Quality & Safety Committee

Tue 15 November 2022, 09:00 - 12:00

Virtually via Microsoft Teams

Agenda

09:00 - 09:00
0 min

1.
PRELIMINARY MATTERS

Information *Jayne Sadgrove, Vice Chair (Chair of the Committee)*

1.1.
Welcome & Introductions

Information *Jayne Sadgrove, Vice Chair (Chair of the Committee)*

Attending as Observers:
Dr Mary Self, Mental Health Medical Director
Melanie Barker, Deputy Director of Therapies & Health Sciences

1.2.
Apologies for Absence

Information *Jayne Sadgrove, Vice Chair (Chair of the Committee)*

Hywel Daniel, Executive Director for People

1.3.
Declarations of Interest

Information *Jayne Sadgrove, Vice Chair (Chair of the Committee)*

09:00 - 09:00
0 min

2.
SHARED LISTENING & LEARNING

2.1.
Patient Story - CONFIRMATION OF STORY TO FOLLOW

Discussion

09:00 - 09:00
0 min

3.
CONSENT AGENDA

3.1.
FOR APPROVAL

3.1.1.
Unconfirmed Minutes of the meeting held on 20 September 2022

Decision *Jayne Sadgrove, Vice Chair (Chair of the Committee)*

3.1.1 Unconfirmed Mins Q&S Cmt 20.09.22 EWWPJGGJS.pdf (15 pages)

3.1.2.
Unconfirmed Minutes of the In Committee meeting held on 11 October 2022

Decision *Jayne Sadgrove, Vice Chair (Chair of the Committee)*

3.1.2 Unconfirmed Mins In Committee Quality & Safety 11.10.22.pdf (2 pages)

3.1.3.
Quality & Safety Committee Terms of Reference Review

Decision *Cally Hamblyn, Assistant Director of Governance & Risk*

3.1.3a Quality & Safety Committee Terms of Reference Review - Cover Paper.pdf (3 pages)
3.1.3b Appendix 1 - Draft - GC01 - Standing Orders - Schedule 3.8 - Quality & Safety Committee ToR -reviewed 31.10.2022.pdf (11 pages)

3.2.
FOR NOTING

3.2.1.
Action Log

Information *Cally Hamblyn, Assistant Director of Governance & Risk*

3.2.1 Action Log QSC 20.9.22.pdf (8 pages)

3.2.2.
Committee Annual Cycle of Business

Information *Cally Hamblyn, Assistant Director of Governance & Risk*

3.2.2a Committee Cycle of Business - Cover Paper QSC 15 November 2022.pdf (2 pages)
3.2.2b Quality & Safety Committee Cycle of Business November 2022.pdf (4 pages)

3.2.3.
Forward Work Programme

Information *Cally Hamblyn, Assistant Director of Governance & Risk*

3.2.3 Quality & Safety Committee Forward Work Programme - 15 November 2022.pdf (9 pages)

3.2.4.
Welsh Ambulance Services NHS Trust Patient Experience Report

Information *Greg Dix, Executive Nurse Director*

This item has been moved to the main agenda at 6.11 as the Executive Nurse Director will provide a verbal update.

3.2.5.
Quality Governance - Regulatory Review Recommendations and Progress Updates

Information *Greg Dix, Executive Nurse Director*

3.2.5 - Quality Governance - Regulatory Review Recommendations and Progress Update.pdf (6 pages)

3.2.6.
Health & Care Standards Annual Report

Information *Greg Dix, Executive Nurse Director*

3.2.6a Health & Care Standards Annual Report QSC cover Nov 22 LM.pdf (6 pages)
3.2.6b HCS Audit Report 2022 FINAL.pdf (72 pages)

3.2.7.
National Prescribing Indicator (NPI) Annual Report

Information *Dom Hurford, Executive Medical Director*

3.2.7 National Prescribing Indicator (NPI) Annual Report.pdf (11 pages)

3.2.8.
Clinical Education Annual Report

Information *Dom Hurford, Executive Medical Director*

3.2.8 Clinical Education Annual Report - V2.pdf (41 pages)

3.2.9.
Clinical Audit Quarterly Report

Information *Dom Hurford, Executive Medical Director*

3.2.9a Clinical Audit Quarterly Report - 2022NovVer1_0.pdf (7 pages)
3.2.9b Clinical Audit Annual ReportV1_4.pdf (18 pages)

3.2.10.
Nosocomial Covid-19 Incident Management Programme

Information *Greg Dix, Executive Nurse Director*

3.2.10 CTM Nosocomial COVID-19 Incident Management Programme October 2022.pdf (9 pages)

3.2.11.
Human Tissue Authority Act Progress Report

Information *Gethin Hughes, Chief Operating Officer*

3.2.11 HTA Progress Report November 2022.pdf (7 pages)

3.2.12.
Annual Review 2021/22 – Welsh Risk Pool and Legal & Risk Services

Stephanie Muir, Assistant Director of Concerns and Legal Services

3.2.12a Annual Review 202122 – Welsh Risk Pool and Legal & Risk Services.pdf (3 pages)
3.2.12b Annual Review 202122 – Welsh Risk Pool and Legal & Risk Services - 202209Sep09-Letter to CTMUHB.pdf (1 pages)
3.2.12c Annual Review 202122 – Welsh Risk Pool and Legal & Risk Services - WRP Annual Review 2021-22 ENGLISH.pdf (55 pages)

09:00 - 09:00
0 min

4.
MAIN AGENDA

4.1.
Matters Arising not Considered within the Action Log

Discussion *Jayne Sadgrove, Vice Chair (Chair of the Committee)*

09:00 - 09:00
0 min

5.
GOVERNANCE

5.1.
Organisational Risk Register – Risks Assigned to Quality & Safety Committee

Discussion *Cally Hamblyn, Assistant Director of Governance & Risk*

To Follow

5.1a Organisational Risk Register November 2022 Review - QSC Report 15.11.2022.pdf (5 pages)
5.1b Master Organisational Risk Register -Final November 2022 - QSC Assigned Risks 15.11.2022.pdf (11 pages)

5.2.
Datix Cymru - Assurance Report

Discussion *Stephanie Muir, Assistant Director of Concerns and Legal Services*

5.2 Datix Cymru Incident Reporting.pdf (8 pages)

5.3.
Health, Safety & Fire Sub Committee Highlight Report

Dilys Jouvenat, IM and Chair of the HS&F Sub Committee

5.3a Health, Safety & Fire Sub Committee Highlight Report.pdf (4 pages)
5.3b HSFSC - Appendix 1 Health Safety & Fire Sub Committee Annual Report.pdf (8 pages)

5.4.
Infection, Prevention & Control Committee Highlight Report

Greg Dix, Executive Nurse Director

5.4 Infection, Prevention & Control Committee Highlight Report - Nov 22.pdf (3 pages)

09:00 - 09:00
0 min

6.
IMPROVING CARE

6.1.
Maternity and Neonatal Improvement Programme Highlight Report September 2022

Discussion *Greg Dix, Executive Nurse Director /Sallie Davies, Deputy Medical Director*

6.1 Maternity & Neonatal Improvement Programme Highlight Report September 2022.pdf (43 pages)

6.2.
Ty Llidiard Progress Report

Discussion *Lauren Edwards, Executive Director of Therapies and Health Sciences*

6.2 Ty Llidiard Progress Report.pdf (12 pages)

6.3.
Quality Dashboard

Discussion *Louise Mann, Assistant Director of Quality, Safety & Safeguarding*

6.3 Quality Dashboard Rpt QSC 02.11.22 LMGDKNDH.pdf (38 pages)
6.3a QPAR_All Wales_Summary Dashboard_Sept22.pdf (1 pages)
6.3b QPAR_CTM_Summary Dashboard_Sept22.pdf (1 pages)
6.3c 20221010 Compliance Summary Alerts.pdf (2 pages)
6.3d 20221010 Compliance Summary Notices.pdf (4 pages)
6.3e Data Details_All Wales Dashboard.pdf (2 pages)
6.3f Data Details_UHB Dashboards.pdf (2 pages)

6.3.1.
First Quality & Safety Report: Mental Health Care Group

6.3.1 First Quality & Safety Report Mental Health Care Group - QSC 151122.pdf (13 pages)

6.3.2.
Care Group Exception Reports

6.4.
Report from the Chief Operating Officer

Discussion *Gethin Hughes, Chief Operating Officer*

6.4 COO's Report QS November 2022.pdf (6 pages)

6.5.
WHSSC Quality & Patient Safety Committee Chair's Report

Discussion *Dilys Jouvenat, Independent Member*

6.5a WHSSC Quality & Patient Safety Committee Chairs report.pdf (14 pages)
6.5b Appendix 2 WHSSC Quality Newsletter.pdf (16 pages)
6.5c Appendix 3 - WHSSC Quality Internal Audit Report.pdf (11 pages)

6.6.
Learning from Mortality Reviews

Discussion *Dom Hurford, Executive Medical Director*

6.6 Learning from Mortality Reviews Update 20102022.pdf (10 pages)

6.7.
Quality Strategy

Discussion *Lauren Edwards, Executive Director of Therapies & Health Sciences*

6.7a Quality Strategy - Cover Paper Nov 22 v2.pdf (3 pages)
6.7b Quality Strategy 0.21.pdf (15 pages)

6.8.
Civica - People's Experience Feedback System

Discussion *Sharon O-Brien, Assistant Director of Nursing & Peoples Experience*

6.8a Civica - Peoples Experience Feedback System.pdf (7 pages)
6.8b Appendix A CIVICA Report - Push_Report_Heat Map Sept 22.pdf (6 pages)

6.9.
Peer Review of Urgent Primary Care (Out of Hours and UPCC) In CTMUHB

Discussion *Julie Denley, Deputy Chief Operating Officer (Primary Care, Community, Mental Health and Learning Disabilities)*

6.9 Peer Review of Urgent Primary Care (OOH and UPCC) In CTMUHB.doc.pdf (12 pages)

6.10.
Ward Based Nursing Assurance Report

Discussion *Becky Gammon, Head of Nursing Professional Standards & Education*

6.10 Ward Based Nursing Assurance Report.pdf (6 pages)

6.11.
Welsh Ambulance Services NHS Trust Patient Experience Report

Greg Dix, Executive Nurse Director

Verbal Update

09:00 - 09:00
0 min

7.
ANY OTHER BUSINESS

Discussion *Jayne Sadgrove, Vice Chair (Chair of the Committee)*

7.1.
Highlight Report to Board

Jayne Sadgrove, Vice Chair (Chair of the Committee)

7.2.
How did we do in this meeting

Discussion *Jayne Sadgrove, Vice Chair (Chair of the Committee)*

09:00 - 09:00
0 min

8.
DATE AND TIME OF NEXT MEETING - TUESDAY 24 JANUARY 2023 AT 1.30PM

09:00 - 09:00
0 min

9.
CLOSE OF MEETING

Agenda Item Number: 3.1.1

Minutes of the Meeting of Cwm Taf Morgannwg University (CTMUHB) Quality & Safety Committee held on the 20 September 2022 as a Virtual Meeting via Microsoft Teams

Members Present:

Jayne Sadgrove	Independent Member (Chair)
James Hehir	Independent Member
Nicola Milligan	Independent Member
Dilys Jouvenat	Independent Member
Carolyn Donoghue	Independent Member
Patsy Roseblade	Independent Member

In Attendance:

Debbie Bennion	Deputy Director of Nursing
Louise Mann	Assistant Director of Quality & Safety
Emrys Elias	Health Board Chair
Gethin Hughes	Chief Operating Officer
Georgina Galletly	Director of Corporate Governance
Dom Hurford	Executive Medical Director
Hywel Daniel	Executive Director for People
Julie Denley	Director of Primary, Community & Mental Health Services
Nicola Bresner	Healthcare Inspectorate Wales
Rhys Jones	Healthcare Inspectorate Wales
Ana Llewellyn	Nurse Director, Bridgend Integrated Locality Group
Claire Appleton	Head of Quality & Patient Safety
Jane Armstrong	Clinical Director of Primary Care
Suzanne Hardacre	Director of Midwifery
Shelina Jetha	Maternity & Neonates Improvement Programme Manager
Sallie Davies	Deputy Medical Director
Shane Mills	Clinical Director for Collaborative Commissioning (In part)
Robert Foley	Head of Operational Flow
Richard Hughes	Nurse Director, Merthyr & Cynon ILG
Gaynor Jones	RCN Convenor
Lauren Edwards	Executive Director of Therapies & Health Sciences
Chris Beadle	Head of Operational Health, Safety & Fire
Emma Samways	Internal Audit
Stephanie Muir	Head of Legal Services (In part)
Emma Walters	Corporate Governance Manager (Committee Secretariat)

Agenda Item

1.0 PRELIMINARY MATTERS

1.1 Welcome & Introductions

In opening the meeting, the Committee Chair provided a bilingual welcome to all those present, particularly those joining for the first time, those observing

and colleagues joining for specific agenda items. The format of the proceedings in its virtual form were also noted by the Chair.

1.2 Apologies for Absence

Apologies for absence were received from:

- Kelechi Nnoaham, Executive Director of Public Health;
- Greg Dix, Executive Director of Nursing;
- Carole Tookey, Nurse Director, Rhondda Taf Ely Integrated Locality Group

1.3 Declarations of Interest

No interests were declared

2.0 SHARED LISTENING AND LEARING

2.1 Patient Experience Story

Mr Foley shared a patient story with Members that related to the care that had been given to his wife.

The Committee Chair extended thanks from Committee Members to Mr & Mrs Foley for sharing their story and sought clarity as to whether the couple made a complaint in relation to the treatment received. Mr Foley advised that whilst they had chosen not to make a formal complaint, they had highlighted their poor service experience with a view to wanting to influence improvements that could be made in particular to changes made to facilities for gynaecology assessments.

The Committee Chair stated that the issues relating to the Gynaecology Day Assessment Unit had been a cause for concern for the Committee for some time and therefore it was positive to hear of the improvements that had been put into place to improve the care and experience women received and noted the learning from this would now be rolled-out further.

S Hardacre advised Members that the Independent Maternity Services Oversight Panel had recently visited the Health Board and were assured by the improvements that had been made. D Hurford expressed his regret regarding the experience this couple had received which demonstrated the importance of procedures being followed and effective timely empathetic communication with patients. J Hehir welcomed the patient story and advised that it was important for the Committee to hear these stories especially where something positive had been achieved.

G Hughes expressed the importance of hearing the voice of patients and their experiences so that such information could be triangulated using feedback provided by staff, and data from complaints and incidents etc. to drive service improvement and influence the provision of services in the future.

G Galletly suggested that the Committee may find it helpful to receive an update at a future meeting regarding the new system (CIVICA) put into place to support and improve the patient experience.

Members noted that the Patient Advice Liaison Service model was in the process of being reviewed which would also help to capture patient stories more effectively.

The Committee Chair stated that whilst the story, which related to events in 2020, had identified issues with medication errors, poor communication and lack of care and dignity, it was pleasing to note improvements had in the meantime been made and that further work would be undertaken to continue to address these important issues.

The Committee Chair requested an update at the next meeting as to the processes that had been put into place for women who were experiencing ectopic pregnancies to ensure they were receiving the required care at the most appropriate time.

The Committee Chair reiterated her personal thanks to Mr Foley and his wife for allowing this story to be shared and advised that a letter formally thanking them would follow.

Resolution: The Patient Story was **NOTED.**

Action: Update to be presented at a future meeting in relation to the new CIVICA model.

Action: Update to be presented to the next meeting as to what processes were in place for women who were experiencing ectopic pregnancies to ensure they were receiving the care needed at the most appropriate time.

3 CONSENT AGENDA

The Committee Chair invited D Jouvenat to address the Committee regarding the point she had raised prior to the meeting in relation to the Equality Impact Assessment *(EIA)* process which was an integral part of the content of the report template for Board and Board Committee meetings.

D Jouvenat advised that the report template required identification of whether an EIA had been required (and if so to provide a link to this) and for those instances where it was not required, the reason for this should be set out in this section of the cover report. D Jouvenat went onto say that the only report on the consent agenda that identified no EIA was required was the Annual Cycle of Business and that she was sure this issue was not particular to this Committee.

The Committee Chair concurred that work was required to improve the recording of this issue within reports and sought clarity as to how further assurance could be provided that due process had been followed. H Daniel concurred that a review was required so that staff were aware of what was required. G Galletly added that there was also an opportunity for workforce colleagues to provide

such detail via the report writing sessions training sessions that had been put into place.

The Committee Chair advised that she expected to see improved attention to the completion of the EIA section in future reports.

The Committee Chair raised the following points in relation to items that had been placed on the consent agenda:

- **3.2.5 Transition and Handover from Children to Adults Health Services –** It was important that the Committee noted the transition which was an important change and had the potential to address a long standing issue. The Committee Chair advised that she looked forward to hearing how this progressed;
- **3.2.6 Welsh Ambulance Services NHS Trust Patient Experience Report –** Noted that a discussion would be held on this matter in more detail later in the meeting. The Committee Chair advised that any ambulance that became 'stuck in the system' was more likely to be unavailable for a significant period;
- **3.1.7 Quality Governance Regulatory Review Recommendations and Progress Updates –** The Committee Chair welcomed the report and advised that she was always keen to see the learning gained from inspections being shared across the whole of the service following the introduction of the new Operating Model structures;
- **3.2.9 Thematic Review of the Feedback received from the Community Health Council on primary care responsiveness –** The Committee Chair welcomed the report which she had found to be excellent and added that it had clearly set out the new standards which Primary Care colleagues were expected to meet. The Committee Chair advised that she looked forward the seeing the changes that these standards were expected to produce in terms of patient access despite challenges in service provision remaining.

3.0 For Approval/Noting

3.1.1 Unconfirmed Minutes of the Meeting held on the 19 July 2022

Resolution: The minutes were **APPROVED** as a true and accurate record.

3.1.2 Unconfirmed Minutes of the In Committee Meeting held on the 27 July 2022

Resolution: The minutes were **APPROVED** as a true and accurate record.

3.1.3 Estates Policy – PAT Testing Policy

Resolution: The PAT Testing Policy was **APPROVED**.

3.2.1 Committee Action Log

Resolution: The Action Log was **NOTED**.

3.2.2 Committee Annual Cycle of Business

Resolution: The Report was **NOTED**.

3.2.3 Quality & Safety Committee Forward Work Programme

Resolution: The Forward Work Programme was **NOTED**.

3.2.4 WHSSC Quality & Patient Safety Committee Chairs Report

Resolution: The Report was **NOTED**.

3.2.5 Transition and Handover from Children to Adults Health Services

Resolution: The Report was **NOTED**.

3.2.6 Welsh Ambulance Services NHS Trust Patient Experience Report

Resolution: The report was **NOTED**.

3.2.7 Quality Governance – Regulatory Review Recommendations and Progress Updates

Resolution: The report was **NOTED**.

3.2.8 Radiation Safety Committee Highlight Report

Resolution: The report was **NOTED**.

3.2.9 Thematic Review of the feedback received from the Community Health Council - Primary Care

Resolution: The report was **NOTED**.

3.2.10 CTMUHB Nosocomial Covid 19 Incident Management Programme

Resolution: The report was **NOTED**.

3.2.11 Progress Report following Internal Audit on Concerns & Welsh Risk Pool Review on Claims/Redress/Inquests

Resolution: The report was **NOTED**.

4. MAIN AGENDA

4.1 Matters Arising not considered within the Action Log

There were no further matters arising identified.

5. GOVERNANCE

5.1 Organisational Risk Register – Risk Assigned to the Quality & Safety Committee

G Galletly presented the report.

P Roseblade made reference to Risk 4632 and advised that she felt concerned at the closure and amalgamation of some of the risks relating to stroke services and the proposed development of a new improvement plan which involved further task and finish groups. P Roseblade also advised that although she recognised that the structure was changing, assurance was required that the stroke service provided remained consistent whilst improvements were being made. P Roseblade also expressed concern in relation to the patients with suspected stroke who were waiting excessive amounts of time and sought clarity as to what steps were being taken to address this.

In her role as the executive lead for stroke services, L Edwards advised that there was a Stroke Services Progress report later in the agenda and suggested that these issues be addressed as part of that agenda item. The Committee Chair concurred with this suggestion.

In reference to Risk 5214, P Roseblade sought clarity as to whether there was funding for middle grade doctors or whether there was an inability to recruit into such posts. D Hurford advised that the Intensive Care Unit at the Princess of Wales Hospital had been consultant-led and, with a view to changing this workforce model to one that was more sustainable, funding had been identified to address this. This funding was being used to enable a recruitment drive and D Hurford added that he was confident this would result in around half of the current vacancies being filled which would certainly help the overall position.

P Roseblade made reference to the risk relating to laundry services and asked as to the current status of this service which had previously been due to transfer to Shared Services. G Hughes stated that he did not have this detail to hand and suggested he provided an update outside of the meeting.

N Milligan made reference to Risk 4149 which related to CAMHS and was last updated in June 2022. N Milligan advised that it would be helpful to have a more recent position regarding the impact of the work that had been undertaken in relation to Waiting List Initiatives and additional clinics. A Llewellyn stated that she would provide this following the meeting.

N Milligan made reference to Risk 4512 which related to mental health and sought clarity as to whether an update had now been received from the Deputy

Chief Operating Officer. N Milligan also advised that the risk description stated that the mitigations were 'working well' and sought further detail in this regard. J Denley agreed to share – an update outside the meeting.

C Donoghue made reference to Risk 4479 which related to the decontamination facilities and noted that the update dated June 2022 stated that Joint Advisory Group (JAG) had agreed to extend the accreditation as a result. C Donoghue said that it would be helpful to receive an update on the position. G Hughes advised that a Business Case relating to this was in the process of being developed for presentation to the January 2023 Board meeting for onward consideration by Welsh Government and undertook to include future updates as part of his report.

C Donoghue made reference to risk 4152 which related to reduced imaging capacity and referenced a business case being developed to help address this. G Hughes advised that he would ensure that the risk register was updated outside the meeting and added that investments had been made into imaging capacity and that a regional piece of work was being undertaken in relation to developing a regional community diagnostic service to augment current provision. G Hughes added that work was also underway with a view to balancing waiting time across each of CTM's acute hospital sites.

C Donoghue advised that she was concerned regarding the time that may be incurred in reassigning risks to the new Care Group Model. G Galletly provided assurance that work had already commenced with a projected date for this task being completed being January 2023.

J Hehir made a declaration at this point and advised that he was a Non-Executive Director of Llandarcy Park Ltd. J Hehir stated that the company was working to provide an MRI scanner for Elite Sports, with any extra capacity being allocated to the NHS.

The Committee welcomed the report and the scrutiny that had been undertaken by Members of the Risk Register.

Resolution: The report was **NOTED**

Action: Responses to the queries raised against a number of risks to be shared with Members outside the meeting

Action: Update on progress being made on JAG accreditation to be included in future iterations of the Chief Operating Officer's report.

5.2 Covid 19 Inquiry Preparedness

G Galletly presented the report. Members noted there was a risk in relation to resourcing this piece of work, given the recent departure of the current post holder but that steps were being taken to mitigate the risk this posed.

Resolution: The report was **NOTED.**

5.3 Assurance on the Health Board's plan to improve monitoring and reporting in relation to Continuing Healthcare (CHC) and Funded Nursing Care (FNC) activity.

A Llewellyn presented the report.

P Roseblade expressed sadness that the report had an underlying tone of the financial issues. The Committee Chair concurred commenting that it was important to remember the care of patients remained paramount.

C Donoghue made reference to section 2.13 in the appendix to the report and sought clarity as to the nature of the concerns that had been raised by local authorities in Wales. C Donoghue stated that there were a number of references within the report that she did not understand and indicated that she was content to discuss these further with A Llewellyn outside the meeting.

A Llewellyn advised that in relation to the main source of concerns, the Children's Continuing Care Framework, which was not unique to CTMUHB, the requirements of the Scheme of (financial) Delegation meant that certain aspects of care packages required panel approval. Members noted that through the Regional Partnerships Board, a Multi-Agency Group was in the process of reviewing existing frameworks. A Llewellyn added that the main concerns expressed related to the Children's Continuing Healthcare Framework which required integrated boards within local authorities.

G Hughes advised that there was a need to ensure the care could be provided to patients in a sustainable way. Members noted that an exponential growth was being seen in CHC and FNC providers and there was an awareness that patient care would need to change over a period of time. Members noted that assessments were being undertaken on patients who were being discharged from acute hospital environments with ongoing evaluations being undertaken as to whether the correct packages were in place.

A Llewellyn thanked Committee Members for their reflections on the report and advised that she would welcome a discussion with P Roseblade outside the meeting with a view to ensuring the voice of patients and families were reflected within future iterations of the report. With regard to the frequency of future reports on this issue, the Committee Chair requested a further report be presented to the November 2022 meeting which would help Members determine the interval for future updates.

In response to a question raised by E Elias as to whether the experiences were the same for Section 117 (of the Mental Health Act which required the provision of aftercare), A Llewellyn advised that this was an area that would need to be reviewed going forward.

J Hehir advised that in relation to transitioning from children to adult services, the Committee would need to be sighted on the work being undertaken to

provide ongoing care which could vary over time and would require joint working with local authorities.

Resolution: The report was **NOTED.**

Action: Further report to be presented to the November 2022 meeting so that a decision could be made in relation to frequency of future reporting to the Committee.

5.4 Annual Letter 2021/2022 – Public Services Ombudsman for Wales

S Muir presented the report.

Resolution: The report was **NOTED**.

6. IMPROVING CARE

6.1 NCCU Quality Assessment and Improvement Service - Annual Quality position statement

S Mills presented the report.

J Sadgrove stated that the report contained a lot of useful information. The Committee Chair stated that the learning disabilities aspect of the report had been an area of particular interest for Ministers over recent years.

The Committee Chair asked if there was more that could be done in Wales to ensure patients were placed as close to home as possible. S Mills stated that it was important that patients had a pathway so that they could be placed as close to home as possible and care co-ordinators were key in this regard.

E Elias noted that there were reductions in the length of stay for medium secure services and increased demand in other parts of the service which could lead to patients being cared for in the wrong place. S Mills referenced one of the limiting factors as the state of mental health facilities. E Elias stated that he would raise the importance of such patients being cared for the most appropriate facilities with his fellow Health Board Chairs and J Sadgrove undertook to do the same via the Vice Chair's network.

J Sadgrove referenced the increased commissioning demand for Welsh residents under the care home framework. S Mills advised that this was not new demand but reflected the level of people joining the national framework which was attractive as it provided both contracting and quality assurance strengths.

J Denley stated that the framework which was in place across Wales enabled better discussions to be held as to what services were required across the principality and also enabled patients to be tracked within the system which in turn allowed their care to be better managed.

G Hughes commented that it was important that there was a clear discharge plan in place for patients so it was easier to bring patients back to receive care more locally and asked as to the quality assurance plans in place via the framework. S Mills stated that there was a robust quality assurance process in

place and this was fed back locally to health boards and undertook to include information about this in the next iteration of his report.

G Hughes undertook to speak to Linda Prosser, Executive Director of Strategy & Transformation regarding the best means of supporting regional planning input.

J Sadgrove thanked S Mills for his report which had generated an important discussion.

Resolution: The report was **NOTED.**

6.2 Maternity & Neonates Services Improvement Programme Highlight Report

S Hardacre presented the report.

J Sadgrove referenced the patient story at the start of the meeting and asked what steps were being taken to improve communication. S Hardacre responded that communication has improved greatly and referenced various pieces of work that were in train which included streamlining the care pathway and reducing Emergency Department waiting times. S Hardacre undertook to verify the position as regards scanning facilities for patients presenting at weekends. S Hardacre stated that senior nurses were championing improved communication with staff being offered teaching to improve the environment of care. S Davies stated that it was evident from feedback that communication had improved and that patients and their families were also being involved in discussions where incidents had occurred so that their experience could be captured after the event. Systems were also producing real time feedback.

G Hughes asked how patient stories like the Committee had heard at the beginning of the meeting were being used for staff training. S Hardacre advised that service group Quality & Safety meetings began with a patient story and that the learning from such stories was being channelled into audit and governance meetings and the seven minute briefings. S Davies undertook to consider what other ways the stories could be used to best effect.

With reference to Neonates, S Davies stated that the report showed the level of improvement realised in terms of submitting evidence. S Davies added that the team performed very well at a recent the Safety Summit which was very well received by all who attended including Welsh Government colleagues.

S Davies stated that much work had been undertaken to change attitudes and culture and that the changes to care and treatment were now embedded into daily practice. Whilst acknowledging that the events that had been put before the Committee today via the patient story had taken place in 2020, J Sadgrove stated that there was nevertheless a need for constant need vigilance of service quality.

D Hurford stated that it would also be important to reflect the learning from the changes in maternity and neonatal services to other specialties across CTMUHB.

J Sadgrove concurred commenting that this was why the learning organisation approach being taken by CTMUHB was vital.

S Hardacre referenced data that had been presented at a recent governance meeting explaining that such intelligence was enabling clinical staff to look critically at performance and address anomalies.

N Milligan referenced pages 27 and 28 of the report which stated that communication and professional attitude remained the top two themes of complaints. N Milligan stated that she was aware that S Hardacre had sent a letter to midwifery staff around this and asked whether the same letter would now be sent to medical staff too. S Davies and D Hurford agreed that this should be the case. S Hardacre advised that birth right sessions taking place in next few weeks would be multi-professional in terms of the participants.

The Committee Chair thanked colleagues for the informative report.

Resolution: The report was **NOTED.**

6.3 Ty Llidiard Progress Report

L Edwards presented the report.

J Sadgrove sought an update as to therapist recruitment. L Edwards advised that the clinical lead had now been appointed as had activity co-ordinators and progress was being made with regard to other specialist posts.

D Jouvenat thanked Lauren and Ana for attending Welsh Health Specialised Services Committee's (WHSSC) Quality & Safety meeting recently to provide an update on Ty Llidiard which had been very positively received.

C Donoghue noted that a small number of young people had been admitted to Ty Llidiard as no Psychiatric Intensive Care Beds were available. A Llewellyn stated that staff had managed the situation well.

J Hehir commented that he was pleased to note the team were reaching out to families and patients to help inform future service design which showed they had growing confidence in services.

The Committee Chair encouraged Board Member colleagues to arrange a visit to Ty Llidard so that they could see for themselves the good work that was underway.

Resolution: The report was **NOTED**

6.4 Quality Dashboard

L Mann presented the report.

C Donoghue noted that on page 11 with regard to medication incidents there was reference to the establishment of a community pharmacy forum. D Hurford advised that he would be able to provide further information regarding this outside the meeting.

P Roseblade reference the Datix system not permitting updates to patient safety incidents and queried whether the system was therefore producing accurate reports. L Mann advised that there was an issue with the system in that it was currently only permitting certain staff tiers to update incident reports and this would therefore require some retrospective work once system permissions were revised. L Mann stated that details regard the steps being taken would be addressed in the next iteration of this report.

R Hughes advised that work was underway to review systems in light of the new operating model and this was feeding into the six goals workshop with a view to making it as easy as possible to engage with and comply with internal governance arrangements as well as those with partner organisations and professional groups. This would ensure the organisation was operating as safely as possible during the transition period.

In response to a question from N Milligan, R Hughes advised that the local improvement forums in the Emergency Departments would evolve over coming weeks and would be formally minuted and link-in with general quality governance within care groups. R Hughes advised that the goal was to empower local teams.

The Committee Chair thanked colleagues for the report.

Resolution: The report was **NOTED**.

6.5 Report from the Chief Operating Officer

G Hughes presented the report.

Members noted that cancer service performance and reducing the backlog in a number of tumour sites remained a key focus. Members noted that the urology and lower gastrointestinal pathways remained the two areas of particular pressure and that aspects of pathology were being outsourced to support diagnostic elements of pathways as well as additional urology clinics being put into place.

G Hughes advised that a significant proportion of Bowel Screening Wales patients were being referred at 60 or more days. Members noted that a single pathway of management of colorectal patients was now in place, with more patients being treated each month.

J Hehir sought clarity as to what extent the backlog recovery was being affected by patients presenting with more advanced stages of their diseases. G Hughes advised that it was too early to provide a view on this and added that this would be something that the team could look to review this moving forward.

P Roseblade made reference to the 'red release' bed performance, particularly at Princess of Wales Hospital and also sought clarity as to whether a review and assessment was being undertaken of the Amber 1's that were not accepted. G Hughes advised that whilst the performance data for August 2022 had indicated an improvement, there had been some challenges during September. Members noted that patients at the Princess of Wales Hospital were more likely to experience a delay in discharge compared with patients at the Royal Glamorgan and Prince Charles Hospitals and this was being reviewed so that the issues could be addressed. In relation to the query raised regarding Amber 1 performance, G Hughes confirmed that this data was being discussed at the Unscheduled Care Group meetings and colleagues were engaging with the Welsh Ambulance Services NHS Trust via the 6 Goals Programme in this regard. Data was therefore driving change via a system approach.

The Committee Chair extended her thanks to G Hughes for his report and suggested that this be placed earlier in the agenda for the next meeting if possible.

Resolution: The report was **NOTED.**

6.6 Primary Care Quality & Safety Report

J Armstrong presented the report.

The Committee Chair extended her thanks to the GP Out of Hours Team for the resilience they had shown in addressing the IT issues that had recently been experienced. G Hughes reiterated the thanks expressed by the Committee Chair and advised that the Team had worked incredibly hard to address the outage issues and in particular the dedication of Martine Randall was highlighted. The Committee Chair asked that a letter be sent to the Team to express the Committee's thanks.

In response to a question raised by N Milligan regarding the dental practice in Merthyr Tydfil that was no longer accepting NHS patients. J Armstrong agreed to confirm whether letters had been sent out to patients advising them of which dental practices they had been allocated to and an update would be provided outside the meeting.

Resolution: The report was **NOTED.**

Action: Committee Chair to write to the Out-of-Hours Team extending the Committee's thanks for the work they had undertaken to address the IT outage issues.

Action: Confirmation to be provided outside the meeting as to whether letters had been sent to patients advising them of which dental practices they had been allocated to.

6.7 Stroke Services Progress Report

L Edwards presented the report.

P Roseblade sought clarity regarding the process for patients presenting at the Royal Glamorgan Hospital who may need thrombolysis given this site did not have specialist stroke facilities. D Hurford reassured Members that thrombolysis was administered across all three district general hospital sites, although Emergency Department staff at the Royal Glamorgan site needed to liaise with colleagues at Prince Charles Hospital in order to provide this drug treatment following a scan. P Roseblade welcomed the response provided. Members also noted that it has not been possible to recruit additional support to expand the rota which currently consisted of two stroke consultants based at the Princess of Wales and Prince Charles Hospitals. As a result discussions were ongoing with Cardiff and Vale colleagues to develop a joint rota to support CTMUHB's two Stroke Consultants.

N Milligan made reference to the graph on page 11 of the report which related to 'door to needle times' and sought clarity as to how performance could vary from 70% to 20% for such small numbers of patients. D Hurford advised that this was linked to Emergency Department pressures and a 'hot reporting system' was being put into place to speed-up the process. In response to a question raised by the Committee Chair, D Hurford confirmed that there was no variation in relation to weekends.

The Committee Chair advised that the Committee looked forward to receiving a progress report in six months.

Resolution: The report was **NOTED.**

6.8 Infection, Prevention & Control Committee Highlight Report

D Bennion presented the report which highlighted one matter for escalation which related to the risk of losing JAG accreditation.

Resolution: The report was **NOTED.**

7. ANY OTHER BUSINESS

There was no other business to report.

8. HOW DID WE DO IN THIS MEETING TODAY?

The Committee Chair advised that she would be happy to receive comments outside the meeting as to how Members felt the meeting went today. The Chair advised that further reflection was required as to the number of items contained on the agenda to ensure that items receive adequate discussion.

9. DATE AND TIME OF THE NEXT MEETING

The next meeting would take place at 9am on Tuesday 15 November 2022.

Agenda Item Number: 3.1.2

Minutes of the Meeting of Cwm Taf Morgannwg University (CTMUHB) Quality & Safety In Committee held on the 11 October 2022 as a Virtual Meeting via Microsoft Teams

Members Present:

Jayne Sadgrove	Independent Member (Chair)
James Hehir	Independent Member
Nicola Milligan	Independent Member
Carolyn Donoghue	Independent Member
Patsy Roseblade	Independent Member

In Attendance:

Greg Dix	Executive Nurse Director
Georgina Galletly	Director of Corporate Governance
Louise Mann	Assistant Director Quality & Safety
Dom Hurford	Medical Director
Carl Verrecchia	Director of Operations, Bridgend ILG
Chris Beadle	Head of Health, Safety & Fire
Sarah Fox	Maternity
Myscha Dean	Maternity
Gethin Hughes	Chief Operating Officer
Lauren Edwards	Director of Therapies & Health Sciences
Stephanie Muir	Assistant Director, Concerns & Claims
Emma Walters	Corporate Governance Manager (Committee Secretariat)

Agenda Item

1 PRELIMINARY MATTERS

1.1 Welcome & Introductions

The Chair **welcomed** everyone to the In Committee meeting of the Quality & Safety Committee.

1.2 Apologies for Absence

Apologies for absence were received from:

- Dilys Jouvenat, Independent Member
- Ana Llewellyn, Nurse Director, Bridgend Locality

1.3 Declarations of Interest

No declarations of Interest were received prior to the meeting.

2 MAIN AGENDA

2.1 Patient Falls and Absconsions: Lessons Learnt Report

C Verrecchia and L Mann presented the report.

Following discussion, the Committee Chair asked Committee Members to relay any comments or observations arising from today's report in order that this could be fed into the next iteration of the report which would be further considered by the Committee at its next In Committee meeting.

Resolution: The Report was **NOTED**.

2.1.1 Stillbirth Thematic Review 2021

Myscha Dean presented the report.

The Committee Chair extended thanks to colleagues for the report providing evidence that stillbirths were continuing to be reported openly and accurately which provided the Committee with the necessary assurances in this regard.

Resolution: The report was **NOTED**.

3. ANY OTHER BUSINESS

There was none.

4. DATE AND TIME OF THE NEXT MEETING

The next In Committee meeting would take place on Thursday 17 November 2022 at 9:30am.

AGENDA ITEM
3.1.3

QUALITY & SAFETY COMMITTEE

QUALITY & SAFETY COMMITTEE TERMS OF REFERENCE (STANDING ORDERS SCHEDULE 3.8)

Date of meeting	15/11/2022
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	CallyHamblyn, Assistant Director of Governance & Risk
Presented by	Cally Hamblyn, Assistant Director of Governance & Risk
Approving Executive Sponsor	Director of Corporate Governance
Report purpose	ENDORSE FOR BOARD APPROVAL

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Quality & Safety Committee Members via email.	12.10.2022	COMMENTS RECEIVED

ACRONYMS	
SO's	Standing Orders

1. SITUATION/BACKGROUND

1.1 The Cwm Taf Morgannwg University Health Board Standing Orders form the basis upon which the Health Board's governance and accountability framework is developed and, together with the adoption of the Health Boards Standards of Behaviour Policy is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.

1.2 All Health Board members and officers must be aware of the SOs and, where appropriate, should be familiar with their detailed content.

1.3 The Quality & Safety Committee Terms of Reference form schedule 3.8 of the Standing Orders and the purpose of the paper is to consider their accuracy as required by an annual review.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.2 **Standing Orders – Schedule 3.8 Quality & Safety Committee Terms of Reference**
The Terms of Reference are included at Appendix 1. Proposed changes are identified in red.

The Terms of Reference were shared with Committee Members and Attendees outside the meeting and amendments made as appropriate.

It was noted that the Community Health Council representation at the meeting may require review once the Citizens Voice Body comes into force in April 2023.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 If endorsed for approval the amendments will be received for approval at the Health Board meeting in November 2022.

3.2 The Standing Orders will be further strengthened in year as and when required.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	Compliance with the SO's support robust quality governance arrangements.
Related Health and Care standard(s)	Governance, Leadership and Accountability
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	If no, please provide reasons why an EIA was not considered to be required in the box below.
	Not required.

Legal implications / impact	No
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

5.1 The Committee is asked to **ENDORSE FOR BOARD APPROVAL**

- The amendments to the Quality & Safety Committee Terms of Reference as outlined in section 2 of this report.

Schedule 3.8

BOARD COMMITTEE ARRANGEMENTS

This Schedule forms part of, and shall have effect as if incorporated in the University Health Board Standing Orders

QUALITY & SAFETY COMMITTEE

TERMS OF REFERENCE & OPERATING ARRANGEMENTS

Review October 2022 for receiving at the November 2022 Q&S Committee

INTRODUCTION

The Cwm Taf Morgannwg University Health Board (CTMUHB) standing orders provide that "The Board may and, where directed by the Welsh Government must, appoint Committees of the UHB either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by Committees".

In accordance with Standing Orders (and the CTMUHB scheme of delegation), the Board shall nominate annually a committee to be known as the **Quality and Safety Committee**. The detailed terms of reference and operating arrangements set by the Board in respect of this committee are set out below.

~~*The term locality team, when used within this document, is to describe out of district general hospital services e.g. Community (in and out of hospital) and Independent Contractor services (GPs, Dentists, Pharmacists and Optometrists).*~~

CONSTITUTION & PURPOSE

The purpose of the Quality and Safety Committee "the Committee" is to provide assurance to the Board on the provision of workplace health & safety and safe and high quality care to the population we serve, including prevention through public health, primary and secondary care. The Committee embraces the values of the Health Board and the objectives outlined within its Integrated Medium Term Plan (IMTP) which are:

- To **improve** quality, safety and patient experience.
- To **protect** and **improve** population health.
- To **ensure** that the services provided are accessible and sustainable into the future.
- To **provide** strong governance and assurance.
- To **ensure** good value based care and treatment for our patients in line with the resources made available to the Health Board.

The Committee will:

- Put the needs of patients, carers and the public at the centre of all its business.
- Ensure appropriate arrangements are in place to support workplace health & safety.

- Provide evidence based and timely advice to the Board, based on local need, to assist in discharging its functions and meeting its responsibilities.
- Provide assurance to the Board in relation to the CTMUHB's arrangements for safeguarding the public and continuously improving the quality and safety of the services we provide.
- Ensure that care is delivered in accordance with the Health & Care Standards for Health Services in Wales.

SCOPE AND DUTIES

SCOPE:
In order to deliver its stated aims the Committee will, in respect of its provision of advice to the Board:

- Oversee the development of the CTMUHB's strategies and plans for the development and delivery of high quality, staff safety, patient safety and public health, consistent with the Board's overall strategic direction.
- Provide strategic direction and scrutiny for the development of the UHB's corporate strategies and plans for those of its stakeholders and partners.
- To receive high level reports and recommendations from external bodies and ensure robust action is taken, monitored and fully implemented.

The Committee will seek assurances from the sub groups established by the Quality and Safety Committee (Appendix 1) that arrangements are appropriately designed and operating effectively, to ensure the provision of high quality, safe and effective healthcare and workplace health & safety across the whole of the CTMUHB's primary, community and secondary care activities.

DUTIES:
To deliver its aims, the Committee's programme of work will be structured as follows:

Strategy

- Oversee and monitor the development and implementation of the UHB's Strategies for patient quality and safety and staff workplace health & safety:
    - **Patient Quality and Safety**
        - Provide assurance to Board on implementation of the Quality aspects within the Integrated Medium Term Plan (IMTP) for CTMUHB
        - Provide assurance to the Board in relation to the Quality Governance Framework.

        - Contribute to and oversee the development of the Health Board's Annual Quality Statement
        - Monitor quality via the Quality Dashboard
        - Approve the content of the CTMUHB Annual Quality Statement which relates to the committees work programme
    - **Workplace Health & Safety**
        - Provide assurance to Board on the development of related strategies and operating practices to ensure arrangements for staff workplace health & safety are safe and in compliance with associated legislation.
- Monitor and receive reports on the organisation's progress with embedding and implementing the Health & Care Standards
- Scrutinise Quality and Safety arrangements for the Independent Contractor Professions
- Ensure that the organisation, at all levels, has the right systems and processes in place to deliver - from a patient's perspective - efficient, effective, timely and safe services
- Ensure arrangements are in place to undertake, review and act on Clinical Audit activity which responds to National and Local priorities
- Receive recommendations made by internal and external review bodies, ensuring where appropriate, that action is taken in response;
- Receive assurance that the organisation protects the health of the population, by promoting delivery and uptake of screening and immunisation programmes
- Receive assurance that the organisation has robust infection, prevention and control measures in place.

Hosted Bodies

The Committee will also consider issues in respect of the roles and responsibilities of Committees hosted by the UHB namely, Emergency Ambulance Services Committee, Welsh Health Specialised Services Committee and the National Imaging Academy, as appropriate. The Committee will consider any quality and safety issues associated with services commissioned for Cwm Taf Morgannwg residents and those services provided by Cwm Taf Morgannwg UHB.

Organisational Risk

- Monitor the arrangements in place to assess, control and minimise risk and
    - Regularly review the high and extreme risks included on the organisational Risk Register and assigned to the Committee by the Board;

Policies and Procedures

- Approve appropriate Policies (once reviewed and endorsed by the appropriate sub group) and where appropriate any related Procedures.
- Oversee the register of policies, ensuring that it is maintained, and that all assigned policies are subject to review at least every three years.

Research & Development

- Receive reports on progress with Research & Development activity within the organisation. These will:
  - Take into account the national objectives published by ~~National Institute for Social Care and Health Research (NISCHR)~~ Health and Care Research Wales.
  - Focus on the outcomes for patients and compliance with Research Risk Governance arrangements.

Quality Improvement activities

The Quality Governance Framework provides the framework for quality improvement projects. The Quality and Safety Committee will:

- Receive regular reports on progress with delivery of its priorities relating to quality improvement.
- Receive at each meeting a Quality Report and Quality and Performance Dashboard – Receive, scrutinise and triangulate quality information to ensure appropriate prioritisation for improvement.

Patient Experience

- Receive and review progress reports relating to the requirements identified in the UHB Patient Experience Plan.
- Receive and review reports on the progress relating to the implementation of the Citizen Engagement Plan.

Concerns

- Receive as presented within the quarterly quality report, reports on Concerns (reported patient safety incidents, complaints, compliments, clinical negligence claims and inquests) reporting trends, with particular emphasis on ensuring that lessons are learnt, and to inform the Annual Quality Delivery Plan
- Receive assurance of effective and timely management of concerns across the University Health Board
- Receive, review and approve the Annual Concerns Report on behalf of the UHB.

Staff Experience

- Receive assurance that there are appropriate systems in place to support workplace health & safety and to listen to staff views, embracing the principles of the Listening Organisation, in order to promote effective team working and staff satisfaction to provide the best possible outcomes for patients.
- Receive assurance that the workforce is appropriately selected, trained and responsive to the needs of the service, and that professional standards and registration/revalidation requirements are maintained.

DELEGATED POWERS

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 its organisation.

AUTHORITY

The Committee is authorised by the Board to:

- Investigate or have investigated any activity 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
    - Any other committee, or group set up by the Board to assist in the delivery of its functions.

- 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

- approve policies relevant to the business of the Committee as delegated by the Board.

Sub Committees

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.

The Quality & Safety Committee has established the following sub-committee:

- Health, Safety and Fire Sub Committee

This Sub Committee supports the Health Boards statutory obligation by virtue of the Health and Safety at Work etc. Act 1974 (Section two sub-section seven) to establish and maintain a Health and Safety Committee*: "it shall be the duty of every employer to establish in accordance with Regulations (i) a safety committee having the function of keeping under review measures taken to ensure the health and safety of his employees and such other functions as prescribed".*

ACCESS

The Chair of the Committee shall have reasonable access to Executive Directors and other relevant senior staff.

MEMBERSHIP

Members:

A minimum of **(6)** members, comprising

Chair	Independent Member of the Board
Vice Chair	Independent Member of the Board
Members	Four Independent Members of the Board

Attendees

- Executive Nurse Director
- Medical Director
- Director of Public Health
- Director of Therapies and Health Sciences
- Executive Director of Operations
- Director of Governance / Board Secretary
- Community Health Council Representative
- Executive Director for People
- ~~Integrated Locality~~ Care Group Director representation
- Staff side representative
- Staff side safety chair or vice chair

Notwithstanding the requirement to maintain quorum, Directors may on occasion nominate a suitably senior deputy to attend the Committee on their behalf, but should ensure that they are fully aware and briefed on the issues to be discussed.

By Invitation:

- Other Directors / Health Board Officers may be invited to attend when the Committee is discussing areas of risk or operation that are the responsibility of that Director.

- The Committee may also co-opt additional independent external members from outside the organisation to provide specialist skills, knowledge and experience.

Secretariat

The Director of Governance / Board Secretary will determine the secretarial and support arrangements for the Committee.

Member Appointments

The membership of the Committee shall be determined by the Chair 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.

Members shall be appointed for a maximum of 3 consecutive years before formally reviewing their role on the Committee. During this time a member may resign or be removed by the Board.

The Board shall ensure succession planning arrangements are in place.

Support to Committee Members

The Director of Governance / 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

- Co-ordinate the provision of a programme of organisational development for committee members as part of the overall Health Board's Organisational Development programme developed by the Executive Director of Workforce & Organisational Development.

COMMITTEE MEETINGS

Quorum

A quorum shall be at least three Independent Members (one of which must be the Committee Chair or Vice Chair).

For effective governance, at least two Executive Directors, one of which must be a Clinical Executive Director should be in attendance at the meeting.

Frequency of Meetings
Meetings shall meet no less than ~~on a 10~~ 6 times a year, and otherwise as the Chair of the Committee deems necessary.

The Committee will arrange meetings and align with key statutory requirements during the year consistent with the CTMUHB's annual plan of Board Business.

Withdrawal of individuals in attendance
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.

Circulation of Papers

The Director of Governance / Board Secretary will ensure that all papers are distributed at least 7 calendar days ~~5 working days~~ in advance of the meeting.

REPORTING AND ASSURANCE ARRANGEMENTS

The Committee Chair shall:

- Report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes:
  - oral updates on activity
  - submission of written highlight reports throughout the year;
  - to receive annual reports, which will incorporate key information from Research & Development, progress report on the Annual Quality Delivery Plan, Concerns, Safeguarding, Infection Prevention & Control, Clinical Audit & Effectiveness and Medicines Management
- Bring the Board's specific attention to any significant matters under consideration by the Committee

- Ensure appropriate escalation arrangements are in place to alert the UHB Chair, Chief Executive or Chairs of other relevant Board Committees of any urgent/critical matters that may affect the operation and/or reputation of the UHB.

The Committee shall provide a written, annual report to the Board on its work in support of the Annual Governance Statement specifically

commenting on the adequacy of the assurance arrangement, the extent to which risk management is comprehensively embedded throughout the organisation, the integration of governance arrangements and the appropriateness of self-assessment activity against relevant standards. The report will also record the results of the Committees self-assessment and evaluation.

The Board may also require the Committee Chair to report upon the activities at public meetings or to community partners and other stakeholders, where this is considered appropriate e.g. where the Committee's assurance role relates to a joint or shared responsibility.

The Director of Governance / 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.

RELATIONSHIP WITH THE BOARD AND ITS COMMITTEES / GROUPS

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 its organisation.

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

The Committee, through the Committee 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.

The Committee shall embed the organisational values and strategic objectives 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.

APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

The requirements for the conduct of business as set out in the CTMUHB Standing Orders are equally applicable to the operation of the Committee, except in the area relating to the Quorum.

CHAIR'S ACTION ON URGENT MATTERS

There may, occasionally, be circumstances where decisions which normally be made by the Committee need to be taken between scheduled meetings. In these circumstances, the Committee Chair, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Board, after first consulting with one other Independent Member of the Committee. The Director of Corporate Governance must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

Chair's urgent action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

REVIEW

These Terms of Reference shall be adopted by the Committee at its first meeting and subject to review at least on an annual basis thereafter, with approval ratified by the Health Board.

ACTION LOG QUALITY & SAFETY COMMITTEE					
Minute Reference	**Date of Meeting Action Originated**	**Issue**	**Lead Officer**	**Timescale for Action to be completed**	**Status of Action** (as at November 2022)
2.1	September 2022	Update on implementation of the CIVICA system to be added to committee forward work plan.	Assistant Director of Quality & Safety	November 2022	**Completed:** On agenda for November 2022.
2.1	September 2022	Letter on behalf of the Committee Chair to be sent to those involved in the Patient Story to formally thank them for sharing their patient experience with the Committee	Assistant Director of Nursing & Peoples Experience	November 2022	**In progress**
2.1	September 2022	Update on clinical pathway in place for women experiencing ectopic pregnancy	Director of Midwifery / Deputy Medical Director	November 2022	**Deferred to January 2023 meeting**
5.1	September 2022	Organisational Risk Register - Q & S Committee risks : • Update on risk status of the CTMUHB laundry service • Risk 4149 – update required on the impact from the mitigating actions in relation to	Chief Operating Officer / Deputy Chief Operating Officer	November 2022	**Completed:** Update on risks shared (with Committee Members and attendees) via email on 3rd November 2022

		waiting lists and additional clinics • Risk 4512 - update on the current status and further detail as to the mitigations that were working well.			
5.3	September 2022	**Monitoring Continuing Healthcare and Funded Nursing Care Activity** Further update to next meeting	Nurse Director, Bridgend Locality	November 2022	**Deferred to January 2023 meeting.**
6.6	September 2022	**Primary Care Quality & Safety Report** Deputy COO (Primary Care, Community, Mental Health and Learning Disabilities) to write on behalf of the Committee Chair to the Out of Hours service manager to acknowledge their work following national IT outages Confirmation to be provided as to whether dental patients had been contacted to confirm their revised dental practice allocation following their previous practice no longer accepting NHS patients.	Deputy COO (Primary Care, Community, Mental Health and Learning Disabilities) Deputy COO (Primary Care, Community, Mental Health and Learning Disabilities)	November 2022 November 2022	**In progress** **In Progress**

6.7	September 2022	**Stroke Services Progress Report** Update due in six months	Executive Director, Therapies and Health Sciences	March 2023	**Report due in March 2023**
7.1	November 2021 January 2022	**Quality Dashboard** Future hot topics to be presented to the Committee via the Quality Dashboard in relation to Pressure Ulcers and the Deep Dive being undertaken on Thrombosis. Spotlight report to be presented to the July meeting in relation to Medication Errors	Assistant Director of Quality & Safety	Ongoing	**Partially Complete - One action in Progress** Spotlight report on Community Acquired Pressure Damage presented to the March 22 meeting. **Completed.** Spotlight report on Patient Falls presented to the May 22 meeting. **Completed.** Spotlight Report on Medication Errors included in the Quality Dashboard report to the July 22 meeting. **Completed.** Spotlight on Thrombosis to be agreed. **In Progress**
5.1	24 May 2022	**Organisational Risk Register** Health, Safety & Fire Sub Committee Annual Report to be presented to a future meeting of the Committee. Annual Report to include a summary of all the fire risks contained within the risk register	Director for People	November 2022	**Completed** - HS&F sub Committee Annual Report on Q & S agenda for meeting on 15th November 2022.

5.1	24 May 2022	**Organisational Risk Register** Review to be undertaken outside the meeting regarding risks 816 and 3698 which had both been on the risk register for some time.	Director of Corporate Governance	July 2022	**Partially Complete** Review undertaken and responses shared with Committee Members. In response to the update received in relation to Risk ID 3788, the Chair of the Committee has asked the Chief Operating Officer to revisit this risk to ensure that the risk score appropriately reflects the current performance in terms of Waiting Lists for ND Services. An update report has also been added to the Forward Work Plan to be received by the Committee in the autumn.
6.1	19 July 2022	**Response to 'Improving Care, Improving Lives' National Care Review for Inpatients with a Learning Disability** Progress report to be presented to the Committee in six months.	Director of Primary, Community & Mental Health Services	January 2023	**Due to January 2023 meeting**
6.3	19 July 2022	**Quality Dashboard** Committee Members to reflect on what areas they would like future Spotlight Reports to focus on.	Committee Members	September 2022	**In progress**

6.5	19 July 2022	**Chief Operating Officer's Report** Updated Ophthalmology Action Plan to be shared with Members	Chief Operating Officer	September 2022	**In progress**
6.5	19 July 2022	**Chief Operating Officer's Report** Communication and listening issues with staff working in the Emergency Departments to be discussed with the Integrated Locality Group	Chief Operating Officer	September 2022	**In progress**

PREVIOUSLY REPORTED COMPLETED ACTIONS					
Minute Reference	**Date of Meeting Action Originated**	**Issue**	**Lead Officer**	**Timescale for Action to be completed**	**Status of Action** (as at November 2022)
7.8	November 2021	**Maternity & Neonates Services Improvement Programme Report** Discussion to be held with P Roseblade outside the meeting regarding the assurance chain that was currently in place.	Committee Chair	January 2022	**Completed** We are now transitioning from MNIB into business as usual processes for improvement
6.1.4	24 May 2022	**Maternity Metrics Report** Focus to be placed at the next meeting on progress being made in relation to pace of change and improvements being made within Neonatal Services.	Deputy Medical Director	July 2022	**Completed** Report discussed at the July 2022 meeting
6.7	24 May 2022	**Response to 'Improving Care, Improving Lives' National Care Review for Inpatients with a Learning Disability** The report to be deferred to the July meeting for further discussion.	Director for Primary, Community & Mental Health Services	July 2022	**Completed** Report discussed at the July meeting
3.2.11	19 July 2022	**Individual Patient Funding Request Panel (IPFR) Annual Report** Update to be provided as to whether a clinical representative had now been secured for the IPFR panel	Director of Public Health	September 2022	**Completed** Confirmation provided that the Locality Director for Nursing at Merthyr & Cynon ILG has agreed to attend the All Wales IPFR Panel

6.2	19 July 2022	**Maternity & Neonates Improvement Programme Highlight Report** Revised target dates to be identified against actions where target dates have slipped.	Director of Midwifery	September 2022	**Completed** Revised target dates included within this report
6.3	19 July 2022	**Quality Dashboard** Delivery Unit Dashboards to be appended to the Quality Dashboard moving forwards	Assistant Director of Quality & Safety	September 2022	**Completed** Dashboards have now been included as appendices to the Quality Dashboard Report.
6.5	19 July 2022	**Chief Operating Officer's Report** Spotlight Report to be presented to the next meeting of the Committee on the pressures being experienced within the Emergency Departments.	Assistant Director of Quality & Safety	September 2022	**Completed –** Included as an appendix to the Quality Dashboard Report for Sept 2022 meeting
6.6.4	19 July 2022	**Primary Care Quality & Safety Report** Confirmation to be provided outside the meeting regarding the position with Church Street Dental Practice in Merthyr Tydfil and whether they are accepting any NHS patients.	Primary Care Clinical Director	September 2022	**Completed** Confirmation provided outside the meeting that Church Street in Merthyr Tydfil have handed back their NHS contract and letters have been issued to the patients. On further investigation, this was one of the practices that the Health Board were aware of and the Primary Care Quality & Safety report should have stated Merthyr instead of Aberdare.

					For assurance this is a small practice and all the NHS patients will be able to be taken on by neighbouring NHS dental practices.
5.1	19 July 2022	**Organisational Risk Register** Response to be provided to Committee Members outside the meeting regarding the queries raised against some of the risks.	Director of Corporate Governance	September 2022	**Completed:** Response shared with Committee Members on 9 September 2022 regarding Risks 4887, 4721, 1133 and 5014

AGENDA ITEM
3.2.2

QUALITY & SAFETY COMMITTEE

QUALITY & SAFETY COMMITTEE ANNUAL CYCLE OF BUSINESS

Date of meeting	15th November 2022
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Emma Walters, Corporate Governance Manager
Presented by	Cally Hamblyn, Assistant Director of Corporate Governance
Approving Executive Sponsor	Director of Corporate Governance
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**

ACRONYMS	

1. SITUATION/BACKGROUND

1.1 The Quality & Safety Committee should, on annual basis, receive a Cycle of Business which identifies the reports which will be regularly presented for consideration. The annual cycle is one of the key components in ensuring that the Committee is effectively carrying out its role.

1.2 The Cycle of Business covers the period 1 January 2022 to 31 December 2022.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 The Cycle of Business has been developed to help plan the management of Committee matters and facilitate the management of agendas and Committee business.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 Please refer to **Appendix 1** – Quality & Safety Committee Cycle of Business for further detail. Any changes have been identified in red.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	Evidence suggests there is correlation between governance behaviours in an organisation and the level of performance achieved at that same organisation. Therefore ensuring good governance within the Trust can support quality care.
Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below)
	Not required.
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

5.1 The Committee is asked to **NOTE** the Committee Cycle of Business.

Quality & Safety Committee

Cycle of Business

(1st January 2022 – 31st December 2022)

The Quality & Safety Committee should, on annual basis, receive a cycle of business which identifies the reports which will be regularly presented for consideration. The annual cycle is one of the key components in ensuring that the Committee is effectively carrying out its role.

The Cycle of Business covers the period 1st January 2022 to 31st December 2022.

The Cycle of Business has been developed to help plan the management of Committee matters and facilitate the management of agendas and committee business.

The principal role of the Committee is set out in the Standing Orders 1.0.1.

Quality & Safety Committee Cycle of Business (1st January 2022 – 31st December 2022)

Item of Business	Executive Lead	Reporting period	Jan 2022	Feb 2022	Mar 2022	April 2022	May 2022	June 2022	July 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022
SHARED LISTENING & LEARNING														
Shared Listening & Learning Story	Director of Nursing	All regular meetings	✓		✓		✓		✓		✓		✓	
CONSENT AGENDA ITEMS – FOR APPROVAL/NOTING														
Minutes of the previous meeting	Director of Corporate Governance	All regular meetings	✓		✓		✓		✓		✓		✓	
Action Log	Director of Corporate Governance	All regular meetings	✓		✓		✓		✓		✓		✓	
Committee Annual Cycle of Business	Director of Corporate Governance	All regular meetings	✓		✓		✓		✓		✓		✓	
Committee Forward Work Plan	Director of Corporate Governance	All regular meetings	✓		✓		✓		✓		✓		✓	
Committee Annual Report	Director of Corporate Governance	Annually					✓							
Quality & Safety Committee Terms of Reference	Director of Corporate Governance	Annually											✓	
Quality & Safety Committee Annual Self-Assessment	Director of Corporate Governance	Annually			✓ Deferred to May		✓							
WHSSC Quality & Patient Safety Committee Chairs Report	Director of Corporate Governance	Bi-monthly	✓		✓		✓		✓		✓		✓	
WHSSC Quality & Patient Safety Committee Annual Report	Director of Corporate Governance	Annually							✓					
Putting Things Right Annual Report	Director of Corporate Governance	Annually							✓					
Organisational Wide Policies for Approval	Director of Corporate Governance	As and when they arise												
Shared Listening & Learning Forum Highlight Report	Director of Corporate Governance	Bi-Annually					✓				✓ Deferred to Nov		✓ Deferred to Jan 23	
Safeguarding & Public Protection Annual Report	Director of Nursing	Annually											✓ Deferred to Jan 23	
Health & Care Standards Annual Report	Director of Nursing	Awaiting confirmation from WG as to whether this is require for 2022							✓ Deferred to Sept		✓ Deferred to Nov		✓	
Welsh Ambulance Services NHS Trust Patient Experience Report	Director of Nursing	Quarterly			✓		✓				✓			

Item of Business	Executive Lead	Reporting period	Jan 2022	Feb 2022	Mar 2022	April 2022	May 2022	June 2022	July 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022
					Not received									
Infection, Prevention & Control Committee Highlight Reports	Director of Nursing	Bi-monthly	✓		✓		✓		✓		✓		✓	
Infection, Prevention & Control Annual Report	Director of Nursing	Annually							✓ Deferred to Sept		✓			
Quality Governance – Regulatory Review Recommendations and Progress Updates	Director of Nursing	All regular meetings	✓		✓		✓		✓		✓		✓	
Delivery Unit Performance Dashboards	Director of Nursing	All regular meetings	✓		✓		✓		✓		✓		✓	
Controlled Drugs Local Intelligence Network (CDLIN) Annual Report	Medical Director	Annually					✓							
Cancer Services Annual Report	Medical Director	Annually					✓							
Prescribing Annual Report	Medical Director	Annually											✓	
RADAR Committee Highlight Reports	Medical Director	Bi-Annually					✓ Deferred to July		✓				✓	
Clinical Audit Quarterly Report	Medical Director	Quarterly			✓				✓				✓	
Clinical Audit Annual Plan	Medical Director	Annually			✓									
Clinical Education Annual Report	Medical Director	Annually									✓ Deferred to Nov		✓	
Individual Patient Funding Request Annual Report	Director of Public Health	Annually							✓					
Health, Safety & Fire Sub Committee Highlight Reports	Director for People	Quarterly	✓		✓		✓				✓ Deferred to Nov		✓	
Radiation Safety Committee Highlight Reports	Director of Therapies & Health Sciences	Bi-Annually			✓ January meeting not held						✓ Deferred to Nov		✓ Deferred to January 23	
Learning Disabilities Six Monthly Report	Chief Operating Officer	Bi-Annually	✓						✓					
Community Health Council National Surveys and Quality Monitoring Reviews	Director of Nursing	All regular meetings (from July onwards)							✓		✓		✓ Deferred to January 23	
Covid 19 Inquiry Preparedness	Director of Corporate Governance	Bi-Annually (from September onwards)									✓			
Nosocomial Investigation Update Report	Director of Nursing	All regular meetings (from July onwards)							✓		✓		✓	
Ombudsman's Annual Letter	Director of Corporate Governance	Annually									✓			
GOVERNANCE														
Organisational Risk Register – Risks Assigned to Quality & Safety Committee	Director of Corporate Governance	All regular meetings	✓		✓		✓		✓		✓		✓	

Item of Business	Executive Lead	Reporting period	Jan 2022	Feb 2022	Mar 2022	April 2022	May 2022	June 2022	July 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022
Welsh Risk Pool Review of Claims, Redress Cases and Inquests – Progress Against the Action Plan	Director of Corporate Governance	Quarterly	✓				✓				✓ Deferred to Nov 23		✓	
CREATING HEALTH														
Covid-19 – Vaccination Report	Director of Public Health	All regular meetings	✓		✓ Closure report									
IMPROVING CARE														
Maternity & Neonates Services Improvement Programme	Director of Nursing/Medical Director	All regular meetings	✓		✓		✓		✓		✓		✓	
Quality Dashboard	Director of Nursing	All regular meetings	✓		✓		✓		✓		✓		✓	
Integrated Locality Group Quality & Safety Reports	Director of Nursing/Chief Operating Officer	All regular meetings	✓		✓		✓		✓		✓		✓	
Report from the Chief Operating Officer	Chief Operating Officer	All regular meetings	✓		✓		✓		✓		✓		✓	
Planned Care Improvement Programme Progress Report (to include Follow Up Outpatients Not Booked and Harm Reviews)	Chief Operating Officer	Quarterly	✓				✓				✓			
Stroke Services Progress Report	Director of Therapies & Health Sciences	Bi-Annually			✓ Deferred to May		✓				✓			
Mortality Indicators and Mortality Reviews	Director of Public Health/Medical Director	Bi-Annually			✓								✓	
Ty Llidiard Progress Reports	Director of Therapies & Health Sciences	All regular meetings					✓		✓		✓		✓	
SUSTAINING OUR FUTURE														
Human Tissue Authority Act Progress Report	Chief Operating Officer	Bi-Annually					✓						✓	

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

QUALITY & SAFETY COMMITTEE – FORWARD WORK PLAN				
Origin of Request	**Category of Report / Presentation (Deferred Item/ Additional Item/ Ad-Hoc Item)**	**Item Title**	**Lead Officer**	**Intended Meeting Date**
Request made by Director of Nursing for this to be added to the agenda for the January meeting	Additional Item	Reviewed Quality & Safety Framework based on the Gap Analysis	Director of Nursing	18 January 2022 – Deferred to March meeting. Discussion held at the March agenda planning session that it would be best to delay the report until further guidance had been received from Welsh Government. Following discussion at agenda planning held on 6 April 2022 – it was agreed that this needed to be deferred to the November 2022 meeting in light of the discussions being held in relation to the future operating model. **Defer to January 2023 - the revised and Quality & Safety Framework is scheduled to be an agenda item for the Committee in January 2023.**
Email request received from the Committee Chair on 14 March 2022	Additional Item	Learning Disabilities Report: • addressing the recommendations of the 2020 report; • including the action plan developed by CTM as a result of that report; and • a progress report against the action plan.	Chief Operating Officer	24 May 2022 – Now July 2022 – Report deferred to the July meeting due to the absence of the Director of Primary, Community & Mental Health Services. **Completed. Committee requested that an update was presented on this matter in January 2023.**

Origin of Request	Category of Report / Presentation (Deferred Item/ Additional Item/ Ad-Hoc Item)	Item Title	Lead Officer	Intended Meeting Date
On the Quality & Safety Committee Action Log from the February In Committee	Additional Item	Child Safeguarding	Director of Nursing	14 June 2022 In Committee **Completed and Ongoing – Further update to be provided to the Committee in January 2023.**
Committee Referral made by the Audit & Risk Committee at its February 2022 meeting	Additional Item	Assurance on the Health Board's plan to improve monitoring and reporting in relation to Continuing Healthcare (CHC) and Funded Nursing Care (FNC) activity.	Director of Nursing	19 July 2022 – This item has now been deferred to the September 2022 meeting following agreement by the Committee Chair. On agenda September 2022. – Agreed at the September meeting that a further update to be presented to the November meeting to determine future frequency of reporting. **Subsequent agreement by the Chair and Director of Nursing to defer this item until January 2023 following discussion at the November agenda planning meeting.**
Agenda Item agreed at the June Quality & Safety Committee Agenda Planning session	Additional Item	National Maternity & Neonates Assurance Tool	Director of Nursing/Deputy Medical Director	20 September 2022 **Learning from Mortality Reviews is captured on the November 2022 agenda.**

Origin of Request	Category of Report / Presentation (Deferred Item/ Additional Item/ Ad-Hoc Item)	Item Title	Lead Officer	Intended Meeting Date
Email Request received from the Assistant Director Quality & Safety	Additional Item	Quality Strategy	Director of Therapies & Health Sciences	19 July 2022 – Completed and Ongoing **Quality Strategy is on the agenda for November 2022.**
Action agreed at the May Quality & Safety Committee	Additional Item	Deep Dive into CAMHS	Chief Operating Officer	20 September 2022 – **Agreed at the agenda planning session to defer. Agreed with the Director of Primary, Community & Mental Health Services to defer this to January 2023**
Email request from the Director of Nursing	Additional Item	Civica System - Progress Report and Report Examples	Director of Nursing	**On Agenda 15 November 2022**
Email request received from the Committee Chair	Additional Item	CTMUHB peer review report and action plan	Chief Operating Officer	**On Agenda 15 November 2022**
Email request from the Director of Corporate Governance following discussion held at Health, Safety & Fire Sub Committee raising this as an area of concern	Additional Item	Datix Cymru – Assurance Report	Director of Corporate Governance	**On Agenda 15 November 2022**

Origin of Request	Category of Report / Presentation (Deferred Item/ Additional Item/ Ad-Hoc Item)	Item Title	Lead Officer	Intended Meeting Date
Actions agreed at the September Quality & Safety Committee – Request made by the Committee Chair	Incorporated into Maternity and Neonatal Update	• Report on processes in place for women who are experiencing ectopic pregnancies • IMSOP Publication • Gynaecology pathway	Director of Nursing	**Update from the Deputy Medical Director and Executive Director of Nursing Office – to note that this update will be captured in an integrated update in January 2023.**
Request from the Chair following MHAMC Agenda Planning	Item Deferral as MHAM Committee only monitors the application of the MH Act.	Update on the new Liberty Protection Standards	Director of Nursing	**Planned for January 2023**
Request from Strategic Planning & Commissioning Manager	Item deferred from November to January to allow for consultation period.	CYP 16-17 year's Acute Admission Policy – For Approval.	Strategic Planning & Commissioning Manager	**Planned for January 2023**

Completed Activity From the Forward Work Programme:

Origin of Request	Category of Report / Presentation (Deferred Item/ Additional Item/ Ad-Hoc Item)	Item Title	Lead Officer	Intended Meeting Date
Notified by the Director of Nursing at the March Quality & Safety Committee	Additional Item	Presentation – Digitisation of the Nursing Care Record	Director of Nursing	19 July 2022 – **Completed**
Agenda Item agreed ay the June Quality & Safety Committee Agenda Planning Session	Additional Item	Community Health Council National Surveys and Quality Monitoring Reviews	Director of Nursing	19 July 2022 – **Completed**
Email Request received from the Assistant Director Quality & Safety	Additional Item	Incident Management Framework – Listening, Learning and Improving Safety	Director of Nursing	19 July 2022 – **Completed**
Report received from RTE ILG. Director of Nursing agreed to add to the agenda	Additional Item	National Nosocomial Covid-19 Programme – CTM Update	Director of Nursing	19 July 2022 – **Completed**

Origin of Request	Category of Report / Presentation (Deferred Item/ Additional Item/ Ad-Hoc Item)	Item Title	Lead Officer	Intended Meeting Date
Email received from the Director of Corporate Governance	Additional Item	Report on Parc Prison – Quality & Performance of Service Provision	Director of Primary, Community & Mental Health	19 July 2022 – **Completed**
Email received from the Facilities Governance & Compliance Manager	Additional Item	Facilities Policies for Approval: Security Policy	Chief Operating Officer	19 July 2022 – **Completed**
Email received from the Director of Primary, Community & Mental Health Services	Additional Item	Dental Contract Reform	Director of Primary, Community & Mental Health	19 July 2022 – **Completed**
Email Request from the Director of Nursing	Additional Item	Delivery Unit Report - Maternity and Neonatal Services Serious Incidents Assurance Review & Board Systems and Processes for Reporting, Management and Review of Patient Safety Incidents	Director of Nursing	19 July 2022 – **Completed**
Request made at the May Quality & Safety Committee	Additional Item	Neonatal Deep Dive Review Update	Medical Director	19 July 2022 – **Completed**

Origin of Request	Category of Report / Presentation (Deferred Item/ Additional Item/ Ad-Hoc Item)	Item Title	Lead Officer	Intended Meeting Date
Additional report received by email from the Director of Midwifery	Additional Item	Maternity Services Self-Assessment against Maternity National Assurance Framework for Wales	Director of Nursing	27 July 2022 In Committee – **Completed**
Long standing action on Board Action Log. Agreement given by the Medical Director for a report to be shared with Quality & Safety Committee outlining the progress made against the plans	Additional Item	Safe, Sustainable and Accessible Emergency Medicine and Minor Injury and Illness Services for the People of Rhondda Taff Ely	Medical Director	19 July 2022 – An update on progress has been included in the Rhondda Taf Ely Integrated Locality Group report to the July meeting. **Completed**
Email request received from the Director of Corporate Governance	Additional Item	Learning From Events Report – Progress Update	Director of Corporate Governance	19 July 2022 – An update has been included as an appendix in the Quality Dashboard report - **Completed**

Origin of Request	Category of Report / Presentation (Deferred Item/ Additional Item/ Ad-Hoc Item)	Item Title	Lead Officer	Intended Meeting Date
Email Request received from the Committee Chair	Additional Item	Neuro Development Disorder Services – Plans to Address Performance	Chief Operating Officer	20 September 2022 – Update included in the Chief Operating Officers Report. **Completed**
Action agreed at the July Quality & Safety Committee	Additional Item	Spotlight Report – Increased Demand within A&E/Emergency Department Improvement Work	Chief Operating Officer	20 September 2022 – **Completed**
Action agreed at the July Quality & Safety Committee	Additional item	Thematic Review of the feedback received from the Community Health Council to include Primary Care	Director of Nursing/Director of Primary, Community & Mental Health Services	20 September 2022 – **Completed**
Email Request received from the Committee Chair	Additional Item	Risk Assessment and Recording of Absconsions - Global review across all our hospital settings to minimise risk of recurrence	Director Nursing/Chief Operating Officer	20 September 2022 – **Report to now be presented to the In Committee session on 11 October 2022 – Completed.**
Email Request received from the Committee Chair	Additional Item	Urgent Dental Care Access – Risks and Issues and the Plans in place to mitigate	Director of Primary, Community & Mental Health Services	20 September 2022 – **Completed**
Email Request received from the Assistant Director of Corporate National Collaborative	Additional Item	NCCU Quality Assessment and Improvement Service - Annual Quality position statement	NCCU Clinical Director for Collaborative Commissioning	20 September 2022 – **Completed**

Commissioning Unit				
Origin of Request	**Category of Report / Presentation (Deferred Item/ Additional Item/ Ad-Hoc Item)**	**Item Title**	**Lead Officer**	**Intended Meeting Date**
Email Request received from the Head of Planning & Commissioning	Additional Item	Transition and Handover from Children to Adults Health Services	Director of Strategy and Transformation	20 September 2022 – **Completed**
Email Request received from the Head of Assets, Governance & Technical Services	Additional Item	Estates Policy for Approval – PAT Testing Policy	Director of Finance	20 September 2022 – **Completed**

AGENDA ITEM
3.2.5

QUALITY & SAFETY COMMITTEE

REGULATORY REVIEW RECOMMENDATIONS AND PROGRESS UPDATE
HEALTHCARE INSPECTORATE WALES (HIW) ROUTINE QUALITY CHECKS

Date of meeting	15th November 2022
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Lydia Thomas, Head of Quality and Patient Safety Louise Mann, Assistant Director, Quality, Patient Safety & Safeguarding
Presented by	Greg Dix, Executive Director of Nursing
Approving Executive Sponsor	Executive Director of Nursing
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
(Insert Name)	(DD/MM/YYYY)	Choose an item.

ACRONYMS	
HIW	Healthcare Inspectorate Wales
IRMER	Ionising Radiation (Medical Exposure) Regulations
CMHT	Community Mental Health Team
CIW	Care Inspectorate Wales
ED	Emergency Department

1. SITUATION/BACKGROUND

1.1 This report is based on Healthcare Inspectorate Wales activity and correspondence since the last report for committee in September 2022. Due to the bi-monthly nature of these meetings, this report will cover the 6 week period from the previous report.

1.2 An overview table has been included below in 2.1 to provide a 'summarised snapshot' of most recent activity.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 Quarter 3 (2nd September- 25th October 2022) HIW activity across Cwm Taf Morgannwg University Health Board included:

Number of Unannounced	**2**
Number of Announced	**0**
Number of patient/staff concerns via HIW	**0**
Number of concerns raised through Fieldwork	**0**
Number of ongoing improvement plans	**3**

2.2 **Unannounced Inspections:**

There has been 2 unannounced inspections in this quarter.

1. **Princess of Wales Hospital Emergency Department (17th- 19th October)**

Immediate assurance was requested following gaps being identified in September and October 2022 in the checking of resuscitation equipment trollies in both major and minor departments.

The Health Board ED senior teams are currently formulating a response outlining the actions to be put in place to ensure robust checking is logged within the department consistently and timely.

The final HIW report is expected to be published 18th January 2023.

2. Maternity Service: Prince Charles Hospital (PCH) 27th-28th September 2022

An unannounced inspection took place within PCH maternity service. Formal feedback has yet to be received. Verbal feedback has established the inspection was satisfactory, however further analysis is taking place with regards to the staff survey.

It is anticipated that the full report will be published 29th December 2022.

2.3 **Announced Inspections:**

There has been 1 announced inspection in quarter 2 of the Princess of Wales Diagnostic Unit (IRMER) 27th & 28th September 2022.

Overall the inspection found that even though the ED department is a continual challenging environment, the challenges were managed well, with a hard working workforce with mitigating risks being managed appropriately. Some concerns were raised in respect of mandatory and statutory training compliance.

The final HIW report is expected to be published 29th December 2022.

2.4 **Future Planned HIW activity**

i. Surgery Governance Arrangements

A review of the governance arrangements within Surgery is anticipated within the next few months. A date has not yet been provided, however this is anticipated to be February 2023. This is part of the joint review into governance arrangements by HIW & Audit Wales. A vast amount of evidence has been collated to be sent to HIW. An extension was given for the evidence being submitted from end of September to mid-October. Evidence has been provided by the senior teams on all hospital sites and is being collated by the Corporate Governance Team.

ii. Community Mental Health Team (CMHT) - Maesteg Hospital

CMHT inspection visit by HIW and Care Inspectorate Wales (CIW) to the Health Board and Bridgend Council will be undertaken on 13th and 14th December 2022. The selected CMHT is Bridgend North CMHT, Maesteg Hospital. The inspection will be conducted over two days, and will include discussions with CMHT staff, service users and carers, as well as examining documentation including service user records, policies, staff records and system reviews. Senior leads have been identified to facilitate the

inspection and contact details have been provided to HIW. A self-assessment is currently being undertaken by the team and evidence being collated for submission to HIW by 11th November 2022.

2.5 **No Public Concerns raised via HIW**

2.6 **Local Reviews:**

i. Discharge Arrangements for Adult Mental Health Patients:

HIW are conducting a local review of mental health services across CTM UHB as part of HIWs annual review programme for 2021-22 to assess *'Do the current arrangements for the discharge of patients from inpatient mental health services into the community support the delivery of safe, effective and timely care?'*

It was highlighted in July's report a summary of concerns were raised during the fieldwork. Written assurance was provided by the Director of Mental Health and an improvement plan is in progress and was submitted and accepted by HIW. A full report from HIW was expected in August 2022. A verbal update received from HIW states the report is currently in progress and the health board can expect the report for factual accuracy checking mid November.

2.7 **National Reviews:**

i. **National Review Patient Flow (Stroke Pathway)**

A National Review is underway, reviewing patient flow with a focus to gain a greater understanding of the challenges that health care services face in relation to how patients flow through healthcare systems. In addition, it will test if arrangements for patient flow are robust. As part of the test process, HIW will focus on patients travelling through the stroke pathway. HIW had an onsite visit to The Princess of Wales Hospital for 3 days from 23-25 May 2022. No immediate concerns were raised or escalated. A verbal update from HIW reports the field work is still ongoing across the health boards. An overarching report of findings from all health boards will be published in one report. The health board will not receive an individual feedback report. It is expected that the report will be published between January and February 2023.

2.8 Further work is still being scoped to use the AMAT system to capture the actions arising from HIW activity to allow themes and trends to be identified and allow one dedicated space to capture oversight of HIW actions/ recommendations across the Health Board. This is also part of the HIW/HEIW improvement plan.

All HIW Summary Findings can be accessed via the following link: https://hiw.org.uk/

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

That governance, monitoring, scrutiny and oversight of ongoing action plans in relation to HIW service reviews is maintained without interruption within the new Care Group Model.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	Subject to the findings and outcomes of the HIW reviews.
Related Health and Care standard(s)	Staff and Resources
	All of the Healthcare Standards Governance, Leadership & Accountability Staff & Resources Staying Healthy Safe Care Individual Care Timely Care Dignified Care Effective Care

Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below.
	• Report for information on HIW activity • No service or staff impact in direct response from report, this is considered through the improvement action plans • Report not requesting proposal for any changes to services or staff
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	Yes (Include further detail below)
	Subject to the findings and outcomes of the HIW reviews
Link to Strategic Well-being Objectives	Provide high quality, evidence based, and accessible care

5. RECOMMENDATION

5.1 There are no specific recommendations or requirement for endorsing in this report.

5.2 The Committee are asked to **NOTE** this report.

AGENDA ITEM
3.2.6

QUALITY & SAFETY COMMITTEE

HEALTH & CARE STANDARDS ANNUAL REPORT 2022

Date of meeting	15/11/2022
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Becky Thomas, Senior Nurse, Quality Improvement Louise Mann, Assistant Director, Quality and Safety.
Presented by	Greg Dix, Executive Director of Nursing
Approving Executive Sponsor	Executive Director of Nursing
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
(Insert Name)	(DD/MM/YYYY)	Choose an item.

ACRONYMS	

1. SITUATION/BACKGROUND

Since 2009, the NHS in Wales has undertaken a national audit of care and service delivery which has included three elements:

- Patient Experience Survey – where we asked patients about their experiences of care.
- Operational – This included a retrospective examination of patient records to measure compliance against the standards and triangulation of information and observation of clinical practice.
- Staff Survey –where we asked staff about their experience of working within the Organisation.

The Health and Care Standards provide the framework for how services are organised, managed and delivered on a day-to-day basis. They establish a basis for improving the quality and safety of healthcare services by providing a framework against which standards of care can be measured and highlight focus areas for improvement.

The 22 Health and Care standards have been designed to fit with the seven quality themes identified in the NHS Outcomes and Delivery Framework which were developed through engagement with the public, patients, clinicians and stakeholders.

Each theme includes several standards which have been mapped against the NHS Outcomes and Delivery Framework measures, the measures relating to the fundamental aspects of care and specific areas that comply with legislation and guidance. The benefits of the engaging in the annual audit are:

E*nables patients/carers to:*

- Share their views and experiences on what we do well and where we need to improve, which will be used to help improve the services we provide.
- Have a voice in the quality of the care they receive.

Empowers staff to:

- Make a difference and ensure ownership of their practice.
- Have a voice in the care that they provide and ensure the focus is on essential elements of care and caring.
- Identify areas of good practice and highlight issues for concern.
- Develop action plans to monitor change.

Enables Organisations to:

- Have a mechanism to monitor/measure the quality of nursing care.
- Develop organisational policies and procedures.
- Identify key themes for improvement.
- Adopt a culture of openness and transparency with the quality standards.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

The findings from the 2022 Annual Health and Care Standards operational audits, patient survey and staff survey are presented in the attached detailed Health & Standards Annual report. The narrative of this report will focus on the areas of good practice identified by the operational audit, our patients and our staff, as well as attempting to recognise and explain any areas of concern that emerge from the findings. It is important to note that this audit report is a partial, specific view of health board performance and should be seen within the context of other health board data and broader system challenges.

When making comparisons to year-on-year results, it must be recognised that there are limitations in making summative comparisons as the number of areas undertaking the audit has increased year on year. In addition, it is important to note that there is no longer a requirement to submit the findings to the Chief Nursing Officer, where data from other Organisations is available. Therefore, the results should not be used to compare Organisations across Wales; it is more helpful to provide assurance information to our Board, our stakeholders, our colleagues and the patients and populations we serve.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 Feedback from our population

Between 1st April 2022 and 30th June 2022, a total of **646** patient experience surveys were completed across the participating clinical areas. This is compared with the **1,307** surveys completed in 2019. **444** (69%) were completed by the patient/service user, **62** (10%) by a friend/ family/carer and 54 (8%) completed with the support of a Healthcare Professional.

Feedback from patients confirms the high standards of care provided across the Health Board with an overall satisfaction rate of 90% albeit a slight decrease to the 93% achieved last year. They are also complimentary towards

the attitude and behaviour of staff and nearly all patients (99%) who participated in this year's audit felt that they had been 'always' or 'usually' treated with dignity and respect during their stay or attendance to hospital.

There are two low scores this year, the first relating to the ability to speak Welsh to staff if needed with an overall patient satisfaction rate of 86% however it's heartening to see an increase on last year's 77%.

The second was related to getting enough sleep and rest, with a score of 88% a slight increase from last year's 86%. Sleep and rest in our hospitals is a continual challenge for us and we need to continue to think creatively on how we can improve this experience for our patients.

3.2 Feedback from our staff

Feedback from staff remains low overall and sees a decrease this year to an overall satisfaction rate of 67% in comparison to last year's 78%. This could be in part attributable to the unprecedented pressures staff have experience over the last two years with the pandemic. However, we must be mindful not to make assumptions and some significant work needs to take place to understand more fully the responses provided by staff

The 3 elements that received the lowest score were:

1. Make you feel a valued member of the organisation and have a sense of belonging (55%) a stark decrease to last year's 78%, some work needs to be undertaken to understand this further

2. Make you feel safe at work (62%) a reduction on last year's 82%

3. Make you feel proud to be a nurse / allied health professional (60%) Whilst this score keeps us in an AMBER position it must be noted that it's a worrying decrease of 22% from last year's 82%.

There is considerable activity in respect of promoting staff wellbeing within the Health Board however it must be acknowledged that those whom replied to this survey report a concerning reduction in feeling valued, safe and feeling less connected to their profession. This apparent loss of morale can potentially have an impact on the quality of care delivered to our patients.

3.3 Operational Audit findings

The operational audit findings have confirmed a top 3 key areas of good practice and areas where improvements could be made.

Top 3 areas of good practice

1. Ongoing successful implementation of the Welsh Nursing Care Record
2. Introduction of a standardised Virtual Visiting service
3. Implementation of Safe to Start across sites

Top 3 areas for improvement

1. **Safe Care** – How will we ensure good patient hydration.
2. **Dignified Care** – How will we improve the environment of care for patients and their families. For example, providing privacy for patients and their relatives during visiting.
3. **Individual Care** – How will we improve the assessment and care of patients experiencing delirium and those patients who have a diagnosed learning disability.

This learning will be shared within the Listening and Learning Forum, added to the Learning Repository and specific improvement requirements subject to further analysis, action planning and outcome monitoring. The planned Ward Assurance Programme will also provide assurance of 100% compliance with the health care standards for future confidence on the quality, safety and effectiveness of our services.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	Patient care and staff experiences
Related Health and Care standard(s)	Safe Care
	All Health care standards affected

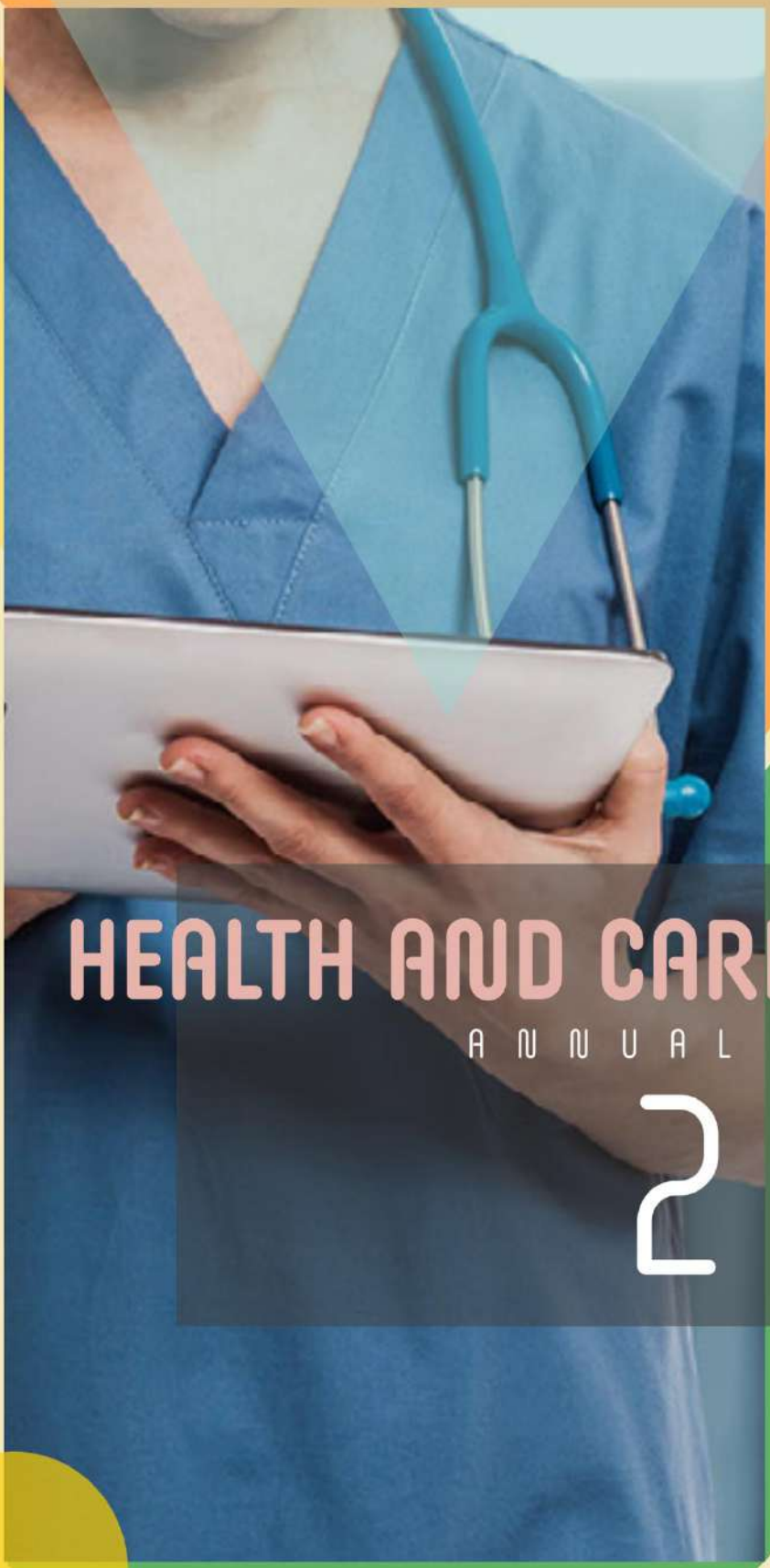
Equality impact assessment completed	Not required
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Well-being Objectives	Provide high quality, evidence based, and accessible care

5. RECOMMENDATION

The Quality & Safety Committee is asked to:

- **NOTE** the position of the Health Board with regard to the Health & Care Standards
- **NOTE** the areas of good practice that have been reported within this paper and areas for improvement.

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board



HEALTH AND CARE STANDARDS

ANNUAL AUDIT REPORT

2022

Contents

Executive Summary

The findings from the 2022 Annual Health and Care Standards operational audits, patient survey and staff survey are presented in this report. The narrative of this report will focus on the areas of good practice identified by the operational audit, our patients, and our staff, as well as attempting to recognise and explain any areas of concerns that emerge from the findings. When making comparisons to year-on-year results, it must be recognised that there are limitations in making summative comparisons as the number of areas undertaking the audit has increased year on year.

Feedback from patients confirms the high standards of care provided across the Health Board with an overall satisfaction rate of 90% albeit a slight decrease to the 93% achieved last year. They are also complimentary towards the attitude and behaviour of staff and nearly all patients (99%) who participated in this year's audit felt that they had been 'always' or 'usually' treated with dignity and respect during their stay or attendance to hospital.

There are two low scores this year, the first relating to the ability to speak Welsh to staff if needed with an overall patient satisfaction rate of 86% however it's heartening to see an increase on last year's 77%.

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The operational audit findings have confirmed a few key areas for improvement.

Top 3 areas of good practice

1. Implementation of Safe to Start across sites (p. 17)

2. Introduction of a standardised Virtual Visiting service (p.42)

3. Ongoing successful implementation of the Welsh Nursing Care Record (p. 47)

Top 3 areas for improvement

1. **Safe Care** – How can we ensure good patient hydration?

2. **Dignified Care** – How can we improve the environment of care of care for patients and their families. For example, providing privacy for patients and their relatives during visiting?

3. **Individual Care** – How can we improve the assessment and care of patients experiencing delirium and those patients who have a diagnosed learning disability?

The detailed results of the audit are presented in this report

"I would like to extend my gratitude to all the patients, carers and staff involved with the 2022 Health and Care Standards audit process and for providing assurance of where we are delivering excellent standards of care and for identifying where we need to focus our continuous quality improvement during 2023 and beyond."

Greg Dix

Executive Director of Nursing

Background

The Health and Care Standards provides the framework for how services are organised, managed, and delivered on a day-to-day basis. They establish a basis for improving the quality and safety of healthcare services by providing a framework against which standards of care can be measured and highlight focus areas for improvement.

The 22 Health and Care standards have been designed to fit with the seven quality themes which were developed through engagement with the public, patients, clinicians, and stakeholders.

The benefits of the engaging in the annual audit are outline below:

E*nables patients/carers to:*

- Share their views and experiences on what we do well and where we need to improve, which will be used to help improve the services we provide.
- Have a voice in the quality of the care they receive.
- Be central to the design of new services to ensure they meet the requirements of our populations.

Empowers our workforce to:

- Make a difference and ensure ownership of their practice.
- Have a voice in the care that they provide and ensure the focus is on essential elements of care and caring.
- Identify areas of good practice and highlight issues for concern.
- Develop action plans to monitor change.

Enables organisations to:

- Have a mechanism to monitor/measure the quality of nursing care.
- Develop organisational policies and procedures.
- Identify key themes for improvement.
- Adopt a culture of openness and transparency with the quality standards.

Assessment

Compliance Matrix:

The agreed compliance matrix for all elements of the audit

Equal to or greater than 85%
51% to 84%
50% or less

Triangulation of data:

The results from this audit are a part of the wider picture of the services being provided in the organisation. This report will refer to information from other data sources as it helps us to triangulate the information available to us to determine if our organisation is doing the right thing well and providing care which is dignified, safe and effective to meet the needs of individuals.

Source of the data:

Individual question compliance – the source of the data in this report is taken from the Health & Care Monitoring System. The audit includes percentage as well as (Yes/No) type responses for the audit questions. In addition, for the staff and patient surveys a scale of 'Always', 'Usually', 'Sometimes' and 'Never' was introduced.

Interpreting the results

Overall Summary

The HCM audit involves asking patients about their experiences of care and reviewing delivery of care and the assessment of the operational application of the 22 HCSs. This included:

- Examination of patient records to measure compliance against the standards
- Observation of clinical practice
- Environmental assessment

It is important to note that some questions are not included in the operational audit and patient surveys for all areas.

Patient Experience Summary

"I was brought into hospital and was expected to die. Once I recovered my family and I could not be more impressed by the excellent nursing and consultant teams care afforded to me."

(Patient, Ward 5, RGH)

Understanding the experiences of patients, and their relatives/ carers is a key priority for the Health Board, and the HCS audit Patient survey is only **ONE** method by which we can monitor the standard of care provided and better understand the patient experience.

Between 1st April 2022 and 30th June 2022, a total of **646** patient experience surveys were completed across the participating clinical areas. This is compared with the **1,307** surveys completed in 2019. **444** (69%) were completed by the patient/service user, **62** (10%) by a friend/ family/carer and 54 (8%) completed with the support of a Healthcare Professional.

The results of this year's patient survey demonstrate that many patients were satisfied with the standards of care that they received from the Health Board and are complimentary regarding the professional and respectful behaviour of most of the staff. The survey also demonstrates that we do not get it right all the time and this feedback is essential to improve practice. When asked to rate their overall satisfaction with the care provided service users gave the organisation a rating of 90% enabling the Health Board to maintain a RAG rating of green. This is to be commended when considering that the surveys were undertaking during the height of the pandemic

Service User Question	Overall Rag % 2018	Overall Rag % 2019	Overall Rag % 2020/21	Overall Rag % 2022
On a scale of 1-10, where 1 is very bad and 10 is excellent, how would you rate your overall experience?	**90%**	**89%**	**93%**	**90%**

Highlights for the Service User Experience

The outcome of this years' patient survey does not vary greatly from the findings of last year's survey. Patients are telling us that they are being treated with dignity and respect. Patients are telling us that staff are kind, helpful and polite. In addition, nearly all patients who responded feel safe.

However, patients are not always able to speak to staff in Welsh if needed. Patients are not having enough sleep and rest. The survey outcome acts as a reminder of what we are doing well most of the time and what we need to improve to make the experience of all service users better.

"Arrived nervous agitated, disoriented completely out of my comfort zone, but from the moment I was met in the car by Bethan who also kindly brought me a wheelchair. My perception began to change and so it went, still a scary time but literally every member of staff was superb, friendly helpful kind and empathetic still not a nice time when you have an operation, but certainty helps 100% by the people on the ward."

"getting sleep was an issue during the night some staff could of shown more consideration by lowering their voices, which of course woke the patients many times through the night and early hours of the morning. however I am very grateful to all the staff"

(Patient, Ward 12, RGH)

"Since my admission I have been treated with nothing more than respect, kindness and dignity off staff and the care received is second to none, should say all staff is A1+. When calling for help with something as rushed and busy as they are they are with you as quickly as possible and always polite and helpful."

(Patient, Ward 6, PCH)

"Everything has been brilliant; I was really nervous after so much scaremongering but honestly I can't fault how the hospital is being run."

(Patient, ACEU, RGH)

Staff Survey Summary

Between 1st October 2020 and 30th April 2021, a total of **249** staff surveys were completed across the participating clinical areas.

Staff Survey Question	Overall Rag % 2018	Overall Rag % 2019	Overall Rag % 2020/21	Overall Rag % 2022
Using a scale of 1-10, where 1 is very bad and 10 is excellent, how would you rate your overall satisfaction with your organisation	**69%**	**70%**	**78%**	**67%**

Highlights for the Staff Survey

The outcome of this years' staff survey varies from the findings of last year's survey.

Staff are telling us that they can access up to date information which supports them in doing their job. Whilst ¾ of staff who responded feel that the organisation supports them in having the knowledge and skills to deliver a consistent standard of compassionate care. Furthermore 89% of staff feel that we put local citizens at the heart of everything we do.

It is however concerning to note that just over half of the staff surveyed do not feel a valued member of the organisation and do not have a sense of belonging. In addition, only 40% of our staff report being proud to be a nurse/allied healthcare professional.

In response to this feedback and other sources of information, we promoted and utilised our Values that were launched in October 2020. Values workshops are being delivered by local managers, heightening people's awareness of the importance of our values and its direct impact on patient outcomes. The Leadership Development program launched in March 2022 seeks to elicit behavioural change in our people managers across CTM, with elements of the program focussing on bestowing value on teams and upholding the tenets of compassionate leadership.

Introduction to our Values Sessions form part of nursing and overseas nursing induction events. Staff recognition through our Values based thank you cards / e-cards has been an effective vehicle for managers to thank staff who have upheld our Values.

Furthermore, a Values and Behaviours Health Check assessment tool has been successfully piloted, enabling the leader to identify specific areas of focus based on the shared experiences of their staff. Feeling valued is synonymous with feeling heard and the ability to provide feedback is essential.

Creating a culture of psychological safety is also a key priority as open and honest feedback cannot exist when people do not feel psychologically safe. The values health check reveals where psychological safety is not present enabling targeted support to be sensitively deployed.

In October 2022, our Senior Executive team embarked on a Reverse Mentoring program in partnership with our BAME Network colleagues. This is a strong signal to our staff that our senior leadership are open to learn more about staff experiences and for this to potentially influence their decision-making in the future.

