	To be confirmed	Site walkabout 13/4/2020

Consultants ANC **All Antenatal Consultant Clinics in West including Llandudno Consultant ANC to be re provided/re located back to YG – St David's OPD.**
USS Services **Llandudno and Alltwen USS lists will be re-provided on the YG Site on Monday afternoons.**

Appendix 1

MATERNITY SERVICES BUSINESS CONTINUITY
COVID 19- COMMUNITY MIDWIFERY AND MATERNITY SERVICES TEMPORARY RELOCATION PLAN
APRIL 2020

CENTRAL	COVID SITE PLAN	MIDWIFERY/MATERNITY SERVICE POSITION	RE-LOCATION	DATE OF MOVE
Llandudno Hospital	Red Site	Services to be relocated	**Ysgol John Bright Llandudno LL30 1LF**	**16/4/20**
Colwyn Bay Hospital	Red Site	Services to be relocated	**Eirias Park Colwyn Bay LL29 7SP**	**9/4/20**
Denbigh Royal Infirmary	Red Site	Continue with services in the OPD Building separate to the Hospital	No – plan confirm with IPC team	N/A
Royal Alexander Hospital Rhyl	Green Site	Continue with OPD/Consultant ANCs	No – continue and centralise service	N/A
Ffordd Las Rhyl	Green Site	Continue with Services (new flooring)	No – continue with services on Site	
Holywell Hospital	Red Site	Services to be relocated	**Holywell Leisure Centre CH8 7UZ**	**7/4/20**
Consultants ANC • **Llandudno to YG.** • **Colwyn Bay to ILB and then Glan Traeth, Alex OPD** • **Holywell – to Glan Traeth, Alex OPD**				
USS Services • **Llandudno Service to YG.** • **Holywell and Cowlyn Bay Service to Alex Radiology Dept.**				

Appendix 1

MATERNITY SERVICES BUSINESS CONTINUITY
COVID 19- COMMUNITY MIDWIFERY AND MATERNITY SERVICES TEMPORARY RELOCATION PLAN
APRIL 2020

EAST	COVID SITE PLAN	MIDWIFERY/MATERNITY SERVICE POSITION	RE-LOCATION	DATE OF MOVE
Deeside Hospital	Red Site	Services to be relocated	**Wrexham Maelor**	Week commencing 13/4/20
Chirk Hospital	Red Site	No Services on Site	USS to Wrexham	20/4/20
Buckley		No Services on Site	N/A	N/A
Mold	Green Site	ANC Services to be maintained	NO	N/A
Connahs Quay Deeside	Red/Green	Continue services on Green Area	NO	3/4/20
Caia Park Clinic Wrexham	N/A	Continue services	NO	N/A
Ruabon Clinic	N/A	Continue Services	NO	N/A
Brynteg Clinic Wrexham	N/A	Continue Services	NO	N/A

Consultants ANC

- **Deeside to Wrexham Maelor (+Gynae Onc)**
- **Chirk to Wrexham Maelor.**

USS Services

- **Deeside and Chirk USS Service move to Wrexham Maelor,**

Appendix 1

MATERNITY SERVICES BUSINESS CONTINUITY
COVID 19- COMMUNITY MIDWIFERY AND MATERNITY SERVICES TEMPORARY RELOCATION PLAN
APRIL 2020

Cyfarfod a dyddiad: **Meeting and date:**	Quality, Safety & Experience Committee 05.05.2020
Cyhoeddus neu Breifat: ***Public or Private:***	Public
Teitl yr Adroddiad **Report Title:**	Corporate Risk Register and Assurance Framework Report
Cyfarwyddwr Cyfrifol: **Responsible Director:**	CRR02 Executive Director of Nursing and Midwifery CRR03 Director of Primary and Community Care CRR05 Executive Director of Nursing and Midwifery CRR16 Executive Director of Nursing and Midwifery CRR03 Director of Primary and Community Care CRR13 Director of Mental Health and Learning Disabilities CRR20 Executive Director of Workforce and Organisational Development CRR21 Executive Director of Workforce and Organisational Development CRR22 Executive Director of Nursing and Midwifery CRR23 Executive Director of Workforce and Organisational Development CRR24 Executive Director of Workforce and Organisational Development CRR25 Executive Director of Workforce and Organisational Development CRR26 Executive Director of Workforce and Organisational Development **Risk for Escalation** • No risks for escalation at this moment. **Proposed Risk for De-escalation** • CRR28 - Risk of infection from COVID-19 to staff and patients as a result of inadequate supply, quality or usage of PPE.
Awdur yr Adroddiad **Report Author:**	Mr Matthew Joyes, Associate Director of Quality Assurance Mr David Tita, Head of Risk Management
Craffu blaenorol: **Prior Scrutiny:**	The full Corporate Risk and Assurance Framework (CRAF) is scrutinised by the Health Board twice per year and is published on the Board's external facing website. Individual risks are allocated to one of the Board's Committees for regular consideration and review. This report has been approved for submission to the Committee by the Deputy Chief Executive / Executive Director of Nursing and Midwifery.
Atodiadau **Appendices:**	Appendix 1 – Details of Corporate Risk Register Report.
Argymhelliad / Recommendation:	
The Quality, Safety and Experience Committee is asked to: 1) Consider the relevance of the current controls. 2) Review the actions in place and consider whether the risk scores remain appropriate for the presented risks. 3) Approve the proposed reduction in risk score of CRR28 – PPE (	

4) Note, approve and recommend this extract of the Corporate Risk Register (CRR) to the Audit Committee and to gain assurance that the risks articulated herein are appropriately managed in line with the Health Board`s risk management strategy and best practice.

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

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

Sefyllfa / Situation:

The attached report has been produced from the web-based Datix system and details the risk entries allocated to the Quality, Safety and Experience Committee (QSE). The QSE regularly reviews, scrutinises and calibrates risk information articulated on its risks captured on Datix within the wider context of strengthening our risk governance arrangements while engineering shared learning and continuous improvements of our risk management journey, process and culture.

Updates captured as a result of the review and scrutiny of this corporate risk register (CRR) report will be presented to the Audit Committee in May 2020 for further scrutiny, assurance, approval and recommendation to the Board.

Cefndir / Background:

The emergence of the current challenging Covid-19 situation underlines the importance for organisations including healthcare providers like the Health Board to place effective risk management at the heart of business/organisational planning, objectives/priority setting, performance reporting and in ensuring financial viability and sustainability.

This does not only emphasise the need for innovation, agility, anticipation and a paradigm shift in continuously scanning the horizon for emerging risks but also highlights the primacy of engaged/thought leadership in driving and embedding an effective organisational risk management culture and awareness.

Although the Health Board had undertaken a complete re-write of its risk management strategy that was due to be launch in April, 2020, the emerging situation due to the outbreak of COVID-19, has thus made it difficult for the launch to go ahead. The launch of our new Risk Management Strategy and Policy has thus been differed for the next six months until 1st October 2020 as this has been ratified by the Board. In order to ensure that risk management activities across the Health Board continue to be carried out in line with best practice, the current risk management strategy and its procedural documents has been extended until 30th September 2020.

This postpone has provided the opportunity for resources to be channelled towards supporting the effective delivery of the Health Board`s Covid-19 strategic plan while ensuring that a dynamic risk-based approach is at its heart.

Asesiad / Assessment & Analysis

It is worth underlining that the updates and progress on the effective mitigation of some of the risks herein is largely the same as per the last report that was presented to the QSE following review and scrutiny of their risks at the Audit Committee. The updates have thus largely stayed the same as they have been no significant changes and movements in these risks since the last report.

Some of the risk entries are similar to those presented in the previous report as explained above. The following risk entry summaries and the changes encapsulated herein have been made to the below risks since the last report was received by the QSE Committee: -

CRR02 Infection Prevention and Control.

Key progress: Following a review of this risk during the previous meeting, it was noted the mitigating controls and further actions remain on track. A further review by the Risk Handler has been undertaken with the mitigating controls updated to reflect the change of the monthly Executive-led scrutiny meetings to 6 weekly. Further actions have also been identified to support the achievement of the target risk score and these include implementation of the key actions arising from further reports by Jan Stevens, continue work on the influenza preparedness and review of the Pandemic Policy, further development of the Infection Prevention Team in 2020 and closure working alongside Tissue Viability, Pharmacy and Continence service in relation to HCAIs. There has been no change to the current risk scoring.

CRR03 – Continuing Health Care

Key progress: This risk has been reviewed and re-assessed with emphasis placed on the CHC elements while the component around Care Homes and their development will be risk assessed as a new distinct risk, therefore the risk description has been slightly revised taking this into account. The mitigating controls have been strengthened to include area and divisional CHC Teams in place, implementation of the revised CHC Improvement Group and CHC Operational Groups with clear reporting and governance arrangements in place and the establishment of the partnership arrangements with the National Commissioning Unit to oversee strategy development. Further actions have also been revised and include implementation of a programme of CHC support with the NCCU to focus on training, development, performance management and stakeholder engagement, development of KPIs within the new IT system, development of the CHC commissioning strategy and implementation of a joint contracting process for providers in formal escalation. There has been no change to the current risk scoring.

While the CHC component has been maintained on the CRR in replacement of the old CRR03, the Care Home elements which were risk assessed as a distinct risk and approved for de-escalation as per the last meeting, is now being appropriately managed at Tier 2.

CRR05 Learning from Patient Experience.

Key progress: The risk description has been reviewed and updated with more detail included to describe the risk and the impact of the risk should it materialise. Mitigating controls have been refreshed to include revised meetings and scrutiny routes to manage processes and strengthen lessons learnt across the whole Health Board, nan Health Board quality improvement collaborative programmes commenced, new Patient Advice and Liaison Service (PALS) in place and fully resourced, training programme in place, Patient Safety Alerts process in place, Quality and Safety Group in place to oversee patient safety and to cascade learning from patient safety issues, Joint protocol in place between Health Boards and Welsh Ambulance Service Trust to undertake joint investigations when appropriate, Mortality review process in place to support learning from deaths. Further actions have

also been revised and include a full concerns processes review and redesign, Patent Safety Alert process to be moved to the Patient Safety and Experience Department allowing for greater integration of data/insight and activity, development of a Patient Safety and Experience Learning Library and Bulletin to further promote learning, implementation of new "Once for Wales" RLDatix concerns management system to aid learning across the Health Board and Wales. There has been no change to the current risk scoring, however the target risk score is being recommended for adjustment so that the impact remains the same but the likelihood will decrease with the implementation of the mitigating controls. This also then aligns with the Health Board's risk appetite statements.

CRR13 Mental Health Services.
Key progress: As part of the corporate risk review at the Audit Committee on the 12th December 2019, a request to update the controls and further actions with completion dates was requested. No further update has been provided. A footnote under the graph has been incorporated to note between August 2018 and October 2019 a reduction in score was unauthorised and now been reverted to correct score.

CRR16 Safeguarding.
Key progress: As part of the corporate risk review at the Audit Committee on the 12th December 2019, the title of the risk has been updated. Risk controls have been strengthened to include implementation of key controls relating to the review and effectiveness of the Safeguarding structure and action plans, this relates to increasing DoLS signatories, development of a Signatories Governance Framework and Specialist training. Bespoke DoLS Training and reporting of compliance and activity at Safeguarding Forums in accordance with the Safeguarding Reporting Framework has also been put in place, bespoke training continues to be delivered to key high priority areas with responsibilities for 16/17 yr olds who may be / or experience a deprivation of their liberty as a result of a Supreme Court Judgement. Further actions have also been updated to reflect the required changes to be implemented. There has been no change to the current risk scoring.

CRR20 Security Risk.
Key progress: As part of the corporate risk review at the Audit Committee on the 12th December 2019, concerns were raised regarding the appropriate scoring for the target risk. This was an error and has been addressed so that the Impact remains a 5 but the likelihood is reduced. There has been no change to the current risk scoring.

CRR21 Health & Safety Risk.
Key progress: As part of the corporate risk review at the Audit Committee on the 12th December 2019, key controls have been updated to include Health and Safety risk assessment system is in place in some service areas. There has been no change to the current risk scoring.

The following risks have been added onto the CRR since the last report:

CRR22 Potential to compromise patient safety due to large backlog and lack of follow-up capacity
Key progress: Approved and recommended for inclusion onto the CRR. Updates have been included which comprise some information from Informatics following a paper that was done around resourcing a permanent validation team for the Health Board as the cost of independent or external validation is very high. This will be important in informing and shaping how this risk is mitigated and managed going forward.

CRR23 Asbestos Management and Control
Key progress: Discussed, approved and recommended for inclusion onto the CRR. Target score needs re-considering as it sits outside the Health Board's risk appetite.

CRR24 Contractor Management and Control
Key progress: Although the QSE recommended this risk for inclusion onto the CRR, members at the RMG requested for some further work to be done in strengthening the controls and further actions in place and for the title to be refreshed to focus on the potential risk and not the issue.

CRR25 Legionella Management and Control.
Key progress: Members at the RMG reviewed this risk and recommended that the current score should be changed to 16 to reflect the controls in place. Target score needs re-considering as it sits outside the Health Board's risk appetite.

CRR26 Non-Compliance of Fire Safety Systems
Key progress: Members at the RMG reviewed these risks and requested for some further work to be done in strengthening its controls and further actions. Target score needs re-considering as it sits outside the Health Board's risk appetite.

The following two risks were approved for inclusion onto the CRR following review and scrutiny at the last Board meeting.

CRR27– Risk to public health and safety arising from an outbreak of COVID-19 and demand outstripping organisational capacity.
Key Progress: The newly added risk focuses on highlighting the potential impact to public health and the safety of staff and patients which may result from the outbreak of Covid-19 as this could negatively affect the Health Board`s resources and operational capabilities in effectivley mitigating and managing this pandemic.

CRR28 - Risk of infection from COVID-19 to staff and patients as a result of inadequate supply, quality or usage of PPE.
Key Progress: This risk was discussed and approved at the last Board meeting as the shortage of PPE items, the challenge with sourcing the right PPE kits and ensuring that these are readily and sufficiently available to frontline staff has become a huge national conundrum. The need to effectively mitigate and manage this risk so as to protect the health, well-being and safety of both staff and patients was emphasised. This risk is regularly reviewed and monitored by the PPE Work-stream.

Proposed Risk for Escalation
There is currently no risk being presented for review, scrutiny and recommendation for inclusion onto the CRR.

Proposed Risk for De-escalation
The PPE Taskforce discussed CRR28 at its daily meeting on 27 April 2020. The recommendation for approval by the QSE Committee is that the likelihood score is reduced from 3 to 2 based on the implementation of the mitigations.

Previously Deescalated Risk
CRR04 – Maternity Services risk was de-escalated in July 2018 following agreement at the Board meeting on the 12th July 2018.
Reference ID2950 – Potential inability of care homes to provide safe quality care de-escalated in December 2019 following approval from the Audit Committee meeting.

Current Risk Level		Impact				
		Very Low - 1	Low - 2	Moderate - 3	High - 4	Very high - 5
Likelihood	Very Likely - 5			CRR03	CRR22 CRR26	
	Likely - 4			CRR05	CRR13	CRR20 CRR21 CRR23 CRR24 CRR25
	Possible - 3				CRR16	CRR02
	Unlikely - 2					
	Rare – 1					

Strategy Implications
In line with the Health Board's Risk Management Strategy, all corporate risks are reviewed by a dedicated Committee of the Board which provides a structure and framework to consistently manage both strategic and operational risks as drivers for better decision making. These risks will identify the risks associated with the delivery of the Health Board's objectives as defined in the 3 year plan and annual plans.

Financial Implications
The effective and efficient mitigation and management of risks has the potential to leverage a positive financial dividend for the Health Board through better integration of risk management into business planning, decision-making and in shaping how care is delivered to our patients thus leading to enhanced quality, less waste and no claims.

Risk Analysis
No risks have been identified from crafting this report as the risk of inaction is far greater than that of positive engagement with its content.

Legal and Compliance
Due to the nature of this report, legal and compliance issues are addressed as part of the risk assessment for each risk entry.

Impact Assessment
Due to the nature of this report, Impact Assessments are not required.

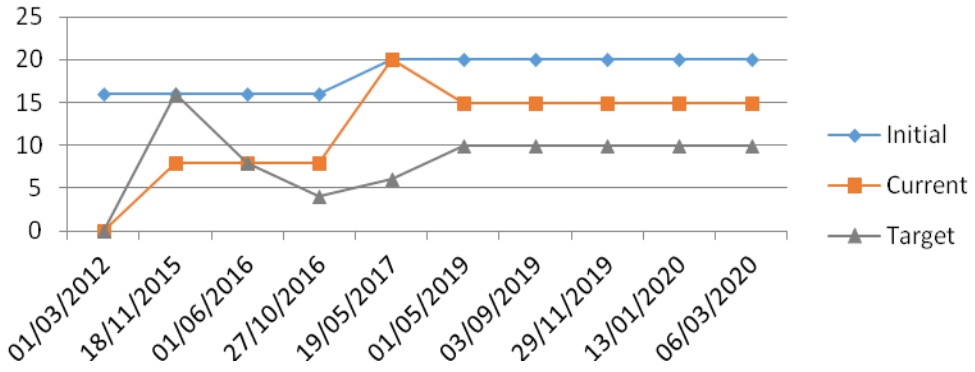
Future Review
The Executive Director of Nursing and Midwifery has requested (at the QSG meeting on 24 April 2020) that a review of the CRAF is undertaken to reflect the emerging environment created by the COVID-19 outbreak. This work is underway at the time of writing.

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

Appendix 1: Details of the Corporate Risk Register

CRR02	**Director Lead:** Executive Director of Nursing and Midwifery	**Date Opened:** 1 March 2012
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 6 March 2020
	Risk: Infection Prevention & Control	**Target Risk Date:** 30 September 2020

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



	Impact	Likelihood	Score
Initial Risk Rating	5	4	20
Current Risk Rating	5	3	15
Target Risk Score	5	2	10
Movement in Current Risk Rating since last presented to Board in November 2019	**No Change** ⟺		

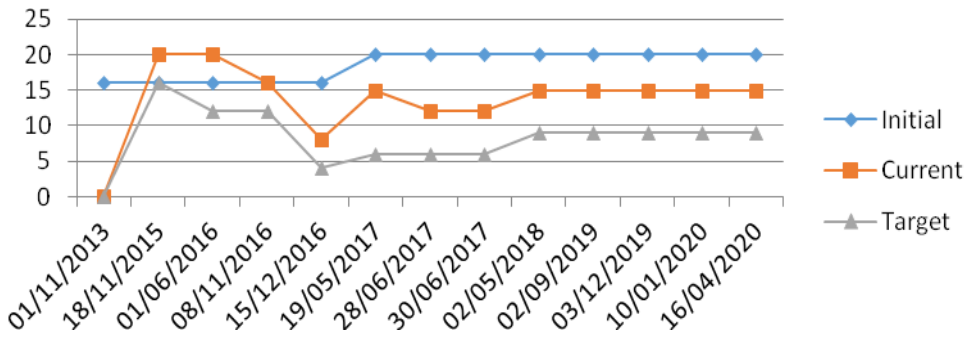
Controls in place	Further action to achieve target risk score
1. Infection Prevention Sub-Group scrutinise trajactories and performance through the regular cycle of business, quarterly and annual reports to Quality and Safety Group. 2. Surveillance systems and policies/SOPs in place for key infections, with data presented through the governance route to Board. 3. Areas and Secondary Care sites governance arrangements are in place.	1. Continue the implementation of SCC and IP via annual work programmes. 2. Consider aligning SCC with IP Annual Work Prgramme. 3. Implement the other actions identified in the 2019-20 annual infection prevention programme. 4. Implement actions in response to Welsh Government Antimicrobial Delivery Plan, relevant Welsh Health Circulars and in response to multi-drug resistant organisms. Part of the ARK study and rollout.

4. 6 weekly Executive-led scrutiny meetings to review infections and learning from each site in place. 5. Continued progress on ANTT staff training, with key trainers in place, increased focus on medical staff supported by MDs, competencies held by individuals managers. 6. External review performed August 2017; report on further actions presented to Board. Second review report received in August 2019 shows improvement, as does the internal audit on Safe Clean Care (SCC) assurance in June 2019. 7. SCC Programme launched 29-01-18. 8. CAUTI snapshot carried out in September 2019. 9. Deep dive considers every 6 organisms under WG scrutiny.	5. Continue to progress key actions from Duerden and Jan Stevens reports 2016, 2017, 2019 in relation to Variation, Consultant Microbiologist staffing and capacity, Antimicrobial Stewardship, Estates and Facilities, policies and procedures and Safe Clean Care. 6. Scrutinise every avoidable infection and lessons learnt from these are shared formally from Post Infection Reviews and Deep Dives. 7. Continue work on influenza preparedness and response for Winter 19-20 and review Pandemic policy and procedures. 8. 12 Key action points carried out HB wide in November 2019 which showed a decrease in 5 of the 6 trajactories. 9. Educational event and Link practitioners in place December 2019. 10. Canula devices and documents approved for distribution. 11. Collaberative work with Continence, Tissue Viability and pharmacy to address unwarrented variation. 12. Improved visability across the HB from IP service. 13. Review of all IP policies and SOPs. 14. Development of IP team 2020. 15. Working alongside Tissue Viability, Pharmacy and Continence service in relation to HCAIs.

Assurances	**Links to**		
1. Professor Duerden report 2016. 2. WG review of decontamination. 3. Demonstrable improvement in line with National Benchmarks. 4. CHC Bug watch visits. 5. HSE reviews. 6. Internal Audits of Governance Arrangements.	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	1 2 3 4 5 6 7	PR1	Leadership

CRR03	**Director Lead:** Director of Primary and Community Care	**Date Opened:** 1 November 2013
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 16 April 2020
	Risk: Continuing Health Care	**Target Risk Date:** 31 March 2021

There is a risk that the CHC National Framework is not complied with. This is due to limited understanding of the framework and inconsistent application. This could lead to poor patient experience, outcomes and value for money.



	Impact	Likelihood	Score
Initial Risk Rating	4	5	20
Current Risk Rating	3	5	15
Target Risk Score	3	3	9
Movement in Current Risk Rating since last presented to Board in November 2019	**No Change** ⟺		

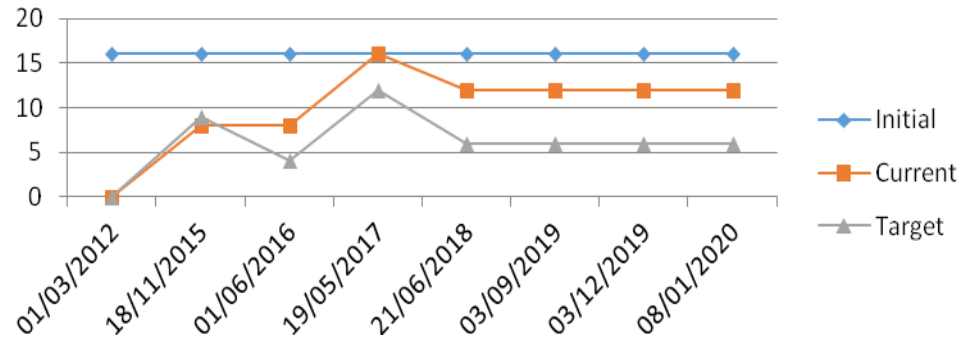
Controls in place	**Further action to achieve target risk score**
1. National CHC Framework. (2014). 2. Area and divisional CHC team with local accountability. 3. Revised BCUHB CHC Improvement Group and CHC operational Group Reporting and Governance Framework agreed. 4. Annual WG self assessment. 5. Contracts and contract monitoring team in place. 6. CHC Contracts in place for all placements. 7. Partnership established with the National Commisioning Collaborative Unit to oversee overarching strategy development improving quality, experience and value.	1. Progress programme of CHC support with NCCU, to include focus on training and development, data and performance management, standard operating proceedures, stakeholder engagement and realignment of CHC within the Health Board. 2. Development of dashboard KPI's for CHC with Broadcare. 3. Monthly exception reporting. 4. Develop CHC commissioning strategy. 5. Develop and finalise the joint contracting process for providers in formal escalation.

Assurances	**Links to**

1. Regular meetings with Regulators (CSSIW). 2.Inter-agency processes in place to review escalated concerns. 3. FNC Judicial Reviews of NHS Wales fee setting methodology implemented. 4. National reporting on CHC placements.	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	2 3 4 5 6 7	PR1	Strategic and Service Planning

CRR05	**Director Lead:** Executive Director of Nursing and Midwifery	**Date Opened:** 1 March 2012
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 08 January 2020
	Risk: Potential inability to learn from patient safety and experience concerns	**Target Risk Date:** 31 December 2020

There is a risk that the Health Board does not listen and learn from patient safety and experience due to the untimely management, investigation and subsequent improvement actions from concerns (incidents, complaints, claims, inquests). This could lead to repeated failures in quality and safety of care, poor patient experience, loss of organisational memory and reputational damage to the Health Board.



	Impact	Likelihood	Score
Initial Risk Rating	4	4	16
Current Risk Rating	3	4	12
Target Risk Score	2	3	6
Movement in Current Risk Rating since last presented to Board in November 2019	**No Change** ⟺		

Controls in place	**Further action to achieve target risk score**
1. Processes in place to manage concerns (incidents, complaints, claims, inquests) in accordance with PTR Regulations. 2. Corporate and divisional meetings to manage processes and cascade learning including daily reviews within divisions, weekly reviews within divisions and a weekly pan Health Board Incident and Complaint Review Meeting. 3. Reporting to share learning and monitor performance at divisional and pan Health Board levels; including divisional quality and safety reports, divisional patient experience reports and a	1. Concerns processes (incidents, complaints, claims, inquests) being fully reviewed following appointment of the new Assistant Director of Patient Safety and Experience – full process re-design will take place throughout 2020 in co-production with stakeholders, building on national best practice. 2. Patent Safety Alert process to be moved to the Patient Safety and Experience Department allowing for greater integration of data/insight and activity. 3. Development of a Patient Safety and Experience Learning Library on the intranet to further promote learning.

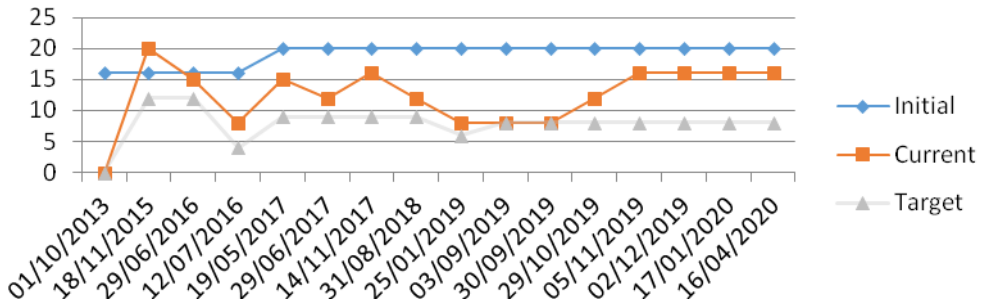
Health Board monthly and quarterly Patient Safety Report and quarterly Patient Experience Report. 4. Harm Dashboards available for local clinical leaders to identify opportunities for learning and improvement. 5. Pan Health Board quality improvement collaborative programmes commenced based on identified risks including a Falls Collaborative, Sepsis Collaborative and a Healthcare Acquired Pressure Ulcer (HAPU) Collaborative. 5. Patient Safety and Experience Department in place to develop and manage processes and systems and offer advice and assurance – supported by divisional governance teams and linked to the BCU Quality Improvement Hub. 6. New Patient Advice and Liaison Service (PALS) fully resourced and launched in 2019. 7. Learning from Event (LfE) Reports prepared for all claims and redress cases. 8. The Head of Patient Safety is part of, and chairs, the All-Wales Redress Case Review Group enabling learning from across the country to be identified. The Patient Safety and Experience Department is represented at, and fully engaged in, each All-Wales concerns related network. 9. Training programme in place to support continued learning, delivered by the Patient Safety and Experience Department. 10. Patient Safety Alerts process in place to cascade learning across the Health Board. 11. Quality and Safety Group in place to oversee patient safety and to cascade learning from patient safety issues, and a Patient Experience Group in place to undertake the same for patient experience (divisions provide reports to both groups).	4. Development of a Patient Safety and Experience Bulletin to further promote learning. 5. Review and update of training and development with a particular emphasis on developing and embedding human factors and systems thinking. 6. Implementation of new "Once for Wales" RLDatix concerns management system to aid learning across the Health Board and Wales. 7. Review of the weekly incident and complaint review meeting and development into a weekly Patient Safety Summit. 8. Structure review within the Patient Safety and Experience Department to improve the focus and profile of patient safety and to integrate complaints with patient experience/PALS. 9. Enhancement of the mortality review process to implement the new national Medical Examiner programme. 10. Workshop to be held with the Community Health Council to develop partnership working.

12 Joint protocol in place between Health Boards and Welsh Ambulance Service Trust to undertake joint investigations when appropriate. 13. Mortality review process in place to support learning from deaths. 14. Site audits by the Community Health Council (CHC) received through a single point of contact within the Health Board. 15. Inspections by Health Inspectorate Wales (HIW) received and coordinated through a single point of contact within the Health Board along with regular meetings with the HIW relationship manager.	

Assurances	**Links to**		
1. Welsh Risk Pool Reports. 2. Monthly review by Delivery Unit. 3. Public Service Ombudsman Annual Report, Section 16 and feedback from cases. 4. Regulation 28 Reports from the Coroner.	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	3 4 5 6	PR9 PR7 PR1	Leadership

CRR13	**Director Lead:** Director of Mental Health and Learning Disabilities	**Date Opened:** 1 October 2013
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 16 April 2020
	Risk: Mental Health Services	**Target Risk Date:** 31 March 2020

There is a risk that patients receive inappropriate care within Mental Health Services due to failings in leadership and governance within the Division which could result in poor quality outcomes for patients.



Between August 2018 and October 2019 a reduction in score was unauthorised, this has been reverted to correct score.

	Impact	Likelihood	Score
Initial Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	2	8
Movement in Current Risk Rating since last presented to Board in November 2019	**No Change** ⇔		

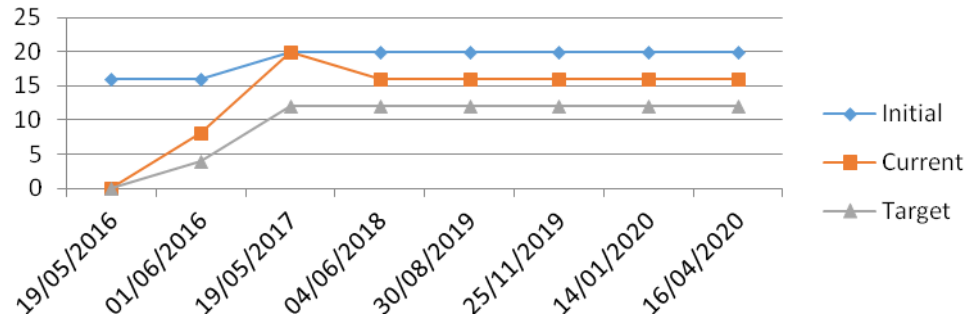
Controls in place	**Further action to achieve target risk score**
1. Board assurance provided at all levels of MHLD governance framework – local, divisional and directors, MHLD presents weekly at Corporate complaints and concerns meeting, monthly at QSG, bi monthly to QSE, Board as required/requested and F&P. 2. More focussed monitoring on progress at Board level agreed and implemented. 3. Achieved and implemented renewed focus and escalation arrangements for dealing with operational issues: weekly operations meeting in each area, daily safety huddles, weekly leadership review, MHLD QSG and MHLD F&P.	1. Review of Tier 7 & 8 in leadership structure underway. 2. Improve the use of patient experience and real time feedback intelligence to inform service improvements. 3. Further embed learning culture across the division. 4. Systematic implementation of Quality Improvement Methodology across the division at all levels. 5. Implementation of actions following skill mix review on inpatients wards to inform our future staffing levels linked to the All Wales Staffing Principles.

4. Governance Framework developed and fully embedded – review of committee names being undertaken to ensure consistency with BCUHB framework. 5. Recommendations from Internal Audit Review (2019) implemented. 6. Mental Health Strategy approved by the Board and now in implementation phase with areas sustaining strategy change and new developments evidenced with new initiatives that are being modelled across MH services as good practice. 7. Senior Management and Clinical Leadership is no longer a holding structure but implemented with a permanent structure of leadership established, including to Tier 5 & 6. 8. External reviews and visits including positive HIW inspections detailed to QSE and Board. 9. MHLD provides Quality and Performance assurance to Executive accountability meetings in two forms of scrutiny i) Divisional presentation and ii) with each area health economy and is not in escalation as a result of current progress. 10. Monitoring continues via SMIF. 11. Implementation of HASCAS investigation and wider governance review including completion of HASCAS recommendation specific to MHLD has been successfully achieved. This is monitored through corporate governance processes and QSE Committee. 12. Ward accreditation embedded. 13. Improved scrutiny at local and divisional level in relation to PTR has resulted in improved KPIs across all of PTR. MHLD is the only division to have 0 complaints overdue. This is monitored via QSEEL. 14. Implementation of Listening Leads and BE PROUD OD Programme across the division with full engagement at Director level.	6. Delivery Unit have undertaken demand and capacity review with the Community Mental Health Teams, which will inform BCUHB and Local Authority future plans for staffing. 7. Additional actions to address Sickness across MHLD includes the development of Wellness strategy developed for MHLD – wellness, work and you!