Development of a CTM Nursing and Midwifery Strategy

The priorities of the Chief Nursing Officer have been developed to set the strategic direction for the Nursing and Midwifery professions. The specific areas of work are supported by and/or led by the Office of the Chief Nursing Officer at Welsh Government to aid delivery of **A Healthier Wales (2018*)***

The 5 overarching priorities which have been agreed are:

1. Leading the Professions
2. Workforce
3. Making the Professions Attractive
4. Improving Health and Social Care Outcomes
5. Professional Equity and Healthcare Equality

Work is underway to revise and develop a refreshed Nursing and Midwifery strategy that is underpinned by the above 5 priorities

Summary Operational Audit

The audit results demonstrate that the UHB achieved a level of compliance for the operational questions of > 85% in all 7 Health and Care Standards themes. The following table provides a breakdown of the operational scores and identifies that improvement has been made across 5 of the standards

Operational Audit Overall Theme Summary	**2017 %**	**2018 %**	**2019 %**	**2020/21 %**	**2022 %**
Staying Healthy	**69.0**	**78.1**	**87**	**86.5**	**88**
Safe Care	**92.1**	**94.0**	**93**	**96.3**	**96**
Effective Care	**85.4**	**88.9**	**91**	**93.1**	**91**
Dignified Care	**84.4**	**88.3**	**88**	**90.5**	**100**
Timely Care	**90.0**	**100**	**98**	**100**	**100**
Individual Care	**87.6**	**91.6**	**93**	**94.4**	**89**
Staff and Resources	**88.5**	**94.9**	**98**	**96.1**	**97**

Operational questions: Overall Standard Summary	**2017 RAG %**	**2018 RAG %**	**2019 RAG %**	**2020/21 RAG %**	**2022 RAG %**
Staying Healthy					
1.1 Health Promotion, Protection, and Improvement	68	78	87	87	88
Safe Care					
2.1 Managing Risk and Promoting Health and Safety	97	95	96	98	97
2.2 Preventing Pressure and Tissue Damage	93	98	95	96	98
2.3 Falls Prevention	91	94	96	97	98
2.4 Infection Prevention and Control (IPC) and Decontamination	97	98	98	98	99
2.5 Nutrition and Hydration	88	88	89	93	91

Operational questions: Overall Standard Summary		2017 RAG %	2018 RAG %	2019 RAG %	2020/21 RAG %	2022 RAG %
2.6	Medicines Management	95	98	95	98	99
2.7	Safeguarding Children and Safeguarding Adults at Risk	92	93	90	94	99
2.8	Blood Management	78	94	90	81	100
2.9	Medical Devices, Equipment and Diagnostic Systems	98	97	98	97	100
Effective Care						
3.1	Safe and Clinically Effective Care	80	89	93	93	87
3.2	Communicating Effectively	88	92	94	95	93
3.3	Quality Improvement, Research, and Innovation	89	75	98	92	100
3.4	Information Governance and Communications Technology	100	100	97	97	93
3.5	Record Keeping	85	89	89	93	92
Dignified Care						
4.1	Dignified Care	84	88	88	90	93
4.2	Patient Information	88	90	93	95	94
Timely Care						
5.1	Timely Access (paediatrics only)	90	100	98	100	100
Individual Care						
6.1	Planning Care to Promote Independence	87	91	92	94	86
6.2	Peoples Rights	100	100	99	98	100
6.3	Listening and Learning from Feedback	95	96	100	97	100
Staff and Resources						
7.1	Workforce	88	95	98	96	96

	Question	2017	2018	2019	2020 /21	2022
All excluding neonates, theatres, District Nursing	For this episode of care, is there evidence that the patient's smoking habits been assessed?	76%	81%	87%	89%	97%
All excluding neonates, theatres, District Nursing	For this episode of care, where the patient is identified as a smoker and wishes to stop smoking, is there evidence that they have been provided with information in relation to smoking cessation?	48%	64%	75%	68%	92%
All excluding neonates, theatres, District Nursing	For this episode of care, is there evidence that the patient's weight has been measured?	86%	89%	92%	91%	82%
All excluding neonates, theatres, District Nursing	For this episode of care is there documented evidence that where the patient's weight is unhealthy that they have been provided with information in relation to a healthy diet?	70%	73%	96%	91%	75%
All excluding neonates, theatres, District Nursing	For this episode of care has the patient's alcohol intake been assessed?	79%	81%	87%	92%	89%
All excluding neonates, theatres, District Nursing	Where the patient has an identified problem with their alcohol intake, is there an up-to-date plan of care, which is being implemented and evaluated and has been reviewed within the agreed timescale?	55%	67%	80%	79%	77%
All excluding neonates, theatres, District Nursing	For this episode of care has the patient's illicit substance use been assessed?	40%	59%	75%	72%	100%

	Question	2017	2018	2019	2020 /21	2022
All excluding neonates, theatres, District Nursing	Where the patient has an identified problem with illicit substance use, is there an up-to-date plan of care, which is being implemented and evaluated and has been reviewed within the agreed timescale?	43%	56%	57%	72%	75%
District Nursing	Is the community nursing service able to demonstrate that systems and processes are in place for patients and their carers to access appropriate health improvement opportunities within the community?	100%	100%	100%	100%	100%
District nursing	Is the community nursing service able to demonstrate that systems and processes are in place to achieve individual service user outcomes?	100%	100%	100%	100%	100%

The principle of staying healthy is to ensure that people are well informed to manage their own health and wellbeing.

People's health related behaviours are influenced by a range of factors including social, economic, and physical environment and mental well-being. By making it easier for people to adopt healthy behaviours we will reduce the burden of disease and help narrow the gap in health inequalities arising from long term conditions such as obesity, cancers, heart conditions, stroke, respiratory disease, and dementia.

This means:

- Rapidly reducing smoking prevalence
- Increasing physical activity and promoting healthy weight
- Preventing harm from a range of behaviours including substance use

The questions for this standard focus on promoting these healthy behaviours.

Smoking Reduction

Of the records reviewed a compliance score of 97% was achieved for the assessment of patients smoking habits, compared to 89% in 2020/21.

Notable Good Practice

- The health board's smoking cessation service offers free and friendly support to staff, inpatients and outpatients who wish to stop smoking and would benefit from one-to-one support. We have Over **200 'No Smoking Champions'** now located on all sites and in most wards, departments, and units.

- The Cardiovascular Risk Reduction Health Check Programme that aims to reduce premature mortality from CVD, targeting more socio-economically deprived areas where prevalence of CVD is highest.

Illicit Substances

This year we have seen a significant increase in the assessment of a patient's illicit substance use from 72% to 100% moving us from an AMBER position to GREEN.

Promoting Healthy Weight

Whilst it's disheartening to see that the records demonstrated a 9% decrease in compliance in the measuring of patients' weight (82% from 91% last year), the comments made by staff in the audit suggest that there were several patients who were too unwell to be weighed, in these instances staff should record an answer of N/A.

Notable Good Practice

The catering team in Cwm Taf Morgannwg UHB have been developing several initiatives to help patients, staff, and the wider population to make the healthier choice. Working with the dietitians, they introduced a range of healthier options. The healthier option meal deal runs Monday to Friday and includes two of your recommended five a day of fruit and vegetables.

In addition, the Bar Barista outlets offering coffees and teas that are only served with semi-skimmed or skimmed milk. As well as providing tasty, healthier, meal deal options. The restaurants at Prince Charles and Royal Glamorgan hospitals now offer a fresh, delicious salad bar.

The catering team have also developed a scheme to encourage patients, relatives, service users and staff to eat more fruit. The Fruit Loyalty Card scheme has been launched across Cwm Taf Morgannwg UHB – buy six pieces of fruit and get one free.

	Question	2017	2018	2019	2020 /21	2022
ALL except OPD	Do all patients wear an identification band which states their first and last name, date of birth and NHS number?	94%	98%	99%	99%	100%
ALL	Is the patient's identity checked visually and verbally prior to undertaking a procedure?	96%	99%	99%	100%	100%
ALL except Neonates, OPD, Theatres	For this episode of care, is there documented evidence that the patient has an up-to-date manual handling risk assessment?	88%	89%	96%	97%	99%
ALL Except Neonates, OPD, Theatres	For this episode of care, where the patient has an identified manual handling risk, is there evidence that there is an up-to-date plan of care which is being implemented and evaluated and has been reviewed within the agreed timescale?	83%	87%	93%	97%	98%
ALL except Neonates, OPD	If a patient has been assessed as requiring bed rails, is there an up-to-date risk assessment in place?	87%	92%	95%	96%	96%
ALL	Within the clinical area, are all fire restraint doors free from obstruction or closed if not automatic self-closing?	95%	98%	94%	99%	98%

	Question	2017	2018	2019	2020 /21	2022
Paeds only	Is the Child/Young Person in an age-appropriate bed with cot sides/bed rails in situ?	100%	100%	100%	100%	100%
Endoscopy & theatres only	Is there evidence of the team brief and de brief being undertaken?	100%	100%	100%	100%	100%
Endoscopy & theatres only	Is there evidence that the department is compliant with the WHO checklist?	100%	100%	100%	100%	100%

The overall score for this standard remains consistently high across annual audits, demonstrating that the safety and welfare of our patients is taken seriously.

Patient Perspective: Many patients felt that they were made to feel safe whilst in hospital with 99% of the patients responding positively to this question.

Introducing Safe to Start

A new innovative approach to managing patient flow has been launched. The aim of Safe 2 Start is to bring together all ward managers to discuss staffing, capacity, quality, and safety across the hospital site in order to ensure all wards and departments are safe to start the day.

The daily meetings are a way for nurses and departments to express any concerns and to ensure the hospital can deal with the current pressures by ensuring that all wards are staff and working to full capacity and if not, for staff to be mobilised across the hospital to support each other.

The project has successfully been able to support numerous wards that were not safe to start due to staffing constraints and support the extremely busy emergency department to help cut long ambulance delays and bed waits through the identification of ward capacity and planned patient movement.

Embedding the Safe 2 Start concept was key to the delivery of improvement and change for the teams. We have created a structured approach for the teams to describe the demands on their wards, but also to understand the demands other areas are also seeing. In exposing all

ward areas to this, we have now seen a cultural shift where wards are owning and sharing the response to try and minimise and mitigate the risk that patients are experiencing on site.

The safety of our patients is the key priority across the Health Board and this new approach places the patient truly at the centre of all hospital decisions.

'Safe 2 Start' daily meetings are now in place across all community and acute hospitals in CTM UHB.

	Question	2017	2018	2019	2020 /21	2022
ALL except neonates	For this episode of care, is there documented evidence that the patient's skin condition has been assessed and discussed with the patient or advocate?	90%	97%	95%	98%	99%
ALL except neonates	For this episode of care, where the patient has been identified as requiring assistance with looking after their skin, is there evidence that there is an up-to-date plan of care, which is being implemented and evaluated and has been reviewed within the agreed timescale?	98%	98%	95%	94%	98%

Standard 2.2 Preventing Pressure and Tissue Damage

Of the patients reviewed, 99% of the patients had evidence that their skin condition had been assessed and discussed with them or their advocate an increase of 1% compared to last year.

Of the patients who were identified as requiring assistance with looking after their skin, 98% had evidence that they had an up-to-date care plan, which was being implemented, evaluated and had been reviewed within the agreed timescale. An increase from last year's 94%.

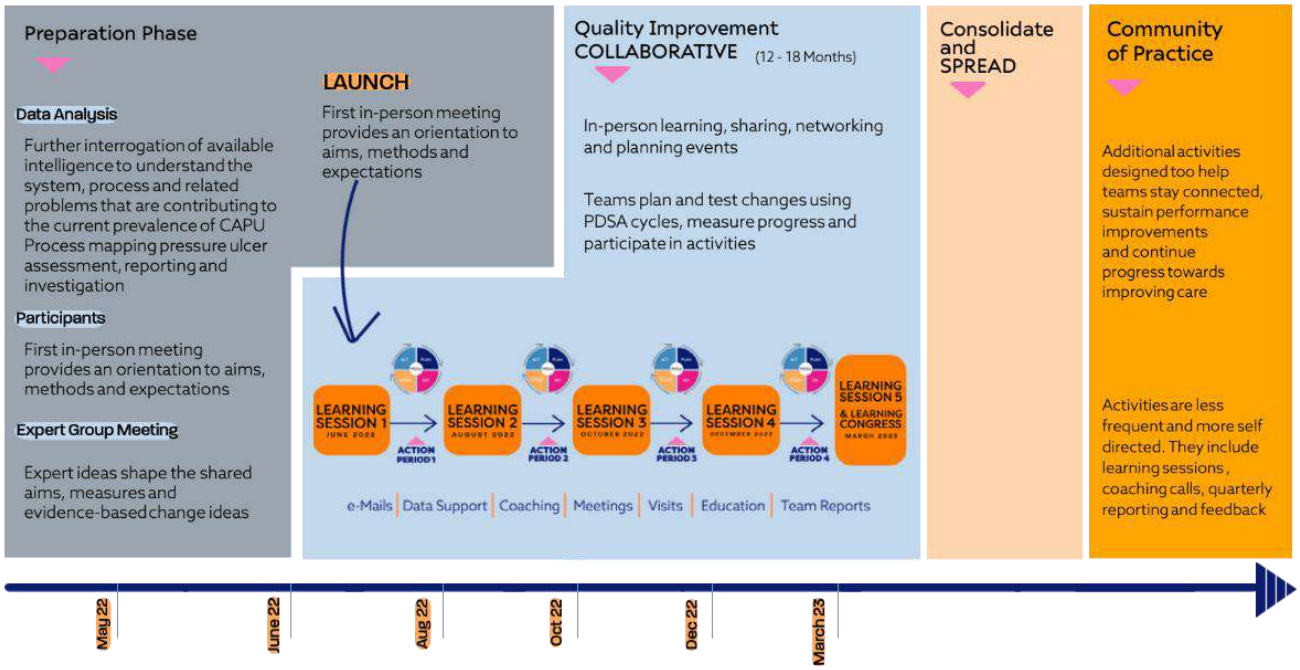
Avoidable Community Acquired Pressure Ulcer Improvement Collaborative Program

For the most part pressure ulcers are avoidable, and their incidence may be related to several system factors such as poor in-hospital flow and over-burden of nurses. When one arises it is painful, debilitating and can have life threatening and devastating impact on patients and their families

The Pressure Ulcer Prevention Collaborative program is a quality improvement initiative designed to support healthcare teams to reduce the incidence of avoidable pressure ulcers in the community.

The primary aim of this initiative is to reduce the number of **avoidable** pressure ulcers across the collaborative areas. A secondary aim is to increase the capacity and capability of frontline clinical teams to improve the care they deliver using quality improvement methods.

This proven methodology enables teams to become part of an active learning community learning from other teams and recognised experts around a chosen topic or focused set of objectives. The collaborative model provides a framework for improvement and sets a momentum and pace for executing sustainable change. The collaborative will run for 12-18 months following the methodology promoted by the IHI (Fig.1).

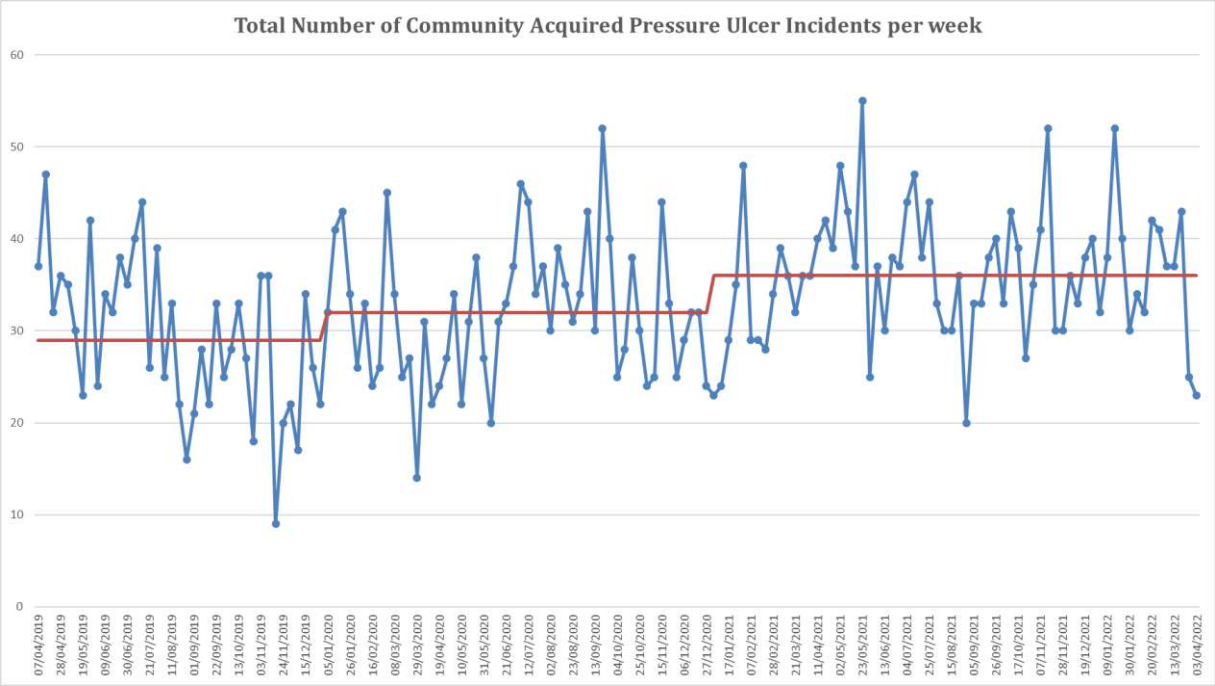


(Fig.1).

Discovery Phase: Understanding the problem

Further interrogation of available intelligence has helped us to start to understand the system, process and related problems that are contributing to the current prevalence of CAPU

The run chart below shows a steady increase in the total community acquired pressure ulcers over the last 3 years



The major themes for action cycles will be identified through a series of learning sessions with periods of action and facilitation between them to promote and produce sustainable change. Teams will be supported to take local ownership for improvement and to build processes of care that are reliable enough to achieve the goal. (*See below*)

Key Milestone dates agreed to date

1. **May 19th** – Inaugural meeting of Expert Faculty
2. **29th June** – Collaborative Launch Event
3. **16th September** - First Learning Session

Pressure Ulcer Investigation Panels

To support a culture of learning and improvement we have introduced a fortnightly programme of investigation panels where we scrutinise all pressure ulcers incidents. The panels consist of a head of nursing, tissue viability nurse and a safety improvement manager.

The senior nurse, ward manager and ward staff attend the panels and present their cases using the patients' nursing records which are reviewed to help identify any areas for improvement and learning.

Where an outcome of avoidable harm has been made which would indicate that there have been missed opportunities, a referral to safeguarding is made. An improvement plan which aims to address all missed opportunities with a view to improve care, patient experience and outcomes along with a proposed percentage reduction of pressure ulcer incidents at clinical level is developed and monitored for progress.

The benefits recently identified through this process include:

- the importance of using the correct equipment immediately
- escalation of any difficulties in obtaining equipment
- actual repositioning of patients (and not moving the patient back to the original position),
- use of knee brakes,
- use of cushions when a patient sits out

Patient Perspective:

"During your stay, were you given help and advice on how to prevent damage to your skin?"

93% of the patients answered positively to this. This is an increase on last year's 86%

	Question	2017	2018	2019	2020 /21	2022
ALL except neonates & OPD	For this episode of care, is there documented evidence the patient's mobility has been assessed and discussed with the patient or advocate?	96%	97%	96%	99%	99%
ALL except neonates & OPD	For this episode of care, where the patient has been identified as requiring support and/or assistance with mobility, is there evidence that there is an up-to-date plan of care, which is being implemented and evaluated and has been reviewed within the agreed timescale?	91%	91%	96%	97%	98%
ALL except maternity neonates, paediatrics, OPD, theatres	For this episode of care, is there documented evidence the patient's risk of falls has been assessed and discussed?	91%	95%	96%	98%	99%
ALL except maternity neonates, paediatrics, OPD, theatres	For this episode of care, where the patient has been identified as being at risk of falls, is there evidence that there is an up-to-date plan of care, which is being implemented and evaluated and has been reviewed within the agreed timescale?	84%	94%	96%	93%	97%

Patient safety is a priority for us and reducing the incidence of in-patient falls remains a challenge. Whilst we continue to test and develop initiatives to help us tackle this problem. Being in hospital does not mean we can completely prevent falls, but we are committed as a University Health Board to reducing the number of avoidable falls and any injuries that may occur as a result.

Of the patient records reviewed, 99% of the patients had documented evidence that the patient's mobility had been assessed and discussed. Of those patients identified as requiring support and/or assistance with mobility, 98% had evidence of an up-to-date plan of care, which was being implemented and evaluated and had been reviewed within the agreed timescale, a slightly improved position from last year

This year we have seen an increased compliance with our falls risk assessment and care planning. Of the patient records reviewed, 99% of the patients had documented evidence that the patient's risk of falls had been assessed and discussed. Of those patients identified as being at risk of falls, 97% had evidence of an up-to-date plan of care, which was being implemented and evaluated and had been reviewed within the agreed timescale (up 4% on last year's position).

The Quality Improvement team, central patient safety team and the corporate nursing team continue to support the Integrated Locality teams in a targeted approach to reducing inpatient falls. However, it has been recognised there is a need for a CTMUHB wide Falls Prevention and Management Group to be established (please see section 2.3 for further details).

Falls Scrutiny Panels

Hospital sites and community nursing have regular, robust multidisciplinary team falls panels, which include representation from a medic, physiotherapist, occupational therapist, pharmacist and nurse.

All Wales Falls Investigation Tool

The Delivery Unit and Once for Wales Datix team have confirmed plans for an All Wales Falls Investigation Tool to be launched, which will align with a similar tool which in in place for pressure damage investigation. The introduction of a robust investigation tool which will be used across all ILG's will aid consistency and support a clear outcome from panel, with agreed level of harm and whether the fall was avoidable or unavoidable.

CTMUHB wide Falls Prevention and Management Group

This group will support the Quality & Safety Committee's role and function in its responsibility for ensuring the quality and safety of healthcare in relation to the prevention, assessment and management of falls in line with Health Care Standard 2.2.

The terms of reference for this multidisciplinary group have been drafted and an initial meeting took place in June 2022.

The group will:

- Provide a means for the multidisciplinary representation of the Clinical Service Groups, patient safety team (s), corporate nursing team, safeguarding and quality improvement team to work to develop a robust quality improvement programme**,** which will be a vehicle for reducing the incidence of avoidable harm from falls.

- Monitor progress via an annual plan of work, which will include the creation and launch of CTMUHB Falls Strategy, the monitoring of compliance with NICE guidance and any national audits (e.g. fracture neck of femur audits), and the review of the CTMUHB Inpatient falls policy**.**

- Monitor all aspects of the "Putting Things Right policy" and any Safeguarding concerns as applicable to a patient who has sustained a slip, trip or fall within our health care setting; this will allow the patient experience and any financial penalties in terms of redress and claims to feature at the forefront of any improvement work

Whilst there is a need to focus on inpatient falls, it is recognised that there is an urgent need to work with our partner agencies for example Welsh Ambulance Service, Fire service and third sector teams to reduce the number of slips, trips, falls that occur in our community settings which often result in admission to hospital. This will feature heavily in the proposed CTMUHB Falls Strategy and form part of the Falls Prevention and Management Group agenda.

This Falls Prevention and Management Group will assist the Quality and Safety Committee in measuring the success of quality improvement goals by sharing learning and best practice and identifying trends which should be taken into account in improving and escalating risks.

The progress of the "Falls Prevention and Management Group" will be evaluated at their monthly meetings and report on a quarterly basis to the Quality & Safety Committee.

	Question	2017	2018	2019	2020 /21	2022
ALL	Are staff able to give examples of the correct procedure for infection control?	100%	98%	100%	100%	98%
ALL except maternity, peads, LD, OPD,	Are staff able to give examples of the correct procedure for isolating patients?	98%	99%	99%	100%	100%
ALL Except maternity, neonates, OPD,	Are all patients given the opportunity to wash or cleanse their hands with hand wipes prior to eating food?	92%	97%	94%	95%	100%

We achieved a green RAG rating in all three of the infection prevention & control (IPC) and decontamination questions.

The IPC work programme remains a priority for the health board and the IPC committee aims to ensure that the Board receive assurance that safe and effective policies for Infection Prevention and Control are in place. This has been under pressure in the last 2/3 years with the frequently changing guidance for managing the COVID 19 pandemic

Hand Hygiene:

100 % of the areas confirmed that *all patients are given the opportunity to wash or cleanse their hands with hand wipes prior to eating food (up 5%)*.

The annual audit does not include a general question on hand hygiene, but compliance is monitored on an ongoing basis using the Care Indicator module of the Health & Care Monitoring System. The expectation is that the audit is undertaken for a minimum period of 20 minutes (or until at least 10 opportunities are observed) across all clinical areas at least once a month and the auditor would observe if all staff disciplines working in patient areas have adequately decontaminated their hands, in accordance with the requirements of the WHO 5 moments.

The target compliance for this indicator is 95%. Several wards consistently achieve 100%, however, the result can be influenced by the time of day the audit is undertaken, the staff on the ward at the time and the number of opportunities for decontamination.

Spot audits by the IP&C team to triangulate the results obtained by the teams themselves demonstrated that there was still work to do to ensure consistency in both the audit process and the hand hygiene required.

The IPC Nurses perform an IPC investigation for other preventable bacteraemia infections, for example urinary catheters. This is shared with the Ward/ District Nursing Team/ Bowel and Bladder team to investigate further and for sharing of lessons learned. This process is currently undertaken on paper, and the aim is to introduce an "IPC huddle" for these also.

	Question	2017	2018	2019	2020 /21	2022
ALL except Maternity, neonates, LD, theatres	Prior to eating, are patients that require help, assisted into a suitable position?	98%	100%	100%	100%	100%
ALL except Maternity, neonates, LD, theatres	Prior to meal service, are bed tables and communal areas cleared and tidied prior to eating?	93%	97%	100%	98%	100%
ALL except Maternity, neonates, LD, theatres	Are patients' meals placed within easy reach?	100%	100%	100%	100%	100%
Inpatient, paeds, MH & LD only	Is there evidence that the systems in place to enable staff to identify patients with special eating and drinking requirements are being implemented and their effectiveness evaluated?	96%	96%	97%	100%	100%
Inpatient, maternity MH, Day Units only	Are water jugs changed 3 times daily?	39%	35%	45%	85%	56%
ALL except Maternity, neonates, MH, theatres	Is fresh drinking water available for patients?	100%	100%	100%	100%	100%
ALL except neonates, MH, OPD, endoscopy, theatres	Are drinking water jugs and glasses within the patient's reach?	97%	100%	97%	99%	100%
Inpatient, ED, Maternity, MH & LD only	During a 24-hour period, are a minimum of 7 beverage rounds are carried out within your clinical area?	48%	56%	48%	70%	59%

	Question	2017	2018	2019	2020 /21	2022
Inpatient, ED, paeds, MH & LD only	Does a Registered Nurse co-ordinate every mealtime?	83%	76%	88%	85%	83%
Inpatient, ED, MH & LD only	Is there evidence that all members of the nursing team are engaged in the mealtime service?	98%	85%	97%	96%	97%
ALL except neonates, OPD, theatres	Is a range of snacks available for patients who have missed a meal or who are hungry between meals?	92%	87%	87%	92%	100%
Inpatient, ED, paeds, MH & LD, endoscopy only	Family/friends can assist at mealtimes?	100%	100%	100%	84%	97%

The Health Board is committed to providing and promoting good nutritional care, as nutrition and hydration are vital aspects of patient care. Early detection and management of nutritional risk across community and secondary care promotes well-being and supports better patient outcomes and improved recovery rates.

The 'All Wales Nutrition and Catering Standards for Food and Fluid for Hospital Inpatients' provides a framework for the nutrition and hydration needs of our patients which includes:

- The provision of nutritious meals that meet all patient's nutritional, therapeutic and cultural needs, and preferences.
- Easy availability of snacks at ward level.
- 'Protecting mealtimes' and promoting mealtimes as a crucial part of the treatment process.
- Supporting all patients to meet their nutritional needs; and
- Early enhanced nutrition for patients who are unable to meet their requirements.

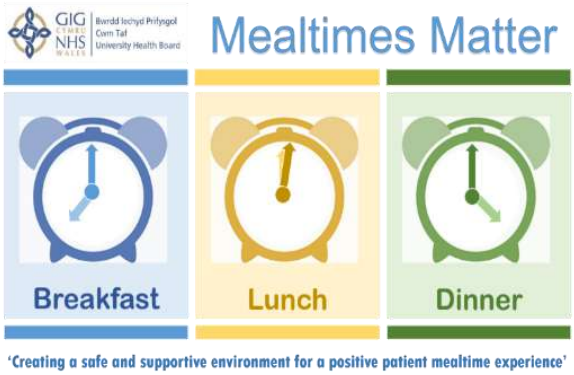
The audit includes several questions around mealtimes and the provision of beverages. We have a consistent low score relating to the changing of water jugs 3 times a day. When looking at the staff comments in the audit they refer to jugs being changed twice a day and then as required.

Conversely, we are scoring 100% for the question relating to the availability of fresh drinking water for patients. In addition, we continue to score low

with the question relating to beverage rounds. Some work needs to be done to understand why this is the case

We need to do some work to understand staff's perception of the three questions to ensure we are getting an accurate reflection of what is happening in clinical practice.

Registered Nurses have a professional accountability for ensuring patients receive appropriate food and assistance to eat where required, monitoring their food & fluid intake in accordance with the All-Wales Catering and Nutrition Standards for Food and Fluid Provision for Hospital Inpatients. Whilst there is an improvement in members of the nursing team engaging in mealtimes there is still some work to be done in improving the co-ordination of mealtimes by a registered nurse.



As a part of identifying priorities for 2020/21 we pledged to redesign our current protected mealtime's policy so that it is more conducive to a supported positive mealtime experience for patients.

A meal does not start with the appearance of food on a table, and it does not end with the last bite. It encompasses various aspects including the preparation of food, the anticipation of a meal, the environment in which it's eaten, the conversation during the meal, eating with dignity, the end of the meal and cleaning up. It is important to realize that an individual's experience around mealtimes extends far beyond the food.

Activities occurring before and after meals, menu choices and how they are offered, how the meal is introduced and the social interactions during mealtimes all need to be actively considered. Each one of these parts affects the individual's overall mealtime experience and consequently their nutritional status. The Patient Mealtime Procedure aims to improve the mealtime experience by:

- Allowing patients to eat meals without unnecessary interruption by limiting non-essential clinical ward-based activities and non-essential patient transfers.

- Ensuring that all patients receive a meal that meets their personal preferences and any specialist dietary requirements, such as modified textured food.

- Supporting clinical staff to prioritise mealtimes.

- Recognising and supporting the social aspects of eating.

- Providing an environment conducive to eating.

- Offering assistance with eating and drinking to those requiring it.

When this procedure is implemented fully it will help in the recovery of our patients empowering nursing and catering staff to provide effective nutritional care. Positive and encouraging behaviour when handling and serving food is essential in '*Creating a safe and supportive environment for a positive patient mealtime experience'*

Using a 'Speaking Mug' to encourage vulnerable patients to drink more

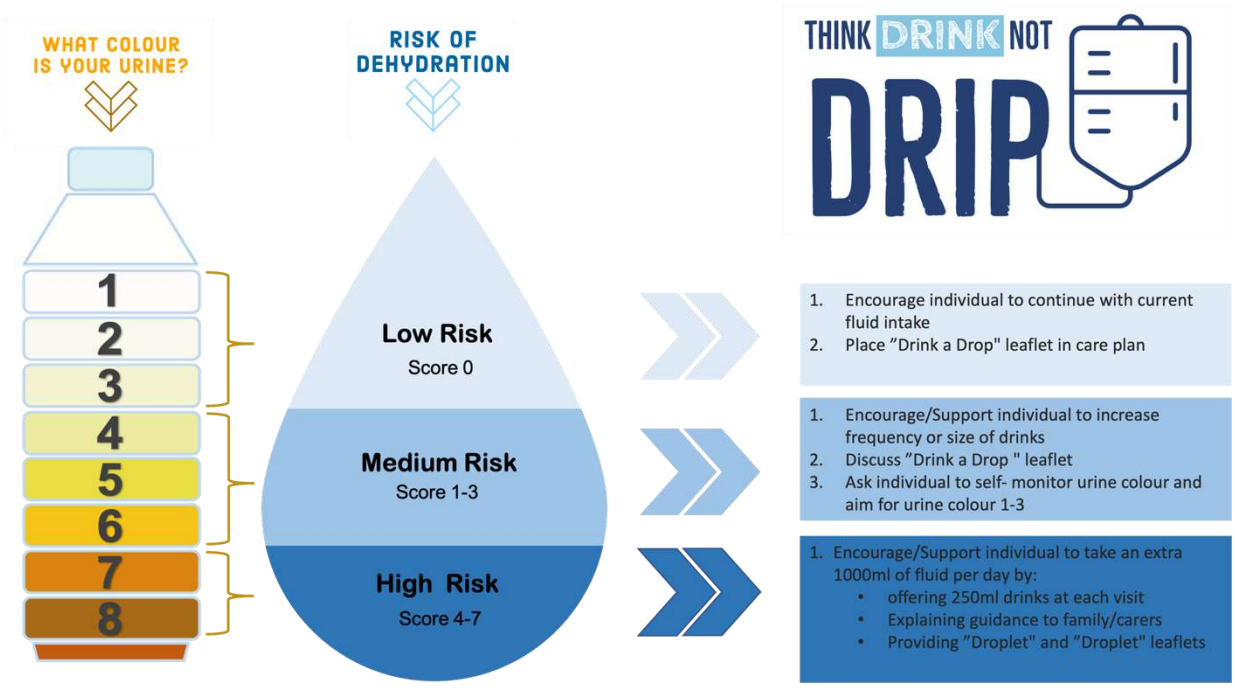
We have tested the use of Droplet® in a bid to see if it helped increase the amount of fluid drunk by our vulnerable patients in hospital. Droplet® is the first hydration aid to tackle dehydration by simultaneously supporting both individuals and carers. Droplet® helps those who need additional support or encouragement to stay hydrated.

We have been testing this across several wards within the Health Board and have seen an average increase of **43%** in the average amount of fluid drunk - that's equivalent to just over 4 8oz glasses of fluid per patient. We need to undertake further tests of change before committing to purchasing further units for the health board

Furthermore Droplet® is one intervention being used in a research study referred to as PARCHED (Prompting And encouRaging Community Hydration through Education). The study aims to test the possibility that education and/or Droplet® can help reduce ill-health in a catheterised community-dwelling population through empowering district nurses to

improve hydration. The study was due to take place over a two-year period but has stalled due to the impact and restrictions imposed by COVID

Building on this work we have been looking at understanding some of the behaviours that might be affecting patient and staffs understanding of the importance of oral hydration. We have developed a poster to raise awareness and need to test this in practice and measure the impact of any behaviour change



Further work is needed to understand the challenges around oral hydration in hospitals

Patient Perspective: The survey scores indicate that most patients are happy with the provision of food and drink and that they are provided with support when required. Overall satisfaction has remained above 97% for all questions.

	Question	2017	2018	2019	2020 /21	2022
ALL except OPD	Are all medication charts completed with the following information: patient demographics and allergies and it is clear whether there is more than one medication chart?	87%	95%	90%	100%	98%
ALL	Is the patient's identity checked visually and verbally prior to giving medication?	96%	99%	99%	99%	100%
ALL	Are all drug cupboards/trolleys locked and secure as per local policy?	93%	100%	100%	98%	98%
All except neonates & OPD	Has the nurse witnessed the patient taking the medication given to them?	100%	99%	97%	97%	100%
All except neonates & OPD	Is there evidence that medication is taken in a timely manner and is not left on lockers/around patient beds?	100%	100%	91%	98%	100%
Neonates & Paeds	Are all medications checked by two qualified nurses?	100%	100%	100%	100%	100%
District Nursing	Is the community nursing service able to demonstrate clearly defined processes including policies and procedures for obtaining and storing medication and for medicines management?	100%	100%	100%	100%	100%

Of the medication charts reviewed, 98% of the charts had the patient demographics and allergies documented on them and it was clear whether there was more than one medication chart completed, however this was a slightly worsened position than last year.

Of those patients observed having medication, 100% of the patients had their identity checked visually and verbally prior to giving medication an improved position from last year

98% of the areas participating in the audit confirmed that all drug cupboards/trolleys locked and secure as per local policy. Where areas were not compliant this was addressed immediately to ensure compliance. Many high-risk areas such as Emergency departments and Theatres are using Mediwell electronic medication dispensary systems. This ensure restricted access and is only accessible with personal identification log in details or fingerprints so no need for keys. Further work is being undertaken with pharmacy to ensure the policy and audit questions relate back to clinical practice in line with local policies.

Additional data can be found in the visual below from the Controlled Drugs Audit. This is conducted monthly as part of the wider point review audits.

Insight detail

Generated on 25th July 2022

Controlled drug medicines and storage audit

Insight detail	Compliance over last 6 periods						Current	Improvement	Overdue actions
Audit	98.1%	97.8%	97.8%	98.2%	99.2%	95.2%	98.3%	▼	4

Low scoring Qs	Compliance over last 6 periods						Current	Improvement	Overdue actions
Q4. Is the nurse in charge clearly identifie? (Eg on duty, on patient at a glance board etc.)	100.0%	100.0%	100.0%	87.5%	100.0%	95.1%	100.0%	▼	
Q6.1. Does the nurse in charge know who has the keys?	100.0%	100.0%	100.0%	100.0%	100.0%	85.7%	100.0%	▼	
Q6.2. Was the person holding the keys a registrant/ ODP?	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	50.0%	➤	
Q10. Are the controlled drug keys separate from the main bunch of keys?	88.9%	100.0%	100.0%	100.0%	100.0%	88.1%	96.2%	➤	
Q18. The receiving person is NOT the same as the person who ordered the CDs?	88.9%	100.0%	85.7%	100.0%	100.0%	80.0%	95.8%	▼	0
Q20. Is there a record that ward CD stocks checked at least once in 24 hours and daily balances checked by two Registrants?	88.9%	75.0%	87.5%	87.5%	87.5%	69.4%	86.4%	▼	2
Q26. Are transfers of CD's to a new page recorded appropriately?	100.0%	100.0%	100.0%	100.0%	88.9%	96.7%	100.0%	▼	
Q27. • Date…	100.0%	87.5%	100.0%	100.0%	100.0%	100.0%	100.0%	▲	

	Question	2017	2018	2019	2020 /21	2022
ALL	Can staff demonstrate they know the procedure if a safeguarding concern is identified?	93%	95%	97%	98%	99%
ALL	Can staff demonstrate they know the safeguarding lead nurse for their area and how to contact them?	100%	100%	100%	100%	100%

Safeguarding and Public Protection training is vital in protecting our service users, their families, and our communities from harm. Safeguarding Children and Safeguarding Adult training is identified as two of the Mandatory training requirements in the NHS UK Core Skills Training Framework. All staff must have achieved the competency level required to their role in relation to children, young people or adults who are at risk.

The corporate team ensures that appropriate training is available for all staff to ensure that they are confident in safeguarding people. Staff will achieve the competency they require through safeguarding training and dissemination of learning as well as research from Practice Reviews and Multi Agency Practitioner Forums.

There are four key dimensions of Safeguarding Training:

- Adults at Risk
- Child at Risk
- Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV)
- DoLS/MCA

The safeguarding team participate in training development and delivery and host several training sessions on Health Board sites to facilitate accessibility for staff. Bespoke training has also been provided by the corporate team to individual staff groups on request where a specific need has been identified.

The Safeguarding Team has undertaken several events and exercises in 2021/22 to embed safeguarding culture and awareness across the health

board including a greater presence on social media and activities during Regional Safeguarding Week. Changes have and will be made to the delivery of safeguarding training for the Health Board for greater accessibility.

Safeguarding training for Adults and Children will be available both virtually and face to face from January 2023. Bespoke level 3 training for adults and children will also be offered to areas of low compliance, where there is an importance to ensure that staff have an appropriate level of knowledge and skills.

The Cwm Taf Multi Agency Safeguarding Hub (MASH) sits within the structure of the Safeguarding Board and acts as the single point of contact for all professionals to report safeguarding concerns across Merthyr Tydfil, Rhondda Cynon Taf and Bridgend. MASH facilitates safeguarding by working together, in one place, sharing information and making collaborative decisions. Through MASH, a more timely and proportionate approach to the identification, assessment and management of safeguarding, child and adult protection enquiries can be achieved.

Cwm Taf Morgannwg currently has two MASHs, one based at Pontypridd Police Station and the other in Bridgend. The success of these Hubs has been developed through a phased co-location of key statutory partners, including the police, health, probation, education, and local authorities. Cwm Taf MASH is the 'front door' for all adult and child safeguarding referrals, including high risk domestic abuse.

The MASH team are available 24 hours day 7 days per week inclusive of the Emergency Duty Team team for out of core hours 9-5pm. Within Health, there are four Public Protection Nurses based in MASH to provide support and guidance to all health colleagues, each allocated to a specific ILG and identified clinical areas for continuity and robust information sharing, they role is pivotal in the facilitate the delivery of the safeguarding agenda across CTM. Our Safeguarding and Public Protection intranet site provides all details for contact numbers for both MASH and the corporate team, relevant email address and information for safeguarding topics. This information is further shared in training and via all communication channels within our governance structures.

The team share learning from adult and child practice reviews and other relevant reviews or investigations. Whilst this is predominantly achieved through the Safeguarding Operational Groups and Quality, Safety and Patient Experience Groups. Further work is required to ensure learning is repeatedly shared effectively throughout the Health Board. Collaborative working with both primary and secondary care will identify further opportunities to provide early help and support with regards to community wellbeing. All Safeguarding policies will be reviewed and updated to reflect the risks and vulnerabilities identified within our communities.

Improved use of SharePoint, social media and comms will improve the ability to repeatedly share learning and key safeguarding messages across the Health Board and communities. Planned audits throughout several services will measure outcomes and evidence if shared learning and changes are effective.

A total of 3,027 safeguarding referrals were submitted by Health and recorded by Cwm Taf Morgannwg MASH for 2021-22. This is inclusive of 2,481 child at risk concerns, 438 adult at risk referrals and 108 related professional concerns relating to staff employed by CTM UHB. This is a reflection on staff awareness in identifying safeguarding concerns and reporting appropriately as guided by the Wales Safeguarding Procedures. The aim of the Safeguarding team is to continue raising awareness and supporting staff to be confident and competent to embed safeguarding within their daily roles and engage within the Safeguarding and Public Protection processes.

Deprivation of Liberty Safeguards and Mental Capacity Act

Deprivation of Liberty Safeguards (DoLS)

Since April 2009 the Mental Capacity Act has been supplemented by the Deprivation of Liberty Safeguards (DoLS). These safeguards protect the rights of people who lack the capacity to consent to treatment or care in a hospital or a care home, where the care might involve depriving the person of their liberty. There is a supplementary Code of Practice for the Deprivation of Liberty Safeguards which explains how to identify when a person might be being deprived of their liberty, how deprivations might be avoided and, where necessary and in a person's best interests, how a deprivation of liberty can be authorised.

A DoLS authorisation application will need to be made for any patient where:

- You believe the patient lacks capacity to validly consent to being in hospital for care and treatment.
- The patient is under continuous supervision and control.
- The patient is not free to leave; and
- These circumstances apply for a not insignificant period of time.

(For more Information see Page 39)

	Question	2017	2018	2019	2020 /21	2022
Neonates only	All staff involved in direct nursing care should have been trained in Blood Transfusion Administration	78%	100%	100%	95%	100%

Overall results for this question show an improved position in compliance of the staff involved in direct nursing care have been trained in blood transfusion administration of 100% a 5% increase on last year.

	Question	2017	2018	2019	2020 /21	2022
ALL except neonates	Are any Manual Handling aids and slings regularly checked for wear and tear?	98%	98%	97%	95%	97%
ALL	Is all equipment used up to date with maintenance and calibration?	99%	96%	99%	99%	97%

The high rating for Standard 2.9 Medical Devices, Equipment and Diagnostics Services shows consistent green RAG rating, this demonstrates that ward staff are proactive in ensuring that equipment is checked and maintained regularly.

	Question	2017	2018	2019	2020 /21	2022
Inpatient areas, emergency departments, mental health and learning disabilities	For this episode of care, where there is doubt about the patients' capacity to make decisions, is there documented evidence that an assessment of capacity has been undertaken?	87%	86%	96%	94%	90%
Inpatient areas, emergency departments, mental health and learning disabilities	Where it has been identified that the patient lacks capacity, is there evidence that there is an up-to-date plan of care, which is being implemented and evaluated and has been reviewed within the agreed timescale?	60%	84%	90%	90%	84%
Inpatient areas, emergency departments, mental health and learning disabilities	For this episode of care, is there documented evidence that where a patient's liberty has been restricted, that a Deprivation of Liberty Safeguard application has been made?	92%	96%	93%	97%	87%
Inpatient areas, emergency departments, mental health and learning disabilities	Where it has been identified that the patient's liberty is being restricted/deprived, is there evidence of an up-to-date plan of care, which is being implemented and evaluated and has been reviewed within the agreed timescale?	80%	97%	84%	90%	76%
Paeds	Are staff able to demonstrate they are aware of the Paediatric Best Practice" guidelines and how to access this document?	100%	90%	100%	100%	100%

Mental Capacity: The Mental Capacity Act (MCA) 2005 has been in force since October 2007 and places the person, who may lack capacity, at the centre of care. In the healthcare context, every adult with mental capacity has the right to decide whether to accept treatment, even if a refusal may risk permanent injury to health or even lead to premature death. If

somebody lacks mental capacity, they should not be deprived of treatment that they need just because they cannot make the decision.

Deprivation of Liberty Safeguards (DoLS): Since April 2009 the Mental Capacity Act has been supplemented by the Deprivation of Liberty Safeguards (DoLS). These safeguards protect the rights of people who lack the capacity to consent to treatment or care in a hospital or a care home, where the care might involve depriving the person of their liberty. There is a supplementary Code of Practice for the Deprivation of Liberty Safeguards which explains how to identify when a person might be being deprived of their liberty, how deprivations might be avoided and, where necessary and in a person's best interests, how a deprivation of liberty can be authorised.

A DoLS authorisation application will need to be made for any patient where:

- It is believed that the patient lacks capacity to validly consent to being in hospital for care and treatment.
- The patient is under continuous supervision and control.
- The patient is not free to leave; and
- These circumstances apply for a not insignificant period of time.

The UHB has received investment from Welsh Government to improve the provision of the MCA and DoLS Service in preparation for the Liberty Protection Safeguards (LPS) implementation.

The Liberty Protection Safeguards will provide protection for people aged 16 and above who are or who need to be deprived of their liberty in order to enable their care or treatment and lack the mental capacity to consent to their arrangements.

The Liberty Protection Safeguards were introduced in the Mental Capacity (Amendment) Act 2019 and will replace the Deprivation of Liberty Safeguards (DoLS) system. The Liberty Protection Safeguards will deliver improved outcomes for people who are or who need to be deprived of their liberty. The Liberty Protection Safeguards have been designed to put the rights and wishes of those people at the centre of all decision-making on deprivation of liberty.

Due to Covid 19 the implementation of the LPS has been delayed by a year with an unofficial implementation date of Spring 2024.

The figures from the survey correlate with the DoLS Teams Welsh Government Data where the Health Board received the most referrals on record 1220 (+18% on last year, and +7% pre-Covid) which demonstrates that wards are correctly identifying patients that lack capacity to consent to their hospital admission for care and treatment require DoLS authorisations.

The DoLS Team has been heavily involved in training and education groups throughout the Health Board completing work with:

- YCC Improvement Group
- MCA Consent Group
- Ombudsman reports and actions at YCR
- D2RA
- Safeguarding Operational Groups
- LPS All Wales Task and Finish Groups
- Advocacy Support
- Bespoke MCA training with regards to consent, MCA, and legal implications in critical care treatment.
- Bespoke MCA/MHA interface training on the older person mental health wards.

	Question	2017	2018	2019	2020 /21	2022
ALL except OPD	For this episode of care, is there documented evidence that the patient's ability to achieve effective communication has been assessed and discussed with the patient or advocate?	93%	96%	98%	97%	97%
ALL except OPD	Patients have an up-to-date care plan in respect of communication needs?	80%	90%	85%	92%	94%
ALL except theatres	Is a nurse present to support the patient during formal senior contact between healthcare professionals' doctors/consultants/GP Questions and patients?	99%	98%	97%	99%	98%
ALL except neonates, day units, theatres	For this episode of care, is there documented evidence that an assessment of the carer's needs has been considered?	70%	78%	94%	86%	94%

Of the patient records reviewed, 97% had documented evidence that the patient's ability to achieve effective communication had been assessed and discussed with the patient or advocate (unchanged from last year); and of those patients identified as requiring assistance with effective communication, 94% had evidence of an up-to-date plan of care, which had been implemented, evaluated, and reviewed within the agreed timescale (a 2% increase on last year).

It was pleasing to note an increase in the compliance of evidence that a carer's assessment had been undertaken, following the significant decrease of 10% last year.

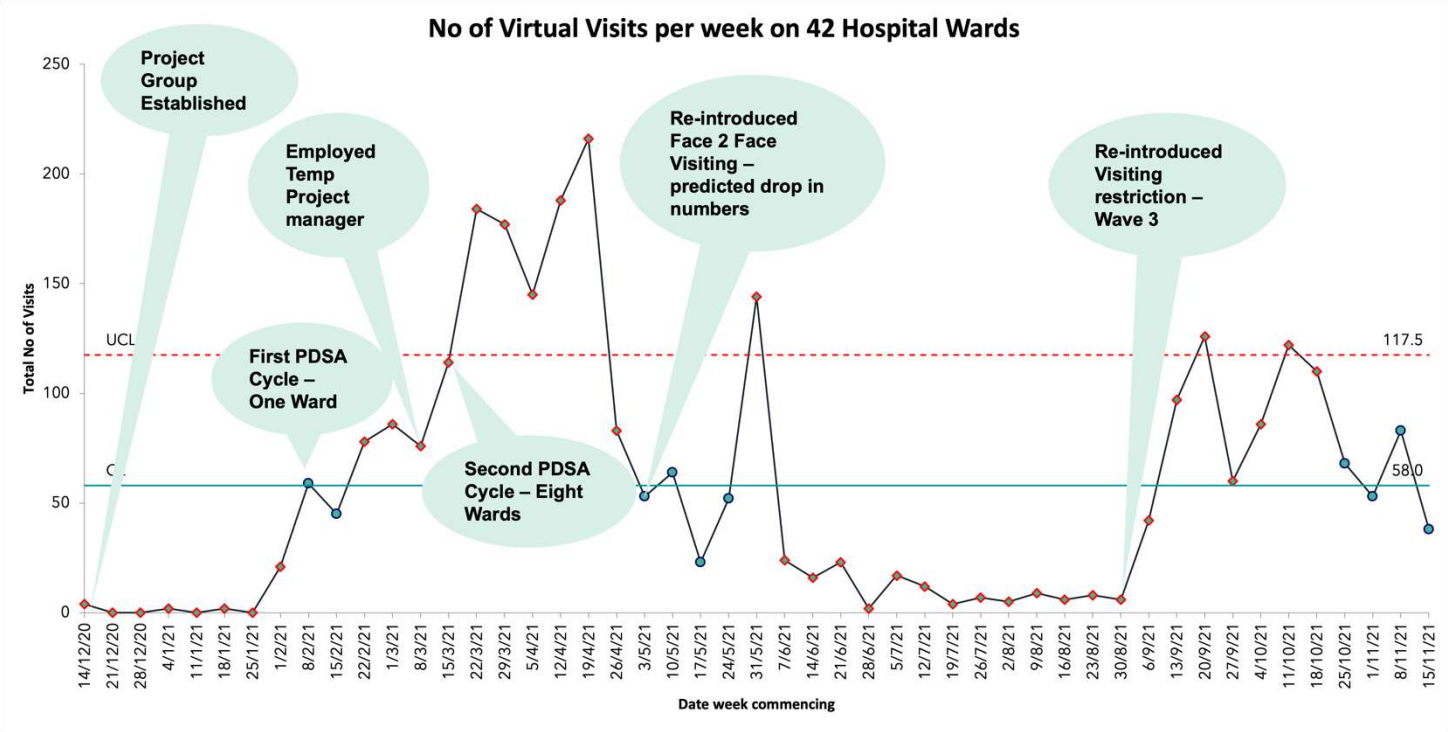
Introducing a Virtual Visiting Service

With its transformative and rapid impact on society, COVID-19 is driving significant changes in our healthcare system. And whilst this has been a catalyst for the need to introduce a virtual visiting service, we must not develop the service for this reason only. Beyond the COVID-19 pandemic and indeed before we know that there are many reasons why relatives/carers may not be able to visit their loved one in hospital. Some examples include simple geography (living away), those who may be housebound and those who are unable to get to the hospital due to transportation issues, to name a few. We know that digital technology has enabled people to stay connected during the crisis and we believe that this can benefit our population beyond the crisis too. With more interactions moving to virtual healthcare models, such as telehealth, we are reimagining how patient care is delivered now and in the future. Our aim was to introduce a Person Centred Virtual Visiting service, to support patient mainlining contact with their relatives while they are in hospital and for whatever reason this cannot be face to face.

What we did

1. Identified key administrators for attend anywhere access
2. Secured and prepared the hardware and software for use
3. Provided Training & technical support for patients & staff
4. Developed Guidelines & resources to support & ensure privacy & security.
5. In partnership with our communications team, developed a communications strategy and resources to support this
6. Undertook an equality impact assessment to ensure we are inclusive of all our citizens needs

The impact of the project can be seen in the run chart below.



We were able to achieve a significant impact for patients and relatives by enabling them to experience / participate in key milestones despite being confined to a hospital bed

	Question	2017	2018	2019	2020 /21	2022
District Nursing	Is the community nursing service able to demonstrate compliance with systems/ procedures/ policies in place to respond to service user and carer feedback?	100%	55%	100%	89%	100%
District Nursing	Is the community nursing service able to demonstrate a process to evidence achievement of outcomes which will include patient reported outcomes, a regular process to audit care plans and discharge records?	75%	75%	100%	89%	100%
District Nursing	Is the community nursing service able to demonstrate engagement with the Health Boards Quality Improvement strategy, using initiatives and projects to effect real, significant, and sustainable change?	75%	73%	100%	89%	100%
All	Are staff supported and engage in regular audits?	70%	80%	80%	100%	100%

District Nursing: The compliance rating for the question regarding compliance with systems/ procedures/ policies in place to respond to service user and carer feedback has improved this year from 89% to 100%.

	Question	2017	2018	2019	2020 /21	2022
ALL	Can staff demonstrate they know how to ensure that confidential patient information is stored safely and securely?	100%	100%	100%	100%	100%
ALL	Can staff demonstrate they know how to report an incident, accident or near miss via the DATIX reporting system and where applicable conduct an investigation?	100%	100%	100%	100%	100%

All staff when questioned about how to ensure patient information is stored safely and securely were able to demonstrate the appropriate knowledge.

All staff were also able to describe the incident reporting process and mechanism for conduction an investigation, if applicable.

	Question	2017	2018	2019	2020 /21	2022
ALL	For this episode of care, are the patient's demographic details clearly recorded (and where required, has a photograph) on all the patient's documentation?	96%	95%	95%	99%	97%
ALL except Neonates , OPD, Theatres	For this episode of care, is there documented evidence that each plan of care has been assessed and discussed with the patient or advocate?	83%	89%	93%	93%	90%

	Question	2017	2018	2019	2020 /21	2022
ALL except theatres	For this episode of care, are the contact details of the first point of contact recorded in the patient's documentation?	99%	95%	98%	98%	98%
ALL	Is the patient's preferred language clearly indicated in the nursing documents?	80%	82%	85%	88%	94%
ALL except neonates	Does the patient's documentation capture their preferred name and/or title?	83%	87%	85%	89%	86%
Inpatients, ED, paeds, LD, endoscopy, only	For this episode of care, where the patient has an identified swallowing problem, is there evidence that there is an up-to-date plan of care which is being implemented and evaluated and has been reviewed within the agreed timescale?	82%	90%	100%	91%	94%
Inpatients, MH, LD, OPD only	For patients who require a food chart, is it signed by a registered nurse for each 24-hour period?	65%	79%	68%	80%	83%
ALL except OPD, theatres	For patients who require a fluid chart, is there evidence that they are kept up to date and evaluated?	94%	92%	99%	98%	75%

Keeping clear and accurate records is a requirement for Healthcare Professionals under their relevant Codes and guidance

The overall RAG rating for Record Keeping is green but the amber ratings achieved for individual questions indicate that improvement is required, in particular around the signing of food and fluid charts by registered nurses.

This is recurring theme from previous audits undertaken, and despite seeing small improvements year on year we need to continue to ensure our registered nursing staff are aware of their responsibility to sign food and fluid charts. In addition, we need to understand any barriers to them achieving this consistently.

Electronic Nurse Documentation

Cwm Taf Morgannwg continues to implement the Welsh Nursing care Record (a digital system to record adult inpatient care) and has successfully implemented this in 3 of our hospitals (Ysbyty Cwm Cynon, Ysbyty Cwm Rhondda, and the Royal Glamorgan Hospital). Prince Charles Hospital will be using the system by mid-September 2022 with the Princess of Wales Hospital planned for Q3/4 2022.

In total 4751 patients have had their care recorded digitally between August 2021-August 2022 with 386,509 digital entries completed. This is the equivalent of 246,458 Pages of A4 paper saved with associated printing cost savings.

A recent audit comparing paper completion to digital completion has demonstrated significant improvement in the completion of key documentation metrics, for example, patients' Spiritual and cultural needs were assessed in 25% of the paper record compared with 92% digitally.
The Implementation of the system has been well received with 69% of staff surveyed agreeing that it has improved the quality of documentation (Survey of 75 staff).

Interviews with 11 ward managers have explored the benefits seen by users with sample comments below.

The evaluation of the implementation and benefits realised will continue until fully implemented across the Health Board. Further releases and content are planned throughout 2022-2024 as part of the national programme to standardise and digitise nursing documentation.

	Question	2017	2018	2019	2020 /21	2022
ALL	If a patient's language of need is Welsh, do staff know how to access a Welsh speaking member of staff?	98%	98%	94%	97%	97%
ALL	For this episode of care, is there documented evidence that the patient's cultural needs have been assessed and discussed with the patient or advocate?	73%	77%	78%	80%	92%
ALL	For this episode of care, is there documented evidence that the patient's spiritual needs have been assessed and discussed with the patient or advocate?	73%	70%	74%	78%	88%
ALL except from theatres	Is there a facility for patients to talk in private to staff (e.g., a quiet room or office)?	97%	100%	97%	95%	95%
ALL except maternity, neonates. OPD, theatres	Is there a quiet room for patients to spend time with their visitors away from their bedside?	55%	61%	60%	69%	50%
Maternity & Neonates only	Are there facilities to preserve a mother's dignity if she wishes to express or feed at the cot-side i.e., patient screens?	100%	100%	100%	100%	
Inpatients, paeds, MH, Endoscopy, Day units	Within the clinical area, are all the bays single sex bays?	83%	85%	94%	73%	72%
Inpatients, paeds, LD, OPD, Endoscopy, Day units	Do all patients have access to single sex toilet and washing facilities?	81%	89%	91%	79%	82%

	Question	2017	2018	2019	2020 /21	2022
All except maternity & neonates	Is there a facility to preserve patient's dignity by communicating to others that care is in progress?	100%	100%	100%	98%	100%
ALL except neonates & theatres	Within the clinical area, are washing and bathing facilities suitable for all Patients?	90%	86%	91%	90%	97%
ALL except neonates & theatres	Within the clinical area, are toilet facilities suitable for all service users?	93%	96%	100%	98%	100%
Inpatients, paeds, MH & LD	Does the clinical area allow patients to bring in personal items to assist with patient orientation/familiarity?	100%	98%	97%	97%	100%
Inpatients, paeds neonates MH, LD only	For this episode of care, is there documented evidence that the patient's normal sleep pattern and needs have been assessed and discussed with the patient or advocate?	79%	86%	80%	84%	95%
Inpatients, paeds, MH, LD only	For this episode of care, where the patient has an identified sleep issue or sleep has been recorded as poor/disrupted is there evidence that there is an up-to-date plan of care, which is being implemented and evaluated and has been reviewed within the agreed timescale?	64%	83%	67%	86%	93%
Neonates only	Does the clinical area allow for a period of 'quiet time' during the day to ensure that babies have a period of rest/sleep period?	100%	100%	100%	100%	100%
Neonates only	Does the clinical area allow for the noise levels to be controlled at the cot-side especially during periods of rest and sleep?	100%	100%	100%	100%	100%

	Question	2017	2018	2019	2020 /21	2022
Neonates only	Does the clinical area allow for the lighting particularly during periods of rest and sleep to be individually controlled at the cot-side?	100%	100%	100%	100%	100%
Inpatients, ED, neonates, paeds, MH, LD only	Except for areas where care is taking place / close observation is required, are lights within the bed space switched off or dimmed at night?	98%	100%	100%	99%	100%
ALL except OPD	For this episode of care, is there documented evidence that the patient's pain has been discussed and assessed using an appropriate pain assessment tool?	87%	93%	83%	94%	99%
All except OPD	For this episode of care, where the patient has an identified problem with pain is there evidence that there is an up-to-date plan of care, which is being implemented and evaluated and has been reviewed within the agreed timescale?	78%	85%	74%	87%	100%
Neonates only	For this episode of care, is their documented evidence that the baby's comfort has been discussed and assessed using a developmental care tool?	50%	100%	100%	96%	
Neonates only	For this episode of care, where the baby has an identified disrupted sleep/rest issue i.e., Neonatal Abstinence Syndrome, there is evidence that there is an up-to-date plan of care that incorporates rest and sleep times, which is being implemented and evaluated and has been reviewed within 24 hours?	100%	100%	100%	100%	
ALL except ED, neonates, OPD, theatres	For this episode of care, is there documented evidence that the patient's concerns/anxieties or fears has been assessed and discussed with the patient or advocate?	76%	79%	82%	86%	91%

	Question	2017	2018	2019	2020 /21	2022
ALL except ED, neonates, OPD, theatres	For this episode of care, where the patient has expressed concerns, anxieties, or fears, is there evidence that there is an up-to-date plan of care, which is being implemented and evaluated and has been reviewed within the agreed timescale?	66%	68%	78%	80%	90%
ALL except OPD, endoscopy, theatres	For this episode of care, is there documented evidence that the patient's hygiene needs have been assessed and discussed with the patient or advocate?	88%	98%	99%	95%	99%
ALL except OPD, endoscopy, theatres	For this episode of care, where the patient's hygiene needs have been identified is there evidence that there is an up-to-date plan of care which is being implemented and evaluated and has been reviewed within the agreed timescale?	93%	90%	97%	99%	96%
District Nursing	Is there evidence that patient's self-care ability to meet their own hygiene needs have been met	58%	82%	93%	80%	100%
Inpatients, paeds, MH, LD, day units only	Are patients given the opportunity to go to the toilet before eating?	96%	98%	100%	98%	100%
Inpatients paeds, MH, LD only	For this episode of care, is there documented evidence that the patient's foot and nail condition has been assessed, and discussed with the patient or advocate?	60%	68%	75%	86%	83%
Inpatients paeds, MH, LD only	For this episode of care, where the patient has an identified risk or requires assistance with foot or nail care, is there evidence that there is an up-to-date plan of care which is being implemented and evaluated and has been reviewed within the agreed timescale?	51%	68%	70%	86%	94%

	Question	2017	2018	2019	2020 /21	2022
ALL except maternity, OPD, day units	For this episode of care, is there documented evidence that the patient has been assessed using an evidence based oral health tool with respect to their oral health needs?	**93%**	**88%**	**98%**	**93%**	**99%**
ALL except maternity, OPD, day units	For this episode of care, where the patient has an identified risk or requires assistance with oral health, is there evidence that there is an up-to-date plan of care which is being implemented and evaluated and has been reviewed within the agreed timescale?	**84%**	**92%**	**85%**	**95%**	**97%**
ALL except neonates	For this episode of care, is there documented evidence that the patient's toilet needs/continence has been assessed and discussed with the patient or advocate?	**90%**	**95%**	**98%**	**95%**	**99%**
ALL except neonates	For this episode of care, where the patient has been identified as requiring assistance with their toilet/continence needs, is there evidence that an appropriate assessment has taken place with an up-to-date plan of care, which is being implemented and evaluated and has been reviewed within the agreed timescale?	**84%**	**92%**	**85%**	**96%**	**99%**

1. Cultural and Spiritual Care:

Spiritual Care is an integral part of healthcare and endorses the need to respect the physical, psychological, and social life values and beliefs of individuals.

Of the records reviewed, 92% of the patients had documented evidence that the patient's cultural needs had been assessed and discussed with the patient or advocate and 88% had documented evidence that the patient's spiritual needs had been assessed and discussed with the patient or advocate, a much-improved position on last year moving us to have a green RAG rating.

2. Environment of care:

Whilst we achieve a GREEN rating for all areas having facilities for patients to talk in private to staff, we achieved an RED rating (50%) for being able to support patients to spend time with their visitors away from the bedside, a noted 19% decrease on last year. Whilst a day room facility is unavailable on many of the wards, we need to consider alternative ways in which we can support private time away from the bedside.

It's very important to note that there has been a slight increase in our compliance scoring related to single sex bays and single sex toilet and washing facilities. Under ordinary circumstances this can be challenging but it is likely that our response to COVID, particularly at its highest peaks has impact on this

3. Rest and Sleep:

Sleep plays a vital role in good health and well-being throughout a person's life. Getting enough quality sleep at the right times can help protect a person's mental health, physical health, quality of life, and safety.

We have seen a significant increase in our assessment and care planning compliance rating moving us to a green RAG score. However, when asking patients about getting enough sleep and rest, we received a score of 88% a slight increase from last year's 86%. Sleep and rest in our hospitals is a continues challenge for us and we need to continue to think creatively on how we can improve this experience for our patients.

4. Ensuring comfort, alleviating pain:

<u>Pain management:</u>

We are pleased to share an improved position in relation to the assessment and management of pain, achieving a GREEN RAG rating with a score of 99%. This can be attributed, in large, to the implementation and increased compliance of the All-Wales pain assessment tool

Patient Perspective: most of our patients continue to feel that they were, as far as possible, always / usually kept free from pain

Patient's concerns/anxieties

We continue to see an improving position with the assessment of patients concerns/anxieties and fears as we also do with the care planning and evaluation of the same. A further increase this year, sees us achieve a GREEN rating.

Patient Perspective: Most of our patients felt that they were always/usually made to feel comfortable.

Personal Hygiene Needs**:**

All areas continue to see a compliance rating of GREEN for the assessment, care planning and evaluation of patient's hygiene needs.

Patient Perspective: 99% of the patients felt that their personal hygiene needs were always/usually met.

Foot Care:

Previous audits have identified concerns around foot care and a significant amount of work has been undertaken to improve both assessment and care planning over the last four years. This year we have seen a 3% decrease in compliance to assessment, moving us back to an AMBER rating. However, it is re-assuring to see an increase in our compliance to care planning and evaluation of patients' foot and nail care. Enabling us to achieve a GREEN RAG rating

Oral Health & Hygiene:

Mouth care is an integral part of nursing practice. Maintaining good mouth care for patients in hospital is imperative in reducing the risk of Health Care Associated Infection and improving patient comfort, nutrition, and experience.

There has again been significant work undertaken in relation to oral health and hygiene, and this year's results show that there is continued compliance for this aspect of care.

Patient Perspective: 93% of the patients responded positively when asked if they were given help with their oral hygiene an unchanged position from last year

Toileting/continence needs:

Promoting continence is a very important nursing role. "Whether or not a patient can be helped to regain continence can have a huge impact on an individual's quality (of life) and wider health and social care" (Learning from Trusted to Care report 2015).

We have continued to see an improvement in compliance with patient records evidencing that the patient's toilet needs/continence had been assessed and discussed with the patient or advocate

And of those patients who had an identified need, 99% had evidence that an appropriate assessment had taken place with an up-to-date plan of care, which had been implemented and evaluated and had been reviewed within the agreed timescale (up 4% on last year).

Patient Perspective: 96% of the patients felt that we always/usually responded quickly and discreetly if they needed help to use the toilet. The comments made by patients give examples of when patients felt that staff did not achieve this, with one patient stating:

"Sometimes I had to wait as staff were busy, but they would always acknowledge my call and tell me they would come as quick as they could" whilst another patient noted that "getting to toilet at night not always timely".

	Question	2017	2018	2019	2020 /21	2022
ALL	Is there evidence to demonstrate that patient identifiable information is treated in a confidential and secure manner?	95%	99%	97%	99%	100%
ALL except neonates, theatres	For this episode of care, is there written evidence in the patient's clinical notes that the patient's consent to the sharing of information with others has been obtained?	76%	76%	88%	88%	85%
Neonates only	Does your unit inform parents that information regarding their baby may be shared with other professionals to ensure appropriate care?	100%	100%	100%	100%	100%
Maternity & neonates only	Is there evidence of information available for women and their families on infant feeding?	100%	100%	100%	100%	100%
Neonates only	Does the clinical area offer translation services and/or professional interpreters to parents?	100%	100%	100%	100%	100%
Neonates only	Does the clinical area have written information available in a language and format appropriate to their local community?	100%	100%	100%	100%	100%
Neonates only	In the clinical area, is there information available regarding unit facilities, local amenities, parking, visiting, local support groups and arrangements for going home?	100%	100%	100%	100%	100%

We have achieved an overall GREEN rating for this standard. However, there is some improvement work to be done in relation to ensuring that there is written evidence in the notes that the patient's consent has been obtained in relation to sharing of information with others.

Examples of good practice include:

- Lockable trolleys are used to store patient records.
- Confidential waste bins are provided on wards.
- Electronic system used where only staff have access.

Patient Perspective: Most patients are satisfied with the information they were given about their care with 96% of the patients responding positively when asked "how often did you feel that you and those that care for you, were given full information about your care in a way that you could understand"

	Question	2017	2018	2019	2020 /21	2022
Paeds only	Is there evidence that the Children and Young People have been correctly triaged on admission?	90%	100%	100%	100%	100%

The above question only applies to paediatric and health visiting areas and relates to the requirement to the recording of core information on the child and young person's admission to hospital. However, there are two questions included in the patient experience survey that relate to this standard.

Most of our patients felt that when they asked for assistance, they got it when they needed it. Patients continue to report that they felt that they were always/usually kept informed of any delays, for example appointment times, tests, treatment, discharge.

	Question	2017	2018	2019	2020 /21	2022
Inpatients, ED, paeds, MH, Endoscopy, theatre, day units only	For patients with no known diagnosis of dementia, delirium or other cognitive impairment at admission, there is documented evidence that within 72 hours of admission, the following screening question has been asked, Have you/has the patient been more forgetful in the past 12 months to the extent that it has significantly affected your/their daily life?	**76%**	**82%**	**81%**	**86%**	**82%**
Inpatients, ED, MH, day units only	For this episode of care, where the patient has an identified care need in respect of cognitive impairment, is there evidence that there is an up to date plan of care, which is being implemented and evaluated and has been reviewed within the agreed timescale?	**75%**	**85%**	**78%**	**90%**	**90%**
ALL except neonates, OPD	For this episode care, is there documented evidence that the patient's level of independence has been assessed and discussed with the patient or advocate?	**93%**	**95%**	**98%**	**97%**	**99%**
ALL except neonates, OPD	For this episode of care, where the patient has been identified as requiring support and/or assistance to maximise independence, is there evidence that there is an up to date plan of care, which is being implemented and evaluated and has been reviewed within the agreed timescale?	**90%**	**94%**	**97%**	**91%**	**95%**
ALL except OPD, Theatres	Where appropriate, do all patients have written evidence of a discharge assessment and plan?	**91%**	**93%**	**94%**	**96%**	**77%**

	Question	2017	2018	2019	2020 /21	2022
ALL except OPD, Theatres	Where appropriate, is there written evidence that the patient's family/carer has been involved in discharge planning?	**91%**	**89%**	**89%**	**95%**	**88%**
ALL except maternity, neonates, OPD, Theatres	Does the clinical area have access to mirrors for patients to use?	**95%**	**93%**	**94%**	**98%**	**94%**
Inpatients, ED, paeds, MH, LD only	Does the clinical area have supplies of toiletries for patients who have been admitted without them?	**96%**	**100%**	**100%**	**100%**	**100%**

Patients with dementia/delirium/Cognitive Impairment:

We have achieved an AMBER compliance rating in the compliance with the documentation that the following screening question has been asked for patients with a known diagnosis of dementia and so further improvement work is needed, a worsened position from last year.

We have achieved a GREEN compliance rating with care planning for a patient identified with a care need in respect of cognitive impairment where we have seen an increase in compliance this year

CAM-ICU Assessment for Delirium in Prince Charles Hospital

Background

Delirium is underdiagnosed in ITU and leads to longer admissions, increased complications, and poorer QOL post discharge. If it is not identified, control measures cannot be introduced to mitigate the impact. A multidisciplinary project is underway looking to improve the assessment of delirium on ITU units in Cwm Taf Morgannwg UHB

Challenges

Challenges were initially team awareness and appreciation of the importance of identifying delirium. Additional barriers around agency workforce, and challenges in terms of how it is recorded were mitigated as best possible

Objectives

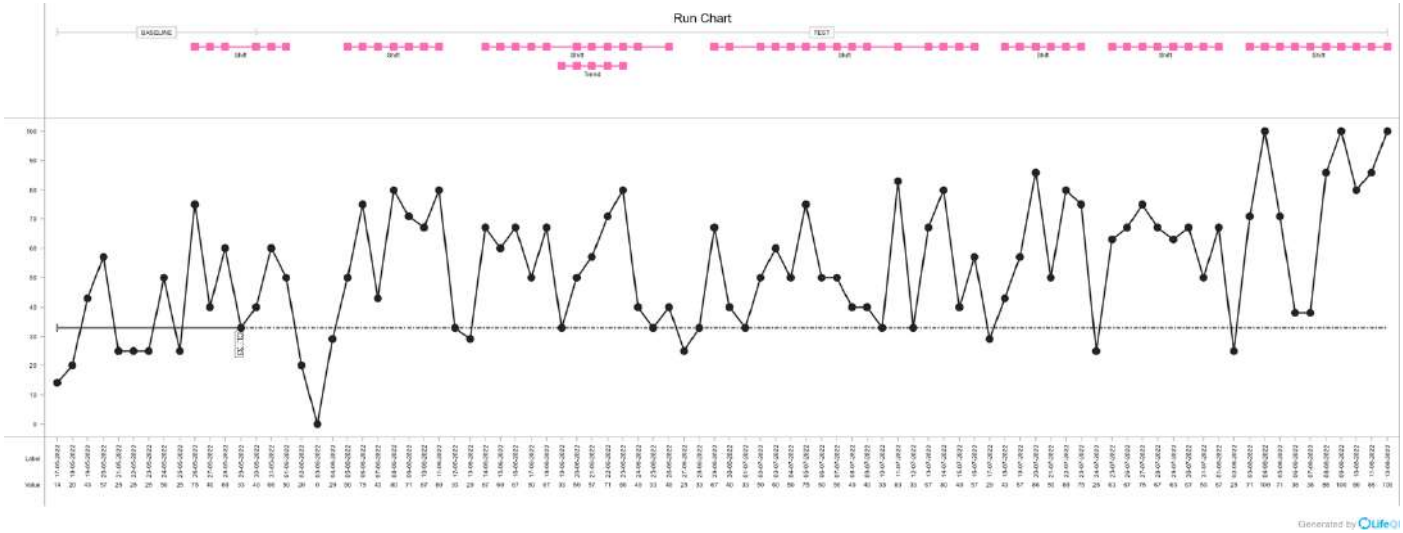
- Increase delirium screening to 75% compliance by the end of the year
- Measure daily compliance and administration errors
- Anticipate improved delirium identification

Solutions

A working party comprised of nursing, psychology, consultants, junior doctors, and member of QI faculty was set up to continuously review the data and plan new cycles of change. This was in liaison with the M&C faculty and advice from the core QI team.

Impacts

The work is ongoing however there has been a significant shift in favor of identification of delirium. Further cycles of change are needed to optimize screening and introduce control measures when delirium identified. The run chart below demonstrates the percentage compliance to delirium screening in ITU



Learning

Further work is ongoing however there is expected to be learning around environmental/human factors that contribute to challenges in delivering care that meets standards outlined in national guidance.

	Question	2017	2018	2019	2020 /21	2022
Inpatients and paeds only	Does the clinical area allow CYP/family/carers to bring in personal items to assist with CYP's orientation/familiarity/anxiety?	**100%**	**100%**	**100%**	**100%**	**100%**
Maternity & neonates only	For this episode of care, is there documented evidence that mothers who require breastfeeding support and/or assistance has been assessed and discussed?	**100%**	**100%**	**100%**	**100%**	**100%**
Maternity & neonates only	For this episode of care, where the mother has been identified as requiring support and/or assistance to establish breastfeeding on the unit, prior to going home, is there evidence that there is an up to date plan of care, which is being implemented and evaluated and has been reviewed within the last 24 hours?	**100%**	**100%**	**100%**	**89%**	**100%**
Paeds only	Are there age appropriate playrooms for children/young people?	**100%**	**100%**	**100%**	**100%**	**100%**

We continue to achieve a GREEN compliance rating in all the areas highlighted for this standard.

	Question	2017	2018	2019	2020 /21	2022
ALL except theatres	In the clinical area, is there accessible information regarding how patients/relatives/advocates can raise a formal or informal concern?	**95%**	**96%**	**100%**	**96%**	**100%**
Neonates only	Does the clinical area allow parents to regularly feedback their experience of the service?	**100%**	**100%**	**100%**	**100%**	**100%**
Neonates only	Does the clinical area allow parents to be involved in the planning and development of service improvements?	**100%**	**100%**	**100%**	**100%**	**100%**

As with the findings of previous audits, it is pleasing that most wards and departments provide information on how to raise formal or informal concerns. Within CTUHB all patients are given the opportunities to give feedback and where a concern is raised the Patient/Carer should receive a timely response and action where required. Patient/Carer feedback is used to continuously improve services.

A joined-up approach between the patient experience team and the clinical education, quality improvement and audit leads sharing information and working together to make continuous improvements in care.

With **accessible patient experience data** which is shared ward to board and the emphasis on **investigation for learning not blaming,** CTMUHB is making continuous improvements to listen and learn from patient experience.

Cwm Taf Morgannwg University Health Board is committed to promoting a culture which values and facilitates learning and in which the lessons learned are used to improve the quality of patient care, safety, and experience.

A framework of ensuring effective listening, learning, and improving is urgently required and has been a significant criticism of the Health Board in external reviews and audits such as the Health Inspectorate Wales/Audit Wales and NHS Delivery Unit review of quality, governance, and incident management processes. Effective learning and improvement processes has also been a cross cutting theme of concern within the Independent Maternity Services Oversight Panel reviews of our maternity and neonatal services.

This Listening & Learning Framework demonstrates how learning will be identified, triangulated, disseminated, and implemented in practice, to facilitate and embed a culture of appreciative enquiry and continually improving health care services.

The Listening & Learning Framework recognises that the Care Groups and Clinical Service Groups have internal governance and learning structures. This Framework, therefore, seeks to complement and build on these arrangements by adding a strategic approach to support the organisation to learn lessons from a range of internal and external sources, to store and use this learning to share knowledge, shape change and create opportunities to develop excellence in practice.

	Question	2017	2018	2019	2020 /21	2022
ALL	All clinical staff wear identification badges	**84%**	**92%**	**96%**	**93%**	**93%**
ALL	All clinical staff comply with All Wales Dress Code	**91%**	**98%**	**100%**	**99%**	**100%**

The All-Wales Dress Code (2010) was developed to encompass the principles of inspiring confidence, preventing infection and for the safety of the workforce.

The principles set out in the code include:

- All staff will be expected to dress in smart (that is, neat and tidy) clean attire in their workplace.
- All staff will present a professional image in the workplace.
- Staff should not socialize outside the workplace or undertake social activities while wearing an identifiable NHS uniform.
- All clinical staff must wear short sleeves or elbow-length sleeves in the workplace to enable effective hand washing techniques.
- All staff must always wear clear identification.
- Staff who wear their own clothing for work should not wear any clothing that is likely to cause a safety hazard.

Staff are to be commended for their efforts to ensure that staff are complying with the All-Wales Dress Code (100%). It is a little concerning to see a decrease in staff's compliance with the wearing of identification badges, down 3%, scoring 93% this could be attributed to the heightened IPC restrictions because of the pandemic

Staff Survey

	Question	2017	2018	2019	2020 /21	2022
ALL	Our organisation aims to make sure you can access up to date information in order to be able to do your job. For example, access to policies, clinical guidelines etc. Do we achieve this?	91%	91%	92%	92%	91%
ALL	Our organisation aims to ensure that as an employee you are treated with dignity and respect. Do we achieve this?	75%	74%	75%	81%	68%
ALL	Our organisation aims to make you feel safe at work. Do we achieve this?	76%	76%	71%	81%	62%
ALL	Our organisation aims to make you feel you have a positive contribution to patient care. Do we achieve this?	79%	77%	79%	85%	68%
ALL	Our organisation aims to provide you with sufficient equipment to do your job. Do we achieve this?	74%	73%	75%	80%	75%
ALL	Our organisation aims to provide you with opportunities to enhance your skills and professional development. Do we achieve this?	72%	72%	70%	78%	74%
ALL	Our organisation aims to provide you with feedback on the outcomes of any incidents/accidents that you report or that are reported within your clinical area? Do we achieve this?	57%	59%	68%	77%	65%
ALL	Our organisation aims to provide you with opportunity to identify and learn from good practice to bring about improvements in care. Do we achieve this?	74%	75%	79%	85%	73%
ALL	Our organisation aims to provide opportunities for you to raise any concerns that you have. Do we achieve this?	75%	75%	73%	83%	74%
ALL	Our organisation aims to provide you with the opportunity to establish a work life balance. Do we achieve this?	63%	66%	70%	81%	67%

	Question	2017	2018	2019	2020 /21	2021/ 22
ALL	Our organisation aims to make you feel a valued member of the organisation and have a sense of belonging. Do we achieve this?	**60%**	**61%**	**64%**	**78%**	**55%**
ALL	Our organisation aims to make you feel proud to be a nurse / allied health professional. Do we achieve this?	**64%**	**64%**	**68%**	**79%**	**60%**
ALL	Our organisation aims to put local citizens at the heart of everything we do'. Do we achieve this?	**77%**	**71%**	**90%**	**63%**	**88%**
ALL	Our organisation aims to ensure that you have the knowledge and skills to deliver a consistent standard in the fundamental aspects of compassionate care. Do we achieve this?	**84%**	**82%**	**86%**	**90%**	**77%**
ALL	Our organisation aims to work together to be the best that we can be. Do we achieve this?	**76%**	**71%**	**74%**	**84%**	**64%**
ALL	Our organisation aims to strive to deliver and develop excellent services. Do we achieve this?	**74%**	**75%**	**72%**	**84%**	**67%**
ALL	Using a scale of 1-10, where 1 is very bad and 10 is excellent, how would you rate your overall satisfaction with the care that you provide for your patients and their families?	**83%**	**81%**	**83%**	**86%**	**78%**
ALL	Using a scale of 1-10, where 1 is very bad and 10 is excellent, how would you rate your overall satisfaction with your organisation?	**70%**	**69%**	**70%**	**78%**	**64%**

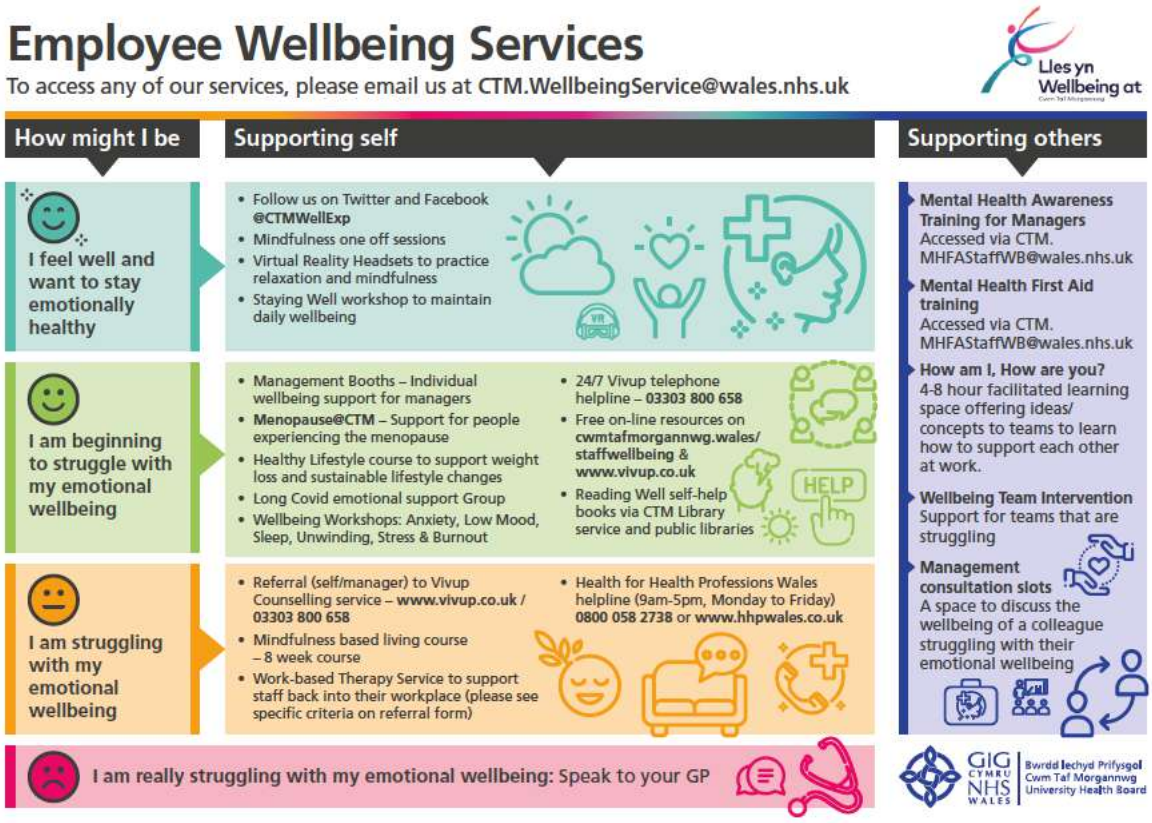
Overall, there is a downward trend in the responses received in this year's Staff Survey. This could be in part attributable to the unprecedented pressures staff have experience over the last two years with the pandemic. However, we must be mindful not to make assumptions and some significant work needs to take place to understand more fully the responses provided by staff

Some of the key themes identified include:

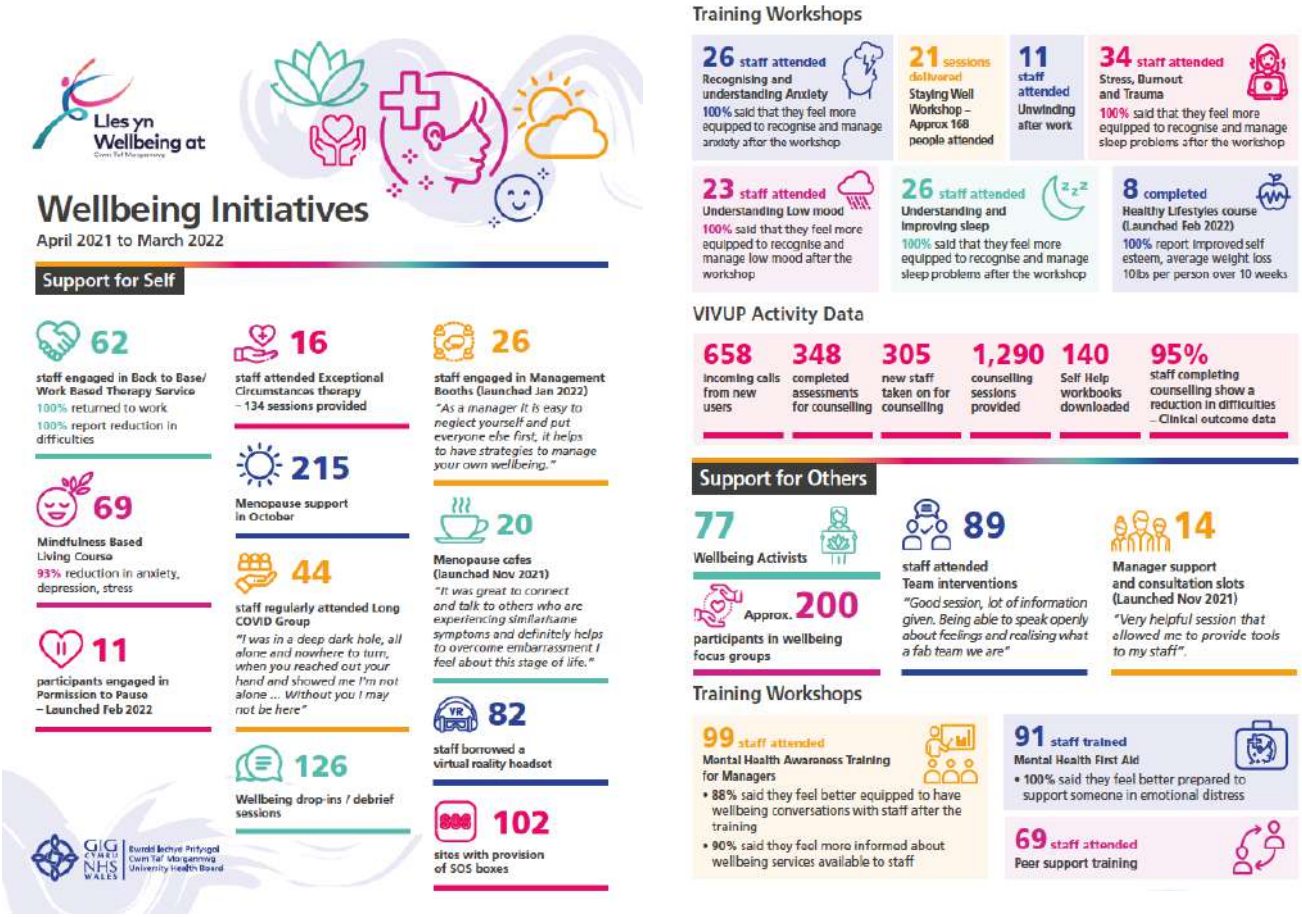
1. Training – often cancelled due to staffing
2. Lack of communication/feedback following an incident
3. Lack of staff
4. Poor skill mix
5. Don't feel valued – perception that organisation focuses on blaming staff when things 'go wrong'

The Wellbeing Service offers a stepped care approach matching the needs of staff to the intensity level of the intervention provided. We continue to contract an Employee Assistance Programme to provide 24/7 telephone support and counselling alongside CBT guided self-help workbooks. We also continue to provide a wide range of Mindfulness based groups and courses.

Over the past 12 months the Wellbeing Service has introduced several new initiatives based on the results of the 2021 Wellbeing Survey (Sleeping Well Course, unwinding after work course), on feedback from our Wellbeing Activists, managers, and other key stakeholders (Manager's Booths, Management consultation slots, how am I, How are you? Course). All the services provided are listed on our Emotional Wellbeing Care Pathway (below)



A summary of our outcome data, activity data and feedback from staff, are listed on our Dashboard (below).



We will be launching the 2022 Wellbeing Survey on 12th September 2022, and we will use those results to review our current service provision.

In the past 12 months we have launched a variety of services for staff impacted by the menopause – either directly or because they live or work with someone going through it. These include Menopause café's, Mindfulness for Menopause, Chill Max pillows and the Permission to Pause cause which looks at key lifestyle areas of reducing stress, improving sleep, nutrition, and exercise levels.

At the request of our male staff, we have launched Men's' Wellbeing @CTM in which we have collated wellbeing interventions specifically designed to appeal to our staff who identify as men.

Earlier this year the Wellbeing Service also launched a Healthy Lifestyles 10-week group which provides a psychologically informed course encouraging staff to adopt healthy approaches to nutrition, hydration, exercise, sleep and to understand their relationships with food. The outcome data so far has been very encouraging. Data from the first 4 cohorts demonstrated that 89% of staff who attended reported a loss in

weight, with an average loss of 8.7lbs per person. This is considered a sustainable and healthy loss in weight over a 10-week period. 92% reported an increase in self-esteem, whilst 100% reported an increase in psychological health and quality of life.

In recognition of the current financial pressures that staff may be experiencing and the negative impact that may be having on their emotional wellbeing, we have also put together a financial wellbeing care pathway which sign posts staff to sources of advice, support and financial assistance if required (see below).

Learning from the 2022 Audit

The service specific results of this audit should be reviewed within the operational team's current governance structures to ensure that any areas of good practice and areas for improvement are identified and shared.

Local action plans must be developed for individual wards, departments and services. The ward mangers and senior nurses are expected to progress the improvements identified and feedback through their governance and monitoring arrangements, overseen by the Listening and Learning Forum that reports to Quality and Safety Committee on a quarterly basis.

The health board is asked to accept the Health & Care Standards (2022) audit findings which are presented in this report as an assurance that the care delivered within the health board continues to achieve a high level of satisfaction amongst patients, whilst also identifying areas of improvement.

Simply Do – *using an ideation platform to improve on top 3 areas identified in the 2022 HCs Audit*

The results of the 2022 audit have highlighted 3 key areas for us to improve across the health board these are

1. Patient hydration
2. Providing a dignified environment of care
3. And improving our assessment and care management of patients suffering with delirium and those patients with a diagnosed learning disability

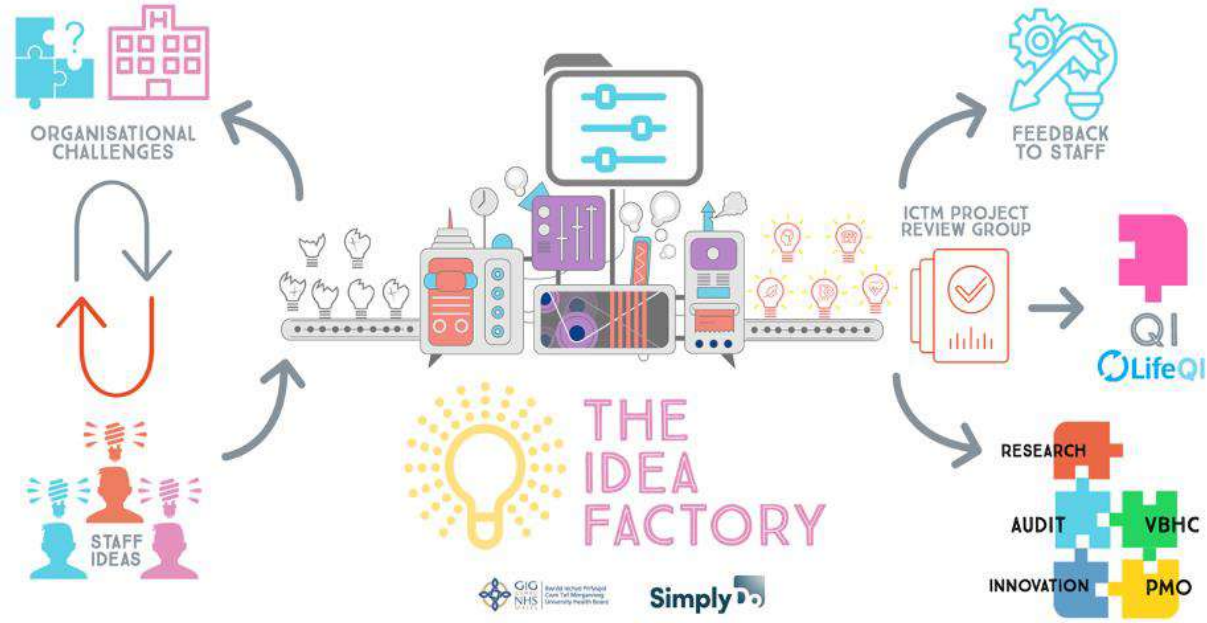
We have launched a challenge on the simply do platform. This challenge has been launched to provide an opportunity for staff to:

- Submit ideas you have that could address one of the 3 key issues raised
- Share those ideas with colleagues via the portal

As part of this collaborative, transparent process, we will:

- Listen to and recognise innovative ideas and approaches
- Share the progress we make together in real-time
- Support you with Improvement training

To find out more about how you can submit an idea go to https://sdi.click/ictmaudit2



AGENDA ITEM
3.2.7

QUALITY & SAFETY COMMITTEE

NATIONAL PRESCRIBING INDICATOR (NPI) REPORT

Date of meeting	15/11/2022
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Hannah Wilton, Chief Pharmacist and Brian Hawkins, Chief Pharmacist Medicines Governance
Presented by	Dom Hurford, Executive Medical Director
Approving Executive Sponsor	Executive Medical Director
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
(Insert Name)	(DD/MM/YYYY)	Choose an item.

ACRONYMS	
CTMUHB	Cwm Taf Morgannwg University Health Board
AWMSG	All Wales Medicines Strategy Group
PPI	Proton Pump Inhibitors
NPI	National Performance Indicators
LCV	Low clinical value

1. SITUATION/BACKGROUND

1.1 The All Wales Medicines Strategy Group (AWMSG) has endorsed the National Prescribing Indicators (NPI's) as a means of promoting safe and cost-effective prescribing since 2003. The *National Prescribing Indicators: Supporting Safe and Optimised Prescribing* were refreshed for 2021-22 with a focus on three priority areas, supported by additional safety and efficiency domains. Due to the workload pressures across NHS Wales during the COVID-19 pandemic, the NPIs for 2020–2021 were then carried forward into 2021–2022. Health board performance and analysis against these indicators is published by the All Wales Therapeutics & Toxicology Centre (AWTTC) on a quarterly basis. This report highlights Cwm Taf Morgannwg University Health Board's performance June 2022 vs June 2021.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 For 2021–2022 there are 13 measurable targets and CTM has achieved the specified target in 10 out of the 13 areas defined. Further details can be found in appendix one.
There are 3 areas where CTM are not achieving the targets. They are:

- Gabapentin & Pregabalin prescribing
- Proton pump inhibitor (PPI) prescribing
- Insulin prescribing

2.1.1 Opioid burden, tramadol and gabapentin / pregabalin prescribing
Medicines management have recruited a Specialist Primary Care Pain Pharmacist (May 2020). This staff member is working with GP and secondary care clinical colleagues to develop pathways and a Multi-Disciplinary approach to pain management and prescribing across the Health Board. This will help support improvement plans against the Opioid, tramadol and Gabapentin/Pregabalin NPI's. There have been improvements made in opioid prescribing and tramadol prescribing (see appendix 1). Prescribing of gabapentinoids has increased. Improvement in these areas needs to be part of a long term, multidisciplinary approach to pain management. Management of pain forms part of the proposed new primary care prescribing management scheme for 2022-23 and will be a priority area for the HB wide prescribing performance group that is being established.

2.1.2 Proton pump inhibitors
PPI prescribing has increased across all of Wales. In part this may be due to shortages in other therapeutic alternatives. This will form part of the work plan in primary care in 2022-23.

2.1.3 Long acting insulin analogues
The health board has seen an increase in the prescribing of long acting insulin analogues. It should be noted that CTMUHB is historically the lowest prescribing health board in Wales.

In the clinical areas where the health board meets the NPI targets, we are continuing to work with colleagues to further improve performance.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 Long-term improvement in all NPI clinical areas (especially pain management and antimicrobial stewardship) will need ongoing resource to ensure sustainability of multi-disciplinary improvement plans.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	This report outlines areas where the health board are achieving, and failing to achieve national agreed standards of safe and effective prescribing.
Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If no, please provide reasons why an EIA was not considered to be required in the box below.
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications /	Yes (Include further detail below)

Impact	This report shows that investment into pharmacist posts to support safe and effective prescribing have had a positive impact. Further improvement will require further investment and development of specialist prescribing support teams. Details of this will be explored in the Medicines Management IMTP.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

The committee are asked to **NOTE** the contents of the report

Appendix 1

National Prescribing Indicator (NPI) Report 2022-2023: Cwm Taf Morgannwg UHB

Indicator	Applicable to / data source	Target met	comment
1. PRIORITY AREAS			
1.1 ANALGESICS **1.1.1 Opioid burden** Measure: ADQ / 1000 patients Target: Maintain performance levels within the lower quartile, or show a reduction towards the quartile below.	Primary care	**YES**	CTMUHB remains the highest prescriber of opioids in Wales. However, we have seen the second highest % decrease of prescribing of the HBs in Wales. There was a decrease in prescribing of 3.45% in quarter 4 2021/22 compared to quarter 4 2020.21. The national decrease was 1.69%. The health board appointed a specialist primary care pain pharmacist in May 2020. This pharmacist continues to work with clinicians in primary and secondary care to develop pathways and strategies for improving opioid prescribing across the health board. Ongoing investment in pain services is essential. Management of opioid prescribing was included in the health board primary care prescribing incentive scheme for 2021-22 and in the proposed scheme for 2022-23.
1.1.2 Tramadol Measure: DDD/1000 patients	Primary care	**YES**	CTMUHB is the second highest prescriber of tramadol in Wales. There was a decrease in prescribing of 9.46% in quarter 4 2021/22 compared to quarter 4 2020/21 (again, the second highest decrease of all Welsh HBs). The national

Target: Maintain performance levels within the lower quartile, or show a reduction towards the quartile below			change was -6.5%. The health board appointed a specialist primary care pain pharmacist in May 2020. This pharmacist continues to work with clinicians in primary and secondary care to develop pathways and strategies for improving tramadol prescribing across the health board. Ongoing investment in pain services is essential. Management of tramadol prescribing was included in the health board primary care prescribing incentive scheme for 2021-22 and in the proposed scheme for 2022-23.
1.1.3 Gabapentin & Pregabalin (DDD/ 1000 pts) Measure: DDD/1000 patients Target: Maintain performance levels within the lower quartile, or show a reduction towards the quartile below	Primary care	**NO**	CTMUHB is the highest prescriber of gabapentin and pregabalin in Wales. There was an increase in prescribing of 0.11% in quarter 4 2021/22 compared to quarter 4 2020/21. The national increase was 0.66%. The health board appointed a specialist primary care pain pharmacist in May 2020. This pharmacist is currently working with clinicians in primary and secondary care to develop pathways and strategies for improving prescribing in this area across the health board. Ongoing investment in pain services is essential. Management of gabapentinoid prescribing was included in the health board primary care prescribing incentive scheme for 2021-22 and in the proposed scheme for 2022-23.

1.2 ANTICOAGULANTS IN PRIMARY CARE			
1.2.1 Measure: Number of patients who have a CHA_2DS_2-VASc score of two or more who are currently prescribed an anticoagulant as a percentage of all patients diagnosed with AF. Target: to increase the number of patients with AF and a CHA_2DS_2-VASc score of 2 or more prescribed an anticoagulant.	Primary care		Currently 90.5% of patients in CTMUHB with a CHA_2DS_2-VASc score of 2 or more are prescribed anticoagulation. This is an increase from the previous. The overall Wales average is 91.1% so there is room for further improvement. This will be a priority area for the HB wide prescribing performance group that is being established.
1.2.2. Measure: Number of patients who are currently prescribed an anticoagulant and have received an anticoagulant review within the last 12 months, as a percentage of all patients diagnosed with AF who are prescribed an anticoagulant. Target: To increase the number of patients who are prescribed an anticoagulant and have received an anticoagulant review within the last 12 months	Primary care	**YES**	The health board currently has 56.7% of patients meeting this indicator; this is an increase of 12.2% from the same period in 2021. The national average is 53.7%. Anticoagulant clinics in primary care are supported by cluster pharmacists.

1.2.3. Measure: Number of patients who are prescribed antiplatelet monotherapy, as a percentage of all patients diagnosed with AF. Target: to reduce the number of patients with AF prescribed antiplatelet monotherapy	Primary care	**YES**	CTMUHB currently scores 4.37% when measured against this indicator; this is an absolute decrease of 1.29% from the comparator period, with a relative reduction of 22.8% (average reduction across Wales is 16.95%). Whilst this is a strong performance, the national average is 3.67%, so there is still room for improvement.
1.3 ANTIMICROBIAL STEWARDSHIP **1.3.1 Total antibacterial items** Measure: items per 1,000 STAR-PUs Target: Reduce prescribing by 5% vs baseline of Q4 2019-20	Primary care	**YES**	CTMUHB remains the highest prescriber of antibacterials in Wales. There was a decrease in prescribing of 15.3% in quarter 4 2021/22, compared to quarter 4 2019/20. The national change was -15.6%. The health board currently has only one specialist antimicrobial pharmacist. Further ongoing investment in antimicrobial services is essential. Management of antimicrobial prescribing was included in the health board primary care prescribing incentive scheme for 2021-22 and in the proposed scheme for 2022-23.
1.3.2 4C antimicrobials (co-amoxiclav, cephalosporins, fluoroquinolones and clindamycin) Measure: items per 1,000 patients	Primary care	**YES**	CTMUHB is the 4th highest prescriber of "4C" antibacterials in Wales. There was a decrease in prescribing of 28.8% in quarter 4 2021/22 compared to quarter 4 2019/20. The national change was -11.9%.