Assurances	Links to		
1. Board and WG oversight as part of Special Measures. 2. External reviews and investigations commissioned (Ockenden and HASCAS). 3. HIW Reviews. 4. Internal objective accreditation. 5. External Accreditation. 6. Delivery Unit oversight of CTP. 7. Caniad coproduction and objective day to day review of services. 8. Enhanced WG support has now concluded following intense scrutiny and input due to assurances provided by MHLD, including PAC report as submitted evidence.	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	1 2 3 4 5 6 7	PR1	Mental Health

CRR16	**Director Lead:** Executive Director of Nursing and Midwifery	**Date Opened:** 19 May 2016
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 16 April 2020
	Risk: A Failure To Discharge Statutory and Legislative Safeguarding Responsibilties	**Target Risk Date:** 31 March 2020

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



	Impact	Likelihood	Score
Initial Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	3	12
Movement in Current Risk Rating since last presented to Board in November 2019	**No Change** ⟺		

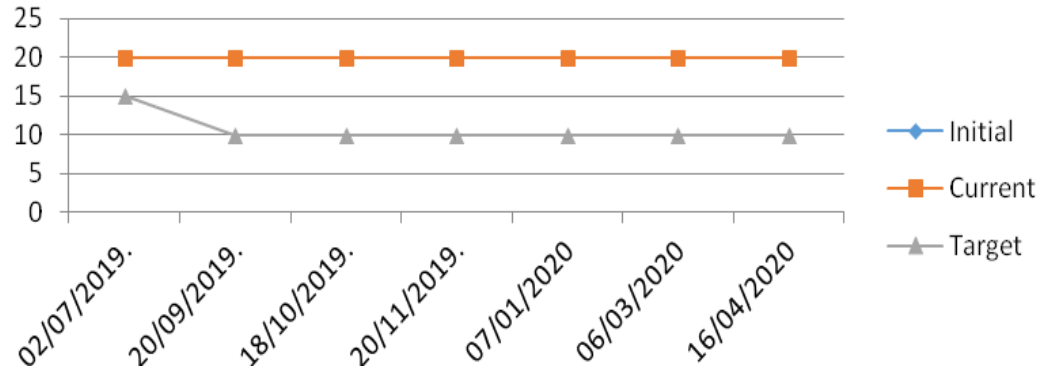
Controls in place	**Further action to achieve target risk score**
1. A cycle of Business Planning meetings have been implemented within the Nursing and Midwifery Directorate which scrutinises and reviews Level 1 and 2 Risks and is attended by the Associate Director of Safeguarding. 2. A refreshed Safeguarding Reporting Framework has been implemented which sets out clear lines of accountability and is underpinned by a Cycle of Business.	1. The third and final phase of the review of all Safeguarding JDs will be submitted to A4C January 2020. 2. Vacant posts continue to be progressed through the establishment control approval process to maintain a fully funded Safeguarding Team. 3. Further structural activity is planned to ensure business continuity and stability within the Corporate Safeguarding Team. This includes the provision of a 7 day on call, flexible working service. This was incorporated into the Structure Report at QSG 10th January 2020.

3. A standardised data report on key areas including Adult at Risk, Child at Risk and DoLS is submitted to Safeguarding Forums in order that data is scrutinised and risks identified. 4.Risk Management has been embedded into the processes of the Reporting Framework by being included as a standing item on the Safeguarding Governance and Performance and Safeguarding Forum[s] Agendas. Issues of Significance reports require risks to be identified and reported on in terms of mitigating action. 5. The new Senior Management tier has been appointed to within the Safeguarding Structure. This will strengthen strategic oversight in key areas. 6. A paper has been presented to QSG on the 10.1.20, in line with HASCAS / DO recommendation Numbers 8 and 6 and 11 and 9. This is relating to the review and effectiveness of the Safeguarding structure and progress report relating to the DoLS 2017-2018 action plan. Key controls have been implemented by increasing the number of DoLS Signatories, development of a Signatories Governance Framework and Specialist training. Bespoke DoLS Training and reporting of compliance and activity at Safeguarding Forums in accordance with the Safeguarding Reporting Framework has been put in place. See Risk 2548. 7. Bespoke training continues to be delivered to key high priority areas with responsibilities for 16/17 yr olds who may be / or experience a deprivation of their liberty as a result of a Supreme Court Judgement 26.9.19.	4. In line with the HASCAS Recommendation / DO Recommendation 8, 6, 11 and 9. A Business Case is to be presented to the Finance and performance Group. 5. The legal framework and organisational accountability for Deprivation of Liberty Safeguards [DoLS] continues to place increased demands upon the organisation. In addition DoLS will be replaced by the Liberty Protection Safeguards [LPS] in 2020/2021 and will have a greater impact upon activity. The recent Supreme Court Judgement relating to 16/17 yr olds, came into force on the 26.9.19. A National Task and Finish Group and a BCU implementation group is to be convened to support the review and identify the impact the new legislation will have on organisations. 6. The programme of work to support the implementation of the Supreme Court Judgement and the increased activity is to be driven by a Task & Finish Group as agreed by QSG and completed by 31.3.20 (see Risk 2548. 7. A review of the DoLS structure and service provision is a priority activity for 2019-20 and a key requirement from HASCAS. An options paper which sets out options for the DoLS Team will be presented to QSG in January 2020. See Risk 2548. 8. The appointment of a Named Doctor, Adult at Risk remains outstanding however positive discussions have taken place with the Office of the Executive Medical Director. The business case to be presented at Finance and Performance Group is to include the financial requirements to support the appointment of a Named Doctor Adult at Risk and additional clinical support. 9. Fully engage with the Corporate Safeguarding Governance Audit and Deprivation of Liberty Safeguarding [DoLS] Audit, conducted by the NHS Wales Shared Services Partnership Audit and Assurance Service. Engage with any actions identified.

Assurances	**Links to**		
1. Strengthened Governance and Reporting arrangements. 2. Enhanced engagement with partner agencies. 3. Safe and effective data collection and triangulation of organisational data to identify risk. 4. Improved compliance against recognised omissions relating to the review and development of Safeguarding policies and Training materials. 5. Regional Safeguarding Boards.	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	3 7	PR9	Governance

CRR20	**Director Lead:** Executive Director of Workforce and Organisational Development	**Date Opened:** 2 July 2019
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 16 April 2020
	Risk: Security Risk	**Target Risk Date:** 1 November 2020

There is a risk the Health Board fails to ensure that a suitable systems are in place to protect staff, patients and stakeholders from security, violence and aggression incidents arising out of our work activity. This is due to lack of formal arrangements in place to protect premises and people in relation to CCTV, Security Contract issues (personnel), lone working, lock down systems, access control and training that provides assurance that Security is effectively managed.



	Impact	Likelihood	Score
Initial Risk Rating	5	4	20
Current Risk Rating	5	4	20
Target Risk Score	5	2	10
Movement in Current Risk Rating since last presented to Board in November 2019	**No Change** ⟺		

Controls in place	**Further action to achieve target risk score**
1) There is a system in place for a contractor (Samsun) to manage the physical/people aspects of Security for the organisation. 2) A V&A Case manager is in place to support individuals who have been exposed to violence and aggression incidents. 3) An external contractor is supporting the Head of H&S to review all aspects of Security across the Board.	A systematic approach is required to both physical and people aspects of the risks identified. This includes: 1. A complete review of CCTV and recording systems. 2. Finalise and implement the CCTV Policy. 3. Clear lines of communication with the contractor, review of the contract in relation to key holding responsibilities and reporting on activities to be implemented. 4. Responsibilities of Security roles within BCUHB to be clearly defined.

<table>
<tr><td colspan="2">4) An external Police Support Officer is in place part time to support the organisation and staff.</td><td colspan="3">5. Lone worker procedures and risk assessments further established.
6. Reducing numbers of violence incidents to staff through clear markers and systems for monitoring violent patients.
7. Comprehensive review of Security on gaps in system which was provided to the Strategic OHS group.</td></tr>
<tr><td colspan="2">Assurances</td><td colspan="3">Links to</td></tr>
<tr><td colspan="2" rowspan="2">1. Health and Safety Leads Group
2. Strategic Occupational Health and Safety Group
3. QSE</td><td>Strategic Goals</td><td>Principal Risks</td><td>Special Measures Theme</td></tr>
<tr><td>3</td><td></td><td>SM4 SM1</td></tr>
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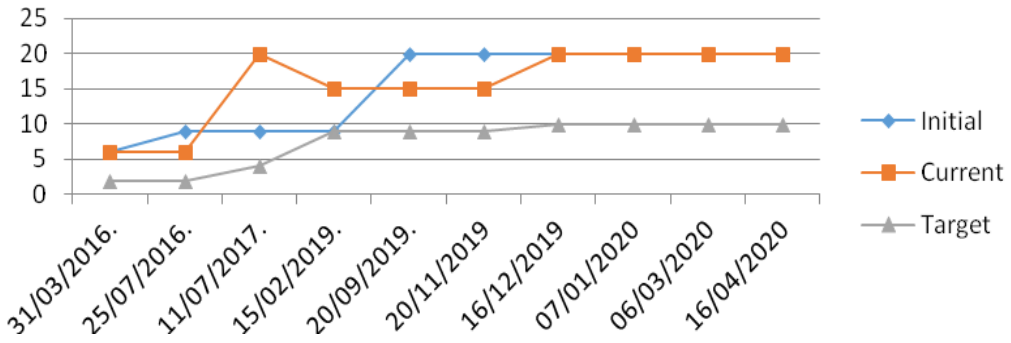
CRR21	**Director Lead:** Executive Director of Workforce and Organisational Development	**Date Opened:** 31 March 2016
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 16 April 2020
	Risk: Health & Safety Leadership and Management	**Target Risk Date:** 1 November 2020

There is a risk that the Health Board fails to achieve compliance with Health and Safety Legislation due to insufficient leadership and general management. This could have a negative impact on patient and staff safety, including organisational reputation and prosecution.



	Impact	Likelihood	Score
Initial Risk Rating	5	4	20
Current Risk Rating	5	4	20
Target Risk Score	5	2	10
Movement in Current Risk Rating since last presented to Board in November 2019	**No Change** ⟺		

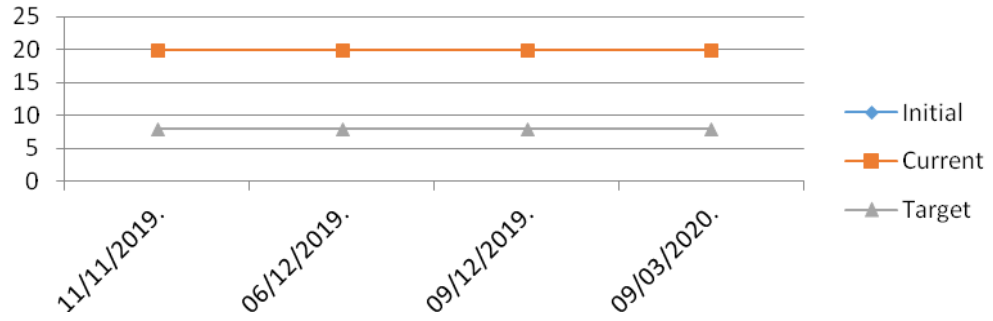
Controls in place	**Further action to achieve target risk score**
1. Health and Safety risk assessment systems are in place in some service areas to protect staff, patients and others from hazards. 2. Health and Safety Management arrangements further developed. 3. Strategic Health and Safety Group in place meeting regularly (3 times in 3 months). 4. Risk Assessments and safe systems of work in place. 5. Mandatory Training in place. 6. Clinical and Corporate Health and Safety Teams established. 7. Corporate Health and Safety Team established. 8. Programme of Annual Self-Assessment Audits.	1. Undertaken gap analysis of 31 pieces of legislation. Completed within specified time frame (117 inspections in 7 weeks). 2. Action plan developed based on non compliance with legislation. 3. Develop a programme of intervention and training through TNA Review. 4. Identified RIDDOR reports and scrutiny of process, looking at improved RCA system.

9. Gap analysis in place. 10. Health and Safety Walkabouts. 11. Health and Safety Report to QSE and Board. 12. Health and Safety Improvement Project Plan.	5. 12 Month action plan developed and 3 year strategy, that is owned by Divisions and Senior Leaders. 6. Further develop individual risk register for items of none. compliance identified through gap analysis 8-10 specific items. 7. Review Divisional governance arrangements so that they marry with H&S governance system and reporting to Strategic OHS Group. 8. Implement findings of internal audit review of process of inspection and governance.

Assurances	**Links to**		
1. Health and Safety Leads Group 2. The Strategic Occupational Health and Safety Group 3. QSE	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	1 2 3		SM4 SM1

CRR22	**Director Lead:** Executive Director of Nursing and Midwifery	**Date Opened:** 11 November 2019
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 09 March 2020
	Risk: Potential to compromise patient safety due to large backlog and lack of follow-up capacity.	**Target Risk Date:** 31 December 2020

The is a risk that patient safety and experience may be comprised due to the Health Board's lack of follow-up capacity especially in outpatients specialities within Secondary across all three sites. This could lead to claims, poor patient experience, harm, reputational damage and deterioration in patient conditions who might have missed their 100% follow-up target.



	Impact	Likelihood	Score
Initial Risk Rating	4	5	20
Current Risk Rating	4	5	20
Target Risk Score	4	2	8
Movement in Current Risk Rating since last presented to Board in November 2019	**No Change** ⇔		

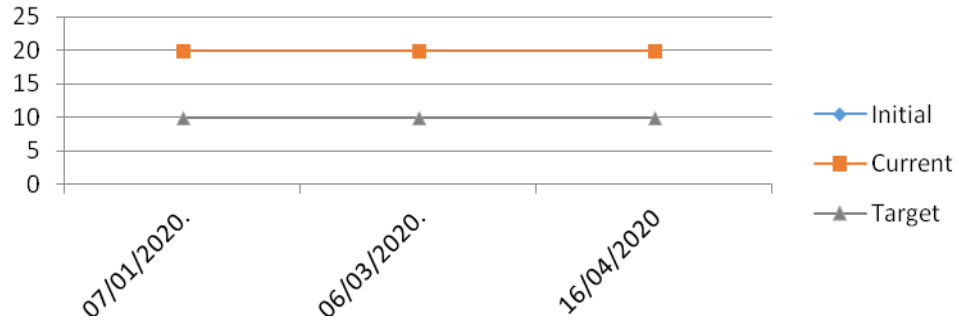
Controls in place	**Further action to achieve target risk score**
1. Ophthalmology and Cancer services have been validated and patients who might have come to harm due to missing their follow-up have been prioritised and seen in clinics. 2. Monitoring of follow-up numbers at weekly meetings. 3. Tendering completed for an external company to validate all follow-ups in OPD. 4. Close links with all services to ensure appropriate care planning for patients are in place. 5. Strong clinical engagement and project management support established.	The current reported number of backlog patients who have exceeded their follow up time by a 100% stands at 57,187 as of the end of December, of which 6,332 are booked and 50,855 are un-booked. 1. Continue the work to date outlined in the previous action plan following the best practice methodology but support with the best practice methodology outlined above. 2. Focus on the highest risk specialities for the immediate implementation of harm reviews with agreed trajectories for reduction by:

6. Prioritisation of patients at clinical risk and harm reviews being undertaken for all patients who have missed their 100% follow-up.	- Urology - Cardiology - General surgery - Ophthalmology 3. Work on the trajectory of 15% reduction of the backlog by March 2020 and monitor these on a weekly basis through the local PTL meeting. 4. Establish a process that will allow the Health Board to contact all patients who are over 52 weeks and currently un-booked to establish if they still require an appointment in the larger specialties. 5. Review any new patient breaching 52 weeks or over 100% beyond their follow-up appointment will have a harm review to prevent growth of the backlog. 6. Agree monitoring and governance arrangements. 7. Discussion on resourcing a sustained in-house validation team ongoing as procuring indepndent validation is expensive.

Assurances	**Links to**		
1. Monitoring and governance arrangements for this risk in place. 2. Review of Ophthalmology and Cancer patients now completed. 3. Risk is now regularly reviewed at QSE with potential of adding onto the CRR.	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	2 3 4 5 7	NA	Strategic and Service Planning

CRR23	**Director Lead:** Executive Director of Workforce and Organisational Development	**Date Opened:** 7 January 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 16 April 2020
	Risk: Asbestos Management and Control	**Target Risk Date:** 2 November 2020

There is a significant risk that BCUHB is none compliant with the Asbestos at Work Regulations 2012. This is due to the evidence that not all surveys have been completed and re-surveys are a copy of previous years surveys. There are actions outstanding in some areas from surveys. This may lead to the risk of contractors, staff and others being exposed to asbestos, resulting in death from mesothelioma or long term ill health conditions, claims, HSE enforcement action including fines, prosecution and reputation damage to BCUHB.



	Impact	Likelihood	Score
Initial Risk Rating	5	4	20
Current Risk Rating	5	4	20
Target Risk Score	5	2	10
Movement in Current Risk Rating since last presented to Board in November 2019	**No Change** ⟺		

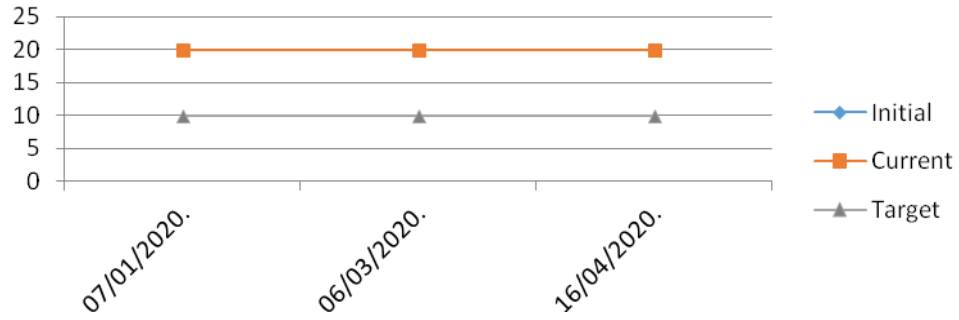
Controls in place	**Further action to achieve target risk score**
1. Asbestos Policy in place and partially implemented due to lack of complete asbestos registers on all sites. 2. A number of surveys undertaken, quality not determined. 3. Asbestos management plan in place. 4. Asbestos register available on some sites, generally held centrally. 5. Targeted surveys were capital work is planned or decommissioning work undertaken. 6. Training for operatives in Estates.	1. Undertaking a re-survey of 10-15 premises to determine if the original surveys are valid. This is problematic as finances are not available for this work, increasing the risk of exposure to staff and contractors. 2. Update and review the Asbestos Policy and Management Plan. 3. Review schematic drawings and process to be implemented to update plans from Safety Files etc. This will require investment in MiCad or other planning data system. 4. Ensure priority assessments are undertaken and highest risk escalated. 5. Evaluate how contractors are provided with information and instruction on asbestos within their work environment. Ensure work is monitored.