Target: Reduce prescribing			The health board currently has only one specialist antimicrobial pharmacist. Further ongoing investment in antimicrobial services is essential. Management of antimicrobial prescribing was included in the health board primary care prescribing incentive scheme for 2021-22 and in the proposed scheme for 2022-23.
2 SAFETY			
2.1 Proton pump inhibitors (PPI's) Measure: DDDs per 1,000 PUs Target: reduce prescribing	Primary care	**NO**	CTMUHB is currently the 2nd highest prescriber of PPIs in Wales. There was an increase in prescribing of 2.12% in quarter 4 2021/22 compared to quarter 4 2020/21. The national change was 2.05%. This may have been in part due to national supplies issues with alternative products for the management of GI problems. Management of PPI prescribing was included in the health board primary care prescribing incentive scheme for 2021-22 and in the proposed scheme for 2022-23.
2.2. Hypnotics & anxiolytics (H&A) Measure: ADQs per 1,000 STAR-Pus Target: reduce prescribing	Primary care	**YES**	CTMUHB is the highest prescriber of hypnotic and anxiolytics in Wales. There was a decrease in prescribing of 7.27% in quarter 4 2021/22 compared to quarter 4 2020/21. The national change was -7.64% The health board appointed a specialist primary care mental health pharmacist in July 2020. This pharmacist is currently working with clinicians in primary and secondary care to develop pathways and strategies for improving prescribing in this area across the health board. Management of H&A prescribing was included in the health board primary care

			prescribing incentive scheme for 2021-22 and in the proposed scheme for 2022-23.
2.3 Yellow cards Number of Yellow Cards submitted per GP practice, per hospital, per health board and by members of the public. Number of Yellow Cards submitted by community pharmacies, by health board Target: To increase reporting	Health board wide	**YES**	The number of yellow cards reported in CTM has increased in all areas (except secondary care where reporting remains consistent).
3 EFFICIENCY INDICATORS			
3.1 Best value biological medicines Measure: Quantity of best value biological medicines prescribed as a percentage of total 'biosimilar' plus 'reference' product Target: Increase the appropriate use of cost-efficient biological medicines, including biosimilar medicines. **3.2 Insulin** Measure: Items/number of long-acting insulin analogues as a percentage of	Primary and Secondary care	**YES** **No**	There has been a modest increase in biosimilars across the 5 reference pharmacological agents listed in the WAPSU report, apart from adalimumab where CTMUHB has achieved an increase of 24.5%. The NHS Wales average across the 5 products is 89%: CTMUHB is only achieving 80%, with 20% reference product still in use in the health board. A programme of switching to biosimilar adalimumab is currently ongoing in CTM and will be a priority in 2022-23. CTMUHB had the lowest % use of long-acting insulin analogues in Wales, but this rose from September 2021 to

total long- and intermediate-acting insulin prescribed Target: Reduce prescribing of long-acting insulin analogues and achieve prescribing levels below the Welsh average	Primary and Secondary care		March 2022 in secondary care. There was an 11.7% increase in prescribing from quarter 4 2021/22 compared to the same period 2020/21. The All Wales prescribing change was -3.76%. In primary care, CTMUHB remains the lowest prescriber of long-acting insulin analogues in Wales. There was an increase of 0.3% compared to the equivalent period in 2020.
3.3 low value for prescribing Measure: Low value for prescribing UDG spend per 1,000 patients Target: Maintain performance levels within the lower quartile or show a reduction towards the quartile below	Primary care	**YES**	CTMUHB has the highest spend of low clinical value (LVC) medicines in Wales. There was a decrease of 8.72% in quarter 4 2021/22 compared to quarter 4 2020/21. The national change was -6.92%. Management of LCV prescribing was included in the health board primary care prescribing incentive scheme for 2021-22 and in the proposed scheme for 2022-23.

AGENDA ITEM
3.2.8

QUALITY & SAFETY COMMITTEE

CLINICAL EDUCATION ANNUAL REPORT 2021-22

Date of meeting	15/11/2022
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Janet Gilbertson- Head of Clinical Education
Presented by	Greg Dix (Executive Director of Nursing, Midwifery & Patient Care) Dom Hurford (Executive Medical Director)
Approving Executive Sponsor	Executive Director of Nursing
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Executive Leadership Group		Choose an item.

ACRONYMS	
CTMUHB	Cwm Taf Morgannwg University Health Board
HEIW	Health Education and Improvement Wales
NEWS	National Early Warning Score
RADAR	Recognition of Acute Deterioration and Resuscitation

1. SITUATION/BACKGROUND

1.1 The purpose of this report is to highlight the activities and performance of Clinical Education for the academic year 2021-22 and to share the Strategic Direction for Clinical Education.

1.2 The Clinical Education Annual Report is presented in Appendix 1 for noting

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 That investment in education and training of our workforce underpins the required transformation to the way we work. Underpinning the CTM2030 strategy will be the development of staff including new clinical roles, career development programmes, staff wellbeing and leadership development. Education and support is key and as our workforce is forever changing, this is an ongoing need.

2.2 An effective culture of learning at every level enables the workforce to re-frame their knowledge and includes developing a strong workplace learning infrastructure, cultivating a reputation for training and support and excellence in education.

2.3 To note the progress that has been made in 21-22 towards the delivery of the Strategic Direction for Clinical Education including;

2.3..1 Raising the profile and identity of our service through a branding and refresh of Clinical Education facilities across all sites.

2.3..2 Commencement, with Finance, of a three year plan to align and standardise Service Increment for Teaching (SIFT) funding, enabling the robust resource support structures of the undergraduate medical education activity, and increasing governance and clarity over the utilisation of SIFT funds.

2.3..3 Development of and appointment to the first Multi-professional Practice Education Facilitator role in Wales. A model supported by HEIW.

2.3..4 Governance processes established and developed;

2.3..4.1 Establishment of the Clinical Education Forum and reporting forums as a robust organisational wide education governance infrastructure to assure high quality education and training meeting the requirements and standards.

2.3..4.2 RADAR committee continues to drive forward quality standards and training in Recognition of Acute Deterioration and Resuscitation including an up-to-date consistent approach

across CTMUHB to NEWS, Sepsis, Rapid Response activity, resuscitation audit & training compliance improvements and equipment standardisation.

2.4 Recognition of the organisational contribution of this function through its many education and training activities to safe working practices and patient care.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 Permanent accessible training accommodation continues to be a challenge as the demand for increased clinical space becomes an issue across all sites and services. It is recommended that the creation of a dedicated multi-professional Education and Learning facility is included as part of the strategic site development plan.

3.2 Continuing support will be needed from executives for the 3 year plan for the re-alignment and re-allocation of SIFT throughout the organisation.

3.3 Continued progress on the delivery of quality standards, training and governance around acute deterioration recognition and Sepsis is at risk as the Acute Deterioration Lead and Clinical Lead for RADAR posts are only funded until 31st March 2023. Recurrent funding of these posts needs to be established.

3.4 The establishment of strong strategic workforce planning activity considering the workforce as a whole is needed to better inform education commissioning, in order to support multi-disciplinary service redesign to deliver our Clinical Strategy.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	The quality and investment of education and training of our healthcare workforce is essential for patient safety and improving care.
Related Health and Care standard(s)	Governance, Leadership and Accountability
	Staff and Resources, Safe Care, Effective Care.
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below)
	No policies or services are new or have been withdrawn.

Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Sustaining Our Future

5. RECOMMENDATION

5.1 It is recommended that the Quality and Safety committee **notes** the Clinical Education Annual Report 2021-22 and the contribution quality education and training makes to our services and improving patient care.

Clinical Education

Cwm Taf Morgannwg

University Health Board

Annual Report

Academic Year

2021-2022

What will this Annual Report tell you?

Our Annual Report provides you with information about the Clinical Education Service within Cwm Taf Morgannwg University Health Board (CTMUHB), what we do and how we work in partnership with external organisations including Universities and Health Education and Improvement Wales (HEIW), and what we plan to do to deliver and continually improve healthcare education, in order to meet changing demands and future challenges.

It provides information about our performance, achievements in 2021/2022 and how we have made progress towards delivery of our strategic ambition to create a CTM Learning Academy, developing and embedding an organisational Learning Culture that enables staff to work flexibly and with agility to respond to the health needs of our population by;

- Encouraging life-long learning
- Generating openness to collaboration and effective co-design
- Developing a greater understanding of human intelligence.
- Promoting multi-professional learning.
- Developing staff to work at the "top of their licence" both registrants and support staff.

It is well recognised that there is a strong causal relationship between targeted and well-designed education and training, service improvement and patient outcomes and that quality healthcare for patients is supported by maintenance and enhancement of clinical, management and personal skills.(1)

Our Annual Report for 2021-22 includes:

- Current health education context in Wales
- Current Education context in CTMUHB
- University Health Board Status
- About us and what we do & activity in 21-22
- Progress with our strategic direction & where we plan to go next.

Contents:

Introduction

Health Education Context in Wales.

Health Services in Wales continue to deliver the vision, ambition and approaches that are needed to deliver '*A Healthier Wales'* (1). The demand for services, increasing health and wellbeing inequalities, higher public expectations, the additional challenges due to the impact of COVID-19 on health and social care services, as well as the possibilities that new and emerging medical and digital technologies offer, are set against a backdrop of changing demography, recruitment and resource challenges as healthcare services reset and recover.

It is now four years since the creation of Health Education and Improvement Wales (HEIW) and they continue to work to deliver *The Workforce Strategy for Health and Social Care* (2) to deliver '*A Healthier Wales'*.

It acknowledges that what we spend on our workforce is not a cost, but an investment. This is critically important when it comes to education and training and establishing a truly learning organisation culture.

The required transformation to the way we work will need to be underpinned by education; expanding existing roles, developing new roles, building skills and capability in areas we have not done so previously and embracing new technology in delivering our services.

The strategy articulates 7 themes

Fig 1 HEIW Strategy Themes

Context in CTMUHB

The Cwm Taf Morgannwg workforce has continued to adapt to new working models and service challenges against the disruption to life in and out of work caused by the pandemic, all the while ensuring that patients and their families receive high-quality care.
Quality is at the heart of the Health Board and the aim is to improve outcomes for our people, whoever they are and wherever they live, by providing access to high quality health and care, delivered through a sustainable culture of learning and improvement.

Underpinning the CTM2030 strategy will be the development of staff including new clinical roles, career development programmes, staff wellbeing and leadership development. Education and support is key and as our workforce is forever changing, this is an ongoing need.

Fig 2 – CTMUHB 2030 Strategy

An effective culture of learning at every level enables the workforce to re-frame their knowledge and includes developing a strong workplace learning infrastructure, cultivating a reputation for training and support and excellence in education.

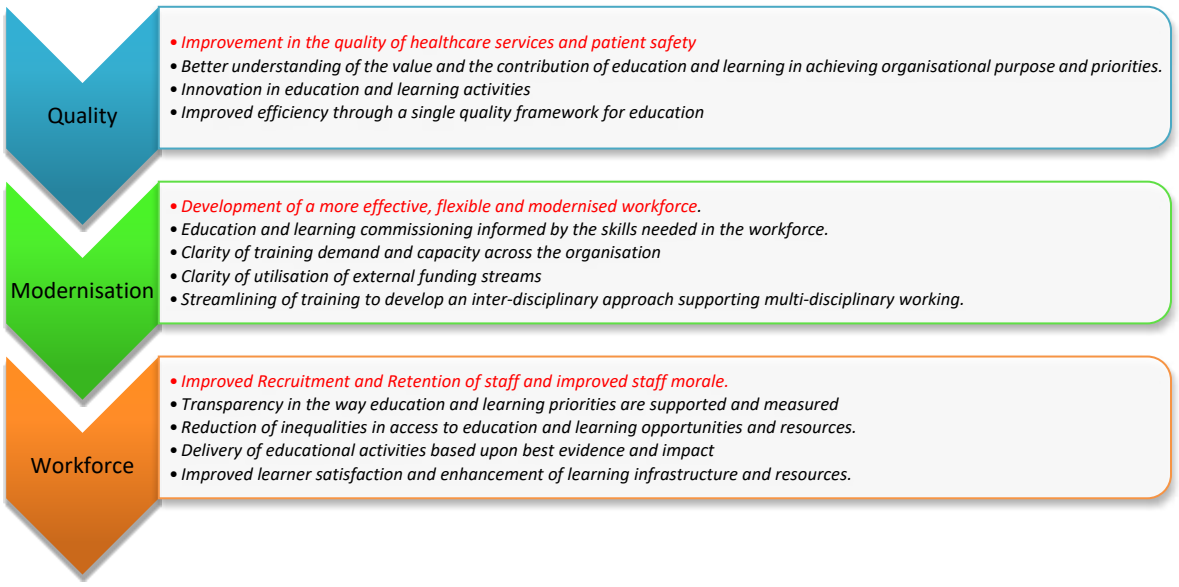


Fig (3) Organisational Benefits of Excellence in Education

University Health Board Status.

Cwm Taf Morgannwg continues to be recognised as a University Health Board, a status first awarded in 2013, due to activity in three pillars; Education & Training, Research & Development, and Innovation.

Welsh Government has recently changed from a Triennial status review to incorporation of the review into the annual Intermediate Medium Term Planning process, requiring consideration and evidence of university health board activity at every level of strategy and delivery. They have also introduced this year, a requirement for a 6 monthly progress update submission.

The potential of University Health Board status, is in the manifestation of the symbiotic and synergistic relationship between three priority activities:

Fig 4

A Learning Culture energises all three elements of university health board activity resulting in Innovation and Improvement

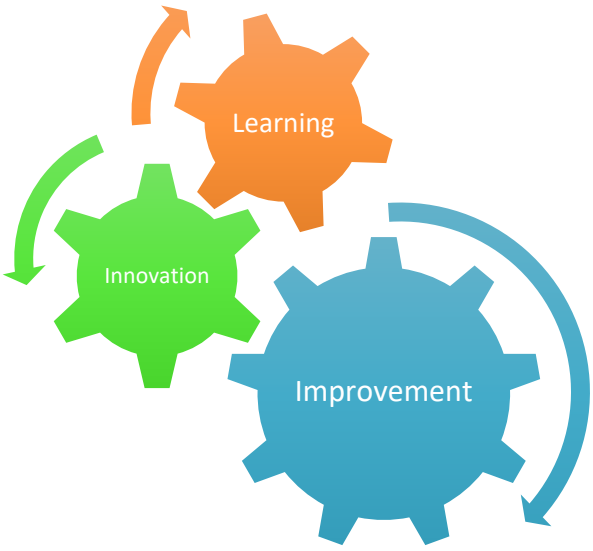


Fig 5

Working in partnership with our Higher Education Institutions (HEI) colleagues in the fields of research, teaching, innovation and evidence based practice, is vital to drive up standards and build momentum for co-creative roles and a collective drive for a better future for our communities.

About Us:

The Clinical Education function sits within the portfolio of the Executive Director of Nursing and Midwifery. There are also strong professional leadership accountability lines with the Medical Director and Director of Therapies & Health Care Sciences.

Over 21-22 focussed development work commenced to bring together what was a group of separate departments to create a cross-functional multi-disciplinary Clinical Education Service. This work will continue over 22-23 and will support and enable the delivery of the Strategic Direction for Clinical Education in CTMUHB.

Fig 6 Clinical Education Team.

The Clinical Education Service encompasses the following functionalities:

Fig 7 Clin ED Services

We are a highly-skilled education workforce of both clinical and specialist administration staff. A central management structure ensures overarching CTMUHB wide consistency of service whilst dedicated education teams manage, deliver and support education activity across all 3 acute hospital sites; Prince Charles, Royal Glamorgan and Princess of Wales and at Keir Hardie Academic Centre. Over 21-22 we have also utilised temporary training accommodation in Ysbyty George Thomas.

Clinical Professional Education.

Undergraduate/ Pre-registration Education and Training

CTMUHB as an organisation contributes significantly to the education and training of healthcare professional students in Wales. Each year our organisation delivers undergraduate clinical placement training weeks including:

- > 6000 medical student training weeks
- > 10,000 student nurse weeks
- > 1600 AHP student weeks

Over 2021/22 we have worked in partnership with 5 universities (HEIs) to deliver clinical placements for healthcare professional students:

- University of South Wales including–
  - Nursing & Midwifery. (*Operating Department Personnel and Part time Occupational Therapy, Physiotherapy courses commencing 2022/23*)
- Cardiff University including
  - Medical, Physiotherapy, Occupational Therapy, Health Care Sciences.
- Swansea University including
  - Nursing, Paramedics and Physicians Associates.
- Cardiff Metropolitan University including
  - Speech and Language Therapy, Dietetics, Podiatry.
- Open University (will be Bangor University from 22-23)
  - Nursing.

Focus on Nursing

The following preregistration routes to nursing are supported:

- Full-time 3 year programmes
- Flexible routes in either Adult or Mental Health (Adult and Child Fields)

The Practice Education Facilitators (PEFs) within the Nurse Education Team actively support the clinical placements within the health board and also deliver clinical teaching within the university. The PEF team also support student issues both clinically and pastorally in collaboration with our clinical and HEI partners.

Student training capacity

CTMUHB	2019/20	2020/21	2021/22	2022/23
Nursing first year student numbers	253	311	323	370

Table 1 Student Nurse allocation numbers

In response to ongoing workforce shortages the number of commissioned undergraduate places for all healthcare professional students is rising. The table above shows the intake number of nursing students allocated to CTMUHB over the last 4 academic years. These nursing students stay with us through the whole of their 3 year programme and represent

our future nursing workforce. Practice Education Facilitator Team work closely with the clinical areas and university partners to ensure areas are supported to provide a positive learning environment. Monthly meetings with our partner HEI's help identify areas for development including those out of compliance with educational audits & struggling with student numbers and also those who go over and above to support our students in practice.

Training capacity is a constant challenge and we are continually working to create innovative placement developments. New for this year were the Community Vaccinations Centres and corporate team placements. Following successful pilot results the Collaborative Learning in Practice (CliP) model is now embedded in a number of areas with further roll out in nursing and across other professions planned. CliP develops peer supervision capability, third year students support the first year students and are overseen by Practice Assessors/ Supervisors, also resulting in increased training capacity. Feedback has been excellent with 3rd year students reporting that they have been able to develop their teaching, leadership and management skills and 1st year students enjoying having a more experienced student to approach and support them.

Fitness to Practice (FtP)/Cause for concerns

The increase in student numbers is also accompanied by an increase in student issues. These can include pastoral and clinical concerns. The PEF team and Senior Nurse work across university and health board processes, including referral of clinical cause for concern issues to universities attending FtP panels and participating in FtP hearings as 'expert witness'. They also ensure students are supported in practice through the development of bespoke action plans to achieve required proficiencies and ensure safe and knowledgeable practitioners upon registration. Through the Covid 19 pandemic there was a rise in students needing additional support. We are working closely with university partners to monitor this situation. In 2021/22 there were ten Official Cause for Concern referrals following clinical issues with three resulting in discontinuation from the programme.

New Nursing Education Standards.

The new Nursing and Midwifery Council's (NMC) Standards of Proficiency and Education for Registered Nurses were launched in May 2018. The new standards made significant changes to proficiencies for registered nurses, standards for preregistration programmes, and student supervision and assessment. They also introduced a new education framework and standards for prescribing programmes. These reforms are designed to enable nurses to meet the changing health needs of patients, provide them with more clinical autonomy where appropriate, and prepare them for leadership roles in service.

All nursing students on clinical placements require Practice Assessors (PA) and Supervisors (PS). The PEFs have planned and delivered a programme of preparation for the supervisors and assessors addressing the need to upskill our current staff to support and assess students with aspects of the requirements. There are currently 2233 PA/PS that have received this training on the database (NMC requirement) for CTMUHB.

As the changes to preregistration nursing training become apparent there is also the need to upskill our current workforce to similar levels if not already achieved. The Practice Development Nurses (PDN's) work closely with the PEF's to ensure existing staff will be upskilled and up-to-date.

Internationally Educated Nurses (IEN's)

After a 10 month gap the International Nurse Recruitment project recommenced with a plan to recruit 97 Internationally Educated Nurses (IEN's) by the end of 2023.

A dedicated education team was appointed to support the recruitment and education of IEN's. Previously, with the first cohort, first time pass rate was 90% however this fell to 25% for the 2nd cohort with 4 candidates needing to sit a third and final attempt. Whilst the first time pass rate across Wales seems to be lower throughout all test centres for this phase, an immediate review was carried out. Potential reasons identified within CTMUHB included a newly established exam centre, a required curriculum increase from 10 to 33 skills and an increase in test stations from 6 to 10, and also changes in the timing of training programme delivery.

To improve future exam results the following mitigating actions have been put in place;

- Focussed OSCE training time increased from 20 to 25 days immediately prior to OSCE exams.
- Re-establishment of a Mock OSCE
- 10 days following exam for other relevant and mandatory training.
- Concerns escalated nationally and with NMC.

We will continue to monitor progress closely with the expectation of improved results with cohort 4. (Training for cohort 3 had been completed by the time results for cohort 2 were received)

As a continuing support to the development in practice of the IENs and in response to feedback from the previous project from the IEN's and Ward Managers, a 'Post OSCE' programme has been developed.

Focus on Medical Undergraduate Training

During Academic Year 21/22 we delivered teaching/placements across the 5 year medical undergraduate (UG) programme–

Year of course	Student weeks	Number of students
1	180	113
2	266	222
3	2312	289
4	1952	262
5	1120	140

Table 2 Medical student numbers across 5 year course in 21-22

Focus this year has been the re-establishment and allocation of SIFT funding. Part of the transitional funding was identified to support the development of a new UG faculty with various appointments to be made to support the comprehensive support, coordination and delivery of UG education. As with all the health care professional students these individuals are our future workforce and it is essential that their education, training develops safe, competent and confident clinicians and their experience with our organisation is of one they want to come back to work for in the future.

Clinical Fellows

There are now 6 Clinical Fellows in Medical Education across CTMUHB, 2 based at each of our acute sites. These appointments are one year tenure and include a level 7 education

qualification. The continuous availability of dedicated teaching clinicians has significantly underpinned the robustness of training delivery and has received fantastic feedback from students.

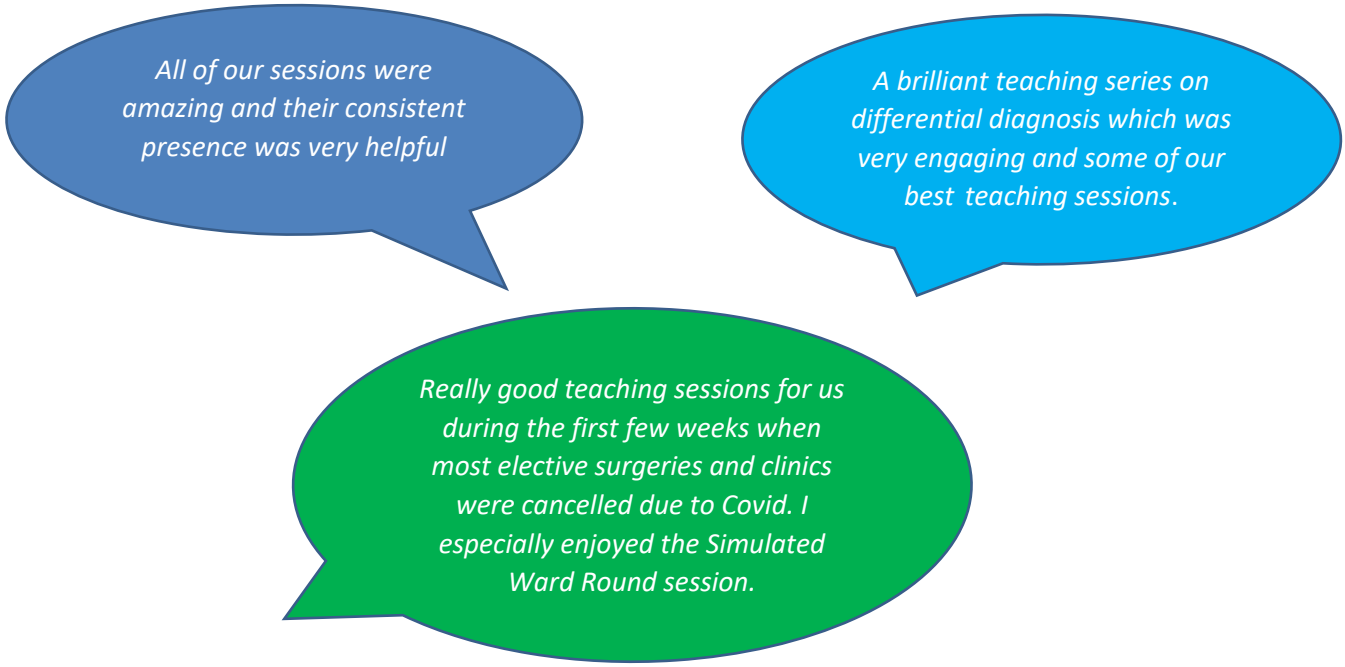


Fig 8 Clinical Fellow student feedback

Underpinning Administration and Co-ordination.

We have also made significant progress in strengthening the underpinning education administrative function. Feedback from students clearly shows the impact of the administration team.

Fig 9 Admin team student feedback

We have additional plans for the use of the development funds in terms of simulation and widening access activity e.g. the creation of simulation scenarios at the USW Simulation suite and various new widening access initiatives.

Undergraduate (UG) Faculty Structure

The following diagram illustrates the progress that we have made so far in strengthening the UG Faculty structure.

We are currently in the process of appointing Module Leads and supporting Honorary Lecturers to the final tier in the organisation chart.

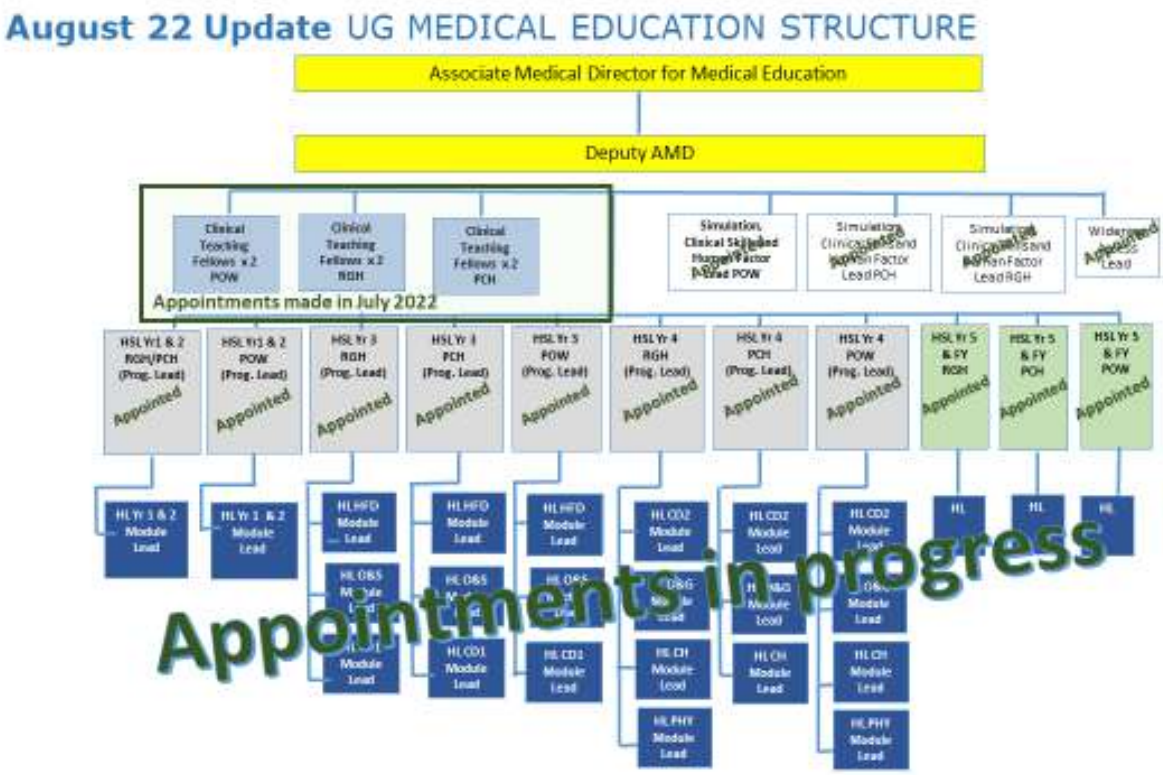


Fig 10 UG Medical Education Faculty Structure

Post Graduate/ Post registration Education and Training.

The Clinical Education Service manages the education, training and development of registered clinical healthcare professionals including:

- Design and delivery of bespoke in-house education programmes to meet training needs e.g. New Nurse Graduate development programme, education packages in response to Clinical Incidents e.g. Nasogastric training, International Nurses training.
- Delivery, Management and co-ordination of Education pathways for Foundation Medical Trainees.
- Management of Health Education Improvement Wales Advanced Practice & Non-Medical Prescribing funding streams.
- Management of HEIW (HEIW) Nursing CPD allocation via University of South Wales.
- Library and Knowledge Management services.
- Recognition of Acute Deterioration & Resuscitation and Clinical Skills including advanced programmes accredited by the Resuscitation Council and Royal College of Surgeons.
- Action Learning Set methodology to support participants to understand organisational context to better apply and embed learning from e.g. MSc in Digital Skills for Health Care Professionals (University of Wales Trinity St David)

Focus on Nursing post registration

The Nurse Education Team have developed and implemented a New Registrant Nurse Induction Programme for all graduate nurses employed within the organisation across all fields of nursing. The structure of the programme is based on research which recommended that, novice nurses are best supported by structuring their experiences in clinical practice while supporting and enabling them to achieve their goals through the learning continuum and their career progression. The aim and structure of the programme was to aid recruitment and retention of newly qualified nurses (or within 6 months of qualifying). The staggered structure of the course allows the graduates to transition into their new role and acquire new skills gradually before they progress to the next level, preventing overwhelm in their new role. The impact of this programme is continually evaluated and amended to ensure clinical need is met. In 2021-22 126 Newly Registered Nurses attended the programme.

The Professional Development and Innovation Programme, targeted for nurses in band 6 roles, focusses on developing their experience of management, leadership and innovation roles to consolidate preparation for the next phase of their careers. The programme is a valuable resource in supporting our Band 6 Nursing workforce, to date 38 Registrants have attended the programme with more dates planned for 2022-23. Leadership and communication themes are at the core of this programme including:

- Demonstrating the role & responsibility of Junior Sister.
- Demonstrating the ability to manage performance.
- Demonstrating their role in relation to managing people.
- Demonstrating their responsibility in relation to managing resources.
- Demonstrating their responsibility in relation to empowering others.

What is clear from the impact of this programme is the agency and self-authorisation shown by the participants to in offering their leadership through their roles and really making a difference, for colleagues, patients and their care.

Focus on Medical post grad

In Academic Year 2021/22 CTM UHB had a total of 72 Foundation Year 1 (FY1) doctors and 59 Foundation Year 2 (FY2) doctors starting their rotations across the three acute hospital sites. In addition, throughout the academic year, we held induction for 281 junior doctors as they started with the UHB. This induction covers corporate/legal requirements and site-specific information.

Foundation training for FY1 and FY2 took place weekly on specific, regular times on each acute site. In addition we held frequent, speciality-related teaching and journal clubs through the year. We also trialled four simulation afternoons for the FYs which proved to be very beneficial for the new curriculum.

For junior doctors we facilitated weekly teaching as well as ad hoc events and "Grand Rounds" for all trainees and consultants.

Performance

Performance is monitored via the HEIW Quality Unit. The HEIW CTM UHB "Risk register", maintained by the Quality Unit, records areas of concern through a number of different data sources, most notably the General Medical Council (GMC) National Trainee Survey.

The sources of concern can range from anecdotal evidence, to formally recorded results on GMC surveys, and the scope of the "risk" from a single point of contact, to covering the whole health board.

HEIW formally review risk position with the health board 3 times a year, operating on a traditional traffic light system. The current version of the risk register (August 22) has 24 risks (23 in September 2021). The Associate Medical Director (Education) and the Clinical Education Manager continue to tackle each individual risk, liaising with trainees and trainers as required, collecting and collating feedback and assisting with the development of action plans. The matrix below shows the risks from September 2021 to August 2022. Medical Education has developed a process for continual monitoring of risks, further detail can be found on p 31 and appendix 1

Acute site Matrix August 22

		Aug 2022	Sept 2021
RED RISK High Risk	RTE	0	0
	MC	3	1
	BRIDGEND	0	0
	ALL	0	1
ORANGE RISK Medium Risk	RTE	5	4
	MC	6	3
	BRIDGEND	4	4
	ALL	2	1
YELLOW RISK Low Risk	RTE	1	4
	MC	1	1
	BRIDGEND	1	4
	ALL	1	0
	TOTAL	24	23

Table 3

Bespoke Education and Training activities

The Teaching skills for Doctors Course is an in-house development which has been so successful that an additional course was commissioned by HEIW. We expect this course to run at least twice a year in the future.

In Prince Charles Hospital we ran the Neonatal Boot camp in August 21, December 21 and April 22, with exceptional feedback and intend to continue this activity.

Likewise we intend to continue development of hybrid study days after a successful Cardiac Study day in Princess of Wales, with a screen of online delegates, and separate cameras and microphones for attending delegates, to ensure interactivity.

The annual Teaching and Educators Development Conference (TED) was held in POW on the 1st of July and was themed "Future Proofing Medical Education." 70 delegates attended and talks and workshops were given with members of CTM UHB clinical staff, as well as contributors from HEIW and Cardiff University.

Continuing Professional Development Education

It is absolutely essential that continuing education for all staff is aligned to and centred on patient care and service developments.

Focus on Nursing

CTMUHB and the University of South Wales (USW) continue to have an excellent partnership and team approach ensuring that the educational requirements of practice are met with the academic infrastructure of the University.
Clinical Education manages utilisation of the contract with USW for continuing post-registration education for nursing and midwifery. The equivalent of approx. 350 module places per annum are available via an internal application and allocation process. Clinical Education continue to work with the USW to develop modules and educational courses which are tailored to support specific service change across the organisation. e.g. Education day on Clinical Supervision.

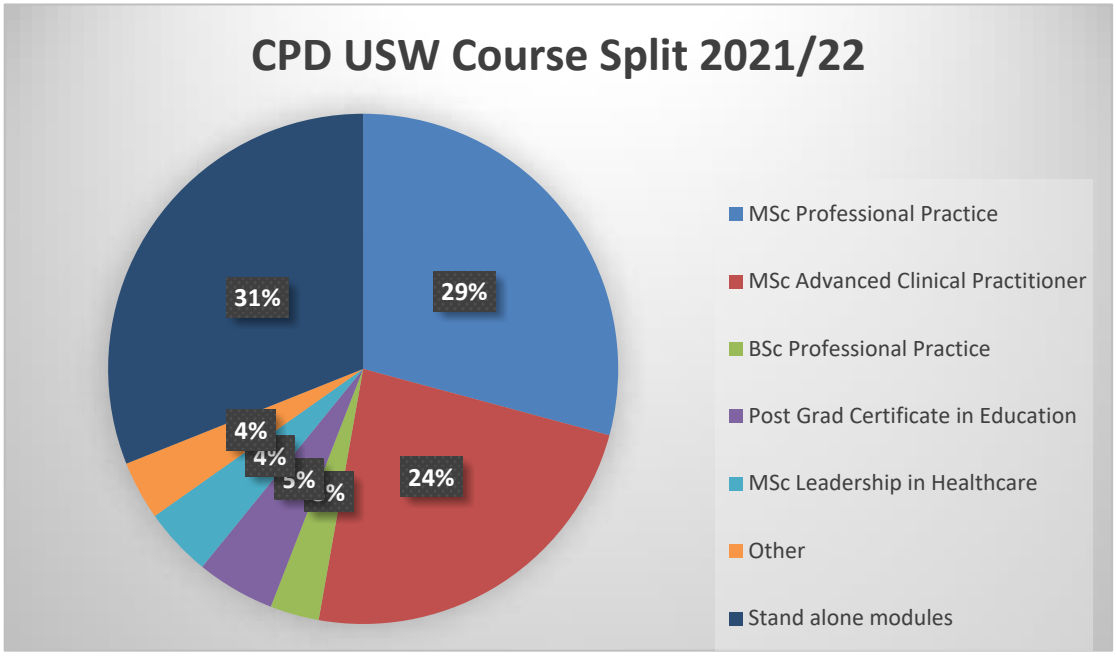


Fig 11 CPD USW Course Split 21-22

Focus on Multi-Professional Advanced Practice

Welsh Government via HEIW continue to invest in health professional education by providing annual funding for *Advanced Practice & Extended Clinical Skills.*

The funding provided by HEIW is to supplement our local investment to ensure that the appropriate staff can access the educational requirements as identified in our Integrated Medium Term Plan (IMTP), in terms of advanced practice/extended skills education requirements and Non-Medical Prescribing programmes. This funding is utilised across our organisation and is inclusive of nursing, therapies & healthcare scientists. There is a separate funding stream for Pharmacy advanced practice and prescribing.

The allocation is informed by an annual CTMUHB Education Commissioning return including undergraduate and advanced practice education requests. HEIW notifies the UHB of its Advanced Practice and Non-Medical Prescribing allocation between April and May each year the allocation is split across primary and priority areas in acute care settings.

Advanced Practice allocation is agreed via a Multi-professional Allocation Group and managed via Clinical Education. All applications must describe the intended service impact to be achieved as a result of the educational request. We meet requests flexibly across both Advanced Practice and Nursing CPD funding streams where appropriate to maximise access to funding for all health care professions and to enable optimal use of resources.

HEIW also funded 40 places for Independent Prescribing Programmes in 21-22 (30UoSW and 10 Swansea). All funded places are available to a range of professions across the organisation.

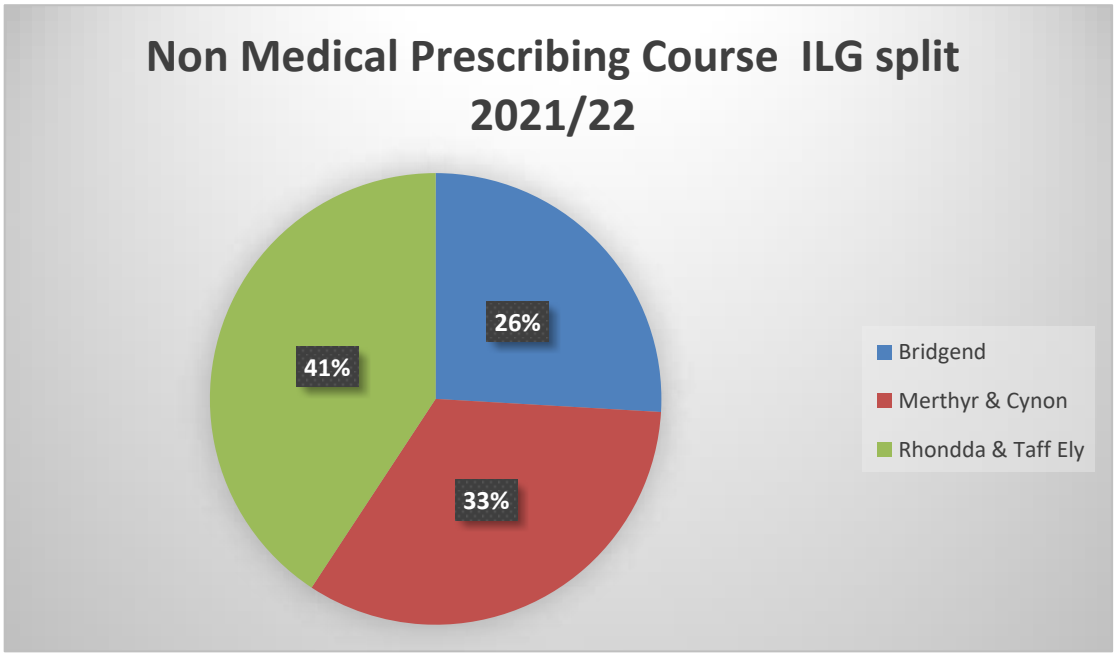


Fig 12 NMP ILG split

New for 2022-23 are Practice Specific Funded training places, these include Child and Adolescent Mental Health, Critical Care, Medical Ultrasound and Reporting Radiology.

Health Care Support Worker (HCSW) Education

Clinical Education supports the skills and career development education pathways for health care support workers across CTMUHB as defined in the HCSW Framework, including clinical and non-clinical roles in primary and secondary care settings.
HEIW continues to allocate funding to CTMUHB for HCSW Education and Development in line with compliance with the All Wales HCSW Framework, with £258,377 being allocated 2021/2022.

21 Clinical HCSW Inductions (5 Day Programme) with 214 staff trained and 16 Consolidation days covering 235 staff were delivered over 21/22. The consolidation days were developed and delivered to the HCSW's that were recruited during the Covid recruitment phase as they had received a shortened, non-accredited Induction, this ensured that any of the HCSW's still in employment worked towards the accreditation in line with other clinical HCSW's.

There were 14 NEWS and Physiological Measurements Agored accredited training days scheduled, due to requests from service and in response to the Acute Deterioration Lead's request. Only 5 days were delivered to 22 HCSW's due to challenges with staff release because of service pressures during the latter part of the year, again due to increase in staff sickness because of another small wave of Covid at the end of 2021. This Covid wave also meant that members of the HCSW Team were redeployed to Community Vaccination Centres for a period of a month to assist with the delivery of immunisations.

The numbers of HCSW's progressing through the framework during this period via Credit and Qualifications Framework Wales (CQF) Level 2&3 Apprenticeships saw a rise as service pressures eased slightly pre-winter and the expansion of the HCSW Team. This has enabled the Clinical Trainers to identify HCSW's that are out of compliance with the framework and aim to enrol them onto heath related apprenticeships, with support from the Apprenticeship's Lead and Coordinator from the Learning & Development team.

There was a healthy interest in the Certificate of Higher Education delivered at USW for September 2022 intake. 29 HCSW's have enrolled on year 1 and 15 enrolled onto year 2 (3 resitting) and 11 graduated and 4 are going directly onto the 2nd year of preregistration nursing via the flexible route at USW. The increased appetite for the Cert HE has been fuelled by the development of Band 4 roles within the community and the need for Level 4 education to underpin these roles.

Reports for compliance with the All Wales HCSW framework are submitted along with an annual detailed bid for ongoing funding to HEIW and this year has seen HEIW request quarterly updates on the progress of the funding spend.

Acute Deterioration, Resuscitation and Clinical Skills

Organisational governance around resuscitation and acute deterioration has been further developed and aligned. The overarching CTMUHB RADAR Committee (Recognition of Acute Deterioration and Resuscitation) is responsible for the strategic management of all Recognition of Acute Deterioration and Resuscitation related issues within the Organisation, supporting the provision of appropriate and effective patient care through implementing operational policies governing the prevention of cardiac arrest and those governing cardiopulmonary resuscitation, practice and training. This approach brought together a number of work streams in order to reduce avoidable mortality and morbidity by improving the function of health board systems that enable early recognition and treatment of deteriorating patients, and cardiopulmonary resuscitation.

It chaired by the AMD for Quality and Effectiveness on behalf of the Medical Director with a Consultant appointed as the Clinical Lead. There is a Lead post for Acute Deterioration which commenced in January 2021 (based within Clinical Education) with a plan to have a structured and unified approach across Cwm Taf Morgannwg University Health board (CTUHB) in the identification, escalation and response to the acutely unwell patient.

This group reports directly to the Executive Leadership Group, via the Medical Director with links to the Quality & Safety Committee

The work of this governance structure is directly supported by the Head of Clinical Education, the Lead Nurse for Education and the Resuscitation & Clinical Skills team.

Acute Deterioration

National Early Warning Score (NEWS)

To provide a consistent approach across CTMUHB the National Early Warning Score (NEWS) chart has been updated to include NEWS 2 principles and standardised across CTMUHB wards. NEWS is based on a simple aggregate system in which a score is allocated to physiological measurements already recorded at the patient's bedside, the aggregated score then generates a clinical response. NEWS aids the identification of the deteriorating patient. In addition to differentiate the escalation procedure within the community hospital environment a tailored escalation procedure has been developed for the community hospital sites.

In order to provide assurance within the health board that the NEWS charts are completed accurately and appropriately escalated an audit pro forma has been developed based upon NICE CG50. Data is entered monthly onto the Audit Management and Tracking (AMaT) system. Results are disseminated to all ward managers, senior and head of nursing for review. Any compliance issues are also discussed within the ILG Recognition of Acute Deterioration and Resuscitation RADAR meetings. NEWS audits are used to provide evidence of learning in Learning from events reports (LFER).

The plan for 22-23 is to perform a health board wide audit of all NEWS charts within a 24hr period within secondary sites to identify the burden of acute illness and evaluate the response to acute illness.

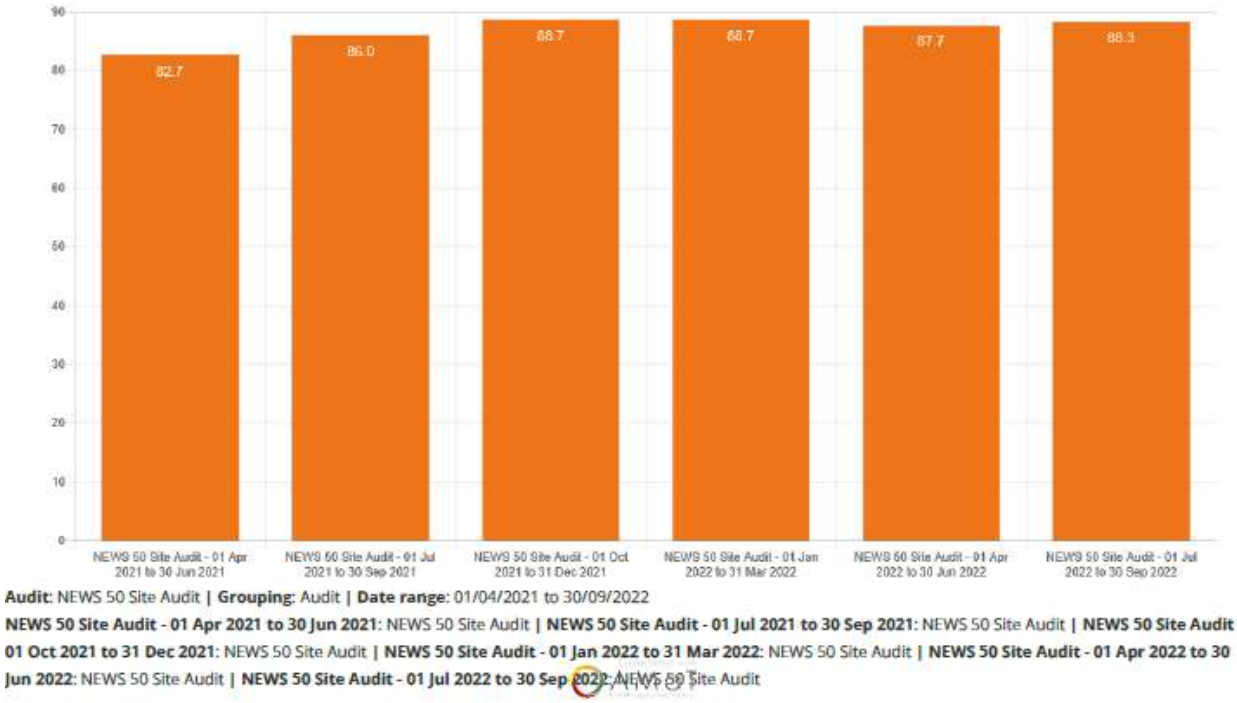


Fig 13. CTMUHB NEWS audits (quarterly view) April 21-Sept 22

The Critical Care Outreach Teams (CCOT) undertake the NEWS training within the secondary sites. NEWS training is also provided by the health care support worker programme and the resuscitation practitioners during Immediate Life Support and Advanced Life Support.

To complement the Immediate Life Support (ILS) course provided by the resuscitation team, the Acute Life Threatening Events-Recognition and Treatment (ALERT) course has been introduced across CTMUHB for all registered nursing staff. This ensures a unified approach to education to manage an acutely unwell patient within a ward environment. The plan for 22-23 is to extend the provision of the course and develop a multi-professional faculty to facilitate, this would provide best learning environment for the candidates on the course.

Rapid Response

To standardise the response to deteriorating patient within CTMUHB a rapid response call has been added to the 2222 emergency call list within Prince Charles and Royal Glamorgan Hospitals. A rapid response call is already established within Princess of Wales Hospital.

The Rapid response call aims to prevent cardiac arrest, initiate treatment decisions, and initiate timely specialist reviews by earlier escalation of the deteriorating patient. To audit the number, timeliness of response and the outcomes of the rapid response calls, a Rapid response and cardiac arrest audit pro-forma has been developed. This together with the emergency call data from switchboard provides information of the effectiveness of the escalation system within CTM.

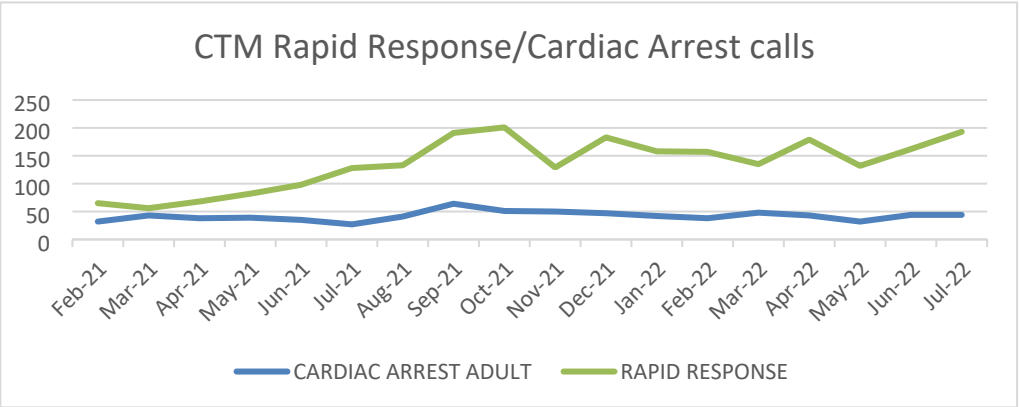


Fig 14. Number of Rapid Response/Cardiac Arrest calls CTM April21-July 22

To further review the escalation system an audit of Cardiac arrests occurring in wards is being developed. This would enable any gaps in escalation to be identified and facilitate training

Fig 4. Rapid Response Outcomes

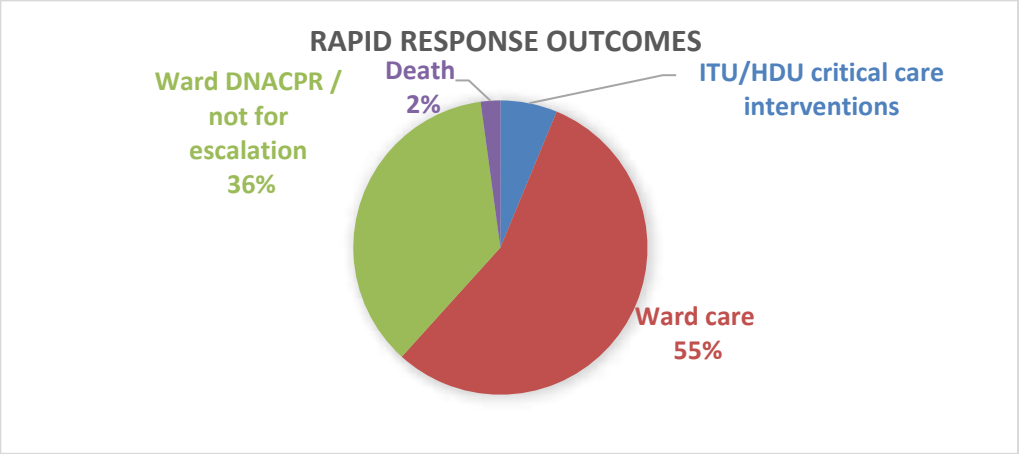


Fig 15 Rapid Response outcomes

Results from data entered into AMaT indicate that over 50% of the rapid response calls result in patients remaining on the ward. This could be due to improving condition following interventions by the Rapid response team. Also 36% of the calls result in timely decision making which can prevent inappropriate admissions to Intensive care and prevent cardiac arrests. It is intended that with the introduction of Treatment Escalation Plans (TEP) that timely decisions around escalation and DNACPR would lead to a reduction in these decisions made at a rapid response call leading to an appropriate outcome for the patient.

Sepsis.

Sepsis can be one of the causes of deterioration within a patient and if not identified and treated timely can lead to multi organ failure and increased admission to Intensive Care and deaths. Within CTMUHB there were several sepsis screening tools in use. Therefore to ensure consistency in the identification of sepsis within the hospital setting a new sepsis tool has been developed using a collaborative approach between pharmacy, medical and

nursing leads. The new sepsis tool focuses on risk stratifying patients into categories to ensure those at most risk receive timely care.

To support the timely administration of antibiotics the first line antibiotics for use within Emergency departments was unified and the addition of a QR code helps to reduce the time to prescription and administration in the patient with probable sepsis.

The sepsis tool was trialled within the three Emergency departments for a period of three months, initial results indicated an increase in the use of screening from 7 screening forms to 90 forms per month and increase in compliance from 34% to 63% with timely treatment.

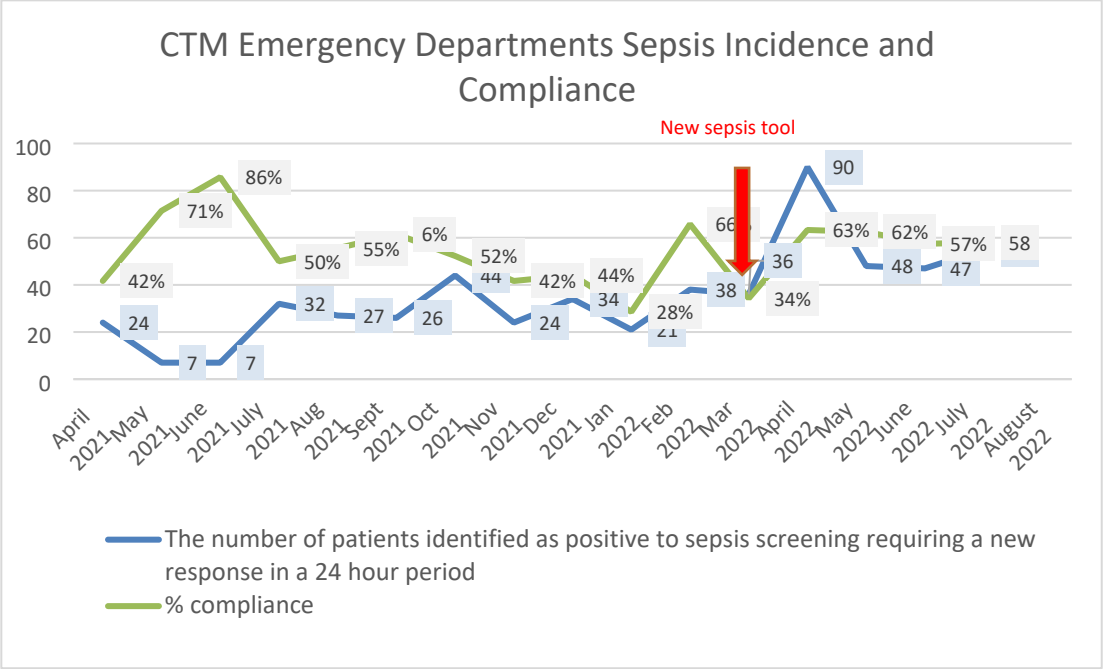


Fig 16 CTM ED Sepsis compliance

Ongoing work continues with the roll out of the sepsis tool to the wards within both secondary and community hospitals and this would formulate the plan moving into 2023. Plans are in place to collaborate with our CTMUHB communities to raise awareness of sepsis and signpost to the relevant areas for support which aligns with **Our Health, Our Future, CTM: 2030**

Resuscitation and Clinical Skills

Throughout 21-22, there was a focus on standardisation of Resuscitation Standards CTMUHB. This included a complete review of the CTMUHB resuscitation policy, and a renewed resuscitation training compliance matrix for the organisation. Additionally, the resuscitation equipment was standardised across the health board, with a major change to equipment taking place in Princess of Wales Hospital with the rollout of new resuscitation trolleys across what was then the Bridgend locality group. The standardisation of equipment, along with the rollout of the Rapid Response Calls, has not only improved patient safety, but has also rationalised equipment with a significant reduction in equipment utilised.

During 21-22 the Royal Glamorgan Hospital and Prince Charles Hospital, received a roll out of 40 new defibrillators along with the relevant training of staff to ensure competence and safe use.

The service also provided support and training for staff to rollout a new standard operating procedure in Ty Llidiard, as part of the response to a Welsh Government investigation into a recent incident. This included working closely with Welsh Health Specialised Services (WHISSC) Committee and Welsh Ambulance Service NHS Trust (WAST) to create a hybrid 2222/999 response to emergency calls.

The Resuscitation Service continues to deliver mandatory life support training from Level 1-3 (graph 1 and 2), for CTMUHB, Powys HB and all local GP's and Dentists. The department is also a leading National provider in the delivery of Level 4 Advanced Resuscitation Courses, for Adults, Paediatrics, Newborns and Trauma. These courses are delivered on an income generation basis, with internal and external faculty engagement required to deliver. The number of staff trained is outlined below.

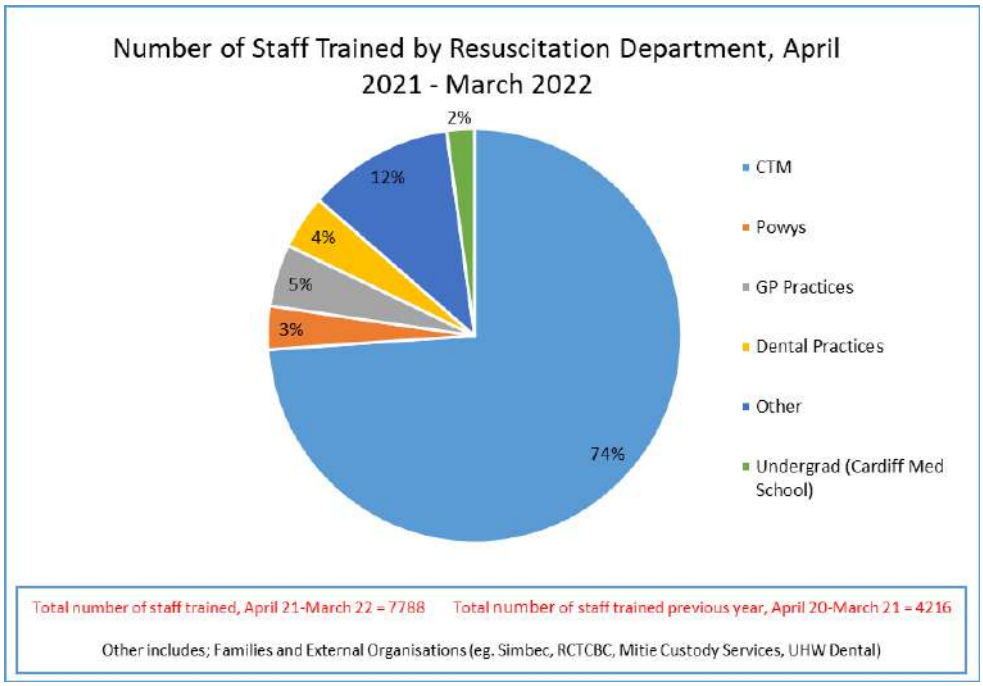


Fig 17 Staff trained, April 2021 to March 2022

Fig 18 Level of training numbers.

Vaccination Teams across the UHB have been supported with training to enable them meet the urgent demand throughout the Covid-19 pandemic. We have also assisted in the upskilling 44 ITU staff and 52 Paediatric staff with level 3 Paediatric Immediate Life Support (PILs) in response to the Respiratory Syncytial Virus (RSV) risk.

Over the past year, the Resuscitation Team worked collaboratively with the Practice Development Nurses and Midwives (PDN & PDM) to deliver 'Train The Trainer' (TTT) 'in house' training programmes for Level 2 Basic Life Support, increasing flexibility and opportunity to offer further training places and therefore increasing compliance. This in turn releases time for the Resuscitation Practitioners and Training Officers to focus on the delivery of Level 3 training, organising and facilitating debriefing sessions following arrest calls, investigating and preparing evidence for Rapid Reviews and scrutiny panels, attending 2222 calls, cardiac arrest audits, and Datix queries. Through this activity areas for improvement are identified and training needs incorporated into future training programmes. E.g. redesign of the cardiac arrest audit form. The revised audit enables identification of areas needing improvement in training and provides a trail of decision making.

Libraries and Knowledge Management.

There are dedicated Libraries on each of the acute sites operating 24/7 access for our staff and students, to our literature collections; journals and books, both electronic and physical, quite study space with IT access & printing. Our specialist librarians are also available for help and support including literature searching, reference sourcing and critical analysis skills. Our libraries are an important part of our health board activity.

Library Usage	**Footfall**	**Loans**	**Literature Searches**	**Current Awareness**	**Articles via Library**
PCH	34917	1054	24	n/a individually	259
POW	21427	3405	163	"	870
RGH	26828	1774	26	"	248
Totals	**83172**	**6233**	**213**	**130**	**1377**

Table 4 Library Usage Stats

Updated Facilities

The Library at PCH has been moved into a new modular building for the next five years as part of Phase 2 redevelopment of PCH.

The library team at PCH worked hard organising the move and ensuring there was as little disruption as possible. The new accommodation is a great improvement on the old facilities and is a bright, welcoming area for users to work and study. Library facilities at RGH and POW have also had a refresh with new furniture and printing facilities.

Fig 19 Updated facilities PCH/ increased study space POW

CLA Submissions

The team at RGH have been working on a new methods of data collection for the Copyright Licensing Agency via the Library Management System which involved working closely with the Systems Librarian at Cardiff University. This is now up and running and is being used across NHS Wales Libraries as the main data collection method for this submission. From 2023 this data is being collected annually rather than 3 yearly and will make the process much quicker and simpler.

NHS Wales Library & Knowledge Services (NHSWLKS) & UpToDate Survey

The NHSWLKS survey was launched on the 10th May until the 4th June 2021. Feedback was excellent with 84% of respondents saying they were very satisfied with the Library & Knowledge Service at CTM.

"The library provide an excellent service and I am truly grateful for all the support they have provided to me. It would not be possible to provide patient care which is in keeping with the latest evidence without their support. They are an essential part of any health board team." [AHP]

Fig 20 Library feedback

UpToDate

To aid the renewal of UpToDate a User Survey was sent to Medical Staff across CTM. The response rate was very good with 96 responses, all recommending that UpToDate is renewed. This information enabled us to repurchase the resource on a 3 year contract (with the option to opt out at the end of each year). Some of the user comments are below:

"I often use up to date to refresh my clinical knowledge of conditions I do not encounter very often. It has also been useful in the wards in reading the latest research on rarer conditions providing better care for those patients."

"Easy point of reference for clinical conditions. Helps to avoid delay in care, unnecessary investigations and offers better patient care. By having one single point of reference it is more efficient to visit one site that searching for multiple."

Staff Development & User Training

A number of online training courses have been made available to Library staff by the NHS Wales Library network. These have ensured that as a service we remain up-to-date with changes and new technologies. Some of the topic covered include:

Advanced literature searching, Artificial Intelligence, Accessing e-Books, Presenting searches to the end user, Using Scopus, Critical appraisal

The Specialist Librarian (POW), received her Chartership from CILIP, the library and information association.

Several online webinars have been provided nationally on how to search databases etc. effectively with support from CTM LKS staff. New short online videos to support library users

have been developed e.g. Accessing e-resources from the NHS Wales network. In person inductions, teaching and training has increased as pandemic restrictions have eased.

Wellbeing

The LKS continues to support the HB wellbeing agenda with a range of books and resources and this year managed the distribution of Chillo pillows to staff.

Bilingual Leaflets

All of the CTM Library guides and leaflets have now been translated into Welsh.

Strategic Direction Progress

This report reflects the progress made over academic year 21/22 to a more integrated Clinical Education Service from departments that have historically functioned separately.

The Strategic Direction for Clinical Education in CTMUHB is to become a Learning Academy meeting the individual education needs of each profession whilst also taking a multi-disciplinary education and inter-professional learning approach, encompassing and enabling benefits from diversity of thought and skill set, contributing to improving patient care and population health and wellbeing.

Creating, sustaining and growing a Learning Culture in Clinical Education

Our Clinical Education Strategy follows a hierarchy of needs model to build and ensure motivation of the individual and therefore supporting and nurturing the development of a Learning Culture in CTMUHB.

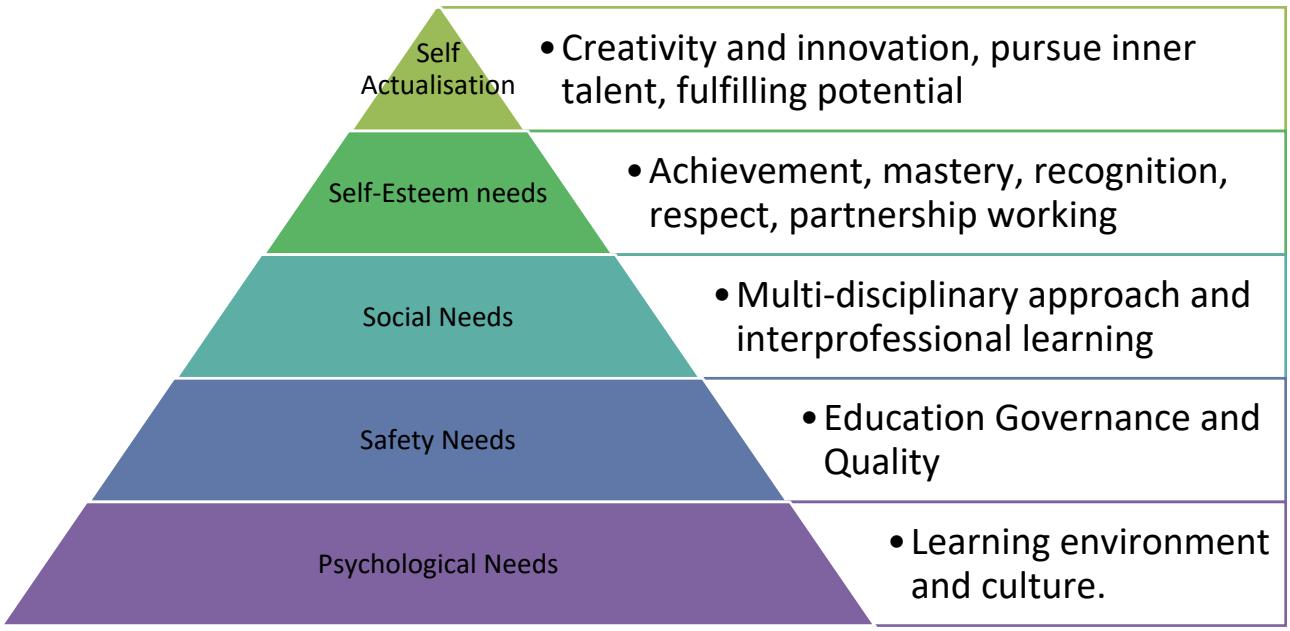


Fig 21 Heirarchy of Needs

Learning Environment and Culture: Resource investment and utilisation

Direction:

- *Quality and excellence in Education and Training is an established and valued part of organisational culture.*
- *CTMUHB is a Centre of Excellence for multi-professional learning.*
- *There are clearly defined, recognisable, flexible, accessible, up-to-date Clinical Education facilities that meet the learning needs of learners from all professional groups.*

Progress over 21-22

Our Facilities

Over 21/22 inspired by work with University of South Wales, we have raised the profile and identity of our service through a branding and refresh of Clinical Education facilities across all sites.

Additional study areas have been added which have been popular with our HCP students and staff using our libraries facilities.

Fig 22 RGH Refresh

During January 2022, the Clinical Education function in PCH moved to its new interim accommodation as part of the PCH rebuild. This has enabled the co-location of some historically separate elements of Clinical Education resulting in beneficial integration of services, efficient sharing of resources, updated facilities and improved layout.

Fig 23 PCH Clinical Education Centre

Learning from this move has also highlighted the need when planning commences for the final location of Clinical Education in PCH, to include libraries and nursing education in the co-located provision.

We are also, with financial investment through IT, coming to the end of a comprehensive Audio Visual (AV) equipment refresh, to ensure that all the rooms available for Clinical Education, have consistent and functional AV capability.

Much work has been done to align and standardise Service Increment for Teaching (SIFT), funding that the organisation receives to deliver medical student education and training as per Cardiff University C21 curriculum requirements.

Significantly, following extensive discussion and evidence gathering, Clinical Education and Finance agreed a two/three year plan with the purpose of better identifying the flow of SIFT funds to services and directorate budgets. This will enable the robust resource support of the undergraduate medical education activity, alongside increasing governance and clarity over the utilisation of SIFT funds.

Permanent training accommodation continues to be a challenge as the demand for increased clinical space becomes an issue across all sites and services.
It has been recommended that the creation of a dedicated multi-professional Education and Learning facility should be included as part of the strategic site development plan.

Strong workplace infrastructure - Education Governance and quality infrastructure.

Direction:

CTMUHB has established effective systems of educational governance and leadership

1. *A robust and established Clinical Education Governance infrastructure providing confidence and assurance for individuals and the organisation of excellence in Clinical Education and Learning activity.*
2. *A clear and well developed understanding of Clinical Education, Training and Learning activity and risk management across the organisation.*
3. *Maturing organisational processes around clinical education commissioning, informed and aligned with service delivery priorities and training needs analysis,*

supporting the development of new models of care, innovative service redesign and workforce modernisation.

Progress towards these aims in 21-22

1. Significant progress has been made over 21/22 to develop and establish robust organisational wide education governance infrastructure to assure high quality education and training meeting the requirements and standards determined for the NHS in Wales, with oversight of undergraduate and postgraduate education and continuing professional development for all registered health care professions and clinical healthcare support workers.

   The purpose of the Clinical Education Forum is to provide effective systems of educational governance and leadership that ensure optimal investment and resource utilisation in education activity to support and underpin the capability, capacity and confidence of our clinical workforce.

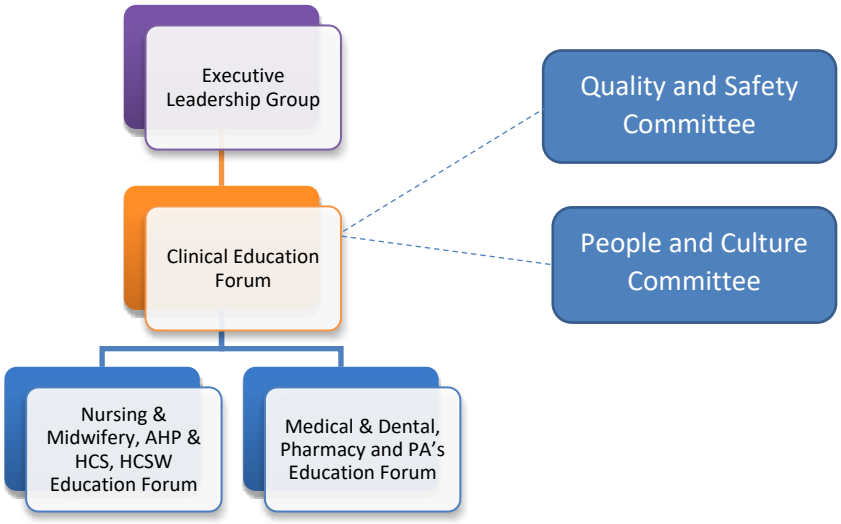


Fig 25 Clinical Education Governance Structure

2. Our risk management processes are maturing and example of this is the approach developed for managing postgraduate medical education risk register as maintained by Quality Unit HEIW.
   a. Medical Education have now developed a process for continual monitoring of the register and formally request updates from Faculty members, seeking continuing consideration of the issues by acute site. The risk register is addressed and updated formally within the internal Medical Education function (AMD Education and Clinical Education Manager). Alongside this process, HEIW undertake a series of targeted visits, meeting with trainees and trainers to assess issues and monitor progress.
   An example of a monthly monitoring report can be seen in Appendix 1

3. Over 21-22 the Head of Clinical Education worked in close partnership with the Deputy Director of Workforce and OD to develop a more robust process for collating annual Education Commissioning numbers return for HEIW. Heads of Workforce and OD worked with locality directors and profession leads to identify requirements at a locality level and these were collated into an overarching CTMUHB wide commission.

Regular sense check meetings were held to review submission status, compare to previous years, identify any outstanding gaps in information and to develop an accompanying service development and workforce position narrative. Further refinement of this process and consideration of the new organisational structure will be reflected in activity for 2022-23.

Multi-disciplinary Learning and Inter-professional Development.

Direction:
*There is a high quality multi-professional education model that delivers equitably for **ALL** healthcare professionals and their support staff. Meaningful inter-professional learning and development is evident throughout the education model.*

As part of a Review of Health Care Professional Education in Wales, HEIW has given a clear direction to education providers that, in addition to meeting professional regulatory standards there must be delivery of meaningful inter-professional learning opportunities through clinical placement activity and beyond into post grad/ post registration career pathways.

Progress in 21-22

We are making good progress in establishing more meaningful interprofessional learning within the health board.

- As a result of learning from a joint project with Swansea University; Working in Partnership to develop a Learning Outcomes approach to Clinical Placements for Paramedics and Nurses' (3) CTMUHB developed and appointed the first Multi-Professional Practice Education Facilitator (MPEF) role in Wales who works across all clinical professions and HEI's with a focus on learning activity opportunities to meet the HEIW requirement of 150hrs of interprofessional learning on clinical placements.
- Informed by the recommendations from the project above, over 22-23 HEIW are looking to provide targeted funding for further MPEF roles across health boards in Wales.
- The staff on the MSc for Digital Skills for Health and Care professions were supported through the first year of their programme with regular multi-disciplinary Action Learning Sets (ALS) to enable their learning through orientation to the landscape of CTMUHB digital context and building of key networks to sustain application of learning directly back into the organisation at pace. Inter-professional learning was enabled by dedicated time and space for reflection, knowledge sharing and sense making. Key digital organisational contacts linked into the group included Director of Digital and Chief Information Officer who were able to share vision, strategy and approaches to governance that enable wider benefits from digital transformation.

  Example feedback from digital ALS.

  "Listening to other peoples experiences can make you reflect on your own journey. Having come from a clinical background with some management experience, it can be difficult to have a wider understanding of other department's roles, expectations and how they manage their journey to ensure policies and guidance is met. Organisational structure is not something I have thought about and how it affects integration for other departments. Therefore this as certainly made me consider my approach and the

realisation of the wider picture for health board's structure and the difficulties and challenges it can pose."

Multi-Agency Training Event (MATE)

At the end of July, we held the first refreshed multi-agency training event (MATE) at Tonypandy Fire station, with the Welsh Ambulance Service and South Wales Fire and Rescue Service. This enabled FYs and Junior Doctors and nurses to be involved in realistic Road Traffic Accident scenarios alongside the agencies with whom they would be working.

We are developing this scenario work further and will also be holding and event for junior doctors in conjunction with USW in the New Year.

Fig 26 MATE Event July 2022

In 22-23 further progress will be made towards establishing an Inter-professional Learning (IPL) Faculty. The early work for this faculty will be focussed on establishing undergraduate IPL opportunities including:

- Consulting with professional leads and Higher Education Institutes regarding common themes, learning outcomes, and barriers to IPL placements and possible solutions.
- Scoping out opportunities across the health board and developing structured IPL opportunities/ placement models/ simulation / student learning sessions in practice for students.

Innovative models for training capacity will continue to be explored including a project to create an education infrastructure to support the newly introduced undergraduate pharmacy clinical placements as part of a central Clinical Education Service which will also enable more interprofessional education and learning opportunities.

Partnership, Achievement, Recognition and Mastery

Direction:

Our workforce are our most significant asset. There will be clear educational frameworks to support career development pathways in CTMUHB.

Learning and development frameworks establishing levels of practice from foundation through to consultant are being taken forward nationally with profession / speciality and

multi-professional scope. Career development pathways must be supported through multi-professional development frameworks defining our educational offer for:

- Early / foundation years
- Extended/ Specialist/Advanced Practice – including Clinical fellowships; practice, education, research, leadership, clinical informatics
- Consultant.

Over 21-22 Clinical Education staff have been directly involved in National work including;

- Phase 1 of the HEIW strategic review of commissioning of Healthcare Professionals education tender process.
- Development of Multi-professional Learning and Development Frameworks, Advanced and Consultant level frameworks.
- Simulation strategy consultations
- Interprofessional Clinical Placements Principles development.

Pathways for medical staff are relatively well developed however the rest of the health care professional workforce needs further work.

Over 2021-22 work commenced to create a CTMUHB Nurse Education Strategy. This work has been delayed due to workplace pressures however will be completed in 2022-23 and will also be carried out with other professions including AHPs and Pharmacy. This will develop education strategies recognising individual professional requirements built around a common Clinical Education quality infrastructure framework.

These frameworks will also enable timely, agile service redesign and responsive workforce modernisation with more robustly informed Education Commissioning.

In 2022/23 another focus of work will be on developing clinical supervision and preceptorship in alignment with the Chief Nursing Officer priorities.

Widening access

To aid recruitment to the Health Board, both Pre and Post Registration nurse teams along with our corporate nursing colleagues have visited a number of schools across Rhondda Cynon Taf and Merthyr to speak to both Primary and Secondary school children about Nursing as a career. The team will develop this work stream further in the next academic year.

As has taken place in previous years, we ran a Medical Work Observation Scheme for pupils of Year 12+ from 4 July to 22 July 2022. The content included a mix of virtual and on-site opportunities, to use work experience as a crucial tool in helping pupils decide whether to pursue a career in Medicine or Dentistry.

One hundred school pupils were enrolled on this scheme in 2022 and the feedback was overwhelmingly positive.

Opportunity, Vision and Innovation.

Direction:
Cwm Taf Morgannwg Learning Academy.

A space where people could feel inspired to think, create and dream, build relationships and collaborate and learn together to improve practice and health.

A living manifestation of University Health Board Status, networked with multiple HEI partners, and HEIW creating a virtuous cycle of learning, innovation and improvement.

- *Innovation ideas supported e.g. Bevan fellowship/ exemplars, Environmental Impact.*
- *Challenge exchange*
- *Systems Design Thinking*
- *Collaborative work e.g. Product Designers 3D personalised healthcare innovation*

Progress and plans.

We have continued to deepen relationships with our partner universities and research and innovation colleagues.

With a focus on advances in simulation Clinical Education was successful in obtaining Levelling Up Funding from WIDI (Wales Institute for Digital Informatics) to release staff time to develop a Digital Simulation Education Strategy (Multi-professional) and a pilot education package. This work commenced in April 2022 and is on track to deliver December 2022 and is being supported by colleagues in Cardiff Metropolitan University and University of South Wales.

In partnership with University of South Wales we will be progressing the development of educational packages utilising their Hydra facility. An area of early focus will be on the Recognition of the Deteriorating Patient.

Over 2022-23 we will be involved in project work with Health and Care Research Wales to embed research into health professional careers.

Refs:

1. *A Healthier Wales: https://gov.wales/sites/default/files/publications/2019-04/in-brief-a-healthier-wales-our-plan-for-health-and-social-care.pdf. Accessed 10.10.2019*
2. *Workforce Strategy for Health and Social Care.* https://heiw.nhs.wales/files/workforce-strategy-for-health-and-social-care1/
3. *Final report of a project delivered by CTMUHB for HEIW, mentioned in the paper, is available upon request. It is for interest and gives a written example of the work Clinical Education are undertaking.*

Appendix 1: **Post graduate Medical Education Specialty Matrix – Movement since September 2021**

	August 2022	September 2021	Score rating movement
HIGH RISK	TP256 Emergency Medicine- PCH	TP256 Emergency Medicine- PCH	↔
		TP361 Psychiatry – All	↓
	TP487 Surgery – PCH		↑
	TP544 General Internal Medicine - PCH		NEW
MEDIUM RISK	TP361 Psychiatry – All		↓
	TP431 Medicine – POWH	TP431 Medicine – POWH	↔
	TP483 Paediatrics - POWH	TP483 Paediatrics - POWH	↔
	TP531 Diabetes & Endocrinology		NEW
	TP078 Ophthalmology –RGH	TP078 Ophthalmology –RGH	↔
	TP488 Anaesthetics - PCH	TP488 Anaesthetics - PCH	↔
	TP160 General Surgery – RGH	TP160 General Surgery – RGH	↔
	TP484 General Internal Medicine – POWH	TP484 General Internal Medicine – POWH	↔
	TP319 Multiple Specialties - All	TP319 Multiple Specialties - All	↔
		TP344 Obs & Gynae - POWH	REMOVED
		TP316 T & O - PCH	↓
		TP430 Medicine –RGH	REMOVED
		TP487 Surgery – PCH	↑
		TP318 T & O – RGH	↓
	TP523 Otolaryngology – RGH		NEW
	TP543 Acute Internal Medicine –PCH		NEW
	TP545 GP – PCH		NEW
	TP546 General Medicine – RGH		NEW
	TP547 Paediatrics – PCH		NEW
	TP548 Acute Medicine – PCH		NEW
	TP549 Cardiology – RGH		NEW
	TP552 General Surgery - PCH		NEW
LOW RISK		TP489 Clinical Radiology	REMOVED
		TP485 GP- Bridgend	REMOVED
		TP519 Diabetes & Endocrinology	REMOVED
		TP448 GP –MC	REMOVED
	TP316 T & O - PCH		↓
		TP459 Anaesthetics - All	REMOVED
		TP486 GP - Bridgend	REMOVED
	TP318 T & O – RGH		↓
	TP245 Obs & Gynae – RGH	TP245 Obs & Gynae – RGH	↔
	TP428 Geriatric Medicine – POWH	TP428 Geriatric Medicine – POWH	↔
		TP432 Paediatrics -RGH	REMOVED

AGENDA ITEM
3.2.9

QUALITY & SAFETY COMMITTEE

CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD (CTMUHB) NATIONAL CLINICAL AUDIT PROGRAMME UPDATE 2020-2021

Date of meeting	15/11/2022
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Mark Townsend – Head of CA&QI, Natalie Morgan - Thomas Deputy Head of CA&QI & Lead Nurse for Clinical Effectiveness & Lauren Dyton – Clinical Audit & Effectiveness Manager
Presented by	Dr Dom Hurford – Executive Medical Director
Approving Executive Sponsor	Executive Medical Director
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
		Choose an item.

ACRONYMS	
CTMUHB	Cwm Taf Morgannwg University Health Board
TARN	Trauma Audit Research Network
NHFD	National Hip Fracture Database
CA&QI	Clinical Audit & Quality Informatics Department
NACEL	National Audit for Care at the End of Life
NAIF	National Audit of Inpatient Falls

1. SITUATION/BACKGROUND

1.1 The purpose of this report is to provide an update for the Quality and Safety Committee on progress against the CTMUHB Clinical Audit Forward Plan 2022-2023 aligned to the National Clinical Audit and Outcome Review Plan for 2022/23, which is also available via the Welsh Government website: https://gov.wales/national-clinical-audit-and-outcome-review-plan-2022-2023, published June 2022.

1.2 **29** out of 35 national audits and 9 clinical outcome reviews (tier 1) are green fully compliant and **5** amber where the audits are delayed, a backlog exists but a plan is in place to comply with the national audit deadline. **1** clinical outcome review audit is red because the deadlines has passed, and we were only able to achieve limited participation (NCEPOD Epilepsy Study).

1.3 The reduction in the Clinical Audit overall budget allocation for 2022-23 by approximately £100k, which resulted in the loss of the 3 substantive posts and the requirement to manage the increase in mortality activity within the constraints of the existing clinical audit budget continues to impact on the organisations compliance with the national audit programme resulting in significant backlogs developing in a number of clinical audits e.g. TARN, NHFD, Heart Failure.

1.4 A further reduction of organisation priority (tier 2) audits is in under review.

1.5 The AMaT ward and area module providing ward and community team regular monthly audit assurance is progressing. After completion of the rollout to all 25b nurse staffing act wards the focus is currently on the roll out to emergency departments Health Board wide.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 **Clinical Audit Forward Plan 2022-2023 Current Position**

The NACEL end of life audit was completed successfully in September 2022, as planned. Therefore, compliance has been revised from amber to green. The Lead Nurse for Clinical Effectiveness within the Clinical Audit department completed all acute casenote reviews and medical staff from YCR undertook the community hospital reviews, due to the clinical pressures on the palliative care team, who were unable to participate.

A clinical lead remains outstanding for the COPD National audit for PCH.

The NEIAA (Arthritis) audit is amber, but good progress is being made to achieve compliance. The current focus for the audit team in quarter 3 and

4, 2022-2023 is to recover the NAIF, TARN, NHFD and Heart Failure non-compliance positions. The following actions are being taken:

- National audit target compliance reduced from 100% to 80% (minimum accepted compliance for national audits that require clinical audit staff input. This will release experienced clinical audit staff time for additional TARN sessions.
- Continue with set TARN only audit days across all 3 sites and priorities TARN cases when there is a gap in other audit compliance sessions.
- Identified a Senior Clinical Audit facilitator with a clear focus on TARN quarterly targets.
- Prioritising current TARN quarter over previous quarters where the deadline has already been missed.
- Reallocation of resources to cover NHFD
- Reviewing more timely case identification sources other than clinical coding, which has historically been a cause of national audit delays particular in relation to identification of heart failure cases.
- Overtime being offered to staff, funding permitting.
- Looking to secure additional band 3 cover to undertake basic admin tasks to release experienced band 5 clinical audit facilitator time for national audit key tasks.

Noting the above exceptions the clinical audit team are working to ensure completion of the full CTMUHB Clinical Audit Forward Plan 2022-2023, by the end of March 2023.

2.2 **Key clinical audit publications, findings and actions**

FFFAP - Falls & Fragility Fracture Audit - National Hip Fracture Database (NHFD) Annual Report (2021 data): Improving understanding Based on data from England and Wales, the report encompasses both 2020 and 2021 data and presents how current care 'since COVID-19' compares with the baseline of 2019 'before COVID-19'.

The report found that services have generally succeeded in getting patients out of bed by the day after surgery (81% in both 2019 and 2021) and then returning them to their original residence (71% in 2019 and 70% in 2021).

The provision of orthogeriatric assessment and screening for/prevention of postoperative delirium both temporarily deteriorated, in parallel with successive waves of the pandemic, but have since returned to baseline.

A more progressive and persistent deterioration in the promptness with which patients receive surgery, and the extent to which the operation is consistent with the recommendations of NICE was highlighted (down from 74% in 2019 to 71% in 2021).

CTM update – Findings from the report are being reviewed by the multidisciplinary team to draw up a local action plan for improvement.

Trauma and Audit Research Network (TARN)
The 4th Biennial National Severe Injury In Children Report - 2019-2020 (England & Wales)

During January 2019 to December 2020 there were 1637 severely injured (ISS > 15) children treated in England & Wales. Pedestrian injury resulting in traumatic brain injury is still the commonest cause of severe injury and mortality after the age of 1 year, Suspected Physical Abuse (SPA) being the predominant cause in the first year of life. Other types of road traffic incident and falls are also common. Despite being uncommon injury mechanisms, the highest case fatality rates were for asphyxia and drowning. This is shown in the new data on the injury mechanisms and in the breakdown of patients injured in road traffic incidents.

The number of severely injured children follows a well-known seasonal pattern (peaking during the summer) and weekly pattern (more cases occurring at weekends) and daily pattern (a small morning and larger late afternoon / evening peak). The pattern of arrival of severely injured children has not changed and still implies that staffing for paediatric trauma needs to be focussed 'out of hours' to match high rates of arrival in the evening and at weekends. There continued to be few patients arriving after midnight.

CTM update – Findings from the report are being reviewed by the multidisciplinary team to draw conclusions from the report and develop a local action plan for improvement.

2.3 Key issues affecting clinical audit data inconsistencies as detailed in the *Resource Evaluation to Improve Data Quality across CTMUHB for National Clinical Audits SBAR*, approved in the December 2019, Management Board.

Development of clinical dashboard for real-time monitoring and validation of inconsistencies in patient data between systems before the data leaves the organisation.

The proposal was to increase the organisations available Qlik Sense development resources to support the development of a number of specialist Qlik Sense dashboards for the monitoring and reporting of compliance against national clinical audits that are dependent on information from operation clinical and administrative information systems.

National Maternity & Perinatal Audit (NMPA) Dashboard
A clinical dashboard is currently under development and first iteration released for review in quarter 3, 2022-23 to support improved data quality

for the NMPA national audit. The dashboard includes key metric from the NMPA to identify any inaccuracies of data being recorded between the casenotes (via clinical coding data) and Maternity Information System (MITS). This will enable identification of inconsistencies in the data that can then be rectified for improved clinical outcomes and reduce the risk of the organisation being identified as an outlier due to a data quality issue.

Quality Metrics Dashboard
A quality dashboard to reflect the organisation metrics presented in the quarterly quality dashboard report to Quality and Safety Committee. This development has been delayed awaiting the establishment of the link between the new Datix system and the Health Board data warehouse. No date available when this interface will be re-established, so development on hold.

Rapid Response & Cardiac Arrest Dashboard (new development request)
A review underway to consider the development of a new dashboard based on a regular ward audit undertaken across the organisation that look at the timely and appropriate response to cardiac arrests.

2.4 **Clinical Audit Training**

In July 2022, a programme of bespoke clinical audit and effectiveness training for year 2 Student Nurses commenced. Student nurses spent two weeks gaining an insight into the portfolio of the Clinical Audit & Quality Informatics Department. Initial feedback has been positive.

Bespoke clinical audit training was delivered to Primary Care-based Nurse practitioners in August 2022, the afternoon covered the key principles of clinical audit and was well received by the attendees.

Examples of feedback from the session: *"It has changed my view on clinical audits, in a positive way, giving me a better understanding of clinical audits and the importance of them"*, *"Content and delivery of the course was excellent. It met all the intended aims, objections and expectations. The clinical audit process is much clearer following the session and I know feel I understand the process more with a clear framework to follow"*.

2.5 **Clinical Audit & NICE Monitoring System (AMaT) Implementation**

With the implementation of AMaT the organisation is now able to monitor the CTMUHB Clinical Audit Forward Plan in real-time and compliance with NICE guidelines, standards and focus at present is on the ward and area audit module rollout.

The AMaT ward and area module rollout is progressing well with a health board wide focus on Emergency department services by Christmas 2022.

Mental Health and Therapy departments currently under review for inclusion in the rollout plan for quarter 4 2022.

2.6 **NICE Compliance Programme of work**

The CTMUHB NICE Reference Group (NRG) established in September 2021 has been suspended due to funding issues and senior management restructuring removing the dedicated clinical lead post to support this function within the Clinical Audit and Quality Informatics department.

The assurance oversight, scrutiny and a governance function in relation to NICE guidance within CTMUHB will now remain with directorates and individual clinical leads.

A review of the Clinical Audit policy and Strategy is being undertaken to reflect this.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 Reduction in the Clinical Audit budget allocation by approximately £100k for 2022-23, associated restructuring and increase in mortality review activity will mean a need to focus limited clinical audit resources on tier 1 priority national audits and a further reduced programme of tier 2 organisation priority audits for 2022-23. It will also require directorates and lead clinicians to take responsibility for all NICE compliance monitoring activities.

3.2 A lack of early detection of 'outlier status' or assurance around the monitoring of NICE clinical guidance and standards and risk of failure to comply with national audit programme tier 1 targets.

3.3 The detrimental impact of poor data quality submission to national audits has a cost to organisational reputation, loss of confidence of the service users and time spent on retrospective data validation and resubmission.

3.4 A lack of reliable benchmark data can result in a failure to identify key areas for improvement as in the report on Health Boards Maternity services.

3.5 The quality of the clinical casenote and scanned version currently available as part of the digitization project is increasing the time to review national clinical audit documents and impacting on the audit teams ability to achieve national targets or provide assurance around the submitted data.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
Related Health and Care standard(s)	Effective Care
	If more than one Healthcare Standard applies please list below:
Equality impact assessment completed	Choose an item.
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goal	Improving Care

5. RECOMMENDATION

5.1 That the committee **NOTE** receipt of the compliance position and mitigating action being taken to achieve compliance for the CTMUHB

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Llywodraeth Cymru Welsh Government

NICOR

HQIP

NAD NATIONAL AUDIT OF DEMENTIA

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

Royal College of Physicians | NACAP

Evidence
Guidance
Quality standards
Improved outcomes

NJR Quality Data Provider for commitment to patient safety through the National Joint Registry 2018/19 CERTIFICATION FOR DATA SUBMISSION & QUALITY

TARN THE TRAUMA AUDIT & RESEARCH NETWORK

NICE National Institute for Health and Care Excellence

AMaT Audit Management and Tracking

Clinical Audit and Effectiveness

ANNUAL REPORT 2021-22

Clinical Audit & Quality Informatics Department

Information for Improvement

Content

Deputy AMD for Clinical Audit & Effectiveness

The National Clinical Audit and Review Outcome Plan confirms the National Clinical Audits and Outcomes that health boards are expected to participate in. This annual rolling program shows how findings from audits and reviews will be used to evaluate and improve healthcare quality and safety in Wales.

Clinical Audit is an integral part of the process for measuring the quality of services against set standards for comparison and identification of improvement opportunities.

Considering the challenges the Health Service is now facing across Wales being able to identify improvements and optimise efficiency has never been more important. When working in partnership with multiple disciplines, managers and policy makers the NCAROP enables objective assessment of the quality of healthcare to guide decision making.

The Clinical Audit and Quality Informatics Department champions education and engagement with the process at every level within the Health Board. There are clear lines of communication to ensure escalation to the Executive board and Medical Director as well as dissemination to all relevant departments.

The Mortality Review process, which continues to expand in scope and demand, is also being run by the Audit Department to great effect.

I wish to commend and recognise the hard work and dedication of our Clinical Audit and Quality Informatics Department who have produced all of this against a challenging backdrop of squeezed budgets, decreased staffing and increased demand. I also wish to thank the Clinical Audit Leads, the Medical Director and all those who have participated in the Audit process for their engagement and enthusiasm.

The Department

The Clinical Audit and Quality Informatics (CA&QI) Department is responsible for facilitating all clinical audit projects, incorporating both national, organisation and local priorities, throughout CTMUHB. It is an integral part of the Medical Directors Office which is accountable to the Executive Medical Director and Executive Board.

The department provides expertise and support to clinical specialties to monitor and improve patient care through:

- Clinical audit training, awareness and support to all clinicians
- Support and facilitation to clinicians and other relevant staff conducting and / or managing clinical audits
- A formal review of the Clinical Audit & Effectiveness Programme to ensure that it meets the organisations aims and objectives as part of the wider quality improvement agenda.

Findings from national audits are presented quarterly to the Clinical Audit, NICE and Effectiveness Group (CANE) prior to inclusion in update reports to the Quality & Safety Committee. The Quality and Safety Committee is responsible for receiving assurances for all national audits.

A report is also provide annually for the organisation Audit Committee on clinical audit activity.

Clinical directorates hold bi-monthly Clinical Audit / Quality Assurance and Governance meetings at which they cover standing quality agenda items which include clinical audit. The meetings are also used to plan how the directorates will implement the recommendations made as a result of national clinical audits.

The CA&QI department also manages the organisation's Mortality Review process, VTE/HAT monitoring, NICE Compliance, Ward Audits (including compliance with the Nurse Staffing Act) and provision of an informatics service from ward to board.

Workforce
Staff Development

Staff retention and development remains a key goal and through succession planning four staff have secured promotion and one has been supported in extending their secondment to the Medical Directors Office.

17 staff attended formal clinical audit training, with five successfully attaining accreditation.

3 staff have completed CMI Level 7 course.

A number of individuals with the team have also achieved:

- BSc in Computer Studies (1st)
- ILM Level 5 (NVQ) in Leadership and Management
- Won the prestigious Woodford TARN Audit Coordinator of the year Award

Training Programme

Total clinicians Trained 2021-22

Clinical Audit **115**

Ward & Area Audit **245**

In addition to the standard package of training the following tailored group sessions were provided:

June 2021
Clinical audit session for Pharmacy Technicians

September 2021
Clinical audit & AMaT training session for F1 / F2 Doctors

December 2021
Clinical audit & AMaT session for Pre-registration Pharmacists

November 2021 to March 2022
AMaT ward audit training for nursing staff

Workshop-based group training spread over 4 sessions has been provided that covered clinical audit techniques from inception to presentation. The core topics are; (1) Clinical audit overview; (2) Identifying your audit criteria; (3) Preparing an audit proforma and data collection; (4) Analysing audit results; (5) Preparing for presentation and sharing the findings (report writing and action planning).

Training sessions have been adapted for delivery using MS Teams in a condensed format and tailored to the needs of clinical teams. In addition to formalised training sessions, all clinical audit staff are able to provide clinical audit advice, support and training on an ad-hoc basis.

In addition, training sessions have been provided for clinicians on the use of the Audit Management and Tracking (AMaT) system. Demonstrations are a regular feature of clinical audit meetings, to ensure that clinical staff are able to register audits and upload audit information on the new system.

Sharing the learning from Clinical Audit

Since October 2021, a clinical audit newsletter is published on a quarterly basis to publicise key national audit findings, information on clinical audit services and to provide evidence of any associated improvement work.

Clinical Audit Newsletter

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Quarter 3
Oct - Dec 2021

Welcome to our new Senior Clinical Audit Facilitators

We are excited to announce our new appointments, as November 2021 saw our new Senior Facilitators take their posts. Debra Townley (Bridgend) and Sean Thomasson (Merthyr & Cynon) join Fiona Weston (Rhondda & Taff Ely) to make up our team of senior clinical audit facilitators.

Congratulations to Debra & Sean!

CANE Group established

Clinical Audit, NICE & Effectiveness (CANE) Group

The CANE Group was officially launched on 14th December at the inaugural meeting chaired by Mr Dai Morgan, Assistant Medical Director. Audit Leads from across the Health Board were invited to attend to set the direction for Clinical Audit for the months to come.

At the meeting the role and responsibilities of the CANE Group were set out, which include:-

- Review reports to Audit & Risk Committee and Quality & Safety Committee
- Support development of annual Clinical Audit Programme
- Identify Health Board priority clinical audit topics to register on the Clinical Aud Programme
- Monitor national clinical audit recommendations and action plans
- Receive summaries of national clinical audit reports and completed baselin assessments to agree recommendations and actions
- Receive completed local clinical audit reports and recommendations
- Review progress of Health Board and ILG Clinical Audit Programmes and escalate concerns to Audit and Risk and Quality and Safety Committee
- Receive NICE & Royal College Guidance compliance reports from the NICE Reference Group

ILG Clinical Audit & Effectiveness Leads were also introduced and the structure of the Clinical Audit Department was discussed. An update was provided on the features of AMaT (Audit Management and Tracking) software. Developments with NCEPOD studies, key national audit activity and the latest national audit publications were also outlined.

Updates from the Team

Accredited Clinical Audit Training

On 1st November 2022 virtual clinical audit training was delivered by Tracy Ruthven and Stephen Ashmore from the Clinical Audit Support Centre for our Team. The training covered all the essential elements of undertaking a clinical audit. For more information on the work of the Clinical Audit Support Centre visit the website: www.clinicalauditsupport.com

TARN Co-ordinator Success Story

We are pleased to announce that Nichola Jenkins, TARN Co-ordinator based in the POWH Clinical Audit Team has recently been appointed as chair of the South Wales Trauma Network TARN Co-ordinators' Forum. Encouraging conversations on this key national audit both within the network and across Wales.

Support for the Community Vaccination Centres

Clinical Audit

Over the Christmas period staff from the Clinical Audit Department ably supported the COVID-19 Booster campaign at our Community Vaccination Centres across the localities. Our staff were involved in welcoming members of the public to the centres, manning the reception desks and our clinical staff administered vaccinations.

New National Clinical Audit Reports

Quarter 3 was a busy period for national clinical audit reporting, with a high number of publications released covering broad subject area. Local action planning based on these reports will take place with audit facilitators and clinical teams during Quarter 4.

National audit reports released in October were predominantly in the field of maternity & child health and cardiac care:-

- National Pregnancy in Diabetes (NPID) Audit
- MBRRACE-UK Perinatal Mortality Surveillance Report 2019
- National Maternity and Perinatal Audit Clinical Report 2021
- National Perinatal Mortality Review Tool 3rd Annual Report
- National Heart Failure Audit (2021)
- National Audit of Cardiac Rhythm Management
- Myocardial Ischaemia National Audit Project (2021)

November publications:

- National Emergency Laparotomy Audit (NELA) – 7th Annual Report
- National Audit of Inpatient Falls Annual report 2021 - The Falls and Fragility Fracture Audit Programme (FFFAP)
- Ethnic and socio-economic inequalities in NHS maternity and perinatal care for women and their babies - National Maternity and Perinatal Audit (NMPA)

December publications:

- National Oesophago-Gastric Audit Annual Report 2021
- Sentinel Stroke National Audit Programme Annual Report 2020/21

Looking ahead

Development of Clinical Audit Forward Plans (2022/23) will take place from January with our audit leads and facilitators.

Standardised Clinical Audit meeting agenda template is planned for release in February 2022 to allow greater consistency.

Relocation of the Clinical Audit offices at PCH to take place in January.

For further information on Clinical Audit contact Natalie Morgan-Thomas, Deputy Head & Lead Nurse for Clinical Effectiveness:
Natalie.Morgan-thomas@wales.nhs.uk

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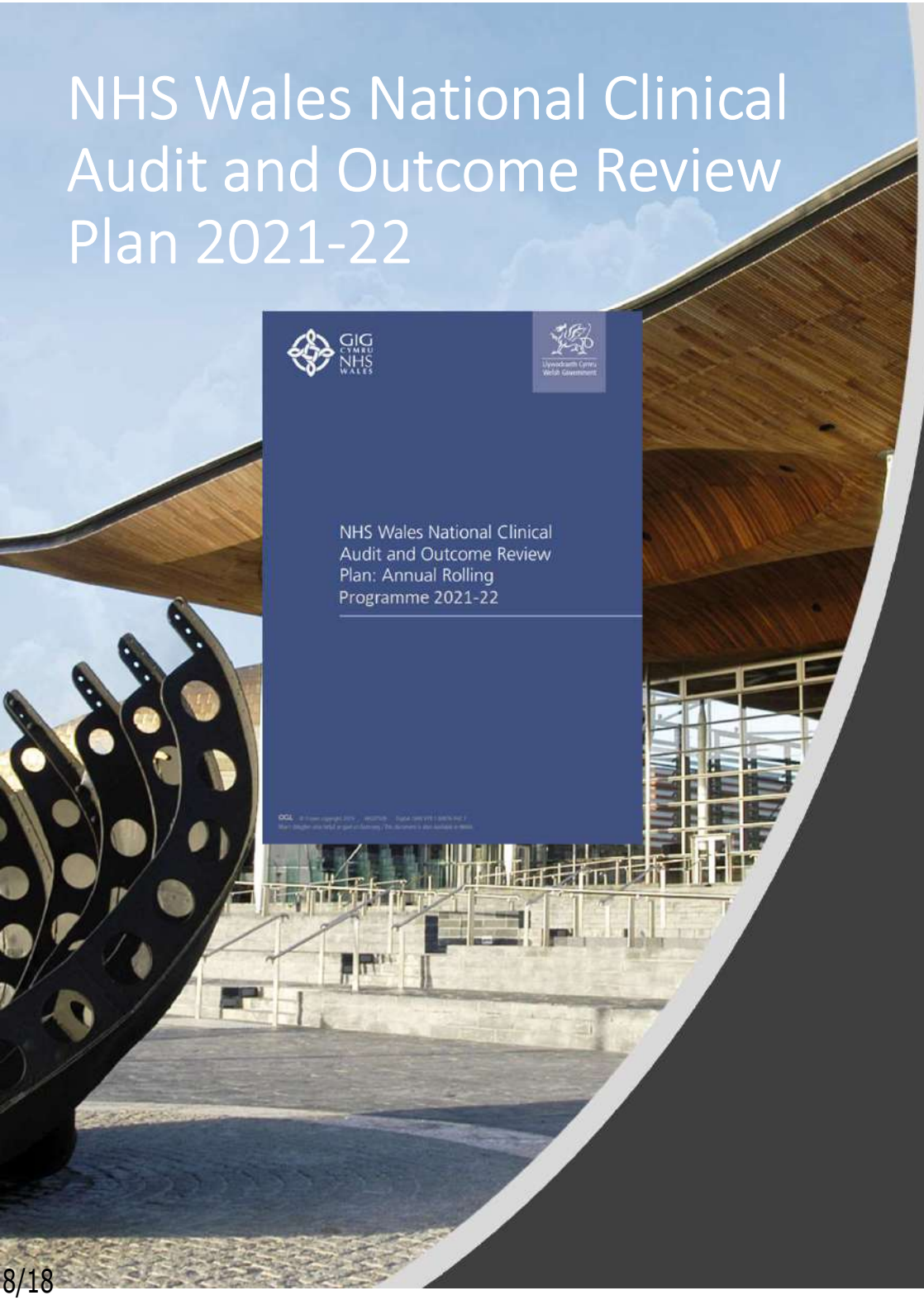
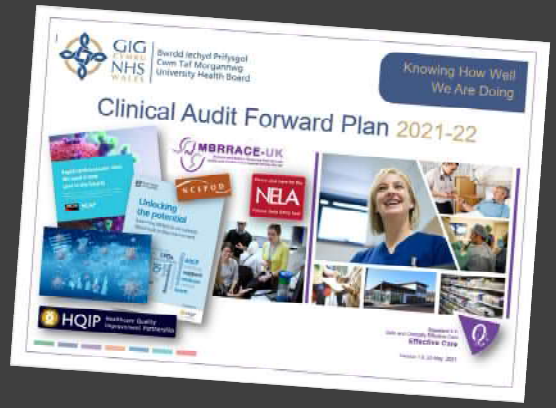
NHS Wales National Clinical Audit and Outcome Review Plan 2021-22





All organisations in Wales are required as part of their Quality Strategy to have an annual Clinical Audit Forward Plan in place to fully participate in all relevant national clinical audits and outcome reviews listed in the annual National Clinical Audit & Outcome Review Annual Plan.

The Cwm Taf Morgannwg University Health Board (CTMUHB) Clinical Audit Forward Plan identifies all of the clinical audit projects from the National Clinical Audit and Outcome Review Plan for 2021-22 that must be undertaken by CTMUHB.

Clinical audit is a fundamental component of the organisations quality assurance process, based on transparency and candour. Quality assurance provides a systematic approach to maintaining consistently high quality by constantly measuring and reporting on effectiveness, highlighting the need for improvement and enabling the sharing of good practice.

The CTMUHB Clinical Audit Forward Plan sets out a programme of prioritised continuous improvement activities, including clinical audit, and is designed to help to embed the above principles into the everyday working practice of individuals and clinical teams to improve clinical outcomes for patients, through focused and structured work. The plan for 2021-2022, was determined at both corporate, locality and directorate level based around priority categories established by the Healthcare Quality Improvement Programme (HQIP) and defined as:

1. External "must do" - Externally monitored audits that are driven by commissioning and quality improvement are treated as the priority and appropriate resources are provided to support these. Failure to participate or deliver on these externally driven audits may carry a penalty for the Health Board
2. Internal "must do" - Based on the classic criteria of high risk or high profile identified by health board management. They may include national initiatives with health board-wide relevance but no penalties exist for non-participation. Many of these projects will emanate from Health Board governance issues or high profile local initiatives.

The 10th annual National Clinical Audit and Outcomes Review Plan was delayed due to purdah and the transfer of responsibilities for the NHS Wales National Clinical Audit & Outcome Review Plan (NCA&ORP) from Welsh Government to Digital Health and Care Wales.

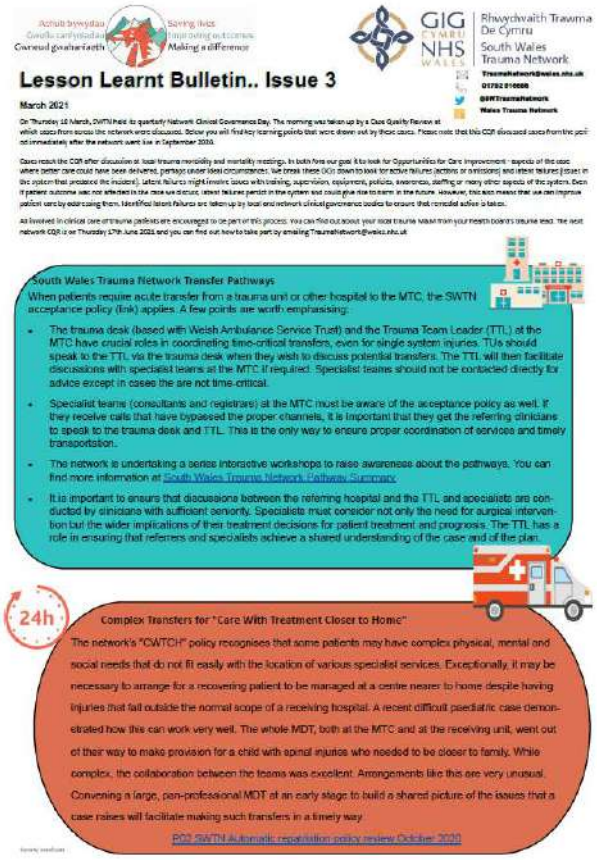
A key component of the work undertaken in 2021-22 was to align audit activity to the Integrated Locality Group structure. Clearly identified responsibilities and timeframes for completion of audit work and continuous monitoring of progress against the plan has ensured the improved compliance position for CTMUHB. The weekly national audit monitoring of compliance that was introduced in April 2019 and the implementation of the Clinical Audit & NICE Compliance Management system from April 2020 has ensured that the organisations compliance with all national audits has improved at a time of extreme pressure due to the pandemic.

Pages 10 to 14 of this report provide some examples of the national audits undertaken by the organisation as part of the CTMUHB Clinical Audit Forward Plan. A full list of national audits that the organisation participates in can be found in the published CTMUHB Clinical Audit Forward Plan 2021-22.

TARN

THE TRAUMA AUDIT & RESEARCH NETWORK

Improving patient outcomes



Lesson Learnt Bulletin.. Issue 3

March 2021

On Thursday 18 March, SWTN held its quarterly Network Clinical Governance Day. The morning was taken up by a Case Quality Review at which cases from across the network were discussed. Below you will find key learning points that were drawn out by those cases. Please note that this CQR discussed cases from the period immediately after the network went live in September 2020.

Cases reach the CQR after discussion at local trauma morbidity and mortality meetings. In both fora our goal is to look for Opportunities for Care Improvement - aspects of the case where better care could have been delivered, perhaps under ideal circumstances. We break these OCIs down to look for active failures (actions or omissions) and latent failures (issues in the system that predated the incident). Latent failures might involve issues with training, supervision, equipment, policies, processes, staffing or many other aspects of the system. Even if patient outcome was not affected in the case we discuss, latent failures persist in the system and could give rise to harm in the future. However, this also means that we can improve patient care by addressing them. Identified latent failures are taken up by local and network clinical governance bodies to ensure that remedial action is taken.

All involved in clinical care of trauma patients are encouraged to be part of this process. You can find out about your local trauma team from your health board's trauma lead. The next network CQR is on Thursday 17th June 2021 and you can find out how to take part by emailing Traumanetwork@wales.nhs.uk

South Wales Trauma Network Transfer Pathways

When patients require acute transfer from a trauma unit or other hospital to the MTC, the SWTN acceptance policy (link) applies. A few points are worth emphasising:

- The trauma desk (based with Welsh Ambulance Service Trust) and the Trauma Team Leader (TTL) at the MTC have crucial roles in coordinating time-critical transfers, even for single system injuries. TUs should speak to the TTL via the trauma desk when they wish to discuss potential transfers. The TTL will then facilitate discussions with specialist teams at the MTC if required. Specialist teams should not be contacted directly for advice except in cases the are not time-critical.
- Specialist teams (consultants and registrars) at the MTC must be aware of the acceptance policy as well. If they receive calls that have bypassed the proper channels, it is important that they get the referring clinicians to speak to the trauma desk and TTL. This is the only way to ensure proper coordination of services and timely transportation.
- The network is undertaking a series interactive workshops to raise awareness about the pathways. You can find more information at South Wales Trauma Network Pathway Summary
- It is important to ensure that discussions between the referring hospital and the TTL and specialists are conducted by clinicians with sufficient seniority. Specialists must consider not only the need for surgical intervention but the wider implications of their treatment decisions for patient treatment and prognosis. The TTL has a role in ensuring that referrers and specialists achieve a shared understanding of the case and of the plan.

24h

Complex Transfers for "Care With Treatment Closer to Home"

The network's "CWTCH" policy recognises that some patients may have complex physical, mental and social needs that do not fit easily with the location of various specialist services. Exceptionally, it may be necessary to arrange for a recovering patient to be managed at a centre nearer to home despite having injuries that fall outside the normal scope of a receiving hospital. A recent difficult paediatric case demonstrated how this can work very well. The whole MDT, both at the MTC and at the receiving unit, went out of their way to make provision for a child with spinal injuries who needed to be closer to family. While complex, the collaboration between the teams was excellent. Arrangements like this are very unusual. Convening a large, pan-professional MDT at an early stage to build a shared picture of the issues that a case raises will facilitate making such transfers in a timely way.

P02 SWTN Automatic repatriation policy review October 2020

Every year across England and Wales, 12,500 people die as a result of a serious injury. It is the leading cause of death among children and young adults of 44 years and under. There is also significant amount of evidence available to show that patients who suffer a major trauma have a greater chance of survival and recovery if they are treated within a Major Trauma Network (MTN).

In March 2018, CTMUHB as part of the South Wales region was approved for the establishment of **Major Trauma Centres (MTC)** at the Princess of Wales and Prince Charles hospitals, with the aim of enhancing clinical care and patient experience through introduction of specialist teams and a major trauma pathway.

TARN is the national clinical audit for traumatic injury and forms part of the **National Clinical Audit and Outcome Review Plan** for Wales. CTMUHB participates in the TARN audit that informs the major trauma programme of work.

The team are responsible for ensuring that all TARN cases are identified and input onto TARN within 28 days of discharge from hospital.

Compliance with TARN quarterly reporting deadlines has not been achieved in 2021-22 compared to full compliance in 2020-21 due to the additional unplanned Major Trauma activity at the RGH.

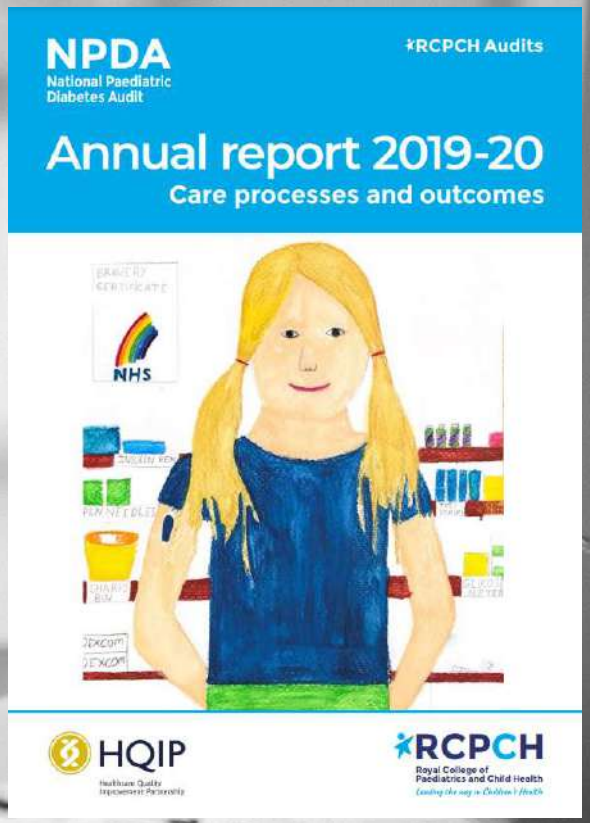
A business case to secure an additional band 4 TARN Coordinator, has been submitted as part of the proposal to recognise RGH as a MTC.

National Paediatric Diabetes Audit (NPDA) Annual report 2019-20 (Published in June 2021)

The audit covers the health checks and outcomes for children and young people with diabetes who have attended PDUs (paediatric diabetes units) from 1 April 2019 to 31 March 2020.

Findings

There were a number of positive findings that included establishment of CTMUHB Diabetes Team to restructure service and standardise care across all three sites; participation in Diabetes QI project by the Royal College of Paediatrics and Child Health (RCPCH), which has emphasised a focused on the management of newly diagnosed patients and high completion rates noted for certain care processes e.g. blood pressure, urine, retinopathy and feet checks.



Actions:

- High number of patients with levels of HbA1c >69 and this number has been increasing. (New policy in development to address this matter)
- Inability to offer 4 Consultant led clinics a year for each patient and perform 4 HbA1c measurements a year. (Lead clinician from each ILG identified who is responsible for ensuring this is completed).
- High DNA rates (A new DNA policy has been developed and implemented).
- Lack of Psychology service provision for the patient group. (Funding approved for 1WTE post to provide a psychology service for paediatrics)

The National Audit of Care at the End of Life (NACEL)

NACEL is a national comparative audit of the quality and outcomes of care experienced by the dying person and those important to them during the last admission leading to death in acute hospitals, community hospitals and mental health inpatient providers in England, Wales and Northern Ireland.

Round 3 of NACEL took place between April and October 2021, where members of the Palliative Care Team undertook detailed case note reviews, looking closely at the quality of care provided by clinical teams across Cwm Taf Morgannwg UHB (Acute, Community and Mental Health services) during April and May 2021.

National Audit of Care at the End of Life

Learning points

There were a number of key learning points identified that included:

Acute setting

Need for clear treatment plans, requirement for face-to-face Palliative Care team involvement in patient care and DNACPR documentation to include details of discussion with the patient and family members. The importance of Advanced Care Plans (ACP) developed in care homes with individuals and their family.

Community Setting

Difficult to find pertinent records, late recognition of dying phase and limited detail documented regarding discussions with family members.

Mental Health Setting

Care Decisions for Last Days of Life guidance to be used to enable individualised care.

Findings

The bespoke dashboards for NACEL Round 3 containing findings on key themes and the organisation's position against the national average are awaiting publication and the full report was released to the public in July 2022. Following the publication of the dashboards and audit report local improvement activity can begin.

Please click here for the NELA Patient Data Entry tool

The National Emergency Laparotomy Audit (NELA) was started in 2013 because studies showed this is one of the most risky types of emergency operation, lives could be saved, and quality of life for survivors enhanced by measuring and improving the care delivered.

NELA aims to enable the improvement of the quality of care for patients undergoing emergency laparotomy, through the provision of high quality comparative data from all providers of emergency laparotomy.

The Year 7 report published in November 2021 and highlighted the following key findings for CTMUHB:

Positive findings

- Post-operative critical care was maintained at levels comparable with the national average during this period, which included the peak of the COVID-19 pandemic.
- Risk adjust mortality rates were below the national average for Prince Charles Hospital and Princess of Wales Hospital, and comparable to the national average for Royal Glamorgan Hospital.

Concerns

- Timely administration of antibiotics.
- Lack of perioperative assessment by a consultant geriatrician for patients aged 80 and over or fail patients aged 65 years and over.

Recommendations

- The need for geriatric support in the management of frail and elderly surgical patients was a consistent message from across the acute hospital sites.
- A specialist emergency surgery nurse specialist to manage patients through the perioperative period was deemed necessary (Prince Charles Hospital).
- A lead clinician within the Emergency Department to support the initial management of emergency laparotomy patients was put forward to enhance care at the Princess of Wales Hospital.
- Electronic booking system for emergency surgery theatre lists also proposed for the Princess of Wales Hospital.

National Joint Registry
www.njrcentre.org.uk
Working for patients, driving forward quality

NJR is described as a global exemplar of an implantable medical device registry, which covers England, Wales, Northern Ireland, the Isle of Man and Guernsey continues to be the largest orthopaedic registry in the world, with an international reputation and holds over 3 million procedure records in order to provide timely warnings of issues relating to patient safety.

The registry's purpose is to record patient information and provide data on: the performance and longevity of replacement joint implants: the surgical outcomes for the hospitals where these operations are carried out; and on the performance outcomes of the surgeons who conduct the procedures.

Data Quality Award

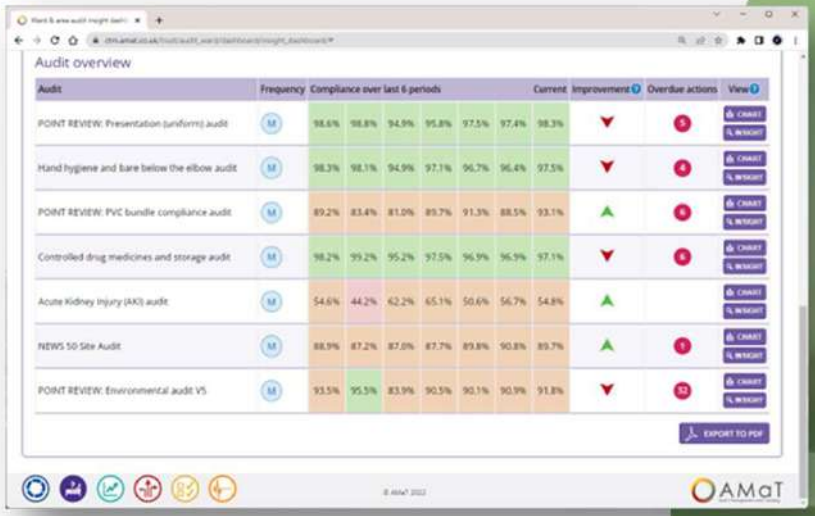
Dr. Dom Hurford, Medical Director praised members of the Clinical Audit Team for their diligence and dedication to data quality, when the National Joint Registry awarded Cwm Taf Morgannwg UHB the Quality Data Provider status award for 2021/22 in August.

"I know that achieving compliance in order to win this award is no mean feat and is testament to the departmental effort of you all."

The award offers public recognition for achieving excellence in supporting the promotion of patient safety standards through their compliance with the mandatory National Joint Registry (NJR) data submission.

Ward & Community Team real-time clinical audits

AMaT Insight Clinical Dashboard



In April 2020 the ward and area audit module of the AMaT system was first deployed into the Maternity Unit at CTMUHB.

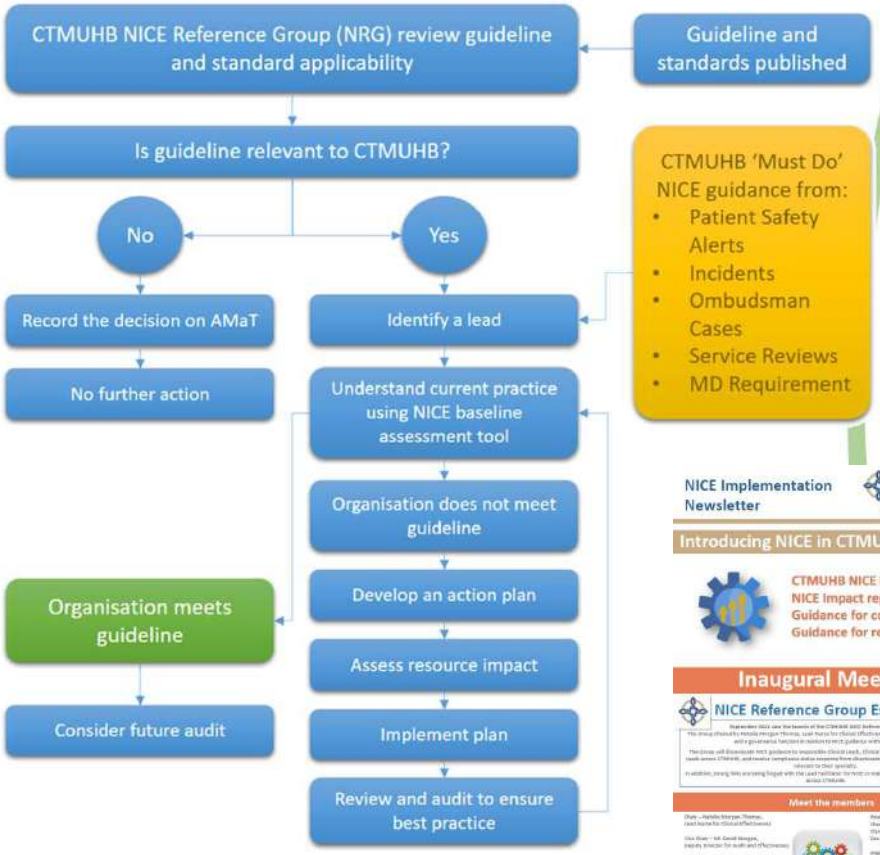
Following the success of the implementation within maternity a decision was made in April 2021 to extend the system rollout Health Board wide with a primary focus on 25b Nurse Staffing Act wards.

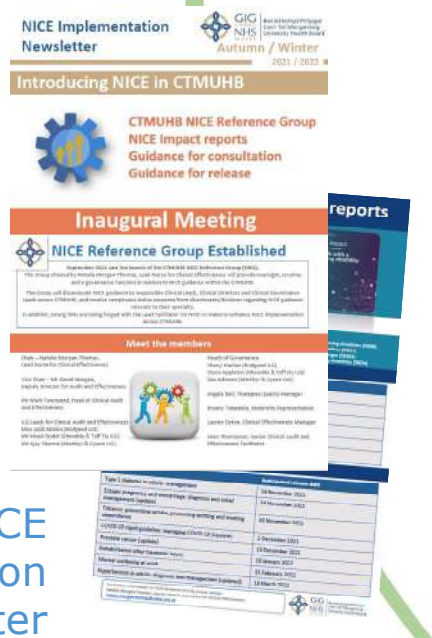
The rollout was completed as planned during 2021-22 and has provided significant assurance to the nursing unit around a number of key care metrics.

Some of the key metrics feed into the Health Board bi-monthly Quality Dashboard Report to the Quality and Safety Committee.

NICE
National Institute for Health and Care Excellence

NICE Implementation Process Model





NICE Implementation Newsletter

In 2021 the organisation set out to develop and deliver an exemplar model to manage all NICE guidance and quality standards.

The following has been achieved in 2021-22:

- Appointed a Lead Nurse for Clinical Effectiveness (who has since qualified as a NICE Scholar)
- Established a NICE Reference Group to review and manage and monitor NICE compliance across the organisation
- Secure a system AMaT to enable the online recording of compliance against NICE guidelines and standards
- Appointed a NICE clinical lead in each of the 3 Integrated locality Groups
- Developed a NICE Newsletter to share best practice
- Working collaboratively across Wales with the NICE Implementation Facilitator for Wales through regular meetings and by helping to lead sub groups of the Welsh NICE Health Network
- Developed a pathway for the implementation of NICE guidelines and standards

Learning from Mortality Reviews

The introduction of Medical Examiners across NHS Wales has provided an opportunity to look at how mortality reviews can be conducted to identify themes and trends, maximise learning, prevent future harm and improve the experience of patients, families and NHS staff.

The Mortality Review Framework for Wales aims to provide a co-ordinated and systematic all Wales approach to the mortality review process to enable local and national implementation of learning, targeted clinical audit and quality improvement work.

Every stage of the mortality review process provides an opportunity for learning and recognizing notable practice. The learning captured is shared via a quarterly newsletter. Immediate make safe cases are instantly communicated to the directors of the ILG's and Directors of nursing if required. Going forward the mortality review module within DATIX will assist us with capturing this information in a more systematic way and each learning point will have an action plan assigned to it.

In 2021-22 CTMUHB has led on:

The redevelopment of the Once for Wales (DATIX) Mortality Review Model and implementation of the module.

Quarterly Learning from MR Newsletters that identify key themes and trends, MR process performance and identified learning

Monthly Mortality Review (MR) training is undertaken by the Lead Nurse for Clinical Effectiveness and Medical Examiner. The aim to update clinicians on the new MR process nationally and locally within CTMUHB. In addition the training aims to provide clinicians with the knowledge on how to undertake a Hospital mortality review.

MR Learning Events planned for 2022-23

Clinical Audit and Effectiveness Annual Report 2021-22

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Clinical Audit &
Quality Informatics Department
part of the Medical Directors Office

AGENDA ITEM
3.2.10

QUALITY & SAFETY COMMITTEE

CTMUHB NOSOCOMIAL COVID-19 INCIDENT MANGEMENT PROGRAMME

Date of meeting	15/11/2022
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Carole Tookey, Nurse Director for Planned Care
Presented by	Carole Tookey, Nurse Director for Planned Care
Approving Executive Sponsor	Executive Director of Nursing
Report purpose	FOR APPROVAL

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Nosocomial COVID-19 Incident Management Programme Group	27/10/2022	Choose an item.

ACRONYMS	
CHC	Community Health Council
COVID-19	COVID-19 is an illness caused by a strain of coronavirus called SARS-CoV-2. This virus is responsible for the global pandemic since 2020.
CTMUHB	Cwm Taf Morgannwg University Health Board
DHCW	Digital Health and Care Wales
DU	NHS Wales Delivery Unit

IMSOP	Independent Maternity Services Oversight Panel
IPC	Infection, Prevention and Control
NNCP	National Nosocomial COVID-19 Programme
PTR	Putting Things Right
SRO	Senior Responsible Officer

1. SITUATION/BACKGROUND

1.0 The purpose of this report is to provide the Quality and Safety Committee of Cwm Taf Morgannwg University Health Board with assurance regarding the progress and delivery of the CTMUHB Nosocomial COVID-19 Incident Management Programme. This is linked to the National Nosocomial COVID-19 Programme (NNCP).

1.1 On 25 January 2021, the Quality & Safety Team at the NHS Wales DU were commissioned by Welsh Government to develop a national Framework to support a consistent national approach towards investigations following patient safety incidents of nosocomial COVID-19. In March 2021, the National Framework for the 'Management of patient safety incidents following nosocomial transmission of COVID-19' was published and updated in October 2021.

1.2 In January 2022, the Minister for Health and Social Care announced £9m additional funding over 2 years to increase the pace of the implementation. The key outcome of the programme will be to provide a high level of assurance that all patient safety incidents of nosocomial COVID-19 are investigated in line with the requirements of the National Health Service (Concerns, Complaint and Redress Arrangements) Regulations 2011 – Putting Things Right.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

PROGRAMME OVERSIGHT

2.0 At the end of Year 1, Quarter 2, the Health Board is compliant in meeting the milestones outlined on the National Roadmap for programme delivery. Another national self-assurance exercise is planned for future to re-assess programme delivery status.

2.1 There is a now a full-time Head of Programme in post whose initial focus has been the refinement of the investigation approach and development of end-to-end processes for work flow as well as addressing urgent and escalating programme risks.

2.2 Current programme spending is within allocated budget however there is an unfunded workforce spend at the beginning of 2024/25. Finance colleagues have been unable to clarify funding requirements regarding in-year expenditure constraints and this information is now being sought by the national programme lead.

2.3 Rates of COVID-19 transmission are once again increasing across the nation and in our local communities. Cases of possible and confirmed nosocomial transmission of the virus continue to occur in our hospitals and healthcare settings with the associated consequences this has on affected patients and their loved ones.

2.4 Nosocomial COVID-19 cases recorded after the 30th April 2022 will also be subject to the requirements of the National Framework and PTR regulations. National discussions continue to reflect the recognised need for consistency of approach and equal resource commitments for all cases of nosocomial COVID-19, irrespective of acquisition date.

2.5 An updated version of the National Framework was issued in early October 2022, providing clarity on the application of PTR to commissioned care arrangements. The team will ensure that our commissioning responsibilities are fulfilled in accordance with the newly published framework where COVID-19 acquisition is concerned. The guidance is additionally applicable to other types of patient safety incidents and complaints (non-COVID-19 related) and has been shared with Health Board Quality and Governance colleagues for adoption in applicable circumstances.

2.6 The NHS DU undertook a site visit to the team on 20 October 2022 to review the programme progress in CTMUHB, the investigation approach and to observe an investigation scrutiny panel. This provided an important opportunity for the team to reflect critically on the programme approach and take on board national good practice. The feedback was overwhelmingly positive and the team is grateful for the constructive support offered.

WORK STREAMS

2.7 **Establish team, investigation methodology and governance arrangements**

2.7.1 A further clinical investigator post has been successfully appointed to and an additional non-clinical post in the team is progressing through the recruitment approval process. The additional resource this brings will support an increase in delivery pace.

2.7.2 The CTMUHB Nosocomial database which is being used to record investigation work has undergone a quality assurance review. This identified some minor data entry validation issues which are being addressed. Dependency on Information colleagues to support this can be challenging owing to existing workloads and priorities in the Information team.

2.7.3 The Nosocomial database has been further developed since the last update to this Committee to facilitate progress reporting. The ability to quickly and accurately report on the status of all investigations is critical to providing national monthly data submissions as well as internal data on areas of challenge in our in process flows so they can be promptly worked through.

2.7.4 Accommodation issues have been resolved and the team is working effectively from Dewi Sant Health Park site. A dedicated team base and sufficient storage for medical records will be needed throughout the duration of the programme.

2.7.5 The CTMUHB Nosocomial COVID-19 Incident Management Programme Group continues to run on a bi-monthly basis to ensure the Health Board's SRO is sighted on progress and risks.

2.8 Investigations and quality assurance

2.8.1 A national dashboard has been developed to provide consistent monthly data sets and easily accessible oversight of completion trajectories. The Health Board is grateful to the data team at the DU for developing this. The status of investigation work correct as of 30th September 2022 is presented in **Appendix 1.**

2.8.2 Investigation delivery pace is now a key focus for the team whilst maintaining high quality and we recognise the challenge ahead of us. Additional recruitment and targeted training within the existing team is helping to build our delivery pace and ensure that the Health Board will be able to comply with programme timescales.

2.8.3 Whilst effective work has been undertaken to address some of the issues affecting the pace of investigation work such as team resource, Mortality Review completion rate and Scrutiny Panel quoracy, other influencing factors have been less amenable to influence despite efforts to do so. This includes the poor retrospective functionality of the CITO electronic medical records system, workforce issues in the Medical Records service and the empty COVID-19 Information Manager post.

2.8.4 Audit work to provide assurance on the quality and consistency of the entire investigatory process has been commenced by the programme's Clinical Lead.

2.9 Stakeholder, patient and family contact

2.9.1 A National Communications and Engagement officer is due to be appointed who will liaise closely with the Communications Lead in post.

2.9.2 Progress updates and engagement continues to take place in staff forums to inform and reassure staff about the purpose of the Review Programme. A staff well-being pathway is in place if needed, to support clinical staff who are required to contribute to the investigations.

2.9.3 A dedicated helpline as a point of contact for supporting families continues to be available to any member of the public wishing to contact the team.

2.9.4 A number of FOI requests have been responded to in the appropriate timescales. The requests have largely been enquiries about the number of investigations and completion rates.

2.9.5 Enhanced quality assurance of the clinical investigations is ensuring that the individual PTR responses received by families will thoroughly address all aspects of qualifying liability and that the complex investigation process and findings are shared in a sensitive and comprehensible manner.

2.10 **Thematic learning and improvement**

2.10.1 As the clinical investigation and investigation scrutiny panel process is fully optimised, focus will be given to collating, analysing and sharing thematic and incident-specific learning from the programme. This will include examples of good practice as well as opportunities for improvement.

2.10.2 This will be undertaken in conjunction with national workstreams and learning repositories.

2.10.3 Learning will be shared and implementation overseen through a number of Health Board forums including the Shared Listening and Learning Forum and the IPC Committee.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.0 To receive assurance regarding the Health Board's Quarter 1 and 2 position against the National Nosocomial COVID-19 Programme roadmap.

3.1 To note the challenging completion trajectory for investigations as the team build to full delivery pace. This is being addressed through additional recruitment however some factors, such as medical records service fragility and difficulties with the CITO electronic records system are not amenable to resolution.

3.2 To be advised that a full programme risk register is being reviewed bi-monthly at the Nosocomial COVID-19 Incident Management Programme Group and the overarching Programme risk is also reviewed at the Infection, Prevention and Control Group. Currently there are no risks that meet the threshold for escalation to the Organisational Risk Register.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	Large numbers of our population were affected themselves or lost relatives as a result of nosocomial COVID-19 infection.

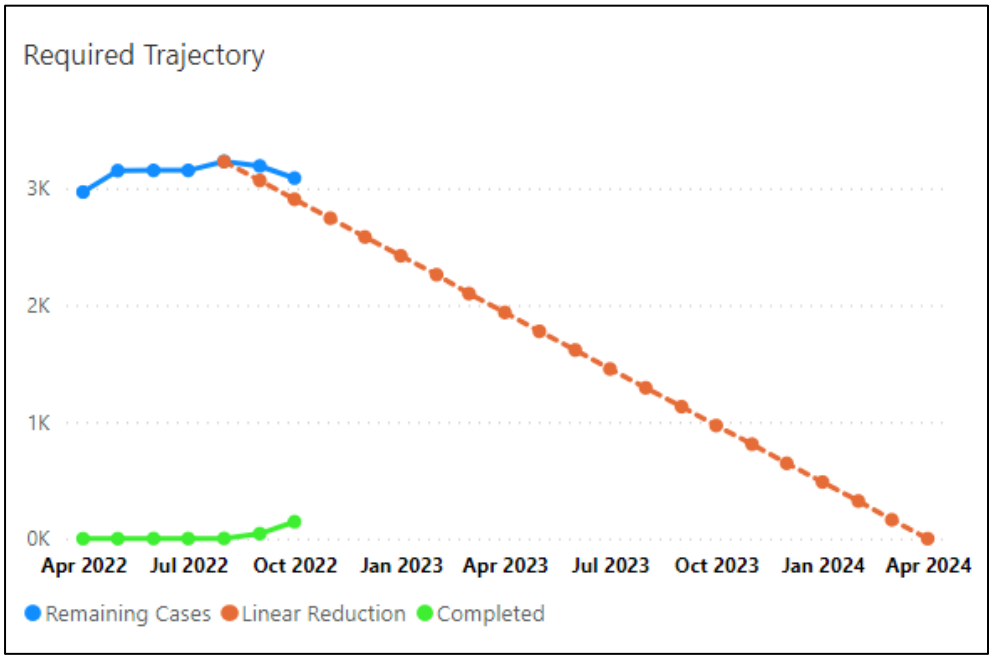
	This report details key steps in addressing their concerns and learning for future infection management or pandemic responses.
Related Health and Care standard(s)	Governance, Leadership and Accountability
	Relevant to all Healthcare Standards
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) Any new or altered services would have their own EIA undertaken.
Legal implications / impact	Yes (Include further detail below)
	Any incidents where a breach of duty or qualifying liability is believed to exist will follow appropriate legal process. The Health Board will work closely with NWSSP Legal and Risk services.
Resource (Capital/Revenue £/Workforce) implications / Impact	Yes (Include further detail below)
	Dedicated fixed term workforce will be recruited. The funding stream is confirmed and provided by Welsh Government. No additional financial impact is anticipated other than through existing legal Redress and Claims provision.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

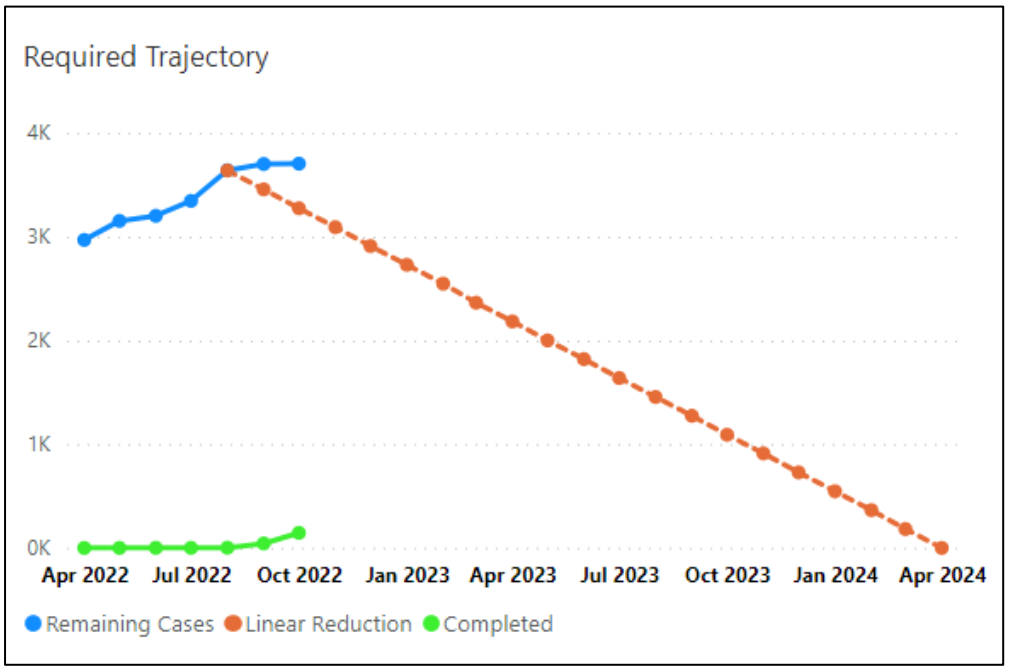
5.1 The Quality & Safety Committee is asked to **NOTE** this report.

Appendix 1.

Nosocomial Dashboard (Waves 1-4)



Nosocomial Dashboard (Waves 1-4 and live reporting)



*Data correct as of 17/10/22

Case status

	Wave 1 (27/2/2020 - 26/7/2020)	Wave 2 (27/07/2020 - 16/05/2021)	Wave 3 (17/05/2021 - 19/12/2021)	Wave 4 (20/12/2021 - 30/04/2022)	Live 01/05/2022 -
Total Incidents	479	1488	314	952	616
Under Investigation	133	444	81	121	82
Not Started	346	880	233	831	534
Referred to Scrutiny Panel	0	19	0	0	0
Completed Investigations	0	144	0	0	0
Downgraded / Recategorised	0	1	0	0	0

*Data correct as of 30/09/22

AGENDA ITEM
3.2.11

QUALITY & SAFETY COMMITTEE

HUMAN TISSUE ACT (2004) COMPLIANCE AND PROGRESS REPORT

Date of meeting	15/11/2022
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Dr Paul D Davies, AD & HTA Designated Individual
Presented by	Mr Gethin Hughes, Chief Operating Officer
Approving Executive Sponsor	Chief Operating Officer
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Executive Medical Director & Chief Operating Officer	26/10/22	NOTED

ACRONYMS	
CTMUHB	Cwm Taf Morgannwg University Health Board
HTA	Human Tissue Act
HTAuth	Human Tissue Authority
DI	Designated Individual
HTARI	Human Tissue Act Reportable Incident

1. SITUATION/BACKGROUND

1.1 The purpose of this progress report is to present the progressive work of the Designated Individual for the Human Tissue Act (2004) and provide assurance to the Health Board that services are compliant and prepared for inspection.

1.2 CTMUHB manage a range of clinical and support services which are involved in the removal, storage, use and disposal of human tissue.

1.3 CTMUHB is thus subject to the legal requirements of the HTA (2004) which subsequently established the Human Tissue Authority (HTAuth) who then regulate relevant sectors.

1.4 Within CTMUHB the main focus of the relevant HTAuth standards and guidance is the Post Mortem sector, although specific guidance around the management of pregnancy loss (< 24 weeks) in a number of services (i.e. Maternity, Theatres, Gynaecology) also apply.

1.5 CTMUHB is licensed by the HTAuth at our three main District General Hospital sites and compliance inspections take place every four years or as required (last inspection 2018).

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 The Designated Individual was appointed by the Health Board and Human Tissue Authority (HTAuth) in November 2020 and has worked toward strengthening the governance of compliance with the standards set out within the HTA. The focus has predominantly been focused upon six key themes;

2.1.1 Quality Control
2.1.2 Engagement
2.1.3 Deep Dive events
2.1.4 Standard Operating Procedures
2.1.5 Education
2.1.6 Trend analysis

2.2 To ensure transparency these six key themes are the basis of the Designated Individual reporting to the HTA Board chaired by the Licence Holder, Dr Dom Hurford Executive Medical Director.

Quality Control

2.3 The Quality Control Department within Pathology have a specific role in terms of ensuring there is an annual and cyclic programme of audit around the specific standards with the HTAuth Codes, predominantly Code A (Consent) and the recently updated Code B (Post Mortem). These standards can be perused at Home | Human Tissue Authority (hta.gov.uk)

2.4 This quality system is augmented through regular inspections of a range of services by the DI including Mortuary Departments, Maternity Services, Emergency Departments, Theatres, Early Pregnancy Units and Gynaecology Wards.

2.5 For those departments outside Pathology, the focus is mainly upon compliance with guidance regarding the sensitive disposal of pregnancy loss remains under 24 weeks and dignity of the deceased.

2.6 During 2021 the DI conducted 31 inspections. From January to September 2022 a total number of 33 inspections have been conducted. The frequency of inspections at all three Mortuary departments have been increased in preparedness for HTAuth inspection.

2.7 The outcomes of each local inspection is reported to the Persons Designated for the clinical area and corrective actions put in place.

2.8 Shared learning arising from all inspections is reported widely to clinical teams and the HTA Board.

2.9 Within the last 24 months the Designated Individual has observed significant improvements through inspections and shared learning, including the following examples;

- New flooring at the Royal Glamorgan Hospital Mortuary Department body store and a number of improvements in the general estate
- Replacement of equipment to maintain health and safety
- Introduction of a checklist at Ward level for improving care and dignity for the deceased prior to transfer to the Mortuary Department
- Improvements in the clinical pathway for patients attending Emergency Departments and requiring Gynaecology services
- Revisions in Policies and Standard Operating Procedures
- Improvements in security and controlled access to Mortuary Departments.

2.10 The inspection process, coupled with the quality control programme within Pathology will continue and indeed intensify to ensure the Health Board is HTA compliant and ready for inspection.

Engagement

2.11 Engagement is key to ensuring there is compliance with the HTA and making sure there is effective communication on a number of issues such as audit findings, incident outcomes, standard operating procedure reviews, improvements in standards and seeking ideas on the development of services.

2.12 To assist this goal the Designated Individual has introduced a network of 15 Persons Designated across a wide range of services and specialities within the Health Board, focused mainly at the three HTA licenced sites; Prince Charles Hospital, Royal Glamorgan Hospital and Princess of Wales Hospital.

2.13 Person's Designated appointed by the DI are able to directly influence services in relation to licensable activities.

2.14 The HTA recommend that the role is supplementary within the governance framework, although the DI remains responsible for supervising the activities to be authorised by the licence.

2.15 The DI meets with the Person's Designated group every six weeks to share learning, discuss developments and provide support where needed.

2.16 Establishing such a wide ranging network ensures that there is support across departments. To date this has been received well.

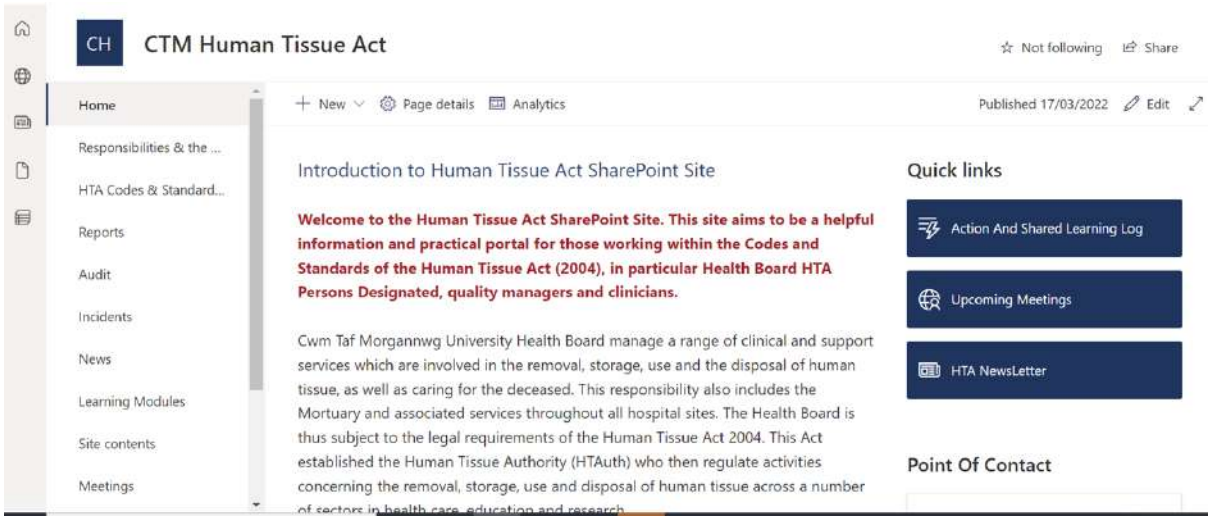
2.17 One key area of development for engagement is the introduction of an Office360 Sharepoint page specifically to support Persons Designated and relevant clinicians/ managers in relation to the HTA.

2.18 With the support of the Assistant Director of ICT this intranet portal is now operational and has been helpful as a *one stop* site for all matters related to the HTA to support departments throughout the Health Board.

2.19 For example, the following information can be found at this site for shared learning by Persons Designated and for prospective inspection by the HTA;

- Outcomes of local inspections and audit
- HTA newsletters
- Incident Trend Analysis
- Shared Learning log
- Educational Powerpoint presentations
- Estate reports on service records for the ventilation systems within the Mortuary Department

2.20 This new sharepoint page continues to be improved and developed.



Deep Dive events

2.21 Since October 2021 the DI has led a number of *Deep Dive* sessions to examine in detail each of the HTAct standards within Code A and B to undertake a gap analysis and subsequent corrective actions.

2.22 Further sessions have been conducted in 2022 focusing upon Post Mortem tissue traceability and Post Morten examination.

2.23 Such *Deep Dive* events have ensured there is a detailed review of compliance and preparedness for the next HTAuth inspection. In particular, an analysis of any outstanding Standard Operating Procedures for review.

2.24 These events will continue as needed to ensure compliance with the HTA standards.

Standard Operating Procedures

2.25 Contemporary, evidence-based Polices and Standard Operating Procedures are the bedrock to compliance.

2.26 Through the method of *Deep Dive* events all Policies and Standard Operating Procedures have been reviewed for relevancy and whether they remain contemporary.

2.27 There are no significant outstanding reviews and recently the DI has led a review of PATH 02, our Policy for the sensitive disposal of pregnancy remains. The newly revised policy is now operational and update sessions are available to clinical staff.

Education

2.28 The Mortuary Department have an on-going training programme with regards to HTA standards which is checked on a regular basis for compliance.

2.29 A PATH 02 training Powerpoint presentation with a competency checklist has been rolled out beyond Maternity services to Emergency Departments, Theatres, Early Pregnancy Units and Gynaecology services.

2.30 The DI has been leading teaching sessions in Gynaecology regarding PATH 02 for new staff and an essential update for existing staff members.

Incident Trend Analysis

2.31 All Datix reports which have indicated that an incident involved a deceased person and/or have key words such as "Pregnancy Loss Remains", "Death" or "Mortuary" are automatically copied to the DI.

2.32 This provides an 'early warning' system so that the DI can quickly follow-up such incidents, alert Persons Designated and support corrective actions.

2.33 All HTA related incidents are compared and presented on a quarterly basis to the HTA Board and Persons Designated; Graph 1 presents the first two quarters of this financial year.

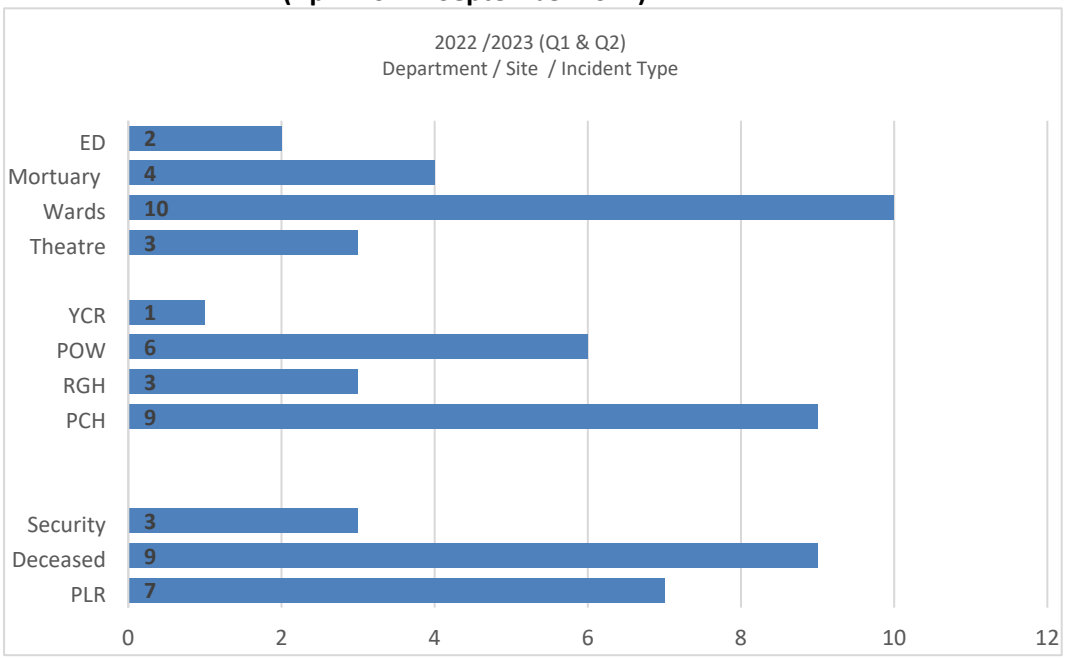
2.34 There were **19** HTA related incidents in the first two quarters of 2022/23, including 1 HTARI (mortuary) and 1 HTARI near-miss (security).

2.35 In 2021/22 there were **34** HTA related incidents in the first two quarters, including 2 HTARIs.

2.36 Tissue Traceability continues to be a trend and represents 74 % of all incidents reported.

2.37 As with the audit programme, any shared learning from the outcomes of the incidents is communicated and discussed within the Persons Designated group.

GRAPH 1 **A summary of 19 Datix Incidents relating to HTAct standards (April 2022– September 2022)**



3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 The overall Mortuary space capacity will be significantly challenged over the winter months and the Pathology Directorate are leading plans to provide an immediate solution to address this need for

consideration by the Health Board. The plans have been presented to the Executive Capital Planning Group on 26th October 2022.

3.2 The Mortuary Department at the Royal Glamorgan Hospital is the main centre for Post Mortems and the estate is in need of a major refurbishment to maintain its future compliance with the HTA. The Pathology Directorate will be leading plans to submit an outline case to the Health Board for such work.

3.3 Within the two Gynaecology clinical pathways at both the Princess of Wales Hospital and Prince Charles Hospital for women experiencing early pregnancy loss it is important that the ring-fenced beds at ward level are maintained to ensure there is a 'fast-track' from Emergency Departments on presentation. This is essential to maintain dignity and safety.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
Related Health and Care standard(s)	Individual Care
	If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If no, please provide reasons why an EIA was not considered to be required in the box below.
	No changes reported to services or new policies to consider
Legal implications / impact	Yes (Include further detail below)
	The Human Tissue Act is a legal requirement
Resource (Capital/Revenue £/Workforce) implications / Impact	Yes (Include further detail below)
	Pathology Directorate are leading business plans for investment in the Mortuary Department estate and to increase resilience with Mortuary Capacity
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

5.1 The Quality & Safety Committee are requested to **NOTE** the on-going work undertaken to assure compliance with HTA standards.

5.2 The Quality & Safety Committee are requested to **NOTE** the highlighted key risks looking ahead, which may adversely impact upon HTA compliance.

AGENDA ITEM
3.2.12

QUALITY & SAFETY COMMITTEE

ANNUAL REVIEW 2021/22 – WELSH RISK POOL AND LEGAL & RISK SERVICES

Date of meeting	15th November 2022
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Stephanie Muir, Assistant Director of Concerns & Legal Services
Presented by	Georgina Galletly, Director of Corporate Governance
Approving Executive Sponsor	Director of Corporate Governance / Board Secretary
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Quality & Safety Committee	20/09/2022	Choose an item.

ACRONYMS	
PSOW	Public Services Ombudsman for Wales

1. SITUATION/BACKGROUND

1.1 The Welsh Risk Pool is a mutual body which supports all health organisations in NHS Wales by administering the risk pooling scheme, which provides the means by which all Health Boards, Trusts and Special Health Authorities in Wales are able to indemnify against risk. The role of the Welsh Risk Pool is to have an integrated approach towards risk assessment, claims management, reimbursement and

learning to improve. The team works with NHS colleagues across Wales to promote and facilitate opportunities to learn and support the development and implementation of improvements to enhance patient and staff safety and clinical outcomes.

1.2 Legal & Risk Services provide legal advice and representation for all health bodies in Wales. With specialist experience, knowledge and understanding of the legal, administrative and policy issues that affect the operation of the NHS in Wales, the Legal & Risk teams are able to support organisations in providing safe and efficient health and care services to the population of Wales.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 The Annual Review reports the following in respect of CTM:

2.2 Open clinical negligence matters
In terms of trend CTM saw a steady increase from 2012-13 with open clinical negligence matters being 221, peaking at 293 in 2015-16, then reducing to around 200 in 2018-19, this has gradually increased to around 250.

2.3 In 2021/22 within CTM 53% of clinical negligence cases were successfully defended and closed without damages, this has been a slow but steady increase over the last three financial years. This sits at 10% higher than the all Wales average. Note: The report notes "closed without damages", however the graph title notes "closed with damages". This has been queried with WRP and clarified that 53% have been closed **without** damages.

2.4 In 2021/22 the principal clinical specialty identified in clinical negligence matters being managed within CTM was Maternity at 21.69%, Emergency Department at 15.66% and Trauma and Orthopaedics at 10.24%, which is in line with the top clinical areas for clinical negligence matters across Wales.

2.5 The number of open personal injury matters has remained steady within CTM over the past 3 years, with an average of 93.

2.6 In 2021/22 within CTM 47% of personal injury cases were successfully defended and closed without damages, this is a significant increase from 16% in 2019/20. The 2021/22 position is in line with the all Wales data.

2.7 Over the last 3 financial years, CTM have seen an increase in the number of redress cases being managed. However, it is clear that the closure rate of these cases remains relatively low.

2.8 The Health Board has made 15 periodical payments over the last five years totalling £1.3 million.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 The Health Board are asked to:

- Receive the annual review
- Use information within the annual review to support the quality and safety agenda within CTM.
- Note that the Redress closure rate is relatively low, but take assurance that this has been noted and is being addressed through the operational model review and an invest to save bid.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	There are no specific quality and safety implications related to the activity outined in this report.
Related Health and Care standard(s)	Safe Care
	All Health and Care Standards Apply
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If no, please provide reasons why an EIA was not considered to be required in the box below.
	Not required
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

5.1 The Committee is asked to receive and formally **NOTE** the annual review from Shared Services.

Gwella Diogelwch Cleifion Trwy Ddysgu
Improving Patient Safety Through Learning

Welsh Risk Pool
Operations Team
Alder House
Alder Court
St Asaph Business Park
Denbighshire
LL17 0JL

Cronfa Risg Cymru
Tim Gweithrediaudau
Ty Alder
Cwrt Alder
Parc Busness Llanelwy
Sir Ddinbych
LL17 0JL

01745 366760

Welsh.RiskPool@wales.nhs.uk

Paul Mears
Chief Executive
Cwm Taf Morgannwg University Health Board

via email only

Date: 9th September 2022
Our Ref: WRP-LARS Annual Review
Your Ref:

Dear Paul,

I am pleased to enclose a copy of the Annual Review for Welsh Risk Pool and Legal & Risk Services for 2021/22.

The Annual Review outlines the caseload of claims and redress cases across NHS Wales. It provides some trend history and outlines the distribution of specialities associated with matters.

Providing a summary of the expenditure of the Welsh Risk Pool budget during 2021/22, the review outlines details of the finances which have been reconciled to the annual accounts. Whilst the overall number of claims has not grown, the value of claims has continued to increase - placing pressure on limited NHS resources.

The review report also outlines some of the improvement programmes being coordinated by the Welsh Risk Pool, along with a summary of the work of the teams within Legal & Risk Services. Of particular note are the savings & successes achieved by our team, which amount to over £74m.

A key aspect of the work undertaken by the Welsh Risk Pool is to help organisations to recognise the causes of claims and redress cases, identify lessons learned, and establish the improvements needed to reduce the risk of reoccurrence. We will continue to focus on this work to further reduce the causes of litigation.

In addition to the Annual Review report, I am pleased to provide a supplement which outlines the health body's data in comparison to the all-Wales position.

I also enclose a copy of the latest case summary of matters being managed on behalf of the health body by Legal & Risk Services.

I do hope you find the Annual Review and organisation-specific supplementary documents of use in your work in the quality & safety sector.

If you and your Board & senior management colleagues would find a meeting with Welsh Risk Pool and Legal & Risk Services staff of value in analysing the information contained in the Annual Review and additional documents, the team would be delighted to make appropriate arrangements. Please contact the team at welsh.riskpool@wales.nhs.uk if you would like to plan a meeting.

Yours sincerely,

Mark Harris
Director of Legal & Risk Services and Welsh Risk Pool - NWSSP

Welsh Risk Pool Services and Legal & Risk Services

Annual Review 2021-2022

GIG CYMRU NHS WALES

Partneriaeth Cydwasanaethau
Shared Services Partnership

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Foreword

Members of the public in Wales are proud of, and thankful for, the services provided by their NHS and this was clearly evidenced by the gratitude and appreciation shown to the service and its staff during the pandemic.

During my career in the NHS, I have constantly been impressed with the dedication and expertise of the staff who work tirelessly to provide care and treatment when it is required and support our communities to improve their health and wellbeing. When compared to the number of patient contacts undertaken by NHS Wales each year, the number of times when problems occur, or things go wrong, is very small.

Professor Tracy Myhill OBE, Chair of NHS Wales Shared Services Partnership

However, for every time something does go wrong and harm occurs, or systems fail, the NHS must have robust processes to learn lessons, improve processes and share best practice. The Welsh Risk Pool and Legal & Risk Services play a vital role in supporting health bodies to investigate what has happened, put preventative measures into place where possible and achieve a satisfactory resolution for any person affected.

It is widely recognised that all areas of the NHS across the UK are experiencing a high level of claims. This is seen in NHS Wales. Whilst it is pleasing to note that the number of claims is not increasing in NHS Wales we must recognise that the value of individual claims does increase year on year. Successful claims provide some recognition and recompense for patients and families, although unfortunately cannot change what has happened. On average, 45% of personal injury and clinical negligence claims are successfully defended.

Using an entirely in-house legal service to manage clinical negligence and personal injury claims in NHS Wales, our professional influence is also achieving considerable savings to the Welsh taxpayer. The wide experience of the in-house legal service, in all areas of law affecting modern health bodies, provides rapid and effective advice to leaders throughout the NHS.

The Safety & Learning programme operated by the Welsh Risk Pool involves investing some of the money which would otherwise be spent on claims to achieve reductions in incidents and thus lead to improved services with fewer claims. The programmes are well respected amongst clinical teams in Wales and are having a genuine impact.

The most frequently occurring specialty for claims is in maternity services and it is vital we support health bodies to learn and improve from what has gone wrong in these cases. We have introduced the PROMPT Wales and Community PROMPT Wales programme and this important initiative was recognised when its lead, Midwife Sarah Hookes, was awarded the Wales RCM Midwife of the Year accolade.

The introduction of the Putting Things Right regulations in Wales ten years ago has provided a system for the smooth and effective resolution of concerns raised by patients and their relatives whilst reducing the burden of legal costs on the NHS. With the responsibility for reimbursing expenditure for redress cases now placed with the Welsh Risk Pool, the team is able to provide a fuller picture of the causal factors and lessons learned which arise from redress cases as well as claims and continue to work with local clinical teams to identify areas for improvement.

The General Medical Practice Indemnity Scheme, operated by Legal & Risk Services, was introduced in 2019. This team works closely with primary care services to help with investigations and reduce the potential for litigation in this area. This scheme introduces national scrutiny of lessons learned within the primary care sector for the first time.

I am very proud of the work done by the Welsh Risk Pool and Legal & Risk Services working with colleagues across the NHS in Wales. The purpose of this report is to outline the current position and forecast for claims and redress cases and to outline the incredible work that the team does every day.

My senior team will be working with every Board in NHS Wales to maximise learning and to improve quality and safety, using the data related to each individual health body to the maximum possible.

About Tracy Myhill

Tracy was appointed Chair of NWSSP in 2021 having previously retired from the NHS following a career that spanned 37 years. Beginning her career as a receptionist in Cardiff's Dental Hospital, Tracy progressed into the human resources sector and held roles at local and national level. She has previously worked as Chief Executive of the Welsh Ambulance Service NHS Trust and of Swansea Bay University Health Board.

Our Services

The Welsh Risk Pool is a mutual body which supports all health organisations in NHS Wales by administering the risk pooling scheme, which provides the means by which all Health Boards, Trusts and Special Health Authorities in Wales are able to indemnify against risk.

The role of the Welsh Risk Pool is to have an integrated approach towards risk assessment, claims management, reimbursement and learning to improve. The team works with NHS colleagues across Wales to promote and facilitate opportunities to learn and support the development and implementation of improvements to enhance patient and staff safety and clinical outcomes.

Legal & Risk Services provide legal advice and representation for all health bodies in Wales. With specialist experience, knowledge and understanding of the legal, administrative and policy issues that affect the operation of the NHS in Wales, the Legal & Risk teams are able to support organisations in providing safe and efficient health and care services to the population of Wales.

Welsh Risk Pool

Reimbursement
We reimburse losses and special payments incurred by health bodies in accordance with the WRP Reimbursement Procedures.

Consent
We coordinate the all-Wales approach to Consent to Examination & Treatment, provide a national training solution for clinicians involved in the consent process and procure a library of approved consent information leaflets to support clinicians in ensuring patients can give informed consent.

Once for Wales Concerns Management System
We lead the design, implementation and use of the Once for Wales Concerns Management System, which provides consistency in the platform for capturing, investigating and reporting on all concerns in health bodies and primary care.

Concerns Management Training
We provide training to claims managers, redress case managers and staff involved in coordinating inquest cases.

Safety & Learning
We scrutinise the learning from events relating to claims and redress cases. We coordinate a national learning advisory panel to consider and share best practice and lessons learned from cases.

PROMPT Wales
We coordinate the all-Wales approach to PROMPT Wales and Community PROMPT Wales, which delivers obstetric emergency training to midwives, obstetric doctors and anaesthetists involved in maternity care.

Specialist Investigation Support
Using the vast clinical experience across NHS Wales, we support health bodies with complex and organisational investigations where the independence of the WRP can add value.

Legal & Risk Services

General Medical Practice Indemnity
A team of highly skilled solicitors with a particular focus and expertise in managing clinical negligence claims arising from primary care practice.

Clinical Negligence
A department of in-house solicitors and legal support staff who manage the clinical negligence caseload across all health bodies. We aim to handle claims proactively, fairly and consistently.

Employment
A team of solicitors and legal executives advising on high level strategic policy matters, case management and tribunal hearings.

General Healthcare Advice

A wide spectrum of issues can be faced by health bodies and clients. This team draw from the diverse experience within Legal & Risk Services to provide timely advice.

Inquests
Our inquests team offer full support to our clients, from initial investigations through inquest hearings and beyond.

Commercial, Regulatory and Procurement
A team of highly specialised lawyers who support health bodies in managing these issues in a practical and timely manner.

Complex Patient (Court of Protection)
A team of very experienced healthcare lawyers who provide rapid advice to ensure NHS staff are able to comply with legal requirements and deal with complex legal issues regarding the provision of care and treatment.

Personal Injury
This team have intimate knowledge of the NHS enabling swift and efficient advice on managing claims and providing expert advice on reduce risks in the workplace.

Property acquisitions, disposals and leases
This highly specialised team work closely with Specialist Estates Services to support all health bodies on matters relating to the NHS Wales estate.

Putting Things Right
We offer a flexible and hands-on approach to health bodies in dealing with matters under the PTR regulations.

Our People

Mark Harris

Mark Harris is the Director of Legal & Risk Services and the Welsh Risk Pool. Mark has an LLB law degree, an LLM Master's degree in Commercial Law/Marine Affairs and a Postgraduate Certificate in Health Service Management.

Having worked in Legal & Risk for over two decades, Mark has vast experience of working on clinical negligence and general advisory matters and was a Team Manager and the Deputy Director of the service prior to being appointed as the Director.

Mark's areas of special interest are clinical negligence claims, health funding disputes and governance. Mark has provided legal advice on a very wide range of one-off legal conundrums that face NHS bodies in their day-to-day business, having advised on a multiplicity of individual legal issues in the last decade. Mark led Legal and Risk Services' engagement with Welsh Government to implement the GP indemnity scheme which commenced in 2019.

Daniela Mahapatra

Daniela Mahapatra is the Deputy Director of Legal & Risk Services. Daniela qualified as a Solicitor in 2005. She obtained her LLB Law degree at the University of Wales, Swansea, before moving to Cardiff to undertake the Legal Practice Course. Practicing in employment law, Daniela advises all health bodies in Wales in complex employment cases.

Daniela is a member of the HPMA Wales Committee, arranging various training events for the NHS Wales HR workforce (Workforce & OD).

In May 2016, Daniela was elected as the Wales representative for the Employment Lawyers Association. As part of this role, Daniela assisted with the roll out of the Employment Tribunal Litigants in Person Support Scheme (ELIPS) in the Wales Employment Tribunal, which provides free assistance to unrepresented litigants (claimants and respondents) at the Employment Tribunal.

Daniela has taught the Employment Law module on the HRM course at the University of South Wales. Daniela is also a mentor as part of the Coleg Y Cymoedd mentoring scheme.

Sarah Watt

Sarah Watt is the Head of Healthcare Litigation, the strategic lead for clinical negligence claims, Putting Things Right and Public Inquiry work. Sarah has a LLB Law Degree, Law Society Finals Examination pass and Level 5 Qualification from the Institute of Leadership and Management.

Sarah joined Legal & Risk Services in 2003 after working for leading UK healthcare law firms. She became a Team Leader in 2005 and was appointed Head of Healthcare Litigation in 2021.

Sarah is particularly experienced in high profile investigations, very high value claims and is leading the work to support health bodies giving evidence to the coronavirus public inquiry.

Jonathan Webb

Jonathan Webb is the Head of Safety & Learning and is the operational lead for the Welsh Risk Pool. Jonathan is a Registered Paramedic, an experienced Clinical Mentor and has worked in the NHS since 1990. Having completed a degree in Education at Wolverhampton University and studied Management at University of Reading Henley Business School, Jonathan has completed a Master's degree in Occupational Health & Safety at Loughborough University.

Prior to joining Legal & Risk Services in 2016, Jonathan was Head of Risk Management in an English Acute Trust where he developed an investigation training programme for clinical leaders. He has previously held a similar role in the Channel Islands, where he was responsible for coordinating a States-Wide Risk Register & Assurance Programme. Jonathan's role focusses on scrutinising and sharing lessons learned from claims and redress cases, delivering bespoke programmes to address areas of litigation, leading the Once for Wales Concerns Management System and coordinating assessments of health bodies' systems for handling concerns.

Sue Saunders

Sue Saunders is the Head of Finance for Welsh Risk Pool. The financial functions of the Welsh Risk Pool and Legal & Risk Services are coordinated by the Corporate Finance Team within NHS Wales Shared Services Partnership. Sue is responsible for the Welsh Risk Pool and Legal & Risk accounts. Chairing the sub-Technical Accounting Group for Welsh Risk Pool matters, Sue ensures that the application of financial principles is consistent throughout NHS Wales.

A qualified accountant, Sue has many years of experience in NHS accounting and supports health bodies with their financial returns relating to the Welsh Risk Pool to Welsh Government.

Our people are our biggest asset in the Welsh Risk Pool and Legal & Risk Service.

With over 125 whole time equivalent solicitors, chartered legal executives, pre-qualified lawyers and support staff, the Legal & Risk service is able to support all health bodies in NHS Wales in all areas of law.

With twelve whole time equivalent established staff and a flexible workforce of bank and seconded colleagues, the Welsh Risk Pool is able to draw on clinical and operational experience from across NHS Wales to deliver its services.

Welsh Risk Pool Committee

Decisions in relation to the rimbursement procedures, workplans for reviews and the reimbursment of claims & redress cases are taken by a national committee drawn from executive and associate roles from Health Bodies and Welsh Government. Members represent their roles and peers across Wales rather than their individual organisation.

Acting as a sub-committee of the Shared Services Partnership Committee, the Welsh Risk Pool Committee ensures consistency in decisions and effective scrutiny of this complex sector.

Our Caseload

The majority of people who receive care from NHS Wales receive an excellent service that is provided by a dedicated and well-trained workforce. Whilst NHS Wales should be justifiably proud of its achievements, there is no room for complacency and occasionally mistakes happen or processes and systems fail, which can lead to claims being paid to patients or staff affected or expenditure on redress.

In addition to the harm experienced by those involved in events which lead to litigation, every penny spent on claims and redress cases cannot be spent on providing health and care in NHS Wales.

The Welsh Risk Pool and Legal & Risk Services will continue to work carefully with each party in every matter to achieve the right resolution in the case and a fair outcome for all parties.

Through the process of learning from events, causal factors that have led to a claim or redress case are identified and learning or improvements put into place to reduce the potential for repeat events.

Claims & Redress Case Profile

The profile of cases managed by the Welsh Risk Pool and Legal & Risk Services relate to clinical negligence, personal injury and redress matters.

The Welsh Risk Pool administers the risk pooling arrangement and meets the cost of financial losses for claims over £25,000 and all reimbursable expenditure on redress cases. The most significant element of expenditure relates to clinical negligence matters.

Clinical negligence and personal injury claims are managed using the legal processes outlined in the pre-action protocols and legal procedures issued by the courts of England & Wales. If a claim proceeds to court, the conduct of the claim is coordinated by a judge.

Redress cases are conducted using the requirements set out in the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011, which are known as the Putting Things Right Regulations, and these have a published legal guidance which sets out the expectations of parties.

Clinical Negligence Matters

The number of substantive open clinical negligence cases at the end of each financial year provides a useful indicator of the current clinical negligence caseload pressure experienced by NHS Wales. This data for the last ten years is shown in Fig1. These figures do not include cases from the Scheme for General Medical Practice Indemnity, which are managed separately.

Some cases remain open for a considerable period of time, as matters are analysed and financial values determined. Some more complex cases can remain open for over ten years.

There was a spike in cases as we approached 2013 because of a rush by Claimant's solicitors to open new cases before conditional fee agreements were abolished by a change in the law.

We also changed our methodology for opening new cases from 2017/18 - only accepting those with a letter of claim or that fell into the criteria for our early reporting scheme, where we require health bodies to inform us of specific incidents as they occur. Prior to that we accepted matters even if there was not yet a letter of claim, such as pre-action disclosure requests. We have done our best to exclude these essentially non-substantive matters within the numbers shown in Fig1. However, the way the data is held presents some challenges to easy to identify these matters. Therefore, there is a chance that some remain included in the data prior to 2017/18.

Due to the duration of some cases remaining open, the spike in cases around 2013 and the change in methodology of accepting cases in 2017, it is not possible to identify an overall determinable trend in case numbers. There is, however, an increase in the complexity and value of cases, with a consequential financial impact to NHS Wales.

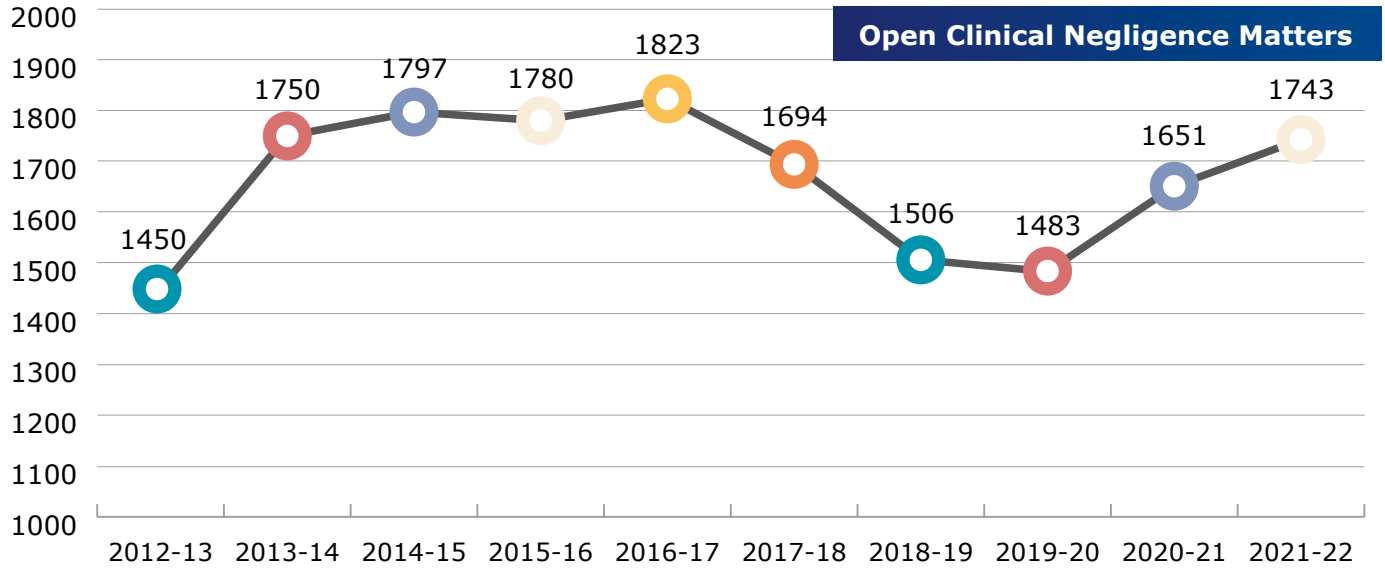


Fig1 Open Clinical Negligence Matters

On behalf of NHS Wales, Legal & Risk Services carefully investigates all matters brought against health bodies and is successful in defending cases where this is possible, which reduces avoidable costs for the Welsh taxpayer.

Fig 2 provides a summary of the number of cases closed without damages over the last three years. This shows that we are consistently defending approximately 45% of cases.

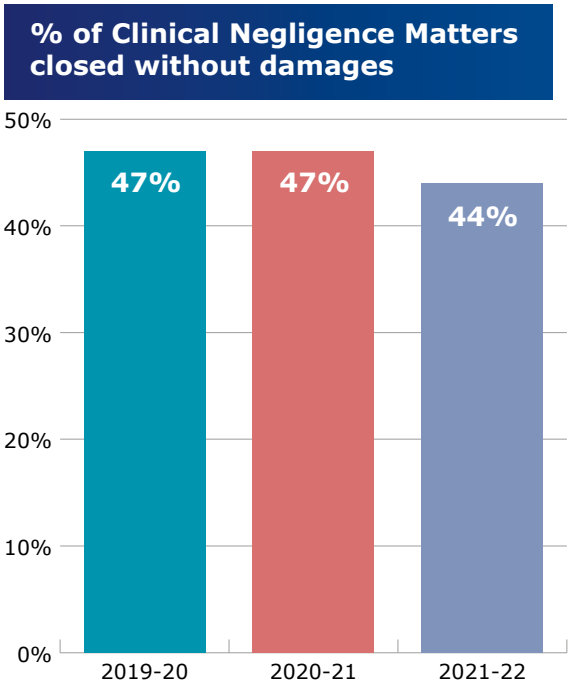


Fig2 Percentage of Clinical Negligence Matters closed without damages paid

NHS Wales undertakes a wide range of clinical procedures and provides care and treatment in a wide array of clinical settings. Claims may arise from any clinical contact and the Welsh Risk Pool monitors the distribution of the principal clinical specialties identified in a claim.

The most frequently occurring specialty relating to clinical negligence claims is maternity services, which includes obstetrics and midwifery-led services. These represent 17.73% of all clinical negligence cases being managed by Legal & Risk Services during 2021/22. The Welsh Risk Pool has invested significantly to work with clinical teams in maternity services across NHS Wales to address the causal factors for claims.

Matters relating to the assessment, treatment and surgery, in orthopaedic and trauma cases represent 13.51% of all clinical negligence cases being managed by Legal & Risk Services during 2021/22. These matters include the wide range of orthopaedic procedures which are conducted by NHS Wales.

Many patients present to emergency departments, specialist assessment units and minor injury services and claims related to these settings represent 11.60% of all clinical negligence matters being managed by Legal & Risk Services during 2021/22.

The list of specialities captured by the Welsh Risk Pool and Legal & Risk systems relate to a bespoke list that was first utilised in approximately 2000. With the introduction of a new electronic Case Management System over the next few years, it is anticipated that the speciality data will be published in future using the national NHS Wales list as far as possible and that this will help organisations to extrapolate and use data from a range of performance and quality management sources.

Fig3 outlines the distribution of the top ten clinical specialties in clinical negligence and Table1 provides a breakdown of all clinical specialities.

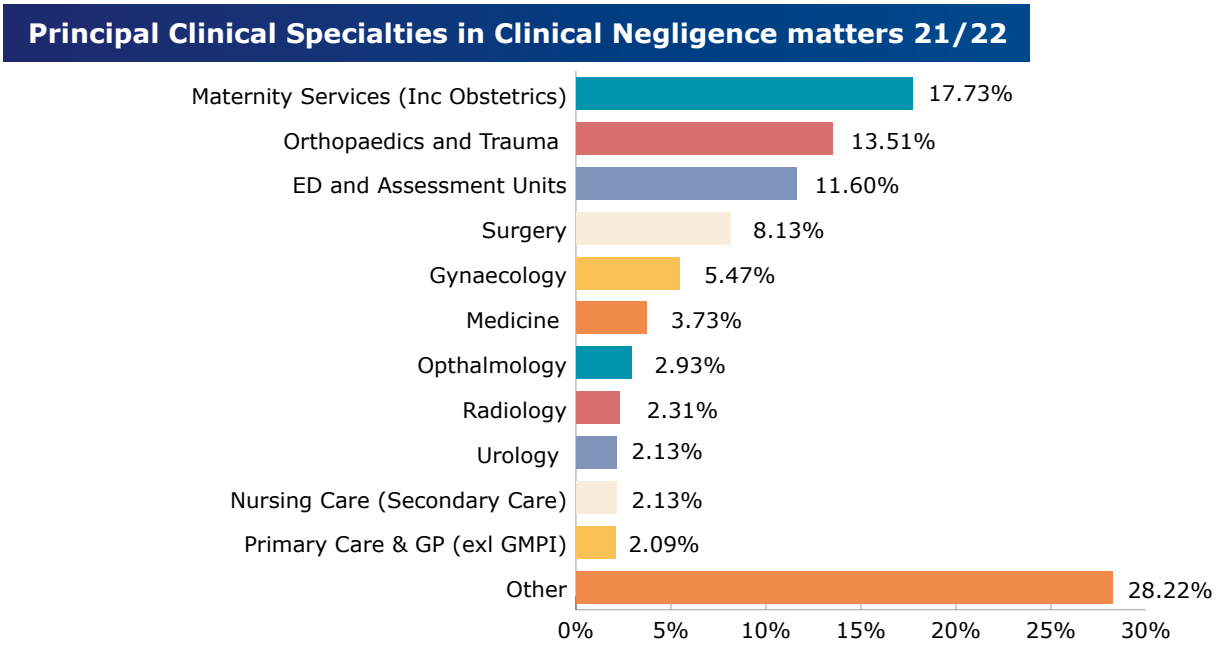


Fig3 Breakdown of Principal Clinical Specialties in Clinical Negligence matters

Principal Specialty in Clinical Negligence matters	%	Principal Specialty in Clinical Negligence matters	%
Admin, Estates & Business Services	*0.13%*	Mental Health & Psychology	*2.31%*
Ambulance / Paramedics	*1.24%*	Nephrology	*0.49%*
Anaesthetics	*0.80%*	Neurology	*1.07%*
Audiology	*0.04%*	Neurosurgery	*1.11%*
Cardiology	*1.42%*	Nursing Care (Secondary Care)	*2.13%*
Cardiothoracic Surgery	*0.36%*	Oncology	*1.42%*
Colorectal Surgery	*0.76%*	Ophthalmology	*2.93%*
Cytology	*0.31%*	Oral & Maxillofacial Surgery	*0.44%*
Dental	*0.49%*	Orthopaedics & Trauma	*13.51%*
Dermatology	*0.53%*	Paediatrics	*2.84%*
District Nursing & Health Visiting	*0.36%*	Pathology, Histology & Microbiology	*0.40%*
Ear Nose & Throat	*1.51%*	Physiotherapy	*0.53%*
Emergency Dept & Assessment Units	*11.60%*	Plastic Surgery	*0.13%*
Gastroenterology	*1.16%*	Podiatry	*0.18%*
Genetics	*0.09%*	Primary Care (excl GMPI)	*2.09%*
Genitourinary Medicine	*0.13%*	Radiology	*2.31%*
Geriatric Medicine	*0.44%*	Respiratory	*0.36%*
GP Out of Hours	*0.36%*	Rheumatology	*0.27%*
Gynaecology	*5.47%*	Speech Therapy	*0.04%*
Haematology	*0.53%*	Surgery	*8.13%*
Maternity Services	*17.73%*	Urology	*2.13%*
Maxillofacial	0.44%	OTHER / UNSPECIFIED	5.51%
Medicine	3.73%		

Table1 Summary of Principal Specialties in Clinical Negligence matters

Personal Injury Cases

In addition to claims for alleged clinical negligence, the Welsh Risk Pool and Legal & Risk Service also deal with matters of public liability, occupier's and employer's liability brought against NHS Wales health bodies. These can be complex matters involving the gathering of evidence relating to operational issues, health & safety compliance and risk assessments.

At the end of 2021/22 there were 470 open personal injury matters against NHS Wales and there is an upward trend in personal injury matters since 2005. There was a peak in new personal injury matters opening in early 2013 caused by the approach of fixed recoverable costs and a change to the law which limited the grounds on which personal injury claims could be brought.

Fig 4 shows the number of open personal injury matters since 2005. We are reliably able to report this far back because historically we have only opened personal injury claims on receipt of a letter of claim.

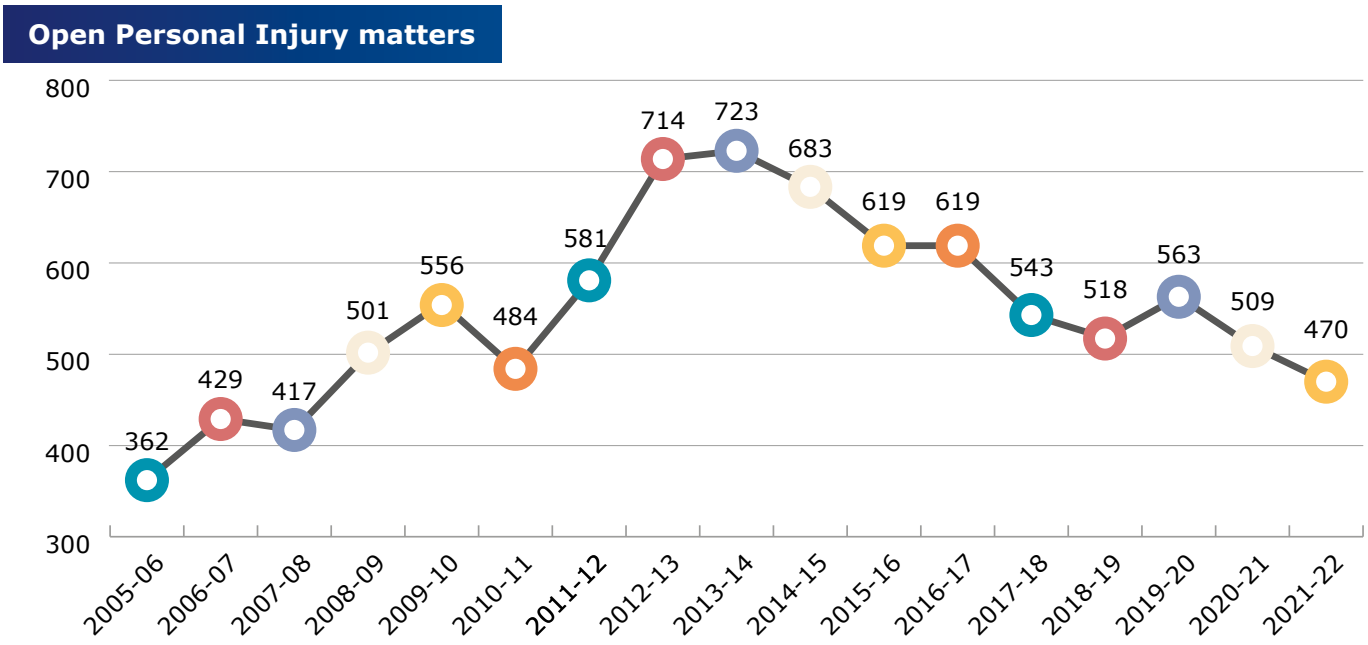


Fig4 Open Personal Injury matters

The Legal & Risk Services team work closely with managers within health bodies to defend cases where this is possible, reducing the burden of legal costs to organisations. NHS Wales has successfully defended over 45% of personal injury cases. Fig 5 shows the continuing positive trend in successfully defended personal injury claims.

EXAMPLE CASE – claim successfully defended at trial

A claim was brought by a former employee of an organisation which provides services to all health bodies in NHS Wales, stating that they had injured their knee due to poor parking and access arrangements at the hospital they were deployed to. The claim was strenuously defended and proceeded to trial in January 2022.

The Judge found that the employing organisation and the hospital had reasonable measures in place, the former employee had received sufficient training and there were suitable arrangements for escalating issues. The claim therefore failed, and no damages were awarded.

Fig 5 shows a gradual increase in successfully defended personal injury claims.

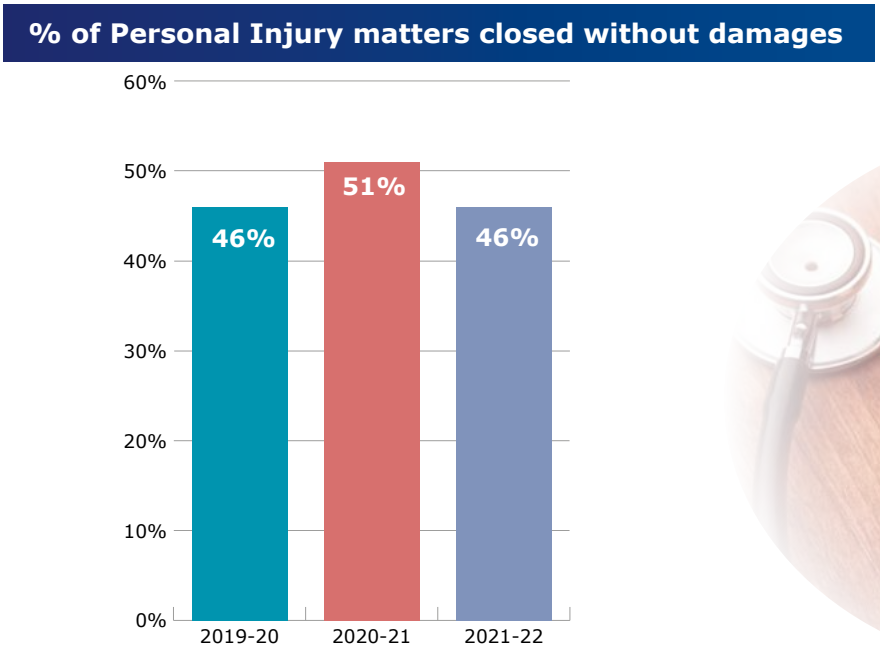


Fig5 Percentage of Personal Injury matters closed without damages

Redress Cases

The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 places duties on health bodies to consider payment of appropriate redress in matters where there is a qualifying liability. The Regulations require health bodies to consider redress in circumstances where harm is alleged and the likely value of any claim would not exceed £25,000 in damages. Dealing with these cases in this way has a significant impact in reducing the legal costs associated with claims brought in the traditional way and provides an effective resolution for those affected and achieves significant savings for the NHS.

Cases that may lead to consideration of redress include incidents reported by staff within organisations and complaints received from service users or their representatives. Health bodies are required to investigate matters and to determine whether there is a qualifying liability.

Since 2018, the Welsh Risk Pool has been allocated responsibility for the scrutiny of learning and reimbursement of expenditure incurred by health bodies in relation to redress cases.

Redress cases are managed locally by specialist teams within health bodies. The Legal & Risk Service has a specialist team which advises and supports organisations in relation to redress matters. Formal reviews by the Legal & Risk team are required in all cases where a proposed damages payment exceeds £25k, where payments to the UK Government Compensation Recovery Unit exceeds £3k and in all cases where qualifying liability is considered to have been met in a matter relating to the coronavirus pandemic.

From 2019, health bodies have been required to provide information on their current caseloads to assist with planning and budgeting. This provides an insight into the progress of matters across NHS Wales.

In 2021/22, a total of 924 redress cases were being managed by health bodies in NHS Wales. This represents a 6% reduction in the overall caseload and follows a small reduction in 2020/21.

The reduction that has been seen can be attributed to a reduction in incident and complaint investigations during the pandemic and it is expected that 2022/23 will see a sharp increase in the caseload.

Fig6 outlines the redress caseload over the last three years.

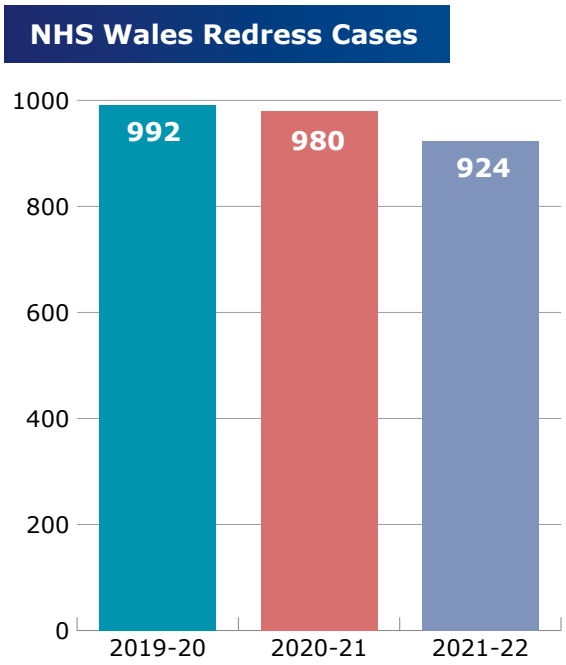


Fig6 Redress Cases for last 3 years

Considering the clinical speciality to which a redress case relates is a useful indicator of themes and trends.

Traditionally, each health body has considered redress cases in relation to its own list of specialties which do not align to provide a national picture. With all organisations now utilising the Once for Wales Concerns Management System to capture and manage redress cases, it is anticipated that a national picture will be available from 2022/23.

From case analysis, the most commonly occurring specialities within redress cases are Emergency Department, Orthopaedics, and General Surgery.

Periodical Payment Orders

In the vast majority of personal injury and clinical negligence matters, settlement as damages is made in the form of an immediate payment of a lump sum directly to the claimant.

In matters in which the court is making an award relating to future pecuniary loss, it may order that the damages take the form, whether wholly or partly, of periodical payments. The Damages Act 1996 empowers the court in personal injury & clinical negligence proceedings to make a periodical payments order, a lump sum award or a combination of the two.

Periodical Payment Orders are generally seen in cases where a payment is needed to provide care and support for a claimant over a sustained period of time.

The payments are index-linked, rising by an agreed inflation measure each year to ensure that the claimant receives an appropriate sum to meet their needs.

The Welsh Risk Pool administers all Periodical Payment Orders for NHS Wales health bodies. At the end of 2021/22, there were a total of 141 active Periodical Payment Orders (PPOs). Seven PPO arrangements have been agreed in cases which settled recently, but which the payment has not yet started. PPO payments made in 2021/22 totalled £16.644m.

With the growth in inflation and increasing numbers of active PPOs, the value of PPOs have increased by £5,775m in the last five years. This represents a 53% increase in payment costs with a 27% increase in active cases from 111 in 2017/18. This is outlined in Fig7.

Periodical Payments over last five years

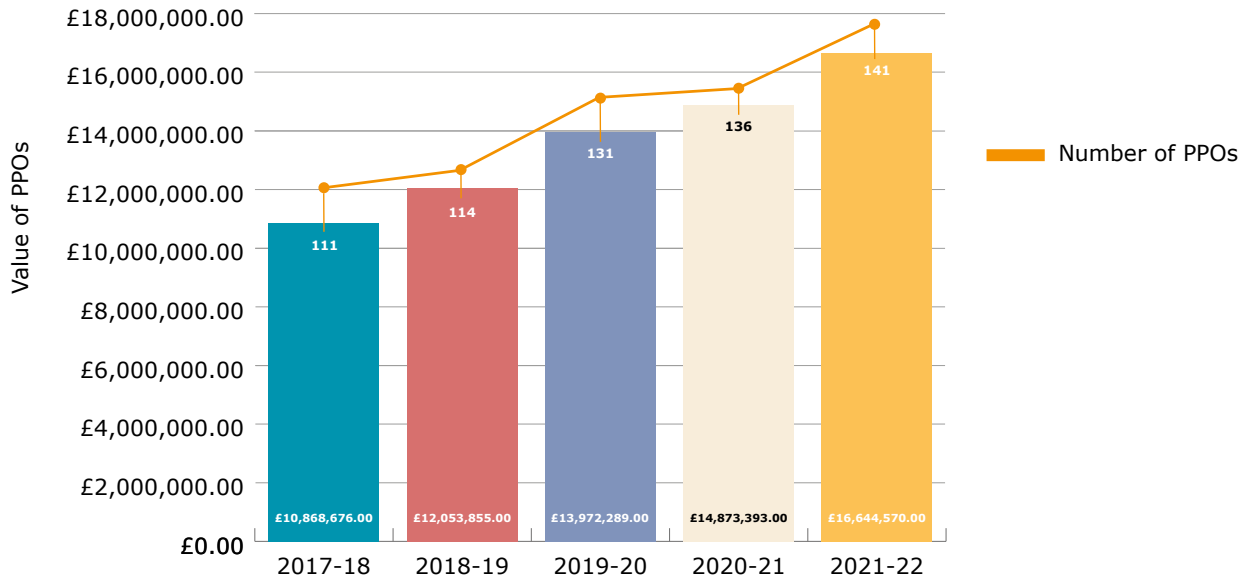


Fig7 Value & Number of PPOs over last five years

Legacy matters from Former Health Authorities

The Welsh Risk Pool manages claims brought against former Health Authorities in NHS Wales. These legacy organisations were replaced with a number of NHS Trusts across Wales between 1993 and 1996 and these new organisations did not inherit the liabilities of the predecessor organisations. Where a claim arises, these matters are managed by the Welsh Risk Pool and are conducted on behalf of Welsh Government, in the name of Powys Teaching Health Board through a Service Level Agreement.

As time progresses, the number of open matters continues to steadily decline. Whilst legal limitation may prevent a number of claims being brought successfully, some areas of claim cannot rely on limitation.

The most common claim now being brought against former Health Authorities relates to alleged exposure to asbestos between the 1960's and 1980's leading to a diagnosis of mesothelioma. These claims can be very challenging to investigate and personnel and potential evidence may simply not exist.

At the end of the 2021/22 period there were 25 open matters involving claims against former Health Authorities. Fig8 provides a breakdown of the number and types of these matters.

Former Health Authority Matters 2021/22

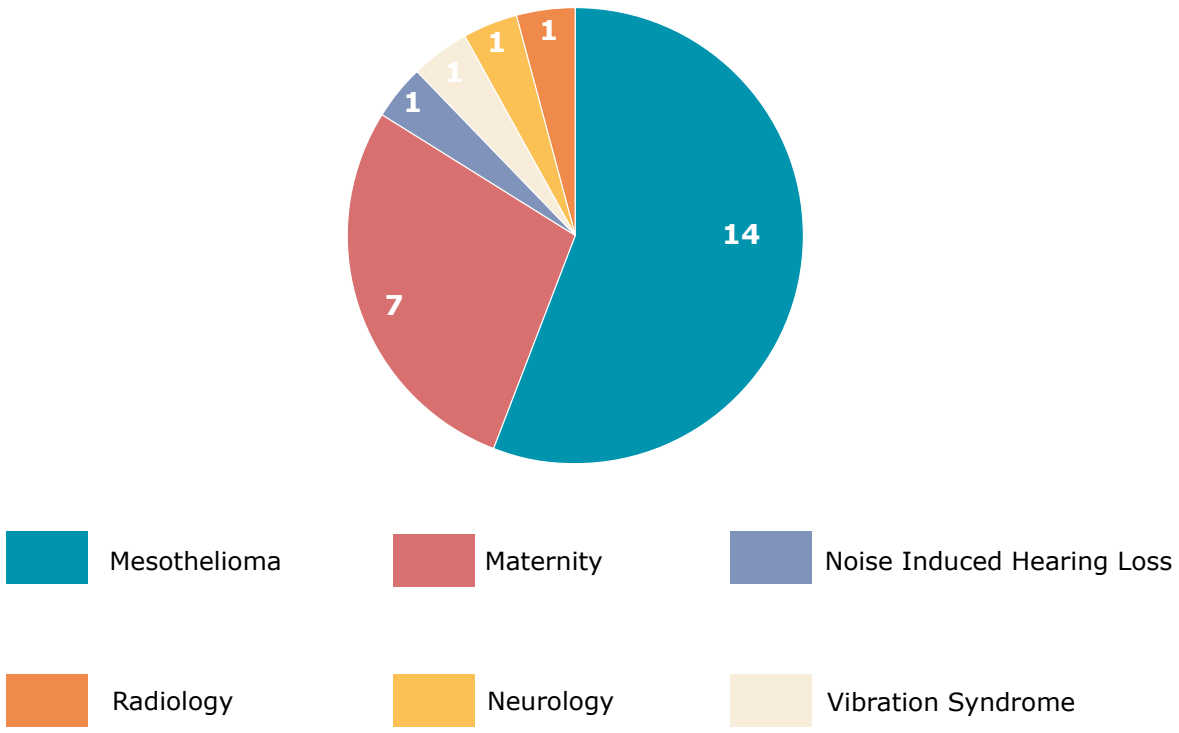


Fig8 Current Former Health Authority Matters 2021/22

Financial Planning & Performance

The Welsh Risk Pool receives two funding streams:

- Departmental Expenditure Limit (DEL) is used to meet the in-year costs associated with settled claims & redress cases. The DEL is funded by a core allocation provided by Welsh Government that is sourced from the annual healthcare budget. This is augmented with additional expenditure provided by Welsh Government and a risk sharing agreement that involves contributions from each health body using a formula depending on the size, claims experience and risk management standards of an organisation.

- Annually Managed Expenditure (AME) to meet the cost of accounting for the long term liabilities of claims.

The NHS Shared Services Partnership Corporate Finance Team, led by Director of Finance & Corporate Services Andy Butler, provides oversight and guidance on the management of the Welsh Risk Pool Budget.

Analysis of the current budget and use of financial forecasting tools enables the Welsh Risk Pool to confidently plan for settlement of case in-year and prepare for the likely financial requirements in the ensuing years.

2021/22 Budget Position

The Welsh Government core allocation for the year in 2021/22 was £107m for clinical negligence and personal injury claims and a £1.259m allocation for redress cases. Additional funding was provided by Welsh Government to support case progression. The funding is further supported by the risk sharing agreement which makes up the remainder.

The DEL funding for 2021/22 is outlined in Table2.

WRP DEL funding 2021/22	£m
Welsh Government Core	*107.000*
NHS Wales Risk Sharing Agreement	*16.495*
Welsh Government Additional Funding	*4.861*
Welsh Government Redress	*1.259*
Total Funding	**129.615**

Table2 WRP DEL funding 2021/22

The redress outturn for 2021/22 was £1.679 compared to the Welsh Government core allocation for this sector of £1.259m. Overspending on redress cases is recognised to have a beneficial effect on reducing the number of claims which are brought. The £420k overspend on redress was charged to the overall DEL expenditure and funded via the additional funding streams in-year.

The value of £16.495m risk sharing agreement contribution had been notified to health bodies during the budget planning phase and remained unchanged during funding reviews of the year. This enables health bodies to plan more confidently for their available expenditure.

Expenditure on DEL is a useful indicator to identify the current position and can be tracked to previous years. The expenditure within the DEL budget for 2021/22 compared with 2020/21 can be further analysed as shown in Table3.

WRP DEL Expenditure	2020/21 £m	2021/22 £m
Claims reimbursed & WRP Managed Expenditure	72.255	99.922
Redress Reimbursements	1.479	1.909
Periodical Payments	14.873	16.644
Safety & Learning Programmes	0.22	0.288
Clinical Negligence Team Funding	0.205	0.55
Movement on Claims Creditor	34.806	10.302
2021/22 expenditure	**123.838**	**129.615**

Table3 WRP DEL expenditure 2021/22

The creditor movement is an indicator that shows payments that have been made by health bodies which are not yet subject to reimbursement by the Welsh Risk Pool. The creditor movement has increased since the beginning of the financial year. This increase is partly related to the timing of settlements, a number of which were heavily profiled to the latter part of 2021/22.

Health bodies have therefore not had an opportunity to complete the learning review process and submit returns in order to receive reimbursements for these cases. Cases where approval of the learning plans have been deferred by the Welsh Risk Pool also account for an increase in the creditor movement.

Looking Forward – the Forecast

When considering the funds needed for future years, the Welsh Risk Pool and Legal & Risk Services categorise all claims and matters by allocating a rating depending on the likelihood of the case settling. The categories include, Remote, Possible, Probable and Certain and these are outlined in Table4.

Assessment of probability of settlement	
0% - 5%	Remote
6% - 49%	Possible
50% - 94%	Probable
95% - 100%	Certain

Table4 Breakdown of probably of settlement

For budget planning purposes, Probable and Certain cases are included in the forecast. The core DEL funding for the Welsh Risk Pool for 2022/23 is £109.435m which is a result of the pooling of the claims and redress allocations and an uplift of £1m for redress cases.

Planning and forecasting for the Welsh Risk Pool is included in the NHS Wales Shared Services Partnership Integrated Medium Term Plan (IMTP).

The current forecast for 2022/23 shows a resource requirement of £134.780m and the shortfall will be achieved through the application of the risk sharing agreement. Table5 provides a breakdown of the DEL forecast for the next three years.

3 Year Forecast	2022/23 £134.780M	2023/24 £136.138M	2024/25 £137.505M
Core WG Allocation	£109.435M	£109.435M	£109.435M
Risk Sharing Agreement 2022/23 to 2024/25 (Core Claims Growth)	£25.345M	£26.703M	£28.070M
Total DEL Forecast	***£134.780M***	***£136.138M***	***£137.505M***

Table5 Breakdown of DEL forecast for next three years

In 2021/22, the provisions have risen to £1.429bn which is an increase of £296.254m when compared to 2020/21. The provisions in 2020/21 experience a small decrease of £960k when compared to 2019/20 and this can be attributed to the impact of the first phase of the coronavirus pandemic. A profile of the provisions over the last three years is shown in Fig9 and a breakdown of the provisions is shown at Table6.

It is important to note that the significant increase in provision values does not relate to increased case numbers. The increase is primarily caused by the application of financial adjustments for inflation and the discounting of liabilities to net present value.

Provisions for future claims over the last 3 years

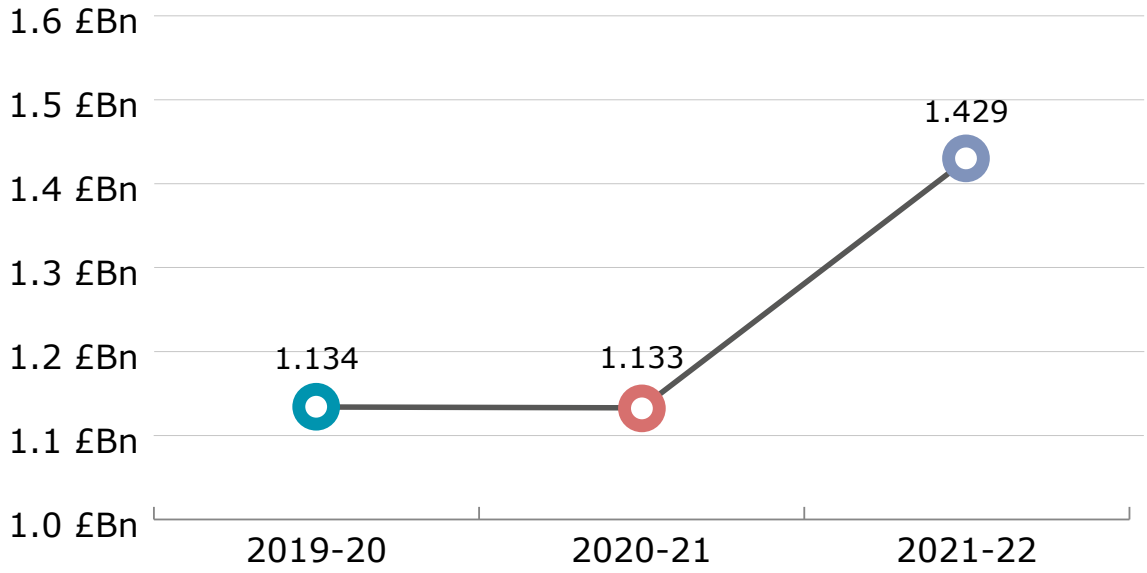


Fig9 WRP Provisions for last three years

Welsh Risk Pool Provisions	2019/20 £Bn	2020/21 £Bn	2021/22 £Bn
Probable & Certain Clinical Negligence Cases	0.676	0.646	0.781
Probable & Certain Personal Injury Cases	0.005	0.008	0.004
Probable & Certain Redress Cases	0.003	0.003	0.002
Defence Legal Fees and Others	0.009	0.009	0.009
Periodical Payment Orders	0.441	0.468	0.632
Total Provisions	**1.134**	**1.133**	**1.429**

Table6 Breakdown of WRP provisions

Risk Sharing Agreement

To support the in-year resource requirements, the Welsh Risk Pool requires contributions from its member health bodies to supplement the core allocation provided by Welsh Government.