7. Air monitoring undertaken in some premises where there is limited clarity on asbestos condition.	6. Ensure all asbestos surveys are available at all sites and there is a lead allocated for premises. 7. Annual asbestos surveys to be tracked and monitor for actions providing positive assurance of actions taken to mitigate risks. 8. Update intranet pages and raise awareness with staff who may be affected by asbestos. 9. QR Code identification to be provided on all areas of work with identified asbestos signage in non public areas. 10. Lack complete asbestos registers on all sites picked up in H&S Gap Analysis Action Plan.

Assurances	**Links to**		
1. Health and Safety Leads Group 2. Strategic Occupational Health and Safety Group 3. QSE	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	1 2 3		SM4 SM1

CRR24	**Director Lead:** Executive Director of Workforce and Organisational Development	**Date Opened:** 7 January 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 16 April 2020
	Risk: Contractor Management and Control	**Target Risk Date:** 1 December 2020

There is a risk that BCUHB fails to achieve compliance with Health and Safety Legislation due to lack of control of contractors on sites. This may lead to exposure to substances hazardous to health, non compliance with permit to work systems and result in injury, death, loss including prosecution, fines and reputation damage.



	Impact	Likelihood	Score
Initial Risk Rating	5	4	20
Current Risk Rating	5	4	20
Target Risk Score	5	4	10
Movement in Current Risk Rating since last presented to Board in November 2019	**No Change** ⟺		

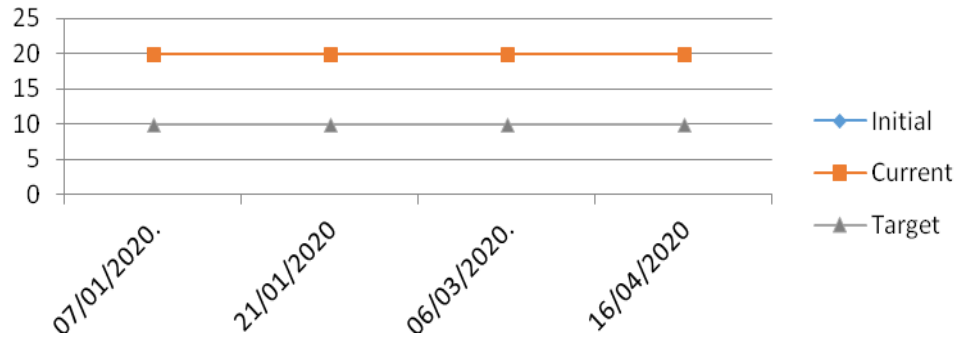
Controls in place	**Further action to achieve target risk score**
1. Control of contractors procedure in place and partially implemented due to lack of consistency and standardisation. 2. Evaluation of standing orders and assessment under Construction Design and Management Regulations. 3. Induction provided to some contractors but not all. Not all come through operational Estates such as IT. 4. There are a number of permit to work paper systems in place.	1. Identify current guidance documents and ensure they are fit for purpose. 2. Identify service Lead on each site to take responsibility for Contractors and H&S Management within H&S Policy). 3. Draft and implement a Control of Contractors Policy that all adhere to including IT and other services who work on BCUHB premises. 4. Identify current tender process & evaluation of contractors, particularly for smaller contracts consider Contractor Health and Safety Scheme on all contractors. This will ensure minimum H&S are implemented and externally checked prior to coming top site.

	5. Evaluate the current assessment of contractor requirements in respect of H&S, Insurance, competencies etc. Is the current system fit for purpose and robust? 6. Identify the current system for signing in / out and/or monitoring of contractors whilst on site. Currently there is no robust system in place. Electronic system to be implemented such as SHE data base. 7. Identify level of Local Induction and who carry it out and to what standard. 8. Identify responsible person to review RA's and signs off Method Statements (RAMS), skills, knowledge and understanding to be competent to assess documents (Pathology, Radiology, IT etc.). 9. Identify the current Permit To Work processes to determine whether is it fit for purpose and implemented on a pan BCUHB basis. 10. Lack of consistency and standisation in implementation of contractor management procedure picked up in H&S Gap Analysis Action Plan.

Assurances	**Links to**		
1.Health and Safety Leads Group 2.Strategic Occupational Health and Safety Group 3.QSE	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	1 2 3		SM4 SM1

CRR25	**Director Lead:** Executive Director of Workforce and Organisational Development	**Date Opened:** 7 January 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 16 April 2020
	Risk: Legionella Management and Control.	**Target Risk Date:** 30 November 2020

There is a significant risk that the BCUHB is non-compliant with COSHH Legislation (L8 Legionella Management Guidelines). This is caused by a lack of formal processes and systems to minimise the risk to staff, patients, visitors and General Public, from water-borne pathogens (such as Pseudomonas). This may ultimately lead death, ill health conditions in those who are particularly susceptible to such risks, and a breach of relevant Health & Safety Legislation.



	Impact	Likelihood	Score
Initial Risk Rating	4	5	20
Current Risk Rating	5	4	20
Target Risk Score	5	2	10
Movement in Current Risk Rating since last presented to Board in November 2019	**No Change** ⟺		

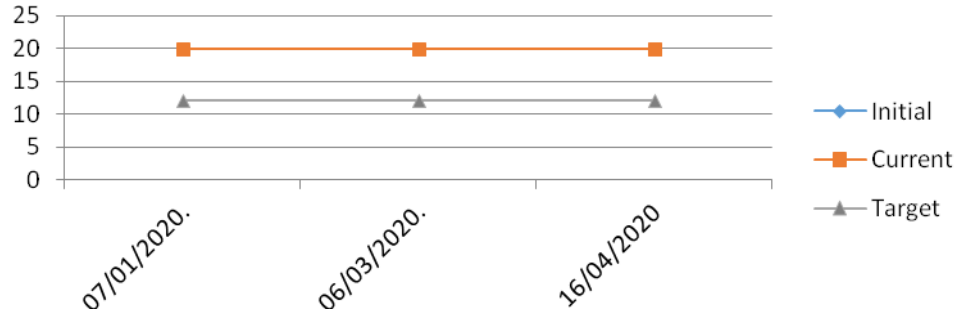
Controls in place	**Further action to achieve target risk score**
1. Legionella and Water Safety Policy in place and being partially impemented due to lack of consistency and standardisation. 2. Risk assessment undertaken by clear water. 3. High risk engineering work completed in line with clearwater risk assessment. 4. Bi-Annual risk assessment undertaken by clear water. 5. Water samples taken and evaluated for legionella and pseudomonis.	1. Update Corporate H&S Review template and H&S Self Assessment Template to ensure that actions are completed by all wards and Departments to ensure systems are in place. 2. Ensure that engineering schematics are in place for all departments and kept up to date under Estates control. Implement MiCAD/database system to ensure all schematics are up to date and deadlegs easily identified. 3. Departments to have information on all outlets and deadlegs, identification of high risk areas within their services to ensure they can be effectively managed.

6. Authorising Engineer water safety in place who provides annual report.	4. Departments to have a flushing and testing regime in place, defined in a Standard Operating Procedure, with designated responsibilities and recording mechanism Ward Manager or site responsible person. 5. Water quality testing results and flushing to be logged on single system and shared with or accessible by departments/services - potential for dashboard/logging system (Public Health Wales). 6. Standardised result tracking, escalation and notification procedure in place, with appropriate escalation route for exception reporting. 7. Awareness and training programme in place to ensure all staff aware? Departmental Induction Checklist. 8. BCUHB Policy and Procedure in place and ratified, along with any department-level templates for SOPs and check sheets. 9. Water Safety Group provides assurance that the Policy is being effectively implemented across all sites, this requires appropriate clinical and microbiology support to be effective. 10. Lack of consistency and standardisation in the implementation of the Legionella and Water Safety Policy picked up in the H&S Gap Analysis Action Plan.

Assurances	**Links to**		
1. Health and Safety Leads Group 2. Strategic Occupational Health and Safety Group 3. QSE	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	1 2 3		SM4 SM1

CRR26	**Director Lead:** Executive Director of Workforce and Organisational Development	**Date Opened:** 7 January 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 16 April 2020
	Risk: Non-Compliance of Fire Safety Systems	**Target Risk Date:** 1 November 2020

There is a risk that the Health Board's is non-compliant with Fire Safety Procedures (in line with Regulatory Reform (Fire Safety Order 2005). This is caused by a lack of robust Fire Safety Governance in many service areas /infrastructure (such as compartmentation), a significant back-log of incomplete maintenance risks, lack of relevant operational Risks Assessments. This may lead to major Fire, breach in Legislation and ultimately prosecution against BCUHB.



	Impact	Likelihood	Score
Initial Risk Rating	4	5	20
Current Risk Rating	4	5	20
Target Risk Score	3	4	12
Movement in Current Risk Rating since last presented to Board in November 2019	**No Change** ⟺		

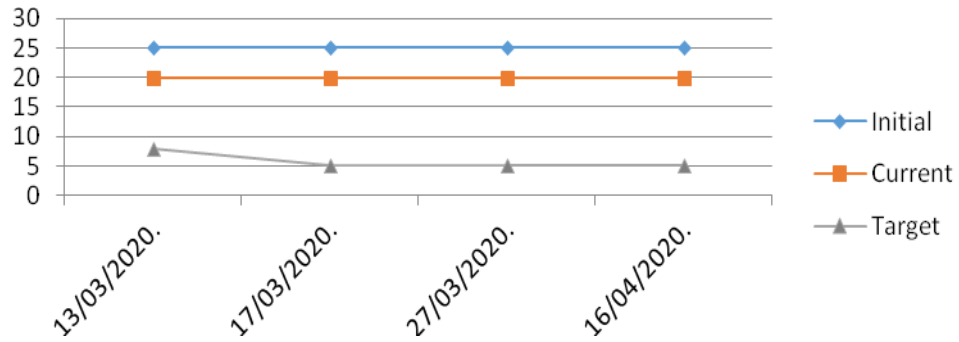
Controls in place	**Further action to achieve target risk score**
1. Fire risk assessments in place in a number of service areas. 2. A number of areas have evacuations. 3. There is a fire safety group established. 4. There is a fire Policy in place. 5. The Fire Authority regularly inspect BCUHB premises and provide reports on their findings which have action plans in place. 6. Appointed fire engineer in place who oversees fire safety system in place. 7. Commission independent shared services audits.	1. BCUHB required to comply with all elements of the Fire Safety Order 2005. 2. Review Internal Audit Fire findings and ensure all actions are taken. 3. Identify how actions identified in the site FRA are escalated to senior staff and effectively implemented. 4. Identify how site specific fire information and training is conducted and recorded. 5. Consider how bariatric evacuation training - is undertaken define current plans for evacuation and how this is achieved? 6. How is evacuation training delivered / monitored?

8. Information from unwanted fire alarms and actual fires is collated and reviewed as part of the fire risk assessment process.	7. How is fire safety advice provided to contractors, define when this happens? 8. AlbaMat training - is required in all service areas a specific training package is required with Fire and Manual Handling Team involved. 9. Ensure actions from the fire authority findings are escalated and actions completed reporting back to the Strategic OHS Group.

Assurances	**Links to**		
1. Health and Safety Leads Group 2. Strategic Occupational Health and Safety Group 3. QSE	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	1 2 3		SM4 SM1

3117	**Director Lead:** Executive Director of Nursing and Midwifery	**Date Opened:** 13 March 2020
	Assuring Committee: Quality, Safety and Experience Committee Strategic, Partnership and Population Health Committee	**Date Last Reviewed:** 16 April 2020
	Risk: Risk to public health and safety arising from an outbreak of COVID-19 and demand outstripping organisational capacity	**Target Risk Date:** 31 December 2020

There is a risk to public health and safety from an outbreak of coronavirus (COVID-19) and this may impact on the ability of the Health Board to respond to this, arising from increased unscheduled demand on healthcare resources (including specialist resources and equipment) and a reduction in available resource to meet that demand such as workforce shortages arising from staff who are unwell or self-isolating.



	Impact	Likelihood	Score
Initial Risk Rating	5	5	25
Current Risk Rating	5	4	20
Target Risk Score	5	1	5
Movement in Current Risk Rating since last presented to Board in November 2019	**No Change** ⟺		

Controls in place	**Further action to achieve target risk score**
Preventative controls: 1 - Health Emergency Control Centre (HECC) activated 7 days per week supported by local control centres 2 – Specialist work streams in place reporting to incident control team including clinical group 3 – Emergency plans and business continuity plans 4 – Access to specialist public health, clinical, operational and governance advice	1 - Ongoing real time management via Health Emergency Control Centre (HECC), local control centres and work streams - each work stream as a PRAID log to track and management actions 2 – Establishment of a recovery group and recovery plan

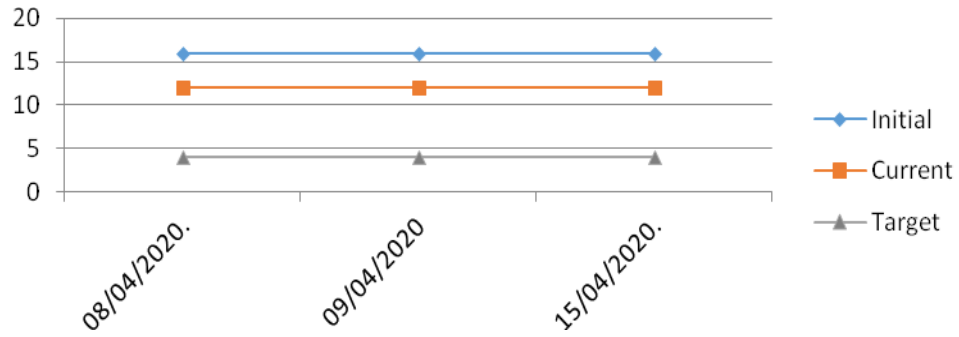
5 – Coordinated communication links with Welsh Government and Public Health Wales 6 – Public health messages including on social media and posters in hospitals 7 – Infection control measures in line with national guidance 8 – National guidance reviewed and cascaded - daily staff bulletin 9 – Advice for staff issued by Workforce and Organisational Development Response controls: 1 - Health Emergency Control Centre (HECC) activated 7 days per week (extending hours as necessary) supported by local control centres 2 – Specialist work streams in place reporting to incident control team including clinical group 3 – Emergency plans and business continuity plans 4 – Access to specialist public health, clinical, operational and governance advice 5 – Coordinated communication links with Welsh Government and Public Health Wales 6 – Infection control measures in line with national guidance 7 – National guidance reviewed and cascaded - daily staff bulletin 8 – Self isolation measures for staff in line with national guidance 9 – Agreement to utilise temporary staffing off framework 10 – Non-essential activities stood-down i.e. corporate meetings 11 – Cancelling clinically appropriate non-urgent and elective activity 12 - Development of additional capacity and field hospitals 13 - Staff testing in line with national guidelines 14 - Additional staffing through retired staff returning and volunteers 15 - Public donations being coordinated through Awyr Las and checked for infection control and health and safety standards 16 – Multi agency co-ordination through SCG and TCG and Military Liaison Officer 17 - Establishment of daily PPE Taskforce led by Executive Director of Nursing and Midwifery/Deputy CEO	

18 – Staff wellbeing support through BCU Staff Wellbeing & Support Service and national Health for Health Professionals Wales (HHPW) Recovery controls: 1 – Establishment of a recovery group and recovery plan	

Assurances	**Links to**		
1. Command and contol structures (see COVID-19 Command Structure Framework)	**Strategic Goals**	**Principal Risks**	**Special Measures Theme**
	1 2 3 4 5 6 7	PR7 PR1 PR3 PR8 PR4	Not Applicable

3138	**Director Lead:** Executive Director of Nursing and Midwifery	**Date Opened:** 8 April 2020
	Assuring Committee: Quality and Safety Group	**Date Last Reviewed:** 15 April 2020
	Risk: Risk of infection from COVID-19 to staff and patients as a result of inadequate supply, quality or usage of PPE	**Target Risk Date:** 31 December 2020

There is a risk to patients and staff arising from the shortage of PPE supply (as a result of increased demand globally) and the quality of PPE being less than needed (as a result of utilising alternative supply chains and manufacturers). It is also recognised that staff have anxieties about these issues and this may impact on their wellbeing, confidence and resilience.



	Impact	Likelihood	Score
Initial Risk Rating	4	4	16
Current Risk Rating	4	3	12
Target Risk Score	4	1	4
Movement in Current Risk Rating since last presented to Board in November 2019	**No Change** ⟺		

Controls in place	**Further action to achieve target risk score**
1. Daily PPE Taskforce led by Executive Director of Nursing and Midwifery 2. Daily PPE Stock Report to HECC Silver and Gold Command 3. PPE guidance to staff issued in line with national guidance from Public Health Wales 4. PPE guidance detailed in daily staff COVID bulletin 4. Expert advice to senior leaders and clinical leaders available from infection control team 5. Dedicated PPE email account for staff queries and concerns 6. Face fit testing programme in place	1. Modelling tool to be developed detailing PPE requirements against future predicated demand 2. Flow of communication in regards to PPE to be simplified 3. Development of an SOP for ordering, storage, distribution and monitoring of PPE 4. Telephone line to be established for staff to raise concerns

7. Donations of PPE received via Awyr Las and checked against infection control and health and safety standards	

Assurances	**Links to**		
	Strategic Goals	**Principal Risks**	**Special Measures Theme**
1. Command and control structures (see COVID-19 Command Structure Framework) 2. PPE Taskforce (daily meeting led by Executive Director of Nursing and Midwifery / Deputy CEO) 3. Daily PPE Stock Report to HECC Silver and Gold Command 4. Regular review of risk by PPE Taskforce and governance meetings	3 5 6	PR9 PR1 PR4	Not Applicable

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety & Experience Committee 05.05.2020
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Ward Accreditation Update
Cyfarwyddwr Cyfrifol: Responsible Director:	Reena Cartmell, Associate Director of Nursing Matthew Joyes, Acting Associate Director of Quality Assurance
Awdur yr Adroddiad Report Author:	Diane Read, Head of Quality Improvement Team, Corporate Nursing Alison White, Business Support Manager
Craffu blaenorol: Prior Scrutiny:	Quality & Safety Group receive Quarterly updates
Atodiadau Appendices:	Not applicable

Argymhelliad / Recommendation:

The Committee are asked to support the ongoing Ward Accreditation process post Covid-19 Pandemic.

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

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

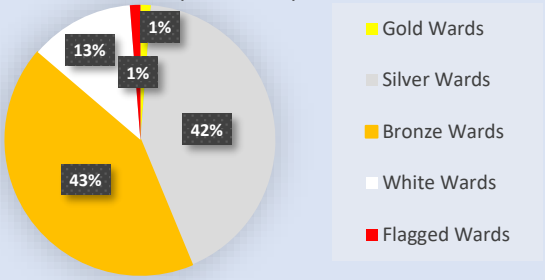
Sefyllfa / Situation:

At the end of February 2020, 88 Wards have been visited, and 80 wards have received their result following validation panels. The following are the overall scores of the wards following validation:

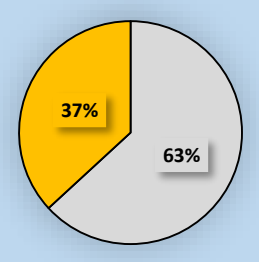
- 1 Gold
- 34 Silver
- 34 Bronze
- 10 White
- 1 Flagged

Please find below an overview of the Ward Accreditation scores as of February 2020:

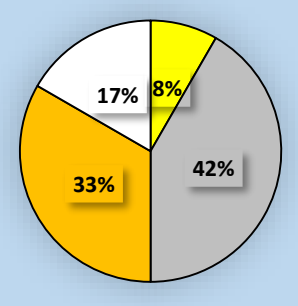
BCUHB Wide: Ward Accreditation Results
Year 1 (Feb 2020)



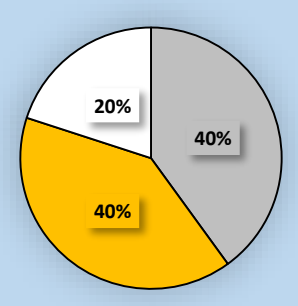
Community
Ward Accreditation Results - Year 1



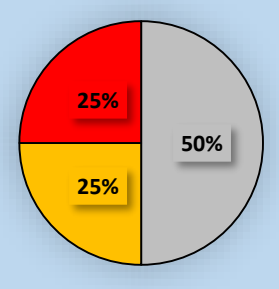
Mental Health and Learning Disabilities
Ward Accreditation Results - Year 1



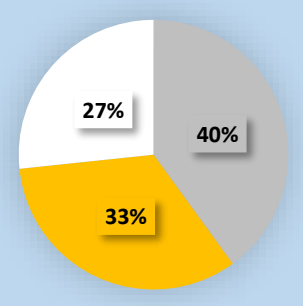
Midwifery and Womens Services
Ward Accreditation Results - Year 1



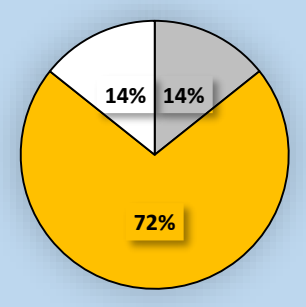
Peadiatrics
Ward Accreditation Results - Year 1
Note: Flagged = 1 Ward



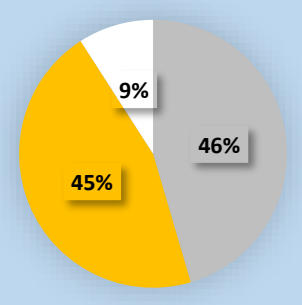
Glan Clwyd Hospital
Ward Accreditation Results - Year 1



Ysbyty Gwynedd
Ward Accreditation Results - Year 1



Wrexham Maelor Hospital
Ward Accreditation Results - Year 1



When analysing these findings at more local level it does indicate that some areas have a higher incidence of challenged wards and work to triangulate this against other indicators is commencing. The work has allowed focussed attention upon speciality and sites to understand themes to influence future learning. It is clear from this that the impact of the initiative is identifying areas for future improvements at both a local and strategic level.

Following the onset of the Covid -19 pandemic preparations the Health Board has placed the Ward Accreditation visits and validation panels on hold during this time. The Corporate Nursing Quality Improvement Team have been supporting many of the Covid -19 work streams and in particular working in partnership with the Nurse Education team developing and delivering the Back to the Floor training programme for upskilling of our existing nurses who have been non ward based, bank nurses new to the HB and Staff who are awaiting redeployment as part of the Covid -19 plan. To date, approximately 1,500 nurses from across the Health Board have received training in the last 4 weeks to support their redeployment to provide safe care.

Cefndir / Background:

The Health Board introduced a programme of focused improvement work which included the Ward Accreditation Programme in mid-October 2018. This was quickly followed by the Hospital Acquired Pressure Ulcer Collaborative (HAPU) in late November 2018 and then the Inpatient Falls Collaborative in June 2019.

All key programmes of focused improvements provide an opportunity for the Health Board to embed the principles of a common Quality Improvement language and methodology as well as embedding a set of standards to frame our quality, safety and patient care agenda and to maintain the momentum of the improvements and principles of the Safe Clean Care campaign (SCC).

The Ward Accreditation aims to visit all Acute, Community, Women's, Paediatrics, Mental Health & Learning Disability Wards on an annual basis. Each unannounced visit / accreditation takes approximately 4 hours, with a visit team consisting of a Director of Nursing, Head of Nursing and a member of the Corporate Nursing Quality Improvement Team. Results of visits are then presented to a weekly validation panel (attended by our Directors of Nursing) who receive details of the visit and agree / debate the outcome.

Asesiad / Assessment & Analysis

During this current climate, the benefits of the Ward Accreditation have truly been realised as a programme with the developed supporting resources such as the Intranet page, E-Handbooks and the already implemented standards in terms of the Environment E-Handbook. The Environment E-Handbook provides an overview for a well organised workplace which has been shared with staff on the Back to the Floor Training. This means that staff who have received Back to the Floor training have been able to quickly orientate themselves to the wards. The E-Handbooks have also provided the baseline for Induction Books for staff redeployment (both clinical and also for our Non-clinical staff) with minimal amendments to the existing information.

Strategy Implications

The Implementation of the Ward Accreditation programme standards has supported the Health Board preparation for Covid-19.

Financial Implications

Some ward / area(s) requests for resources (to meet the Health Board's agreed standards as defined in the Ward Accreditation E-Handbooks) are being declined as part of the current procurement process. For example, labelling of resources for ward stores to reduce staff time lost searching for items, washable noticeboards to meet Safe Clean Care principles, colour printing of data for ease of visibility and interpretation by the public. The ward teams are advised to escalate via internal processes initially before escalating to QSG via the Corporate QI team. This has been / is being escalated at a local level to site HMT and has also been escalated to QSG and QSE in previous papers.

Future plans

The Committee is asked to be aware of work commissioned by the Executive Director of Nursing and Midwifery/Deputy CEO to improve how data is triangulated to provide assurance and early warning indictors. This work is being led by the Associate Director of Quality Assurance and will be developed over the coming months,

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety & Experience Committee 05.05.2020
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Reporting and Investigation Procedure following the death or serious illness of a staff member with COVID-19
Cyfarwyddwr Cyfrifol: Responsible Director:	Matthew Joyes, Acting Associate Director of Quality Assurance/Assistant Director of Patient Safety and Experience Peter Bohan, Associate Director of Health, Safety and Equalities
Awdur yr Adroddiad Report Author:	Julie Ward-Jones, Transformation and Improvement Lead, Patient Safety and Experience Department
Craffu blaenorol: Prior Scrutiny:	Review by responsible directors and executive directors
Atodiadau Appendices:	n/a

Argymhelliad / Recommendation:

The Committee is asked to note the procedural guidance for Health Board employees to follow on the death, or serious illness (including hospitalisation), following a positive test result for COVID-19.

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

Sefyllfa / Situation:

The guidance aims to provide a timely, consistent and robust approach to reporting and investigating, both internally and externally (Welsh Government and Health and Safety Executive), when a member of Health Board staff who has tested positive for COVID-19 requires hospitalisation, dies or where there is a high suspicion that the infection may have been workplace acquired.

Cefndir / Background:

It is recognised that health workers are at the front line of any outbreak response, and as such are exposed to hazards that put them at risk of infection with an outbreak pathogen i.e. COVID-19. The Health Board has workforce and occupational health procedures in line with Public Health Wales guidance; it is expected that the majority of staff with COVID-19 will experience only mild symptoms, resulting in a full recovery. A proportion of staff may become seriously ill, my require hospitalisation and/or sadly die with a positive test result for COVID-19 and these incidents require reporting and investigation to provide (1) assurance that workplace hazards are being managed appropriately and (2) lessons will be learned.

Asesiad / Assessment & Analysis

Strategy Implications

This guidance supplements the existing incident reporting procedure (PTR 01) and Health and Safety incident reporting under RIDDOR.

The Associate Director of Quality Assurance/Assistant Director of Patient Safety and Experience has been involved in national work through the “HOPE Network” of quality and governance leads to standardise processes across Wales. This procedure is in line with that work.

Legal and Compliance

In accordance with regulations, there is a requirement to report certain COVID-19 related incidents under RIDDOR to the Health and Safety Executive (HSE) and to Welsh Government under PTR.

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

Reporting & Investigation procedure following staff members who have tested positive with COVID-19

This procedure will be reviewed/amended as necessary to reflect future National or all-Wales guidance.

1. Introduction

The Health Board recognises that health workers are at the front line of any outbreak response, and as such, are exposed to hazards that put them at risk of infection with an outbreak pathogen (in this case COVID-19). Hazards include pathogen exposure, long working hours, psychological distress, fatigue, occupational burnout, stigma, and physical and psychological violence.

Employees' health, safety and well-being during this pandemic is paramount. The Health Board is committed to providing a safe place to work, and to ensure staff feel safe and secure in their employment. To achieve this, the Health Board will continue to be proactive in protecting staff and minimise the risk of infection amongst staff.

The Health Board has procedures in place for the management of staff who acquire COVID-19, which are in line with Public Health Wales guidance; it is expected that the majority of staff with COVID-19 will experience only mild symptoms, resulting in a full recovery.

This guidance will cover all members of staff who have tested positive for COVID-19 where there is a high suspicion that the infection is workplace acquired, those who are subsequently hospitalised, and on the death of a staff member.

2. Incident reporting – internal

An incident report (DATIX©) must be completed and submitted when a healthcare staff member of the Health Board

- has received a positive test for COVID-19, and there is a high suspicion of , or confirmed, that it is work related
- is hospitalised with a COVID-19 related illness
- dies whilst testing positive for COVID-19

The incident report must be completed by the line manager within **24hrs** of it becoming known. An initial investigation should be undertaken by the service using the investigation toolkit, and a Make it Safe review completed within 72hrs. This should then be sent through to the Patient Safety and Experience team via BCU.WelshGovernmentIncidents@wales.nhs.uk

To support consistent reporting, staff must use specific categories in the mandatory fields for incident classification:

DATIX© Reporting	**Staff testing positive only**	**Staff testing positive and hospitalised**	**Death of a staff member with a positive result**
Subject	Incidents affecting Staff	Incidents affecting Staff	Incidents affecting patients
Classification	Accident that may result in personal injury	Accident that may result in personal injury	Implementation of care or ongoing monitoring/review
Detail	Exposure to electricity, hazardous substance, infection, etc.	Exposure to electricity, hazardous substance, infection, etc.	Infection control
Adverse event	Hazardous and avoidable exposure to infection	Hazardous and avoidable exposure to infection	Outbreak
Result	Personal injury	Personal injury	Death
Severity	Major	Major	Catastrophic

Also:

- **Description** : identify date of admission and if applicable, death; confirmation of positive COVID-19 result
- **Action**: state that this has been reported as per corporate request
- **Coronavirus (COVID-19):** is this incident related to coronavirus – yes
- **RIDDOR reportable?**: yes

3. External reporting

3.1 Welsh Government

In accordance with Welsh Government (WG) requirements, the death of any employee with COVID-19 needs, within **24hrs** of the death, to be reported by the service to WG through the Health Board WG '*No Surprises'* reporting process (template available on DATIX©). This is submitted to the Corporate Patient Safety and Experience Department via: BCU.WelshGovernmentIncidents@wales.nhs.uk.

**This may be upgraded to a Serious Incident if the investigation finds that the infection is workplace acquired.*

Due to potential media attention, the Health Board should notify WG within 4 hours of being made aware of the death. Where this occurs "out of hours" (i.e. weekdays before 9am and after 5.30pm or at weekends) the Welsh Government press office will be contacted by the Lead Executive on call. In addition, if relevant, the relevant professional lead at WG should also be notified via the relevant Executive Lead. E.g. following the death of member of the nursing team the Executive Director of Nursing will notify the Chief Nursing officer.

For all other employees who have a positive COVID-19 test result which has been found to have been acquired from the workplace, then a Welsh Government (WG) *No Surprises* notification (template available on DATIX©) must be completed by the service and submitted to the Corporate Patient Safety and Experience Department via: BCU.WelshGovernmentIncidents@wales.nhs.uk.

**for smaller community hospitals where clusters of staff have been tested positive, reporting can be done via one incident report and one WG notification.*

3.2 Health and Safety Executive (HSE)

In accordance with Health & Safety incidents, there is a requirement to report certain COVID-19 related incidents under RIDDOR, to the HSE. These are:

- an unintended incident at work has led to someone's possible or actual exposure to coronavirus. This must be reported as a dangerous occurrence.
- a worker has been diagnosed as having COVID 19 and there is reasonable evidence that it was caused by exposure at work. This must be reported as a case of disease.
- a worker dies as a result of occupational exposure to coronavirus.

In all instances of the above circumstances, regardless of level of evidence, the incident handler/manager should select the RIDDOR field in DATIX© to "Yes". The Corporate Health & Safety Team will receive a trigger from the DATIX© system of all potential RIDDOR reportable incidents. They will then investigate and ensure reporting occurs within the appropriate timescales.

For further information, please contact your Corporate Health and Safety Adviser; details are via this link or refer directly to the HSE guidance: https://www.hse.gov.uk/news/riddor-reporting-coronavirus.htm

4. Investigation

The initial reporting and investigation is the responsibility of the service in which the employee works. This initial investigation will focus on the member of staff's working environment, including a timeline of events and contact with any patients known at any time to be COVID-19 positive.

As previously mentioned an investigation toolkit has been developed to ensure a consistent approach to the investigation. This initial investigation, will indicate if:

- additional interventions are required;

- any remedial actions are required;
- identification of any opportunities for internal or external shared learning;
- whether the investigation findings should be reported to Welsh Government as a Serious Incident,
- if the incident is RIDDOR reportable, and
- whether an internal serious incident review and root cause analysis (RCA) is required

In the event of the initial investigation identifying any further concerns and it is decided that a full serious incident investigation and RCA is required, this will be undertaken by a member of the corporate Patient Safety team. This must be completed within 30 working days.

A reasonable investigation is required for all incidents that are reported via the incident reporting system DATIX© , and under RIDDOR, to ensure that root causes, contributable factors and lessons learnt are identified to prevent similar incidents occurring again. These investigations will be supported by key advisory and corporate support services, such as the Health and Safety Team, the Patient Safety and Experience Department and Infection, Prevention and Control teams as required.