The Risk Sharing Agreement provides a formulaic approach to calculating the required contributions and considers the size, claims experience and effectiveness of learning for each organisation.

Each of the five measures are outlined in Table7.

	Measure	Detail	Weighting
A	**HSCS and Prescribing Allocation**	Current measure	**30%**
B	**Claims History**	Last 3 years – rolling basis	**20%**
C	**New Claims transferred from the Service to LARS:** Number of New Cases < £25k	Last 12 months	**10%**
D	**Claims potentially affecting next years' spend:** 1. Cases with cash flows < 1 yr 2. PPO Allocation Utilisation	From CN database: 15% Actual Costs: 10%	**25%**
E	**Management of Concerns and Learning from Events** 1. Management of Concerns 2. Learning from Events	Annual WRP Inspections: 7.5% 7.5%	**15%**

Table7 Risk Sharing Agreement Measures

The first measure relates to the Health & Social Care Services Allocation (HSCS) and Prescribing Allocation allocated to an organisation by Welsh Government. This is major indicator of the size and complexity of an organisation.

The claims history considers the last three years and is calculated from the records of cases submitted for reimbursement and includes claims settled.

Measure C, cases under £25k, considers matters which could have been resolved through the redress case management system. The data for this is drawn from the Legal & Risk matter database.

The risk sharing calculation then considers claims that are likely to affect the next year's expenditure, considering each organisations profile of claims with cash flows, where payments are expected, within the next twelve months. This measure also considers the utilisation of PPOs which is taken from the forecast projections.

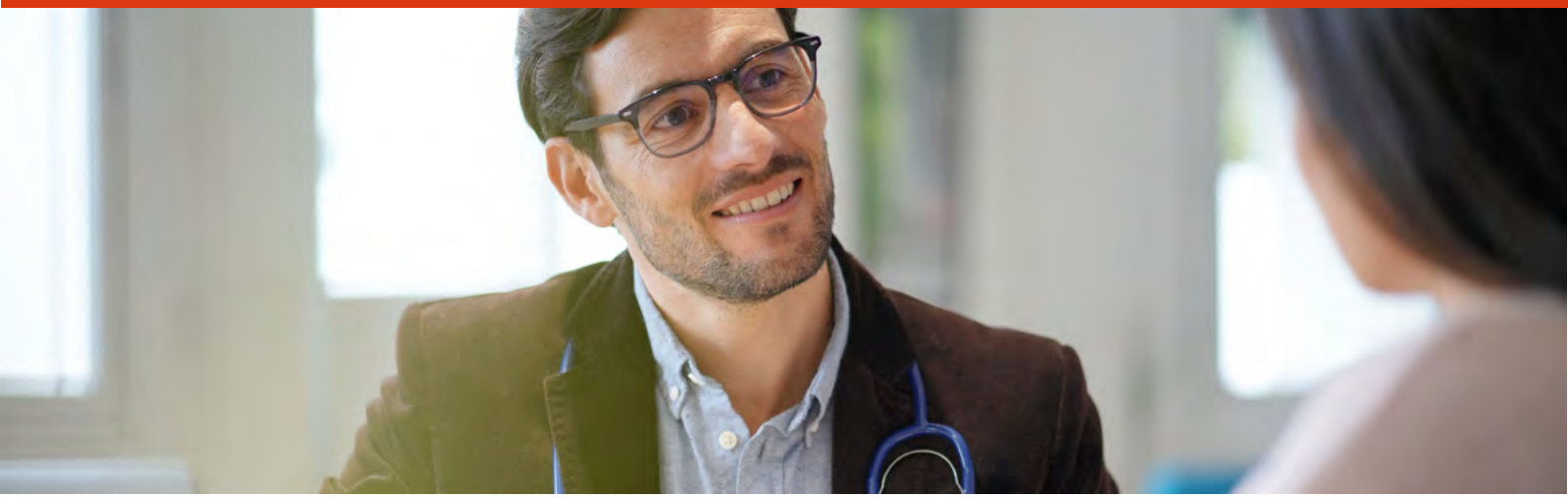
The final, and arguably most influential, measure is the Management of Concerns and Learning from Events. Each year the Welsh Risk Pool undertakes inspections of the processes and arrangements in each health body. The Welsh Risk Pool considers whether health bodies have complied with the WRP Reimbursement Procedures, the Once for Wales Concerns Management System and the guidance for the Putting Things Right legislation. The inspection programme was paused due to the pandemic and will recommence in the autumn of 2022/23.

Each organisation receives an individual contribution value which is a percentage of the total contributions required.

The Risk Sharing Agreement

- Weights the various measure in order to provide a balanced and equitable system
- Is transparent and auditable in its application
- Provides reward for organisations who are managing the Putting Things Right requirements effectively
- Is updated every year to reflect recent activity and progress
- Does not rely heavily on past events – providing emphasis on activity and behaviours of the last year.

General Medical Practice Indemnity



Scheme for GMPI

Legal & Risk Services are appointed by Welsh Government to operate the Scheme for General Medical Practice Indemnity ('GMPI'), launched on 1 April 2019.

GMPI provides clinical negligence indemnity for providers of GP services in Wales for compensation arising from the care, diagnosis and treatment of a patient following incidents which happen on or after 1 April 2019.

The GMPI team aim to resolve any claim for compensation brought by a patient in relation to their clinical care under the NHS as fairly and as quickly as possible. Equally, the team recognises the importance of robustly defending claims where appropriate and of protecting GPs, their staff and their reputations.

Full details of the Scheme and Guidance and FAQs can be found on Legal & Risk's website.

The GMPI Team

Legal & Risk has a dedicated Primary Care Clinical Negligence Team (the GMPI Team) that operates the Scheme for GMPI. The lawyers specialise in managing clinical negligence claims against GPs and GP Practice staff across Wales and work closely with NWSSP's in-house GP advisors.

Since the GMPI team formed in April 2019, the team has been recognised for its work and has been shortlisted as finalists in 3 external legal awards:

- The Law Society Awards 2021, shortlisted in the 'In-House Team of the Year' category.
- South Wales Law Awards 2021, Finalist in the 'Personal Injury (clinical negligence)' category.
- Wales Legal Awards 2020, Finalist in the 'In-House Team of the Year' category.

Operation of GMPI

The GMPI team currently:

- operates an email and telephone helpline used by GP Practice staff and Health Boards across Wales seeking information about indemnity arrangements and support with clinical negligence complaints/ claims. There were over 4000 communications between 1 April 2019 to 31 March 2022.

- helps GP Practices to respond to patients' clinical concerns by providing guidance and support. The team seeks input from NWSSP's in-house GP medical advisors and feeds back to GP Practices any suggested learning. The team assisted GP Practices with approx. 360 patient concerns in the first 3 years of the Scheme (1 April 2019 – 31 March 2022). The guidance given by the team reflects NHS Wales Putting Things Right (PTR) concerns procedure.

- provides All-Wales training and bespoke virtual training to Health Boards and GPs/Practices/Trainee GPs across Wales. including 19 workshops and information sessions on the new scheme which were provided face to face to Health Boards and GP Practices across Wales prior to the Covid-19 pandemic. Other training topics have included tips for GP referrals during COVID-19, effective handling of patient concerns, the clinical negligence Legal Test, Case Studies, Confidentiality and Learning from Events in General Medical Practice. Training is mostly delivered virtually now.

- contributes articles to the Legal & Risk Newsletter sent to Health Boards and GP Practices.

- meets regularly with other NWSSP divisions (including for example NWSSP Primary Care Services, NWSSP Employment Services and the Welsh Risk Pool) and is a member of NWSSP's Primary Care Steering Group which has been set up to support sustainable primary care and to contribute to the development and delivery of the primary care model in Wales.

Through the support highlighted above, early input by the GMPI Team with patient concerns assists practices with resolving complaints at an early stage and help avoid clinical negligence claims where possible. However, it is recognised that some claims will, inevitably, be pursued, where for example, a Practice has made concessions, or the claimant feels aggrieved and pursues the matter regardless of the merits of the case. At 31st March 2022, 3 years after the introduction of the scheme, there have been only 2 patient concern matters, with which the GMPI team had assisted, that have developed into formal clinical negligence claims.

The GMPI claims are increasing, and good results have been achieved to date with GP Practices reporting back that they were "Very Satisfied" with the overall management of the case and provision of advice.

In 2021-22, the GMPI Team led the successful defence of a claim at Trial.

GMPI claim successfully defended at trial

The claim was brought against a GP Practice by a Litigant in Person who served court proceedings without notice. The amount of damages sought by the claimant was low, but it was important to defend the claim, to support the GP Practice staff who firmly disputed liability and to discourage similar unmeritorious claims.

This was an example of the GP Practice, the Health Board and GMPI Team working together to manage a sensitive and difficult claim brought against a particular GP Practice.

Learning from Events

The GMPI Team has worked with Welsh Risk Pool and NWSSP's in-house GP advisors to develop and implement a tailored process for learning from events in primary care GP matters – including shared learning between primary and secondary care on an All-Wales basis. Part of the procedure requires GP practices to commit to undertake any improvements identified and the Health Boards to monitor and verify the identified improvements, which helps to promote closer links and collaboration between primary care and secondary care and helps to improve patient safety.

The GMPI Team co-ordinates the robust learning from events process in General Medical Practice. It is hoped that this additional support service around learning from events will help to reduce incidents and prevent claims arising against Practices and Health Boards.

Existing Liabilities Scheme

In addition, Legal & Risk Services has been appointed by Welsh Government to operate the Existing Liabilities Scheme ('ELS') for eligible clinical negligence claims made against GPs and others working in a general practice setting as a result of an act or omission occurring prior to 1 April 2019.

ELS is only available where the medical defence organisation (which previously would have provided the indemnity) has completed an agreement to transfer these liabilities into the Scheme. To date, only two defence organisations have completed such an agreement. All eligible claims held by these defence organisations have been transferred into the Scheme and are being handled within the dedicated GMPI team.

Supporting Safety, Learning & Improvement

Safety & Learning Networks

The Welsh Risk Pool supports health bodies across NHS Wales to learn together and share experience and good practice through the Safety & Learning networks. These provide a forum for practitioners in patient safety, concerns management and service user feedback to improve practice across NHS Wales.

Safety & Learning Networks provide a forum for discussion and to achieve consensus and consistency across NHS Wales. The work of the networks is commissioned by the Welsh Risk Pool Committee. The work of the networks also report to the Listening & Learning from Feedback Group which is an all-Wales group coordinated by Welsh Government.

The principal aim of the networks is to provide an opportunity for NHS Wales staff to meet, share & learn. A core objective of the networks includes achieving consistency across NHS Wales. This provides opportunity for other national groups to request that a network considers a particular topic or area of concern.

There are a number of Safety & Learning Networks:

- Claims Management
- Complaints Handling
- Inquest Case Management
- NHS Wales Ombudsman Liaison Officers
- Redress Case Management
- Service User Feedback

In addition to the Safety & Learning Networks, the Welsh Risk Pool also facilitates the Head of Patient Experience Network, which is a membership group for senior managers within the Putting Things Right sector to meet, share and learn.

Facilitated by senior members of the Welsh Risk Pool team, networks are chaired by practitioners within the sector, operating on the principle of 'for the service, by the service'.

The Networks follow some core principles:

- **Topic Focus** to ensure all topics are given space to be discussed.
- **Practitioner Focus** attended and chaired by practitioners within the topic area.
- **Outcome Focus** enable practitioners in the field to consider service design and improvement through practical discussions on concepts for change and reaching a consensus of direction.
- **Space for consensus development** providing an environment for considered and worthwhile discussion; there are also opportunities for partner organisations, regulatory bodies and other interested parties to be invited to meetings in order that options can be explored.

During the pandemic, meetings transitioned to a virtual platform and are now routinely held using Microsoft Teams. This maximises the attendance and participation of members. Occasional meetings will be held in-person when this is considered to be necessary and beneficial to the items being discussed, but the majority of network meetings will remain on a virtual platform.

Network meetings are popular with members and attendance levels are excellent. The Welsh Risk Pool leadership team regularly receive compliments and thanks for providing the network process.

> "During the pandemic, having the networks available via Teams was an essential way for me to keep in touch with colleagues who were experiencing the same challenges as I was identifying. The meetings are really valuable."
>
> ***Claims Manager, NHS Wales***

> "The network has made a real difference in reaching a common way of working across NHS Wales. I have been able to shape our policy following discussion at the network."
>
> ***Redress Officer, NHS Wales***

During 2021/22, a total of thirty network meetings were held. During 2022, a meeting of all of the Network Chairs was held, led by the Chair of the Listening & Learning from Feedback Group.

This reflected on how the networks have matured:

- People are clear on the objectives of the networks and have identified the benefits of attending meetings
- The allocation of a dedicated facilitator has been incredibly effective in strengthening the maturing network system and promoting cross-working.
- The use of Share Point for document and information distribution has been a success.
- Task & Finish groups for specific topics have been extremely successful, and the networks are at a level of maturity where this can continue to happen.
- Positive feedback has been received from NHS Wales colleagues who attend other networks.

Learning from Events

The Welsh Risk Pool plays a key role in assuring learning action plans which are implemented from events arising from claims and redress cases. Additionally, sharing the learning across NHS Wales is a key aim of the Learning from Events programme.

A clinically led and multi-professional Learning and Advisory Panel (LAP) has been established as a recognised subcommittee of the Welsh Risk Pool. Chaired by established leaders from the Putting Things Right sector, the panel meets monthly to scrutinise the learning which has been implemented by organisations from cases where a decision to settle has been made. Each panel reviews around eighty cases.

The panel's recommendations are presented to the Welsh Risk Pool Committee. Where improvement in learning or action plans are needed, deferral of reimbursement of the costs of a claim is directed.

Where improvements in learning or action plans are not considered to be significant, decisions on recommending approval of learning and reimbursement of the costs in a case are delegated to a focussed panel – known as the amber review panel. This examines the feedback provided to a health body and confirms assurance that necessary steps have been taken.

For cases where the expenditure exceeds £1m, Medical Officers from Welsh Government attend the panel meetings and support the scrutiny of learning.

A quarterly newsletter, Doctrina, which targets themes, trends and identified cases of interest, is shared widely and well received by clinical leaders. The panel has identified that commonly occurring themes show that around a third of cases are in relation to missed or delayed diagnosis and this has been shared via the newsletter.

During 2021, the Welsh Risk Pool has worked closely with the NHS Wales Delivery Unit to migrate the Learning from Events for Nationally Reportable Incidents onto a single LFER form. This captures the essential information required by both organisations and ensures that local clinical teams have only one design and layout of the form to be familiar with.

During the 2021/22 period, the panel met monthly, with additional panels held if the caseload required it. A total of eighteen panels were held and over 1700 cases were scrutinised. The panel achieved effective multi-disciplinary attendance from various professions and specialities across NHS Wales.

> "The panel was a fascinating insight into the issues which led to claims. The meeting offered me an opportunity to review information from other organisations which I have been able to adopt in my own practice. I recommend that every junior doctor should attend a panel at least once during their training."
>
> ***Junior Doctor, NHS Wales***

> The panel is not just looking at paperwork, it carefully considers the circumstances which have led to a claim or redress case being brought against a health body and what actions have been taken to reduce the risk of a repeat incident. The input from clinical staff is vital to ensure that the panel is familiar with the operational context in which services are delivered.
>
> ***Panel Chair***

To enable organisations to focus on the response to the pandemic, the established deadlines for submission of Learning from Events Reports were relaxed in March 2020. Following careful analysis by the Welsh Risk Pool Committee, these have been reinstated. The deadline of 60 working days from a decision to settle a case to the submission of learning information is a key driver in ensuring prompt action is implemented to reduce the chances of a repeat event.

Clinical Reviews

The Welsh Risk Pool Committee commissions clinical reviews of topics or sectors when themes and trends are identified in cases. The reviews generally examine systems and processes which underpin the procedure or process being considered.

During 2021/22, the number of clinical reviews was reduced from the usual level due to the challenges arising from the pandemic. Three reviews were undertaken.

Venous Thromboembolism (VTE)

The review was commissioned in 2021, when the Learning Advisory Panel identified increased numbers of redress and clinical negligence cases relating to VTE.

Patients who are hospitalised and acutely unwell are widely recognised to be at a higher risk of developing a VTE than people in the general population. Given the increased numbers of hospital admissions of acutely unwell patients with Covid-19, there was concern that the number of cases presenting to the LAP would increase significantly. In the most recently available data, the Office of National Statistics shows that 369 people died in Wales, in 2020, from VTE related illness.

The review consisted of the analysis of patient records for patients admitted to hospital under medical specialty or selected surgical specialties. Criteria for the review were developed following discussion with members of the All-Wales Hospital Acquired Thrombosis (HAT) Committee. These were formulated to assess application of the current All-Wales Thromboprophylaxis Policy standards and to identify whether the patient had received a documented VTE risk assessment on admission, whether the VTE section of the Adult In-Patient Medication Administration Record had been correctly completed and whether thromboprophylaxis had been administered as prescribed.

The review found that compliance with correct completion of the Record for patients where thromboprophylaxis had been prescribed was excellent across all NHS Wales health bodies. However, in cases where thromboprophylaxis had not been prescribed, compliance with correct completion of the Record was poor.

Draft reports with recommendations and a proposed all-Wales WRP Standard for VTE have been circulated to health bodies. Development of a bespoke e-learning programme for VTE is almost complete and all health bodies have committed to implementing the all-Wales Thromboprophylaxis Policy. The Welsh Risk Pool Safety & Learning Team will actively support the HAT committee going forward.

The review will complete its work during 2022/23 and a re-inspection will be commissioned in the future by the Welsh Risk Pool Committee to assess progress.

Radiology (unexpected findings)

This review was a re-examination of the findings of a review we undertook in 2018. The review is triggered due to the sustained level of cases where a key finding is the failure of an organisation to act on findings of a radiological examination.

Analysis of the claims and redress cases related to this issue has identified that a radiologist or reporting radiographer may identify, and record, unexpected abnormal findings in their report but that the necessary clinical steps are not taken in response. This can lead to delays or missed opportunities for diagnosis and intervention and can result in significant harm for some patients. The review found this to occur more frequently in emergency department settings where staff who request radiological reports may not be on duty when the report is received, with the patient often already discharged.

Following the review in 2018, health bodies established working practices to address our findings and to try to reduce the potential for a case being missed.

Our analysis during 2021 identified that the issue continues to arise in claims and the established working practices in response to our recommendations are commonly manual tasks which are recognised to be at risk of error.

To help drive progress towards a digital solution, the NWSSP Medical Director has coordinated a task & finish group of radiology, emergency department and digital colleagues to explore opportunities within existing software that can be exploited to help reduce this risk.

Progress with this review will be reconsidered by the Welsh Risk Pool Committee in 2023/24.

Intrapartum Fetal Surveillance

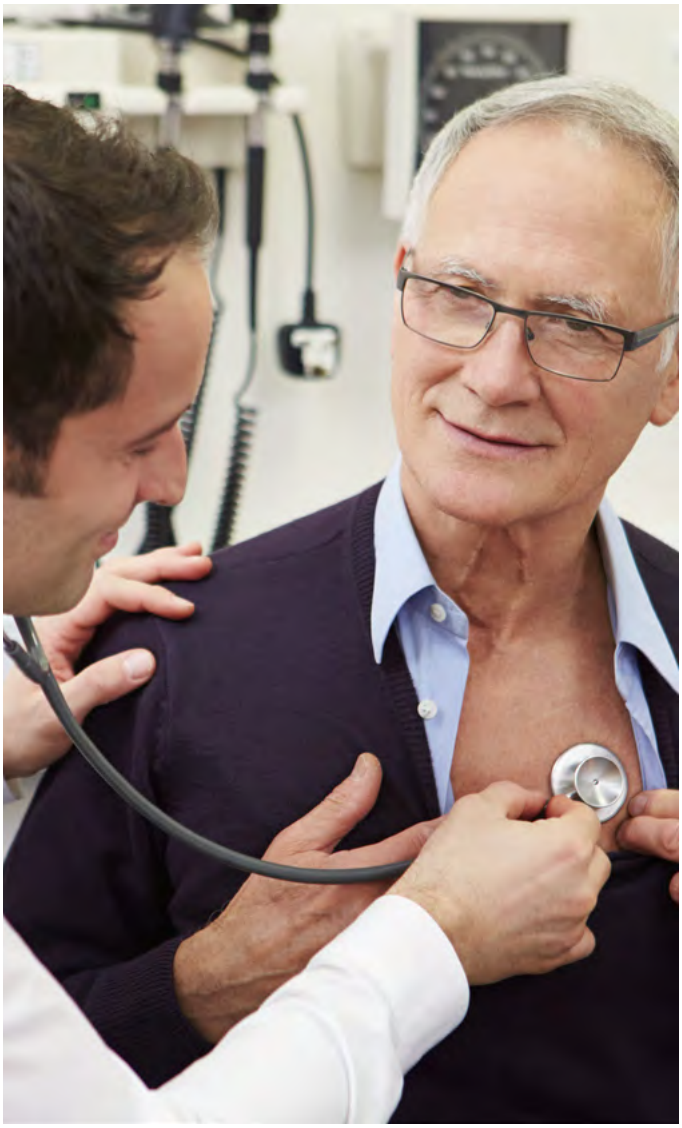
Claim information highlights that allegations associated with failures in intrapartum fetal surveillance continue to be at an unacceptable level. One third of the 131 maternity claims, which were settled in the five year period between 2016 and 2020, featured intrapartum fetal surveillance as a contributory factor. Poor documentation, failure to escalate concerns and delay in acting were the significant factors involved in these cases. This amounted to over £86m in clinical negligence reimbursement.

The WRP commissioned the Safety & Learning Team to undertake a review of the application of the Intrapartum Fetal Surveillance Standards (2018) across NHS Wales. A preliminary review was undertaken in 2019. A national collaboration meeting was held in early 2019. The completion of the full review, which involves fieldwork throughout NHS Wales, has been delayed by the impact of the pandemic. The full review has now been completed and the findings are presented in a national report.

The review included fieldwork reviewing clinical notes of births between defined dates. The review also involved a survey of clinicians throughout NHS Wales in relation to documentation related to intrapartum fetal monitoring.

The review has identified areas of good practice and a number of areas where improvement can be implemented to reduce the risk of harm for women and babies. The main finding for improvement is that the quality and consistency of documentation related to fetal surveillance is limited and the risk of litigation remains unacceptable - the need is identified for a standardised approach which captures the documentation requirements in the standards.

A total of nine recommendations were made for the maternity services sector to collaborate on improvement. These will form a work plan for the WRP Safety & Learning Team during 2022/23.



Consent to Examination & Treatment

Litigation associated with issues related to the consent process continue to represent a regular feature in claims experienced in NHS Wales. To support organisations in providing information to patients, the Welsh Risk Pool has funded the provision of consent information for over ten years.

An improvement programme has been established to coordinate work in this area. During 2021/22, the programme has undertaken a series of work streams.

Library of Consent Information Leaflets

In July 2020, an alert was issued to ensure a more consistent national approach to procedure-specific patient information leaflets. It requires organisations to ensure that either EIDO procedure-specific patient information leaflets, where available, or procedure-specific patient information leaflets produced by recognised professional bodies or other national bodies, are provided to patients.

The library of leaflets has progressed through an all-Wales competitive tender, which was awarded to EIDO Healthcare. Evaluation of the tender responses was supported by a small cohort of clinicians and leaders from health bodies.

The programme team have continued to work with EIDO Healthcare to promote the availability of the Download Library across all health bodies. The team have also coordinated the facility for NHS Wales clinicians to provide feedback on current leaflets or request the development of new leaflets that are not currently available. This has led to the development and publication of a range of new leaflets.

Provision of consent information through the medium of Welsh is an important aspect of the programme. A structured piece of work has been coordinated by the NWSSP Welsh Language Services team to ensure that the standard of Welsh translation for every EIDO leaflet is reviewed and adjustments made where necessary to ensure that the translation meets the highest possible standards. Leaflets are presented in a bilingual format with Welsh and English versions side by side. A quality assurance function has been established, led by the NWSSP Welsh Language Services team, to monitor the translation of updated and new leaflets.

There has also been focussed engagement with Public Health Wales and the Welsh Blood Service, who develop national procedure-specific leaflets, to ensure these are available as a central resource through links on the Download library.

A further development in the materials available include access to Easy Read leaflets, in a bilingual format. These are leaflets aimed at providing key consent information to service users who may have additional needs or a learning difficulty.

Learning & Development in Consent

The programme team coordinated a national Webinar for clinicians in conjunction with EIDO on the question of

"How Can Technology Support the Consent Process During the Covid-19 Pandemic?"

Over 80 attendees joined the webinar; it was also recorded and made available as a resource via the NWSSP YouTube channel for those unable to attend.

Following a competitive tender exercise, the development of a bespoke e-learning package for NHS Wales healthcare professionals involved in the consent process has been implemented. This has included on-line video segments of key NHS Wales and Welsh Government leaders.

The SoundDoctor™ package is available via ESR and Learning@Wales for all NHS Wales staff.

Resources & Information

Webpages have been developed on both the internet and NWSSP intranet to provide an information resource on Consent to Examination & Treatment for both NHS employees and the public. This information includes links to the All Wales Model Policy and consent forms, e-learning and other useful documents or guidance (including legal and ethical resources during the Covid-19 pandemic).

All Wales Consent Group

The improvement programme is underpinned by the All Wales Consent to Examination and Treatment Group, which has representation from all health bodies. This national group has been established to:

- Coordinate and gain consensus amongst clinicians / Health Boards / Trusts about the Consent to Examination, Treatment and Screening process in Wales.
- Act as an advisory Group to the WRP Committee.
- Assist Welsh Health Bodies to provide assurance to their Board's and the WRP that relevant law and national guidance concerning consent is applied correctly within their Health Board / Trust.

Maternity Safety & Learning Programmes

Litigation associated with avoidable harm in maternity services continues to represent a significant proportion of claims expenditure across the NHS. Within Wales, approximately a third of Welsh Risk Pool expenditure is attributed to maternity services. It is clear that in addition to the significant litigation expenditure, the catastrophic harm caused to women and babies due to issues in care must be reduced.

The Welsh Risk Pool has established a Maternity Safety & Learning Board which drives improvement programmes aimed at reducing harm and litigation in maternity services.

PROMPT Wales & Community PROMPT Wales

PROMPT (PRactical Obstetric Multi-Professional Training) is an evidence-based training programme for all healthcare professions involved in the delivery of maternity services. It incorporates emergency simulation sessions and human factors training.

PROMPT Wales is a maternity safety programme funded and coordinated by the Welsh Risk Pool. It adapts the principles and resources used in PROMPT to meet the needs of services in NHS Wales and has been running in NHS Wales since January 2019. Introduced to reduce variation and standardise the quality of multi-professional obstetric emergency training across Wales, the overarching aim of PROMPT Wales is to improve outcomes for mothers and babies and reduce litigation costs associated with avoidable harm. Attendance on PROMPT Wales training is mandated by Welsh Government for all midwives, obstetric doctors and obstetric anaesthetists and is recognised in 'Maternity Care in Wales - A Five Year Vision for the Future (2019-2024).'

Each maternity unit in Wales runs courses regularly throughout the year in order to achieve the 95% attendance compliance set out in specially established PROMPT Wales Standards.

The Welsh Risk Pool has established a multi-professional national team to lead the implementation and sustained delivery of the programme. The national team have developed strong, collaborative relationships with maternity services and provide ongoing support by attending local training and providing quality assurance to health board leadership teams.
PROMPT Wales was briefly paused at the beginning of the pandemic but has continued in a hybrid format, with some lectures temporarily presented on a virtual platform. The fundamental principles of PROMPT training requires staff to train together in the clinical environment and a recovery plan to return fully to a standard delivery format is established.

For successful delivery of PROMPT Wales training, there needs to be effective local faculty within each health board. The national team organise Faculty Development training courses to enable health boards to maintain an optimum number of local multi-professional faculty to sustain the delivery of effective courses.

Building on the success of the PROMPT Wales programme, the Welsh Risk Pool has identified a need for a package to support community maternity services. Community PROMPT Wales has been developed specifically in Wales to offer a bespoke training experience for midwife-led teams. Having been developed and peer-reviewed to reduce variation and standardise the delivery and quality of community based obstetric emergency training, the programme is now being adapted for use across the UK and internationally.

Community midwives make up a third of the midwifery workforce in Wales, and along with an expected increase in community births in line with Welsh Government strategy – 'Maternity Care in Wales - A Five Year Vision for the Future (2019-2024),' this programme supports the development of community teams who are skilled to recognise and manage emergency situations efficiently and effectively.

Following a successful pilot, Community PROMPT Wales is now embedded into maternity services and attendance is mandated for those staff who work in midwife-led settings.

The programme has proven very popular - 99% of the 115 staff who completed an online survey found the training beneficial to their practice. Evaluation of survey results identify a 56% increase in the confidence of community midwives in managing an emergency following training.

Supporting PROMPT Wales training in higher education

Bangor University, Cardiff University, Swansea University and the University of South Wales have incorporated the principles of PROMPT Wales into the undergraduate midwifery programme, with PROMPT Wales trained lecturers in each institution.

Student midwives are also encouraged to attend PROMPT Wales training in health boards during their placements. This helps students become more familiar with the clinical environment and dynamics of dealing with an emergency in the clinical setting.

With university representation on the Maternity Safety & Learning Board, the national team and HEIW are collaborating with the higher education sector to standardise access to and experience of PROMPT Wales for student midwives in Wales.

Improving Outcomes

Research has shown that the PROMPT programme was associated with improvements in staff attitudes and organisational culture when rolled out in Victoria, Australia. To measure whether this could be replicated in NHS Wales, a Safety Attitude Questionnaire was distributed pre and post implementation of PROMPT Wales. Nationally, the mean scores from the sample demonstrates improvement in all domains: Teamwork, Safety Climate, Perception of Management, Job Satisfaction, Working Conditions and Stress Recognition. This recognises the contribution that PROMPT Wales training makes to cultural change, in addition to clinical skill, which collectively have been shown to improve the management of obstetric emergencies and safer outcomes.

The national team are currently capturing and validating data streams to enable the analysis of the PROMPT Wales principles on clinical outcomes. Preliminary data indicates that there is improvement since the commencement of PROMPT Wales in 5 minute APGAR score <7. The full suite of clinical outcome measures include:

- 5-minute APGAR <7 (Term births)
- 5-minute APGAR <7 (Preterm births)
- Hypoxic Ischaemic Encephalopathy Grade 2 + 3
- Shoulder dystocia (as a denominator for BPI)
- Brachial Plexus Injury at birth
- Brachial Plexus Injury at 12 months
- 1500ml PPH (Primary)
- 2500ml PPH (Primary)
- Maternity admissions to level 3 care

The successful implementation of PROMPT Wales is attributed to the collaborative approach between the Welsh Risk Pool, Wales Maternity & Neonatal Network, the PROMPT Maternity Foundation and all seven NHS Wales health boards.

The success of this national programme has been recognised by Professor Tim Draycott, Joint PROMPT Maternity Foundation Lead, Consultant Obstetrician at North Bristol Trust and Vice President of the Royal College of Obstetricians and Gynaecologists.

> PROMPT Wales has provided a consistent approach to multi-professional training for all units and services across Wales with national leadership by the Welsh Risk Pool. Furthermore, the implementation of PROMPT Wales at unit level has been the most coherent and robust of any maternity training programme in the literature, even with the challenges of the geographically widespread sites and the rapid timescale. Finally, I consider that the success of the programme has largely been due to an ambitious and joined up approach that is a model for scaling future programmes internationally.
>
> ***Prof Tim Draycott***

Intrapartum Fetal Surveillance

Documentation is a recurring theme in WRP claims related to issues with fetal monitoring. This includes issues relating to the standard of both cardiotocograph (CTG) and intermittent auscultation (IA) documentation, including decisions on when to clinically intervene.

Following the completion of the clinical review into Intrapartum Fetal Surveillance, it has been identified that there is divergence of practice in relation to the form and content of CTG and IA documentation. Training was also found to have considerable variation.

The team led an all-Wales survey, which was completed by 264 maternity staff to generate staff attitudes around the use of stickers which are used to categorise CTGs.

The team have developed an all-Wales virtual workshop training package on fetal monitoring during labour. This unique training focuses around a 'labour ward board,' whereby the multi-professional team will need to make collaborative decisions and prioritise care, whilst remaining situationally aware of the labour ward as a whole. Human factors are incorporated in response to national reports which demonstrate that a loss of situational awareness contributes to over 70% of avoidable neonatal brain injury or death.

Members of the national team are represented on the Wales Maternity & Neonatal Network Guideline group, reviewing the all-Wales Intrapartum fetal surveillance Standards. The group are working on the development of an all-Wales CTG documentation tool, and are also discussing the best approach to training on intrapartum fetal surveillance. As part of these discussions, the virtual workshop training package will be considered as one option.

Once for Wales Concerns Management System

The Once for Wales Concerns Management System Programme was developed from the recommendations made by Keith Evans in the report commissioned by Welsh Government – "The Gift of Complaints". The programme aims at bringing consistency to the use of the electronic tools used by all NHS Wales health bodies when handling concerns to investigate and improve quality & safety.

The programme moves organisations away from using independently configured systems to a series of products with a common Once for Wales configuration and design. Following a successful procurement exercise, two products currently form the Once for Wales system – Datix Cymru and Civica Experience Wales. These are bespoke products, adapted to meet the needs of NHS Wales.

The functionality and configuration of the various modules within the software are designed by a series of workstreams which consist of subject matter experts from NHS Wales organisations. This enables the system to be designed by the service, for the service.

Datix Cymru

The Datix Cymru product is a cloud-based software tool with multiple modules that have been adapted, configured and implemented specifically for NHS Wales. Fig10 outlines the core functionality of the product.

RLDatix

Datix Cymru

- ✓ Incidents
- ✓ Inquest Cases
- ✓ Safdety Alerts
- ✓ Risk Registers
- ✓ Complaints
- ✓ PALS Enquiries
- ✓ Mortality Reviews
- ✓ Safeguarding
- ✓ Redress Cases
- ✓ Claims Management
- ✓ Medical Examiners
- ✓ Cyber Resilience Reports

Fig10 Core Functionality of Datix Cymru

The Datix Cymru programme is divided into three phases of implementation. Phase 1 introduces the systems and coding processes on a Once for Wales basis and all health bodies are now using the platform. Phase 1 modules include Incidents, Complaints, Claims & Redress, PALS, Inquests, Mortality Reviews. Phase 2 during 2022/23 aims to implement the risk registers and safeguarding functionality.

The phase 1 implementation also included some specific functionality for specialist services in NHS Wales. The Wales Medical Examiner Service utilises a dedicated Datix Cymru module. The Cyber Resilience Unit, which oversees the Security of Networks and Information Systems Regulations, also uses a bespoke configuration of the Datix Cymru product to capture and analyse data in relation to cyber security matters.

Using a cloud-based platform, the Datix Cymru system enables primary care contractors and key stakeholders to use the system – facilitating an integrated approach.

With the decommissioning of the National Reporting & Learning Service, Welsh Government has requested that interim solutions are put into place to enable primary care contractors to report patient safety matters, and this has been particularly embraced by the pharmacy services in NHS Wales. This will be further expanded in 2022/23.

Capture, Categorisation & Coding of information is a vital element of the Datix Cymru system. By aligning all of the coding used across all organisations, NHS Wales has generated a dataset that enables structured analysis of the causal factors of things that have gone wrong and when things go well – sharing best practice throughout all health bodies.

The first national coding dataset was introduced in 2020 and this is regularly reviewed by a dedicated workstream of subject matter experts. All organisations are now utilising the national coding dataset for Incidents and these will be incorporated into the other modules during 2022/23.

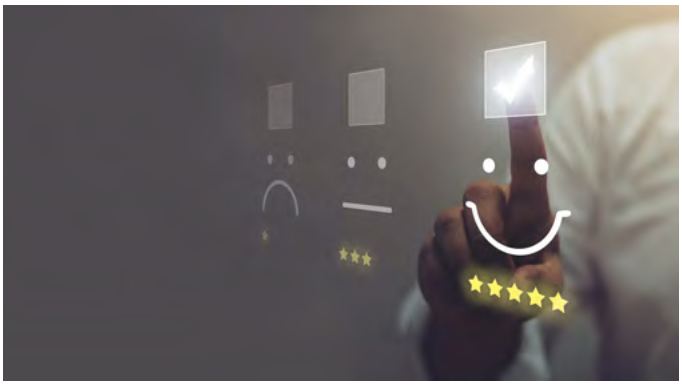
The programme has established a dedicated workstream to consider Intelligent Monitoring, Dashboards and Data Analysis – identifying the most effective reporting tools that can provide strategic, organisational and operational information to drive safety and quality improvements. With all organisations utilising a bespoke NHS Wales coding dataset, this enables reports that have not been possible to produce before to be obtained from the system.

The power of the Datix Cymru system enables the creation and configuration of specific Investigation Tools, bringing consistency to the methodology used to investigate where things have gone wrong. This work has commenced with a specialist workstream introducing the Yorkshire Framework of causal factors. The development of specific investigations tools will be expanded in 2022/23.

The Health and Social Care (Quality and Engagement) (Wales) Act 2020 introduces a Duty of Candour within Wales. During 2021/22, the OfWCMS Central Team have worked with key stakeholders and Welsh Government to ensure that the Datix Cymru system is fully ready to support this important new duty. The workflows and design of the Duty of Candour reports have been developed with the support of a workstream of subject matter experts. The system enables primary care contractors and other providers to report cases where the duty of candour has been triggered to their commissioning health bodies.

During 2021/22, over 30,000 Incidents were reported using the Datix Cymru system as organisations migrated to the new platform. Approximately 20,000 Complaint and Early resolution Investigations were conducted using the system. Early results indicate that the all-Wales workflow and consistency coding provides higher quality data.

As the system becomes embedded further, it is estimated that over 180,000 incidents will be reported and managed through the system each year.



Service User Feedback

As the Keith Evans report reminds NHS Wales, obtaining feedback from users of our services is a vital element to be able to identify what is going well and where there are areas for improvement.

The Once for Wales Concerns Management System has established the Civica Experience system in each health body and some national groups. This common platform enables structured surveys to be designed and distributed to service users, gathering real-time valuable feedback for service leads and clinical leaders. Through integration with local ICT systems, survey information can be directed and focussed to the right recipients.

The Civica Experience Wales product has a wide range of features, based on a dedicated survey design & analysis tool. Multiple methods of communication with service users are available, including dedicated apps which are installed on portable devices, text messaging to service users' known telephone numbers and interactive voice response messaging. The functionality of the multi-lingual product is outlined in Fig11.

CIVICA

CIVICA Experience Wales

- ✓ Survey Design
- ✓ Results Analysis
- ✓ SMS Messaging
- ✓ IVR Messaging
- ✓ Survey App
- ✓ Local Feedback Capture
- ✓ Children and Young People Surveys
- ✓ Patient Stories

Fig11 Available Functionality of Civica Experience Wales

Once for Wales Governance

The Welsh Risk Pool has worked with all health bodies and national groups to ensure that the information governance arrangements and cyber security requirements relating to the Datix Cymru and Civica Experience Wales are firmly in place. During 2021/22 national Data Protection Impact Assessments have been approved for all elements of the system and these remain under regular review.

Led by a Central Team of system experts which is hosted by the Welsh Risk Pool, each health body has trained Local System Leads to support organisations delivering training to staff, setting up the access to data for staff and helping to get the most from the system.

The Once for Wales Concerns Management System is an excellent example of NHS Wales organisations working collaboratively. The governance structure, established to maintain consistency in system setup and configuration, includes a Programme Board which is chaired by a Chief Executive of one of the health bodies, a Steering Group which formulates and guides the development and implementation plan and a Content & Governance Group, which provides oversight of the system developments requested by organisations.

Assurance – Putting Things Right

The Welsh Risk Pool conducts assurance reviews on behalf of Welsh Government in relation to the application by health bodies of the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 – known as the Putting Things Right (PTR) Regulations.

These reviews are designed to help health bodies comply with the requirements set out in the PTR regulations, and to develop action plans to address any areas for development. The outcomes of the reviews are also included as an indicator that determines each health body's contribution to the risk sharing agreement.

Prior to the pandemic, the reviews were paused to enable a review of the methodology and scoring & rating process – to ensure it provides the most useful information to leadership teams as possible. Work has been undertaken with the Head of Patient Experience Network to identify the key areas of focus for the reviews.

The reviews involve careful analysis of complaint investigation records, policy and procedure documentation and data held in systems. Using a peer-review approach to share best practice across NHS Wales, staff from health bodies join specialist reviewers from the Welsh Risk Pool and Legal & Risk Services in conducting the assessment.

The reviews were not carried out during 2020 or 2021 to enable organisations to focus on the response to the pandemic. Now that the protective measures associated with the pandemic have been relaxed, it is possible to recommence the WRP Review process.

WRP Assessments 2022/23

It is intended to carry out a review with each health body in NHS Wales during 2022/23. To enable organisations to share and coordinate learning and improvement, the data selected as part of the review will relate to concerns handled during January to March 2022. It is intended that the reviews for 2022/23 will be carried out during Q3 or Q4 of the financial year.

The review will consider:

- The health body's policy & procedures for handling concerns.
- The timeliness of complaint investigations.
- The quality of complaint investigations and responses.
- Arrangements for handling concerns about primary care providers.
- The application of the all-Wales workflow within Datix Cymru for concerns.
- Appropriateness use of internal and external expert opinion.
- Suitability of decisions whether there is a qualifying liability in a matter.
- Compliance with the duty to be open, which will become the Duty of Candour in 2023.
- Arrangements for sharing lessons learned from a concern across the organisation.

Supporting the response and recovery from Coronavirus

The pandemic has placed unprecedented pressures onto health and care services in Wales and required organisations to work in new and innovative ways.

To facilitate alternative models of NHS operational delivery needed during the pandemic, the Welsh Risk Pool and Legal & Risk Services have been instrumental in supporting Welsh Government and health bodies by producing guidance and frameworks to support decisions on indemnity.

During the pandemic we established a hub of experienced lawyers to provide advice on legal issues arising from the Coronavirus pandemic. We ensured that claimants were not negatively impacted where possible by offering interim payments of damages and agreeing extensions of time.

This work continues with focus moving to analysis and communication across Wales of the impact of the context of the pandemic on the usual legal tests of negligence.

This is relevant to clinical negligence claims and all Putting Things Right investigations where qualifying liability is being investigated by NHS bodies in respect of events which occurred during the pandemic. It is essential that NHS treatment affected by pandemic is judged in the context in which it was provided and not against pre-pandemic standards. Specialist teams within Legal & Risk Services have been set up to lead on these complex legal issues. This is co-ordinated by Head of Healthcare Litigation Sarah Watt.

Legal & Risk Services is supporting health bodies in their investigations and decision making in respect of the hospital acquired Covid-19 infections which occurred across Wales. It actively supported the Delivery Unit in the establishment of the NHS Wales National Framework for the Management of Patient Safety Incidents following Nosocomial Transmission of Covid-19 and will continue to support all health bodies in these investigations.

Impact & Reach of our Professional Services

Our professional services are designed to actively support health bodies and other clients in providing modern, fit for purpose service.

Clinical Negligence Team

The team is made up of over 50 solicitors and legal executives with extensive experience in defending clinical negligence claims against the NHS in Wales. We are recognised for our excellence and in-depth knowledge of each NHS body we represent within Wales. Most of our lawyers have been with Legal & Risk Services for many years and are experts in the fields of multi-million pound claims, complex litigation and every area of litigation we deal with. We provide training to all clients on a range of topics.

The team supports many All-Wales initiatives and is actively involved in national groups. Client relationships are extremely strong, which is essential in order to defend clinical negligence claims to trial and also to obtain consensus in respect of those claims which should be settled.

The Team aims to settle indefensible cases fairly and quickly in order to minimise anxiety for both patients who have been injured by negligent treatment and NHS staff involved in the legal claims. The strategic focus is to increase the use of alternative dispute resolution procedures, and avoid legal proceedings, in order to save costs and time; review the management of our high value claims and identify any improvements to promote robust financial reserving and improve efficiency; to focus on our lowest value claims and prepare for the likely introduction of fixed recoverable costs in clinical negligence claims next year.

The team also supports all work done by health bodies in respect of the PTR regulations, running regular clinics, providing All-Wales and individual client training and advising on the most complex matters.

The introduction of the Head of Healthcare Litigation will strengthen the strategic focus and drive change to improve efficiencies across Wales in respect to the management of clinical negligence claims.

Commercial, Regulatory and Procurement Team

Our Commercial, Regulatory and Procurement Team have an exceptional number of years of experience in dealing with a vast array of legal disputes, overseeing the procurement process and advising on procedural fairness throughout NHS Wales.

The team advise health bodies throughout Wales on all manner of issues, both contentious and non-contentious, which includes Commercial (contractual arrangements) and public law matters (judicial reviews). We also help the NHS understand the complexities of the maze of regulation that exists.

Below is a non-exhaustive list of some of the topics that we are able to advise on:

- Commercial contracts
- Procurement law (Advice on regulations and procedure)
- Procurement documentation (Advice on drafting Invitations To Tender (ITT), Pre-Qualification Questionnaires (PQQ) and specification)
- Procurement challenges
- Outsourcing treatment and services
- Intellectual Property
- Regulatory law
- Public contract law (General Medical Services/General Dental Services Contracts)
- Public/Private partnership (National Cancer Service)
- Judicial Review of decisions
- Commercial Litigation
- Residency disputes
- Disputes between public authorities regarding funding
- Dispute resolution
- Policy drafting
- Construction
- Criminal
- Civil Fraud
- Injunctions
- Defamation
- Transfer of Undertakings & Protected Employees (TUPE)
- Information law (Data Protection and FOI issues).
- Debt collection
- International law (Memoranda Of Understanding & Service Level Agreements with foreign governments).

Personal Injury Team

The Personal Injury (PI) team is formed of specialist solicitors and chartered legal executives. It deals with personal injury claims across all health bodies. The claims dealt with can range from relatively low value slip and trip claims to more complex matters such as mesothelioma and incidents resulting in permanent injuries.

The team also provides advice to clients in the following fields:

- Employers and Public liability
- Work related stress
- Bullying and harassment
- Violence & Aggression
- Industrial disease, including
- Asbestos
- Hearing loss
- Object and person manual handling
- Repetitive strain injury
- Defective equipment
- Infection Control
- Slip and trip cases

The PI team work cohesively to deliver an excellent service to our clients, including a bi-annual education day which aims to enhance the experience and understanding of NHS leaders.

The team also provides valuable analysis of trends as well as focusing upon learning lessons and giving practical risk management advice in areas that have been identified as vulnerable. We firmly believe that prevention is better than cure.

The team has also become involved in a range of specialist projects; most recently being the NHS Anti-Violence Collaborative titled "Obligatory Responses to Violence in Healthcare". It is recognised that NHS staff (Hospital, Ambulance, Community and Primary Care) are among those most likely to face violence and abuse during the course of their employment and there is a strong public interest in prosecuting those who verbally and physically assault NHS staff deliberately.

Complex Patient (Court of Protection)

Our Complex Patient team is led by Gavin Knox; a specialist team which is comfortable dealing with highly complex and sensitive clinical situations where a patient's life or liberty might be at stake. Early intervention will often improve outcomes for patients. This may be by helping to ensure health board staff are acting in the best interests of the patient, or by resolving disputes that can in themselves cause distress to the individual.

- Mental Capacity Act and Best Interests for Children - there is a growing need for NHS staff to understand and implement the principles and provisions of the Mental Capacity Act. Our team offers a rapid and reasoned response to any capacity or best interests related query. By engaging early with clinicians, patients and families, we can usually assist in resolving disputes or ethical dilemmas and avoid the need for applications to be made to Court. The same applies to disputes about medical treatment or end of life decisions for children.

- Deprivation of Liberty - The full impact of the Supreme Court decision in Cheshire West, that redefined what amounted to a deprivation of liberty, is still being realised with enormous impact on NHS resources. We help health boards avoid unlawful deprivations and provide representation in the Court of Protection when a patient appeals against their detention.

- End of Life Decision Making (adults and children) - There are no more important decisions than those relating to the end of life. We are regularly instructed where disputes arise between clinicians and patients or their family about what treatment can lawfully be given.

- Mental Health - We help staff navigate the legislation and the difficult conflicts and interfaces with the Mental Capacity Act and Deprivation of Liberty.

- Court of Protection & High Court Applications - Not all issues can be resolved locally and ultimately some decisions need to be made by a Court. Often these can be highly contentious, complex, and emotive cases with the health, liberty or life of a vulnerable adult or child in the balance. We have extensive experience of making applications to both the Court of Protection and the High Court, each with their own particular rules and procedures. We offer a service that aims to resolve disputes quickly and sensitively to preserve therapeutic relationships with patients or families.

The Complex Patient team work on a real-time basis and are often involved in out of normal hours discussions, providing advice to clinicians dealing with these issues on a day to day basis.

Inquests Team

We have a dedicated team that is able to support health bodies when preparing for and participating in coronial inquiries and inquest hearings

We support the whole inquest process and focus our legal input on those that raise complex Human Rights issues such as suicides, deaths in prison or involving patients in mental health detention, potential gross negligence, or systemic organisational issues.

Our experienced lawyers support health bodies in triaging inquest matters to determine those which will benefit from formal legal input and representation.

Employment Team

Our Employment Team is led by Sioned Eurig. Since its inception in 2012, the team has acted for health boards and Trusts in a wide and diverse range of Employment Tribunal and County Court cases. The team has also had the privilege of advising on high level strategic policy issues.

The team can help with all types of claims in the Employment Tribunal including, but not limited to:

- Unfair dismissal (conduct and capability)
- Various types of discrimination (disability, sexual orientation, race, age, gender etc)
- Unlawful deduction of wages
- Holiday pay
- Whistleblowing
- Pension
- Agency worker rights
- Doctor disciplinary cases

The team can also help with the with wide range issues facing busy healthcare services:

- Interpretation of policies and procedures on an All-Wales level
- Issues arising out of the employment relationship (including advising on grievances and disciplinary hearings) including termination of employment
- Family friendly policies (i.e. Shared Parental Leave regime)
- Clinician banding appeals
- Severance packages and drafting settlement agreements
- The Transfer of Undertaking (Protection of Employment) Regulations 2006
- Voluntary Early Release Schemes and queries
- Doctor disciplinary issues
- All Wales matters in association with the Welsh Government
- Employment status
- Consultations and Redundancies
- Union Recognition
- Restructures

As well as helping clients to manage cases when things go wrong, the team also works with clients to train Workforce teams and line managers to reduce the risk of claims. Employment law is constantly evolving.

Our Employment team can offer a wide range of educational talks and seminars that can be delivered at our fully equipped premises. We are also able to tailor quarter, half or full day packages at a location to suit our client. Recent topics include:

- Training on the Upholding Professional Standards Policy
- Disciplinary investigations training
- Employment updates
- TUPE training
- Dignity at Work
- Whistleblowing

Property Acquisitions, Disposals and Leases Team

Our property team provides advice across the NHS Wales estate, delivering a quality service at competitive rates. The team has extensive knowledge and experience in commercial property and of the NHS Wales estate.

The team works closely with NWSSP Specialist Estates team and undertakes a range of work, which encompasses:

- Leasehold acquisition of offices on behalf of NHS Trusts and health boards;
- Lease re-gears, including varying principal lease terms and break dates, as well as general management work (licences to alter etc.) in support of tenant works;
- Freehold sales of surplus commercial and residential properties, including provisions to protect future development rights of adjacent land retained by NHS Wales;
- Freehold acquisitions in connection with large-scale developments by NHS Trusts and Health Boards; and
- General, one-off property queries on sundry matters, including in the primary care field.

Savings & Successes

We are justifiably proud of the services provided by all of the staff and teams with the Welsh Risk Pool and Legal & Risk Service.

We regularly monitor the savings that the professional influence of our teams brings to the NHS in Wales. This includes reducing legal costs in cases, successfully defending claims and other matters, influencing policy areas to reduce costs and delivering training to managers and staff throughout the NHS.

Professional Influence Savings

In 2021/22, our professional influence savings and success were:

£74,054,226.00

This is expenditure that would otherwise be incurred by NHS Wales and would not be able to be spent on the provision of care.

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Shared Services Partnership

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GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Shared Services Partnership

AGENDA ITEM
5.1

QUALITY & SAFETY COMMITTEE

ORGANISATIONAL RISK REGISTER

Date of meeting	15/11/2022
FOI Status	Open
If closed please indicate reason	Not Applicable Public Meeting
Prepared by	Cally Hamblyn, Assistant Director of Governance & Risk
Presented by	Cally Hamblyn, Assistant Director of Governance & Risk
Approving Executive Sponsor	Director of Corporate Governance
Report purpose	FOR REVIEW & APPROVAL

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Service, Function and Executive Formal Review		RISKS REVIEWED

ACRONYMS	

1. SITUATION/BACKGROUND

1.1 The purpose of this report is for the Management Board to review and discuss the organisational risk register and consider whether the risks escalated to the Organisational Risk Register have been appropriately assessed and endorse onward reporting to Board/Board Committees.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 The risk updates for this period has been impacted by the implementation of the new Care Group Model. The Executive Leadership Group supported "Guiding Principles: Quality Governance & Accountability during the Operating Model Transition" where the following transitional arrangements have been agreed:

- **Organisational Risk Register:** Workshop approach to realign risks on the Organisational Risk Register led by Nurse Directors. Timeframe: Workshop Sept/Oct 22. Realignment to complete by 31.1.2023.
- Central Quality Governance Team to provide a report to Care Groups which will contain all **Datix Legacy Information** for Risk, Incidents, Claims, Complaints etc. The Nurse Directors to then undertake an exercise to align activity/data to Care Group Model – Timeframe for alignment 31.1.2023.

The Assistant Director of Governance & Risk, along with the Chief Operating Officer and/or Deputy Chief Operating Officers, has started to meet with Care Groups during October and November to review risks in terms of alignment to the new Care Group Model. The Organisational Risk Register will continue to be updated to reflect the changes being made as a result of this activity.

2.2 The following progress has been made since the last report:

- Monthly Risk Management Awareness Sessions (Virtually via Teams). The monthly sessions are set in the calendar until the end of 2022 and will continue beyond that date if required. 344 members of staff trained to date.
- Risks on the organisational risk register have been updated as indicated in red.

3 KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 NEW RISKS

Quality Governance: Concerns and Claims

- Datix ID 5254 – Failure to manage redress cases efficiently and effectively in respect of the Duty of Candour. Risk scored as a 20.

Patient, Care and Safety Function - Nursing

- Datix ID 5267 - There is a risk to the delivery of quality patient care due to difficulty recruiting & retaining sufficient numbers of nurses. Risk scored as 16.

Digital & Data

- Datix ID 5276 - Failure to deliver replacement Laboratory Information Management System, LINC Programme, by summer 2025. Risk rated as a 20.

3.2 **CHANGES TO RISKs**

a) Risks where the risk rating INCREASED during the period

Quality Governance (Compliance)

- Datix ID 4922 – Covid-19 Inquiry Preparedness - Information Management, Risk Score increased from a 16 to a 20.

b) Risks where the risk rating DECREASED during the period

Nil assigned to this Committee.

3.3 **CLOSED RISKS FROM THE ORGANISATIONAL RISK REGISTER**

Patient, Care and Safety Function - Nursing

- Datix ID 4106 - Increasing dependency on agency staff cover which impacts on continuity of care, patient safety.
- Datix ID 4157 - There is a risk to the delivery of high quality patient care due to the difficulty in recruiting and retaining sufficient numbers of registered nurses and midwives.

Rationale for closure and/or removal from the Risk Register is captured in Appendix 1.

3.4 **DISCUSSION POINTS**

Emerging Risks

The Assistant Director of Governance & Risk has been made aware of the following emerging risks in the service that are likely to be escalated to a future Organisational Risk Register return:

Care Groups

- **Unscheduled Care Group:**
  - Lack of funding for priority winter schemes within 2022-23 winter plan
  - Non-resillient NIV Pathway
  - Lack of acute frailty assessment services/pathways
  - Lack of resilience of vascular pathway
  - Absence of D2RA Model and pathways.

- **Diagnostics, Therapies and Specialties**
  - A review of the current overarching Pathology risk as well as other emerging risks in this area including significant concerns around mortuary capacity.

- Radiology risks.

- **Primary Care and Community -** GMS Sustainability

3.5 **Organisational Risk Register** - **Visual Heat Map by Datix Risk ID (Risks rated 15 and above):**

Consequence						
	5			4253 3337 4772 5207	4080 3826 4887 5214	4743
	4				4149 4458 4148 4798 4906 4908 5014 5267 4152 3585 3133 1133 4679 4479 4940 4722	4491 4632 4071 4721 4103 4217 5036 4907 5254 4922
	3					4691 4732 4920 3993 4512 4590 2808 4971
	2					
	1					
CxL		1	2	3	4	5
		Likelihood				

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If no, please provide reasons why an EIA was not considered to be required in the box below.
	Not applicable for the Risk Register item.
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

5.1 The Committee are asked to:

- **Review** the risks escalated to the Organisational Risk Register at Appendix 1.
- **Consider** whether the Committee can seek assurance from the report that all that can be done is being done to mitigate the risks.

Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
5276	Director of Digital	Central Function - Digital and Data	Assistant director of therapies and health science	Sustaining Our Future	Business Objectives - Operational Patient safety Digital Healthcare Wales interdependencies	Failure to deliver replacement Laboratory Information Management System, LINC Programme, by summer 2025,	**IF**: LINC Programme fails to deliver replacement Laboratory Information Management System (LIMS) by summer 2025 **THEN:** CTM would be without a supported Pathology LIMS system **RESULTING IN:** Without the implementation of the new LIMS system the pathology service may fail to produce accurate, timely patient results for diagnosis, monitoring and screening of patients which would impact treatment, patient flow and waiting times.	Currently LINC Programme reports progress against timeline to LINC Programme Board and Chief Executive Group.	As the NHS Wales Health Collaborative becomes part of the NHS Executive it has been agreed that the LINC Programme will move to Digital Health Care Wales	Digital & Data Committee Quality & Safety Committee	20	C4xL5	8 (C4xL2)	New Risk Escalated October 2022	26.10.2022	26.10.2022	26.11.2022
5254	Director of Corporate Governance	Centre Support Function - Quality Governance - Concerns and Claims	Assistant Director of Concerns and Claims	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to manage Redress cases efficiently and effectively in respect of Duty of Candour	**If**: The Health Board is unable to meet the increased work demand in respect of the implementation of Duty of Candour **Then:** the Health Board will not be able to manage cases in a timely manner and will not meet the required targets in respect of Putting Things Right. **Resulting in:** Risk to quality and safety of patient care, resulting from poor management of cases. Financial impact to the Health Board from Redress cases which have been poorly managed and consequently proceed to claim.	Controls are in place and include: * New incident framework developed * Engagement with the All Wales Duty of Candour Network to discuss implementation of the Duty * Reports run on predicted case numbers * Request to the All Wales Duty of Candour Network that an impact assessment is undertaken	October 2022: Invest to save bid has been developed and submitted, which requests 2 Redress Handlers, this should give some capacity, however focus will be on addressing the current backlog. Some resource has been identified through the operating model, which should give some capacity within the current legal service. Impact assessment being undertaken to assess resources needed to manage expected workload when Duty is introduced. Board Development session being arranged to raise awareness of accountabilities of Board in compliance with the Duty of Candour and Duty of Quality (Oct 2022) where local implications will be shared.	Quality & Safety Committee	20	C4xL5	8 (C4xL2)	New Risk Escalated October 2022	07.10.2022	07.10.2022	07.12.2022
4922	Director of Corporate Governance	Central Support Function - Quality Governance (Compliance)	Assistant Director of Governance & Risk	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Covid-19 Inquiry Preparedness - Information Management	IF: The Health Board doesn't prepare appropriately for the Covid-19 enquiry THEN: the organisation will not be able to respond to any requests for info RESULTING IN: poor outcomes in relation to lessons learnt; supporting staff-wellbeing and reputational issues.	The Covid-19 Inquiry Working Group are monitoring a number or preparedness risks such as: - Retention and Storage of information, emails and communication - Capturing reflections of key decision makers prior to any departure from the Health Board - Organisational Member. The Health Board has a Covid-19 Inquiry CTM Preparedness Plan which is monitored via the Covid-19 Inquiry Working Group. The Board and Quality & Safety Committee received a detailed update on the preparedness progress at their respective meetings in March 2022 and September 2022.	Establish a Timeline for CTMUHB - the timeline will have a few elements and uses and will continue to evolve as information is archived. This Timeline does not include the Health Board Information as this requires the archiving of documents in order to populate it. Archiving Information against the Timeline is yet to commence as the current Covid-19 Information Manager resigned from the role and left the Health Board at the end of August. Recruitment for a successor to the role was unsuccessful and therefore the pace of progress in developing the Health Boards Timeline and gathering key documentation centrally is being significantly impacted which could be detrimental to the Health Board being able to efficiently and effectively respond to requests from the Inquiry. The AD for Governance & Risk is exploring other options for resourcing this role including project management support. Following a briefing meeting with Legal Counsel it was clear that the Health Boards focus should be on the timeline and documentary evidence at this stage which has heightened the risk in terms of the resource afforded to the preparedness for the inquiry. Legal Counsel advised the Health Board to pause the introduction of the All Wales Reflection document at this stage of the Inquiry. At the Covid-19 Pandemic Inquiry Working Group on the 11th October the likelihood of this risk was increased from a 4 to a 5 based on the above risk factors.	Quality & Safety Committee	20 ↑ 16	C4xL5	8 (C4xL2)	↑ Increased from a 16 to a 20 in October 2022	23.11.2021	11.10.2022	30.11.2022
5214	Executive Medical Director / Chief Operating Officer	Planned Care Group	Care Group Medical Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Critical Care Medical Cover	If: Depleted Consultant Intensivist numbers at Princes Of Wales (POW) continue as a result of medical reasons, retirement and unable to recruit to vacant posts. No Middle Grade medical tier at POW. Consultant intensivist delivered service. Then: Without Middle Grade tier positions the ability to attract and recruit Consultants will be limited. Resulting in: the Health Board being unable to deliver safe patient care with gaps in rota. Potential for days and nights to not be consultant covered. No medical team to manage patients.	Daily management of the rota. Use of agency to cover gaps. CTM internal cover (limited options). Development of CTM strategy for Critical Care.	Workforce business proposal to fund Middle Grade tier to ELG. Digital solution to provide safe cross site Consultant cover for RGH and POW, requires IT solution across POW and RGH. Develop workforce modelling for next 2 years and 10 years. Appoint Critical Care lead across CTM to establish one department - 3 sites approach (Care Group organisational change).	Quality & Safety Committee People & Culture Committee	20	C5xL4	10 (C5xL2)	↔	19.8.2022	19.8.2022	20.09.2022
4887	Director for Digital	Central Support - Digital & Data Function	Medical Records Manager	Improving Care	Service / Business Interruption		IF: The Medical Records Filing library at Princess of Wales is full to capacity making it very difficult for staff to retrieve and or file case notes. THEN: Risk of unable to manoeuvre mobile racking, therefore unable to access case notes Risk of fire as case notes close to source of ignition Risk of Fire Service or HSE closing access department Very High risk of upper limb injury Risk of notes falling from height causing injury (some case notes are in excess 8.3kg) Risk of Fire Service or HSE closing access to department RESULTING IN: If we could not retrieve any case notes, Consultants would be unable to make clinical decisions impacting on patient care. If the whole library was affected, this would impact 100 of thousands of patients care. Admissions/Outpatients would have to be cancelled staff refusing to continue to work in unsafe environment. Multiple and serious injuries to staff, possibly death.	(The case notes are very tightly packed on shelves. Mobile racking is failing due to age, lack of maintenance, and weight Case notes are being stored inappropriately on floors under desks, and insecurely at height. The working environment is congested, with no dedicated storage space for large ladders. Significant force is required to retrieve each file (123.N - this is 3 times higher than what is considered to be high force).) Broken Racking at Bridgend Offsite Stores - Repairs have been carried out with damaged racking in Bridgend North Rd Offsite stores. Temporary use of container deployed on site. Broken Racking at POW - On each occasion the racking has failed, the engineer has been able to repair it (£500 + VAT) but it continues to fail. Please see progress notes for more information. Access to this specific racking is permitted to Supervisors only, who only access it once a day. The Filing Library is closed to non-Medical Records staff, aside from the Porters who require access for emergency OOH admissions. Task and Finish group establish to address the above risks. Capacity has been identified at Glanrhyd and noticed served to SBUHB to vacate. It is hoped that we will be able to relocate notes to this area in mid-July, which will address the immediate H&S issues. Currently waiting for procurement process to be completed.	Relocation of Case Notes from POW/Bridgend Off-site Store to Glanrhyd Site. Timeframe 19.8.2022 Replace racking and review office environment of POW filing Library. Timeframe 30.01.2023 Creating additional long term storage space. Update 31.10.2022 - Approx. 30,000 records have already been redistributed across POW, North Road Offsite Store and Glanrhyd Library, to improve conditions at POW. Work is still ongoing at POW to redistribute records safely. Original broken rack mostly vacated but other racks holding notes have similar issues. Glanrhyd partly vacated by SBUHB but not fully available for use yet. The Medical Records Department plan to relocate 10 Registration Medical Records staff to the Library Offices in this space. Proposal put forward by an Operational Services Manager to relocate additional 17 Appointment Booking Centre staff into these same offices and also the Library area. This Library space is already identified for boxed records, compromising room for future growth and safer storage; this will affect the ongoing position at POW and North Road. Risk to be reviewed in 6/52, when SBUHB should have fully vacated and a decision made as to who/what will occupy remaining space at Glanrhyd Library.	Digital & Data Committee & Quality & Safety Committee	20	C5xL4	10 C5xL2	↔	27.10.2021	31.10.2022	12.12.2022
4491	Chief Operating Officer	Planned Care Group	Interim Planned Care Service Group Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to meet the demand for patient care at all points of the patient journey	**IF:** The Health Board is unable to meet the demand upon its services at all stages of the patient journey. **Then:** the Health Board's ability to provide high quality care will be reduced. **Resulting in:** Potential avoidable harm to patients	Controls are in place and include: • Technical list management processes as follows: - Speciality specific plans are in place to ensure patients requiring clinical review are assessed. - All patients identified will be clinically reviewed which will include an assessment of avoidable harm which will be reported and acted upon accordingly. - A process has been implemented to ensure no new sub specialty codes can be added to an unreported list, this will be refined over the coming months. - All unreported lists that appear to require reporting have been added to the RTT reported lists - All unreported lists that are to remain unreported (as they do not form part of the RTT criteria) are being reviewed and will be visible and monitored going forward. • Patients prioritised on clinical need using nationally defined categories • Demand and Capacity Planning being refined in the UHB to assist with longer term planning. • Outsourcing is a fundamental part of the Health Board's plan going forward. • The Health Board will continue to work towards improved capacity for Day Surgery and 23:59 case load. • A Harm Review process is being piloted within Ophthalmology – it will be rolled out to other areas. • The Health Board has taken advice from outside agencies especially the DU when the potential for improvement is found. • Appropriate monitoring at ILG and Health Board levels via scheduled and formal performance meetings with additional audits undertaken when areas of concern are identified Planned Care board established. - The Health Board is exploring working with neighbouring HBs in order to utilise their estate for operating.	The Health Board has established a Planned Care Board, with a full programme of work to address FUNB, demand and capacity and a recovery programme which will include cancer patients; The plans have timescales – which are being monitored, however it is likely that it will take time to reduce waiting times to acceptable levels in the post-covid-19 environment. The PCH Improvement Programme has significantly accelerated a number of mitigating actions designed to improve flow, reduce risk and improve the quality of care in the unscheduled care pathway. Updates on this are provided through the Quality & Safety Committee including specific actions and measures. There is also a PCH Improvement Board that meets monthly with the COO as the SRO. The Health Board is centralising the operational management and decision making around all elective services with the clear aim of increasing and protecting elective activity as we deal with the pressures of the Covid-19 pandemic and winter. This process commenced in late October 2021 and greater clarity will be provided in the next review. The IMTP process will drive the development and prioritisation of these plans ahead of implementation in 2022-2023.Additionally as part of the IMTP Process we will be able to complete robust capacity and demand planning for all surgical specialities for the first time, this will allow us to fully understand our likely trajectory for recovery during 2022-2023 and beyond. Update July 2022 - Risk scoring unchanged. Revised Improvement trajectories for each specialty now in place updated via the Planned Care Recovery Programme Board. The Health Board is working with Cardiff and Vale University Health Board and Swansea Bay University Health Board to support recovery actions in high risk specialities. Update September 2022 - Continue delivery of the Planned Care Recovery Actions. Reconfiguration orthopaedic inpatient operation. Commissioning the insourcing of the workforce to deliver to Theatres. Amalgamation of Health Board wide capacity plans. Significant work ongoing in relation to FUNB which is being captured in the performance reports. Update October 2022 – Procurement exercise commenced 20 Oct 22 re the insourcing of the workforce to deliver to Theatres. Recruitment to theatres transformation role from 28 Oct 22. Amalgamation of Health Board wide capacity plans. Significant work continuing in relation to FUNB which is being captured in the	Quality & Safety Committee Planning, Performance & Finance Committee.	20	C4xL5	12 C4 x L3	↔	11.01.2021	28.10.2022	30.11.2022

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4071	Chief Operating Officer All Integrated Locality Groups Linked to RTE 5039 / 4513	Planned Care Group	Interim Planned Care Service Group Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to sustain services as currently configured to meet cancer targets.	**IF:** The Health Board fails to sustain services as currently configured to meet cancer targets. **Then:** The Health Boards ability to provide safe high quality care will be reduced. **Resulting in**: Compromised safety of patients, potential avoidable harm due to waiting time delays for treatment.	• Tight management processes to manage individual cases on the cancer Pathway. • Regular reviews of patients who are paused on the pathway as a result of diagnostics or treatment not being available. To ensure patients receive care as soon as it becomes available. • Regular Quality impact assessments with the MDTs, to understand areas of challenge and risk • Harm review process to identify patients with waits of over 104 days and potential pathway improvements. • Initiatives to protect surgical capacity at the Vale hospital for ASA 1+2 level patients until alternatives become available. • All three ILGs are working to maximising access to ASA level 3+4 surgery on the acute sites. • HB working to ensure haematological SACT delivery capacity is maintained. • Ongoing comprehensive demand and capacity analysis with directorates to maximise efficiencies. • Considerable work around recommencing endoscopy and other diagnostic services whilst also finding suitable alternatives for impacted diagnostics. • Alternative arrangements for MDT and clinics, utilising Virtual options - Cancer performance is monitored through the more rigours monthly performance review process. each ILG now reports actions against an agreed improvement trajectory. Weekly monitoring led by the Chief Operating Officer to monitor progress. Pathology backlog clearance plan funded and in delivery.	Continue close monitoring of each patient on the pathway to ensure rapid flow of patients through the pathway. Active management of the diagnostic backlog (including endoscopy) and exploration of all options to reduce this. Comprehensive planning for repatriation of theatre and haematology services for when private provision is lost. This also needs to consider options for continuation during a potential second surge. These actions are ongoing and assigned to the EDO, DPC&MH and Medical Director. The Cancer Business Unit remain fully involved in the processes to improve care and that at present they are awaiting feedback from ILGs on their plans for restarting elective and other activity and their demand and capacity assumptions. There was a refocus on this risk post Covid-19 impact and there has been a consistently improving position from February to July. During July there was a slight deterioration which is being addressed and actioned. Each ILG has returned a Cancer Recovery Plan to facilitate monitoring by the COO. This remains ongoing with individual issues addressed as they arise. An Operating Framework has been developed with a tightened Performance Management framework which will be monitored by the COO. Update March 2022, the enhanced monitoring process continues with progress being made in all specialities. There is a lag between the increase in activity which is being evidenced and the impact on the Suspected Cancer Pathway (SCP) which results in overall performance still being depressed. Improvement activity in outpatients and diagnostics is in place and being closely monitored. There is an unmitigated risk within the breast cancer specialty where are RTE ILG continue to develop an improvement plan, however, it is worth highlighting the constrained nature of breast cancer capacity across Wales. Update June 2022 - Score unchanged. Recovery trajectories and associated actions in place for each tumour site to address long waiting times and to improve overall performance against the 62 day standard. In addition there is weekly monitoring led by the Chief Operating Officer to monitor progress. Pathology backlog clearance plan funded and in delivery. Update September 2022 - Score remains unchanged. Recovery actions continue with focus on Urology and Lower GI. Improvements are being recognised in Gynae and Breast Surgery which are currently ahead of plan. Cancer treatments remain higher than pre-Covid levels. Update October 2022 - Score remains unchanged. New Cancer Assurance cycle from November 2022. Recovery actions continue with focus on Urology, Lower GI and Dermatology. Improvements are being recognised in Gynae and Breast Surgery which remain in line with plan. Cancer treatments continue to be higher than pre-Covid levels.	Quality & Safety Committee Planning, Performance & Finance Committee.	20	C4 x L5	12 (C4 x L3)	↔	01/04/2014	28.10.2022	30.11.2022
4080	Executive Medical Director Executive Director of People	Central Support Function - Medical Directorate & People Directorate	Assistant Medical Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to recruit sufficient medical and dental staff	**If:** the CTMUHB fails to recruit sufficient medical and dental staff. **Then:** the CTMUHB's ability to provide high quality care may be reduced. **Resulting in:** a reliance on agency staff, disrupting the continuity of care for patients and potentially effecting team communication. This may effect patient safety and patient experience. It also can impact on staff wellbeing and staff experience.	• Associate Medical Director for workforce appointed July 2020 • Recruitment strategy for CTMUHB being drafted • Explore substantive appointments of staff undertaking locum work in CTMUHB • Feedback poor performance and concerns to agencies • Development of 'medical bank' • Developing and supporting other roles including physicians' associates, ANPs	The response to Covid-19 has impacted the original timeframes for these actions due to the requirement to focus on clinical operational service delivery during the pandemic. Revised dates have been included below: 1. AMD and workforce to develop recruitment strategy - 31.3.2021 Update October 2021: The Health Board is in the process of introducing patchwork across Merthyr & Cynon ILG on 6th October and Rhondda Taf Ely on 20th October. This will give an indication of the gaps and the spend, allowing the ILG's to establish a medical recruitment strategy. 2. AMD and DMD to develop retention and engagement strategy - 31.3.2021 – Revised Date February 2022. 3. Reduce agency spend throughout CTMUHB – Update January 2022 - Patchwork rolled out across CTM. Data gathering currently. When sufficient data will have the discussions with HR and clinicians on a fair and appropriate rate card. Update July 2022: Patchwork has been introduced and the data is being used to identify gaps which will support the basis of a business case for additional recruitment aligned to the medical productivity work. 4) Task and Finish group to look into conversion of ADHs into permanent posts. 5) Task and Finish group Retire and return (emphasis on recruit new consultants (and therefore join on call) than R&R approach, use R&R on 1 year contracts and re-advertise posts on yearly cycle.	Quality & Safety Committee People & Culture Committee	20	C5 x L4	15 (C5xL3)	↔	01.08.2013	14.07.2022	31.08.2022
4103	Chief Operating Officer	Planned Care Group	Interim Planned Care Service Group Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Sustainability of a safe and effective Ophthalmology service	**IF**: The Health Board fails to sustain a safe and effective ophthalmology service. **Then:** The Health Boards ability to provide safe high quality care will be reduced. **Resulting in:** Sustainability of a safe and effective Ophthalmology service	Measure and ODTC DU reviews nationally. . Clinical staffing structure stabilised and absence reduced (new consultant, nurse injectors, ODTC's, weekend clinics). . On going monitoring in place with regards RTT impact of Ophthalmology. . In line with other services, to meet the RTT requirement services are being outsourced - maintaining this level of performance will be challenging going forward. . Additional funding for follow up appointments provided and significant outsourcing undertaken (6,500 cases) with harm review piloting to assess all potential harms. . Additional services to be provided in Community settings through ODTC (January 2020 start date). . Intravitreal injection room x2 established with nurse injectors trained. Follow up appointments not booked being closely monitored and outsourcing enactioned. Regular updates re follow up appointments not booked being monitored by Management Board / Q&SR (patient safety issues) and Finance, Performance and Workforce Committee (performance issues). Reviewing UHB Action Plan in light of more recent WAO follow up review of progress. Primary and Secondary Care working Groups in place. Ophthalmology Planned care recovery group established overseeing a number of service developments: WLI clinics, outsourcing of Cataract patients, development of an ODTC in Maesteg Hospital, implementation of Glaucoma shared care pathway, implementation of Diabetic Retinopathy shared care pathway, regional work streams, trial of new Glaucoma procedure (IMS), streamlining pathways. Quality and Performance Improvement Manager post created to provide dedicated focus, detailed demand and capacity analysis being undertaken. All patients graded according to the WG risk stratification R1, R2, R3. Additionally, several specific waiting lists are further risk stratified to ensure that the highest risk patients are prioritised.	Update October 2022: Legacy patients: Temporary funding has been secured for a Senior Lead Nurse until March 2023 to review and complete Clinical Harm Reviews. A paper is being presented to the Executive Director of Nursing in November 2022 to consider governance support. R1: The clinical lead has carried out a sample exercise to review the R1 status. A large proportion of those patients do not meet the R1 criteria. A large proportion of these cases have been downgraded to R2 status. Additional capacity: Plans are being developed for additional weekend sessions between now and 31st December 2022 to reduce the longest waits requiring follow up. Additional capacity: A plan for a see and treat one stop for long waiting cataracts is awaiting approval. In addition a community follow up scheme takes 200 glaucoma patients we are asking additional 150 new slots to clear the 104 week waits by 31st December 2022. Core capacity: has been reviewed to meet pre pandemic levels with the exception of one clinic. Follows Up a validation has been undertaken by a clinical team member and a number of anomalies have been identified from potential discharges and duplicate pathways. Further clinical validation is required, however, current job plans do not cover this at least an additional 6 sessions would be required to review all patients over 12 months. Open Pathways: circa 13,000, 1400 of these were removed following discovery of an IT issue, further validation is required but a dedicated validation team would be required to undertake this. Improvement Programmes: Funding for a Band 6 Service Pathway co-ordinator is awaiting approval. Wet AMD Referral Service will commence in December 2022.	Quality & Safety Committee	20	C4 x L5	12 C4 x L3	↔	01/04/2014	28.10.2022	30.11.2022
4632	Executive Director of Therapies and Health Sciences.	Unscheduled Care Group	Head of Strategic Planning and Commissioning	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Provision of an effective and comprehensive stroke service across CTM (encompassing prevention, early intervention, acute care and rehabilitation)	**IF:** changes are not made to improve and align stroke prevention initiatives, early intervention campaigns, and acute and rehabilitation stroke care pathways across CTM **THEN:** avoidable strokes may not be prevented, patients who suffer a stroke may miss the time-window for specialist treatments (thrombolysis, thrombectomy), and patients may not receive timely, high-quality, evidence-based stroke care **RESULTING In:** higher than necessary demand for stroke services, poorer patient outcomes/increased disability, increased length of stay, and poor patient/carer experience. Impact will extend to the need for increased packages of care, increased demand for community health services, and increased carer burden when discharged to the community.	• Executive-led Stroke Strategy Group in place, with targeted task and finish under development. • ToR and membership of Strategy Group updated. • Close working amongst executive team to escalate and address operational and clinical issues in relation to stroke pathway • Regional and National Stroke Programme Boards established • Unified, evidence-based pathway developed for thrombectomy • Bristol thrombectomy service becoming 24/7 in Autumn • Oversight of performance via regular SSNAP audit results, Performance Dashboard updates and Quality and Safety Committee reports • Full engagement from clinical teams in HIW review of flow of stroke patients in May 22. National report due in Spring 2023.	**Update 1st November 2022:** • Recruitment process underway as part of CTM Consultant Recruitment Drive. CSG working with medical staffing agencies seeking a Locum Consultant for PCH following a resignation. • A more stable rota for on-call stroke consultant rota being developed through joint working between PCH and POW consultants. Continued dialogue with Cardiff and Vale UHB to look at long term solutions to rota, feeding into the South Wales Central Regional Programme Board. • Regional developments with Cardiff and Vale UHB continue to progress to plan, with second meeting of the South Central Regional Programme Board on 25/10/22 and joint CTM/C&V UHB Stakeholder Event 26/10/22. Continued engagement with NHS Collaborative re: timelines for national programme. • Fortnightly Stroke Pathway Task and Finish Group. Review of priorities, progress and risks undertaken. Nominated leads identified and priority actions being progressed at pace. Work underway to review demand/capacity and therapies workforce gaps, exploring potential improvements to data streams and review of pathways for TIA across CTM. • Action taken forward from Stroke and Bed Management Task and Finish Groups to re-start ring fencing stroke capacity on a daily basis. Daily plan to create a ring fenced bed for stroke in PCH and POW to be confirmed through daily flow calls. Confirmation of stroke demand on all three sites (PCH, RGH and POW) communicated through daily flow calls. • Stroke patients needing transfer from RGH to PCH to be prioritised, with POW being explored as an option if significant system pressures. Comms poster to be circulated. • Continued implementation of VBHC stroke prevention programme: optimal management and targeted case finding of atrial fibrillation and hypertension in primary care. GP with Special Interest recruited and other key posts underway. • FAST programme being rolled out nationally. • Analysis underway to understand delayed seeking of help within Merthyr locality. Plan to be developed once reasons better understood. • Changes being planned to rehab pathway. • Unified criteria for thrombolysis agreed across both acute stroke sites. • Unified acute stroke management pathway across both sites under development. • Additional resource proposals included in the 2022/23 IMTP – funding was not available this year (7 day working, ESD, additional rehab beds). Alternative options being actively explored, with ESD provision for Bridgend as a priority	Quality & Safety Committee	20	C4 x L5	12 (C4 x L3)	↔	05.07.2021	1.11.2022	31.12.2022
4743	Chief Operating Officer	All Care Groups	Deputy COO (Acute Services)	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure of appropriate security measures / Safety Fencing	**If:** there is a failure in security measures. **Then:** there is an increased likelihood of patients having unrestricted and inappropriate access on the site. **Resulting In:** absconding events and possible harm to the patient or members of the public	The risk of absconding, and self harm/ suicidal ideation for Mental Health and CAMHS patients is risk assessed on admission and reviewed regularly thereafter. Works programme to review and renew physical barriers such as door locks and restricted window access to limit unauthorised ingress and egress from Mental Health and CAMHS units are in situ. High risk patients are escorted when outside the units Absconding patient policy in place Some fencing is in place in the areas concerned, however, it is aged and fails to provide an adequate barrier.	Funding Bid for approx. £385K has been submitted by Estates Update April 2022: The Car Park Security Fencing in the Bridgend Locality is now largely complete with minor 'snagging issues' to close off. Door systems in Ty Llidiard CAMHS have been upgraded to include an alarm system on the Mag-lock doors. If the Mag-lock does not engage within a set time frame, then an alarm will sound. Multi storey Car Park at Princess of Wales Hospital has had anti-climb security fencing fitted. This was a WG Capital scheme and is awaiting final project sign-off to complete the works. The only outstanding area is the stairwell which will require more detailed technical design work to identify a solution. That work has commenced and once complete the works can be tendered. This will require further funding in 22/23 Capital & Estates Update September 2022 - solution to the fencing of the stairwells has been found and funding uplift approved in August ACMG. This work should commence in the early autumn completing within the financial year. Update October 2022 - Deputy COO Acute Services to review this risk from a pan Health Board perspective and identify actions per Care Group as appropriate. Timescale 31.12.2022.	Quality & Safety Committee	20	C5 x L4	15 (C5xL3)	↔	05.07.2021	1.11.2022	31.12.2022

Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
5036 Link to RTE 5155	Chief Operating Officer	Diagnostics, Therapies and Specialties Care Group	Service Director - Diagnostics, Therapies and Specialties Care Group	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm & Statutory Duty / Legislation	Pathology services unable to meet current workload demands.	IF: Pathology services cannot meet current service demands. THEN: - there will be service failure - there will be continued delays in reporting of Cellular Pathology results - failure to provide OOH services required for acute care - inadequate support and accommodation for Clinical Haematology cancer patients - increased turnaround times for provision of results including timely autopsies - increased pressure on existing staff - inadequate training provision throughout - inability to repatriate services from Bridgend. RESULTING IN: 1. Failure to meet cancer targets and national cancer standards 2. Anxiety for patients waiting for delayed results 3. Unsuspected cancer cases being missed in the backlog potentially leading to patient harm. 4. Delays in the reporting of critical results and issue of blood products OOH leading to patient harm 5. failure to meet the standards required for provision of autopsy reports for the ME service 6. Clinical incidents due to errors and poor training. 7. Poor compliance with legislation and UKAS standards (that are mandated by the HB and Welsh Government). 8. Reputational damage and adverse publicity for the HB. 9. Continued inequity of services provided to CTM	1. Triaging of patient samples (into urgent & routine) as they arrive into Cellular Pathology. 2. Outsourcing of routine Cellular Pathology backlog to an external laboratory (LDPATH) 3. Expansion of Cellular Pathology into POCT training room. 4. Capital bids being progressed for ageing equipment. 5. All Wales LINC programme for implementation of Pathology LIMS and downstream systems. 6. Use of locums throughout all departments. 7. Advertisement and recruitment for vacant posts 8. Use of overtime to cover OOH services. 9. Business case to increase capacity of CNS support for Clinical Haematology patients. A Cellular Pathology Recovery Plan paper has been submitted to the Executive team for review - end of May 2022	Blood Bank Capacity Plan 31/05/2022 Demand & capacity review 30/06/2022 Workforce redesign 30/06/2022 Dedicated Pathology IT resource 30/06/2022 Accommodation review 30/06/2022 Novation of Equipment to the Managed Service Contract 30/09/2022 Update June 2022 - Review scheduled for the end of September 2022 to consider the improvements as a result of the mitigating actions undertaken. Update September 2022 - the Health Board continues to outsource samples and is increasing the volume of outsourcing. Regional working underway to explore longer term solutions for Pathology Services.	Quality & Safety Committee	20	C4 x L5	6 (C3xL2)	↔	02.03.2022	07.09.2022	31.10.2022
3826 Linked to 4839 and 4841 in Bridgend Linked to 4462	Chief Operating Officer	Unscheduled Care Group	Care Group Service Director - Unscheduled Care.	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Emergency Department (ED) Overcrowding	**If:** As a result of exit block due to hospital capacity and process issues patients spend excess amounts of time within the Emergency Department. This is manifested by, but not limited, to significant 12 hour breaches currently in excess of 400 per month. There are also large numbers of patients spending longer than 24hrs and 48hrs within the ED (please see attached information). **Then:** patients are therefore placed in non-clinical areas. **Resulting In:** Poor patient experience, compromising dignity, confidentiality and quality of care. The ability for timely ambulance handover with extensive delays for patients requiring assessment and treatment. Filling assessment spaces compromised the ability to provide timely rapid assessment of majors cases; ambulance arrivals and self presenters. Filling the last resus space compromises the ability to manage an immediate life threatening emergency. Clinicians taking increasing personal risk in management of clinical cases. Environmental issues e.g. limited toilet facilities, limited paediatric space and lack of dedicated space to assess mental health patients. Some of the resulting impact such as limited space has been exacerbated by the impact of the Covid-19 pandemic and the need to ensure appropriate social distancing	Increased number of nursing staff being rostered over and above establishment. Additional repose mattresses have been purchased with associated equipment. Additional catering and supplies. Incidents generated and attached to this risk. Weekly report highlighting level of above risk being generated. All patients are triaged, assessed and treatment started while waiting to offload. - Escalation of delays to site manager and Director of Operations to support actions to allow ambulance crews to be released. - Rapid test capacity in the POW hot lab has recently increased with a reduction in swab turnaround times. - Expansion of the bed capacity in YS to mitigate against the loss of bed capacity in the care home sector and Maesteg community hospital. - Daily site wide safety meeting to ensure flow and site safety is maintained. - There is now a daily WAST led call (including weekends) with a senior identified leader from the Health Board representing CTM and talking daily through the plans to reduce offload delays across the 3 DGH sites. -Twice weekly meetings with BCBC colleagues to ensure that any delays in discharge are escalated at a senior level to maximise the use of limited care packages/ care home capacity. -Appointment of Clinical Lead and Lead Nurse for Flow appointed Feb 21 - Operational Performance is now monitored through the monthly performance review. Performance review process has been restructured to bring more rigour with a focus on specific operational improvements. - Programme improvement is monitored through the monthly Unscheduled Care Improvement Board, which reports into Management Board.	Continue to implement actions identified in the control measures. Action plans are in the process of being reviewed so a timescale will follow once the review has been undertaken by the lead. Update September 2022 – Risk reviewed by Nurse Director for Unscheduled Care, risk to be closed owing to multiple changes to structures and reporting systems since original risk was opened. Risks to be reviewed and understood against new frame work outlined by the Six Goals Board local governance, quality and safety feedback mechanisms and unscheduled care quality and performance reporting mechanisms. Risk will be closed once the detail has been agreed and new risk superseding this current risk. Update 3.11.2022 - mitigations to improve flow and discharge at POW now being addressed through workstreams 2, 3 and 4 of the UEC 6 goals programme, with rapid focus on reducing lost bed days due to discharge delays, formal launch of D2RA model and pathways Dec 22, along with launch of e-whiteboards/discharge referral forms	Quality & Safety Committee	20	C5 x L4	15 (C5xL3)	↔	24.09.2019	03.11.2022	31.12.2022
4907	Director of Corporate Governance	Central Support Function - Quality Governance (Concerns & Claims)	Assistant Director of Concerns and Claims	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to manage Redress cases efficiently and effectively	**If:** The Health Board is unable to meet the demand for the predicted influx of Covid19 related, FUNB Ophthalmology Redress/Claim cases **Then:** the Health Board will not be able to manage cases in a timely manner and will not meet the required targets in respect of Putting Things Right. **Resulting in:** Risk to quality and safety of patient care, resulting from poor management of cases. Financial impact to the Health Board from Redress cases which have been poorly managed and consequently proceed to claim.	Controls are in place and include: * Regular reports run on all Redress cases, with monitoring by the Head of Legal Services & Legal Services Manager * Covid-19 monies secured for one Band 5 Redress Handler to take forward the Covid-19 related cases. A Redress panels have been established where required and meetings with ILGs undertaken when required to ensure legal aspects have been reviewed and validated.	The Health Board have developed an action plan in response to Welsh Risk Pool review, which is in the process of being delivered. Recommendation from the review are being monitored by the Audit & Risk Committee. All actions due to be completed by the end of March 2023. The Health Board has secured Covid funding in respect of the recruitment Covid19 specific Redress Handlers. Update September 2022: The Health Board are starting to realise the risk with evidence of redress cases being moved into claims due to delays, which are being settled for less than £25k, which is non reimbursable through WRP procedures for a claim, however can be reclaimed under redress. An invest to save bid has been developed to address the redress backlog. Update October 2022: Invest to save bid has been developed and submitted. Some resource has been identified through the proposed Quality Governance Operating Model, which should provide some capacity within the service.	Quality & Safety Committee	20	C4xL5	8 (C4xL2)	↔	02.11.2021	30.09.2022	30.11.2022
5267 (Capturing risks 4106 and 4157 which are now closed)	Executive Director of Nursing & Quality	Centre Support Function - Patient Care & Safety - Nursing	Deputy Executive Director of Nursing	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	There is a risk to the delivery of quality patient care due to difficulty recruiting & retaining sufficient numbers of nurses	**IF:** the Health Board fails to recruit and retain a sufficient number of registered nurses and midwives due to a national shortage & Health Care Support workers (HCSW's) **Then:** The Health Board's ability to provide high quality care may be impacted as there would be an overreliance on bank and agency staff. **Resulting in:** The potential for disruption to the continuity and of patient care and risk of suboptimum team communication due Potential to impact on patient safety and staff wellbeing. Financial implications of continue high use of agency cover (includes registered nurses and HCSW's) Please note - this risk is an amalgamation of two previous risks i.e., 4106 and 4157, these have been closed with a narrative to state this combined new risk has been created.	Proactive engagement with HEIW Scheduled, continuous recruitment activity overseen by WOD. Overseas RN project continues. • Close work with university partners to maximise routes into nursing • Retire and return strategy to maintain skills and expertise • Dependency and acuity audits completed at least once in 24 hrs on all ward areas covered by Section 25B of the Nurse Staffing Act; this has now been rolled out to all wards within CTMUHB. • Reporting compliance with the Nurse Staffing Levels (Wales) Act regularly to Board • Regular review by Birth Rate Plus, overseen by maternity Improvement Board • Implementation of the Quality & Patient Safety Governance Framework including triangulating and reporting related to themes and trends • Targeted approach to areas of specific concern reported via finance, workforce and performance committee Nurse Rostering Policy - Now approved with a launch date of December 2022. Automated nursing agency invoicing system implemented within the Health Board by the Bank office team - rosters must be locked down daily to enable the system to work- provides more rigor to roster management at ward/ department level.	NURSE ROSTERING Nurse Rostering Policy to be launched in December 2022. Nursing Productivity Group actions continue to progress well through this forum. Registered Nurse Off contract agency forms have been revised to enable a higher level of scrutiny and sign off by Nurse Directors (in hours) and Exec on call out of hours. The HCSW agency shift requests will follow the same type of forms and sign off from December 2022. Workforce and finance teams are working together to provide joint metrics and monitoring of agency useage and cost progress monitored via Nursing Productivity group who report into the Value & Effectiveness portfolio group. SAFER CARE Roll out in POW site due to be completed by end of November 2022 with plans to roll out to other sites later in 2022. ENHANCED SUPERVISION Corporate nursing team are currently undertaking focused work within POW in the areas of high usage of agency HCSW's, update will be provided in December 2022	Quality & Safety Committee	16	C4xL4	C4xL3	New Risk Escalated October 2022	25.10.2022	25.10.2022	01.12.2022

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4149	Chief Operating Officer	Mental Health Care Group	Clinical Service Group Manager - CAMHS.	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to sustain Child and Adolescent Mental Health Services	**If:** The Health Board continues to face challenges in the CAMHS Service (covering locality CAMHS in CTM and Swansea Bay as well as specialist CAMHS services commissioned by WHSSC - Inpatient Unit at Ty Llidiard and FACTs service) **Then:** there could be an impact in maintaining a quality service **Resulting in:** recruitment and retention challenges and detrimental impact on wellbeing of existing workforce, long waiting times; inability to implement new models of care required to meet increasing demand; supporting patient pathways via services and standards of care planning required by the All Wales Mental Health Measure. If the specialist WHSSC commissioned services are not sustained the impact would be far reaching given the population they serve (inpatient - South Wales, FACTs -whole of Wales) and would result in more complex patients not being supported and treated in Wales. Difficulties remain with waiting times for specialist CAMHS; recruitment of key staff and ability to implement new model of care and the new neurodevelopmental service remains challenging.	o Reported local and Network pressures across the CAHMS Network with variable problems dependent on the area of the network. o Updates provided to Management Board on developing service model to address reported issues and additional investment secured to increase capacity within the service and to address service pressures. Waiting list initiatives in place whilst staff recruitment is being progressed. o Service Model developed around Core CAHMS in Cwm Taf Morgannwg which includes agreement with General Paediatrics to take the lead on Neurodevelopmental Services and shared care protocols with Primary Care. o New investment impact being routinely monitored internally via the SMT and via monitoring meetings with the ILG Monthly commissioning meeting discussions taking place across the Network in relation to service pressures and funding. Additional funding received for investment in services • Implementation of the Choice and Partnership Approach (CAPA) with a new service model introduced ensuring the service aligns itself with All Wales Mental Health Measure. All referrals accepted to CAMHS will now receive a Part 1 Mental Health Assessment to determine the level of support required. Performance is being reported and monitored via monthly performance meetings • A number of service reviews in relation to Ty Llidiard undertaken and monitored via Q,S&R Committee. Additional nursing leadership implemented and progress on required action plans and proposed staffing model. Business case being drafted for additional investment to support staffing model in March 22. Workshops scheduled with WHSSC to review service specification and gap analysis. First workshop took place on 15th Feb 22. Staff and stakeholder consultation event took place in April. Improvement Board set up and improved reporting to WHSSC on actions taken and progress being made. Survey undertaken with colleagues demonstrating improvement. • Community CAMHS in both CTM UHB and Swansea Bay UHB are carrying out WLI via the planned care recovery (PCR) scheme. The additional clinics and dedicated team for assessment and single point of access have helped to reduce waiting times in CTM UHB to approx 4 weeks. Number of patients on CTM waiting list has reduced from 365 to just over 200 patients. The waiting times in Swansea Bay UHB have reduced significantly(from 32 weeks+ to 1.9 weeks). Capacity and demand work has been undertaken with clear improvement trajectories and the implementation of a new service model to aim to meet demand. Planned care recovery schemes	Risk reviewed and updated the controls Ongoing improvement in community CAMHS performance in relation to waiting list - Swansea Bay waiting list reduced down from 462 to 90 in September. CTM waiting list reduced from 365 in May 2022 to 200 in September. Work ongoing to improve compliance with part 1a and 1b. New SIF MH bids funding received and in progress of recruitment. Further work required for community CAMHS performance on part 2, improvement plans in both areas. Continued improvements being made in the escalation plan for Ty Llid via the Improvement Board. values and behaviour leadership survey undertaken which demonstrates good feedback from colleagues on improvement but also helps identifies areas for improvement. FACTs service - consultant interviews taking place on 1st November. Progressing recruitment plan to address vacancies	Planning, Performance & Finance Committee & Quality & Safety Committee	16	C4xL4	8 C4xL2	↔	01/01/2015	07.10.2022	30.11.2022
4479	Executive Director of Nursing & Midwifery	Central Support Function - Infection, Prevention and Control	Deputy Lead Infection Prevention Control Nurse & Decontamination Officer,	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	No Centralised decontamination facility in Princess of Wales Hospital (POWH)	**If:** there is no centralised decontamination facility in POWH **Then:** there are a number of areas undertaking their own decontamination via automated/manual systems. **Resulting In:** possible mismanagement of the decontamination processes/near misses/increased risk of infection/litigation risks and non compliance with national guidance/best practice documents. The hospital site is at risk of losing their JAG accreditation in Endoscopy if plans to centralise decontamination is not progressed. There is no dirty - clean flow for procedure room 2 in endoscopy. There is some decontamination equipment in HSDU that needs replacement. The decontamination equipment in Urology is at the end of it's life and there are regular service disruptions due to failed weekly water testing results.	Monthly audits undertaken in all decontamination facilities in POWH by the lead endoscopy decontamination officer and results shared at local decontamination meetings. AP(D)support available on site. Monthly ILG decontamination meetings take place where all concerns are escalated to the HB Decontamination Committee meeting. SOPs is place Water testing carried out as per WHTM guidance Maintenance programme in place for decontamination equipment 07/10/2021 - In view of aging Urology washer disinfectors, urology service managers to liaise with APDs to initiate/ agree a service contract for maintenance and servicing of equipment with an external. August 2022 Update: Lead IPC Nurse and Deputy Executive Nurse Director reviewed the Controls in Place with no updates reported for August	Centralised Decontamination Facility at POWH - 02/08/21 - SOC approved by WG and design team appointed. Project team group and working group to be set up - Timeframe 30.09.2021. Each area that decontaminates scopes/intra cavity probes(outside CSSD)has developed SOPs detailing the decontamination process. Evidence of SOPs to be shared at decontamination meeting in POWH. Lead IPCN to ask Operational Lead for Decontamination to action. 02/08/21 - Operational lead for Decontamination has requested assurance from the lead endoscopy decontamination officer in POW. Timeframe 30.11.2021. 15.12.2021 - risk peer reviewed and agreed that the risk remains as a 20. Development of a business case to create a single centralised decontamination facility on the POWH site has commenced with Welsh Government Funding support. Business case expected to be completed by Spring 2022. Availability of WG funding to create the unit remains a risk. Update June 2022 - Risk reviewed at Infection Prevention Control committee 28/06/2022 and update provided - JAG have agreed to extend accreditation in Princess of Wales for a further 6 months and have requested a progress report on plans for central decontamination. Update: Lead IPC Nurse and Deputy Executive Nurse Director reviewed the Action Plan with no updates reported for August. 17/08/22 - contingency plan being developed with key service users. Central decontamination facility at detailed design stage and business case should be ready for submission by end of January 2023	Quality & Safety Committee	16	C4xL4	2 C1xL1	↔	30.12.2020	1.11.2022	30.11.2022
1133	Chief Operating Officer	Unscheduled Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Long term sustainability and staffing of the Emergency Department (ED) at the Royal Glamorgan Hospital. (RGH).	**If:** the Clinical Service Group (CSG) is unable to deliver a sustainable staffing model for the Emergency Department at the RGH; **Then:** the Health Board will be unable to deliver safe, high quality services for the local population; **Resulting in:** compromised safety of the patients and staff and possible harm.	ED sustainable workforce plan developed and being implemented (May 2021). Option 1 funded so risks around sustainability remain particularly in respect of the consultant workforce. Financial position remains a challenge as locum and agency staff still used. No agreed plan to align staffing to benchmarking standards and the staffing levels on other sites within CTM. Boundary change and challenges across CTM continue to have a significant impact on the RGH site. September 2022 Review by Nurse Director for Unscheduled Care: Currently 6.3 wte ANPs in post with 3 new trainees commencing. Advert for locum Consultant in progress Ad-hoc locum for middle grade to cover for absences and planned leave	ED sustainable workforce plan developed and being implemented (May 2021). Reviewed no change as at 7th September 2021. Reviewed 21.09.2021 - remains working progress. Update September 2022 - Nurse Director Review 7/9/22: Unscheduled care group to review immediate workforce resource across all three acute sites by end of October 2022. Actions to then be decided in terms of immediate measures for distribution of staff, governance lines to be agreed (nursing, AHP and Medical) and immediate plan for winter months to be agreed and acted upon. Medium term and substantive plans for workforce requirements and innovations to be worked through as part of six goals board and advanced practice board.	Quality & Safety Committee. People & Culture Committee - Workforce aspect	16	C4 x L4	12 (C4xL3)	↔	20.02.2014	07.09.2022	31.10.2022
3133	Chief Operating Officer	Central Support Function -Facilities	Governance and compliance manager, Facilities	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Due to capacity issues to deal with Covid-19 staff not attending medical gas safety training and courses being rescheduled.	**If:** Staff are not able to attend Medical Gas Safety training or courses are being continuously rescheduled. **Then:** Staff are not being trained in safe storage and flow of cylinders (e.g. oxygen). **Resulting In:** Failure to adequately and safely obtain and continue flow of cylinders (e.g. oxygen), potentially causing harm to patients.	PSN041 Patient Safety Notice and local safety alert disseminated to all staff. Posters developed and displayed in areas to encourage attendance. New staff trained at induction. TNA has been undertaken. Refresher training is undertaken, however current attendance levels by clinical staff for Medical Gas Safety training is poor, hence the current risk score. Medical Gas Cylinder Policy developed with training section completed by Medical Device Trainer, referencing the mandatory requirement for training by all users. Completed To make it a key requirement that staff can be released to attend training to re-enforce safety and operating guidelines of medical gas cylinders. Completed. Medical Device Trainer has put in place a B4 role who is undertaking a rolling programme for Medical Gas Training, with two sessions, twice a month, at each ILG every month. However, although training has been undertaken for Porters and graduate nurses, nursing staff currently in post are still not attending and attendance continues to be poor due to current circumstances with Covid-19 and due to not being able to be released for the 2 hours of training. Medical Device Trainer and Assistant Director of Facilities to request again for the Executive Director of Nursing Midwifery and Patient Care to review nursing attendance and make the necessary arrangements to allow nursing staff to attend training and also to look at the possibility of introducing a 'training day' that will allow nursing staff to be released to attend those courses that are struggling with attendance levels. Meeting held and COO has requested for Facilities to work on a monthly Medical Device Training Compliance report template that can be presented to both COO and ILG Director leads to inform current compliance position and actions to improve attendance and compliance for all courses including Medical Gas Training. Medical Device Trainer has stated that the current report template needs to be reconfigured to account for the change of wards and Directorates for the new ILG structure and to deal with the pandemic, this will take time to complete, hence the change in action implementation date to account for this.	Update: September 2022. Action: Use reporting template to monitor attendance. Timescale: 31/03/2022 - Complete. Quarterly reports in place for all med device training sent to Corporate Services for dissemination to ILG management, places offered, places attended/competency assessments etc. Medical gas training compliance is 33% in April 2022 report, 8.85% in July 2022 report (DW WG 31/08/2022). No change to mitigation at this time until a sufficient level of compliance for Medical Gas Training is being consistently achieved. Review Date: 30/11/2022	Quality & Safety Committee.	16	C4 x L4	8 (C4xL2)	↔	01/05/2018	21.10.2022	30.11.2022
3585	Chief Operating Officer.	Unscheduled Care Group	Care Group Service Director - Unscheduled Care.	Improving Care	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	Princess of Wales Emergency Department Hygiene Facilities	**If:** the toilet and shower facilities are not increased within the Emergency Department. **Then:** at times of increased exit block the facilities are insufficient for the needs of the patients in the department. **Resulting In:** Poor patient experience, complaints and further concerns raised from the Community Health Council have repeatedly flagged this issue on visits to the department.	There are additional toilet facilities in the radiology department that mobile patients can be directed to however staff do whatever they can within the constraints that they have. Additional facilities being explored as part of departmental capital works.	Additional facilities being explored as part of departmental capital works. There is a capital plan for improvement works in ED. The improvements will be – 1. NIV cubicle, 2. Creation of a second patient toilet, 3. Improvement to HDU area, 4. Relocation of Plaster Room, 5. Creation of 2 paediatric bays with adjoining paediatric waiting room, 6. Redesign of waiting room and reception desk. Prior to the Covid pandemic, improvements 2-6 were planned, but the creation of an NIV cubicle has taken priority. The plans are in the process of being signed off for all areas but there is no confirmed start date yet. There was / is potential for delays in sourcing materials by contractors and we need to consider the need to keep contractors as safe as possible from any Covid contact. Patient numbers are now increasing daily but we are restricting visitors and relatives attending with patients (unless required as carers etc). We have also developed a remote waiting room for patients who can safely wait in their cars. This will help to mitigate the footfall in the department when the capital work commences. June 21 Update - Capital works for NIV room still ongoing and therefore no progress yet with the rest of the capital build. NIV room to be handed back mid June and patient toilet will be the next priority for completion. Update August 2021 - No Change.RCEM audit undertaken. Staffing remains ongoing issues- plans in place and frequently reviewed. ASCU staffing plan agreed at ILG level and ongoing. Surge trolleys in place to cope with additional capacity requirements. Building works progressing and some phases complete. X references to ID4458 & ID3826.Update: Awaiting update from Capital team to confirm start date for next phase of works. Patient toilet is the next priority. Update from Capital Team 6.5.2022: The ILG have been requested to provide availability for a prioritisation meeting for the 22/23 limited discretionary funding that is available - this will need to be discussed alongside their outstanding risks and prioritised for funding. Update June 2022 - Additional toilet works not yet commenced. Agreement from Capital / Estates teams to undertake the work. No start date yet. Update 3.11.2022 - WG funding secured to have works undertaken. CTM capital team progressing ASAP.	Quality & Safety Committee	16	C4 x L4	1	↔	31.05.2019	3.11.2022	30.12.2022