Findings from the initial and, if progressed, the serious incident investigation will be reported to:

- Divisional Quality & Safety Group
- Health Board Quality & Safety Committee
- Gold Command
- COVID-19 work streams: Workforce, Governance and Risk

5. Family involvement

It is essential that from the point of notification of the death of an employee with COVID-19 that a single point of contact with the family is established. This must be recorded on DATIX©. Initially to convey condolences, offer any support and guidance and agree any communications. The family point of contact, will at

relevant points in time, being sensitive to the situation, keep the family updated of Health Board investigation plans, findings and reporting status.

Any questions, clarification should be sent to the Patient Safety and Experience Team via the BCU.WelshGovernmentIncidents@wales.nhs.uk

Version 2.1
Date Reviewed: 21.04.2020
Date agreed: 22.04.2020
Review date: 22.05.2020

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety & Experience (QSE) Committee 5th May 2020
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Committee Annual Report 2019-20
Cyfarwyddwr Cyfrifol: Responsible Director:	Mrs Gill Harris, Executive Director of Nursing and Midwifery
Awdur yr Adroddiad Report Author:	Mrs Kate Dunn, Head of Corporate Affairs
Craffu blaenorol: Prior Scrutiny:	The Committee Annual Report has been scrutinized by the Committee Chair and Lead Executive. The report has previously been circulated to Committee members as part of the agenda for 17th March 2020 although the item was subsequently deferred.
Atodiadau Appendices:	1. Committee Annual Report (which itself has three accompanying appendices)

Argymhelliad / Recommendation:

The Committee is asked to approve the Annual Report for 2019-20

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

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

Sefyllfa / Situation:

Committee approval to the Annual Report for 2019-20 is sought.

Cefndir / Background:

The Annual Report has been prepared on a BCU-wide template and will be submitted to the next meeting of the Audit Committee.

Asesiad / Assessment & Analysis

Risk Analysis

The report contains references to risks identified throughout the year.

Legal and Compliance

Normally all Committees are required to produce an annual report which forms part of a composite report to the full Health Board. Due to the ongoing Covid-19 pandemic, the only Committees required to produce an annual report for 2019-20 are the QSE Committee and Audit Committee.

There are no relevant matters to highlight relating to strategy, finance, and impact assessment

Quality, Safety & Experience Committee Annual Report 2019-20

1. Title of Committee

Quality, Safety & Experience Committee (QSE)

2. Name and role of person submitting this report:

Mrs Gill Harris, Executive Director of Nursing and Midwifery

3. Dates covered by this report:

01/04/2019-31/03/2020

4. Number of times the Committee met during this period:

The QSE Committee was routinely scheduled to meet six times and otherwise as the Chair deemed necessary. During the reporting period, it met formally on six occasions plus two additional workshops were held. Attendance at formal meetings is detailed within the table below. It is confirmed that all formal meetings were quorate although the attendance for the 17.3.20 meeting had been reduced with the agreement of the Chair in light of the Covid-19 pandemic.

Independent Members of the Committee	21.5.19	16.7.19	24.9.19	19.11.19	28.1.20	17.3.20
Lucy Reid (Chair)	P	P	P	P	P	P
Cheryl Carlisle	P*	A	P	P*	P*	X
Jackie Hughes	A	P	P	P	P	P
Lyn Meadows	P	P	P	A	P	P

Directors and Officers - formally In attendance (as per Terms of Reference)	21.5.19	16.7.19	24.9.19	19.11.19	28.1.20	17.3.20
Deborah Carter Associate Director of Quality Assurance (NB was acting Exec Director of Nursing & Midwifery from April to Aug 2019)	P	P	P*	P	P	X
Gareth Evans Chair of Healthcare Professionals Forum	A	A	A	X	A	X
Sue Green Executive Director of Workforce & OD	P	A	P	P*	P	X
Gill Harris Executive Director of Nursing & Midwifery	A	A	A	A	P*	P
David Fearnley Executive Medical Director	◆	◆	P	P	P	X
Melanie Maxwell Senior Associate Medical Director / 1000 Lives Clinical Lead	A	A	P*	P*	P	X
Evan Moore Executive Medical Director	P	A	◆	◆	◆	◆
Jill Newman Director of Performance	P*	P	P*	P*	P	X
Teresa Owen Executive Director of Public Health	P*	P	A	P*	P*	X
Chris Stockport Executive Director of Primary & Community Services	P*	P	A	P*	P	A
Andy Roach Director of Mental Health & Learning Disabilities	X	P	A	A	A	A
Lesley Singleton Acting Director of Mental Health & Learning Disabilities	◆	◆	◆	P*	P	X
Adrian Thomas Executive Director of Therapies & Health Sciences	P	P	P	P	P	X

Key:

P - Present
P* - Present for part meeting
A - Apologies submitted
X - Not present
◆ Not a member of the Committee at this time.

In addition to the above core membership, other Directors and Officers from the Health Board regularly attend meetings of the Committee/Group/Forum. Other independent members may also attend on a co-opted basis. For a full list of attendance, please see the approved minutes which can be accessed on the Health Board's website via the following pages:- https://bcuhb.nhs.wales/about-us/committees-and-advisory-groups/

5. Assurances the Committee is designed to provide:

The Committee is designed to provide assurance to the Board on the following key areas as set out in its Terms of Reference as follows:-

- Ensure that arrangements for the quality and safety of patient care are in accordance with its corporate goals, stated priorities within the Quality Improvement Strategy and the principle of continuous quality improvement including organisational learning;

- Ensure the adequacy of safeguarding and infection, prevention and control arrangements;

- Provide assurance in relation to improving the experience of patients, citizens and all those who come into contact with the Health Board's services, as well as those provided by other organisations' or as part of a partnership arrangement;

- Seek assurance on the robustness and appropriateness of Health and Safety arrangements across the Health Board including aspects impacting on patient care, quality and safety and experience;

- Ensure that all reasonable steps are taken to prevent, detect and rectify irregularities or deficiencies in the quality and safety of care provided and in particular that:

    - Sources of internal assurance (including clinical audit) are reliable
    - Recommendations made by internal and external reviewers are considered and acted upon on a timely basis
    - Appropriate review is carried out and corrective action is taken arising from incidents, complaints and claims known collectively as 'Concerns'.

- Receive assurances from the Quality Improvement Strategy and Legislation Assurance Framework to allow the Committee to review achievement against the Health and Care Standards including accessible health care to inform the Annual Quality and Annual Governance Statements;

- Seek assurance on the quality and safety of services commissioned from external providers (including care homes) and others who provide a commissioning role on behalf of the Health Board e.g. Welsh Health Specialised

Services Committee (WHSSC); Emergency Ambulance Services Committee (EASC).

- Review and seek assurance on the appropriateness of the quality indicators defined within the Integrated Quality and Performance Report (IQPR) and scrutinize the quality dimensions contained within the IQPR;

- Review the sustainability of service provision across the Health Board in terms of quality of service, patient experience and model of care provided.

- Provide advice and assurance to the Board regarding the quality impact assessment of strategic plans as appropriate;

- Receive periodic updates in respect of the workforce flu vaccination.

During the period that this Annual Report covers, the Committee operated in accordance with its terms of reference. V5.0 were operative up until July 2019 and V6.0 for the remainder of the year. Copies are provided at Appendices 1 and 2.

The work programmes, cycles of business and overall performance of the Committee are reviewed by the Committee Business Management Group (CBMG) which meets quarterly. The CBMG oversees effective communication between Committees, avoiding duplication and ensuring all appropriate business is managed effectively and efficiently through the Health Board's Governance framework.

The Committee is required to publish its agenda and papers 7 days ahead of the meeting, and a breach log is maintained by the Office of the Board Secretary where there are exceptions to this requirement. During the reporting period there were 3 breaches of this nature in terms of a range of individual papers not being available 7 days before the meeting.

6. Overall *RAG status against Committee's annual objectives / plan: AMBER

The summary below reflects the Committee's assessment of the degree to which it has met these objectives. The supporting narrative included alongside the assessment below describes this in more detail.

Objective as set out in Terms of Reference	**Assurance Status (RAG)***	**Supporting narrative** *(Please provide narrative against all red and amber including the rationale for the assurance status)*
Ensure that arrangements for the quality and safety of patient care are in accordance with its corporate goals, stated priorities within the Quality Improvement Strategy and the principle of continuous quality improvement including organisational learning;	Amber	Good evidence in parts of the organisation but not consistently pan-BCU wide. Occasions where committee not being sighted on key risks in a timely fashion. Need to strengthen organisational learning.

Ensure the adequacy of safeguarding and infection, prevention and control arrangements;	Green	
Provide assurance in relation to improving the experience of patients, citizens and all those who come into contact with the Health Board's services, as well as those provided by other organisations' or as part of a partnership arrangement;	Red	Some improvements in patient feedback and access to PALS. In year the impact of the centralisation of vascular services has reduced patient confidence in the Health Board. Further work around patient experience and complaints required. More robust data is available but Board needs to use it more effectively to improve experience.
Seek assurance on the robustness and appropriateness of Health and Safety arrangements across the Health Board including aspects impacting on patient care, quality and safety and experience;	Amber	Greater level of assurance around H&S across the organisation and actions in place to mitigate risks.
Ensure that all reasonable steps are taken to prevent, detect and rectify irregularities or deficiencies in the quality and safety of care provided and in particular that: • Sources of internal assurance (including clinical audit) are reliable • Recommendations made by internal and external reviewers are considered and acted upon on a timely basis • Appropriate review is carried out and corrective action is taken arising from incidents, complaints and claims known collectively as 'Concerns'.	Amber	Committee is better informed but there are actions outstanding.
Receive assurances from the Quality Improvement Strategy and Legislation Assurance Framework to allow the Committee to review achievement against the Health and Care Standards including accessible health care to inform the Annual Quality and Annual Governance Statements;	Amber	Partially assured but more consistency required.
Seek assurance on the quality and safety of services commissioned from external providers (including care homes) and others who provide a commissioning role on behalf of the Health Board e.g. Welsh Health Specialised Services Committee	Amber	In year the Committee have reduced the risk score re care homes. Reports received regarding women's services in England (eg; Shrewsbury). WHSCC Quality & Patient

(WHSSC); Emergency Ambulance Services Committee (EASC).		Safety Committee minutes are shared. Further actions to improve assurances around Board's own externally commissioned services.
Review and seek assurance on the appropriateness of the quality indicators defined within the Integrated Quality and Performance Report (IQPR) and scrutinize the quality dimensions contained within the IQPR;	Amber	Lack of confidence that the Committee are seeing all appropriate indicators. Concern that the narrative within the IQPR is variable.
Review the sustainability of service provision across the Health Board in terms of quality of service, patient experience and model of care provided.	Amber	Review liaison between QSE and SPPH. QSE has confirmed the sustainability of safe services – eg; endoscopy, but sustainability from a financial or performance perspective is not within remit.
Provide advice and assurance to the Board regarding the quality impact assessment of strategic plans as appropriate;	Red	Some progress has been made in Q4 to better recognise that a more risk based approach will help inform these discussions.
Receive periodic updates in respect of the workforce flu vaccination.	Green	

Key:

Red	*= the Committee did not receive assurance against the objective*
Amber	*= the Committee received assurance but it was not positive or the Committee were partly assured but further action is needed*
Green	*= the Committee received adequate assurance against the objective*

7. Main tasks completed / evidence considered by the Committee during this reporting period:

7.1 The Committee received a range of standing and regular items as per its cycle of business (see Appendix 3). The agenda setting process also allows for flexibility to bring ad-hoc papers to the Committee usually these relate to providing assurance against a current risk or issue, an all Wales issue requiring local consideration, or to ensure governance and scrutiny of an issue ahead of a forthcoming Health Board meeting. A summary of such reports in 2019-20 is as follows:-

- A comprehensive response to the recommendations arising from the Welsh Government's Review of maternity services at Cwm Taf. Of the 70 recommendations, 6 were rated as ongoing improvement required. The

actions would be monitored by the QSE Committee and a briefing provided to the Board;

- An update on the management of risk for the handover of patients between the Ambulance Service and the Emergency Departments. Measures being taken included a regular review of corridor congestion within the Emergency Department and handover delays.
- The Medicines Management Report identified key risks being managed by the service. The lack of pharmacy support for Mental Health services in the East was discussed and the plans to address this. There was also discussion around the implications for patients of recent changes to repeat prescribing services in community pharmacy.
- An inspection report of HMP Berwyn's health services undertaken by HM Inspectorate for Prisons and Healthcare Inspectorate Wales. The findings were positive overall but identified the main area for improvement was dental services. This service has been constrained by estates issues that have resulted in difficulties being able to provide additional dental services resulting in long waiting times for prisoners.
- The Committee received an update on an extraordinary meeting of the Local Partnership Forum to discuss the nurse rota changes and there was a commitment to move forward in partnership with the changes.
- An update was provided on a joint venture between WAST and the Health Board to develop the advanced paramedics multi-disciplinary team working programme. This is operational across 5 cluster areas and initial reports of its impact are very positive;
- The Health Board's response to HIW's Thematic review of Children's Services was received providing details of how the Health Board will be implementing learning arising from the findings;
- The externally commissioned follow up Infection Control and Prevention Report by Jan Stevens was received and highlighted significant improvements across the Health Board as part of the Safe Clean Care work.
- Monitoring of HASCAS / Ockenden recommendations with end of year position that 19 of the 35 recommendations have been closed, with 14 of the remaining open ones being assessed as 'green' and 2 reporting as 'amber'. Claire Brennan to provide figures
- An update report on dementia services which demonstrated significant progress in improving dementia support for patients and detailed the work of the Dementia Strategy Group.
- The Committee were sighted on significant waiting times for psychological therapy services and were informed that a review had been identified as a key piece of work as part of the annual plan. Following this review, a Task and Finish Group would oversee the implementation of the recommendations with progress to be monitored by the QSE Committee.
- The Self Assessment of Quality Governance Arrangements was formally received and the Committee would receive an action plan at the next meeting to monitor progress;
- The Committee were briefed on the 17.3.20 on the emerging Covid-19 pandemic situation and assured that a Command structure had been established with supporting workstreams.

7.2 Patient stories provide a patient, carer or relative with an opportunity to tell us about their lived experiences of using our services; what was good about the experience, what was bad and what could be improved. Within 2019/2020 the QSE Committee ratified revised Patient Stories Guidelines (ISUE01) which provided a renewed emphasis on using patient feedback as the basis for quality assuring our services in line with our Patient Experience Strategy (BCUHB, June 2019), and our mandatory responsibilities in the following key policy frameworks;

- NHS Delivery Framework 2019/2020 (NHS Wales, April 2019)
- Listening and Learning from Feedback – A Framework for Assuring Service User Experience (WG, 2015a)
- Health Care Standards for Wales (WG, 2015b)
- Wellbeing of Future Generations (Wales) Act (WG, 2014a)
- Social Services and Wellbeing (Wales) Act (WG, 2014b)
- Parliamentary review of Health & Social Care in Wales (2018)

The following patient stores have been presented to the QSE Committee in 2019/2020.

Helen's Story - I am not a service user; the role of ICAN within ED

Key Themes;	**Learning/Actions;**
• Patient voice not being listened to • Terminology used to label patient • Needs of the individual not being recognised due to demand on the service • Different service received after 7pm. • Training for external agencies	• Ensure people are listened to and respected, whilst having their individual needs understood • Promote and develop the ICAN service it changes and saves lives. • Further training and information for external agencies. • Include increased awareness of the ICAN services within the PALS operational model.

Arthur's Story - Importance of Welsh Language Service Provision – Acute Care

Key Themes;	**Learning/Actions;**
• *Receiving sufficient Information* such that patient and family members can be fully, informed and involved in decisions made in relation to Arthur's care. • *Welsh Language/Communication in Welsh* – clear failure to respect Arthur's communication needs resulting in lack of information about, and involvement in decision concerning ongoing care • *Informed Consent* • Staff Attitude/Knowledge & Skills; there was a complete lack of empathy and response to Arthur's stated communication needs	• The ability to provide care through the medium of Welsh is essential for the provision of clinically effective care and is an essential for involvement and the provision of information and a prerequisite of informed consent. • Reminder to staff of how to contact the relevant interpretation services if no Welsh speaker available to ensure compliance with the Welsh Language Measure 2011 (WG, 2011). • Included questions relating to satisfaction with ability to 'speak Welsh to staff if you wanted to' within our real-time feedback questionnaire. • Recruited to ensure the bilingual provision of the Patient Advice and Liaison Service (PALS).

	• Incorporate guidance on the (Welsh Language Measure (Wales), WG 2011) within Customer Care Training.

Importance of Developing Dementia Services – Linda's Story told by Ben

Key Themes;	**Learning/Actions;**
• .Lack of adequate Dementia Care within Acute and Community Hospitals	Since Linda's admission to hospital the following improvements have been made to enhance patients care: • Patient activities have been increased • Dementia Care Worker has been appointed August 2019. • Occupational Therapist is doing daily activities in the Day Room. Some patients are being encouraged to prepare their own breakfast to promote independence –this is known as 'Functional Friday' • Physiotherapist is supporting physical therapy with patients of all abilities • New Dementia friendly flooring and cutlery tare to be purchased.