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4148	Executive Director of Nursing & Midwifery	Central Support Function - Quality Governance (Quality & Patient Safety)	Assistant Director Quality, Safety & Safeguarding	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Non-compliance with Deprivation of Liberty Safeguards (DoLS)legislation and resulting authorisation breaches	**IF:** the Health Board fails to adequately resource the DoLS Team to address the backlog of authorisations and adequately manage a timely and effective response to new authorisations. **Then:** the Health Board will be unlawfully depriving patients of their liberties and failing to comply with the DoLs legislation **Resulting in**: the rights, legal protection and best interests of patients who lack capacity potentially being compromised. Potential reputational damage and financial loss as a result of any challenge by the ombudsman or litigation.	During February 2022 review of this risk the control measures have been revisited and streamlined. - Prioritisation assessment is being undertaken on the urgent authorisations. - Hybrid approach to the management of authorisations which includes the ability to offer a virtual format if necessary, although face to face is the preferred mechanism. - As at February 2022, the DoLS Team have now returned to full establishment which will support the resilience within the function. - A temporary Best Interests Assessor has now commenced with the Health Board whose role will be to focus on reducing the backlog. This post have been extended for a further year following CTMUHB being granted further WG funding to address the backlog. - A temporary Practice Educator has also been appointed whose role will be to prepare the Health Board for the Liberty Protection Safeguards and ensure that all staff are trained in the Mental Capacity Act. This post has been extended for a year following CTMUHB being granted further WG funding. - From February 2022, the DoLs Training has been revised and is running virtually on a monthly basis. - Audits are undertaken by the DoLS Team to look at compliance across the Locality Groups with the support of AMaT. - Capacity issues are also being supported by addition resources sourced through CTM Staff Bank. August 2022 Update: As a result of enhanced WG funding MCA training has been reviewed an delivered virtually and face to face across sites within CTMUHB. Both YCC and YCR staff have received bespoke training in response to concerns raised by the DU. In addition, training has been agreed and planned to be delivered to service groups within all three ILG. Compliance is being monitored through the Safeguarding Executive Group. Quarter 1 had the highest recorded number of referrals in a quarter, this coincides with the additional training. It is reassuring that the referrals are correctly identifying those people who need urgent and standard DoLS.	The Health Board has received confirmation that the Welsh Government will be offering funding to address backlogs in authorisations, to provide training in the MCA and prepare the implementation of the Liberty Protection Safeguards. This will be offered in three stages. CTMUHB have already succeeded in securing a £123,000, this has been used to extend the Best Interest Assessor and the Practice Facilitator roles. There will also be a three day Best Interest Assessor post going out to audit in May 22. It is anticipated that the Health Board will need to apply for further funding throughout the year to address any backlog and plan to implement the LPS. - The implementation of the change in legislation with regards the Liberty Protection Safeguards will improve the Health Boards compliance however the date of implementation is still awaited. The Code of Practice is currently out for consultation. - The DoLs Team are meeting with leads within the Locality Groups to work with CSGs to progress the action plan in order to enhance the awareness of the MCA, the risks associated with DoLs authorisations and timely review required and reporting compliance. This work has commenced within YCC and YCR. There are plans to extend this work throughout CTMUHB. Update July 2022 - funding of £90K received to facilitate continued improvement in MCA awareness and training. Training sessions being delivered. to targeted areas in the UHB to improve awareness and therefore quality of care and safety. A Learning Event is planned to highlight the issues in respect of capacity, the MCA and planned changes as a result of new legislation. No further steer on the implementation of LPS. Awaiting feedback in relation to the consultation on the code of practice. Update August 2022 - CTMUHB have received further WG funding of £184K. A further four BIA posts have recently gone out to advert. Two further Mental Capacity Practitioners will be advertised in September 2022. It is anticipated that the substantial increase in the teams resources will enable the BIA to address the current backlog and respond to the increase in DoLS requests. The appointment of two further MCA Practitioners will allow for increased capacity to deliver MCA training and prepare for further LPS training throughout CTMUHB. Sessions to highlight the issues in respect of capacity, the MCA and planned changes as a result of new legislation have commenced. Comments in respect of the proposed code of conduct have been submitted to WG by CTMUHB. Once all vacancies have been filled it is anticipated that the backlog of outstanding authorisations can be significantly reduced and the risk reviewed.	Quality & Safety Committee	16	C4 x L4	8 (C4xL2)	↔	01/10/2014	25.08.2022	21.10.2022
4152	Chief Operating Officer	Diagnostics, Therapies and Specialties Care Group	Care Group Service Director.	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Back log for Imaging in all modalities / areas and reduced capacity	**If:** there is a backlog of imaging and reduced capacity **Then:** waiting lists will continue to increase. **Resulting in** delay and diagnosis and treatment. Due to the Covid-19 outbreak, all routine imaging has stopped and there is reduced capacity for imaging of USC sand Urgent patients.	Additional clinics, locum appointments, clinical validation of waiting lists, outsourcing and alternative contracting arrangements and the use of additional mobile scanners. The constraining factor in all of these measures is the availability of a suitably skilled workforce. The ending of double-time enhanced rate payments in early May 2022 presents an additional challenge. All patients requiring Radiology diagnostics as part of the Single Cancer Pathway are closely tracked and not waiting beyond 20 days.	Increased capacity required for current referrals to address backlog, particularly in CT/MRI /Ultrasound. Require funding and procurement of mobile scanners in the longer term. Actions: Staffing Resource, Capacity and Demand Planning and business case. No change to risk score or mitigation.	Quality & Safety Committee	16	C4 x L4	4	↔	01/06/2020	04.05.2022	30.06.2022
4458	Chief Operating Officer	Unscheduled Care Group	Care Group Service Director - Unscheduled Care.	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to Deliver Emergency Department Metrics (including 15 minute Handover and 4 and 12 hour breaches.)	**If:** the Health Board fails to deliver against the Emergency Department Metrics **Then:** The Health Boards ability to provide safe high quality care will be reduced. Patients will be waiting in the ambulance rather than being transferred to the Emergency Department. **Resulting In:** A poor environment and experience to care for the patient. Delaying the release of an emergency ambulance to attend further emergency calls. Compromised safety of patients, potential avoidable harm due to waiting time delays. Potential of harm to patients in delays waiting for treatment.	Senior Decision makers available in the Emergency Department. Regular assessments including fundamentals of care in line with National Policy. Additional Capacity opened when safe staffing to do so. Senior presence at Health Board Capacity Meeting to identify risk sharing. Winter Protections Schemes Implemented within ILG's. Operational Performance is now monitored through the monthly performance review. Performance review process has been restructured to bring more rigour with a focus on specific operational improvements. Programme improvement is monitored through the monthly Unscheduled Care Improvement Board, which reports into Management Board.	The Unscheduled Care Improvement Board will monitor progress on the programme on a monthly basis. Given the decrease in compliance for 12 and 4 hour waits, it is impossible to outline progress at this point. It is anticipated that the work of the Urgent Care Improvement Group will be able to report some improvement in the coming months. Update September 2022 Update – UEC Six Goals Improvement Programme now commenced – workstream 2 (integrated front door) – rapid mobilisation of other elements of the front door (SDEC, Acute frailty assessment, Hot/rapid access clinics) to facilitate ED de-crowding and timely ambulance offload. Update 3.11.2022 - now being addressed via UEC 6 goals programme, workstreams 2, 3 and 4. Aim to improve whole hospital/system flow, implementing D2RA model and pathways Dec 22, implementing enabling processes to improve flow and discharge - including e-whiteboards/e-dischage referrals, discharge hub, additional components of integrated front door (including acute frailty ax, hot clinics, SDEC), discharge lounges on each site.	Quality & Safety Committee Planning, Performance & Finance Committee	16	C4 x L4	12 (C4 x L3)	↔	04/12/2020	3.11.2022	31.12.2022
4679	Executive Director for People (Executive Lead for Occupational Health)	Central Support Function - Occupational Health	Head of Service - Employee Health Wellbeing Service (Occupational Health)	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Absence of a TB vaccination programme for staff	**If:** the Health Board is not providing TB vaccination to staff **Then**: Staff and patients are at risk of contracting TB **Resulting in**: Failure to comply with the Department of Health and Social Care guidance and lack of confidence in the service	The 'fitness letter' issued by Occupational Health to the appointing line manager following an employee health clearance highlights vaccination status. Screening for latent TB for new entrants and offering T spot testing to assess positive or negative.	Update May 2022 - Training to be provided to the CTM OH nurses from the CAV OH nurses via a 'train the trainer' approach. Dates being arranged for May 2022. All necessary paperwork in place. Update June 2022 - Training Ongoing. Risk reviewed and remains same. Update August 2022: training has been delayed due to staffing issues within OH department. New dates have been identified in September. New recruits continue to be risk assessed for active TB symptoms and where appropriate new staff from areas of high risk of TB are screened for latent TB. Update October 2022 - Risk reviewed and remains same. Trainer has been identified no date confirmed as yet to commence training the OH Nurses.	Quality & Safety Committee People & Culture Committee	16	C4xL4	8 C4xL2	↔	09.06.2021	31.10.2022	31.12.2022
4798	Executive Director of Therapies & Health Sciences Therapies hosted by Merthyr & Cynon Integrated Locality Group	Diagnostics, Therapies and Specialties Care Group	Clinical Director of Allied Health Professionals - Therapies	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Unsafe therapy staffing levels for critical care services at Prince Charles Hospital, Royal Glamorgan Hospital and Princess of Wales Hospital.	**If** the therapy services (physiotherapy, speech and language therapy, dietetics, occupational therapy) continue to not be at the recommended staffing levels according to national level requirements (GPICs), **Then:** the critical service will be unable to meet the need of patients requiring therapy, **Resulting in:** significant negative impact on patient outcomes, ability to recover from critical illness and length of stay in critical care unit and consequently in hospital longer than needed.	Currently staff stretch to cover and prioritise patient need as much as possible. During winter pressures have tried in the past to recruit locums but availability still remains an issue for some services and not sustainable. Sighted within HB Critical Care Board as significant gap and within peer review response. Update 16-9-21 Continuing with therapy business case as actions below. No other updates	Completed comprehensive business case detailing recommendations for staffing, gaps, impact and consequences of gaps Next steps require consideration for prioritising of funding for gaps in therapy posts in critical care within ILGs to decrease risk RTE critical care short-term planning business case, identified RGH therapies workforce requirement, however these would need to be recruited to recurrently, as unable to recruit to fixed term tenure. Update: The Therapy workforce model has been completed for three bespoke staffing options for a Tier 1 unit with 4-8 PACU beds as part of the reconfiguration work. Update July 2022: no change to mitigations; Emerging discussions are taking place in relation to critical care which are likely to impact this risk; Further updates will be provided in 2 months' time Update August 2022 - risk reviewed and no change. Further review added 29.09.2022. No funding has been allocated to enable recruitment of AHP workforce to meet GPIC standards. Options appraisal for the existing AHP critical care workforce will be undertaken, which will include consideration of consolidation onto a single site for some of AHP professions with minimal staffing. AHP Clinical Director to review the options and propose a plan by October 2022. Update 31/10/22 - Current Situation Full engagement by AHP Leads with all Critical Care meetings and submission of all required therapy workforce info in line with GPICS standards but no confirmed investment in therapies for Critical Care across CTM. SLT and Dietetics are the most affected, with no cover in PoW and very limited cover in RGH and PCH. Recent Datix for PoW when team became aware that the 'emergency' enteral feeding regime was 10 years old, not written by a dietitian, and recommending a feed no longer stocked in PoW. Actions: Actions continue to try to improve safety at PoW, led by Head of Nutrition & Dietetics. Ongoing Therapy & ITU discussions with PoW and RGH regarding repurposing monies to fund SLT sessions. CD for AHPs met with PCH intensivist w/c 24/10/22. Meeting to be planned for upcoming weeks to review the AHP situation across CTM. Intensivist is engaging the Critical Care Network to seek support and advice. Risk remains high across all 3 sites.	Quality & Safety Committee	16	C4xL4	8 C4xL2	↔	20.08.2021	28.10.2022	30.12.2022

Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
4906	Director of Corporate Governance	Central Support Function - Quality Governance (Concerns & Claims)	Assistant Director of Concerns and Claims	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to provide evidence of learning from events (Incidents and Complaints)	**If:** The Health Board is unable to produce evidence of learning from events. **Then:** the Health Board will be unable to recoup any costs from Welsh Risk Pool for personal injury or clinical negligence claims made against the Health Board. **Resulting in:** Risk to quality and patient safety with potential for further claims as learning and improvement will not have taken place. Financial impact to the Health Board	Controls are in place and include: * Monitored and reported through the weekly Executive Quality & Safety meeting. * Regular engagement and meetings with the Executive team to assist in gathering of learning. Improvement plan implemented by WRP with monthly targets to submit the backlog. * Learning From Event Report (LFER) Standard Operating Procedure devised and disseminated * LFER 'How to Guide' devised and disseminated * Ad-hoc training available on request. * Internal targeted monitoring in place.	The Health Board are developing a Learning Framework to ensure Learning is captured and shared across the organisation. Currently at consultation stage. The Health Board have developed an action plan in response to Welsh Risk Pool review, which is in the process of being delivered. Recommendation from the review are being monitored by the Audit & Risk Committee. All actions due to be completed by the end of March 2023 Welsh Risk Pool have implemented a targeted improvement plan. Initial target was marginally missed, however, work continues to meet the overall deadline for 1st June. Update September 2022: Work continues in this area, however this is still proving a challenging area of work. The new operational model has ensured that this area of work is included as part the Care Group Governance Team. Update October 2022: A data reconciliation with WRP has demonstrated that the data held by CTM and WRP now correlate. This has been achieved through updating data and an in depth data validation. This will be invaluable going forward as service areas will have a clear position in relation to LFERs. The Governance teams continue to support service areas with the completion of LFERs. Guiding principles for the governance and accountability for quality and safety have been developed to support service areas through the transitional process to the new operating model.	Quality & Safety Committee	16	C4 x L4	8 (C4xL2)	↔	02.11.2021	30.09.2022	30.11.2022
4908	Director of Corporate Governance	Central Support Function - Quality Governance (Concerns & Claims)	Assistant Director of Concerns and Claims	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to manage Legal cases efficiently and effectively	**If:** The Health Board was unable to sustain ongoing funding for the two temporary Legal Services Officers **Then:** the Health Board will not be able to manage cases in a timely manner and will not meet the required targets in respect of Putting Things Right. **Resulting in:** Risk to quality and safety of patient care, resulting from lack of capacity to management cases in a efficient and effective manner, which could result in failure to comply with the WRP procedures resulting in financial penalties	Controls are in place and include: * Regular reports run on all Redress cases, with monitoring by the Head of Legal Services & Legal Services Manager Some funding secured in respect of one Band 5 Redress Handler, however there still remains a Redress backlog and there has been an influx of inquests. A Redress panels have been established where required and meetings with ILGs undertaken when required to ensure legal aspects have been reviewed and validated.	The Health Board have developed an action plan in response to Welsh Risk Pool review, which is in the process of being delivered. Recommendation from the review are being monitored by the Audit & Risk Committee. All actions due to be completed by the end of March 2023. Update September 2022 - Benchmarking exercise completed, which demonstrates low staffing to workload capacity with counterparts across Wales. Invest to save bid has been drafted with a hope to recruit 2 Redress Handlers. In addition opportunities are being explored to realign resources from the changes to quality and safety within the Operating Model review and workshop is being held in Sept 2022 to review skill mix in the claims handling team. Update October 2022 - Invest to save bid has been completed and submitted for consideration, with a hope to recruit 2 Redress Handlers. In addition opportunities are being explored to realign resources from the changes to quality and safety within the Operating Model review. A workshop has been held with the Legal Services team to review ways of working moving forward into the new operating model.	Quality & Safety Committee	16	C4 x L4	8 (C4xL2)	↔	02.11.2021	30.09.2022	30.11.2022
4940	Executive Director of Nursing	Central Support Function - Quality Governance (Patient Experience)	Assistant Director of Nursing & People Experience.	Improving Care	Quality, Complaints & Audit	Delay to full automated Implementation of Civica	**If:** the Information team are not be able to complete the necessary data extraction requirements, **Then:** there will be a delay to the roll out of the automated survey process within the Civica system, **Resulting in:** a lack of service user feedback and opportunity to areas of improvement as well a good practice.	The Health Board launched the electronic ""Have your Say"" and Generic Patient Experience Survey on the 13.02.22. Posters containing QR codes are displayed on notice boards in our hospital sites, KHHP and Dewi Sant. In addition links are available on our internal and external webpages, along promotion on available social media channels. A small card (like a business card) containing a QR code has been developed which will displayed in main thoroughfares such as Emergency Departments, Outpatients and community settings. Their will be made available to staff that are providing services in patients' homes. Exploration is taking place as to how the posters/cards can be promoted within he wider non-health board community settings. August 2022 Update: Value Based Health Care are working together with patient safety and quality to ensure the Health Board can align patient/peoples engagement / feedback. There is an objective in the new WG transformation strategy where we all have to work together and embed proms and prems. There is currently only one member of staff working on the Civica system (PT)and therefore resource is currently a major factor for the implementation and maintenance of the system. No change to the challenges relating to the full automation of Civica which remains an issue. Due to this CTM response rate to patient feedback is considerably lower when compared to other Health Boards e.g SBUHB, HDUHB, ABUHB, BCUHB. Volunteers within POW are now actively engaging with patients in regards to the Have your say/ patient experience survey	Implementation of the Civica System. Information Team has completed provision of all data feeds (August 2022) Whilst the overall consequence and likelihood of the risk is not extremely high, the SMS component remains high as currently there is no target date for full implementation of the automated element of Civica which would increase real time response rates. Reactive feedback continues be received and reported on via complaints, claims and compliments. August 2022 Update - SMS component remains high as currently there is no target date for full implementation of the automated element of Civica which would increase real time response rates. CIVICA system piloted in PoW in August using volunteers to capture feedback using the CIVICA system via IPADS.	Quality & Safety Committee	16	C4 x L4	12 (C4xL3)	↔	09.12.2021	25.08.2022	21.10.2022
5014	Chief Operating Officer	Children and Families Care Group	Children and Families Care Group Service Director and Clinical Services Group Manager	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Care of Obstetric & Gynaecology patients in the ED at the Royal Glamorgan Hospital	IF patients continue to present at the ED at the RGH with obstetric and gynaecology related issues and if boundary changes and diverts at times of high demand lead to increased risks for this patient cohort . THEN they will need to transfer to the ED at PCH where the appropriate services are in place. RESULTING IN a delay in the provision of appropriate care and treatment and this could lead to in-utero death, neonatal injury or disability, death of a pregnant lady due to blood loss and a loss of reproductive ability.	Pathways in place and subject to regular review. WAST is aware of the patient pathway and the need for O&G patients to go straight to PCH. Patients self presenting at the RGH ED would be prioritised for transfer to PHC Emergency cases would receive immediate general surgical care from non O&G specialists	Update October 2022 - the Assistant Director of Governance & Risk met with the Care Group Director and the Clinical Services Group Manager for the Children and Families Care Group regarding this risk and agreed that a review will be undertaken by the end of December to consider if the implementation of the On Call rota has mitigated this risk sufficiently to reduce the risk score. This will include engagement with the Executive Medical Director. Review by 31.12.2022	Quality & Safety Committee	16	C4 x L4	9 (C3xL3)	↔	15.02.2022	01.11.2022	31.12.2022
4722	Chief Operating Officer	Mental Health Care Group	Service Director - Mental Health and Learning Disability Care Group	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Senior Medical Workforce Shortfall	**If** the gaps in the senior medical workforce in RTE are not addressed (2wte vacancy OP, 1wte LTS, 1wte Non clinical duties plus paternity leave and isolation) **Then** routine work such as clinics will be cancelled, clinical decision making will be delayed and emergency escalation compromised along with the ability of the service to discharge the powers of the Mental Health Act. It is also possible that the training of junior doctors will be negatively affected. **Resulting in** poor quality and unsafe patient care, increasing concerns, risk of litigation, compromise of the UHB's reputation and removal of UHB from Psychiatry training programme.	Regular meetings with interim CSGD and Consultants to plan cover arrangements and support on weekly basis. Medical model change to functional inpatient at the RGH MHU covered by 3 Locum Inpatient consultants (22 sessions - 12/6/6) to cover 2 x Treatment Wards (28 beds) and 1 x PICU (6 beds). Recruitment - Vacancies out to advert for locum and substantive contracts. Exploring options for overseas recruitment. All staff being offered additional hours. In-patient team has been bolstered by an additional Registrar and 2 x SHOs ANP's covering appropriate PCMHSS AND CMHT clinics.	Update 06/06/22 - Vacant post in Rhondda Adult MH and been notified that Locum for Taff Ely who also covers in patient wards 1 day a week will be leaving the end of this weak. This leaves 2 vacancies in sectors for adult and an inpatient day short fall. Update Sept-22 - All adverts agreed to go in BMJ as part of wider recruitment drive. JDs have been reviewed and refreshed. Update November 2022 - Locum cover secured to mitigate partial risk pending substantive appointments. Recruitment exercise underway an interest has been received. Medical Director appointed into the Mental Health and Learning Disability Care Group to provide oversight and leadership on sustainable medical workforce activity.	People & Culture Committee Quality & Safety Committee	16	C4xL4	6 (C2xL3)	↔	28/06/2021	01.11.2022	31.12.2022

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2808	Chief Operating Officer	Children and Families Care Group	Clinical Service Group Manager	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Waiting Times/Performance: ND Team	IF: The Neurodevelopment service does not have capacity to achieve the WG assessment target (80% of assessments to commence within 26 weeks of referral) and to follow up patients in a timely way, due to demand exceeding capacity Then: Patients will wait excessive periods to reach a diagnosis and children on medication that require titration and monitoring may not be able to be seen within the appropriate timeframes Resulting in: Delays in appropriate treatments being commenced, delays in accessing support e.g. in school following a diagnosis, delay in being effectively titrated, risks associated with delays in medication monitoring	The service is operating as efficiently as possible e.g. enhanced roles for SLT/CNS/Pharmacist. Pathways have been reviewed e.g. ADOS's limited to only those cases where clinically necessary. Clinical Lead role created to support this (as below). Non-recurrent investment of the below posts have been given for 12 months, but Clinical Service Group has highlighted the requirement for these posts to be made permanent. *1.0 wte Psychiatrist (clinical lead role) *Uplift from 8a to 8b 0.6 wte Pharmacist *1.0 wte Band 3 admin *0.6 wte Band 3 HCSW Additional clinics are currently being held on weekends to address longest waiters. (WLI has been carried out in the service since 6 months of the service being set up) Meetings with National Lead for Values Based and Prudent Health Care arranged to look at modelling of the service. Bids have been submitted through successive IMTPs and previously against new WG funding sources for the ND service. Within Bridgend the Directorate is reviewing the feasibility of repatriating the SLA from Swansea Bay so that a local service can be developed	Seeking confirmation that non-recurrent funding is made permanent for fixed term posts - timeframe 31.3.2022. Consideration required for further investment in the service to allow us to meet the demands on the service and reach the Welsh Government target of 80% of assessments being seen within 26 weeks. This will also reduce the need for WLI every year. Further investment in the service following D&C review - Timeframe - 31.03.2022. September 2022 Update – it was agreed at the August PCR Board meeting that funding would be made available to support an additional Consultant, uplift to for a member of the Pharmacy staff, the appointment of an Administrative Assistant and a Health Care Support Worker. In addition, Welsh Government has announced that there will be funding for ND services across Wales over the next few years. The funding will be allocated to Regional Partnership Boards for distribution in-line with Regional Integration Fund aligned to the six national models of care with emphasis on taking a whole system approach with education, social care, health and 3rd sector working to deliver new models of care. October 2022: Risk remains unchanged however, review underway with Clinicians. Next review 31.12.2022.	Quality & Safety Committee	15	C3 x L5	9 (C3xL3)	↔	14.07.2017	02.11.2022	31.12.2022
3993	Executive Director of Strategy & Transformation	Central Function - Planning Project Risk	Head of Capital, Strategic and Operational Planning	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Fire Enforcement Notice - POW Theatres.	**IF:** The Health Board fails to meet fire standards required in this area. **Then:** the safety of patients, staff, contractors/visitors etc. and the protection of the buildings could be compromised. **Resulting in:** potential harm, risk of fire. Possible further enforcement in the form of prosecution.	Storage room obtained on ward 16 to store theatre equipment to ensure evacuation corridor is kept free for evacuation. Staff training on lift evacuation. Closed storage cupboards purchased for safe storage of equipment. "safe" areas identified with Senior Fire officer for storage of equipment in corridors. Weekly meetings to discuss and plan building work necessary to meet requirements of the enforcement notice. Enforcement notice has been extended to December 2021. Need to plan for drop in theatres to mitigate work commencing	Need building work to be undertaken to ensure safety. Operating theatres will need to close for this to occur. Fire enforcement notice has been extended to December 2023 by South Wales Fire and Rescue Service, work is ongoing with the construction supply chain partner to complete detailed design, obtain planning permission, a costed programme and submit a business case to Welsh Government by Spring 2022. WG have requested an options review be urgently undertaken on this as the preferred decant option is indicatively costed at £50M. The ILG are confirming availability for a management review of alternative options for delivery prior to a stakeholder session. Post this a report will need to be prepared for and discussed with WG to determine the way forward in terms of business case processes and timings. Update September 2022 from Capital & Estates - initial meeting with WG indicated that further work required to follow up on alternative options to the 6 theatre modular build so follow up WG meeting being arranged for late October / early November. Supply Chain partner reengaged to undertake more detailed engineering and design works. Update November 2022 - Risk remains unchanged as the options work is ongoing and meeting with WG is likely to be at the end of November with an outcome to the options review being discussed at that meeting. It is expected that this meeting will confirm the preferred way forward.	Quality & Safety Committee Health, Safety & Fire Committee	15	C5xL3	8	↔	31.01.2020	17.10.222	31.12.2022
4512	Chief Operating Officer	Mental Health Care Group	Deputy COO - Primary, Community and Mental Health	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Care of patients with mental health needs on the acute wards.	**If:** there is a consistent number of patients with mental health needs who are being cared for on the acute wards without RMN support or there are delays in discharge an appropriate EMI setting; **Then:** patients who have been sectioned and / or are under medication review may remain on wards where specialist mental health therapy and input is not possible; **Resulting in:** incidents of staff and patients assaults may occur; poor patient experience; increased supervision needed.	MHL team contacted for each patient who required support; 1:1 patient supervision where required; Ward manager and senior nurse undertake regular patient reviews; Regular meetings with the mental health CSG in place. , number of working groups established and working well.	Regular meetings with the mental health CSG in place, number of working groups established and working well. No change to mitigation or risk score. Update September 2022 - update requested from the Deputy COO - Primary Care, Community and Mental Health. Update October 2022 - Deputy COO - Primary Care, Community and Mental Health and Interim Clinical Service Group Manager, Mental Health are reviewing this risk and consider that the risk score will be reduced in the next update of the Organisational Risk Register. Timeframe assigned: 31.12.2022.	Quality & Safety Committee	15	C3 x L5	9 (C3xL3)	↔	30/12/2020	02.11.2022	31.12.2022
4590	Executive Medical Director	Diagnostics, Therapies and Specialties Care Group	Chief Pharmacist	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Critical Care Pharmacist Resource	**If:** additional resource is not identified to increase the critical care clinical pharmacy service **Then:** there is a risk that insufficient support can be provided to meet national standards and there would be lack of capacity to support future surges in demand, such as Covid. **Resulting In:** an increasing risk to patient safety, increased workload for critical care nursing and medical staff and lack of appropriate support for digital developments such as e-prescribing	SBAR included in Medicines management and advised to include in ACT directorate IMTPs. Meetings to discuss potential funding arranged with ACT leads. Baseline level of service (0.2wte) pharmacist time per site. A small pool of CC trained pharmacists are providing clinical services to acute wards which would be impacted if they are redeployed to support ITU, resulting in risk to patient safety and flow on acute wards.	June 21: Current situation included in planning review of CTMUHB ICU services Aim is to secure funding for 1WTE 8a specialist pharmacist for each critical care in RGH, POW and PCH and also supporting technician resources Update November 2021 as reported to the Quality & Safety Committee: Discussions are ongoing with ILGs so that pharmacy resource costs are included in any new business cases e.g. PACU and progress can be made to meeting the standards. Update February 2022: Discussion are ongoing with ILG's and submission for funding was made in Medicines Management in IMTP Feb 2022. Update August 2022 - Currently 40% gap in staff in post vs standards (1.5 wte) across all acute sites. Funding agreed for RGH and staff recruited into post. Currently non-recurrent. Funding request submitted within IMTP.	Quality & Safety Committee	15	C3 x L5	9 (C3xL3)	↔	05.04.2021	08.09.2022	08.10.2022
4732	Chief Operating Officer	Unscheduled Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Lack of orthogeriatrician as NICE guidance and KPI1 NHFD	IF: If we do not have this specialist service THEN: our patients will receive suboptimal care than others in the UK and across Wales with potential for non achievement of KPIs set by the Welsh Government, increased length of stay, increased complications such as delirium and pressure ulcers and increased mortality. RESULTING IN: The inability to achieve good outcomes and care appropriately for our patients has a detrimental effect on staff wellbeing too.	The already stretched on call medical team are contacted for ad hoc advice. There is no COTE service and no specialist advice available	Recommendation: Employ a frailty team at each site to care for this complex group of patients. This may have cost benefits such as reduced length of stay, reduced complications and reduced complaints. Timeframe: 31.01.2022 Update June 2022: Funding for Consultant Orthogeriatrician identified and two COTE elderly posts in place. Update September 2022 - COTE and Orthogeriatrician service model being finalised for PCH. Timescale within next 3 months.	Quality & Safety Committee	15	C3 x L5	4 (C2 x L2)	↔	30.06.2021	07.09.2022	03.10.2022
4772	Chief Operating Officer	Central Support Function - Facilities	Governance and compliance manager, Facilities	Improving Care	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	Replacement of press software on the 13 & 10 stage CBW presses	**If:** The 10 & 13 stage Lavatec presses have old software control systems, and are both vulnerable to failure. Following a fault developing and a recent maintenance call out it was identified that the 10 stage press is working intermittently caused by a software problem. **Then**: If the 10 Stage press control system fails the consequence of not purchasing the software replacement would result in the laundry service being unable to produce to full capacity and reduced to around 55%. If the Stage 10 press control system software fails then it could also impact on the Stage 13 press. The consequence of both presses failing and not purchasing the software replacement would result in the laundry service being unable to process any laundry which will result in all CTMUHB laundry being outsourced to commercial laundries. The costs will be significantly higher than those incurred in-house. **Resulting In:** •Potential of service failure due to existing system. •Potential of CTM sites being without bedding and linen at existing volumes and turnaround times. •Potential increased costs resulting from having to outsource laundry processing to commercial laundries in the event of equipment failure.	The All - Wales Laundry review continues, and at the current time, it is likely that services will be provided from CTM laundry until at least 2024. After this time, the equipment could be moved and rehoused elsewhere to continue to support CTM and the All-Wales Laundry agenda. Previous IMTP submissions have included as a priority £375K for a replacement automated sorting and roll cage washer/dryer system at the laundry. The software that controls system for the CBW forms an integral part of the current press. Benefits of equipment being replaced: •Reduced risk of service failure and therefore improved confidence in continued production. •Easier to diagnose and put right any mechanical defects. The Laundry is being monitored remotely by the system supplying company. This ensures that we are able to run the system and any problems quickly rectified on the 13 stage CBW. The 10 stage new software has now been installed and updated and all snagging completed. We were in the process of arranging a date for the 13 stage CBW software to be updated when the bolts on the 10 stage sheared, this will be repaired Monday 4th July 2022 we will then arrange for the new software to be updated on the 13 stage. There is a robust contingency plan in place we are able to continue with a normal service until these issues are resolved. We also have the ability to call upon the other L4 region production units. The contingency plan provides for a 5 day full service with ability to call on the other L4 within the All Wales Laundry agreement to produce our linen if needed.	Update September 2022 SON to be submitted and if successful replacement software purchased and installed. Timescale: 30/11/2022. SON approved and funding provided, awaiting installation. Update from Deputy Linen Services Manager that order has been raised to replace. 10 stage press received completed software upgrade. However, since the last review of this risk on the washer the bolts sheared off the press reducing production by 50%. A contractor has been to site to try and carry out repairs but so far have not been able to due to the severity of the problem. The contractor has now gone back to the manufacture on the next steps. Dependent on what the manufacture suggests, it's also lead time and down time of this machine, we are looking at the machine out of service for the next few months leaving the laundry only operating at 50% capacity and limited resilience if the other stage washer fails. Until there is a response received from the contractor, there are no definite answers on parts, costs or timescales. All departments, including Facilities, Estates and NWSSP have been informed of the issue. As a contingency the 13 stage press is being monitored and will be upgraded after the 06/09/2022. Based on this update the risk remains as a high risk and will be reviewed in 3 months time or once the repairs have been undertaken and software has been installed. No Change to mitigation at this time.Review Date: 30/11/2022	Quality & Safety Committee Planning, Performance & Finance Committee	15	15 (C5xL3)	5 (C5xL1)	↔	27.07.2021	21.10.2022	30.11.2022

Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
4920	Executive Director of Therapies & Health Sciences	Diagnostics, Therapies and Specialties Care Group	Deputy Head of Occupational Therapist	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Capacity within the ED/ Medical/ Rehabilitation and Orthopaedic Inpatient Occupational Therapy Service within Princess of Wales	**If:** clinical capacity remains significantly reduced due to staff sickness and vacancies **Then:** clinical service delivery will be negatively compromised. **Resulting in:** increased length of stay, potential clinical incidents, poor clinical outcomes for patients, and increase in complaints. It will impact on staff wellbeing within the team and increase incidence of staff sickness.	Regular team meetings to support prioritisation and wellbeing. Updating AHP lead in Bridgend ILG on potential impact.	Recruitment of locum. Additional hours offered, resulting in part- time staff working additional hours. Redeployment of staff according to clinical priority, utilising a therapies version of daily "safe to start" with AHP Clinical Director, where staffing is monitored daily Update September 2022 - Last review 30.8.22 next rv 31.10.22. No change to mitigations, recruitment in progress, and improvement in staffing is expected by November. Update October 2022 - No change to mitigations, recruitment still in progress.	Quality & Safety Committee	15	C3 x L5	12 (C3xL4)	↔	27.11.2021	21.10.2022	30.12.2022
4971	Chief Operating Officer	Primary & Community Care Group	Assistant Director for Primary Care	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Adult Special Care Dentistry	**If** the Community Dental Service is unable to recruit a special care dentist, **then** there will be no dedicated specialist to undertake the appropriate assessment and dental treatment under GA for vulnerable adults in a timely manner, **resulting in** more patients waiting, longer waiting times, patients being in pain and some having to access secondary care dental services as an urgent or emergency care.	Patients can be seen within the CDS for advice and treatment under local anaesthesia where this can be tolerated by the patient. A Consultant advert has been placed 3 times alongside a Specialist level post to widen the opportunity for recruitment. No applications received. If either post is recruited in to the risk will be mitigated. Although it will take some time to clear the current waiting list. Patients will be contacted regularly as part of safety netting to check that their condition is not deteriorating and no one is left in pain.	All the patients on the list are being reviewed and contacted regularly to assess if their dental condition has deteriorated or if they are in pain . Consideration is being given as to whether treatment can be undertaken in a local routine dental practice as opposed to the community dental service (CDS). This is very much on an individual basis. Discussions are taking place with Medical Staffing, HEIW and Cardiff Dental School with regard to the possibility of recruiting from abroad. Especially in view this is a national recruitment problem and other Health Boards are in a similar position. September 2022 Update – Risk position discussed within Primary Care and rating being reviewed and will be updated once considered via the Primary Care processes. Update October 2022 - Recruitment stage to re-commence with interviews likely to take place in January with two potential candidates expressing an interest with continued dialogue and engagement with them.	Quality & Safety Committee	15	C3xL5	3 C1xL3	↔	04.01.2022	31.10.2022	31.12.2022
3337 Linked to RTE Risk 4813 and M&C 4817.	Chief Operating Officer Director of Primary Care and Mental Health Services	Central Support Function: Digital & Data Mental Health Care Group	Lead Infrastructure Architect Interim Partnerships and Strategic Planning Lead for Mental Health and Learning Disability Services	Creating Health	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Use of Welsh Community Care Information System (WCCIS) in Mental Health Services	**If:** Mental Health Services do not have a single integrated clinical information system that captures all patients details. **Then:** Clinical staff may make a decision based on limited patient information available that could cause harm. **Resulting In**: Compromised safety of patients, potential avoidable harm and compromised safety for staff in the workplace.	1. Process in place for clinical teams to access information via local authority and health board teams. 2. Clinical teams will only use historical information as part of their current risk assessment and if this is not available they will judge the risk accordingly. 3. WCCIS Programme Board establishment for CTM will be finalised by the 30th June 2021, Merthyr and Cynon CGS Lead will Chair this group. The Chair of this group will report to the Senior Responsible Officer. The Task and Finish Groups established and aligned to this Programme board. 4. Local Authority have recently developed reports for Mental Health which identifies practitioner caseloads, admissions and discharges and care plan for compliance. 5. Deployment order in place for all existing WCCIS mental health staff users 6. Community Drug and Alcohol Team in Bridgend have now moved over to WCCIS, early implementation learning continues to take place. 7. WCCIS Regional Working Group now has a representative from the Health Board to maintain pace of delivery for WCCIS mental health rollout. 8.CTM have set up a Project Board in partnership to prepare for implementation of WCCIS 9. Project manager has been recruited. This role is leading on the development and implementation plan. 10. Business Case identifying additional ICT resource to progress the disaggregation process developed and awaiting approval. Workforce capacity impacts on programme deliverables. Patient Safety Controls: • CSG's have undertaken initial review and rationalised staff access to all information systems to understand the presenting need for access. • CSG's have introduced mechanisms to monitor and control access to FACE/WCCIS/W Drive to ensure prudent access to patient information. • Each clinical team has at least one staff member with resources and training to access information in line with agreed permissions to ensure ease of access to available information from all systems. • RTE lead nurse will lead pan CTM MDT working group to develop consistent approach to clinical	1. A Business Case has been developed which identifies additional staff resource required to progress the disaggregation process to bring all CTMUHB staff who currently use WCCIS via local authority over to CTMUHB WCCIS platform. Requires Programme Board approval. Business Case pending approval. 2. Director of Digital, CTMUHB undertaking a review to understand if WCCIS remains the best solution to progress for CTMUHB in general and for Mental Health specifically. WCCIS "go-live" at ABUHB in August 2022. Lessons learnt group is attended by CTUHB Project Manager. 3. Options Appraisal completed with plans to present to the ELG on the 7th November 2022 with a view to progress to full Business Case. A service improvement and learning team is being established and the role of this team will be to develop robust oversight and mitigations in relation to record keeping until such time and integrated system is available.	Quality & Safety Committee	15	C5xL3	6	↔	07/11/2018	28.10.2022	31.12.2022
4691 Linked to RTE Risks 4803, 4799, 3273 and 3019.	Chief Operating Officer Director of Primary Care and Mental Health Services Rhondda Taf Ely Locality	Mental Health Care Group	Interim Partnerships and Strategic Planning Lead for Mental Health and Learning Disability Services	Sustaining Our Future	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	New Mental Health Unit	**IF**: Mental health inpatient environments fall short of the expected design and standards. **Then**: Care delivered may be constrained by the environment, which is critical to reducing patient frustration and incidents as well as presenting more direct risk as a result of compromised observations. **Resulting in**: Compromised safety of patients, potential avoidable harm and compromised safety for staff in the workplace.	The mitigating environment and staffing measures put in place last year are still in place. Anecdotally it is reported that the ward feels safer by night, the challenge for the ward team is to now use QI methodology to make a case for continuing with these staffing levels after the capital work is complete. No incidents involving suspended ligatures have been reported since these measures were implemented. This is reflected in Bridgend CSG risk register. Annual revisiting of all patient ligature risks progress Statement of Needs via capital process for any ligature risks assessed as needing resolution. SRU/ Pinewood – anti-ligature work has been completed. RTE CSG - RTE specific environmental risk mitigation plan in place and under regular review. RGH MHU are currently in the process of extensive anti-ligature upgrades as part of a capital work scheme, including all doors and ensuites on ward admissions/21/22 and PICU being upgraded. PICU is now complete and contractors are currently working on Ward 21. Following this work will proceed to admissions and 22 in turn. Update 28.10.2022 - 28.10.22 Ward 21– Completed Ward 22– Scheduled Completion and handover back to us 25th October 2022 PICU – Scheduled Completion and handover back to us 28th October 2022 Admissions – Due to commence work 31st October 2022, estimated completion date 15th December 2022 M&C CSG - SRU/Pinewood – ligature work has been completed.	1. Discussions to commence with Welsh Government in relation to the inpatient environment. 2. A strategic case to be prepared and submitted to Welsh Government -COMPLETE Strategic Outline Document submitted and agreement to commence a Strategic Outline Business Case received. 3. If the strategic case conversation is supported by Welsh Government, develop a strategic outline business case. Timescale March 22 4. If the strategic outline business case is accepted, progress to the development of a full business case. 5. Full Business Case paused due to pandemic. Resource to be identified to progress full Business Case. A Quality Improvement Programme in relation to inpatient care is being developed and a workstream in relation to therapeutic environments is being established with the aim of optimising the patient experience. Inaugural workshop scheduled for the 20th December 2022. Interviews pending for the Assistant Director of Strategic Transformation and this role will lead a range of strategic programmes including recommencing a new capital business case for a new Mental Health Unit. Update - 28.10.22 with no change to risk rating	Quality & Safety Committee	15	15 (C3xL5)	6 (C3xL2)	↔	15.06.2021	28.10.2022	31.12.2022
4253	Chief Operating Officer	Mental Health Care Group	Service Director - Mental Health and Learning Disability Care Group	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Ligature Points - Inpatient Services	**IF:** the Health Board fails to minimise ligature points as far as possible across identified sites. **Then:** the risk of patients using their surroundings as ligature points is increased. **Resulting In:** Potential harm to patients which could result in severe disability or death.	**Bridgend Locality:** The anti-ligature works has not yet been completed and signed off. There are snagging issues on ward 14 and remedial decoration. On PICU the bathrooms have not been started. All works have been chased by Senior Nurse to project lead for updates on completion. Actions identified for escalation if no update received regarding completion dates. The risk score remains unchanged at present. o Increased Staff observations in areas where risks have been identified. o Any areas of the unit not being occupied by patients are to be kept locked to minimise risks o The use of safe and supportive observations o Risk assessment process for patients and environment is in situ o Some ant-ligature work has been completed in some bedrooms which are used for patients assessed as being at higher risk.	**Bridgend Locality:** o action plan developed with support from the head of nursing within the ILG. o Heath Board has approved additional staffing by night and to fund the outstanding capital anti ligature works. guidance issued to all staff on the implementation of local procedural guidelines. o Use of therapeutic activities to keep patients occupied Update 25.5.2022 - Major Works complete and official handover undertaken on the 25th May 2022 with contractor. Risk scoring reduced from a 20 to a 15. The Target Score has not been met as there are still works to complete internally with Estates. Bridgend 28.10.22 All anti-ligature works in PICU, Ward 14, Angleton have been completed and areas handed over subject to completion of a few outstanding snags by the contractors. Work is awaiting final sign-off. Review end of December 2022 with a review of revisiting the risk score.	Quality & Safety Committee Health, Safety & Fire Committee	15	C5xL3	10 C5xL2	↔	17/08/2020	01.11.2022	31.12.2022
5207	Executive Director of Strategy & Transformation	Primary & Community Care Group or Central Function?	Deputy Director of Strategy and Partnerships	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm & Statutory Duty / Legislation	Care Home Capacity	**If:** the rising costs of delivering care in private facilities drives a number of providers to cease trading. **Then:** there will be a loss of capacity within the system. **Resulting in:** exacerbated delays in hospital flow, an impact on wait times and increased admission to hospital for displaced patients. Patient experience will be impacted due to increased hospital stays. There will also be a longer term impact on residential care opportunities.	Multi Agency Operational Group established that effectively risk assesses the homes and manages any emergent contractual/ provider/ safeguarding issues, we wonder if this is forward looking enough in the current context. Local Authorities have regular contact with Care Homes to assess any challenges that they are facing and will intervene as appropriate based on risk and circumstances.	Via the Regional Partnership Board and other partnership meetings questions will continued to be escalated to seek assurance. Reports on specific incidents will be taken to Planning, Performance & Finance Committee. Care Providers will continue to engage with Welsh Government to escalate their concerns around the current position.	Quality & Safety Committee Planning, Performance & Finance Committee	15	C5xL3	10 C5xL2	↔	19.8.2022	26.10.2022	30.11.2022

Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
4217	Executive Director of Nursing & Midwifery Infection Control	Central Support Function - Infection, Prevention and Control	Lead Infection, Prevention and Control Nurse	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	No IPC resource for primary care	**If** there is no dedicated IPC resource for primary care. **Then:** the IPC team is unable to provide an integrated whole system approach for infection prevention and control. **Resulting In:** non compliance with the reduction expectations set by WG. A significant proportion of gram negative bacteraemia, S.aureus bacteraemia and C.Difficile infections are classified as community acquired infections.	Liaise with specialist services in primary care e.g.. bowel and bladder service IPC team investigate all preventable community acquired S.aureus and gram negative bacteraemia and share any learning with the IPC huddles arranged in primary care to look at community acquired. Update August 2021: the IPC team is working collaboratively with the bowel and bladder service to investigate all preventable urinary catheter associated bacteraemia. Any learning points/ actions is being shared with community teams. Work in progress to start/reintroduce RCAs/IPC huddles for community acquired C.Difficile cases.	A business case for additional resources for an IPC team for primary care to be developed. Due Date: 31.08.2021 07/10/2021 - Lead IPC Nurse is a member of an All Wales task and finish group looking at the IPC workforce across Wales. Report to IPCC once national work complete - Due to complete in December 2021. August 2022 Update: Risk score amended based on control measures in place. No additional measures implemented. Lead IPC Nurse to scope primary care services in next 4 weeks. reviewed by Lead IPC Nurse and Deputy Executive Nurse Director 06/09/2022, risk reduced from 20 (4x5) to 15 (3x5). Consequence score amended and reduced to 3 (from 4). Update 11/10/22 - scoping work delayed but plans to start in next 4 weeks.	Quality & Safety Committee	15	C3xL5	6 C3xL2	↔	16/07/2020	06.09.2022	21.10.2022
4721	Chief Operating Officer	Unscheduled Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Shift of the boundary for attendances at the ED.	IF: the current boundary change to redirect emergency cases from the lower Cynon Valley to the Royal Glamorgan Hospital is not reviewed: THEN: patients will continue to be admitted to a hospital further from their home RESULTING IN: increased pressure on the medical teams to manage an increased patient cohort, lack on continuity of care with follow up arrangements closer to home	Boundary change currently subject to review to understand the impact across CTM.	Boundary change currently subject to review to understand the impact across CTM. Update April 2022 - Meeting to be convened between M&C and RTE clinicians to agree way forward. For discussion at Execs 25th April. Review 30.06.2022. No change to mitigation or risk score. Update September 2022 - Following review of this risk scoring by the COO the consequence score has been reassessed as a 3. This risk remains under constant review.	Quality & Safety Committee	15	C3xL5	12 (C3xL4)	↔	28/06/2021	11.10.2022	30.11.2022

De-escalated Risks from the Organisational Risk Register - November 2022

Datix ID	Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Rating (Target)	De-escalation Rationale
Nil this period											

Datix ID	Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Month Closed on Org RR	Closure Rationale
4106	Executive Director of Nursing and Midwifery	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Increasing dependency on agency staff cover which impacts on continuity of care, patient safety	**IF:** The Health Board increasingly depends on agency staff cover **Then:** the Health Board's ability to provide stability and consistency in relation to high quality care could be impacted. **Resulting in**: disruption to the continuity, stability of care and team communication. Potential to impact on patient safety and staff wellbeing. There are also financial implications of continued use of agency cover.	Recurring advertisements of posts in and nursing continue with targeted proactive recruitment employed in areas of high agency/locum use. Provision of induction packs for agency staff Agency nursing staff are paid via an All wales contract agreement, any off framework agency requests must be authorised by an Executive Director prior to booking (system of audit trail in place). Fixed Term Contracts being offered to all existing HCSW and RN currently on the Nurse Bank. Redesign services wherever possible to embrace a healthier Wales and therefore impact upon the workforce required to deliver services. Updated August 2022. As of July 2021 - the overseas recruitment campaign has ceased pending further scoping exercises by Workforce and Organisational Development. Bi-Annual Nursing Staffing Levels Wales Act - Acuity Audit to be undertaken in June 2021 to report to Board in October 2021. Completed: This has been completed and received by the Board. Nursing & Midwifery Strategic Workforce Group re-established and has met. The Nursing Productivity Outputs will feed into this group along with monitoring roster KPIs and overall nurse recruitment including overseas. (Control Measure).	Deputy Exec DON is currently reviewing the nurse rostering policy in conjunction with the workforce team in order to put in place (in conjunction with workforce team) clear roster monitoring KPI's and Bank usage/recruitment KPI's . Established a new nursing workforce taskforce. Consultation with Local Partnership Forum undertaken and amendments to the policy have been made as appropriate, the policy will be seeking approval at the Quality & Safety Committee in May 2021- Timescale 31.5.2021. Update November 2021: The Revised policy which was based on SBUHB's current policy (in terms of content / KPI's etc. was taken to Local Partnership forum where it was identified further amendments were requested, these were made in terms of making the clear distinction between the current break times in some areas of POW and that of the rest of CTMUHB. The policy is currently with an ILG Nurse Director who has kindly offered to make the policy more "user friendly" Timescale: 31st December 2021 August 2022 Update: Overseas Nurse recruitment recommenced in June 2022 as part of the All Wales Overseas Nurse Recruitment programme. A total of 91 overseas Nurses will be recruited by December 2022 (noting that these will not be qualified RN's). A newly developed retention task & finish group has been established with it's first meeting having been held in August. A gap analysis of the NHS England 7 Steps is underway. Nurse Roster policy back with DEDoN for comments. Risk ID 4106 and 4157 will be amalgamated - timeframe 30.09.2022.	Quality & Safety Committee People & Culture Committee	Nov-22	The Deputy Director of Nursing has merged this risk with 4157 and a new risk created to amalgamate both this risk (4106 and 4157). The new risk is Datix Reference 5267. Reference to these two risks will be made in the narrative of the new risk to ensure the audit trail is transparent. Please see risk 5267 on the Organisational Risk Register.
4157	Executive Director of Nursing and Midwifery	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	There is a risk to the delivery of high quality patient care due to the difficulty in recruiting and retaining sufficient numbers of registered nurses and midwives	**IF:** the Health Board fails to recruit and retain a sufficient number of registered nurses and midwives due to a national shortage **Then:** the Health Board's ability to provide high quality care may be impacted as there would be an overreliance on bank and agency staff. **Resulting in**: Disruption to the continuity and stability of care and team communication Potential to impact on patient safety and staff wellbeing. There are also financial implications of continued use of agency cover.	• Proactive engagement with HEIW continues. • Scheduled, continuous recruitment activity overseen by WOD. Overseas RN project continues. • Targeted approach to areas of specific concern reported via finance, workforce and performance committee • Close work with university partners to maximise routes into nursing • Block booking of bank and agency staff to pre-empt and address shortfalls • dependency and acuity audits completed at least once in 24 hrs on all ward areas covered by Section 25B of the Nurse Staffing Act. • Deputy Exec DON is currently reviewing the nurse rostering policy in order to put in place (in conjunction with workforce team) clear roster monitoring KPI's and Bank usage/recruitment KPI's • Reporting compliance with the Nurse Staffing Levels (Wales) Act regularly to Board • Regular review by Birth Rate Plus compliant, overseen by maternity Improvement Board • Implementation of the Quality & Patient Safety Governance Framework including triangulating and reporting related to themes and trends. successful overseas RN recruitment. - There is an operational Nursing Act Group that reconvened from April 2021. Impact assessment signed off from a Mental Health Nursing perspective in relation to an extension to the Nurse Staffing Act 2016.	Established recruitment campaign - which is monitored at the Nursing Workforce Strategic Group - group due to meet/recommence in April 2021.The Nursing and Midwifery Strategic Workforce Group did not meet in April 2021 as planned due to the need to revise membership in line with ILG structure, however, bi-monthly nursing workforce operational task force meetings have been held chaired by the Deputy Director of Nursing since February 2021. the Strategic workforce group is scheduled to meet on the 11th May 2021. This action has been overtaken by the Nursing Productivity Programme. Revised nurse rostering policy currently being taken through the relevant approval process - Timescale 31.3.2021.Consultation with Local Partnership Forum undertaken and amendments to the policy have been made as appropriate, the policy will be seeking approval at the Quality & Safety Committee in May 2021- Timescale 31.5.2021Complete and currently with WF&OD to finalise through to Approval. Await review of Birth Rate Plus Compliant Tool by WG - Timescale - WG led so await WG timescales - No further update at this time. Remains the same as at February 2022. Impact assessment relating to Health Visiting provision with regards to compliance of the draft principles of the Nurse Staffing Act 2016 to be completed by the end of March 2022. Ward Assurance Pilot Tool tested within PCH and to be rolled out across the other two Acute Hospitals by the end of April 2022. August 2022 Update: The Health Board receives a draft birth rate and compliance report which the Director of Maternity reviews the completes the outputs. A full data set of compliance is completed and sent to WG by the Director of Midwifery. An initial point review audit has been completed on all Wards in CTM using the Ward Assurance template populated through AMaT (Audit Management and Tracking system). An updated paper is being presented to the November 2022 Quality & Safety Committee. Risk ID 4106 and 4157 will be amalgamated - timeframe 30.09.2022.	Quality & Safety Committee	Nov-22	The Deputy Director of Nursing has merged this risk with 4157 and a new risk created to amalgamate both this risk (4106 and 4157). The new risk is Datix Reference 5267. Reference to these two risks will be made in the narrative of the new risk to ensure the audit trail is transparent. Please see risk 5267 on the Organisational Risk Register.

AGENDA ITEM
5.2

QUALITY & SAFETY COMMITTEE

DATIX CYMRU – INCIDENT REPORTING

Date of meeting	(15/11/2022)
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Kellie Jenkins-Forrester, Head of Concerns & Business Intelligence
Presented by	Kellie Jenkins-Forrester, Head of Concerns & Business Intelligence
Approving Executive Sponsor	Director of Corporate Governance / Board Secretary
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
		Choose an item.

ACRONYMS	
CTMUHB	Cwm Taf Morgannwg University Health Board
DCIQ	Datix Cloud IQ

1. SITUATION/BACKGROUND

The Once for Wales programme was established in 2017 by the Welsh Government as part of the response to address the recommendations set out in Keith Evans "The Gift of Complaints" Report.

Aimed at bringing consistency across NHS Wales with regards to the use of electronic tools, the programme commenced development and implementation of DatixCymru (DatixCloudIQ). The new system has many of the features that people will be familiar with from our existing RLDatix system, with the added benefit of being a bespoke cloud-based tool that meets the needs of Putting Things Right, through the development of specific functionality such as the Redress Module and Mortality Review process.

A key objective of the system is to support the Health Board in providing real time data and information that can facilitate ward to board assurance leading to improvements in quality, safety and experience for patients and staff. Through successful embedding of the system, we can take proactive steps to demonstrate that we are a listening and learning organisation.

The Health Board implemented the Incident Management Functionality of Datix Cymru on the 1st April 2022. As part of the implementation of this functionality a new All Wales Coding Structure was adopted. This moved the coding from a two tier structure in the Health Board's Legacy System to a three tier structure in Datix Cymru. In addition to this, a further segregation of incidents has been introduced in relation to who was affected. As result staff are adjusting to the both a new system and a new coding structure.

It was reported at the Health, Safety & Fire Committee that the since the implementation of the Incident Management Functionality, there had been a decrease of 50% in the number of incidents reported relating to staff.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 Incident Reporting Data

A review of the incidents reported between the 01.04.22 and 30.09.22, including a comparison of incidents for the same time period in the previous 3 years has been undertaken. The trend is provided in the chart below.

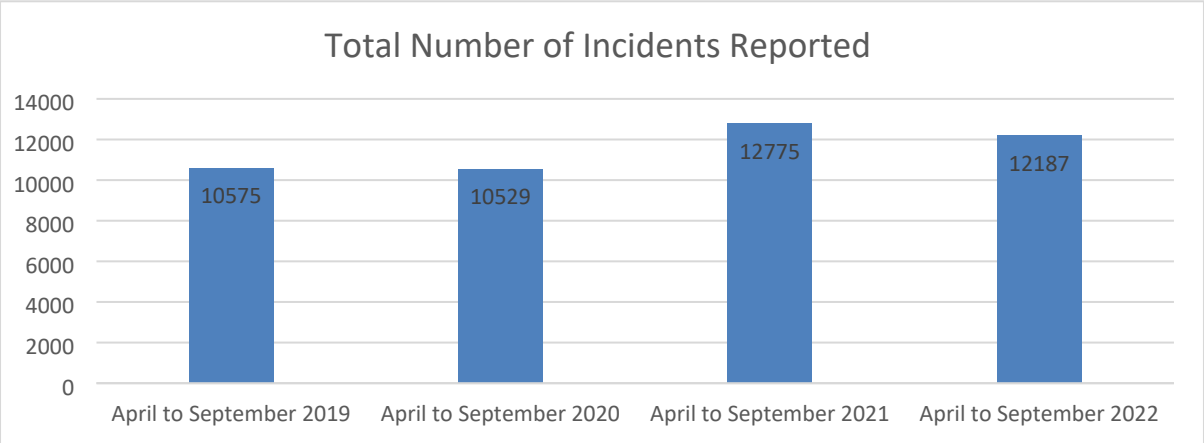


Chart 1: Total number of incidents reported

Whilst the overall number of incidents reported during April to September 2022, has slightly decreased (by 588) compared to 2021, it remains higher than 2019 and 2020. The decrease in 2022 can be attributable to the increase in 2021 associated with the Covid Pandemic and the transition to a new system where a decrease in reported incidents would be expected.

	Legacy System			Datix Cymru
Who was Affected	**2019**	**2020**	**2021**	**2022**
Patient	9,102	9,225	11,138	10,547
Non-Patient Safety	1,473	1,304	1,636	
Organisational			1	697
Staff/Contractor				910
Public/Visitor				33
Totals	10,575	10,529	12,775	12,187

Table 1: Incidents by those affected

The table above demonstrates that the Non-patient safety incidents have similar figures to the combined total of Organisational, Staff/Contractor and Public/Visitor incidents.

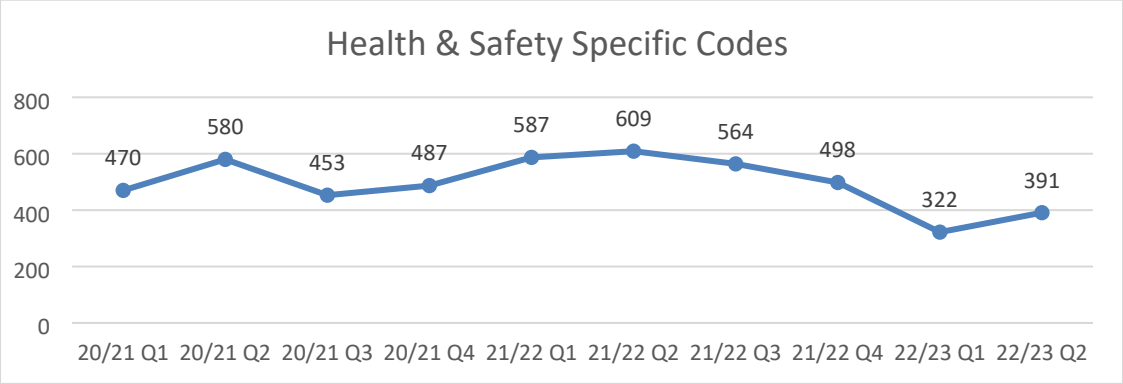


Chart 2: Health & Safety Specific Codes

A review of the Health & Safety specific codes highlights a decrease in the numbers reported, with those reported under the type of clinically challenging behaviour representing the largest reduction (a decrease from 115 to 1 between Q4 21/22 and Q1 22/23). Whilst further scrutiny does not highlight a direct correlation to a significant rise in another incident type, the overall incident figures suggest that incidents continue to be reported but under different coding types.

2.2 Incident Management

There have been no significant changes to the management of the incidents with the Health Board following the implementation of Datix Cymru. This is articulated within the Incident Reporting & Management Framework, which outlines the following:

- Incident occurs - complete immediate make-safes.
- Datix submitted and escalation notification automatically sent via DATIX to senior management.
- Report to other bodies as relevant e.g. safeguarding
- Manager along with key stakeholders identifies what level of harm occurred. If it is unclear, then proceed to RAPID review meeting. Where harm is moderate/severe/death, proceed to RAPID review meeting.
- **no/low harm** - complete level 1 (DATIX only) or level 2 (SBAR) investigation

- **moderate harm** - complete level 2 (SBAR) investigation or for more complex incidents, level 3 RCA investigation may be more suitable.
- **Severe harm/death/Never Event** - complete level 3 (RCA) investigation.
- Following investigation complete a SMART action plan.
- Monitoring of actions via the clinical service group and/or governance teams.

2.3 Training

To support the transition to Datix Cymru, a tranche of training was provided to responsible managers during March and April 2022, which continues to be available on a weekly basis across the Health Board. The training outlines the requirements to undertaken validation as part of the initial including ensuring that the incident is coded under the correct type. In addition a user guide is available via SharePoint and is issued to all users of the system.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

The high level incident data provides assurance that incidents continue to be reported and investigated, with appropriate actions being taken in line with Health Board processes.

Previous reports to Committee regarding the implementation of the Datix Cymru System have highlighted the issue of maintaining of high quality data and reports during the early stages of implementation of the new system. This is a result of the following:

- Information will span two systems adding challenges to providing trend data.
- The Health Board has undertaken developments within the existing system to reflect internal processes and board information requirements that are not available on initial implementation as this forms part of the system enhancement programme. An updated gap analysis is being undertaken, with alternative options to support the

processes being identified. These options will be potentially be more resource intensive, due to the increased manual intervention required in presenting information.

- The effective and efficient extraction of data from DatixCymru at a locality, service group and speciality level continue to be challenging.

Whilst there are system requirements that have been escalated to the National team, there are a number of local measures being implemented to improve the validity of data held within the system. These include:

- Corporate validation following initial reporting of the incident to be undertaken by the Patient Safety, Health & Safety and Business Intelligence Teams. To facilitate this, a quality assurance checklist is being developed to facilitate consistency, highlight key fields for review and act as a prompt for immediate action or escalation. This will ensure incidents are coded appropriately and enable identification for themes and trends.
- Development of detailed guidance for top reporting incidents impacted by the change, i.e. restraints, clinically challenging behavior, community acquired pressure damage.
- Analysis of clinically challenging behavior incidents. Initial review has not identified a decrease in incidents reported within the Mental Health Service, an area where this type of incident was predominantly reported.
- Further scrutiny of incident information to determine areas for targeted training.
- Monthly monitoring of incident information to anticipate areas for flagging and prompt action
- Commencement of weekly audits by the Business Intelligence Team of closed incidents to confirm data accuracy and completeness of all required fields.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	The RLDatix system provides data to enable opportunities for improvement in safety and experience to be identified.
Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below.
	Relates to the implementation of an All Wales System.
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

5.1 The Quality and Safety Committee is asked to **NOTE** the contents of the report.

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

AGENDA ITEM 5.3

QUALITY & SAFETY COMMITTEE

HIGHLIGHT REPORT FROM THE CHAIR OF THE HEALTH, SAFETY & FIRE SUB COMMITTEE

DATE OF MEETING	15 November 2022
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Emma Walters, Corporate Governance Manager
PRESENTED BY	Dilys Jouvenat, Independent Member
EXECUTIVE SPONSOR APPROVED	Hywel Daniel, Executive Director for People
REPORT PURPOSE	FOR NOTING

ACRONYMS	
	None Identified.

1. INTRODUCTION

1.1 This report had been prepared to provide the Committee with details of the key issues considered by the Health, Safety & Fire Sub Committee at its meeting on 12 October 2022.

1.2 Key highlights from the meeting are reported in section 3.

2. PURPOSE OF THE HEALTH, SAFETY & FIRE SUB COMMITTEE

2.1 The purpose of this Sub-Committee is to:

- Advise and assure the Board and the accountable officer on whether effective arrangements are in place to ensure organisational wide compliance of the health Board's health and safety policy, approve and

monitor delivery against the health and Safety priority action plan and ensure compliance with the relevant standards for Health Services in Wales.

- This will be achieved by encouraging strong leadership in health and safety, championing the importance of a common sense approach to motivate focus on core aims distinguishing between real and trivial issues.

Where appropriate, the committee will advise the Board (through the Quality & Safety Committee) and the accountable officer on where and how, its health and safety management may be strengthened and developed further.

3. HIGHLIGHT REPORT

ALERT / ESCALATE	• The **Health & Safety Performance Report** was received. Concerns were expressed by the Head of Health Safety & Fire in relation to the issues being experienced in relation to coding within the new Datix Cymru system and the fact that the numbers of Health & Safety incidents being recorded on Datix had decreased significantly since the new system had been introduced. The Director for People agreed to escalate the concerns raised with the Director of Nursing/Director of Corporate Governance and advised that the matter would also be formally escalated to the Quality & Safety Committee;
ADVISE	• The **Head of Health, Safety & Fire Report** was received. Members noted that a discussion would need to be held in relation to the numbers of individuals not attending Statutory and Mandatory Training sessions, particularly for the category of 'Bank and Agency' . Members expressed concern regarding the staffing issues being experienced within the Health & Safety Team, particularly within Manual Handling and noted that a discussion would be held between the Director for People and the Head of Health Safety & Fire regarding the department resourcing plan. Statutory and Mandatory Training Compliance was also highlighted as an area of concern within the Health, Safety & Fire Legacy Reports; • The **Fire Safety Report** was received. Members noted that and internal appointment had been made into the Senior Fire Officer post which had created a gap at Fire Officer level. Members noted that the two fire enforcement notices remained in place at the Princess of Wales and Prince Charles Hospitals;

	• The Sub-Committee received a report on the **Fire Enforcement Notice at the Princess of Wales Hospital Theatre Department** and noted the ongoing discussions taking place with Welsh Government in relation to possible options to address the issues. The Director for People advised that South Wales Fire & Rescue Colleagues were being kept updated in relation to the position; • A verbal update was provided in relation to the **Internal Audit Follow-Up Review - Fire Arrangements at Princess of Wales Hospital Theatres.** Members noted that work was being undertaken with Internal Audit colleagues regarding progress being made against the recommendations; • An **Update Report: Health & Safety Executive Prosecution - Maesteg Hospital was received.** Members noted that a detailed discussion had recently been held at the In Committee Quality & Safety Committee regarding this matter; • A **Deep-Dive Report into Fire Safety Risks** was received. Members commented that some of the risks appeared to not have been updated for some time and noted that work continued to be undertaken to ensure timely updates were being provided against each risk; • **Health, Safety & Fire Legacy Reports** were received from Bridgend and Merthyr & Cynon Integrated Locality Groups. The Director for People agreed to discuss future reporting requirements in relation to Care Groups with the Chief Operating Officer. It was agreed that the Rhondda Taf Ely ILG legacy report would be shared with Members outside the meeting once the report had been approved by the Chief Operating Officer; • The **Primary Care Health, Safety & Fire Report** was received and noted.
ASSURE	• The **Estates Safety & Compliance report on Ventilation Systems** was received. Members welcomed the reasonable assurance that had been given and that significant improvements had been made; • The **Organisational Risk Register report** was received. Members welcomed the work that had been undertaken to strengthen the risk register
INFORM	• The **Health, Safety & Fire Sub Committee Annual Report** was **ENDORSED** for Committee Approval
APPENDICES	**Health, Safety & Fire Sub Committee Annual Report**

4. RECOMMENDATION

4.1 The Quality & Safety Committee is asked to:

- **NOTE** the report;
- **APPROVE** the Health, Safety & Fire Sub Committee Annual Report

Appendix 1

Health, Safety & Fire Sub Committee

Annual Report 2021-2022

HEALTH, SAFETY & FIRE SUB COMMITTEE
ANNUAL REPORT 2021-2022

1. FOREWORD

I am pleased to be able to commend to you this annual report, which has been prepared for the attention of the Quality & Safety Committee and reviews the work of the Committee for the financial year 2021-2022.

During the year, I have been greatly supported by Vice Chair James Hehir and Nicola Milligan who have contributed their considerable knowledge and wide-ranging experience to the Sub-Committee. I would also like to express my thanks to Mel Jehu who attended the meeting held in June 2021 to ensure that the meeting was quorate.

I would like to express my sincere thanks to all the officers of the Sub-Committee who have supported and contributed to the work carried out and for their commitment in meeting important targets and deadlines. I would particularly like to extend my thanks to colleagues within the Corporate Governance Team for the support they provided me throughout the year.

Going forward the Sub-Committee will continue to pursue a full programme of work covering matters affecting the health and safety of our workplaces with the aims of promoting learning and further strengthening the governance and assurance arrangements of the Health Board.

Dilys Jouvenat
Chair of the Quality & Safety Committee
Cwm Taf Morgannwg University Health Board (CTMUHB)

2. INTRODUCTION

The purpose of the Health, Safety & Fire Sub Committee "the Sub Committee" is to:

- Advise and assure the Board and the accountable officer on whether effective arrangements are in place to ensure organisational wide compliance of the health Board's health and safety policy, approve and monitor delivery against the health and Safety priority action plan and ensure compliance with the relevant standards for Health Services in Wales.

- This will be achieved by encouraging strong leadership in health and safety, championing the importance of a common sense approach to motivate focus on core aims distinguishing between real and trivial issues.

Where appropriate, the sub-committee will advise the Board and the accountable officer on where and how its health and safety management may be strengthened and developed further.

The Sub-Committee has embraced the new Strategic Goals in how it manages its agenda to ensure that its activity supports the **'CTM2030: Our Health, Our Future'** Strategy and the **Values and Behaviours** of the Health Board.

The Sub-Committee meets quarterly, with the key function to provide scrutiny on behalf of the Quality & Safety Committee on all matters relating to Health, Safety and Fire.

3. ROLE, MEMBERSHIP, ATTENDEES AND COMMITTEE ATTENDANCES

3.1 ROLE

The role of the Sub-Committee is to support the Board /Quality & Safety Committee with regard to its responsibilities for health, safety and fire:

- approve and monitor implementation of the annual health and safety action plan;
- review the comprehensiveness of assurances in meeting the Board and accountable officers assurance needs across the whole of the health Board's activities, both clinical and non-clinical;
- the consideration of relevant UHB policies for approval by the Quality & Safety Committee.

3.2 MEMBERSHIP

The membership of the Health, Safety & Fire Sub-Committee comprises of three Independent members, enabling the Sub-Committee to provide robust scrutiny and assurance to the Board/Quality & Safety Committee independently of the management decision-making processes.

A summary of the Independent membership during 2021-2022 is outlined in table 1 below:

Table 1 – Composition & Membership of the Health, Safety & Fire Sub- Committee Apr 2021-March 2022

Name	Period
Members	
Dilys Jouvenat (Sub-Committee Chair) Independent Member	April 2021 – March 2022
James Hehir (Vice Chair) Independent Member	Apr 2021 - March 2022
Nicola Milligan Independent Member	Apr 2021 – March 2022

3.3 ATTENDANCE AT QUALITY & SAFETY COMMITTEE 2021-2022

During the year, the Sub-Committee met on four occasions. All meetings were quorate and were well attended as shown in Table 2 below:

Table 2 - Meetings and Member Attendance 2021-2022

In Attendance	3 June 2021	13 Sept 2021	30 Nov 2021	28 Feb 2022	Total
Dilys Jouvenat – Independent Member Chair of the Committee	✓	✓	✓	✓	**4/4**
James Hehir – Independent Member (Vice Chair of the Committee)	✓	✓	✓	✓	**4/4**
Nicola Milligan – Independent Member	x	✓	✓	✓	**3/4**
Mel Jehu – Independent Member (To Maintain Quoracy in June 2021)	✓				**1/1**

3.4 ATTENDEES

The Sub-Committee's work is informed by reports provided by leads within CTMUHB, colleagues from these areas are invited to attend each meeting of the Health, Safety & Fire Sub-Committee. Invitations to attend the Sub-Committee meetings are also extended, where appropriate and on an 'ad hoc' basis, to specific staff when reports which relate to their specific area of responsibility are being discussed.

4. HEALTH, SAFETY & FIRE SUB COMMITTEE BUSINESS

The Health, Safety & Fire Sub-Committee provides an essential element of the Health Board's overall assurance framework. In response to the Covid-19 pandemic, all meetings continued to be held virtually via Microsoft Teams during 2021/2022 with continued use of the Consent Agenda. Any items included on the consent agenda were considered by Members prior to each meeting, with Members provided with the opportunity to raise questions prior to the meetings regarding the reports. All reports included on the Main Agenda were discussed during each meeting. The Health, Safety & Fire Sub Committee agenda broadly follows a standard format, comprising of specific sections, and the activity of the Committee during 2021/2022 is outlined in Appendix 1 of this report.

Links with Other Committees/Boards

Key risk areas from the Health, Safety & Fire Sub-Committee are highlighted at the Quality & Safety Committee by the Committee Chair via the highlight report.

At each meeting, if any Committee referrals are identified, the Chair of the Sub-Committee or the Corporate Governance Lead will ensure that the following questions are captured to ensure a referral is managed effectively:

- What are you referring?
- Why are you referring?
- What is the outcome you are anticipating from this referral?

5. ACTION LOG

In order to monitor progress and any necessary follow up action, the Sub-Committee has developed an Action Log that captures all agreed actions. This has provided an essential element of assurance both to the Sub-Committee and from the Sub-Committee to the Board.

6. GOVERNANCE

The effectiveness of the Committee is monitored through the following key governance activity:

- Annual Review of the Terms of Reference;
- Committee Annual Report;
- Highlight Reports from the Sub-Committee to the Quality & Safety Committee meetings;
- Forward Work Programme.

The Corporate Governance Team maintain a "Committee Effectiveness Tracker" to ensure the above activity is undertaken at the appropriate times during the year.

7. ASSURANCE TO THE BOARD/QUALITY & SAFETY COMMITTEE

The Health, Safety & Fire Sub Committee considers that on the basis of the work completed by the Sub-Committee during 2021 - 2022, there are effective measures in place that have delivered against its agreed Terms of Reference.

The forward work programme for 2022-2023 and beyond, ensures that the Sub-Committee retains scrutiny on key areas of activity.

In addition the Sub-Committee Chair will meet with the lead officers and the Chair of the Quality & Safety Committee to discuss progress of the work of the Sub-Committee.

The Forward Work Programme has continued to be presented to each meeting of the Sub-Committee during 2021/2022. This supports and helps identify the key areas of focus for the Sub-Committee and is one of the key components in ensuring that the Sub-Committee is effectively carrying out its role. It also facilitates the management of agendas and Sub-Committee business.

8. LINKS WITH OTHER COMMITTEES

The Health, Safety & Fire Sub-Committee will continue to have close links, and share risks with other Committees of the Board, particularly the Quality & Safety Committee and Audit & Risk Committee.

As a Sub Committee of the Quality & Safety Committee, regular highlight reports are presented to the Quality & Safety Committee.

Through either specific meetings or the regular Independent Member meetings there is an opportunity for Committee Chairs to support the work of each of the Committees they Chair, share learning and avoid duplication. All Committee Chairs have access to Committee Highlight Reports to the Board.

APPENDIX 1

1. Preliminary Matters

This included the apologies for absence, welcome and introductions and declarations of interest.

2. Consent Agenda

During 2021 – 2022 the following items were received on the Consent Agenda for Approval/Endorsement:

- Unconfirmed minutes;
- Sub Committee Terms of Reference;

During 2021 – 2022 the following items were received on the Consent Agenda for Noting/Information

- Sub-Committee Action Log;

3. Main Agenda

During 2021 – 2022 the following items were received:

- Organisational Risk Register;
- Head of Health, Safety & Fire Report;
- Health & Safety Performance Dashboard;
- Fire Safety Report;
- Violence & Aggression Updates;
- Health & Safety Policy and Policy Statement;
- Forward Work Programme;
- Control of Ignition Sources;
- Internal Audit Report – Fire Safety Management;
- Post Shielding Risk Assessment Process – Verbal Update;
- Estates Safety & Compliance Update – Water Safety;
- All Wales Internal Audit Review – Estates Assurance Fire Safety;
- All Wales Internal Audit Review – Estates Assurance Water Management;
- Update on Transition to Web Based Health & Safety Handbook Documents;
- RIDDOR Covid-19;
- Occupational Health Report;
- Estates Response to actions identified within the All Wales Internal Audit Review of Estates Assurance – Water Management.

Integrated Health, Safety & Fire Exception Reports were received from the following areas:

- Bridgend Integrated Locality Group;
- Merthyr & Cynon Integrated Locality Group
- Rhondda Taff Ely Integrated Locality Group;
- Primary Care Directorate.

AGENDA ITEM
5.4

Quality and Safety Committee	
HIGHLIGHT REPORT FROM THE INFECTION PREVENTION AND CONTROL COMMITEE	
DATE OF MEETING	15th November 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	BETHAN CRADLE LEAD INFECTION PREVENTION AND CONTROL NURSE
PRESENTED BY	Greg Dix, Executive Director of Nursing
EXECUTIVE SPONSOR APPROVED	EXECUTIVE DIRECTOR OF NURSING

REPORT PURPOSE	For Noting

ACRONYMS	
	None Identified.

1. PURPOSE

1.1 This report has been prepared to provide the Committee with details of the key issues considered by the Infection Prevention and Control (IPC) Committee at its meeting on 18th October 2022.

1.2 Key highlights from the meeting are reported in section 2.

1.3 The Committee is requested to **NOTE** the report.

2. HIGHLIGHT REPORT

ALERT / ESCALATE	The centralised decontamination unit at the Princess of Wales hospital may not be supported by Welsh Government this financial year. The delay in developing a business case may affect JAG accreditation in Endoscopy and decontamination services across the Princess of Wales Hospital site. The operational lead for decontamination is working with service users to develop a contingency plan to replace ageing equipment in Urology/HSDU and upgrade the infrastructure in order to preserve and maintain decontamination services in Bridgend.
ADVISE	Fewer cases of C. difficile infection and E.coli bacteremia have been reported April – September 2022 compared to the same period last year. There has been an increase in cases of S.aureus bacteraemia, Klebsiella and Pseudomonas aeruginosa bacteremia in the same period. Improvement work to reduce preventable infections has been impeded due to a resurgence in COVID cases and vacancies within the infection prevention and control team but this work is high on the IPC agenda. A significant proportion of S.aureus bacteraemia, E.coli and Klebsiella spp. bacteraemia are community acquired infections and additional IPC support is required to introduce targeted interventions in primary care. The Lead IPC Nurse plans to scope primary care to better understand the resource/ support required. COVID continues to cause service disruption across the three acute sites. COVID cases and outbreaks of infection are discussed at the bi-weekly IPC cell meetings. Due to operational pressures and no bed capacity, the IPC advice to close wards is often over ruled following a risk assessment. The patient testing framework for COVID has been revised in line with WG guidance. An outbreak of Ebola virus has been declared in Uganda, affecting five districts. The current risk to the UK is low. The

	IPC team is supporting clinical teams to revisit existing plans/pathways to ensure staff are prepared if the risk to the UK increases. CTM is the highest prescriber of antibiotics in primary care in Wales. Royal Glamorgan Hospital is the highest prescriber of oral and parenteral agents. Concerns have been escalated regarding the shortage of antimicrobial pharmacists in the Health Board. An SBAR has been developed and resource implications will be highlighted to the Diagnostics and Therapies Specialities Care Group.
ASSURE	The IP&C Committee received and noted for assurance the following documents:- • IPC Report (April – September 2022) • IPC/Decontamination Risk Register • Covid-19 summary report October 2022 The IP&C Committee received and noted for assurance the following Exception reports:- • RTE ILG • MC ILG • Bridgend ILG • Health and Safety • Facilities ○ Housekeeping, Waste Management & Food Safety • Occupational Health (verbal) • IPC antimicrobial stewardship report October 2022
INFORM	Vacancies within the Infection Prevention and Control Team are affecting service provision, however the team are prioritizing their workload in order to provide cover across a breadth of service. Two substantive IP&C appointments have been made recently.
APPENDICES	**NOT APPLICABLE**

Agenda Item	6.1

Quality & Safety Committee	
Maternity and Neonatal Improvement Programme Highlight Report September 2022	
Date of Meeting	15th November 2022
FOI Status	Open / Public
Prepared by	Shelina Jetha, Programme Manager MNIP
Presented by	Greg Dix, Executive Nurse Director Sallie Davies, Deputy Medical Director
Approving Executive Sponsor	Greg Dix, Executive Nurse Director Sallie Davies, Deputy Medical Director
Report Purpose	Update the group on the progress of the Maternity and Neonatal Programme.

ACRONYMS

ATAIN	Avoiding Term Admissions into Neonatal Units
CNO	Chief Nursing Officer
EPAU	Early Pregnancy Assessment Unit
GAU	Gynaecology Assessment Unit
IMSOP	Independent Maternity Services Oversight Panel
IPAAF	Integrated Performance Assessment and Assurance Framework
MDT	Multi Disciplinary Team
MNIB	Maternity and Neonatal Improvement Board
NNU	Neonatal Unit
QLM	Quality Leadership and Management (Maternity Workstream)
QWE	Quality Women's Experience (Maternity Workstream)
PCH	Prince Charles Hospital
PREM	Patient Reported Experience Measure
PTR	Putting Things Right
SEC	Safe and Effective Care (Maternity Workstream)
SOP	Standard Operating Procedure

SITUATION/BACKGROUND

The purpose of this report is to provide an update on the progress of the Maternity and Neonatal Improvement Programme in the form of a highlight report.

SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

This section outlines an overview narrative describing some of the key matters within the Maternity and Neonatal Improvement Programme:

- Conditions for sustainability SRO challenge – 4th session held and approved
- Neonatal immediate recommendations progress
- IMSOP report to Welsh Government to be submitted Oct 22
- Change to Governance structure (CSG) – programme reporting
- Progress on MIP wash-up plan
- Neonatal metrics
- Neonatal engagement – progress (June-sept 2022)
- QI - progress

RECOMMENDATIONS

The Quality & Safety Committee are asked to **NOTE** the report.

KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

Please note the **"Programme Risks/Issues"** are captured on slide 3 of the highlight report.

Work to understand the extent of a new risk added in March 2022 is still underway. This relates to a number of recommendations in the Neonatal Deep Dive report specifically seeking additional investment in workforce. Costs have already been predicted to exceed £1m, so this will be significant.

IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below) Please refer to the highlight report for detail.
Related Health and Care standard(s)	Governance, Leadership and Accountability All Health and Care Standards apply.
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) Not required for a progress report.
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	Yes (Include further detail below) Please refer to the highlight report for detail.
Link to Strategic Goals	Improving Care

Maternity and Neonatal Improvement Programme

SROs : Greg Dix and Sallie Davies

September 2022

TOP PROGRAMME RISKS AND ISSUES:

Risks/Issues	Details	Mitigating actions	Rating
The new Health Board Operating model could create uncertainty and impact progress	The programme will need to monitor progress closely and to mitigate uncertainty will need to respond quickly to circumstances as they evolve. The new model should help with some of the current risks within the programme. Discussions are planned to begin exploring how transition of the programme into operating structure, which the operating model could disrupt. Mitigating this we'll focus on areas where accountability and governance structures can be transitioned with minimal disruption. The arrival of the Health Board wide Director of Midwifery role will aid this transition.	The Clinical Care Group was formed on 1st Sept 2022; Triumvirate appointments in new structure of Director of Midwifery, Medical Director and Director of Operations. Maternity and neonatal risk escalation framework developed and approved at MNIB Board on the 28th September and Q&S on the 20th September.	low
Neonatal Deep Dive recommendations lead to increased operating costs	Work is underway to understand the operational cost consequences of a number of recommendations in the Neonatal Deep Dive report (3.3, 3.4, 3.5, 3.6, 3.7 & 3.8). The additional costs are greater than £1M but there are other posts that need scoped and costed.	Key improvement posts appointed; Workforce plan being developed; Risk Manager appointed 30.8.22; benchmarking of UK models of care and identify 3 potential models of care i.e. ANNP; PA, medical etc. to be discussed at a planned away day Sept.22; Supernumerary shift coordinators allocated – issues to be recorded on Datix; also recruiting to post for Maternity and Neonatal Safety champions	Moderate
Sustainability of improvements	The improvements achieved through the MNIP needs to be embed in BAU practices and must be sustainable	Regular audit in place through AMAT maintained by HoMs, DoM, Consultant Midwives and Clinical Directors. Newly appointed Maternity and Neonatal Safety Champions due to commence in post during November as part of the diagnostic and discovery phase of the Mat/Neo Safety Support Programme. QSE committee (formally SWAG) at service group level to provide scrutiny, assurance and oversight. WEESEE practices embedded and monitored through this group.	Moderate

Maternity and Neonatal Improvement Programme

SROs : Greg Dix and Sallie Davies

September 2022

FOUR THINGS YOU NEED TO KNOW:

- Neonatal DD immediate recommendations – IMSOP verified 15, 4 had been submitted by 30.9.22 but all 4 returned unverified; HB request to 'push-back' on Esc 5 (cooling); esc 7 (Sis) and Esc 5.1 (data) and Esc 2 (IUT) further review of evidence; meeting with IMSOP colleagues 18.10.22 to better understand reasons for not verifying
- Conditions for Sustainability last session no. 4 held 21.9.22 (see below): Approved by SROs and independent board member
- IMSOP final report to Welsh Government submitted Oct 22

CONDITIONS FOR SUSTAINABILITY ACTIVITY PROGRESS

Maternity and Neonatal challenge sessions with SROs/independent HB member: **'APPROVED'**

- **Session 1 (5.8.22):**
  - IPAAF
  - RCOG recommendations
  - Programme Management
- **Session 2 (16.8.22):**
  - Engagement
  - Serious Incidents (SI)
- **Session 3 (22.8.22):**
  - Corporate Governance
  - Clinical Review
  - QI and data

CONDITIONS FOR SUSTAINABILITY ACTIVITY PROGRESS

Maternity and Neonatal challenge sessions with SROs/independent HB member: **'APPROVED'**

- Session 4 - final (21.9.22):
  - Strategic vision (i.e. Long-term strategy)
  - Medical Leadership
  - Culture and Leadership
  - Neonatal – immediate actions
  - Neonatal – Long-term actions
  - IMSOP onsite visit (5th and 7th September 2022)

Neonatal – Summary of Immediate actions/Escalations as at 5.10.22

- **Total 19,**
- **15 verified**
- **4 uploaded to IMSOP 30.9.22**
- **All 4 unverified 5.10.22; meeting arranged with IMSOP Neonatal clinical panel 18.10.22**

Submitted to IMSOP 30.9.22 and returned unverified 5.10.22

No.	Immediate Action/Esc. unverified	Workstream (WS)	Leads	Comments
1	Esc. 5 (cooling)	**Clinical Case Assessment**- *The Health Board must review its cooling practice in line with national frameworks and ensure local practice meets this standard.*	Consultant Paediatrician/ Neonatal Governance Nurse	Processes and training in place. No case of HIE for 8 months. Sign off contingent on reviewing a case to ensure processes followed
2	Esc.5.1 (data)	**Wales and National Reporting** - *The clinical team must ensure completeness and accuracy of Neonatal Unit data.*	Consultant Neonatologist / Consultant Paediatrician	On going development of dashboard. Better understanding of what is required following meeting with IMSOP clinicians
3	Esc. 2 (work with Maternity)	**Neonatal Unit functionality** - *The Health Board must continue to show an improvement in the working relationship with maternity services in numerous areas.*	Lead Neonatal Nurse	Under review by HB
4	Esc. 7 (SI/PMRT/Mortality/MDT/NICU)	**Clinical Case Assessment** - *The Health Board must ensure clinical incident reviews, SI reviews and PMRT/Mortality reviews are carried out as an MDT with external support from colleagues within the local NICU to provide clinical expertise and questioning.*	Consultant Paediatrician/ Neonatal Governance Nurse	HB completed SI reviews in conjunction with Maternity Improvement programme, HB working to submit recent reviews to comply with IMSOP requirements.

Maternity and Neonatal Improvement Programme - Workstreams

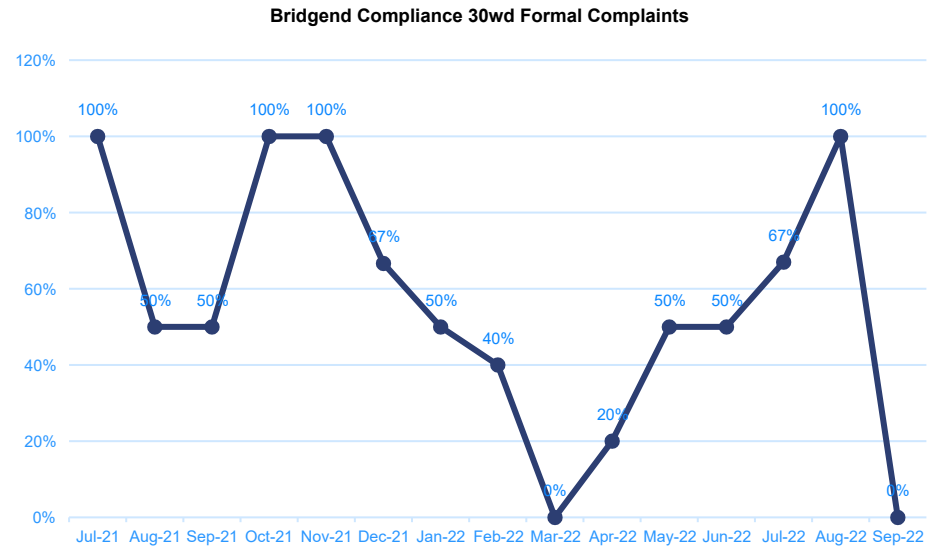
SROs : Greg Dix and Sallie Davies

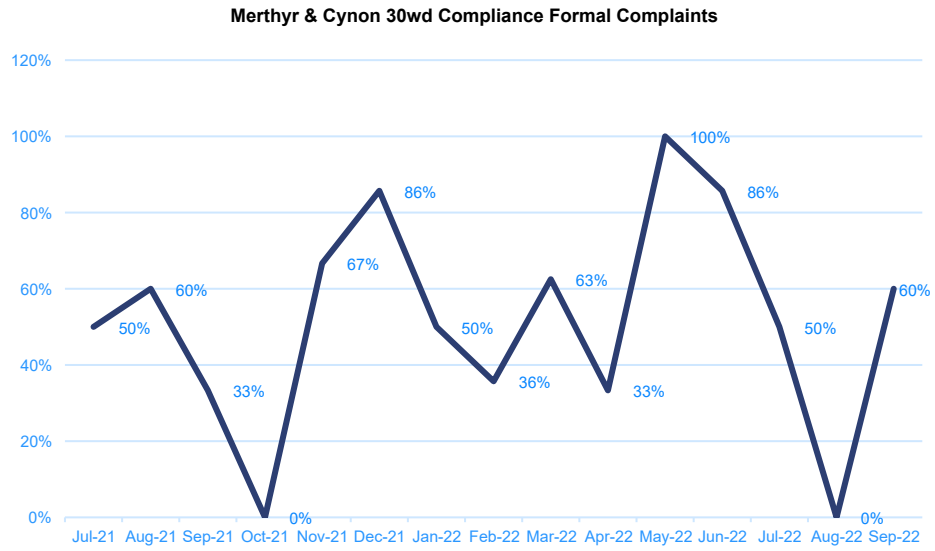
September2022

Things to know: Focus during September has predominantly been on closure of Maternity Improvement programme SEC and QLM; IMSOP visit on 5th and 7th Sept and delivery of the remaining immediate actions (as per previous slides); Leadership courses with protected time; data dashboard development and presentation in various forums such as Q&S; MNIB board etc Coaching from local NICU; SIMS training; Training programme 28.9.22; Extreme pre-term SIMS 12.10.22 at PCH; engagement progress report June-Sept 2022; Some delays in Engagement workstream due to clinical demands on lead but solution now found to provide further support; Culture and Leadership plan completed and uploaded to IMSOP; joint Maternity and Neonatal in engagement with staff and show

Milestone	Due	Progress
Establish mechanisms/processes (CSG assurance)	Aug 22	Quarterly report June to Sept 2022 compiled; shared at NNIP project meeting 10.10.22 and Oct MNIB huddle
Well-being champions as part of the workforce, working together to provide accessible support for staff and families.	Sept 22	Staff on both sites have accessed the mental health first aider course. Psycho social meetings embedded in both wards also.
FIC (care team; plan; working group; passports etc.)	July 22	Leads from POW/PCH identified and aim to have a CTM approach but also dependent on All Wales network solution; further QI training to be provided; Workstream lead provided with further resources due to clinical demands.
Audit: gov. process/outputs and action plan/review by NICU	May 22	Audit system governance process map was shared at NNIT 4th July and further discussion held with clinical leads. Audit process examples provided as part of immediate actions/escalations
Supernumerary Shift Co-Ordinator role	Dec 21	Initiated during Aug 22 and instruction to datix if issues arise
Ensure Clinician NLS training is up to date	Nov 21	19 staff members received NLS since 2018 with expiry dates ranging from 2023 to 2027; HB has 5 instructors; CD to ensure all NLS is completed
IMSOP suggested proformas	Jun 22	Proforma's completed; signed off/some being used by staff but require review of implementation and imrorvement
Infant feeding lead for Neonates JD	July 22	JD completed; protected time and will be included in workforce paper regarding improvement roles and sustainability
Radiology – procedure /reporting/review of image by specialist consultant radiologist	Dec 21	Paediatric Radiologist appointed by HB; stickers on patients notes being used; scbu audit completed; Longumbilical lines audit completed. Verified by IMSOP 21/9/22
PREMS - questionnaire	Aug 22	Developed and shared with Engagement forum; various mediums to be utilised for capturing feedback; trial survey set-up access via QR code and also paper; next - discussion with CIVICA and need to launch on electronic platform
Plan to handover improvement hub to operational team	June 22	This had been showing as delayed in previous reports but has now been set-up and active
Safety Culture Survey	Sept 22	Now on CIVICA and live 2.9.22; next stage to ensure MDT included

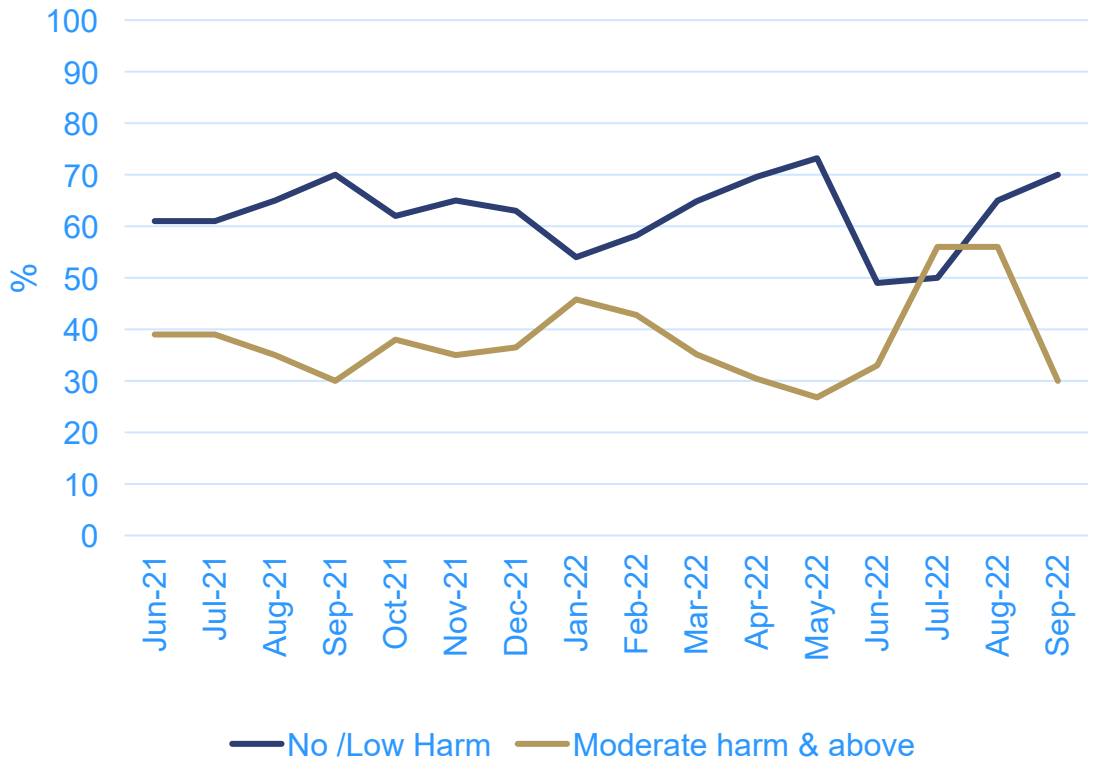
Compliance against 30 working day target concerns (O&G)
Sept 22





Note: All concerns are Quality Assured by the CD and HOM together note: the process is lengthy. Overall, in Sept 6 complaints were closed with an outcome of 'not upheld'. As of 4.10.22 14 complaints are open. One RCA is open and being completed.

Maternity only Clinical Incidents by level of harm
Sept 22



Incidents now reporting on new Once for Wales system which allows a post-review grading of the incident which should provide a more accurate reflection of the severity of the incidents.

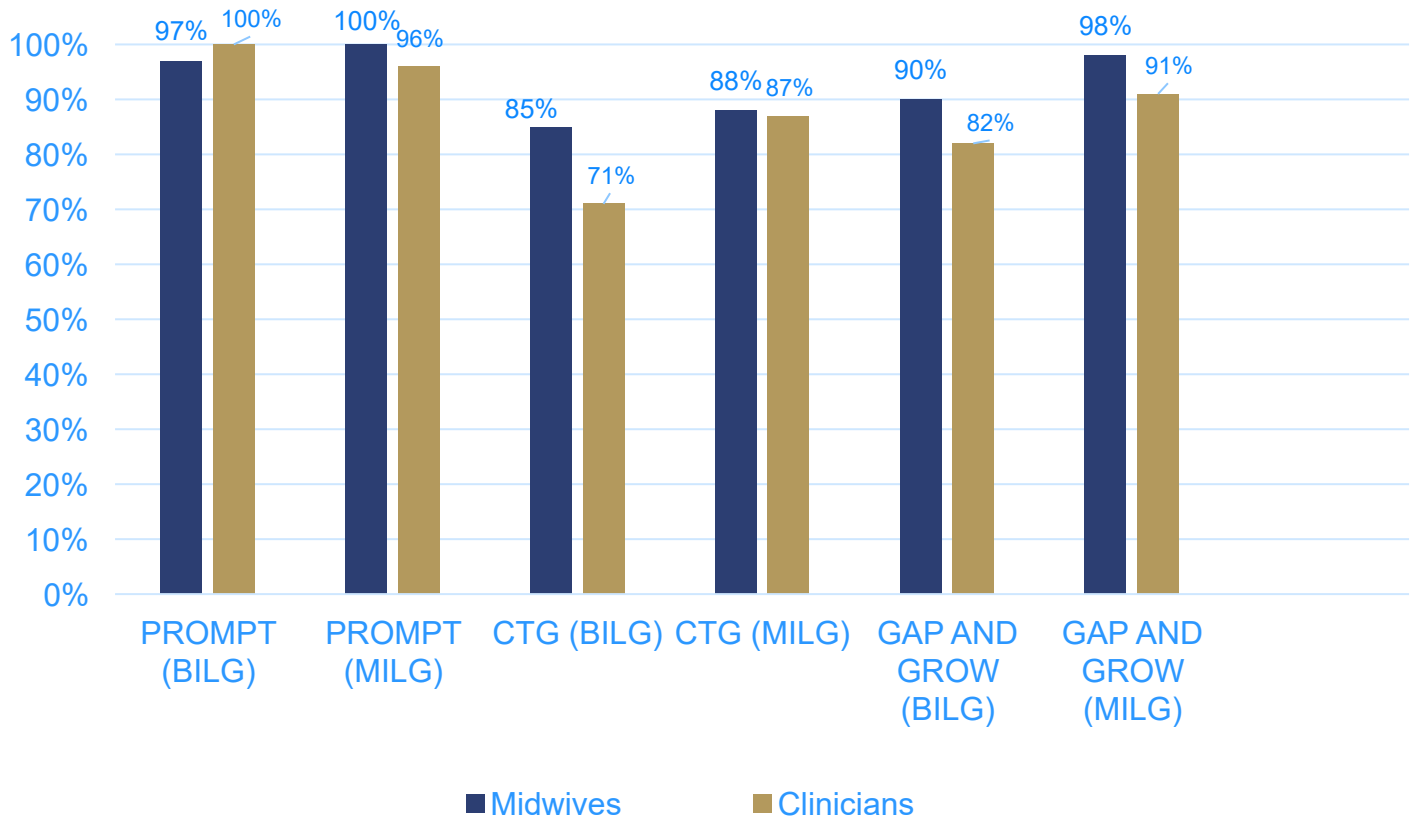
Graph indicates low harm showing an increase but moderate harm showing a significant decrease in September.

Maternity and Neonatal Improvement Programme

SROs : Greg Dix and Sallie Davies

Sep 2022

Training Compliance for Sept 2022 (as at 5.10.22)
(Expected compliance 95%)
(no training in Aug)



MILG: *PROMPT Obs 1 out of compliance and 1 new Registrar booked for Oct 22; non-compliance escalated to matron/CD*

BILG: *PROMPT* – 4 midwives outstanding due to short term sickness; last course in July cancelled due to facilitator sickness but poor staff engagement by Obstetricians to meet their compliance; non-compliance escalated to matron/CD

Maternity and Neonatal Improvement Programme

SROs : Greg Dix and Sallie Davies

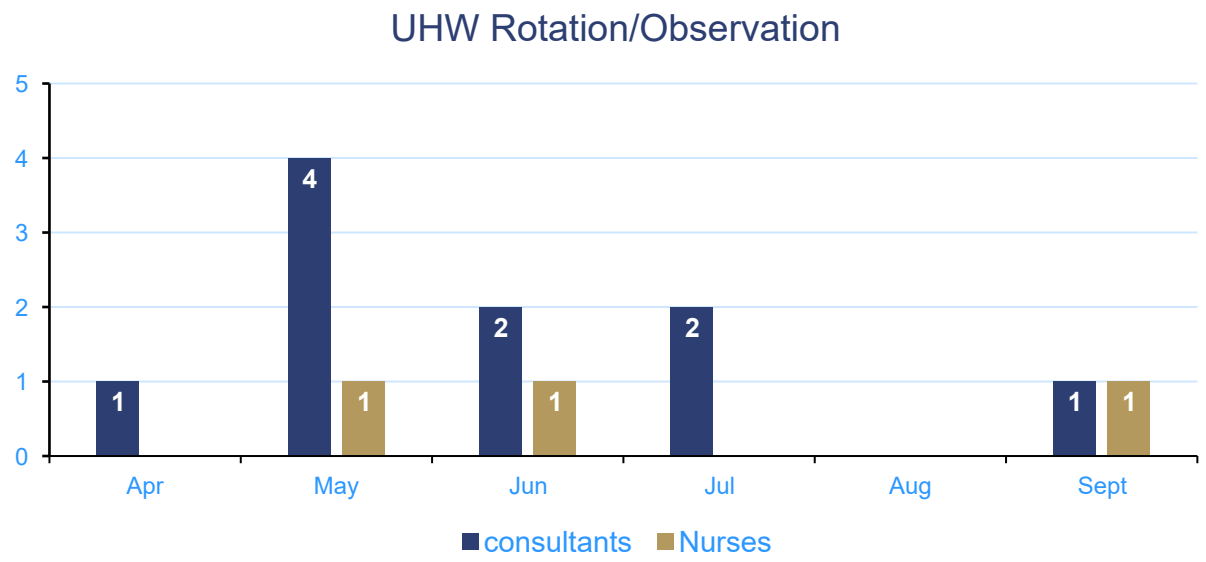
September 2022

KEY PROGRAMME METRICS

Neonatal – Nurses and Consultants rotating in UHW tertiary centre each month by role

- Consultants – 2 day visits in non-patient care role
- Nurses' rotate for a week and are involved in full patient care
- ISSUES: Nurse rotation delays due to DBS and identity checks

Consultant visit timetable: arranged from April 2022 to December 2022 (except August due to A/L and cover)



- Consultants continue to visit as per agreed plan: 10 on visit plan; 8 visited UHW and 3 have visited twice.
- 39 nurses in the dept. But only 3 rotated and 5 are on Maternity leave.
- Nurse rotations in September poor due to delays in DBS and occupational health checks.
- We are in the very early stages of discussions for rotation to other tertiary centres.
- The shared learning from the nurse's experience is presented on neonatal study days, through reflections and by sharing with their colleagues.

Neonatal – Nurses and Consultants rotating in UHW tertiary centre each month – Example of some LEARNINGS

Some Consultant Learnings

1. Plan introducing Non-invasive ventilation using SLE 6000 ventilators. Arrange Local trial of the new F&P 950 humidification system with a view to replacement of current humidifiers
2. TPN light protective giving sets. Cardiff NICU uses different pumps and syringe drivers.
3. Pharmacist and nurses introducing set times of the day for administering common medications such as Caffeine, Iron and multivitamins (minimise drug errors, be cost effective)
4. Noticeboard - Medications errors on Datix on a noticeboard.
5. Noticed a poster about electronic reporting of Learning from Excellence https://learningfromexcellence.com
6. Safety huddle (included signposting to teaching/training events) - our senior nurse has refreshed the framework for safety huddle includes 'key learning messages for the week' emerging from Incident reviews
7. 'neonatal knowledge cards' that go on the lanyard for juniors
8. Re-enforcement of IPC messaging- 'bare below elbow posters'
9. Psychosocial meeting at lunch time - family needs/emotional wellbeing and our working on the same
10. Handwashing/Infection control - reinforce positively the practices of handwashing.

Some Nurse Learnings

Trollies

- Trollies for resuscitation were very organised just the essential things/checked daily
- The neobars were boxed up singularly and just one per colour
- Sealed intubation box; checked once a week for dates or once a month to make sure everything on there was in date, but this held everything you needed to prepare drugs for an intubation
- All stock is placed into cupboards on the unit (minimises the need for trollies)
- Silver trollies for procedures e.g. blood gases or bloods etc and a sterile pack is opened out onto the trolley

Drugs

- Online library of drug monographs with backup of file
- Nurses when drawing up drugs refer to the guidelines online (our Pharmacist working on this)
- Premade antibiotic - new antibiotic stewardship to administer within an hour of being charted.

Neonatal nugget: 'neonatal nugget'/A4 piece of paper/different topic every month/2 mins to read e.g hydrops and different topics written by different staff

IPADS: For long term babies – keep them stimulated used youtube e.g. watch and listen to music and things like colourful fish etc.

MILK : laminated label 'CAUTION! SAME/SIMILAR NAME! PLEASE CHECK CAREFULLY USING M NUMBER, NAME, D.O.B'

Charts: 2 sided use e.g. HDU chart had on the back a blood gas record and an apnoea/bradycardia record

Nurse in charge: Oversee everything. (we now have supernumerary shift coordinators – datix if issues)

Care Plans: in one place e.g. Respiratory, thermoregulation, nutrition, developmental care and safe environment, are all within the admission booklet

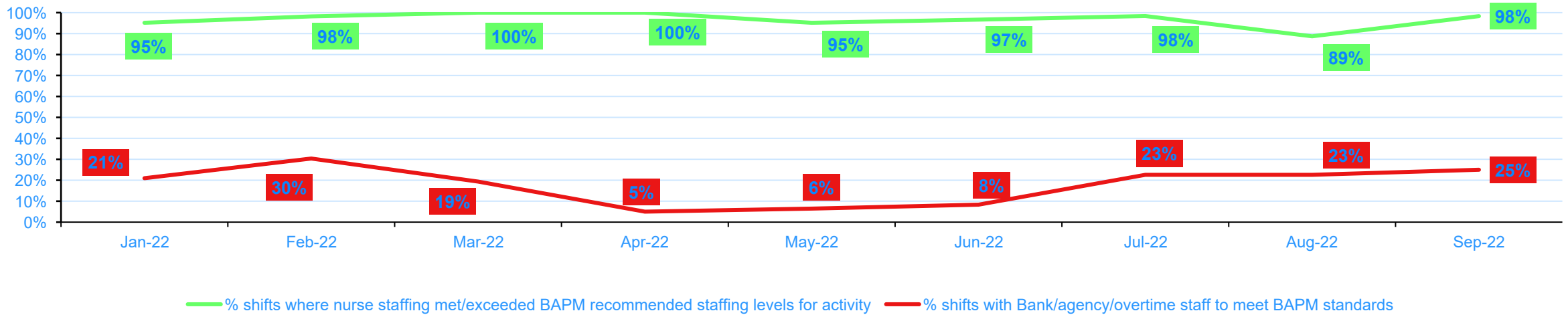
Diaries: All babies have diaries updated on a daily basis,/ parents there really appreciate these little things

Newly qualified nurses: go into ITU, with support; Drs and ANNP's are most of the time – good insight into HDU and ITU before you do your course

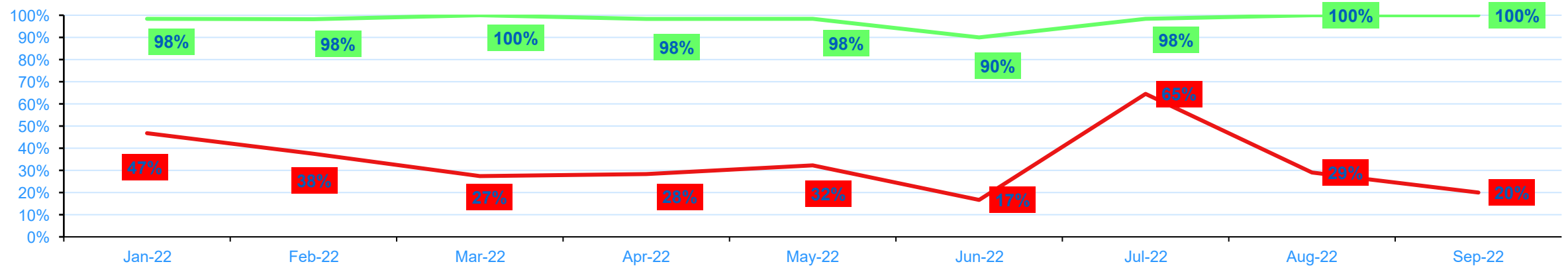
Neonatal Improvement Programme – Metrics
September 2022
David Deekollu/Rebecca Pockett

PCH & POW Nurse Staffing
(Based on shifts per month)

PCH Nurse Staffing



POW Nurse Staffing

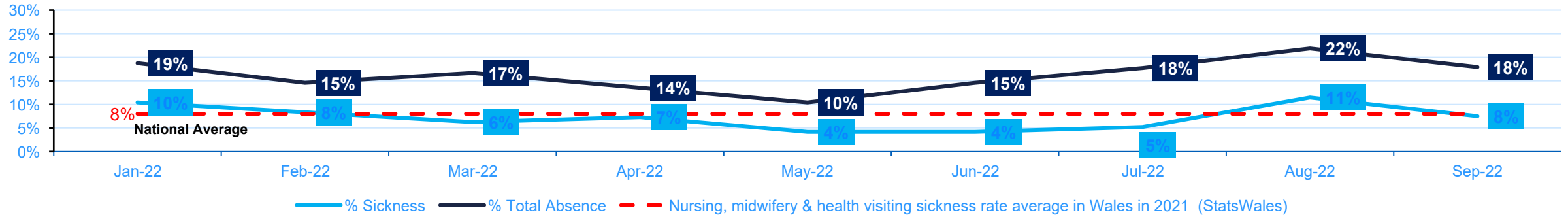


Both Units remained open to admissions. Red line indicates use of bank/agency/overtime staff to maintain BAPM staffing levels, with up to 25% in September.

SICKNESS & ABSENCE 2022

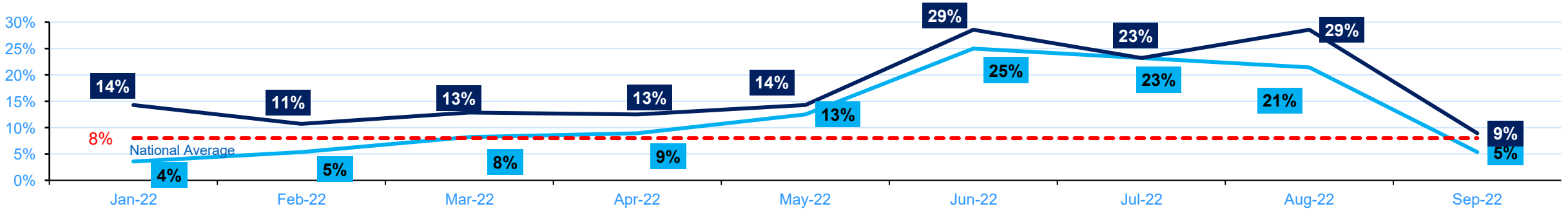
Total absence (unavailable) includes: Sickness, Maternity Leave, Special Leave, Other (e.g. Covid Related). Annual Leave not included as staff potentially available to work.

PCH - Sickness/Absence %



Compared to the national average PCH sickness rate remains at an acceptable level. The increased absence is due to a number of nursing staff being on maternity leave.

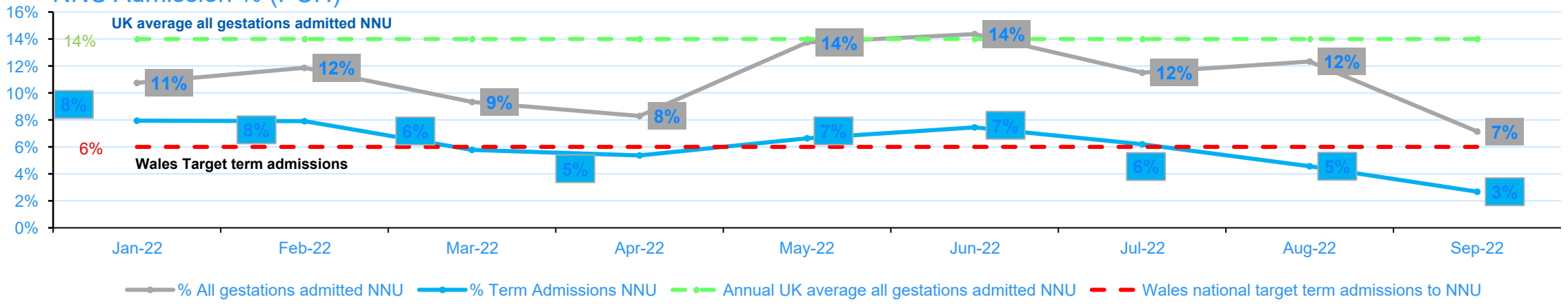
POW-Sickness/Absence %



Although for a period of 3 months sickness in POW was above the national average, it has now reduced to be in line with the national average due staff returning after extended periods of sickness.

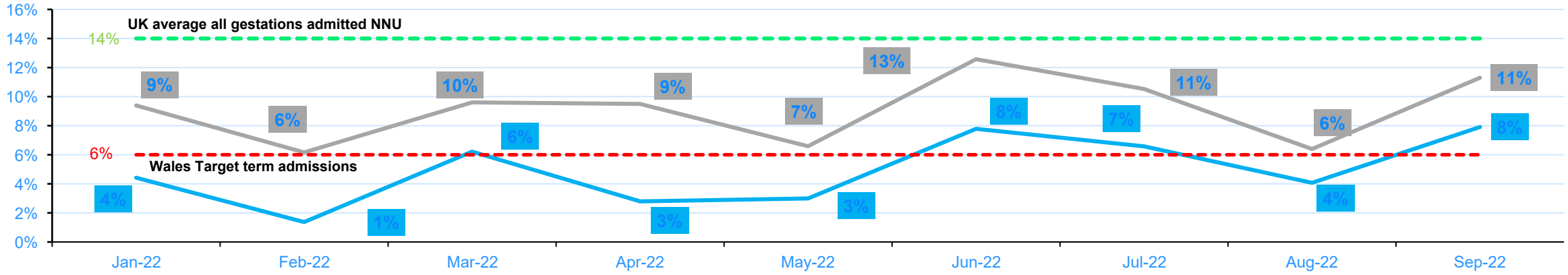
PRINCESS OF WALES - SCBU

NNU Admission % (PCH)



PCH term admission rate has fallen for the third month in succession to be below the national target. There was a significant decrease in all admissions this month even though the birth rate remained similar to the previous month.

NNU Admissions % (POW)



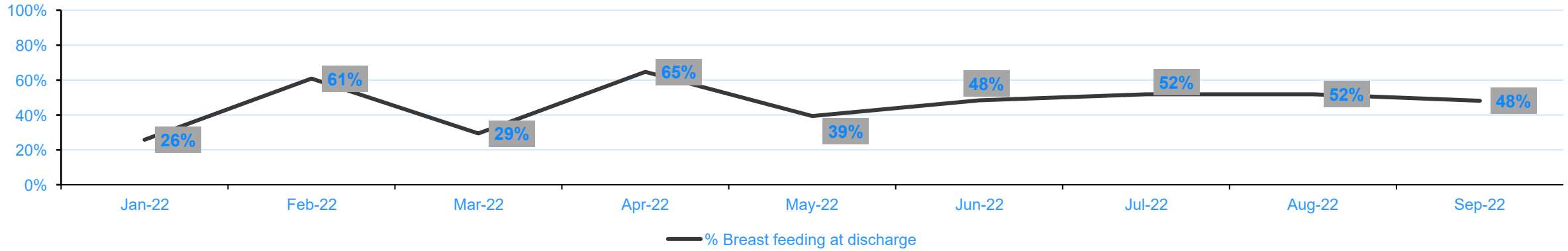
All admissions have doubled from previous month but still below the UK average i.e. all admissions per total births. The term admission rate has doubled and slightly above the national target. Total births has remained similar to previous month.

CTM – Receiving Breastmilk on Discharge

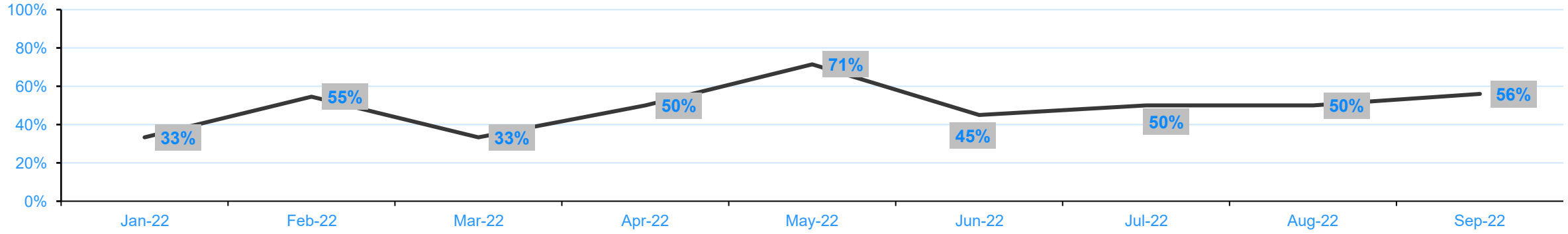
Percentage of all babies discharged to either Post natal ward or Home who were breast feeding or receiving EBM.

(*Wales range 54.2% - 80% of new mums breastfeed at birth and between 29.4% - 54.1% of new mums who still breastfeed at 10 days*)

PCH - % Breast feeding (receiving EBM)at discharge (all gestations)



POW - % Breast feeding (receiving EBM) at discharge (All Gestations)



Although, further improvements are required to improve breastfeeding rates during some months for both units continue to be relatively successful with breast feeding in the first 10 days.

Maternity Improvement Programme – Metrics September 2022

Elinore Macgillivray

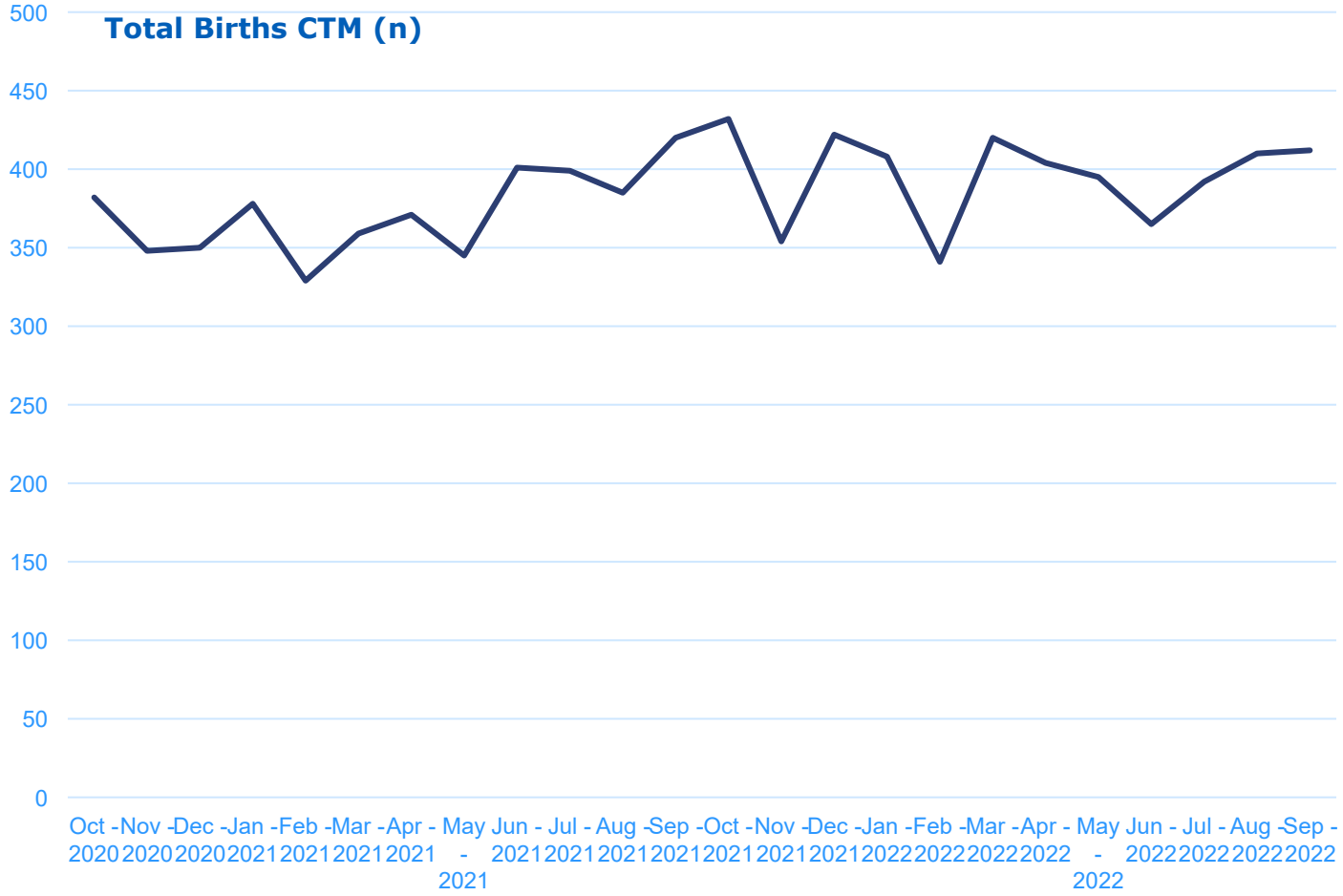
October 2022 – Maternity Metrics for CTMUHB Board Assurance

Quality and Safety Committee – Narrative by Exception

Maternity data are presented as time series data from October 2020- September 2022, extracted from Qlik Sense. Data are auto-populated from the Maternity Information Systems (MITS at PCH &RGH, WPAS at POW). Data will continue to be presented on a rolling 2 year basis unless otherwise indicated. Patient Reported Experience Measures (PREM) will form an integral part of the maternity data set. Measures shown are for October 2021 (launch) to September 2022.

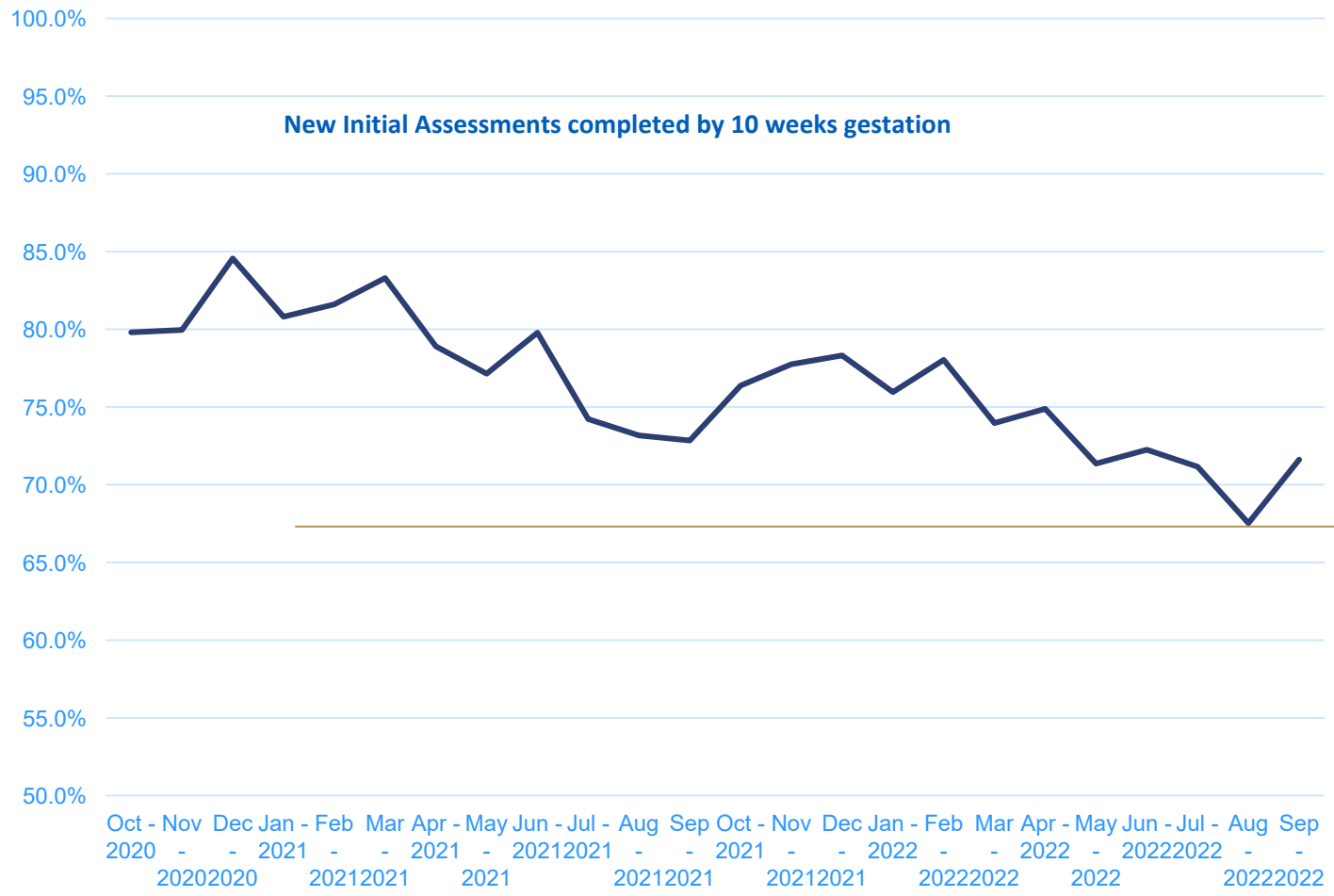
Patient Reported Experience measure (PREMS) was launched in September 2021, with increasing uptake since. The experience data is now a core part of maternity metrics reporting and will be reported as such (as per measures below). All QI projects will include the relevant PREMs data as a key measure (for example the IOL improvement work will include the IOL experience data reported through PREMs).

Neonatal data are manually collected from BadgerNet and input into Excel to create time series data.



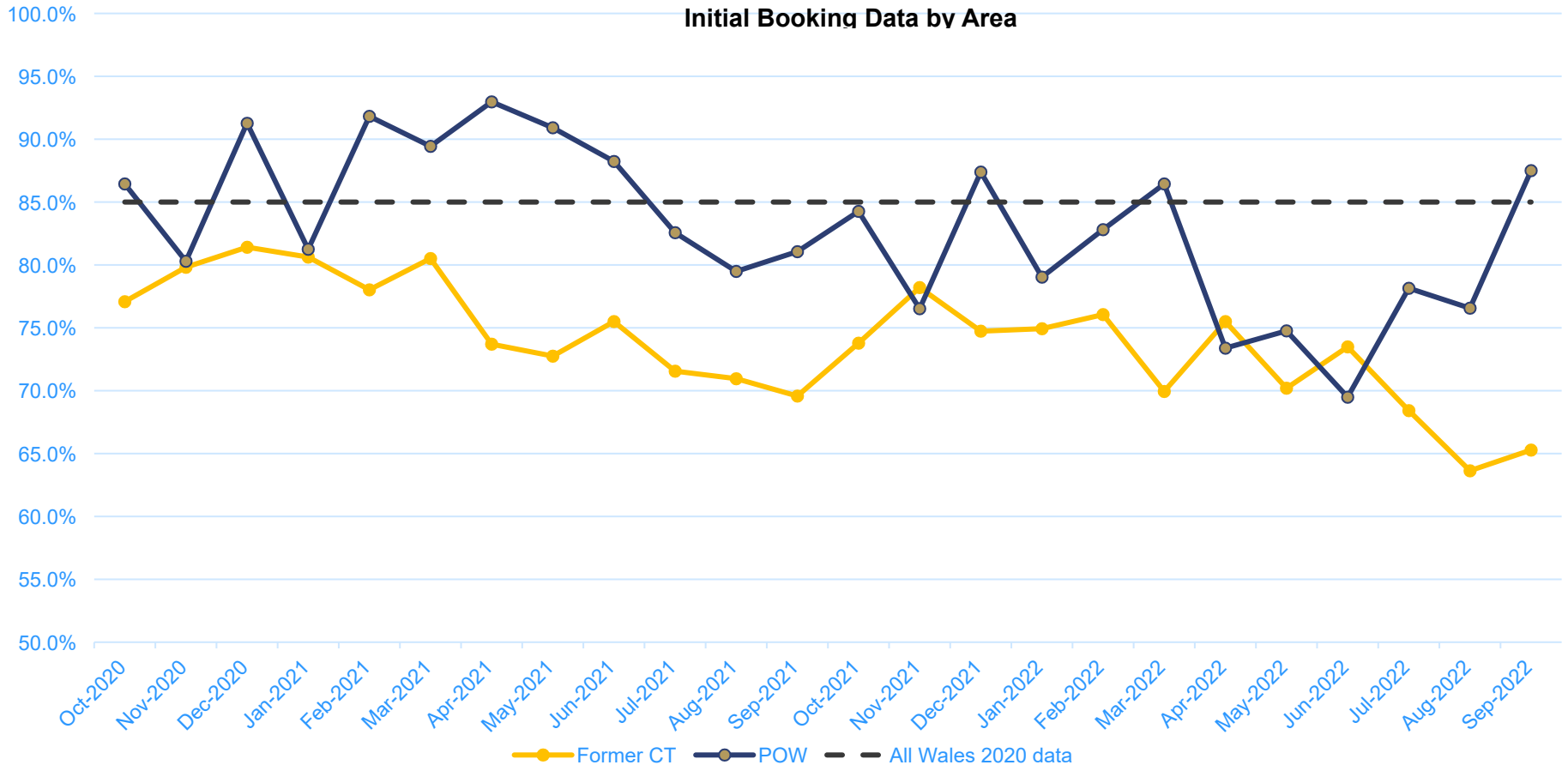
Notes: Total Births

Normal variation over time, data stable overall.
Number of births on each site show no concerning shifts or trends in the data.
Some signs that birth numbers are increasing. This may be a part of normal variation. Next few months' data will be important for understanding the birth numbers.
These data are reported per site at bi-monthly maternity governance meetings.



Notes

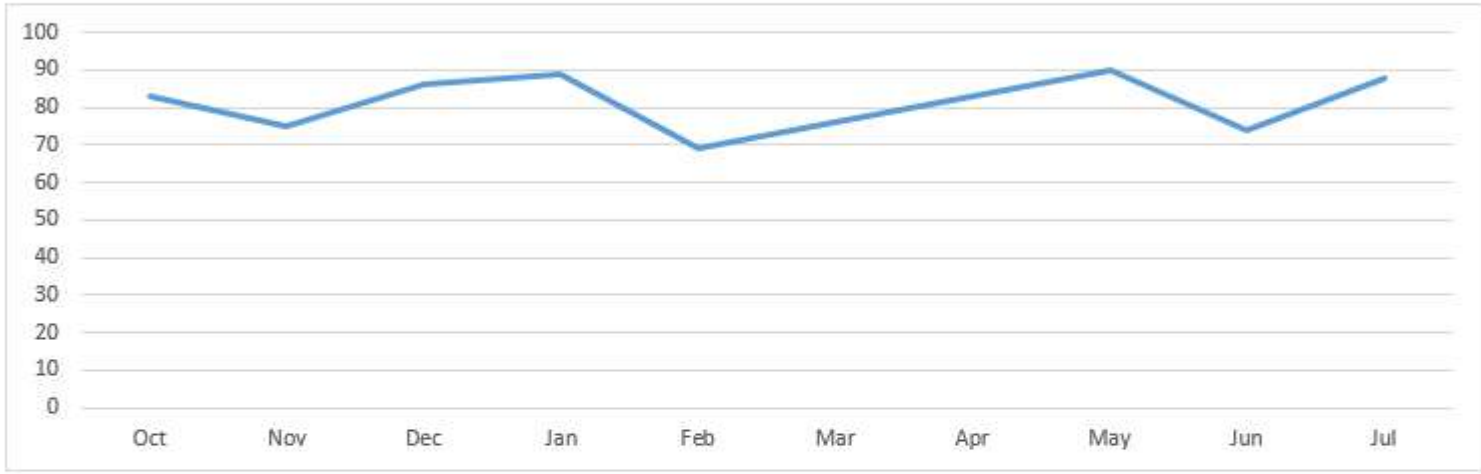
WG target is 85% of new initial assessments to be completed by 10 weeks of pregnancy (shown as amber line).
Decrease over time in achieving target of completing booking by 10 weeks of pregnancy.
Deeper dive into data undertaken. Significant variation in practice identified, as well as waste. Pathway being simplified to release time for midwives to provide care.
SMART improvement plans have been developed, including digitising booking system for easier access by Service Users and prioritisation of appointments for women at later gestations.
Aiming to test the new system in October. These data will provide real time signals of the impact of planned improvements.



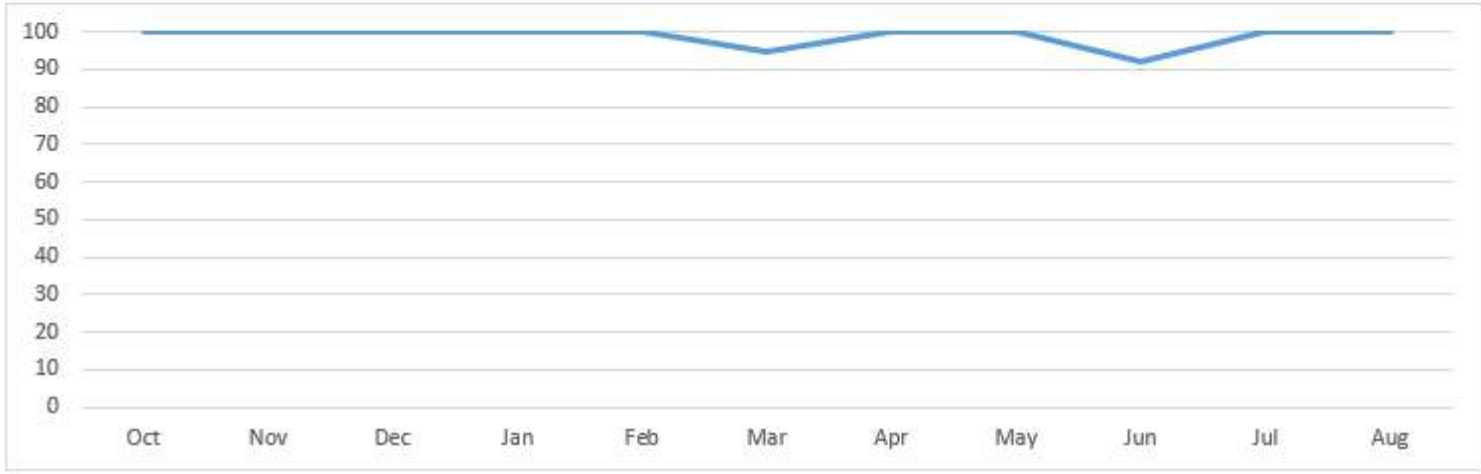
POW are showing significant signs of improvement, although this is not being seen at former CTM. Scoping work suggests this may be down to multiple factors including variation in the initial booking process across sites, and variation in what is considered as the initial booking date.

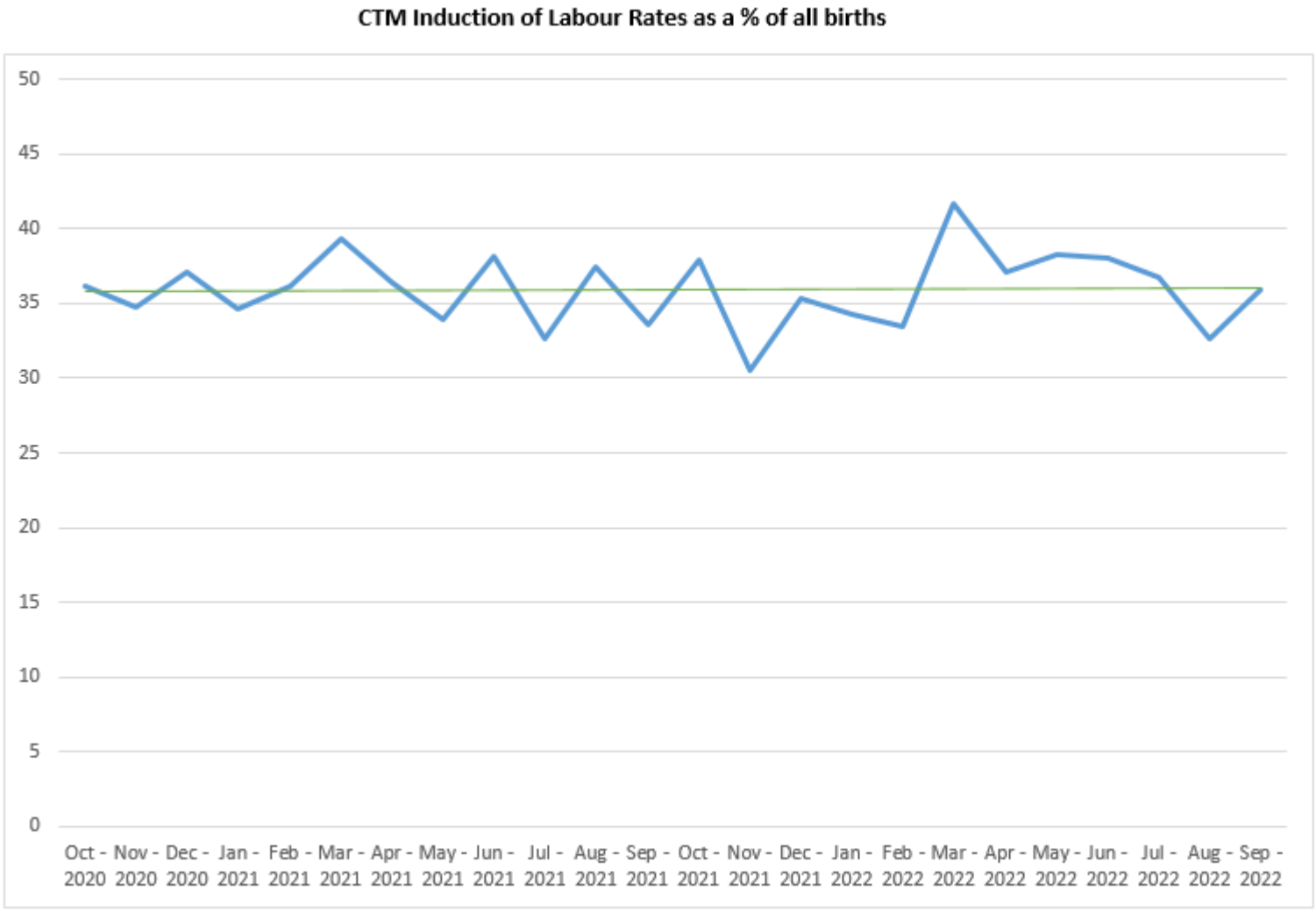
PREM: What women are telling us about early antenatal care

During your early antenatal appointments, were you given enough time to ask questions or discuss your pregnancy?



During your early antenatal appointments, did your midwife ask you about smoking?





Notes

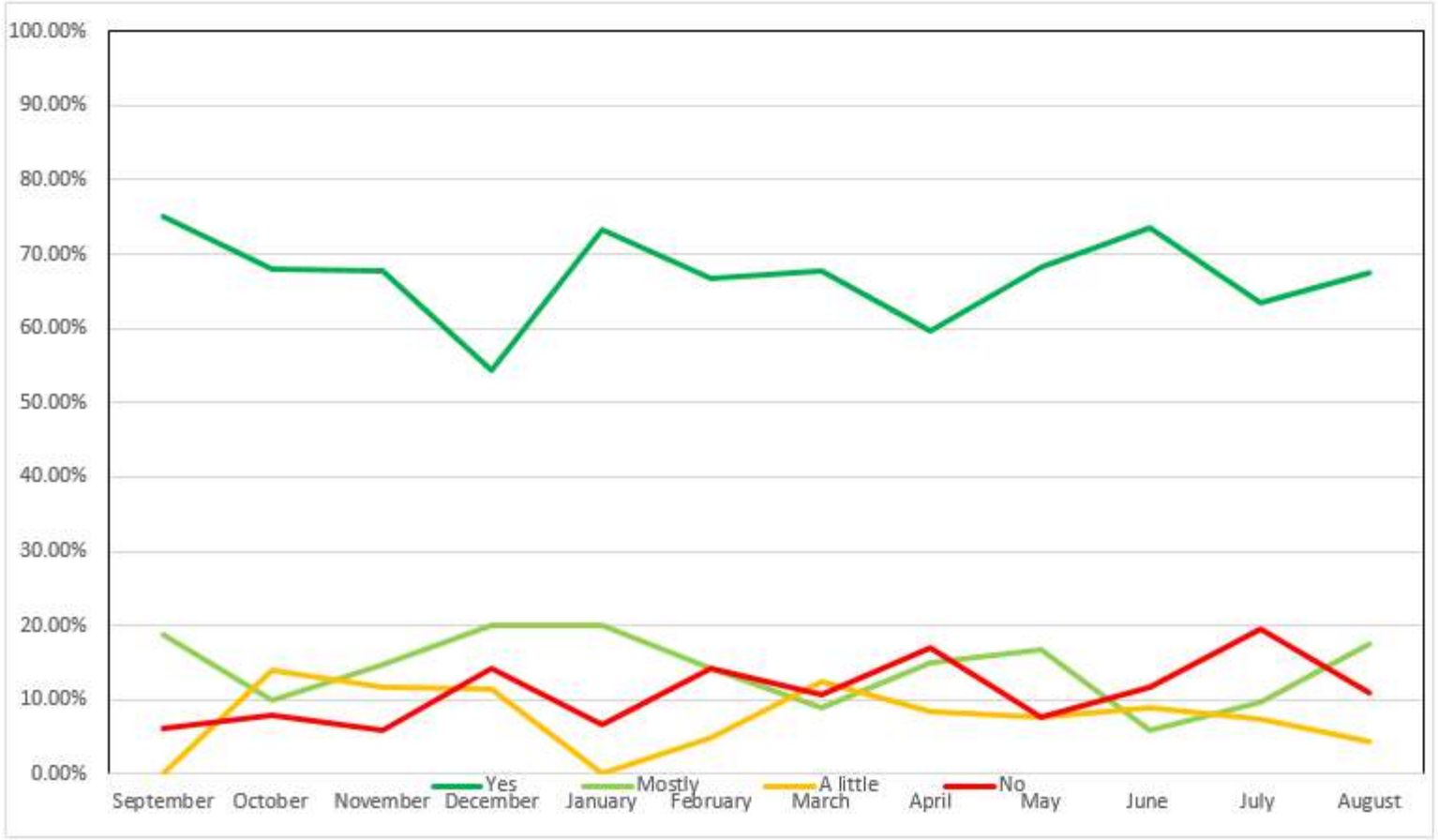
Rates stable- normal variation but no trend or shift seen over 2 year period. Trend line is stable (shown in green).

Induction of Labour rates are increasing across the UK. No target set by WG, as rates impacted by many factors, including local population demographics.

IOL improvement group is undergoing a refresh with a QI methodology approach. Aim is to improve the quality, safety and experience of care. This includes adherence to guidance and supporting women and families with decision making.

What women are telling us about their experiences of making choices about, planning and undergoing induction of labour. These data are extracted from the Patient Reported Experience Measure (PREM) questionnaires sent to women throughout their pregnancy journeys, as previously described.

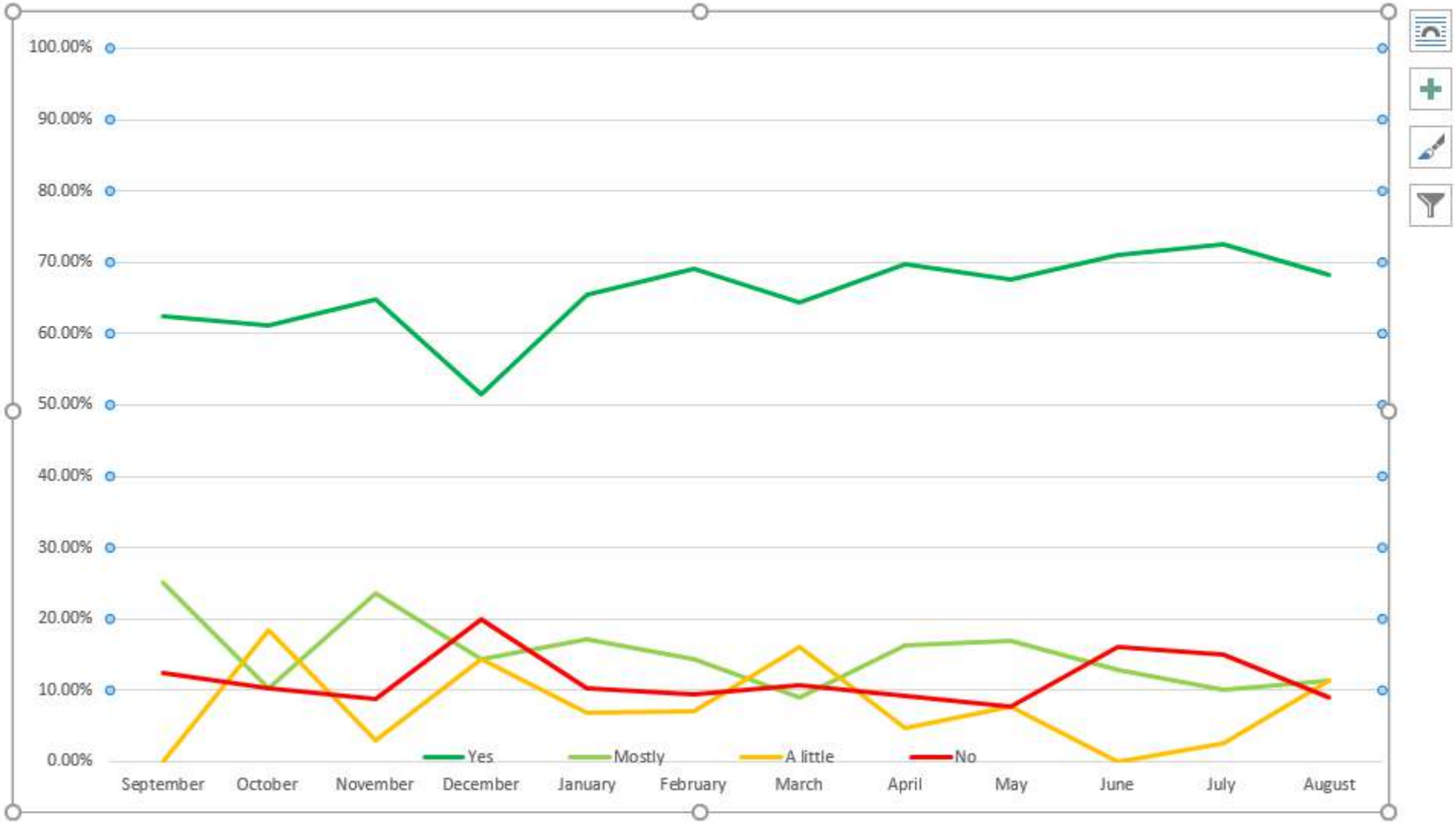
If you were offered an Induction of labour, did you feel fully involved in the decision for this to go ahead?



Notes

PREMs data relating to IOL will be a key metric of the IOL improvement group.

If you were offered an induction of labour, did you feel you were supported with enough information or discussion from your midwife or doctor?



Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Total Caesarean Sections as a % of all births all CTM

Notes

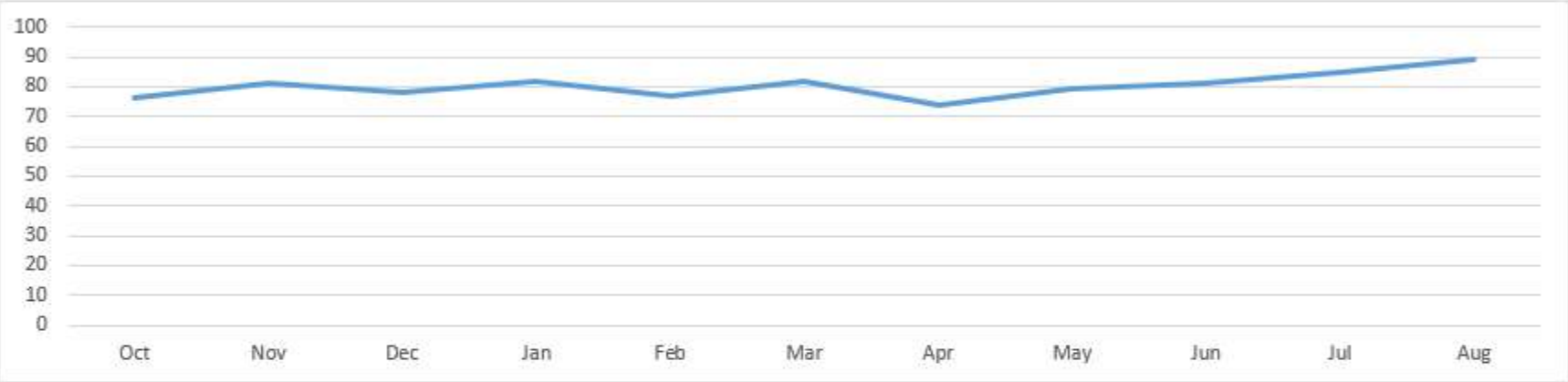
In future, this will be cross referenced against CHKS data, to support data verification.

As part of the maternity dashboard update, all grades of CS will be displayed separately (1,2,3 & 4) allowing for better understanding of CS data.

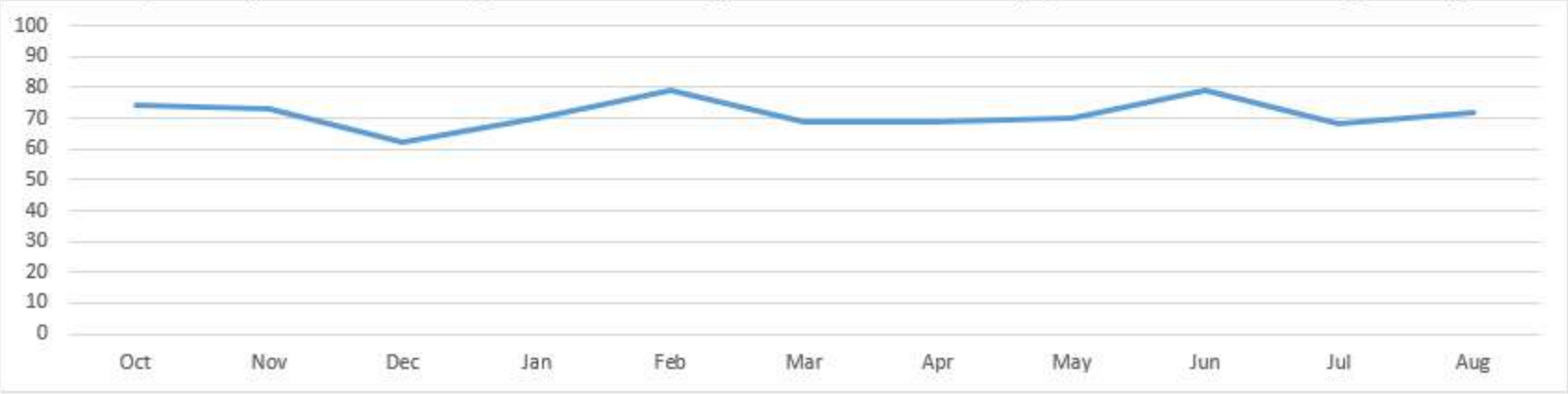
Some signs that total CS rate may be increasing.

No target rate. Focus on supporting information and choice for women, birthing people and families.

PREM question relating to birth planning: During your labour and birth, did your midwife and/or doctor listen to and respect your birth plan/s and preferences?

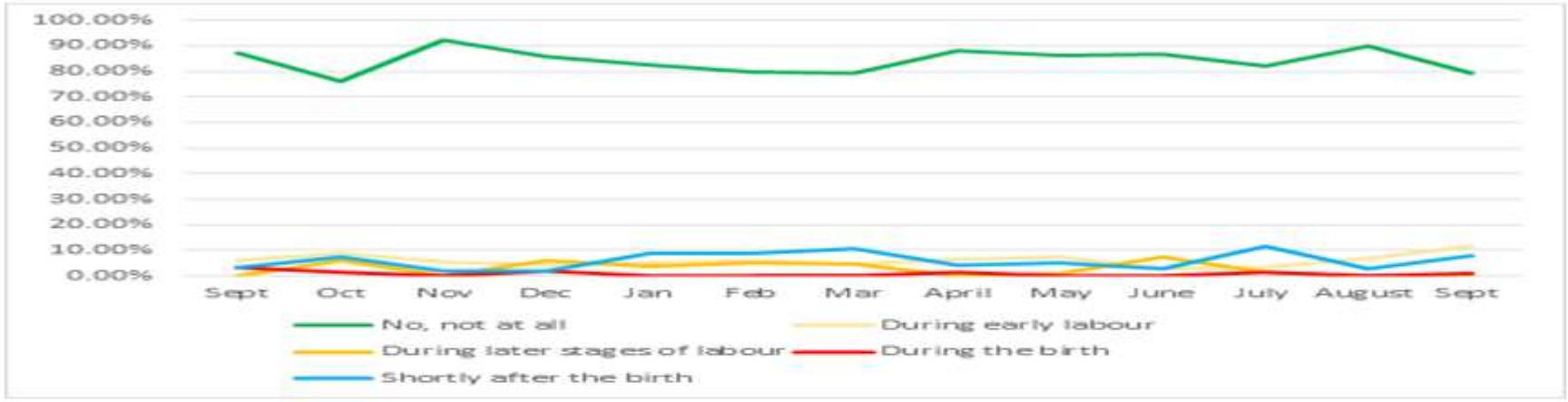


PREM: Do you feel you have had enough information from your midwife/doctor to help you decide where to have your baby?

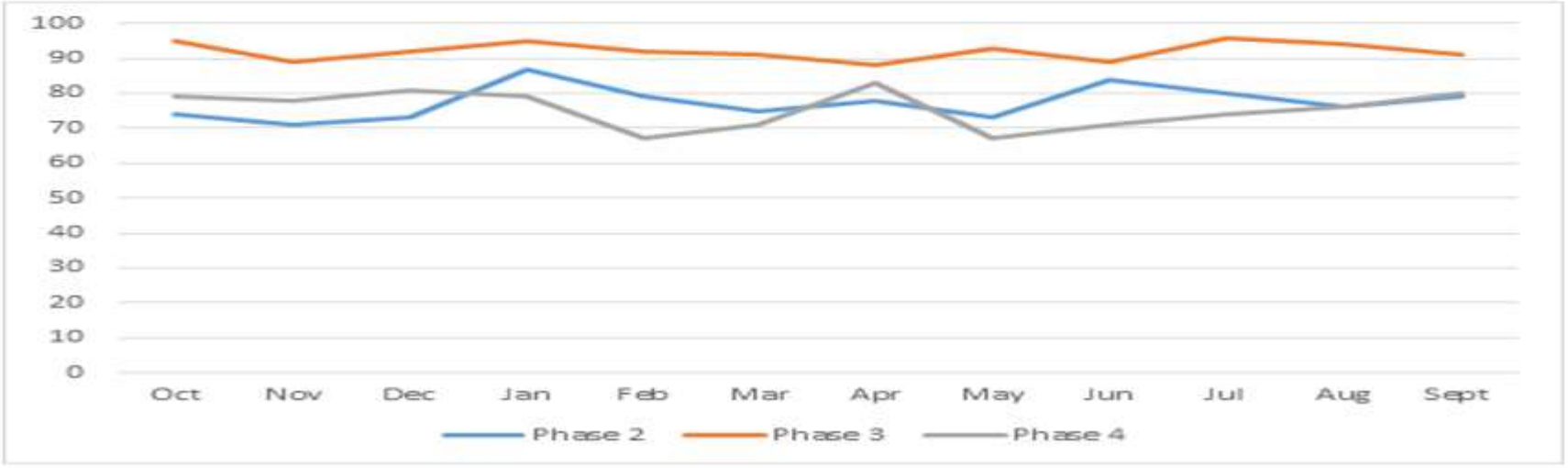


Themes and Trends in PREMs

Were you left alone at a time when it worried you?

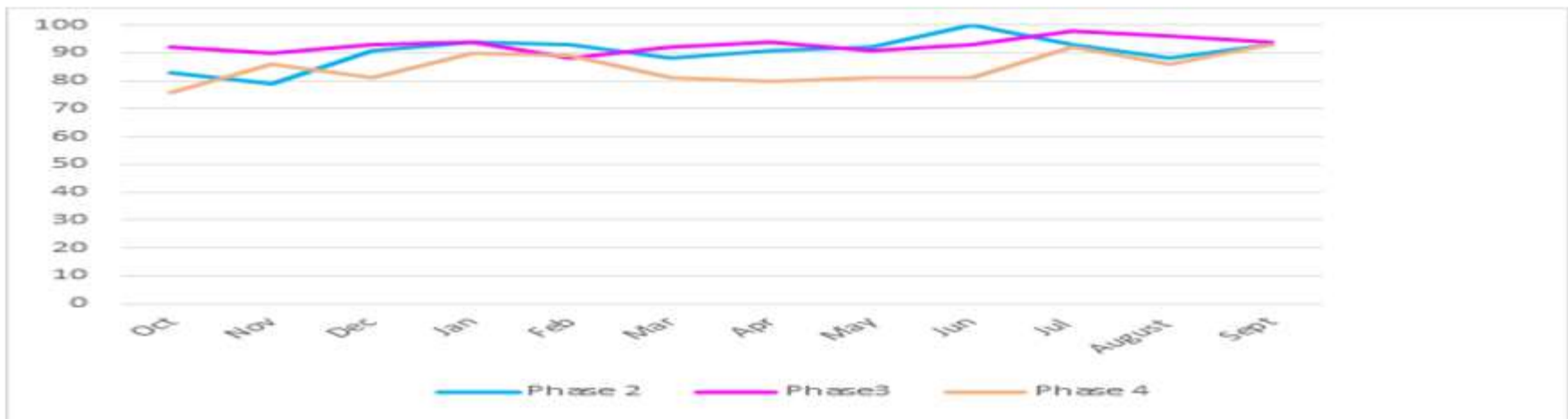


Did you have confidence and trust in the staff caring for you?



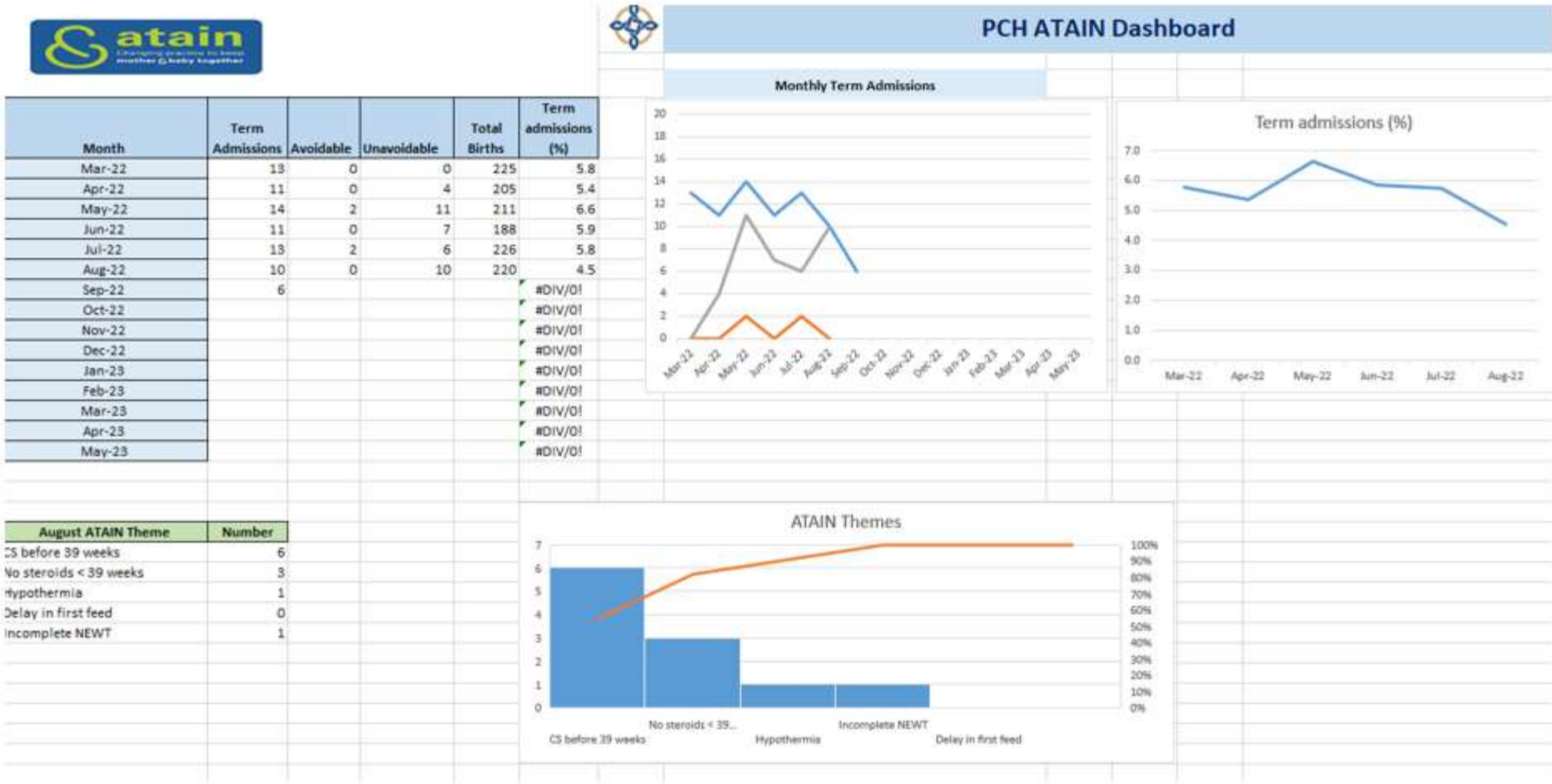
During your care were you given enough time to ask questions or discuss your pregnancy in a meaningful way?

Thinking about your care, were you treated with respect and dignity?



Avoiding Term Admissions to the Neonatal Unit (ATAIN)

The ongoing ATAIN programme is undergoing a refresh with a structured quality improvement methodology approach. The newly appointed Neonatal Governance Lead will be leading this across sites with support from the Maternity and Neonatal QI Lead. An ATAIN dashboard has been developed to capture themes arising from ATAIN multi-professional reviews (screen shot below). These themes will then be used to develop SMART action plans.



Month	Term Admissions	Avoidable	Unavoidable	Total Births	Term admissions (%)
Mar-22	13	0	0	225	5.8
Apr-22	11	0	4	205	5.4
May-22	14	2	11	211	6.6
Jun-22	11	0	7	188	5.9
Jul-22	13	2	6	226	5.8
Aug-22	10	0	10	220	4.5
Sep-22	6				#DIV/0!
Oct-22					#DIV/0!
Nov-22					#DIV/0!
Dec-22					#DIV/0!
Jan-23					#DIV/0!
Feb-23					#DIV/0!
Mar-23					#DIV/0!
Apr-23					#DIV/0!
May-23					#DIV/0!

August ATAIN Theme	Number
CS before 39 weeks	6
No steroids < 39 weeks	3
Hypothermia	1
Delay in first feed	0
Incomplete NEWT	1

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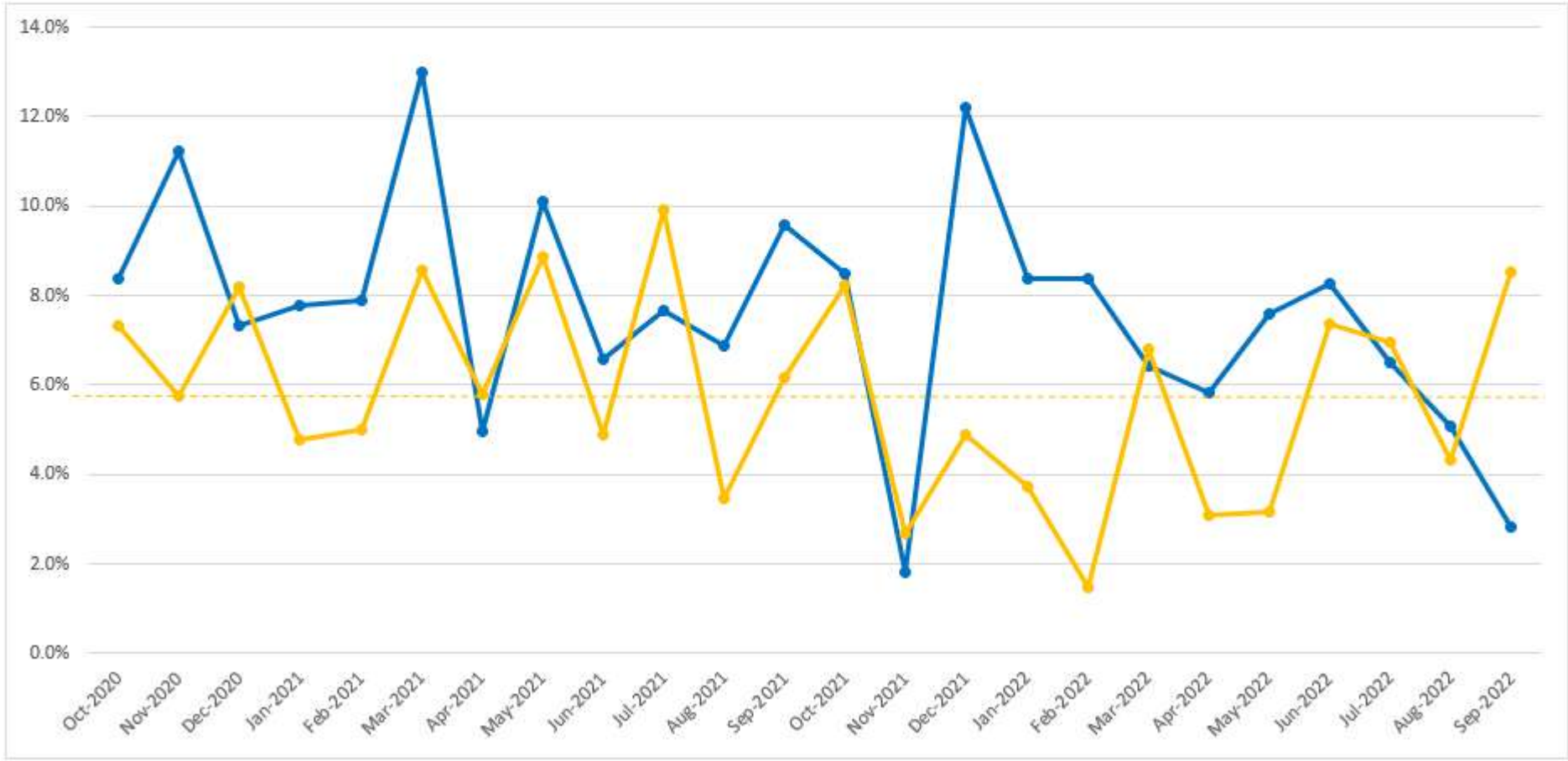
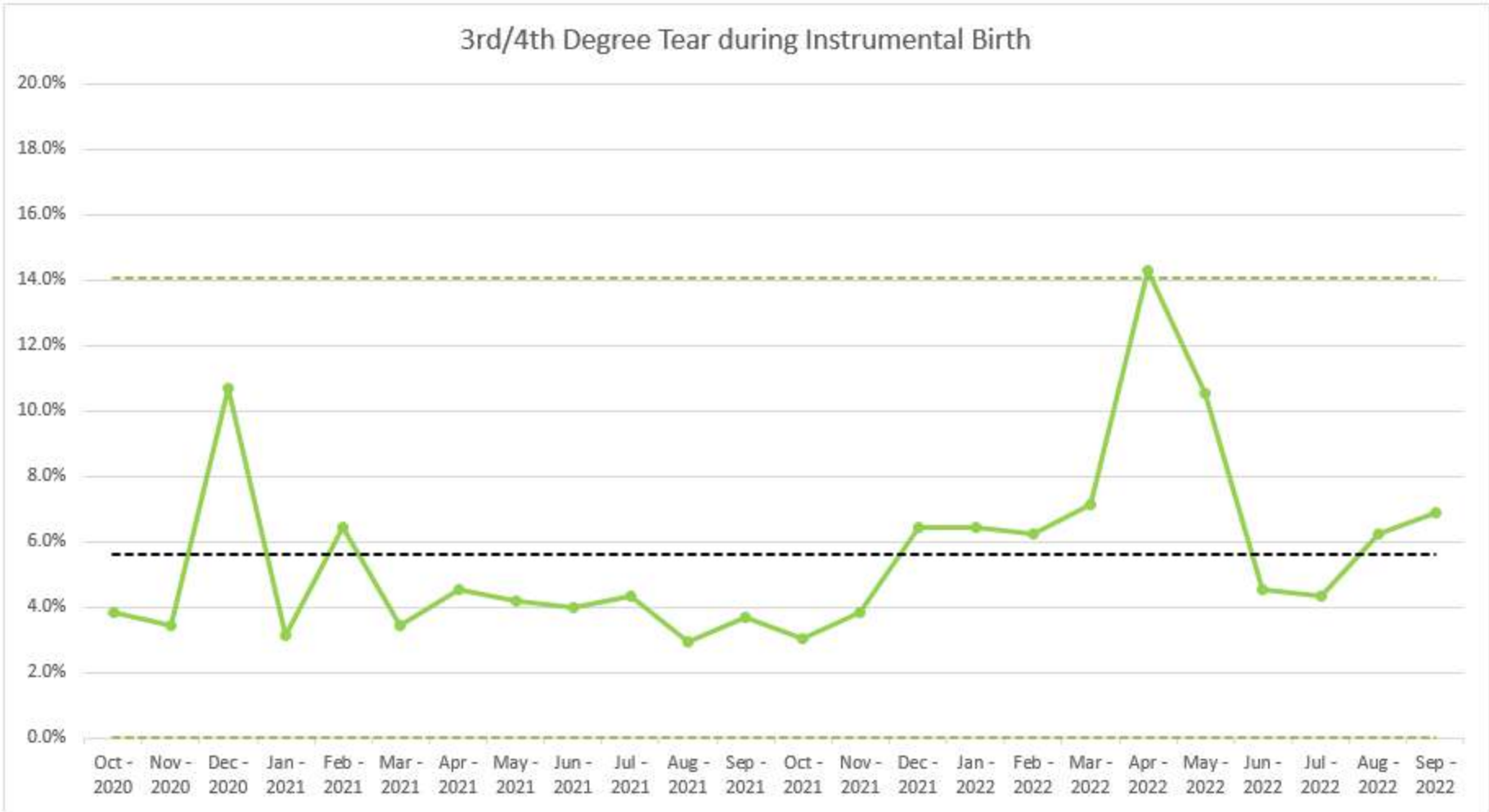
Term Admissions to the Neonatal Unit

Term admission rate at PCH is shown in blue. POW is shown in yellow. There are positive signs of improvement at PCH. The data will continue to be monitored.



Previously raised as a concern as 3rd & 4th degree tear rates were increasing following instrumental birth. OASI implementation in progress. Rates now significantly decreased.



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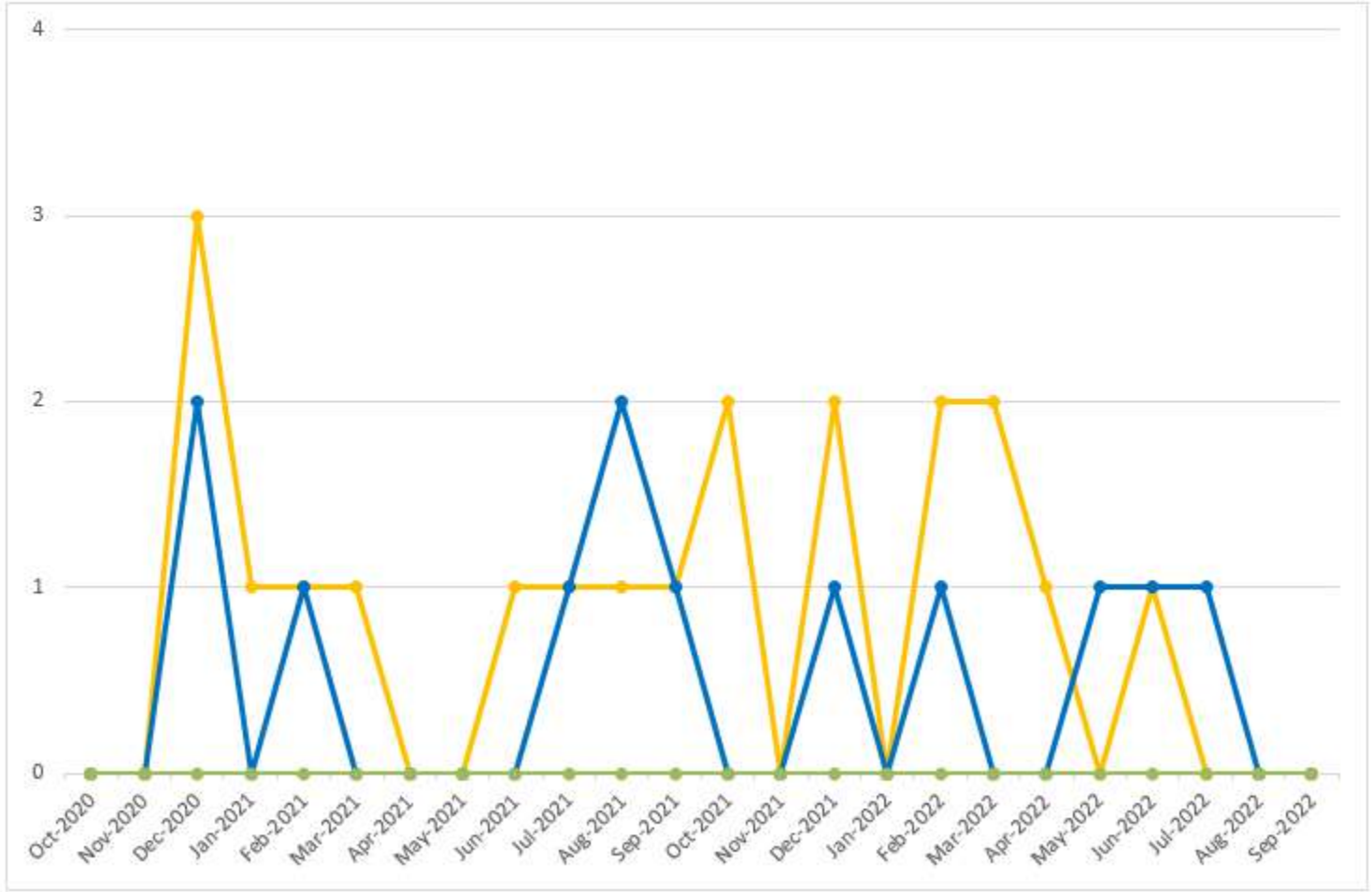
Stillbirth rates



Notes

CTM is not an outlier for stillbirth rates (MBRRACE 2021).

These data appear very variable due to low numbers, but the rates are stable, with no signals of change, or data outside normal variation.

All cases are reported to Datix and rapidly reviewed (within 72 hours).

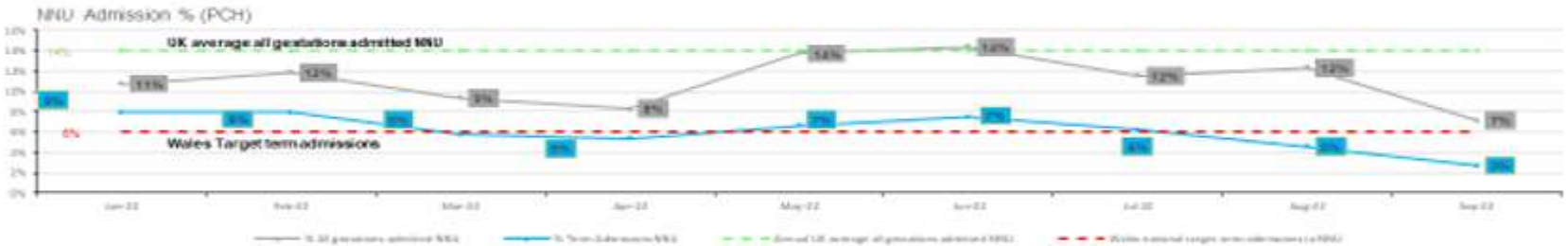
CTM's 'Rainbow Baby Clinic' is in development, to provide enhanced continuity of carer for families experiencing pregnancy after loss.

Neonatal Data

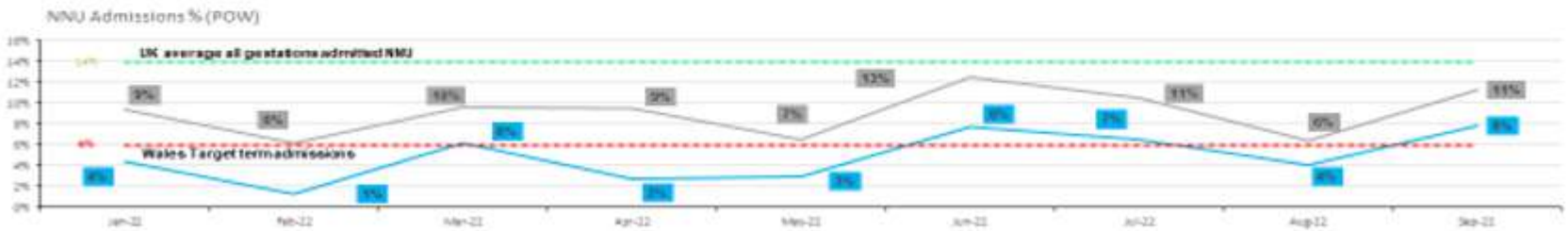
The neonatal dashboard is in early development phase. All data are currently manually extracted from the clinical input system BadgerNet. Options are currently being explored for auto-population of the neonatal monthly dashboard. Some data overlaps with maternity data and therefore could be digitally extracted. Early plans are underway to align the Maternity and Neonatal Dashboard. Currently, there are no examples of this available nationally. Work will align with DHCW's ongoing digital improvement work.

September 2022

PCH & POW



Total live births has remained at a consistent level for the last 3 months. There was a significant decrease in all admissions this month. PCH term admission rate has fallen for the third month (by 2%) and is currently below the national target.



All admissions have doubled from previous month but remains below the UK average for all admissions per total births. The term admission rate has doubled to take the percentage slightly over the national target. Total births have remained similar to previous month.

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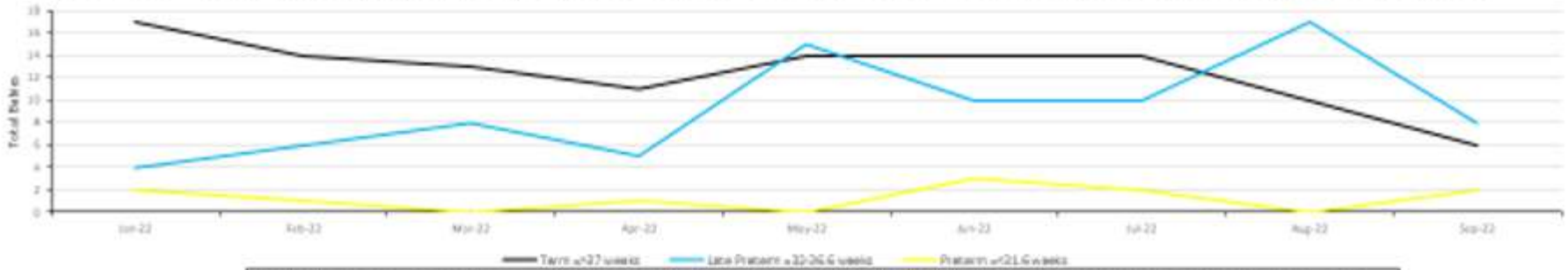
PCH & POW

September 2022

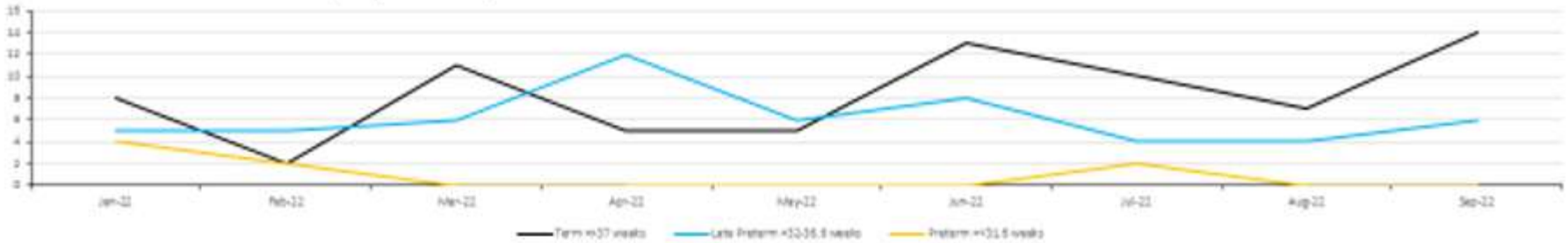
PCH - Total admissions 16 (all gestations). 6 admissions were >37 weeks. 2 admission exceptions outside of unit admission criteria.



Admission Exceptions - 29+6 week twins, transferred to Welsh tertiary centre for intensive care

No Neonatal Deaths

POW - Total admissions 20 (all gestations). 14 admissions were >37 weeks.



No Admission Exceptions

No Neonatal Deaths

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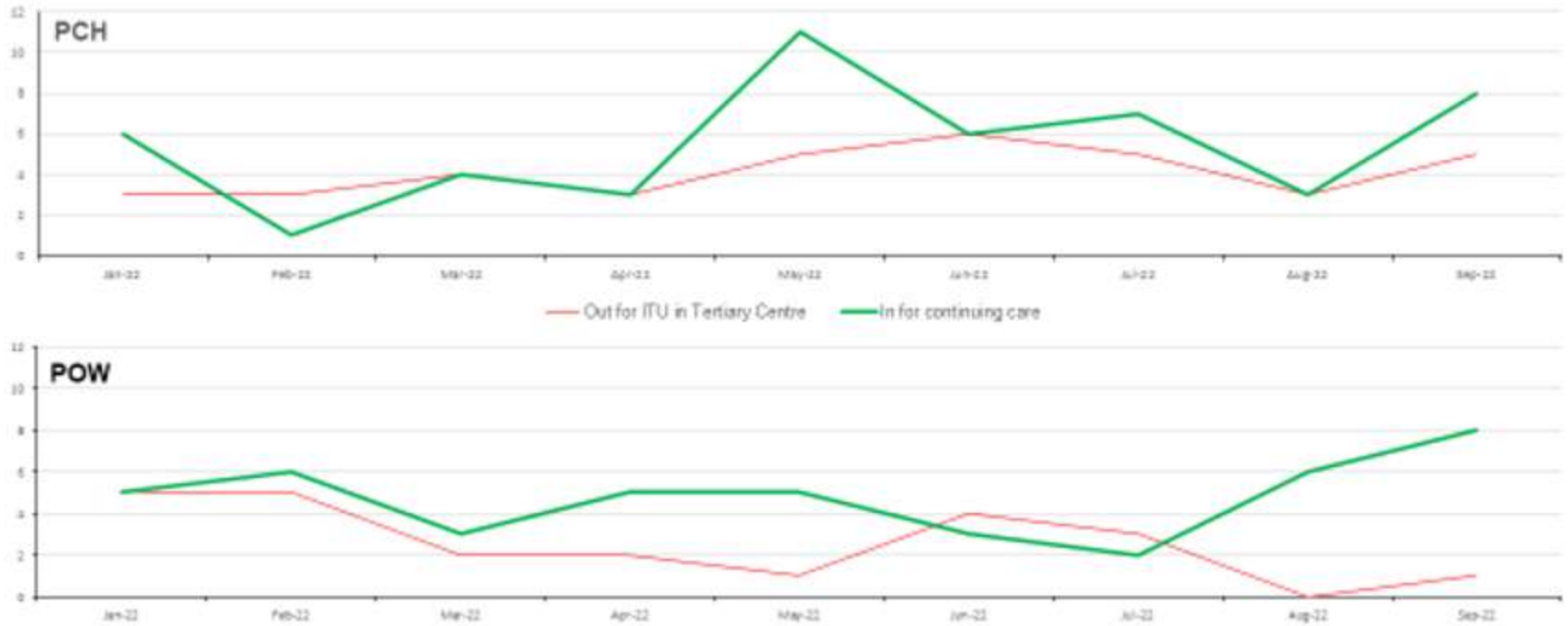
September 2022

CTM UHB – Neonatal Transfers

Transfers out – All babies requiring an increased level of care. Transferred to tertiary centres for intensive care.
Transfers in – Repatriation to be at booking unit having delivered or received care at another hospital. Supporting local tertiary centres, babies who no longer require that higher level of care are transferred to LNU's helping to relieve occupancy pressure



Both units have supported the tertiary centres with repatriations and accepting babies to relieve occupancy pressure during September.

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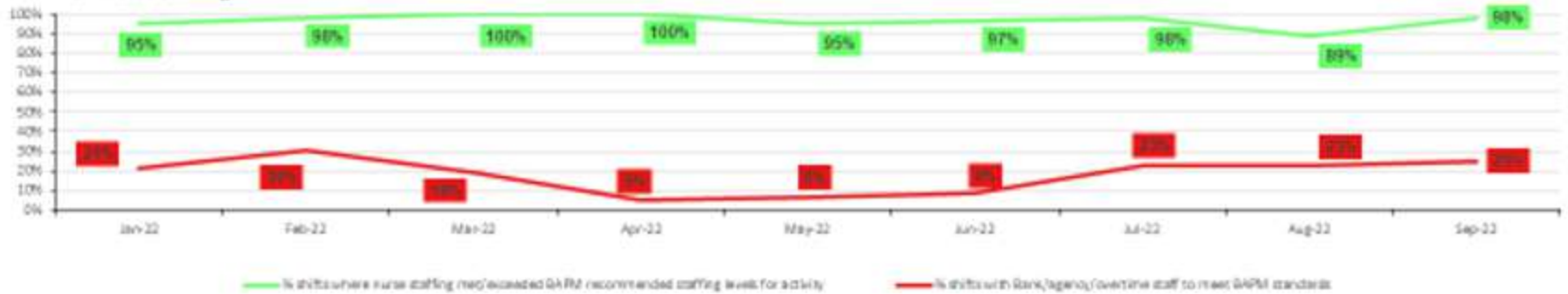
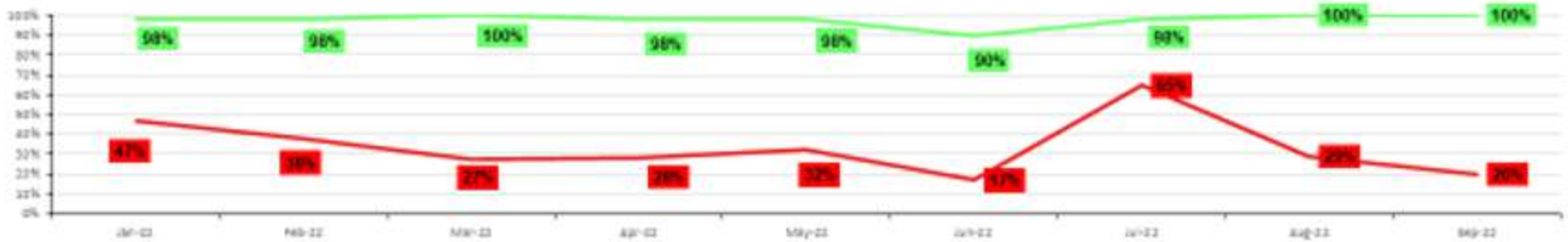
September 2022

PCH & POW Nurse Staffing
(Based on shifts per month)

PCH Nurse Staffing



POW Nurse Staffing



Both Units remained open. The percentages in red are the total number of shifts for the month that required one or more bank/agency/overtime staff to ensure that the units met the BAPM standards.

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SICKNESS & ABSENCE 2022

September 2022

Total absence (unavailable) includes: Sickness, Maternity Leave, Special Leave, Other (e.g. Covid Related).
Annual Leave not included as staff potentially available to work.

PCH - Sickness/Absence %

PCH sickness rate remains at an acceptable level when compared to the national average. The increased absence is due to a number of nursing staff being on maternity leave.

POW-Sickness/Absence %

June to August POW had a sickness rate 3 times the national average. September has seen a significant reduction. This is due to a number of staff returning after extended periods of sickness.

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Maternity Incidents September 2022

Maternity Incidents by Level of Harm

	None	Low	Moderate	Total
Other Sites	1	2	0	3
Prince Charles Hospital	32	19	17	68
Princess of Wales Hospital	15	27	28	70
Royal Glamorgan Hospital	2	7	0	9
Total	**50**	**55**	**45**	**150**

Maternity Incidents by Approval Status (and Unit)

	New incident	Under Investigation	Awaiting closure	Closed	Total
Other Sites	1	1	0	1	3
Prince Charles Hospital	7	41	8	12	68
Princess of Wales Hospital	2	38	5	25	70
Royal Glamorgan Hospital	0	6	0	3	9
Total	**10**	**86**	**13**	**41**	**150**

Maternity Incidents by Incident Type

	Other Sites	Prince Charles Hospital	Princess of Wales Hospital	Royal Glamorgan Hospital	Total
Access, Admission	0	1	8	1	10
Accident, Injury	0	2	1	0	3

Assessment, Investigation, Diagnosis	0	2	4	0	6
Communication	1	2	1	1	5
Equipment, Devices	0	3	0	0	3
Information Governance, Confidentiality	0	0	0	1	1
Infrastructure (including staffing, facilities, environment)	0	14	9	0	23
Maternity adverse occurrence	2	35	40	2	79
Medication, IV Fluids	0	0	1	0	1
Monitoring, Observations	0	1	0	0	1
Safeguarding	0	2	0	0	2
Transfer, Discharge	0	4	1	4	9
Treatment, Procedure	0	2	5	0	7
Total	**3**	**68**	**70**	**9**	**150**

Total absence – sickness, maternity, study

Site	Roster area (cost code)	Sick leave				Maternity Leave				Study Leave				Total Leave (wte)	
		Qual		Unqual		Qual		Unqual		Qual		Unqual		Qual	Unqual
		%	wte	%	Wte	%	wte	%	wte	%	wte	%	wte	wte	wte
POW	H432 core	5.1	2.6	7.0	1.5	5.9	3.1	0	0	2.5	1.3	0.1	0.02	16.0	5.7
	H404 ANC	12.6	0.8	32	0.7	0	0	0	0	0.9	0.1	0	0	2.7	1.1
	Midwives	6.1	0.1			0	0			0	0			0.4	
	Nurses														
PCH	1303 core	12%	9.36	18.3%	4.97	3.9%	3.08	1.9%	0.60	2.6%	2.02	0.8%	0.26	26.70	11.35

	1304 ANC	17.9%	0.42	16.0%	0.56	0	0	0	0	3.8%	0.14	2.7%	0.09	0.56	0.65
Community	H438 Bridgend														
	H438 Bridgend mca														
	MC RTE Community 1306 Cynon 1306 Llan 1306 Merthyr 1306 Ponty 1306 Rhondda	RN 33.3% RM 7.7%	0.32 2.54	0	0	RM 7.6%	2.47	0	0	RN 4.2% RM 3.6%		0.3%	0.01	RN 54.2% RM 36.1%	15.3%
Tirion	4121	0	0	6.7%	1.64wte	0	0	0	0	4.5%	0.30wte	2.6%	0.15wte	1.38	1.95
RGH	4114 YCR	7.8%	0.33	3.3%	0.14	0	0	0	0	1.1%	0.05	1.1%	0.05	0.38	0.19
ISH															
Gynae MCILG RTE			0		3.2		0		0		1		0		3.2
GYNAE BILG	EPAU ANC –qualified nurses														

NB. In future, workforce data will be reported into the dashboard, allowing for monthly review of trends.

Next Steps

The Maternity Dashboard will 'Go Live' in mid-October. Communication will be sent out across the service to ensure all staff members can access the dashboard. Information and training sessions have been planned to demonstrate how to access, understand and utilise the data.

Manual input will need to be timely to ensure the dashboard remains contemporaneous for data which is not currently routinely collected electronically, such as workforce data.

The Neonatal Dashboard is being developed with a view to aligning maternity and neonatal data sets. Neonatal data cannot currently be extracted from BadgetNet the way maternity data can be extracted from QlikSense. Auto-extraction is being explored.

Procuring data analysis software to support improved data presentation and understanding, particularly for metrics with low monthly numbers (ie stillbirth, 3rd & 4th degree tears).

Align dashboard with evolving All Wales Maternity Dashboard, and wider programme of Digital Maternity Cymru work (ongoing as All Wales work progresses).

'Staff Voices' launched in September 2022 to capture real time staff feedback. This will form an integral part of the monthly dashboard and reporting, so the service can triangulate clinical data and workforce data with PREMS and what staff are telling us.

Continue with ongoing priority QI projects: BSOTS Triage Project, Booking by 10 weeks, ATAIN. Also, continue to monitor the dashboard, including PREMs data for early signals of change. To support with QI where data are telling us improvement is required.

AGENDA ITEM
6.2

QUALITY AND SAFETY COMMITTEE

TY LLIDIARD TIER 4 CAMHS INPATIENT UNIT REPORT

Date of meeting	15th November 2022
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Lloyd Griffiths, Head of Nursing for CAMHS
Presented by	Lauren Edwards, Director of Therapies and Health Science
Executive Sponsor	Lauren Edwards, Director of Therapies and Health Science
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
		Choose an item.

ACRONYMS	
CTMUHB	Cwm Taf Morgannwg University Health Board
PALS	Patient Advice, Liaison Service
TL	Ty Llidiard Tier 4 CAMHS Inpatient Unit
YP	Young People/Person

HoN	Head of Nursing
iCTM	Improvement and Innovation CTM (Cwm Taf Morgannwg)
LSU	Low Secure Unit
NG	Nasogastric
PMVA	Prevention and Management of Violence and Aggression
PICU	Psychiatric Intensive Care Unit
WHSSC	Welsh Health Specialised Services Committee
NCCU	National Collaborative Commissioning Unit, part of WHSSC
HIW	Healthcare Inspectorate Wales
QAIS	Quality Assurance and Improvement Service
SI NRI LRI	Serious Incident Nationally Reportable Incident Locally Reportable Incident

1. SITUATION/BACKGROUND

1.1 The purpose of this report is to provide committee members with an update on quality, safety and experience matters in Ty Llidiard (TL), the Tier 4 CAMHS Inpatient Unit within Cwm Taf Morgannwg University Health Board (CTMUHB).

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 TL is in enhanced monitoring arrangements with WHSSC. The focus of the monitoring relates to concerns regarding the service specification and culture/leadership. Positive feedback continues to be received from WHSSC regarding the visibility and oversight of improvements at Ty Llidiard, as well as the reporting standards and progress being made.

3. Quality Assurance

3.1 Patient Safety Incidents (Sept 2022 data as October data incomplete due to reporting timeframes)

3.1.1 There were 19 incidents reported in September 2022. All 19 incidents involved a single young person (YP) and relate to nasogastric (NG) feeding under restraint (although 2 of the incidents have been categorised differently). This YP has been in TL for some time and there have been similar patterns of incidents in the past. The level of harm has been assessed as none/low as there is no resistance but the support required from the team is classified as restraint.

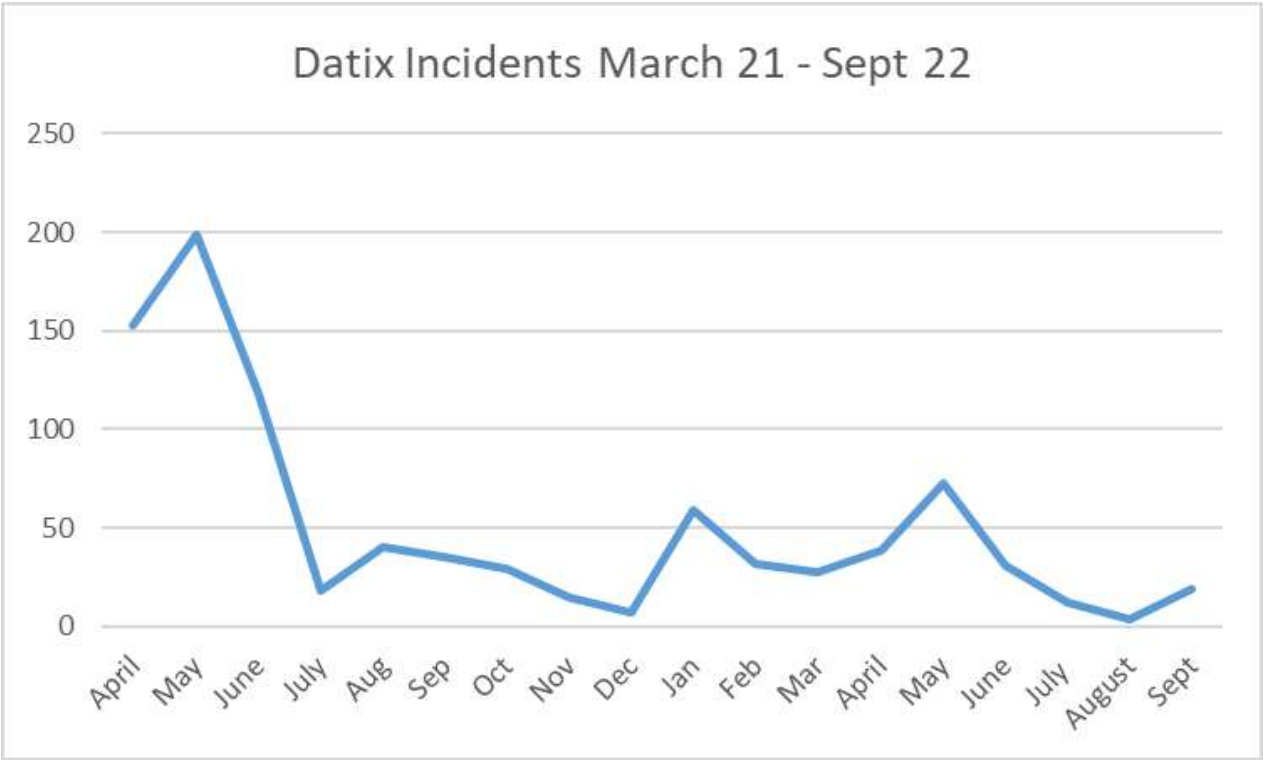


Table 1: Six month summary of incidents by sub-type, grouped by severity and date reported

		Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Total
None	Absconding or missing patient/service user	1	2	1	0	0	0	4
	Aggressive/threatening behaviour	1	0	0	0	0	1	2
	Anti social behaviour	0	0	0	0	0	0	0
	Breach of patient / service user confidentiality	0	0	0	1	1	0	2
	Inappropriate behaviour / attitude	2	1	0	0	0	0	3
	Non-medical equipment	0	0	1	0	0	0	1
	Patient clinically challenging behaviour	1	0	0	0	0	0	1
	Patient/service user refuses / fails to take / discontinue the examination / treatment / medication.	3	3	1	0	0	0	7
	Physical assault (physical contact)	0	0	0	0	0	0	0
	Provision of diet (enteral)	5	15	3	2	0	0	25
	Restrictive practices	10	38	12	4	0	17	81
	Safeguarding - Child	1	0	0	0	0	0	1
	Self-harm / self-injurious behaviour	8	0	3	0	0	0	11
	Staffing	0	1	0	0	0	0	1
	Treatment or procedure issues	0	2	0	0	0	0	2
	Total	32	62	21	7	1	18	141
Low	Aggressive/threatening behaviour	0	1	0	1	0	0	2
	Harassment	0	0	0	1	0	0	1
	Healthcare Acquired Infection (community, primary care or hospital)	0	0	1	0	0	0	1
	Healthcare record	0	0	0	1	0	0	1
	Inappropriate behaviour / attitude	1	0	1	0	0	0	2
	Patient/service user refuses / fails to take / discontinue the examination / treatment / medication.	1	0	0	2	0	1	4
	Provision of diet (enteral)	0	1	0	0	0	0	1
	Restrictive practices	0	1	0	0	0	0	1
	Self-harm / self-injurious behaviour	5	8	7	0	0	0	20
	Struck against or by an object	0	0	0	0	1	0	1
	Total	7	11	9	5	1	1	34
Moderate	Absconding or missing patient/service user	0	0	1	0	0	0	1
	Aggressive/threatening behaviour	0	0	0	1	0	0	1
	Clinical assessment, clinical diagnosis	0	0	0	0	1	0	1
	Environmental hazards / issues	0	0	0	0	0	0	0
	Safeguarding - Child	0	0	0	0	1	0	1
	Total	0	0	1	1	2	0	4
Total		39	73	31	13	4	19	179

3.1.2 During September 2022 there were no incidents reported with a severity classified above low.

3.1.3 There were no incidents involving absconding from TL (actual or attempted).

3.2 Complaints

3.2.1 There were no open or new complaints during this reporting period.

3.3 **Compliments**

3.3.1 Understanding the experiences of our YP and their families during their admission to TL is an important source of learning and the team are striving to increase feedback month on month.

3.3.2 Below is an extract received via the *Experience of Service* questionnaire, a feedback opportunity for all the YP and their parents/carers on discharge from TL:

> *"I would like to thank the reception staff, they were exceptional, professional and supportive. They always had a smile and kind words. They are an asset to your organisation."*

3.3.3 All compliments are shared with the team at Ty Llidiard. There is a board in the staff room where compliments are shared for all to see. The team are in the process of developing a monthly newsletter for colleagues, which will include a compliments section.

3.4 **Current open SIs (NRI or LRI)**

3.4.1 There were no new or open LRIs or NRIs during this reporting period.

3.5 **Ombudsman complaints**

3.5.1 There were no new or open Ombudsman cases during this reporting period.

3.6 **Claims/redress cases**

3.6.1 There were no new or open claims/redress cases during this reporting period.

4. People's Experience/co-production

4.1 The TL team facilitate weekly community meetings (open to all YP on the ward) to seek the views of our YP on what we do well and where we can improve. These meetings continue to be well-attended by our YP and have resulted in valuable insights, including their experience

of ward rounds, suggestions on activities, and how we can improve mobile phone use.