Community Care Collaborative Hub - East

Key Themes;	**Learning/Actions;**
• Service users do have a mistrust of "authority". • The hospital set up as a whole presents multiple barriers, ie appointment letters are sent but patient is homeless. • Because of their lifestyle they may not attend appointments, they are then removed from the waiting lists • Appointment times can be difficult to adhere too. • Patients feel the experience in hospital is negative, they are treated differently.	• Development of 'one stop' interdisciplinary health care in a socially welcoming environment, ensures access to health care services in a non-judgemental manner for service users who would otherwise find it difficult to access traditional health services which involve multiple access points.

Full details of the issues considered and discussed by the Committee are documented within the agenda and minutes which are available on the Health Board's website and can be accessed from the following pages
https://bcuhb.nhs.wales/about-us/committees-and-advisory-groups/

8. Key risks and concerns identified by this Committee in-year which have been highlighted and addressed as part of the Chair's reports to the Board:

Meeting Date	Key risks including mitigating actions and milestones
21.5.19	The Committee were provided with a summary proposal on the Clinical Audit function including a realignment to the Office of the Medical Director. The paper included recommendations on the role of the Audit Committee and QSE Committee going forwards in relation to clinical audit reporting and the approval/monitoring of the plan. The Committee agreed that further clarification of

	this was required and noted that the paper was due to be discussed at Audit Committee in the near future. A Quality Assurance report detailing concerns, claims, incidents and Healthcare Inspectorate Wales recommendations was received for the period January to March 2019. The Committee noted that whilst this report was still developing, further work was required in relation to the quality of thematic reporting and lessons learnt to provide the Committee with assurance. The Reducing Avoidable Mortality Report did not provide the Committee with the clarity required on progress in reducing avoidable mortality across the Health Board. It was noted that there are a number of areas not meeting the expected improvement and the actions planned to address this were unclear. The Committee have asked that this be addressed and a further update provided at a future meeting. The Committee agreed to receive regular updates on the endoscopy review and outpatients follow up backlogs as standing agenda items until further notice. The Committee reviewed the risks currently assigned to it and noted concerns about the target risk scores and whether they were achievable in the timescale documented. It was noted that the risk register is currently being reviewed across the Health Board and should address this issue. The Committee did not agree to the suggested reduction in the risk score for mental health as insufficient assurance had been provided in light of recent reports and the current performance indicators. The quality and content of reporting to the Committee and the associated impact upon the level of assurance that the Committee can take from these reports. A renewed commitment from operational leads was required to ensure that this was addressed.
16.7.19	The Committee noted a number of issues reported across the Health Board with regard to water safety including legionella incidents. The resulting need to close clinical areas due to these issues have a direct impact upon the provision of services for patients. The Director of Estates and Facilities highlighted the operational challenges and that the associated risk of legionella had been escalated appropriately with an action to review and refresh the policy to clarify responsibility. The Committee noted the current risk of non-compliance with Health and Safety legislation which was being addressed through a detailed gap analysis reporting to the Strategic Health and Safety Group.

	The Committee received a Quality and Safety report from MHLDS which provided some quantitative data relating to performance indicators and initiatives across the division. The Committee has requested a further report to be provided at the next meeting in September to include data analysis on lessons learnt, areas for improvement and key performance indicators in order to provide assurance on organisational learning and the implementation of the Quality Improvement Governance Plan. The Children's Services update report identified a number of areas of risk including an increase in waiting times for neuro-development services and the lack of 24/7 provision of the Tier 4 inpatient services for acutely ill high-risk young people. The Committee will receive the organisational response to the recent HIW thematic review of Children's and Young People's Services across Wales at the next meeting.
24.9.19	The Annual Plan Monitoring Report and progress against key actions was reviewed and the Committee noted that there were quality assurance issues with the report. In particular, there were milestones recorded as Red with no accompanying narrative and incorrect colour coding which made it difficult to be assured of progress. There were discussions over the progress against the plans for the provision of diagnostic services and overall productivity. The Committee requested an up to date report to be submitted to members in between meetings. The Committee noted, in the Integrated Quality and Performance Report for August, the high numbers of postponed procedures for non-clinical reasons and there was discussion around the actions being taken to address this. It was also noted that a recent Wales Audit Office report had been discussed at Audit Committee and the recommendations were being worked on. The Committee were informed about concerns with the sustainability of the breast radiology service with limited cover being provided by other areas. A radiologist had recently been appointed but recruitment has been challenging. The Committee were apprised of a shortage in resources within the paediatric ophthalmology service resulting in interim arrangements being made with other sites. The Committee queried the proposed closure of some of the actions in the HASCAS and Ockenden Improvement Group report on the basis of the narrative and other ongoing workstreams. The Occupational Health and Safety Gap Analysis Report was received which identified significant areas of non-compliance against health and safety legislation across the Health Board.

	The report also highlighted the need to improve the risk management structure and the robustness of previous self-assessments undertaken. The report included a comprehensive improvement plan with timescales, but it was noted that some of the requirements may involve significant resources which the Committee were not in a position to consider. The Committee were concerned with the lack of progress with the Follow Up Backlog Clearance. Although the report was inconsistent in part, the size of the backlog has increased and the trajectories for improvement were unclear
19.11.19	Long waits were identified for psychological therapies in the East and a report has been commissioned to review the model in place. Significant pressures were noted within the oncology service as a result of recruitment challenges, which is being reviewed; The Committee were supportive of improving infection prevention and control measures by staff no longer using lanyards. Alternatives are available and these should be used by both clinical and non-clinical staff going forwards; The Committee agreed to escalate the Mortality report to the Board as a result of inadequate assurance being provided. It was agreed that the matter would be discussed further with the Executive Medical Director as the Committee's feedback on the last report had not been actioned;
28.1.20	The level of postponed procedures for non-clinical reasons was discussed and the Committee noted that it had not received the report that had been previously agreed. The Committee requested that due to the numbers reported and the previous audit report, a detailed analysis should be provided to the next Committee meeting. The GMC had placed the junior doctor training service in Wrexham Maelor into Enhanced Monitoring following concerns raised by Health Education and Improvement Wales (HEIW). The Hospital Management Team had developed an action plan to address the concerns and a follow up visit was expected in 2020. The Committee were concerned that the failure to address the issues could result in the withdrawal of training posts and undertook to bring the matter to the attention of the Board;
17.3.20	Due to the Covid-19 the decision had been taken to reduce attendance at the meeting and prioritise discussions within the agenda, to allow Executive officers and other senior leaders to fully focus on the response to the COVID 19 pandemic. A Chair's Assurance Report has to date not been submitted to Board.

9. Focus for the year ahead:

The primary focus of the QSE Committee over the next twelve months will be:

- Develop reporting arrangements to enable better scrutiny at Executive-led groups across the areas of quality and safety; health and safety; patient experience and effectiveness.
- Ensure better informed Committee agendas structured around the Risk Management and Quality Improvement Strategies.
- Undertake review of cycle of business and terms of reference to ensure closer alignment and strengthened focus.

The Committee has established a Cycle of Business for the year ahead covering the breadth of its work, and primarily focussing on its key areas of risk, as defined in the Board's Corporate Risk and Assurance Framework. This is attached as Appendix 3.

V0.4

Betsi Cadwaladr University Health Board
Terms of Reference and Operating Arrangements

QUALITY, SAFETY AND EXPERIENCE COMMITTEE

1 INTRODUCTION

1.1 The Board shall establish a committee to be known as the **Quality, Safety and Experience Committee (QS&E).** The detailed terms of reference and operating arrangements in respect of this Committee are set out below.

2 PURPOSE

2.1 The purpose of the Committee is to provide advice and assurance to the Board in discharging its functions and meeting its responsibilities with regard to quality, safety, patients and service user experience of health services.

3 DELEGATED POWERS

3.1 The Committee, in respect of its provision of advice and assurance will and is authorised by the Board to:-

3.1.1 ensure that arrangements for the quality and safety of patient care are in accordance with its corporate goals, stated priorities within the Quality Improvement Strategy and the principle of continuous quality improvement including organisational learning;

3.1.2 ensure the adequacy of safeguarding and infection, prevention and control arrangements;

3.1.3 provide assurance in relation to improving the experience of patients, citizens and all those who come into contact with the Health Board's services, as well as those provided by other organisations' or as part of a partnership arrangement;

3.1.4 seek assurance on the robustness and appropriateness of Health and Safety arrangements across the Health Board including aspects impacting on patient care, quality and safety and experience;

3.1.5 ensure that all reasonable steps are taken to prevent, detect and rectify irregularities or deficiencies in the quality and safety of care provided and in particular that:

- Sources of internal assurance (including clinical audit) are reliable
- Recommendations made by internal and external reviewers are considered and acted upon on a timely basis

- Appropriate review is carried out and corrective action is taken arising from incidents, complaints and claims known collectively as 'Concerns'.

3.1.6 Review achievement against the Health and Care Standards including accessible health care to inform the Annual Quality and Annual Governance Statements;

3.1.7 Seek assurance on the quality and safety of services commissioned from external providers (including care homes) and others who provide a commissioning role on behalf of the Health Board e.g. Welsh Health Specialised Services Committee (WHSSC); Emergency Ambulance Services Committee (EASC).

3.1.8 Review and seek assurance on the appropriateness of the quality indicators defined within the Integrated Quality and Performance Report (IQPR) and scrutinize the quality dimensions contained within the IQPR;

3.1.9 Review the sustainability of service provision across the Health Board in terms of quality of service, patient experience and model of care provided.

3.1.10 provide advice and assurance to the Board regarding the quality impact assessment of strategic plans as appropriate;

3.1.11 to receive periodic updates in respect of the workforce flu vaccination.

4 AUTHORITY

4.1The Committee may investigate or have investigated any activity (clinical and non-clinical) within its terms of reference. It may seek relevant information from any:

- employee - and all employees are directed to cooperate with any legitimate request made by the Committee; and
- other committee, sub-committee or group set up by the Board to assist it in the delivery of its functions.

4.2 It may also obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements;

4.3 It may consider and where appropriate, approve on behalf of the Board any policy within the remit of the Committee's business concerning Quality, Safety and Patient Experience matters.

4.4 It will review risks from the Corporate Risk Register that are assigned to the Committee by the Board and advise the Board on the appropriateness of the scoring and mitigating actions in place;

5 SUB-COMMITTEES

5.1The Committee may, subject to the approval of the Health Board, establish sub-committees or task and finish groups to carry out on its behalf specific aspects of Committee Business.

6 MEMBERSHIP

6.1 Members

Four Independent Members of the Board.

6.2 In attendance

Executive Director of Nursing and Midwifery (Lead Executive)
Executive Medical Director
Executive Director of Therapies and Health Sciences
Executive Director of Primary Care & Community Services
Director of Performance
Executive Director of Workforce & Organisational Development
Executive Director of Public Health
Associate Director of Quality Assurance
Senior Associate Medical Director / 1000 Lives Clinical Lead
Chair of Healthcare Professionals Forum -Associate Board Member
Representative of Community Health Council
Trade Union Partners

6.2.1 Other Directors/Officers will attend as required by the Committee Chair, as well as any others from within or outside the organisation who the Committee considers should attend, taking into account the matters under consideration at each meeting. The Mental Health & Learning Disabilities Division will attend as per scheduled items on the cycle of business.

6.3 Member Appointments

6.3.1 The membership of the Committee shall be determined by the Chairman of the Board taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government. This includes the appointment of the Chair and Vice-Chair of the Committee who shall be Independent Members.

6.3.2 Appointed Independent Members shall hold office on the Committee for a period of up to 4 years. Tenure of appointments will be staggered to ensure business continuity. A member may resign or be removed by the Chairman of the Board. Independent Members may be reappointed up to a maximum period of 8 years.

6.4 Secretariat

6.4.1 Secretary: as determined by the Board Secretary.

6.5 Support to Committee Members

6.5.1 The Board Secretary, on behalf of the Committee Chair, shall:

- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and
- Ensure the provision of a programme of development for Committee members as part of the overall Board Development programme.

7 COMMITTEE MEETINGS

7.1 Quorum

7.1.1 At least two Independent Members must be present to ensure the quorum of the Committee, one of whom should be the Committee Chair or Vice-Chair. In the interests of effective governance, it is expected that a minimum of two Executive Directors will also be in attendance.

7.2 Frequency of Meetings

7.2.1 Meetings shall be routinely be held on a bi-monthly basis.

7.3 Withdrawal of individuals in attendance

7.3.1 The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

8 RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

8.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of the organisation.

8.2 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these Terms of Reference,

8.3 The Committee, through its Chair and members, shall work closely with the Board's other Committees including joint committees/Advisory Groups to provide advice and assurance to the Board through the:

8.3.1 joint planning and co-ordination of Board and Committee business; and

8.3.2 sharing of information

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.

8.4 The Committee shall embed the corporate goals and priorities through the conduct of its business, and in doing and transacting its business shall seek assurance that adequate consideration has been given to the sustainable development principle and in meeting the requirements of the Well-Being of Future Generations Act.

8.5 Receive assurance and exception reports from the Quality and Safety Group (QSG)

9. REPORTING AND ASSURANCE ARRANGEMENTS

9.1 The Committee Chair shall:
9.1.1 report formally, regularly and on a timely basis to the Board on the Committee's activities via the Chair's assurance report as well as the presentation of an annual report;
9.1.2 ensure appropriate escalation arrangements are in place to alert the Health Board Chair, Chief Executive or Chairs of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

9.2 The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation. In doing so account will be taken of the requirements set out in the NHS Wales Quality and Safety Committee Handbook.

10. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

10.1 The requirements for the conduct of business as set out in the Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

Quorum 11. REVIEW

11.1 These terms of reference and operating arrangements shall be reviewed annually by the Committee and any changes recommended to the Board for approval.

Date of approval:
QSE Committee 29.11.18
Board 24.1.19

V5.0

Betsi Cadwaladr University Health Board
Terms of Reference and Operating Arrangements

QUALITY, SAFETY AND EXPERIENCE COMMITTEE

1) INTRODUCTION

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2) PURPOSE

2.1 The purpose of the Committee is to provide advice and assurance to the Board in discharging its functions and meeting its responsibilities with regard to quality, safety, patients and service user experience of health services.

3) DELEGATED POWERS

3.1 The Committee, in respect of its provision of advice and assurance will and is authorised by the Board to:-

3.1.1 ensure that arrangements for the quality and safety of patient care are in accordance with its corporate goals, stated priorities within the Quality Improvement Strategy and the principle of continuous quality improvement including organisational learning;

3.1.2 ensure the adequacy of safeguarding and infection, prevention and control arrangements;

3.1.3 provide assurance in relation to improving the experience of patients, citizens and all those who come into contact with the Health Board's services, as well as those provided by other organisations' or as part of a partnership arrangement;

3.1.4 seek assurance on the robustness and appropriateness of Health and Safety arrangements across the Health Board including aspects impacting on patient care, quality and safety and experience;

3.1.5 ensure that all reasonable steps are taken to prevent, detect and rectify irregularities or deficiencies in the quality and safety of care provided and in particular that:

- Sources of internal assurance (including clinical audit) are reliable
- Recommendations made by internal and external reviewers are considered and acted upon on a timely basis

- Appropriate review is carried out and corrective action is taken arising from incidents, complaints and claims known collectively as 'Concerns'.

3.1.6 Receive assurances from the Quality Improvement Strategy and Legislation Assurance Framework to allow the Committee to review achievement against the Health and Care Standards including accessible health care to inform the Annual Quality and Annual Governance Statements;

3.1.7 Seek assurance on the quality and safety of services commissioned from external providers (including care homes) and others who provide a commissioning role on behalf of the Health Board e.g. Welsh Health Specialised Services Committee (WHSSC); Emergency Ambulance Services Committee (EASC).

3.1.8 Review and seek assurance on the appropriateness of the quality indicators defined within the Integrated Quality and Performance Report (IQPR) and scrutinize the quality dimensions contained within the IQPR;

3.1.9 Review the sustainability of service provision across the Health Board in terms of quality of service, patient experience and model of care provided.

3.1.10 provide advice and assurance to the Board regarding the quality impact assessment of strategic plans as appropriate;

3.1.11 to receive periodic updates in respect of the workforce flu vaccination.

4) AUTHORITY

4.1 The Committee may investigate or have investigated any activity (clinical and non-clinical) within its terms of reference. It may seek relevant information from any:

- employee - and all employees are directed to cooperate with any legitimate request made by the Committee; and
- other committee, sub-committee or group set up by the Board to assist it in the delivery of its functions.

4.2 It may also obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements;

4.3 It may consider and where appropriate, approve on behalf of the Board any policy within the remit of the Committee's business concerning Quality, Safety and Patient Experience matters.

4.4 It will review risks from the Corporate Risk Register that are assigned to the Committee by the Board and advise the Board on the appropriateness of the scoring and mitigating actions in place;

5) SUB-COMMITTEES

5.1 The Committee may, subject to the approval of the Health Board, establish sub-committees or task and finish groups to carry out on its behalf specific aspects of Committee Business.

6) MEMBERSHIP

6.1 Members

Four Independent Members of the Board.

6.2 In attendance

Executive Director of Nursing and Midwifery (Lead Executive)
Executive Medical Director
Executive Director of Therapies and Health Sciences
Executive Director of Primary Care & Community Services
Director of Performance
Executive Director of Workforce & Organisational Development
Executive Director of Public Health
Associate Director of Quality Assurance
Director of Mental Health & Learning Disabilities
Senior Associate Medical Director / 1000 Lives Clinical Lead
Chair of Healthcare Professionals Forum -Associate Board Member
Representative of Community Health Council

6.2.1 Other Directors/Officers will attend as required by the Committee Chair, as well as any others from within or outside the organisation who the Committee considers should attend, taking into account the matters under consideration at each meeting.

6.2.2 Trade Union Partners are welcome to attend the public session of the Committee

6.3 Member Appointments

6.3.1 The membership of the Committee shall be determined by the Chairman of the Board taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government. This includes the appointment of the Chair and Vice-Chair of the Committee who shall be Independent Members.

6.3.2 Appointed Independent Members shall hold office on the Committee for a period of up to 4 years. Tenure of appointments will be staggered to ensure business continuity. A member may resign or be removed by

the Chairman of the Board. Independent Members may be reappointed up to a maximum period of 8 years.

6.4 Secretariat

6.4.1 Secretary: as determined by the Board Secretary.

6.5 Support to Committee Members

6.5.1 The Board Secretary, on behalf of the Committee Chair, shall:

- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and
- Ensure the provision of a programme of development for Committee members as part of the overall Board Development programme.

7) COMMITTEE MEETINGS

7.1 Quorum

7.1.1 At least two Independent Members must be present to ensure the quorum of the Committee, one of whom should be the Committee Chair or Vice-Chair. In the interests of effective governance, it is expected that a minimum of two Executive Directors will also be in attendance.

7.2 Frequency of Meetings

7.2.1 Meetings shall be routinely be held on a bi-monthly basis.

7.3 Withdrawal of individuals in attendance

7.3.1 The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

8) RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

8.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of the organisation.

8.2 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these Terms of Reference,

8.3 The Committee, through its Chair and members, shall work closely with the Board's other Committees including joint committees/Advisory Groups to provide advice and assurance to the Board through the:

- joint planning and co-ordination of Board and Committee business; and
- sharing of information

In doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.

8.4 The Committee shall embed the corporate goals and priorities through the conduct of its business, and in doing and transacting its business shall seek assurance that adequate consideration has been given to the sustainable development principle and in meeting the requirements of the Well-Being of Future Generations Act.

8.5 Receive assurance and exception reports from the Quality and Safety Group (QSG)

9) REPORTING AND ASSURANCE ARRANGEMENTS

9.1 The Committee Chair shall:

9.1.1 report formally, regularly and on a timely basis to the Board on the Committee's activities via the Chair's assurance report as well as the presentation of an annual report;

9.1.2 ensure appropriate escalation arrangements are in place to alert the Health Board Chair, Chief Executive or Chairs of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

9.2 The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation. In doing so account will be taken of the requirements set out in the NHS Wales Quality and Safety Committee Handbook.

10) APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

10.1 The requirements for the conduct of business as set out in the Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum

11) REVIEW

11.1 These terms of reference and operating arrangements shall be reviewed annually by the Committee and any changes recommended to the Board for approval.

Date of approval:
Audit Committee 30.5.19
Health Board 25.7.19

V6.0

QSE CYCLE OF ANNUAL BUSINESS AND FORWARD PLANNER last updated 03/03/2020 10:46

Part 1 – Annual Recurring Business

Agenda Items	Officer Contact	Jan	Mar	May	Jul	Sep	Nov
Accessible Healthcare Standards Annual Report incorporating WITS report	*Peter Morris Eleri Hughes-Jones*					X	
Annual Quality Statement	*Di Read*		X draft	X final			
Children's Services	*Teresa Owen Alison Cowell*			X			X
Patient Safety Report (formerly CLICH)	*Matt Joyce*	X		X		X	
Clinical Audit – monitoring of outcomes from clinical audit plan	*Adrian Thomas*		X Approval of plan				Via JAQS meeting
Committee Annual Report (inc Review of Terms of Reference and Approval of Cycle of Business)	*Kate Dunn*		X final				
Continuing Health Care (By exception only – main aspects to be brought within primary & community care assurance reports)	*Chris Stockport*						
Corporate Risk Assurance Framework (QSE Risks) EACH MEETING FROM APRIL 2020 ONWARDS (AGREED BY AC WORKSHOP)	*Peter Barry*			X			X
Executive Quality & Safety Updates **In Committee** (To sight the Committee on current issues around complex complaints, never events, key risks, Regulation 28s and any significant quality & safety issues	*All Execs*	X	X	X	X	X	X
Healthcare Inspectorate Wales Annual Report					X		

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Agenda Items	Officer Contact	Jan	Mar	May	Jul	Sep	Nov
Health & Safety (including HSE Reports and Corporate Health at Work updates)	*Sue Green*	X	X	X	X annual report	X	X
Health Protection (PHW Report)	*Teresa Owen*	X					
Improvement Group (HASCAS & Ockenden) Chair's Assurance Report	*Gill Harris*	X	X	X	X	X	X
Incidents (High Risk SUIs) – to focus on organisational learning	*Deborah Carter Matt Joyes*	X	X	X	X	X	X
Infection Prevention & Control	*Amanda Miskell*	IQPR slides only	Q3 report	IQPR slides only	Q4 report	Q1 and annual report	Q2 report
Integrated Quality Performance Report	*Ed Williams Jill Newman*	X	X	X	X	X	X
Learning Disability Strategy – monitoring of implementation Frequency to be determined							
Medicines Management	*Berwyn Owen*		X ann rep			X key risks	
Mental Health Services – Quality & Performance Assurance report on the implementation of T4MH Strategy	*Steve Forsythe*		X		X		X
Mortality & Morbidity (inc lessons learnt from casenote reviews)	*Melanie Maxwell*			X			X
Nurse Staffing Report (as required by Wales Act 2016)	*Debra Hickman*			X Annual report			X mid year update
Patient Stories		X	X	X	X	X	X

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Agenda Items	Officer Contact	Jan	Mar	May	Jul	Sep	Nov
Patient Experience Report (focusing on patient experience and what has changed or is planned as a result of their feedback)	*Carolyn Owen Matthew Joyes*		X		X		X
Policies for Review (as required)	*Varies*	X	X	X	X	X	X
Primary & Community Care Quality Assurance Report incorporating care homes	*Chris Stockport*		X		X		X
Prison Health	*Chris Stockport*		X			X	
PSOW Annual Letter	*PSOW*					X	
Putting Things Right Annual Report (inc link to PSOW Annual Report)				X			
Quality Improvement Strategy 2017-2020 (inc Dementia Strategy)	*Deborah Carter*			X draft	X final		
Quality/Safety Awards and Achievements (added by LR Oct 19. Verbal updates)		X	X	X	X	X	X
Quality Safety Group – assurance report	*Deborah Carter Caroline Williams*	X	X	X	X	X	X
Safeguarding	*Michelle Denwood*			X Ann Rep			X
Standing Items – Opening Business (apologies, declarations of interest, minutes)		X	X	X	X	X	X
Standing Items – Closing Business (items discussed in committee, documents circulated, issues of significance, any other business, date of next meeting)		X	X	X	X	X	X
Tissue & Organ Donation Annual Report	*David Southern*	X					

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Agenda Items	Officer Contact	Jan	Mar	May	Jul	Sep	Nov
Welsh Health Specialised Services Committee – Quality & Patient Safety Committee Minutes and/or Chair's Reports (held in public) *obtained from WHSCC website*	*Cathie Steele WHSCC*	X	X	X	X	X	X
Welsh Risk Pool Services and Legal & Risk Services Annual Review	*Anne Louise Ferguson*				X		

In addition a "Part 2" Rolling Plan of Ad-Hoc Business is maintained by the corporate secretariat

Cyfarfod a dyddiad: Meeting and date:	**QSE**
Cyhoeddus neu Breifat: Public or Private:	*Public*
Teitl yr Adroddiad Report Title:	General Practice Access Standards
Cyfarwyddwr Cyfrifol: Responsible Director:	Dr Chris Stockport Executive Director for Primary Care and Community services
Awdur yr Adroddiad Report Author:	Lynne Joannou, Assistant Director Primary Care Contracting Donna Owen, Primary Care Contracts Officer.
Craffu blaenorol: Prior Scrutiny:	Direct to QSE. *As detailed within the report the normal reporting channel will be through the Primary Care Panel, however, this operational meeting has been cancelled due to Covid19. As this document is an update/report for information which does not require a decision, it is being presented directly to QSE on this occasion to ensure Board level awareness of the GMS contractual changes.*
Atodiadau Appendices:	None

Argymhelliad / Recommendation:

QSE is asked to note the content of the report

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

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

Sefyllfa / Situation:

1.1 The General Medical Services (GMS) Contract changes for 2019/20, which came into force in September 2019, set new access requirements on GP practices under the Quality Assurance and Improvement Framework (QAIF), as well as placing additional responsibilities on Health Boards for monitoring and reporting on accessibility to GP practices. The standards

will be measured against achievement at 31st March 2020 and 31st March 2021, with the intention that 100% achievement is reached across Wales by March 2021.

1.2 Significant temporary changes have subsequently been applied to General Practice contracts by Welsh Government (WG) as a consequence of COVID-19 and this has impacted on the Access Standards reporting requirements.

1.3 This report provides an update position on the contractual requirements; work done to date within the Health Board, towards achieving the standards prior to the Covid-19 pandemic and the current situation and actions in place.

Cefndir / Background:

2.1 In March 2019, the Minister for Health and Social Services made an announcement regarding access standards for GP practices, which was subsequently considered and implemented as part of the GMS contract negotiations.

2.2 Access plays a major role in the experience of a patient, with the ease, or indeed difficulty, of making an appointment being a key factor in how positively a patient will view the service. The Access Standards aim to build on existing good practice already in operation across Wales, and to provide practices with clear expectations to work towards.

2.3 The standards are set out in the QAIF section of the contract; which, similar to the predecessor arrangements under the Quality and Outcomes Framework (QOF) are optional for practices to deliver. Remuneration is through the award of points for achievement and the Access domain comprises of a total possible 125 points.

2.4 The Access standards are set into two Groups; Group 1 focussing on Infrastructure and Systems and Group 2 Understanding Patient Needs. Each group of standards is independent of each other, therefore practices have a range of options in terms of how they plan to reach full achievement by March 2021.

Assesiad / Assessment & Analysis

3.1 Strategy Implications

Improving access to services, delivered at or close to home, is a key strategic priority for Welsh Government and is central to the Primary Care Model for Wales, which sets out the agreed approach to health and well-being in Wales. The model focuses on informing people of the wider options available to them in order to stay as healthy and as well as possible, in line with *A Healthier Wales.*

The local adoption and adaptation of the Primary Care Model for Wales, in line with the national delivery milestones set by the Welsh Government, is now the strategy for achieving accessible and sustainable care.

3.2 Financial Implications
£13m has been invested as part of the GMS contract agreement for 2019-20 across Wales, to support practices to improve access by working towards the standards or to recognise where practices are already delivering and meeting the standards. This includes funding both within the Global Sum (basic contract payment) where £3.7m has been invested to support infrastructure / telephone systems, as well as the income for practices in relation to achievement payments against the standards

3.3 Risk Analysis
Whilst the Minster for Health and Social Services has set clear expectations in terms of achievement against the standards to be delivered across 100% of practices, the fact remains that the Access standards are an optional element of the GMS contract. Uptake against the QOF, which was the predecessor of the Quality Assurance and Improvement Framework (QAIF), has been 100% across North Wales. Whilst the 2019/20 agreement has introduced some fundamental changes, the expectation is that practices will continue to engage in this aspect of the contract.

Participation will be monitored on a quarterly basis; measured against the baseline audit and reviewed quarterly by the Access Forum; reported at Executive and Board level and will also feature routinely in quarterly Quality & Delivery meetings with Welsh Government.

3.4 Legal and Compliance
There are no legal implications.

3.5 Impact Assessment
The report provides an update on the implementation of a WG directive.

3.6 The Access Standards
3.6.1 As stated above, the Access standards are set into two Groups:

- Group 1 – infrastructure & systems (5 standards)
    - Telephony systems
    - Digital access
    - Consistent messaging & signposting

- Group 2 – understanding patient needs (3 standards)
    - A more informed public
    - Understanding & responding to patient needs at a practice & cluster level

3.6.2 Within Group 1, practices can choose to achieve 3, 4 or 5 of the standards and payment will be made accordingly

- Less than 3 standards – no payment (0 points)
- 3 standards – 60% payment (30 points)
- 4 standards – 80% payment (40 points)
- All Group 1 standards met – 100% payment (50 points)

All three standards set out in Group 2 must be achieved (50 points) to trigger payment.

Where practices choose to achieve all standards in both Group 1 and Group 2, then they will be eligible for an additional Achievement Quality payment bonus of 25 points.

Work has been undertaken through the national Heads of Primary Care Group to develop a baseline assessment of the current achievement of Practices against these standards.

3.7 Baseline BCUHB Achievement as at December 2019

Group 1:

Standard	Description	Current Achievement
1	Appropriate telephony and call handling systems are in place which support the needs of callers and avoids the need for people to call back multiple times. Systems also provide analysis data to the practice.	31% of (104) practices
2	People receive a prompt response to their contact with a practice via telephone.	These questions were not covered in the first data collection
3	All practices have a recorded bilingual introductory message in place, which includes signposting to other local services and to emergency services for clearly identified life threatening conditions.	These questions were not covered in the first data collection
4	Practices have in place appropriate and accessible alternative methods of contact, including digital solutions such as SMS text messaging and email, as well as face-to-face.	11% of (104) practices
5	People are able to request a non-urgent consultation, including the option of a call back via email, subject to the necessary national governance arrangements being in place.	16% of (104) practices

Group 2:

Standard	Description	Current Achievement
6	People are able to access information on the different ways of requesting a consultation with a GP and other healthcare professionals. Practices will display information relating to these standards.	39% of (104) practices
7	People receive a timely, co-ordinated and clinically appropriate response to their needs.	56% of (104) practice
8	All practices have a clear understanding of patient needs and demands within their practice and how these can be met.	32% of (104) practices

3.8 Monitoring and Reporting

3.8.1 There are a number of additional requirements placed on Health Boards in relation to the verification, reporting and monitoring of these standards. At Health Board level we are required to establish an "Access Forum" to review and monitor performance against the standards, share best practice and assist with development of initiatives through clusters.

3.8.2 The suggested membership of the Forum is outlined within the contract guidance, and the BCUHB membership is as follows:

- Assistant Director Primary Care Contracting (Chair)
- Assistant Area Director Primary Director x3
- GP Cluster Lead (1 from each Area)
- Area or Assistant Medical Director x3
- LMC representative
- CHC representative
- Primary Care Contract Manager/Officer.

3.8.3 The Forum is required to report to an appropriate leadership group within the individual Health Board, with updates to be provided at Executive and Board level on a quarterly basis. Within BCuHB, the Access Forum is required to report through the Primary Care Panel with quarterly updates provided at Executive and Board level.

3.8.4 Assessment of performance against the Access Standards will also routinely feature at quarterly Quality & Delivery meetings, between WG and Health Board Executives, where the Executive team will feedback on Access Standards achievements and ongoing progress.

3.8.5 The Access Forum met for the first time on 28th January 2020, where the background and detail of the standards were discussed to ensure a common and consistent understanding of WG and contractual expectations across all stakeholders. The second meeting of the Forum was been scheduled for the 28th April 2020, however, this has been cancelled due to the ongoing COVID19 pandemic situation.

3.9 COVID-19

3.9.1 On 13th March, following Welsh Government guidance, practices were provided with further clarity regarding the Access Standards, both in terms of what was required to be delivered and the evidence that they would need to provide as at 31st March 2020 in order to demonstrate achievement and payment in 2020.

3.9.2 However, on 17th March 2020, Welsh Government announced further measures to temporarily change Primary Care contracts to ensure the NHS is able to continue to provide care and support to the most vulnerable people in preparation for the expected increase in the number of confirmed cases of COVID-19.

3.9.3 These measures included the relaxation of GMS contract and monitoring arrangements, with the exception of the Access Standards. It was felt reporting against the Access Standards will support general practices' management of patients during this

outbreak. WG confirmed, however, that practices will not need to provide supplementary evidence for the standards. This is a pragmatic, high trust approach and practices' responses should only be challenged by Health Boards in exceptional circumstances.

3.9.4 Practices are able to confirm achievement via a national electronic tool, developed by NHS Wales Information Services (NWIS) and which is accessible via the Primary Care Portal as at March 31st 2020, by completing a simple self-declaration for each of the standards by 24th April 2020 to achieve payment.

3.9.5 The results will be available to view on the Portal after the submission deadline and will be visible to the Health Board and practices.

Camau Nesau / Next Steps

4.1 The Primary Care Contracting Team (PCCT) will review the year-end practice returns and summarise the achievement, comparing against the baseline assessment to identify progress against the standards. This analysis will then be utilised to work with practices to understand where support may be required in order to enable them to further improve performance against the standards.

4.2 PCCT will also ensure that any changing WG guidance in relation to the Covid19 pandemic and its impact on the Access standards is communicated to practices and implemented correctly.

4.3 A further update report, incorporating the year-end analysis of practice submissions, will be presented to the next meeting of the Primary Care Panel for discussion and onward submission for information at Executive and Board level.