4.2 During these meetings, suggestions have been made by the YP about the type of therapeutic activities they would like to see delivered at TL. This has led to the development of a co-produced Activities Timetable. This timetable is delivered by the newly created Activity Coordination team and therapies team. Our activity co-ordinators are now supernumerary and there is evening cover. This ensures that opportunities for meaningful activity are consistent and protected. The timetable changes regularly in response to individual needs and the requests of our YP.

ACTIVITY TIMETABLE

Weekdays	Monday	Tuesday	Wednesday	Thursday	Friday	Weekends	Saturday	Sunday
8:30 – 9:15	Breakfast Club (Ingredients can be bought the day before)	Breakfast Club (Ingredients can be bought the day before)	Breakfast Club (Ingredients can be bought the day before)	Breakfast Club (Ingredients can be bought the day before)	Breakfast Club (Ingredients can be bought the day before)	8:30 – 9:15	Breakfast Club (Ingredients can be bought the day before)	Breakfast Club (Ingredients can be bought the day before)
9:15 – 9:30	*Morning Meeting (YP plan the activities for the day)*	*Morning Meeting (YP plan the activities for the day)*	*Morning Meeting (YP plan the activities for the day)*	*Morning Meeting (YP plan the activities for the day)*	*Morning Meeting (YP plan the activities for the day)*	9:15 – 9:30	*Morning Meeting (YP plan the activities for the day)*	*Morning Meeting (YP plan the activities for the day)*
9:30 – 10:45	Under 16 – Education Over 16 – Multi-purpose room, planning around vocational skills, cooking, Careers Wales	Under 16 – Education Over 16 – Multi-purpose room, planning around vocational skills, cooking, Careers Wales	Under 16 – Education Over 16 – Multi-purpose room, planning around vocational skills, cooking, Careers Wales .	Under 16 – Education Over 16 – Multi-purpose room, planning around vocational skills, cooking, Careers Wales	Under 16 – Education Over 16 – Multi-purpose room, planning around vocational skills, cooking, Careers Wales	10:00 – 12:30	Group 1 - Off Ward Activity Group 2 - Ward Activity	Group 1 - Off Ward Activity Group 2 - Ward Activity
11:00 – 11:15	*Mindfulness in Sensory Room*	*Mindfulness in Sensory Room*	*Mindfulness in Sensory Room*	*Mindfulness in Sensory Room*	*Mindfulness in Sensory Room*			
11:15 – 12:15	Under 16 – Education Over 16 – Multi-purpose room or off ward activities focusing on agreed vocational or therapeutic aims	Under 16 – Education Over 16 – Multi-purpose room or off ward activities focusing on agreed vocational or therapeutic aims	Under 16 – Education Over 16 – Multi-purpose room or off ward activities focusing on agreed vocational or therapeutic aims	Under 16 – Education Over 16 – Multi-purpose room or off ward activities focusing on agreed vocational or therapeutic aims	Under 16 – Education Over 16 – Multi-purpose room or off ward activities focusing on agreed vocational or therapeutic aims			
1:30 – 3:00	Under 16 – Education Over 16 – Multi-purpose room or off ward activities focusing on agreed vocational or therapeutic aims	Under 16 – Education Over 16 – Multi-purpose room or off ward activities focusing on agreed vocational or therapeutic aims	Under 16 – Education Over 16 – Multi-purpose room or off ward activities focusing on agreed vocational or therapeutic aims	Under 16 – Education Over 16 – Multi-purpose room or off ward activities focusing on agreed vocational or therapeutic aims	Under 16 – Education Over 16 – Multi-purpose room or off ward activities focusing on agreed vocational or therapeutic aims	2:30 – 5:00	Group 1 - Ward Activity Group 2 - Off Ward Activity	Group 1 - Ward Activity Group 2 - Off Ward Activity
3:00 – 3:15	Therapeutic Walk or engagement	Therapeutic Walk or engagement	Therapeutic Walk or engagement	Therapeutic Walk or engagement	Therapeutic Walk or engagement			
3:30 – 5:00	*On or off ward activities as chosen by the young people in the morning meeting*	*On or off ward activities as chosen by the young people in the morning meeting*	*On or off ward activities as chosen by the young people in the morning meeting*	*On or off ward activities as chosen by the young people in the morning meeting*	*On or off ward activities as chosen by the young people in the morning meeting*			
6:00 – 7:00	Phone Time	Phone Time	Phone Time	Phone Time	Phone Time	6:00 – 7:00	Phone Time	Phone Time
7:00 – 7:30	Ping Pong	Activity Room	Board Games	Quiz	Pamper Evening	7:00 – 7:30	Karaoke	Weekly Catch up/ Goal Setting/ Gratitude
8:15 – 9:00	Relaxation/ Mindfulness	Relaxation/ Mindfulness	Relaxation/ Mindfulness	Relaxation/ Mindfulness	Relaxation/ Mindfulness	8:15 – 9:00	Relaxation/ Mindfulness	Relaxation/ Mindfulness

Other suggestions from our YP are visits by therapy pets, including dogs and alpacas. The TL team have arranged this and everyone is looking forward to the visits in the upcoming weeks.

4.3 It is anticipated that positive experiences of engagement and co-production gained by the YP during their admission will result in them being more confident and willing to support future co-produced TL service projects and recruitment processes following their successful discharge.

4.4 The Head of Nursing (HoN) for CAMHS has contacted the family members of all the current inpatients and invited them to a virtual coffee morning to share their experiences and feedback. The feedback received from most people on this session was that individual rather than a group meeting was preferred. The majority of families have now met with the HoN and the feedback was largely positive, with some helpful suggestions for improvement that will be actioned.

4.5 Several family members have expressed an interest in joining a future group of people with lived experience to help with TL's improvement journey in a coproduced way. The feedback received was that they would prefer to be involved after their loved ones have been discharged from TL and so arrangements have been made to keep in touch.

4.6 The above progress represents an important development in Ty Llidiard's culture of openness, engagement and co-production.

5. Quality Improvement

5.1 Since August 2022, a quality improvement group has been established to develop and monitor the various pieces of quality improvement work being undertaken in TL. The group meets every Monday to discuss and review the ongoing improvements and changes that have been made or are in progress.

5.2 Nurses on duty, the Ward Manager, the Quality Safety and Risk lead, Locality Manager, Specialist Social Worker, Consultant Psychiatrists and Therapists are encouraged to attend so that there is a multi-disciplinary approach to all decisions being made. It is through this group that many of the improvements now in place have been identified and implemented. The ideas and changes discussed in this group are then shared with the young people in their community meeting to seek feedback and input.

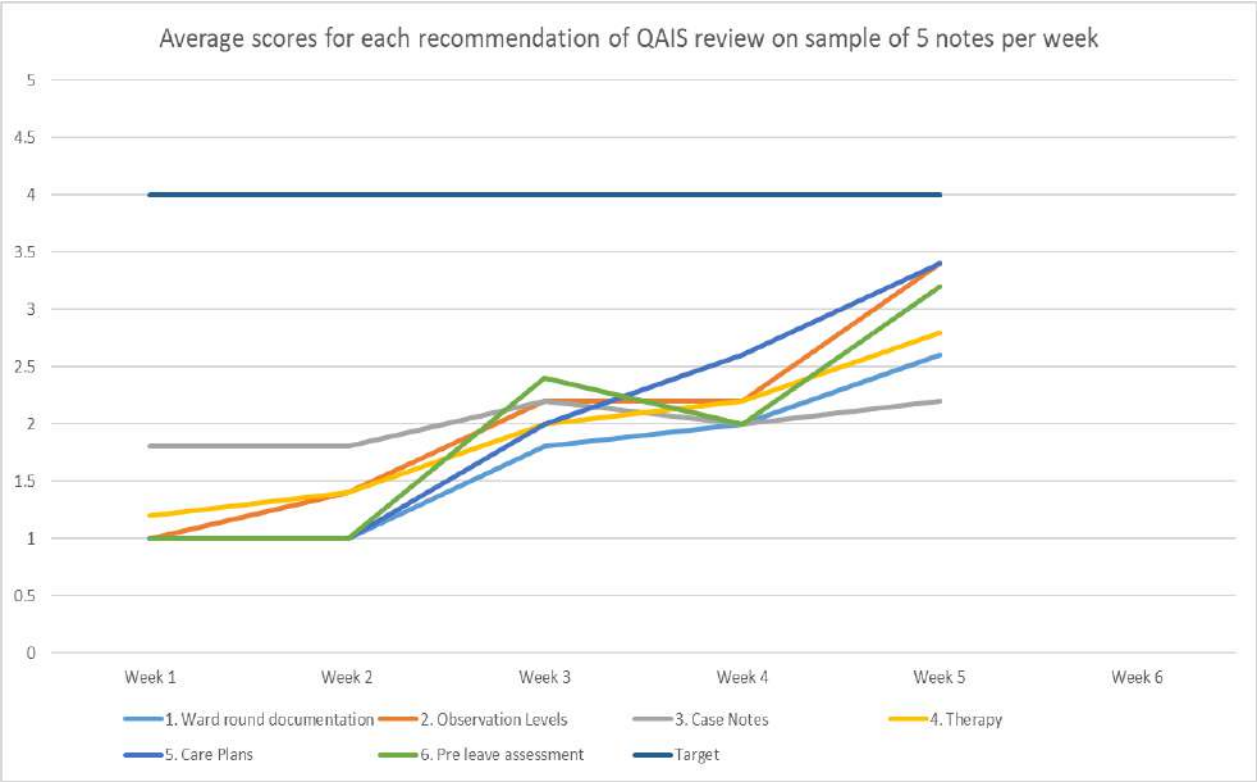
5.3 The improvements and initiatives that have been developed by the group are discussed and supported by the iCTM Team.

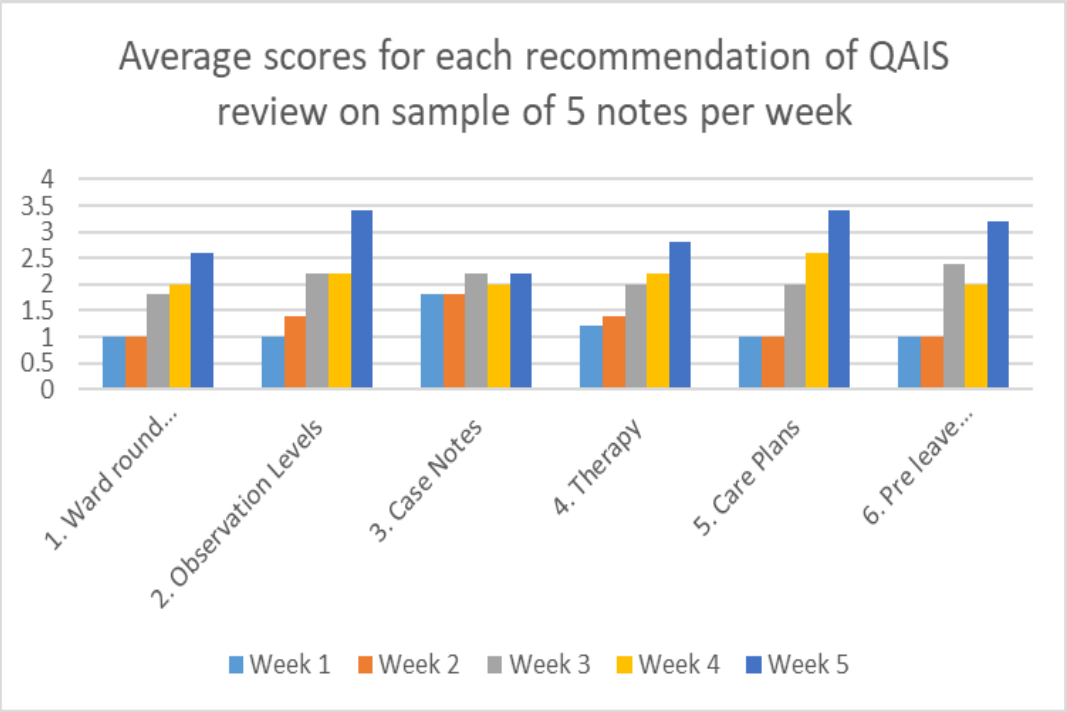
5.4 The TL quality improvement group has developed an audit tool to monitor the 6 main areas covered in both the HIW and the QAIS Supportive Review in March 2022.

5.5 The audit uses a 5 point Likert scale to assess the clinical documentation against the 6 recommendations. The target is to achieve an average score of 4 out of 5 for each of the 6 categories, and an average total score of 24 out of 30. A trajectory has been devised to achieve this by week 10 (currently in week 5). The audits will continue until there is adequate assurance that the improvements consistent are embedded in practice (minimum of 12 weeks after compliance).

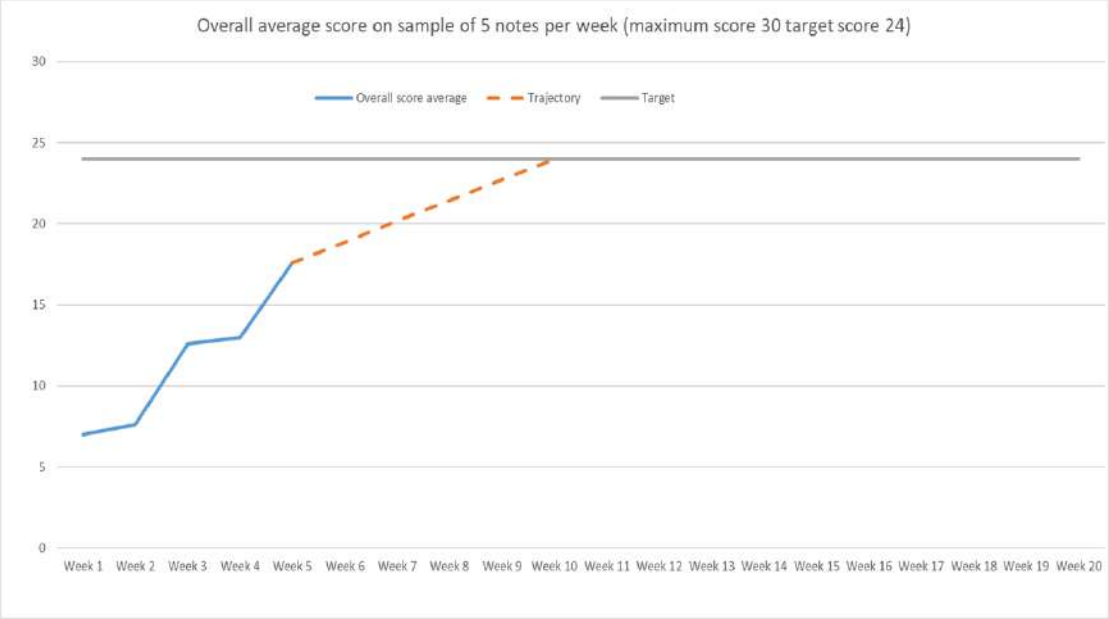
5.6 The work has been well received by both WHSCC and QAIS, who we have invited to quality assure the findings in November 2022.

5.7 The average scores from the 5 sample sets of notes each week are outlined in the graph below





Below is a graph showing the trajectory for improvements.



5.8 Part of the improvement work required related to the individual ward management plans, which are in addition to the statutory Care and Treatment Plan (CTP) that every YP on the ward has. The quality of the ward management plans is assessed in the audit described above, but the TL team have also been asking the YP to feedback on

the changes. This is in the early stages but initial feedback has been positive.

Initial feedback from the YP

YP	Ward Management Plan	New Care Plan
1	2/5	5/5
2	2/5	4/5
3	1/5	3/5
4	n/a	5/5

Scale
Are you happy with your care plan?
1 = Strongly disagree 2 = Disagree 3 = Neither agree nor disagree 4 = Agree 5 = Strongly agree

6. Improvement Board

6.1 A monthly Improvement Board chaired by the Executive Director of Therapies and Health Science (DoTHS) continues to oversee the implementation of changes required to enable colleagues to consistently deliver high quality care and the best outcomes and experiences for the YP and families we care for.

6.2 Monthly escalation meetings continue with colleagues from WHSSC, in addition to regular meetings between the CTMUHB and WHSSC executive leads for TL. Significant improvements have been made to the reporting format for the escalation meetings, resulting in ongoing positive feedback from WHSSC and plans for de-escalation being developed.

6.3 Appendix 1 provides an overview of progress made against the Integrated Improvement Plan for Ty Llidiard. This improvement plan contains actions relating to the escalation status with WHSSC along with wider improvements targets to ensure continuous service improvements for the benefit our young people, their families, and our colleagues.

7. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

6.1 TL remains in Level 4 escalation with WHSSC, who raised concerns in April 2022 regarding the Quality Assessment and Improvement Service (QAIS) report findings and progress in relation to the Escalation Action Plan. Although WHSSC remain assured by the progress being made, the scale and nature of changes required continue to require sustained support and focus within CTMUHB.

6.2 Changes to the clinical model within TL and improvements relating to leadership and culture within the unit have resulted in significant investment in clinical posts from a range of professional groups. Good progress continues against recruitment plans, but national shortages in some specialist areas pose an ongoing risk to recruitment.

6.3 As part of the improvement work within TL, changes to the layout of the unit have been suggested by the National Collaborative Commissioning Unit (NCCU). The senior leadership team have met with the Director of Quality and Mental Health/Learning Disabilities from the NCCU to explore what such changes could look like. Options have worked up with colleagues from Estates but costs are likely to be significant and conversations will be required with WHSSC regarding this, in the context of significantly restrained capital budgets within CTMUHB.

8. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below: Safe Care, Dignified care, Effective Care Individual Care
Equality impact assessment completed	No (Include further detail below)
	Not required as no change to service provision is articulated
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	Estates work suggested by WHSSC/QAIS will be associated with significant capital requirements
Link to Strategic Goals	Improving Care

9. RECOMMENDATION

9.1 Members are asked to **NOTE** the progress outlined in this report and the key risks identified.

APPENDIX 1

Progress against Integrated Improvement Plan

Summary of progress and status of actions within the updated Integrated Improvement Plan from July

	Number of actions green and complete	Number of actions in progress and on target	Number of actions in progress , timescales have slipped but action plan in place	Limited progress and timescales have slipped with concerns in completing the action	Actions to start	Total
Summary of all actions in Ty Llid plan	13	18	12	0	6	49

Workstream theme: Caring and compassionate, safe and effective care	Number of actions green and complete	Number of actions in progress and on target	Number of actions in progress , timescales have slipped but action plan in place	Limited progress and timescales have slipped with concerns in completing the action	Actions to start
To ensure there is a comprehensive and robust multi-disciplinary clinical leadership team who will lead a multi-disciplinary workforce to best meet the needs of the young people and to support good patient experience and outcomes	4	1			
To embed a whole system approach to care and treatment planning and risk assessment and ensure these are up to date, coproduced, individual and person centred and meet the best practice guidelines as set out in the Mental Health (Wales) Measure 2010.	1		5		2
To create an effective MDT infrastructure to support daily review of care and treatment planning and inform therapeutic interventions	1	2	2		1
To ensure there are appropriate processes and policies that support safe and effective care delivery	2	2	3		
To create a training strategy to support all colleague to provide safe and effective care delivery	1		1		2
Total	9	5	11	0	5

Work stream theme: Calm and Confident Leadership and Culture	Number of actions green and complete	Number of actions in progress and on target	Number of actions in progress , timescales have slipped but action plan in place	Limited progress and timescales have slipped with concerns in completing the action	Actions to start
To create a psychologically safe environment where colleague feel that their voices are heard	2	2			
To create an ethos of collective and calm leadership where everyone takes responsibility for delivering safe, reliable and effective care for patients	1	4			
To cultivate a culture of openness, transparency and confidence where our values and behaviours are a lived reality for everyone	1	3	1		1
Total	4	9	1	0	1

Work stream theme: Environment fit for purpose	Number of actions green and complete	Number of actions in progress and on target	Number of actions in progress , timescales have slipped but action plan in place	Limited progress and timescales have slipped with concerns in completing the action	Actions to start
The environment is safe for colleague and young people and is conductive to therapeutic care		4			
Total	0	4	0	0	0

AGENDA ITEM
6.4

QUALITY & SAFETY COMMITTEE

PATIENT SAFETY QUALITY DASHBOARD

Date of meeting	15th November 2022
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Louise Mann, Assistant Director Quality, Safety & Safeguarding louise.mann@wales.nhs.uk Stephanie Muir, Assistant Director of Concerns & Claims Natalie Morgan-Thomas, Interim Deputy Head for CA&QI & Lead Nurse for Clinical Effectiveness natalie.morgan-thomas@wales.nhs.uk
Presented by	Louise Mann, Assistant Director Quality, Safety & Safeguarding
Approving Executive Sponsor	Executive Director of Nursing Executive Medical Director Director of Public Health
Report purpose	FOR DISCUSSION / REVIEW

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Discussions with key individuals in corporate services and within directorates and localities Joint working with Performance and Planning team	Various dates	Choose an item.

ACRONYMS	
CA&QI	Clinical Audit & Quality Informatics
ILG	Integrated Locality Group
CAPU	Community Acquired Pressure Ulcer
NEWS	National Early Warning Score
LFER	Learning from Events Reports
DU	Delivery Unit
RGH	Royal Glamorgan Hospital
PCH	Prince Charles Hospital
POW	Princess of Wales Hospital
CMO	Chief Medical Officer
HCSW	Health Care Support Worker
YCC	Ysbyty'r Cwm Canon
YCR	Ysbyty's Cwm Rhondda
LOS	Length of stay
WAST	Welsh Ambulance Service NHS Trust

1. SITUATION/BACKGROUND

This presentation of the Quality Dashboard to Committee provides data from August 2022 to September 2022. The Health Board is in the process of transitioning to a new operating model, which requires significant change to data alignment, in addition to introducing changes to the quality governance model and arrangements. As key senior leaders prepare and begin to adapt to new roles and responsibilities, the requirement for assurance from the previous Integrated Locality Groups during this interim period has been streamlined and brought together within this document. ILG Dashboards and key matters are contained within **Appendix 1**.

Key areas to note in this reporting period are:

- The average number of complaints over the preceding 12-month period is 94, demonstrating a mean reduction in formal complaints received during August and September. Complaints have risen in the past 3 months, however, they remain on a decreasing trend over the 12 month period. Whilst there is an overall increase in early resolutions, data does not represent a trend and there is no direct correlation with formal complaints. Once the new triage process is fully implemented with the new operating model with centralised complaints, a drive for early resolutions will continue.
- For all complaints received in August & September 2022 the top 3 themes remain consistent with previous themes and relate to Clinical Treatment /

Assessment (231), Communication Issues, including attitude & behaviour (138) and Appointments (108).

- CTMUHB Complaints response compliance average is 61% with a target ambition of 75%. Compliance in this reporting period is 64%. Improved systems of complaints triage and early resolution, should continue to increase patient satisfaction in timely health board response to concerns and reduce the need for formal process. However, the impact of a changed operating and governance model may temporarily affect the ability of clinical teams to complete responses in a timely manner.
- Between August 2022 and September 2022, a total of 4,053 incidents were reported across the Health Board. This is a decrease of 265 when compared to the previous two months. Of the patient safety incidents, which were reported with a severity of severe harm or death, a decrease of 74 when compared to the previous 2 months. Functionality issues implementing Datix Cymru persist during this reporting period, which does not permit downgrading of harm following the initial review to the clinical managers. The Datix team are working with the national team to devise a resolution to the system to accurately reflect harm from patient safety incidents following rapid review.
- There is a slight increase in falls reported in September (273) however the number of incidents which have been reported as moderate/ severe or death has significantly decreased. Falls panels continually occur weekly in each ILG and the formulation of how these will be undertaken within the care groups is being discussed. We have introduced falls per 1000 occupied bed days as an improved measure of benchmarking fall rates, with the next step to set reduction goals for numbers and severity of harm. This also facilitates flexibility in identifying areas of greatest risk and setting reduction targets accordingly.
- During August 2022 & September 22, No falls were nationally reportable.
- During August and September 2022, a total of 875 pressure damage incidents were reported, of which 440 were reported as occurring during the current community case load. The remaining pressure damage incidents were reported as being present before admission to this clinical care area/caseload (435). Of the 440, 239 were identified as being hospital acquired and 201 as community acquired. This represents an increase of 47 hospital acquired pressure damage incidents when compared to the previous 2 months. The locations of the high reported hospital acquired pressure damage incidents were within all 3 ED departments and AMU at Princess of Wales Hospital (10). Work is ongoing with ED and WAST colleagues as an increase in numbers is in relation to those patients who are awaiting offload from an ambulance and adequate turning and monitoring is difficult to achieve. This issue has been put forward to be included in the Community Acquired Pressure Ulcer (CAPU) project as detailed below.

- The number of community acquired pressure damage incidents have reduced since April 2022 although there was a slight increase in June and July, this has since reduced in August and September. The Community Acquired Pressure Ulcer prevention strategy was launched at a stakeholder event on the 29th July 2022, and is now in its second Learning Session phase of the collaborative improvement model. The project has seen each of the 6 Community Nursing teams receive a Quality Improvement Lead & patient safety team member to help support with the project work.
- Medication prescribing errors continue on a downward trajectory overall with a reduction in incidence seen since January 2022. Administration errors remain in line with the 12-month average. Raising awareness of medicines safety was the subject for a weeklong range of public facing activities in line with the global theme for World Patient Safety Day. This was a collaborative endeavour with pharmacy, patient safety and CTM improvement team between the 12th – 16th September 2022. This event also helped to further raise awareness of the 'Your medicines, Your Health Campaign'.
- Crude hospital mortality rates remain positively correlated to Covid prevalence and the volume of hospital admissions in last month's report. Regrettably, the data was not available on completion of this report.
- The Recognising Acute Deterioration and Resuscitation (RADAR) group are in the early stages of forming a cross-organisational programme. NEWS training is also being recorded on the new Clinical Audit and NICE compliance monitoring system, so training figures are now available.
- The Unscheduled Care Nurse Director has now broadened the reporting mechanism of the daily Situation report to include quality metrics reflected as part of the safe to start forums happening on each acute site. This will enable key areas of concern regarding quality, safety and patient experience to be discussed as part of the daily operational meetings.
- An update on our current Patient Safety Solutions position will be presented today. At the time of reporting, further compliance has been achieved in Patient Safety Notice PSN059 since the last report to Committee.
- Infection Prevention & Control (IP&C)_Mandatory surveillance continues nationally for five key organisms including C. difficile, Staphylococcus aureus bacteraemia and E.coli, Pseudomonas and Klebsiella bacteraemia. More than half of the bacteraemia reported since April 2022 are community acquired infections and a scoping exercise is required in primary care to understand the requirements/expectations of the current Infection Prevention and Control Team to provide a comprehensive service.

- The Infection Prevention and Control team continue to work collaboratively with the service groups to improve the investigation procedure and root cause analysis process for C. difficile infection and preventable bacteraemia. Learning is shared with clinical teams to inform and influence practice. Further engagement and support is required to introduce this in the primary care setting.
- An increased requirement for end of life care and visits to Continuing Healthcare patients remains a trend within District Nursing Teams and primary healthcare services. Teams are sharing resources and collaborating with other support services to maintain a quality service as acuity and demand increases.
- Learning from Events reports, (LFER's) continue to be a challenge for the Health Board, with a historic backlog of overdue LFERs. This is included on the corporate risk register as a significant risk due to the potential reputational and financial impact. A detailed improvement plan was undertaken with regular monitoring and supportive meetings with the ILGs. This has resulted in a number of historic cases, which were at risk of permanent deferral being closed. A recent data cleanse and validation exercise has taken place and a data reconciliation of open LFERs with Welsh Risk Pool data correlated for the first time. There remains much work to do in order to clear the backlog, and a shift being realised to ensure current incident management/investigation includes evidence provision on Datix for Learning from Events Reports (LFERs). The new operating model and proposed supporting quality, safety and governance arrangements, places responsibility within the Care Group Governance teams to facilitate the completion of the LFERs.

- **The CTM Listening and Learning Event taking place on 23rd September 2022.** This was a significant opportunity to promote and nurture the learning culture supporting continuous improvement and patient safety across the Health Board. Another event is being arranged for 15th March 2023 which will focus on sharing specific learning from across the health board.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

Indicator Description	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	April-22	May-22	June-22	July-22	Aug-22	Sept 2022	Trend
Number of formal complaints (managed through PTR)	132	136	102	94	95	87	84	87	57	84	82	**88**	
Number of formal complaints closed (managed under PTR)	114	114	107	67	117	100	77	83	81	70	81	**69**	
Number of Early Resolution complaints	162	173	117	174	183	229	180	206	168	175	234	**208**	
Number of compliments	55	77	51	71	59	25	60	182	196	99	24	**80**	
Number of Ombudsman Received	5	7	5	8	7	11	9	9	6	6	4	**6**	
Number of never events in month	0	0	0	1	0	0	0	1	0	0	0	**1**	
Number of Nationally Reportable Incidents. New process from 14.06.21	4	4	4	4	7	8	4	5	6	2	9	**2**	
Number of Locally Reportable Incidents	21	16	18	9	17	13	10	5	5	6	7	**17**	

Data run on 05.10.22

Complaints:

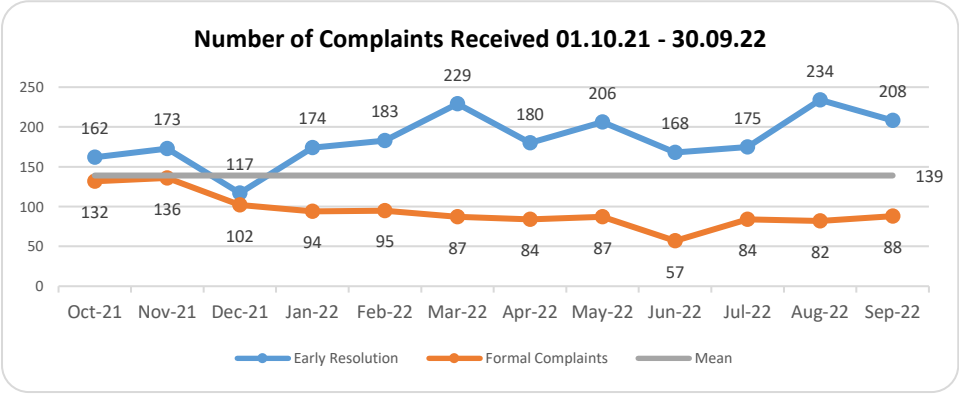
New Complaints Received

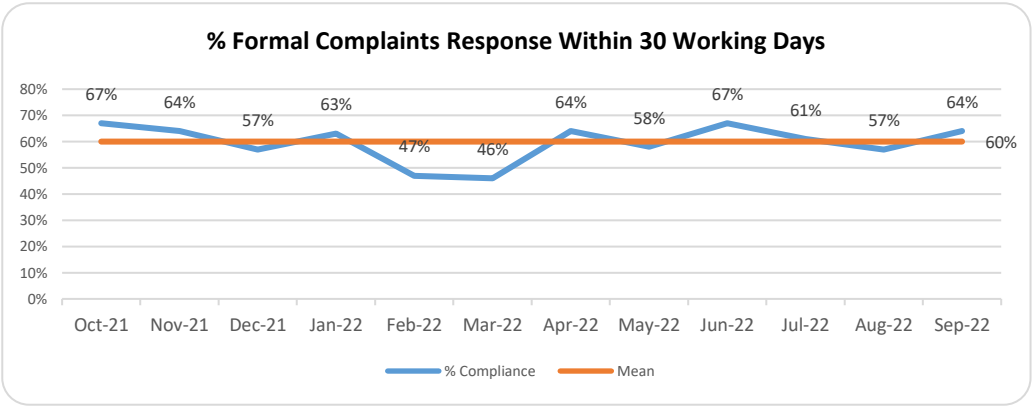
During August and September 2022, there were 170 formal complaints received within the Organisation which were managed in line with the Putting Things Right regulations. The number of formal Complaints managed through PTR has remained relatively consistent over the last 3 months. Within the same period (August and September 2022), the Health Board managed 442 complaints under Early Resolution, representing an increase of 99 complaints when compared to the previous 2 months (343). The Health Board are working hard to change the way it manages complaints by implementing a triage process offering early resolution in a responsive and supportive way to try and resolves concerns at an early stage. The trend in relation to new complaints received is reflected in the chart below.

For all complaints received in August & September 2022, the top 3 themes relate to Clinical Treatment / Assessment (231), Communication Issues, including attitude & behaviour (138) and Appointments (108).

Closed Complaints

Between August & September, the Health Board closed 150 formal complaints (managed through PTR). Compliance with the 30 working day response rate decreased slightly in August 2022 when compared to July, but the trend remains the same with the mean average compliance for 12 months being 60%.





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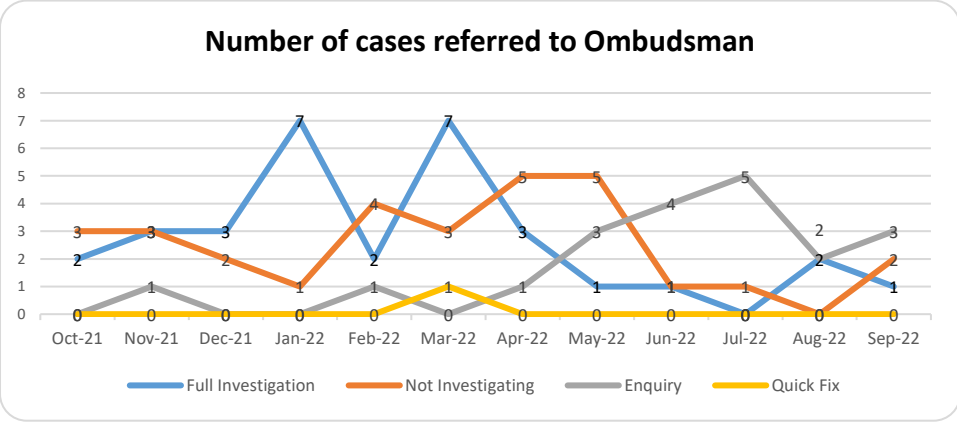
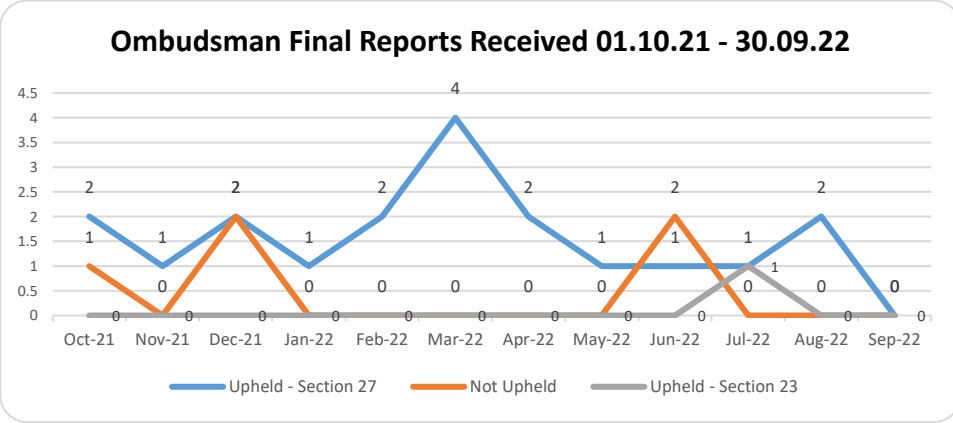
Public Services Ombudsman for Wales

During August and September 2022, the Health Board received notification of 10 Public Services Ombudsman for Wales (PSOW) referrals. This represents a decrease of 2 cases when compared to the previous 2 months. Of the 10 referrals, the PSOW decided not to investigate 2 and 3 were full investigations, with the remaining 5 managed as enquiries.

Between the August & September, the Health board received 2 Final reports from the Public Services Ombudsman for Wales. Both of the final reports received were Upheld (Section 27).





Data run on 05.10.22

Compliments
During August and September 2022, there were 104 compliments recorded on the Datix Cymru system, which represents a decrease of 191 when compared to the previous two months (295). The highest number of compliments recorded during August and September 2022 related to Emergency Care (44), Maternity (26) and Paediatrics (10) all within the Merthyr & Cynon Locality. Ongoing support and training is being provided to service areas to improve the capturing of compliments with the Datix Cymru system to facilitate the analysis of all elements of feedback. In Merthyr Cynon in September a total of 47 early resolutions (ER) have resulted in 3 ERs being escalated to a formal concern. A total of 82 compliments have been captured in this period and the PALs are currently producing newsletters with highlights for all the departments.

Patient Experience:
The latest patient experience data is contained in **Appendix 2**.

Patient Safety Incidents:
Between August 2022 and September 2022, a total of 4,053 incidents were reported across the Health Board. This is a decrease of 265 when compared to the previous two months. Of these, 86% (3,494) were reported under the type of patient safety during the two month period. Of the patient safety incidents, 55 were reported with a severity of severe harm (27) or death (28), a decrease of 74 when compared to the previous 2 months. This equates to 1.6% of the total number of patient safety incidents reported, compared to 3.4% in the previous 2 month period.

Nationally Reportable Incidents:
As highlighted in previous reports, following the introduction of the NHS Wales National Incident Reporting Policy on 14th June 2021, the Health Board distinguishes between Nationally Reportable Incidents and Locally Reportable Incidents (those previously classified as serious incidents). The trend for the last 12 months is reflected in the chart below.

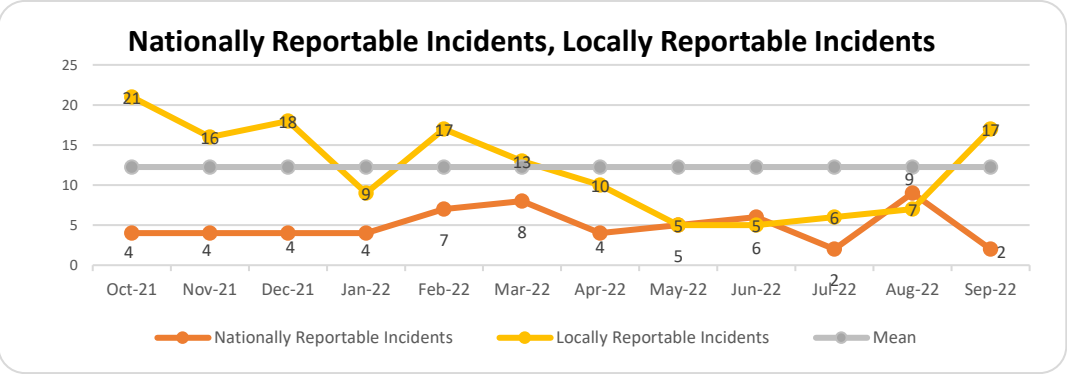
During August 2022 and September 2022, 11 nationally reportable incident notifications were submitted to the Delivery Unit and 24 identified as Locally Reportable Incidents. This represents an increase of 3 nationally reportable incidents when compared to the previous 2 months. During September 2022, 1 Never Event was reported relating to Treatment, Procedure under Trauma & Orthopaedics in Merthyr & Cynon. This incident was in relation to a Right sided femoral component implanted

into the Left knee.

A breakdown of the nationally reportable incidents is provided in the table below:

Type of Nationally Reportable Incidents	Aug-22	Sept-22	Total
Behaviour (including violence and aggression)	2	0	2
Delays	2	0	2
Unexpected of Trauma Related Death	2	0	2
Pressure Damage	1	0	1
Diagnostic Testing – Radiology	1	0	1
Records, Information	1	0	1
Treatment, Procedure	0	1	1
Monitoring, Observations	0	1	1
Total	**9**	**2**	**11**

Data run on 05.10.22



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Patient Safety Solutions:

Summary

There have been no new patient safety notices or alerts issued since previous Q&SC meeting.

The internal management, monitoring and reporting process for Patient Safety Alerts (PSAs) and Patient Safety Notices (PSNs) is now operating in a structure of devolved responsibility to the relevant teams with the central Patient Care and Safety Team providing support, co-ordination and oversight, leading to reporting.

The Safety Alert Broadcasting System Policy is currently under review and is utilising the Delivery Unit (DU) *All Wales Guidance for the Management of NHS Wales Patient Safety Solutions* published in July 2022 for reference. A national working group for safety alerts has been established which aims to support a more standardised approach of managing patient safety alerts/ solutions in health boards. This is going to focus on patient safety alerts and solutions in first instance and then focus on wider alerts such as MHRA's in the second phase of the working group.

Compliance:

In total, there is **1 alert** and 1 **notice** in which CTMUHB are non-compliant. In both cases the non – compliance relates to an ongoing national issue which is currently being scoped externally; health boards are currently unable to directly resolve these issues, the Delivery Unit are fully aware.

Since last report:

Compliance achieved: **PSN059**
Eliminating the risk of inadvertent connection to medical air via a flowmeter, we have now received the evidence for the action which was outstanding from the estates team therefore, full compliance has been approved by the Executive Director Nursing and reported to the DU as of 20/10/22.

Non-compliance

As noted above the Health Board currently reports non-compliance in **1** PSA & **1** PSNs:

PSA008
Nasogastric tube misplacement: Requirement of an All Wales training solution in progress.

PSN063
Deployment of NRFIt (ISO 80369-6) compliant devices in Wales.

Compliance has been reported in some areas within all hospital sites. There is currently a national supply issue. There is currently a national working group for this solution which a number of our anaesthetists attend. A letter has been sent to Medical Directors by the national working group for this patient safety solution to inform them of the national shortages. The letter advises health boards to not to roll out the change over to these devices to further areas at the present time due to the risk of stock not being available. The Delivery Unit have requested health board's to review the notice as compliance may be able to submitted due to a plan in place for all areas to switch, but ensuring the risk is included on corporate risk register. This is currently in progress.

Safety Measure Indicators

Indicator Description	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	April-22	May-22	June-22	July-22	Aug-22	Sept 2022	Trend
Number of medication prescribing errors	15	25	21	10	13	19	14	15	8	8	21	**13**	
Number of medication administration errors	31	42	41	35	35	41	26	37	32	29	24	**26**	
Total number of inpatient falls	295	300	260	300	254	292	260	258	262	242	240	**273**	
Number of inpatient falls where harm has occurred (moderate, severe and death)	9	13	9	10	13	12	22	25	22	25	26	**17**	
Total number of instances of hospital acquired pressure ulcers	133	98	79	86	105	86	109	100	92	100	119	**120**	
Number of hospital acquired pressure ulcers grade 3 and 4	7	8	0	1	6	2	1	5	4	2	10	**5**	
Total number of instances of Community acquired pressure ulcers	153	165	168	170	147	163	105	104	112	116	96	**105**	
Number of Community acquired pressure ulcers grade 3 and 4	18	20	16	19	16	18	6	5	16	17	8	**9**	

Safety Measure Indicators

Indicator Description	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	April-22	May-22	June-22	July-22	Aug-22	Sept 2022	Trend
Number of potential Hospital Acquired Thrombosis (HATs)	14	9	6	6	5	13	5	9	7	11	13	**10**	
% VTE risk assessments documented on the med. Chart	90	94	93	96	98	97	95	91	97	93	97	**91**	
Hospital Arrests (2222 calls) Adult	47	35	48	42	46	49	44	35	44	45	27	**N/A**	
% NEWS audit by site (RGH/YCR/PCH/YCC/PoWH/ Ysbyty'r Seren)	84.2	91.5	89.5	89.8	88.6	87.3	88.9	87.2	87.0	87.7	89.8	**90.8**	
C.difficile Rate/1000 admissions	1.78	1.79	2.87	1.91	2.67	3.56	1.93	1.16	1.6	2.17	2.94	**2.94**	
MRSA bacteraemia Rate/1000 admissions	0	0	0	0	0.22	0	0	0.19	0.40	0	0	**0.21**	
MSSA bacteraemia Rate/1000 admissions	1.07	1.61	2.11	2.12	1.33	2.44	3.22	2.72	1.8	3.15	2.94	**2.52**	
E. coli bacteraemia Rate/1000 admissions	4.46	5.73	5.75	5.1	6.22	4.5	6.22	5.82	6.39	4.92	7.35	**8.82**	
% of patients who spend less than 4 hours in A&E from arrival to admission, transfer or discharge	61	66	65	66	63	63	62	62	62	62	66	**66**	
% of patients who spend less than 12 hours in A&E from arrival to admission, transfer or discharge	90	90	91	88	87	88	87	88	88	88	88	**88**	
AvLOS overall mean (based on discharges only)	5.1	5.3	5.3	5.6	5.8	5.5	6.0	6.0	5.8	5.6	5.6	**5.5**	
Mortality Rate (CHKS)	3.46%	3.30%	3.82%	3.53%	2.76%	2.62%	3.43%	2.66%	2.82%	3.25%	N/A	**N/A**	

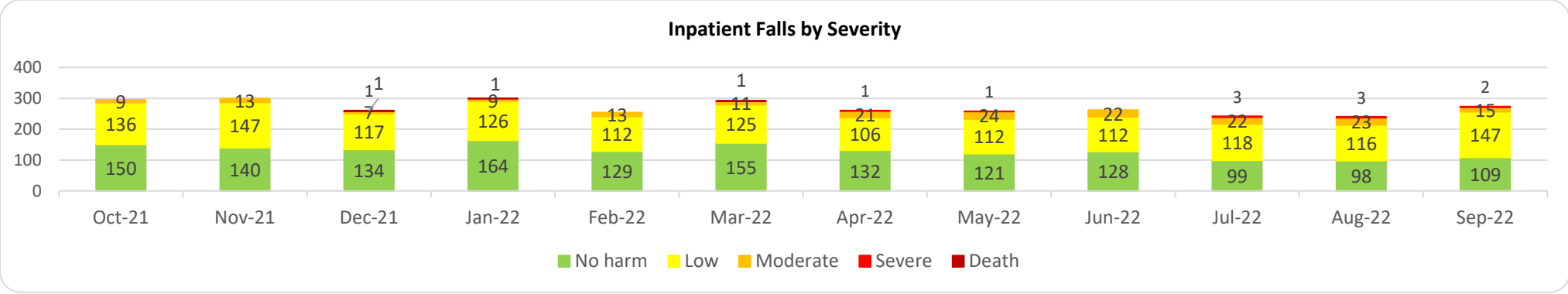
Medication Incidents

A total of 177 medication incidents were recorded during August 2022 and September 2022. 85% of the incidents reported as resulting in no (106) or low (44) harm, with the remaining reported as resulting in moderate harm (16). The introduction of a specific Community Pharmacy form has impacted on data quality for medication incidents as a number of fields are not included for completion. Therefore, for incidents reported during August and September 2022 - 11 incidents do not include the severity of the incident. Pharmacy colleagues have been asked to review this urgently.

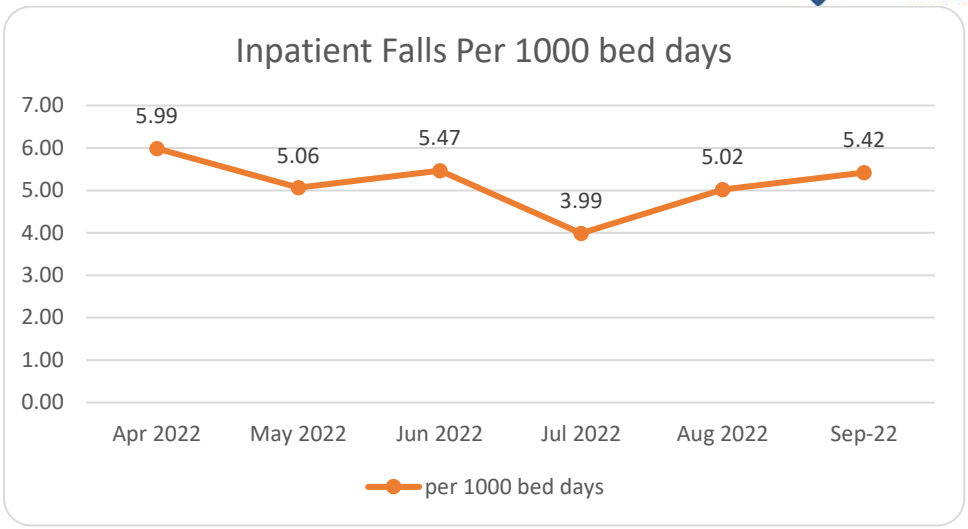
Of the total number of medication incidents reported, the top 3 types of medication incidents relate to administration errors (50) Medication supply errors (47) and Medication prescribing (34).

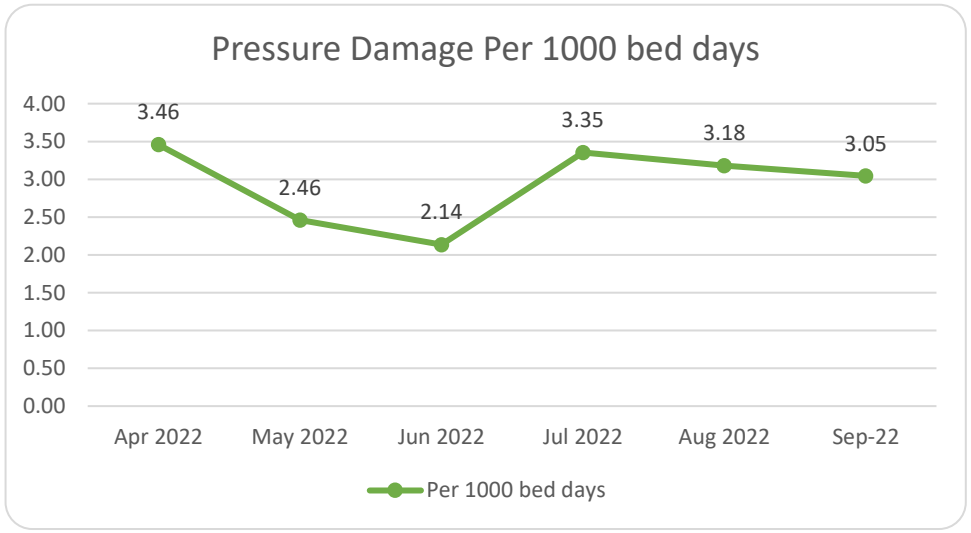
Inpatient Falls

A total number of 513 inpatient falls were reported between August and September 2022, which represents an increase of 9 in the number of falls reported in comparison to the previous two months. Of the falls reported, 92% were reported as no (207) or low (263) harm. The remaining incidents were reported as moderate (38) and severe (5) harm. No incidents relating to inpatient falls were reported as resulting in death. During August and September 2022, the highest number of inpatient falls occurred on Ward 15 at Princess of Wales Hospital (21), Emergency Care Centre at Prince Charles Hospital (19), Ward 7 at Ysbyty Cwm Cynon (16) and Ward 11 at Princess of Wales Hospital (16).



Data run on 05.10.22





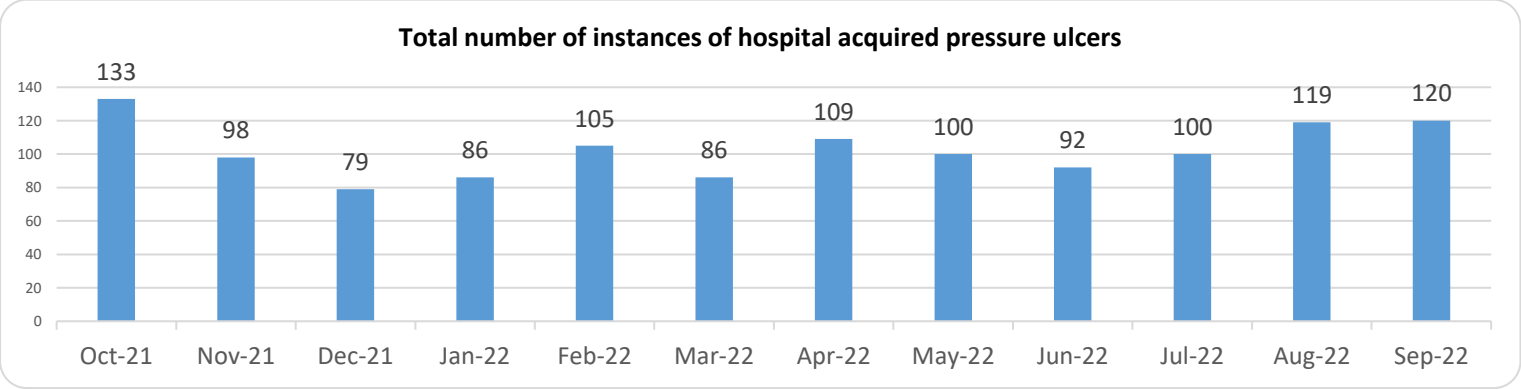
Metrics per 1000 bed days

We have introduced falls and pressure damage metrics per 1000 occupied bed days as an improved measure of benchmarking rates, with the next step to set reduction goals for numbers and severity of harm. This also facilitates flexibility in identifying areas of greatest risk and setting reduction targets accordingly. National figures vary but is around 6 per 1000 bed days for falls with pressure damage much more difficult to average nationally.

Pressure Damage Incidents

During August and September 2022, a total of 875 pressure damage incidents were reported, of which 440 were reported as occurring during the current community case load. The remaining pressure damage incidents were reported as being present before admission to this clinical care area/caseload (435). Of the 440, 239 were identified as being hospital acquired and 201 as community acquired. This represents an increase of 47 hospital acquired pressure damage incidents when compared to the previous 2 months. The locations with the high reported hospital acquired pressure damage incidents were the Emergency Department at Princess of Wales Hospital (27), Emergency Department at Royal Glamorgan Hospital (19), Emergency Care Centre at Prince Charles Hospital (13), and AMU at Princess of Wales Hospital (10). There were 15 hospital acquired incidents reported as Grade 3 in August (10) and September (5) 2022. There was 1 hospital acquired Grade 4 incident reported for Ward 8 - Princess of Wales Hospital during the two month period.

Data run on 05.10.22



Hospital Acquired Thrombosis (HAT) and Venous Thromboembolism (VTE) assessments:
There were 23 potential HATs identified for August 2022 to September 2022 compared to 18 for the previous reporting period from June 2022 to July 2022. It is important to remind Committee that this measure is prior to the investigation of each case to identify if a HAT occurred or not. The ambition is to provide actual HAT's in relation to potential vs actual.

Hospital Cardiac Arrests and NEWS Training:
For August 2022, the number of calls taken were 27 compared to June 2022, 44 calls and July 2022, 45 calls. September 2022 data was not available at the time of this report. Hospital Cardiac Arrest Calls will remain an important metric, as the ultimate goal is for cardiac arrests only to occur in the Emergency Department. Strengthening our pre-arrest reviews and monitoring acute deterioration, as well as improving on our DNACPR processes, NEWS scoring, and training strategy, are integral to this goal.

Recognising Acute Deterioration and Resuscitation (RADAR) group will be expanding metrics to ensure there is a constant review of activities. NEWS training is also being recorded on the new Clinical Audit and NICE compliance monitoring system, so training figures are now available.

Infection Prevention and Control:

The COVID-19 response continues to be at the forefront of the Infection Prevention and Control teams' agenda. COVID-19 continues to cause service disruption across the three acute sites. COVID-19 cases and outbreaks of infection are discussed at the bi-weekly Infection Prevention and Control cell meetings. Service changes and de-escalation of COVID measures have been introduced in order to return to pre-pandemic arrangements but universal mask wearing has been re-introduced in clinical areas. The patient testing framework has been reviewed in line with national guidance. These changes include; stopping routine testing of asymptomatic unscheduled admissions and changes to asymptomatic pre-operative testing. Unvaccinated/partially vaccinated patients will be tested for COVID prior to elective admissions and asked to self- isolate from the test date until admission to hospital. Vaccinated patients will not require pre-operative routine testing.

The ongoing response to the COVID-19 pandemic and staff shortages within the Infection Prevention and Control team has delayed the pace of improvement work but there are arrangements in place to resume and introduce planned work aimed at reducing Health Care Associated Infections (HCAI's).

Mandatory surveillance continues nationally for five key organisms including C. difficile, Staphylococcus aureus bacteraemia and E.coli, Pseudomonas and Klebsiella bacteraemia. More than half of the bacteraemia reported since April 2022 are community acquired infections and a scoping exercise is required in primary care to understand the requirements/expectations on the current Infection Prevention and Control Team to provide a comprehensive service.

The Infection Prevention and Control team continue to work collaboratively with the service groups to improve the investigation procedure and root cause analysis process for C. difficile infection and preventable bacteraemia. Learning is shared with clinical teams to inform and influence practice. Further engagement and support is required to introduce this in primary care.

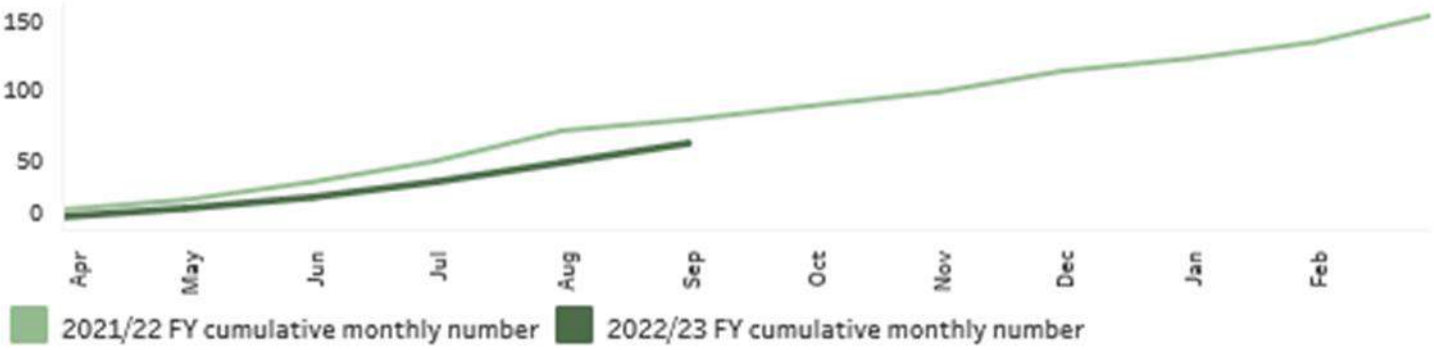
Roll out of Aseptic Non-Touch Technique (ANTT) across Princess of Wales Hospital and workshops in Rhondda Taff Ely and Merthyr Cynon has stalled due to increased workload and vacancies within the Infection Prevention and Control team. Assistance has been requested from the Deputy Medical Director to improve engagement and compliance of Infection Prevention and Control training and ANTT amongst medical colleagues. The Lead Infection Prevention Control Nurse is working with the Head of Professional Standards and Education to standardise the audit tools available on the AMaT system. This will improve benchmarking of information and reliability of results.

A CMO alert has been received alerting Health Boards' in Wales to an outbreak of Ebola virus in Uganda. Work is required to ensure hospital sites have clear plans to identify and manage suspected cases safely with access to appropriate Personal Protective Equipment (PPE).

Infection Prevention and Control plan for the next 3 months –

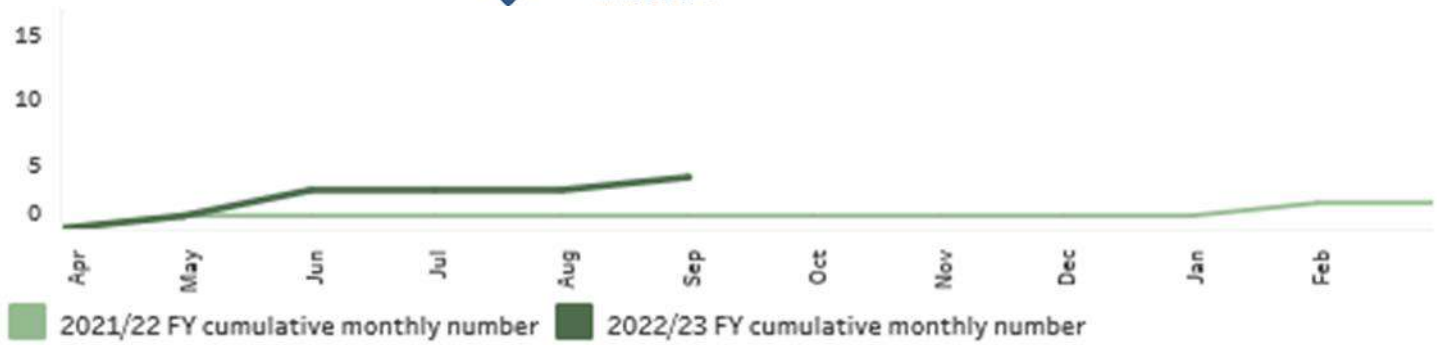
- Review current IPC establishment considering the need for a primary care resource and secure appointments into the IPC Nurse vacancies.
- Support newly appointed IPC Nurses.
- Support Emergency Departments with High Consequence Infectious Disease (HCID) preparedness.
- Support improvement work to reduce health care associated infections.
- Continue to support the respiratory/non-respiratory pathways, testing framework and COVID-19 response.
- Deliver an Infection Prevention and Control service in line with the new organisational structure.

Cwm Taf Morgannwg University Health Board cumulative monthly numbers of C. difficile for April 2022 to September 2022 against the equivalent period in 2021/22



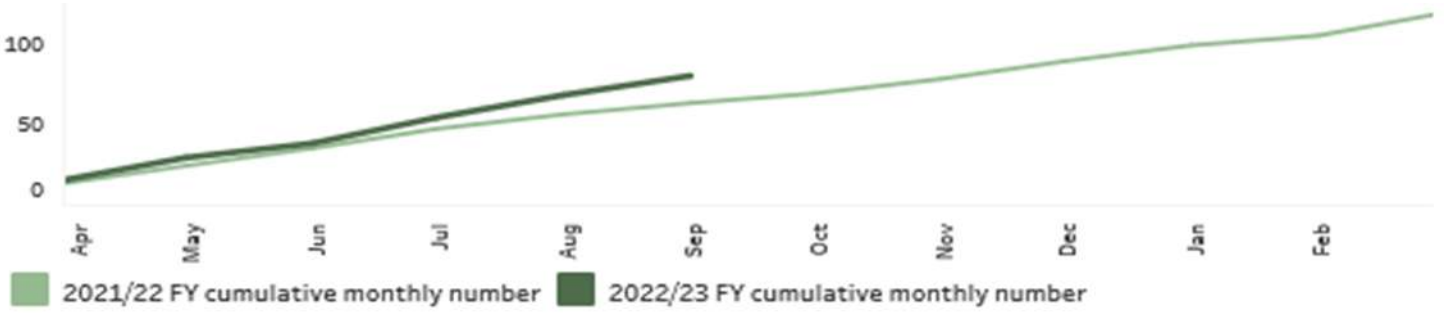
Data run on 5.10.22

Cwm Taf Morgannwg University Health Board cumulative monthly numbers of MRSA bacteraemia for April 2022 to September 2022 against the equivalent period in 2021/22



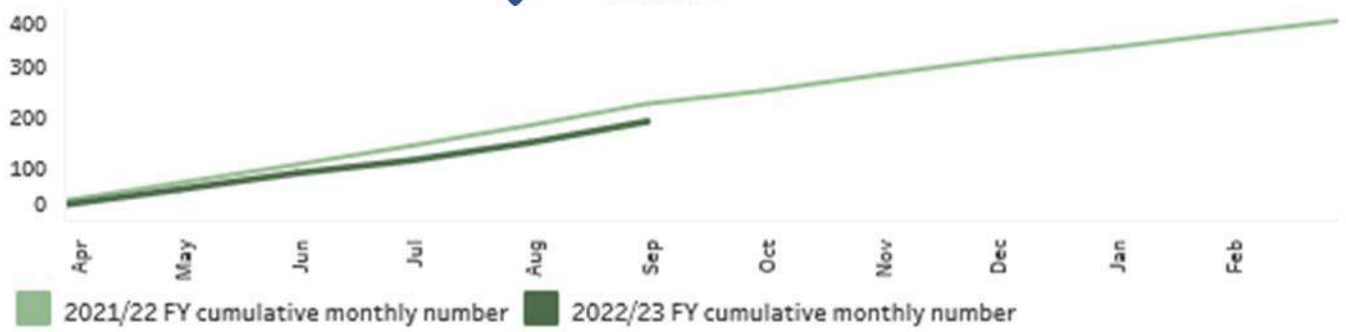
Data run on 5.10.22

Cwm Taf Morgannwg University Health Board cumulative monthly numbers of MSSA bacteraemia for April 2022 to September 2022 against the equivalent period in 2021/22



Data run on 5.10.22

Cwm Taf Morgannwg University Health Board cumulative monthly numbers of E. coli bacteraemia for April 2022 to September 2022 against the equivalent period in 2021/22



Data run on 5.10.22

Emergency Department 4 hour and 12-hour performance:
Compliance with the 4-hour target has increased to 66% compared to the previous reporting period, as front door activity remains high. The 12-hour A&E performance remains comparable with the previous report period at 88%.

Average Length of Stay:
The ALoS has decreased to 5.5 days in September 2022 compared to 5.6 days in August 2022. A full review of COVID cases will be undertaken as part of the National COVID audit and as part of the COVID mortality review process to identify any common themes, trends and learning.

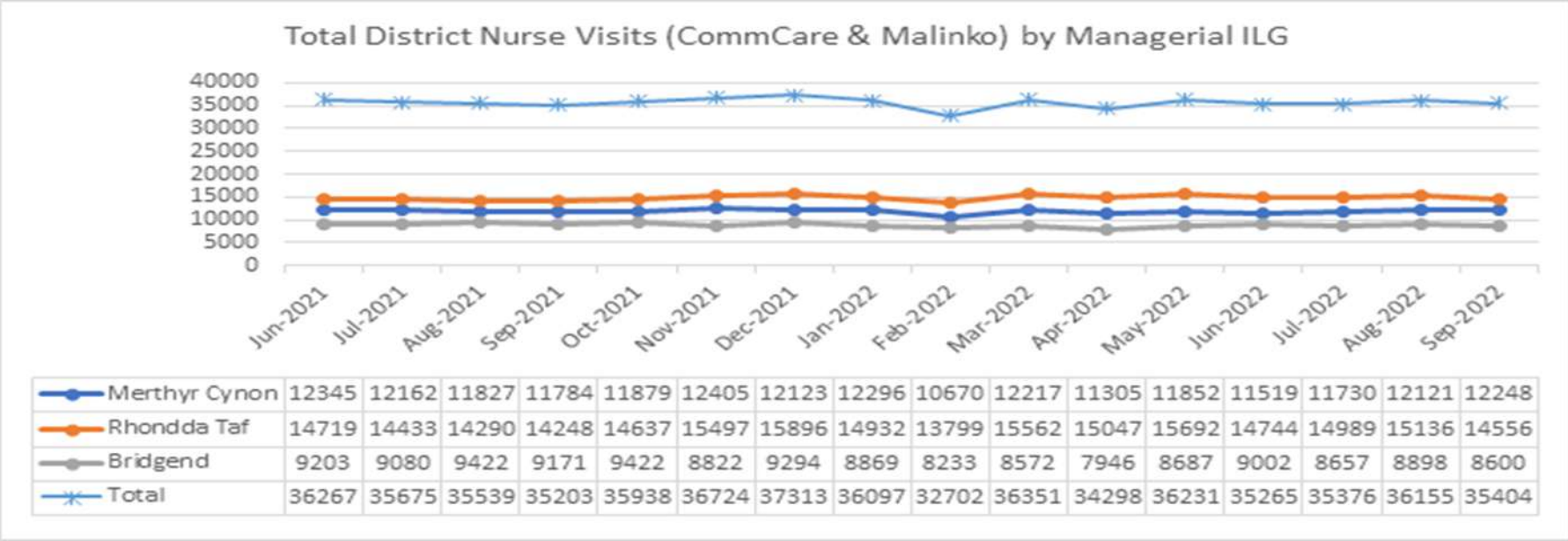
Mortality rate:
There has been an increase in mortality during the months of June 2022, 2.82% and July 2022, 3.25%. August and September 2022 data was not available at the time of this report.

Indicator Description	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	April-22	May-22	June-22	July-22	Aug-22	Sept 2022	Trend
Community Care Metrics													
District Nurse treatments	35938	36724	37313	36097	32702	36351	34298	36231	35265	35376	36155	35404	

Indicator Description	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	April-22	May-22	June-22	July-22	Aug-22	Sept 2022	Trend
Community Care Metrics													
Referral to At Home Services (All Referrals)	97	103	102	109	101	141	90	120	122	129	123	**123**	
Maesteg Hospital (ALOS)	0	0	0	0	0	0	0	0	0	0	0	**0**	
Ysbyty'r Seren (ALOS)	57	43	39	42	54	96	55	63	0*	0*	0*	**0***	
*Princess of Wales Hospital, Ward 21 (ALOS)	-	-	-	-	-	-	-	-	46	63	77	**102**	
Ysbyty Cwm Cynon (ALOS)	49	55	61	55	74	54	61	63	49	51	64	**64**	
Ysbyty Cwm Rhondda (ALOS)	70	58	58	82	69	75	67	70	56	67	55	**62**	
Palliative Medicine, Bridgend (ALOS)	18	13	13	25	27	14	19	14	20	9	10	**24**	
Palliative Medicine, Pontypridd/RGH (ALOS)	8	7	9	18	11	8	4	19	12	7	8	**8**	
Palliative Medicine, YCC (ALOS)	23	24	13	9	26	18	16	13	32	16	36	**4**	

Data run on 17.10.22

District Nurse Treatments and at Home Referrals:



	Jun-2021	Jul-2021	Aug-2021	Sep-2021	Oct-2021	Nov-2021	Dec-2021	Jan-2022	Feb-2022	Mar-2022	Apr-2022	May-2022	Jun-2022	Jul-2022	Aug-2022	Sep-2022
Merthyr Cynon	12345	12162	11827	11784	11879	12405	12123	12296	10670	12217	11305	11852	11519	11730	12121	12248
Rhondda Taf	14719	14433	14290	14248	14637	15497	15896	14932	13799	15562	15047	15692	14744	14989	15136	14556
Bridgend	9203	9080	9422	9171	9422	8822	9294	8869	8233	8572	7946	8687	9002	8657	8898	8600
Total	36267	35675	35539	35203	35938	36724	37313	36097	32702	36351	34298	36231	35265	35376	36155	35404

The data is currently collected at Health Board (HB) level.

RTE

There has been approximately 500 less visits during September. The ongoing demand continues to challenge the service's capacity. The main issue for the service is non-housebound patients on the caseload.

M&C

The number of palliative care visits continue to rise due to the palliative care arena developing to include conditions such as Dementia which is on the increase together with a rise in the elderly frail population also classed as palliative care. Although this group of patients has increased, the resources remain the same. Maintaining the quality of care being delivered remains a challenge due to a combination of both an increase in demand and increasing patient acuity. Teams are mitigating against this through collaborative working, both within District Nursing and with supporting services, to share the risk and maintain a high quality service.

Bridgend
The Band 4 Health Care Support Worker (HCSW) development training is nearly complete for Diabetes management, vitamin B12 injections, catheter and bowel care. A Nurse Staffing Acuity pilot has been completed in Bridgend with good results. Teams are continuing for a further month on the Civica Professional Judgement workbook with completion planned for mid-November for every District Nursing Team. There are representatives from District Nursing Teams engaged in HB Community Pressure Ulcer Collaborative work. There are plans in place to implement Civica Scheduling to the Out of Hours District Nursing Team within Bridgend. 8,600 patients were visited by a District Nurse during September. The service is currently carrying 8WTE RN vacancies.

GP
GP referrals continue to account for the majority of the activity, there continues to be some staffing deficits, however, the staff are still managing to provide a timely response to the patients referred to the service.

ACT
There are currently 22 patients on caseload, with 2 patients on the waiting list with a lead time of 3 days. A total of 31 referrals were accepted in September 2022, with no patients being deferred. No patients receiving IV therapy and 6 patients awaiting a falls assessment. Staffing remains an issue with an absence rate of 36% due to sickness, maternity leave and vacancies.

Community Hospitals Average Length of Stay (ALoS):

YCC
There has been an increase in LOS to 64 days in September 2022. There is still a high number of patients on site awaiting placement within Care Homes or awaiting packages of domiciliary care in the community. Actions are being carried out to improve patient flow through YCC following recommendations from the DU review.

YCR
Discharges have decreased by 2 in month, the issue remains with the lack of capacity of required support in the community for discharge. LOS has increased.

Bridgend Community services

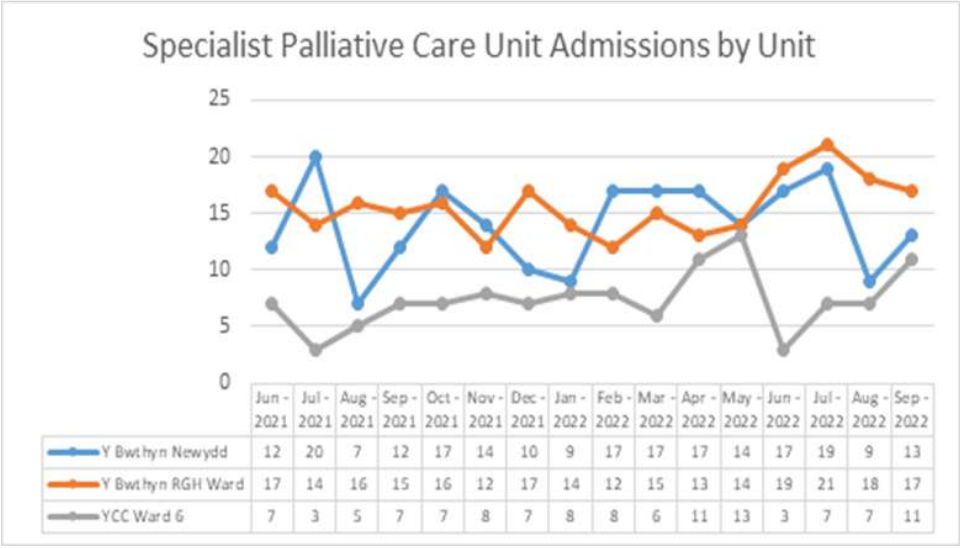
Ward 21 at POWH

Representatives from the Ward Team engaged in CTM Community Pressure Ulcer Collaborative work. The ward have implemented Safe to Start and daily Multidisciplinary board round. Plans in place to pilot the Discharge to Recovery Pathway. Dementia Awareness update training provided for the Ward Team. Pressure ulcer audit findings identified a need for training for bank and agency staff. Nurse Staffing acuity completed daily on the ward. The service is currently carrying 4WTE RN vacancies.

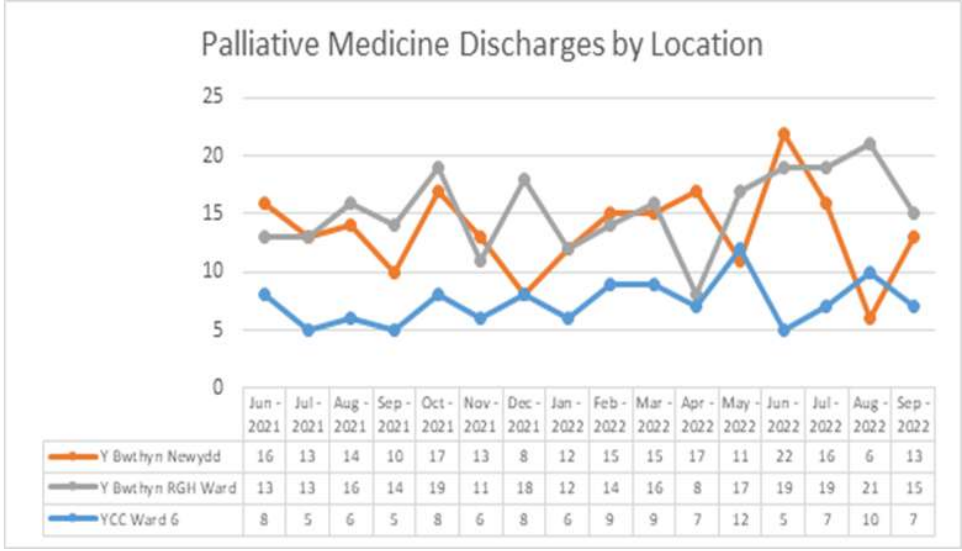
Palliative care inpatient units

Admissions across the 3 inpatient wards have increased from 34 to 41 in September 2022.

Palliative Care inpatient admission data



	Jun - 2021	Jul - 2021	Aug - 2021	Sep - 2021	Oct - 2021	Nov - 2021	Dec - 2021	Jan - 2022	Feb - 2022	Mar - 2022	Apr - 2022	May - 2022	Jun - 2022	Jul - 2022	Aug - 2022	Sep - 2022
Y Bwthyn Newydd	12	20	7	12	17	14	10	9	17	17	17	14	17	19	9	13
Y Bwthyn RGH Ward	17	14	16	15	16	12	17	14	12	15	13	14	19	21	18	17
YCC Ward 6	7	3	5	7	7	8	7	8	8	6	11	13	3	7	7	11



	Jun - 2021	Jul - 2021	Aug - 2021	Sep - 2021	Oct - 2021	Nov - 2021	Dec - 2021	Jan - 2022	Feb - 2022	Mar - 2022	Apr - 2022	May - 2022	Jun - 2022	Jul - 2022	Aug - 2022	Sep - 2022
Y Bwthyn Newydd	16	13	14	10	17	13	8	12	15	15	17	11	22	16	6	13
Y Bwthyn RGH Ward	13	13	16	14	19	11	18	12	14	16	8	17	19	19	21	15
YCC Ward 6	8	5	6	5	8	6	8	6	9	9	7	12	5	7	10	7

Indicator Description	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	April-22	May-22	June-22	July-22	Aug-22	Sept 2022	Trend
Mental Health Care Metrics													
Number of 136 assessments in police cells	0	0	0	0	0	0	0	0	0	0	0	**0**	
Restrictive Practices	4	10	6	9	1	0	3	0	16	22	12	**32**	
Number absconding from wards (overall not just detained) ****	20	25	21	18	23	25	22	22	21	24	25	**17**	

Data run on 05.10.22

Number of 136 Assessments in Police Cells:
This number remains 0 and is showing good compliance with the Crisis care Concordat ensuring that those who require mental health assessment are not detained in custody suites. (All Mental Health Localities included).

Restrictive Practices
Between August 2022 and September 2022, a total of 44 incidents using Restrictive Practices were reported within Mental Health. This is an increase of 6 incidents when compared to the previous two months. Of these, 50% (22) were reported as not care planned and 50% (22) were reported as care planned. Of the 44 incidents, 91% were reported as no (36) or Low (4) harm. The remaining incidents were reported as moderate (4) occurring on Ward 7 at Ysbyty Cwm Cynon (2), Ward 22 at Royal Glamorgan Hospital (1) and Ward 14 at Princess of Wales Hospital (1). All moderate harm restraints were reported as not care planned.

Absconding Incidents
During August and September 2022, a total of 42 Absconding incidents were reported. The highest number of incidents reported were for Ward 22 at Royal Glamorgan Hospital (8), and Emergency Care Centre at Prince Charles Hospital (5). 79% of the absconding incidents reported in August and September 2022 were recorded as No (20) or Low (13) harm, with the remaining reported as resulting in moderate harm (9). Of the Moderate Harm incidents (5) occurred in Mental Health Services at the Royal Glamorgan Hospital, and 4 in Emergency Care at Royal Glamorgan Hospital (3) and Prince Charles Hospital (1) sites.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

The following issues/risks have been identified in relation to quality reporting within the Health Board.

- LFERs remain a challenge, however work continues to address the backlog. In addition, new systems and process in respect of learning and capturing learning have been implemented, which will support the timely management of LFERs for the newly triggering cases.
- Post pandemic recovery and increased demand and pressures of unscheduled care, patient flow and discharge difficulties for patients requiring ongoing support, continues to have considerable and ongoing consequences on the experience of patients and the ability of the HB to provide continuity around its core business. The six goals programme board is being launched within urgent and emergency care.
- The health board is working with the Welsh Ambulance Service Trust (WAST) to review how incidences such as patients being unable to receive an ambulance in the community can be reduced, and to mitigate the risk of harm to those waiting extended periods to be off loaded from ambulance in the meantime. The Unscheduled Care Nurse Director and acute sites Heads of Nursing are working through a set of care principles during delays in offloading to Emergency Departments. This will be co-produced with consultants and WAST.
- Prince Charles Hospital is committed to being an active participant in the development and sustainability of stroke services across CTM. If current increase in number and complexity of stroke patients across these sites continues, then the ability of Occupational Therapy, Speech and Language Therapy, Physiotherapy and Dietetics, to respond and provide a quality service to these patients will reduce and not be sustainable without additional resource. A CTM wide, stroke plan is currently in progress to the previously escalated concerns regarding the staffing and the on call rota; furthermore under the six goals framework the 'hyper acute sites' will be moving to a model of ring-fenced 'hyper acute stroke beds' next month.
- The proposals in relation to a changed operating model presents challenges in ensuring the quality, patient safety and people's experience agenda remains well led and managed throughout.

- Ensuring robust implementation of the RLDatix system, which is aligned to the new operating model and progressing the ambition to develop an IT infrastructure to ensure up-to-date high quality data that is readily accessible enable triangulation and is meaningful.
- Gaining health board wide assurance across the breadth of UHB services, especially during a period of significant change in its operations.
- Actions to address these issues and risks are in place in the improvement action plans relating to the targeted intervention areas. Beyond this, the Health Board require ambitious pursuit of quality and safety in all it does to provide excellence in service delivery to the population of CTM.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	This report outlines key areas of quality across the Health Board.
Related Health and Care standard(s)	Governance, Leadership and Accountability
	This report applies to all Health and Care Standards.
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below.
	• Report for information for health board patient safety & patient experience activity • No service or staff impact in direct response from this report, this is considered through improvement work and other reports • Report not requesting proposal for any changes to services or staff

Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	Yes (Include further detail below)
	The requirements to deliver safe, high quality care impact on resources including workforce. The new operating model will support delivery of safe, high quality care.
Link to Strategic Goals	Improving Care

RECOMMENDATION

Members of the Quality & Safety Committee are asked to:

4.1 **NOTE** the content of the report

4.2 **DISCUSS** the content of the report and flag areas (if not already identified) where further assurance is required

4.3 **NOTE** the risks identified

4.4 **SUPPORT** the direction of travel in developing a wider reach of quality reporting and locality based assurance reports

APPENDIX 1:

ILG Dashboard Reports

APPENDIX 2

Patient Experience
Activity Period August 2022 – September 2022

Understanding how patients/families/carers interact with the services we provide to our community is key to establishing whether we are meeting the needs of our population and how we can improve on these services. This also allows an insight into what is working well to enable shared learning and drives service improvement.

There continues to be engagement with specialty's around patient feedback and the creation of surveys on the Civica system. The team are currently working with the paediatric department to upload surveys in relation to inpatient/outpatient feedback and look at launching a new format webpage with graphics that link into the launch of CTM Children's Rights Charter in November 2022.

To date a total of 2980 responses have been received and a total number of 11595 sms messages have been sent out to patients. The team are presently looking at automating reports via email to staff that have been trained on the system to provide feedback in a format that staff can access more easily. The People's Experience and Volunteer Manager have also put in place a Patient Feedback Volunteer team that is being piloted on Wards 19, 20, 10 and 8, Princess of Wales, to support patients/families/carers in providing feedback to the Health Board, which will be starting in October 2022.

The graph below highlights the surveys that were on the system that have received responses within the last 5 months.

Total Per Month	**362**	**335**	**454**	**302**	**246**	
Survey Name	**May-22**	**Jun-22**	**Jul-22**	**Aug-22**	**Sep-22**	**Total**
Maternity- Antenatal - Phase 1	55	39	34	30	29	**187**
Maternity- Antenatal - Phase 2	59	59	38	45	50	**251**
Maternity- Labour birth and postnatal care - Phase 3	99	99	64	73	56	**391**
Maternity- Postnatal community - Phase 4	42	42	42	28	27	**181**
Maternity- Prem Questionnaire for Birth partners	0	3	0	1	0	**4**
Maternity- Staff Vision Questionnaire	0					**0**
Have Your Say	47	12	53	4	4	**120**
Patient Experience	26	14	21	20	8	**89**
Heart Failure-PREM Survey	2	1	3	9	16	**31**
WREM Survey- Platform Experience Outcome Measures			29			**29**
Paediatrics- Your Time in Hospital - Children's Survey 11 years and upwards	11	3	5	2	1	**22**
Paediatrics- Your Time in Hospital - Children's survey aged 4-11 Years	14	1	15	8	3	**41**
Therapies	1	1	1	1	0	**4**
Frailty Nurse Services	8	1	3	6	2	**20**
Emergency Department - Prince Charles Hospital	59	44	119	17	9	**248**
Integrated Cluster Survey	0	0	0	0	0	**0**
Visiting Survey - Patient	0	0	0	0	0	**0**
Visiting Survey- Staff	0	0	0	0	0	**0**
Wellness Survey	1	0	0	0	0	**1**
Quality of emergency admission patients' experience questionnaire (Infective)	0	0	0	0	0	**0**
Quality of emergency admission patients' experience questionnaire (Trauma)	1	0	0	0	0	**1**
Patient / Service User Experience Survey	0	0	0	0	0	**0**
Parents/Carers Questionnaire	29	9	18	11	15	**82**
YCC Staff Survey	0	0	0	0	0	**0**
Patient Safety Culture Snapshot Survey					20	**20**

HUMA Evaluation Phase 2- July 2022			9	1		**10**
LymPREM Questionnaire			0	0	0	**0**
Paediatrics- Evaluation Questionnaire (allergies)			0	0	0	**0**
RIW Digital Assessments (PREM)		7	0	41	6	**54**
Wellness Improvement Service (WISE) Questionnaire			0	5	0	**5**

Examples of some of the comments received are highlighted below:

Your staff are a credit to the Hospital. So helpful. Thank you.

The staff on this ward are doing an exceptionally good job.

Carers

Carer's co-ordinator continues to link with ward managers across the Health Board to encourage nominations for Carers champions.

Seven Agored learners have now completed training and fifteen learners are still working their way through the training. Going forward this carers training will be provided by Carers Trust UK, a one hour training session that will highlight carer awareness.

The second staff Carers network meeting is arranged for October. There are currently 21 staff who are part of this group. Information is regularly sent, which informs them of any Carer support they may benefit from. Initial feedback from the group is positive and guest speakers are invited to intend to discuss topics the group feel would be of support to them.

The first Carer champion meeting was held in September, with good representation from primary care sector. We currently have over 70 Carer champions and are looking at ways staff can be supported to attend these sessions. This will enable discussions to take place to ensure we can support staff and carers with up to date information/support and explore any barriers that are in place to drive service improvement.

Our new 'Carers Guide - when someone you care for is in hospital' has been published. These have been distributed to every ward in PCH and will be available in RGH and POW within the next two weeks. PDF copies have been sent to all carer champions and staff carer network members, GP surgeries, third sector organisations and given to Carers who the Carer's Co-ordinator meets with on a Thursday from Merthyr MIND.

Posters highlighting our Carer's Co-Ordinator contact details and support are also currently being distributed throughout CTM.

Carers steering group meeting was held 2nd August and invites have been extended to guest speakers for the November meeting. Geraint Evans from RPB will discuss the Population Health Assessment and we plan to invite a representative from Merthyr CAB4Carers to give an update on their project.

Due to the change in directive from WAG to ask Health Boards to tailor funding around supporting carers and hospital discharge there will be a discussion to review membership in the next meeting to look at how we can build further relationships and strengthen the strategic approach within the group.

Since August the Carers Co-ordinator has a presence in two of the three acute sites. Based in the MacMillan hub in PCH on a Wednesday and RGH on a Tuesday. There are ongoing discussions required to secure a desk in the discharge liaison office at POW possibly every Thursday.

Carer's Co-ordinator also has a seat in a number of forums with staff and third sector colleagues within the Health Board to enable a voice from a carer's perspective to drive communication and service improvement.

Chaplaincy Services

Significant Spiritual and pastoral care

Patients	Relatives/Carers	Staff	Religious Rites	Out of hours requests
595	145	258	185	12.5 hrs

The Chaplaincy team officiated at two hospital contract funerals, one patient's funeral, and three foetal collective cremation committal services were held. Following a number of discussions, the collective cremation in Coychurch Crematorium (POW patients) now has an officiated service, taken by a Health Board chaplain, in line with PCH and RGH sites.

The team continues to deliver classroom training to raise awareness of the department and what they do, with a focus upon spirituality and how staff can discover their personal spirituality to help their own wellbeing and enable them to know how to look out for spiritual distress within our patients.

The department offered support to staff members in a number of department's due to death in service, a condolence book was given to each unit. Condolence books were opened in each multi faith room in memory of Her Majesty Queen Elizabeth II. Many conversations have taken place with staff and patients during our Nations mourning period.

Glanrhyd chapel has been opened and services have resumed here, this makes the service more accessible for the patients on the site.

Financially our vacant posts have been approved, we will be undertaking the recruitment process over the next few weeks. Appointment into these roles will enable more 'presence' on our wards. One of our chaplains, Fr Haydn at YCR, summed up this vital aspect of our work during his appraisal and he has given permission for this to include to highlight some of his thoughts in this report and demonstrate the support this service provides.

"*To be a visible presence enables us to extend a ministry of unique pastoral care within the hospital. It is unique in as much as it embraces all members of staff, patient's families and of course the patients themselves, whether individuals have a faith or not. Patients value the reality that chaplains will spend time with them as they know how busy staff are on the wards. Whether religious or not, patients will often open up about aspects deep within themselves that they feel unable to tell anyone else. Many benefit from the rites of passage administered by chaplains and those who practice a faith appreciate prayer and sacramental acts whilst under our care*." Fr Hayden England-Simon YCR chaplain.

Volunteer Service

Volunteer service continues to be a valuable support to our services across the Health Board and as the effects of Covid dissipate, the volunteers are returning to reflect a presence on our hospital sites. The below provides an insight into the number of services they are currently supporting:

Meet and Greet Volunteers

The meet and greet volunteer role provides a wayfinding service for those attending our sites across CTM in supporting with signposting and a resource for advice and information, the following provides an overview of the service.

- The meet and greet volunteers at Dewi Sant Health Park provide a Monday to Friday service. To date there has been positive feedback from volunteers who more recently have been providing signposting to

the on-site vaccination centre. Recruitment of new volunteers to support in this area is currently in discussion.

- Over the past few weeks we have a strong team of volunteers supporting the meet and greet service at the Princess of Wales Hospital. The feedback to date has been positive and we currently have morning and afternoon shifts covered over a Monday – Friday period
- During September, we have been reintroducing the meet and greet service at the Royal Glamorgan Hospital. We currently have cover Monday to Wednesday and Friday mornings, but the aim is to open up recruitment for this role to ensure it is up to capacity over the next few weeks. To date feedback has been very positive and the volunteers are very much appreciated by staff in the area including switchboard who provide support for the volunteers on a daily basis.

Vaccination Programme

Since 2020, our vaccination centre volunteers have supported the work stream across CTM and have been invaluable to the delivery of services. More recently, the vaccination sites have moved to clinical venues and our volunteers continue to offer meet and greet support.

The End of Life Companion Volunteer Service – POW & YCC

The end of life companion volunteer project is a joint initiative between the volunteer service, chaplaincy and clinical staff and was launched on 1st August 2022. There are already monthly supervision meetings planned over the coming months and referrals are now open for staff within the identified ward areas. Up until the end of September, however, no referrals had been received due to no patients requiring this support on the wards currently involved in the pilot. Patient Experience Manager has a meeting set up next month to discuss how we can extend the pilot across all wards in POW with the support of the end of life team in identifying patients that could be supported by this role. In the meantime, the Chaplaincy Service are keen to reintroduce volunteers across CTM and meetings will be arranged to review the current covid situation in terms of green areas and refresher training for volunteers who are not part of the EOL Companion project.

Wellness Improvement Service (WISE) Volunteers

Discussions and planning have been undertaken over many months with the potential for volunteers to support the WISE project work stream and in particular volunteering alongside the Wellness Coaches with classroom and on

line courses. Since the 5th September 2022, volunteers have supported classroom based sessions at Bridgend Leisure Centre and Pontyclun Rugby Club. There are future dates in the pipeline for sessions at St Fagan's Church, Aberdare. To date feedback from coaches and volunteers has been extremely positive. In addition, moving forward the sessions will be evaluated and we are hoping to have feedback over the coming weeks which will be incorporated into the bi-monthly volunteer service activity report.

Pets as Therapy Volunteers

Pets as therapy has previously been extremely popular and to date there are several volunteers and pets available for specific areas across CTM, which includes Mental Health and CAMHS services at POW. During September one of the Pet Therapy Volunteers and his companion, Ozzy has undertaken his local orientation session on the Palliative Care Ward at Y Bwythyn Newydd. There is another local orientation session planned for our second volunteer and his companion Toby on 11th October 2022 at the CAMHS Unit at Ty Llidiard. There has been further expressions of interest from the Dementia Ward at YGT which will be moving back to RGH nearer Christmas and discussions are being undertake with Cariad Pet Therapy regarding identifying a volunteer for this particular area.

Breast Feeding Peer Support Volunteers

Breast Feeding Peer Support Volunteers in conjunction with the research team and infant leads continue to support new mothers with virtual enhanced breast feeding peer support for pregnant ladies from 30 weeks to post-natal care up to 6 months. The BFPS volunteers are also active offering information and support under the supervision of the infant leads and during September a further three BFPS Volunteers were recruited and inducted in order to support this project.

Organ Donation Family Support Volunteer

Our organ donation family support volunteer continues to be on call for our three DGH sites across CTM (RGH/PCH/POW). This project was set up in conjunction with the Specialist nurse/Specialist Requester' in Organ Donation and the Health Boards Lead Chaplain, our volunteer continues to support the organ donation project and work stream at a local and national level.

Arts, Crafts and Gardening Volunteers

We continue to hold workshops with our arts and crafts volunteers with many of the items being donated across wards and community settings. The Arts and Crafts Group are keen to continue the workshops and over the coming

weeks will have a plan of specific themes that our volunteers can support from an arts and crafts perspective. Over the past few weeks some of our arts and crafts volunteers have been supporting with gardening projects across CTM, including memorial gardens at RGH and YCC and the plan moving forward is to look at volunteers supporting the garden at Y Bwthyn RGH. The good to grow project at Y Bwythyn Newydd POW, has been running for some months and the project is going from strength to strength.

More recently to enable our service users to benefit from the good to grow project a number of our existing volunteers offered to support with the volunteer driver initiative, to transport service users from home to the unit and back again. Checks are currently being undertaken in terms of insurance, tax, MOT's and driving licences in line with our volunteer driver handbook.

Patient Feedback Teams

A number of volunteers have been recruited to support patient feedback via the civica system. Volunteers have orientated themselves on wards within POW (Wards 19, 20, 10 and 8) with the support of the ward managers and the pilot is planned to start in October 2022**.**

Going forward

Over the past few weeks and months we have been privileged to be able to reintroduce our existing volunteers in a number of roles identified in this update report. Moving forward we have a number of initiatives that we will be working on, alongside supporting projects up and running which include:

- Possibility of opening up recruitment to support current projects and future projects
- Introduction of meet and greet and ward befrienders at YCC and continue to support the Dementia Task and Finish Group
- Introduction of ward befrienders at YCR
- Recruiting to cover meet and greet shifts at sites across CTM
- Increase volunteer presence in terms of Pet Therapy and organising information sessions in conjunction with Cariad Pet Therapy to encourage interest in order to recruit additional volunteer
- Further ways in which the Volunteer Service and our in-house hospital volunteers can support with CTM's 2030 plan in terms of reducing our carbon footprint

Veterans

The first meeting was held this month with representatives on an all wales basis to explore the systems in use and to look at how we can record and track referrals to ensure that we are meeting the requirements of the Armed Forces Covenant.

Patient Experience Manager has linked in with RCT Armed Forces Liaison Officer, as they are currently offering training to staff across different sectors to highlight the mechanisms of the covenant and how these translate within the NHS. Discussions are ongoing as to how we can promote this with staff with the support of the communications team.

Bereavement

The Health Board has appointed a new Bereavement Clinical Lead to drive the new All Wales Care of the Bereaved standards and pathways. She will be commencing her role in October 2022.

Scoping exercise continue within CTM Bereavement Steering Group regarding support/processes that are in place across for the bereaved across the Health Board. This will ensure parity and consistency across all sectors and staff have the necessary information to support this. A draft Care After Death Policy is being reviewed and updated at present to support this with the view that this information will contain all the necessary details for staff to support families when they lose a loved one.

The new Bereavement Lead will also maintain a presence on the All Wales National and Local Bereavement Steering Groups.

GIG CYMRU NHS WALES | Delivery Unit Uned Gyflawni

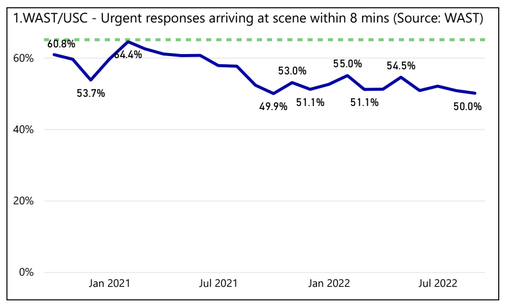
Wales

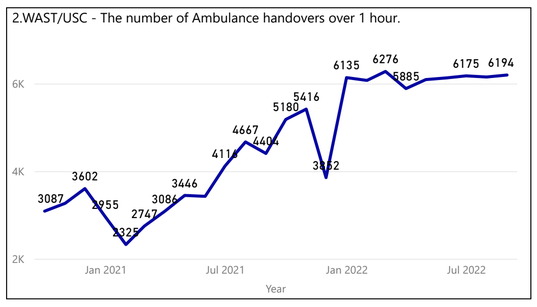
Summary UHB Level Monthly Performance Measures Dashboard (selected measures)

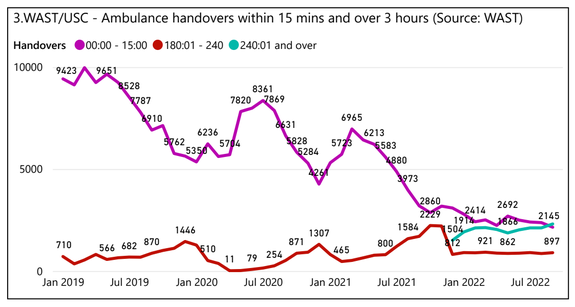
17/10/2022 19:28:55
Last Refreshed

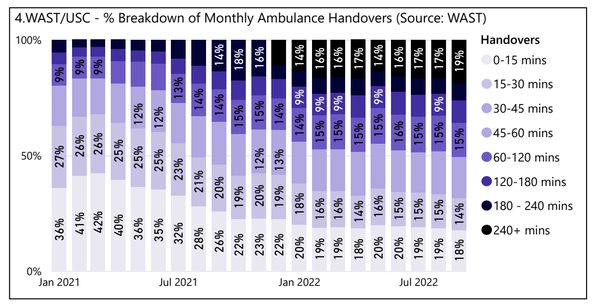
WAST

Site Level Data









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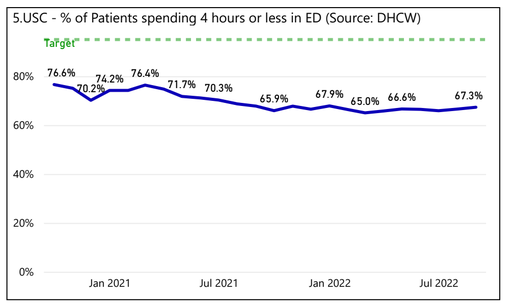
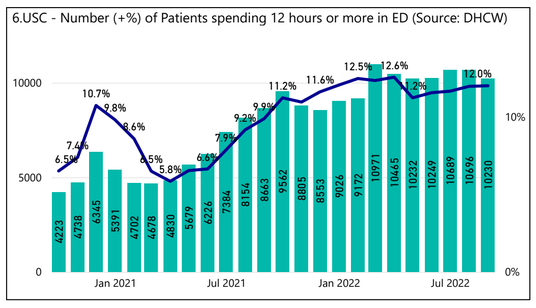
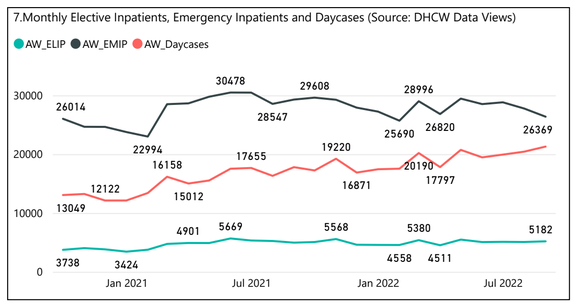
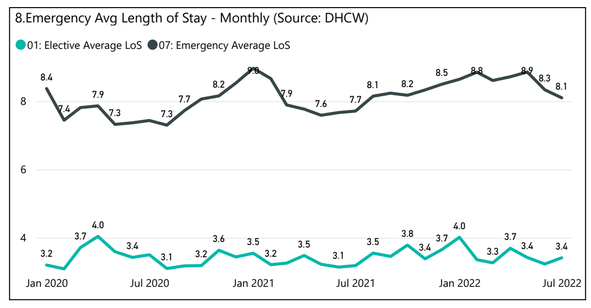
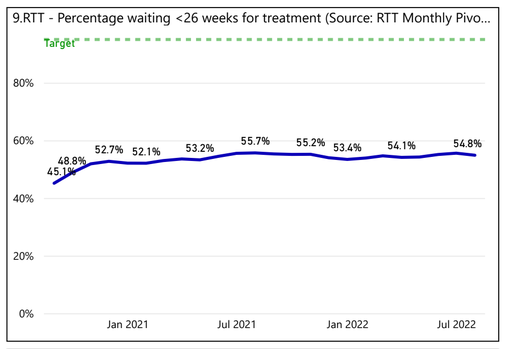


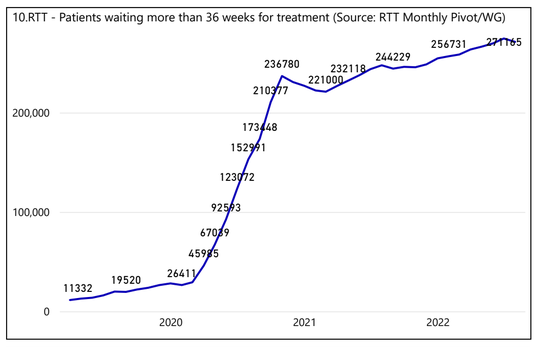


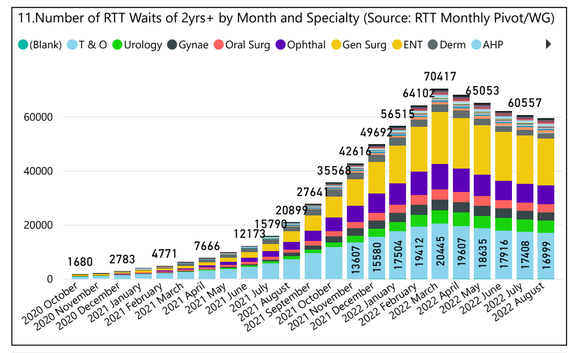


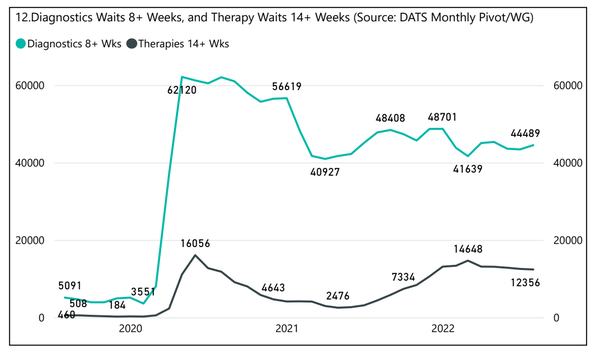


Planned Care

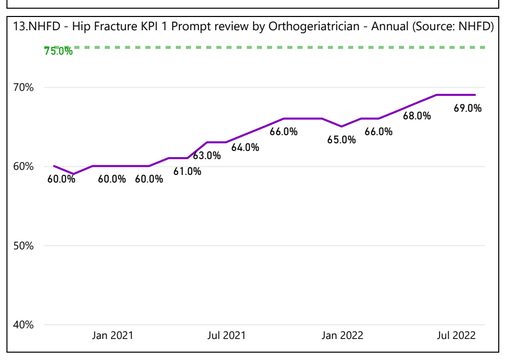


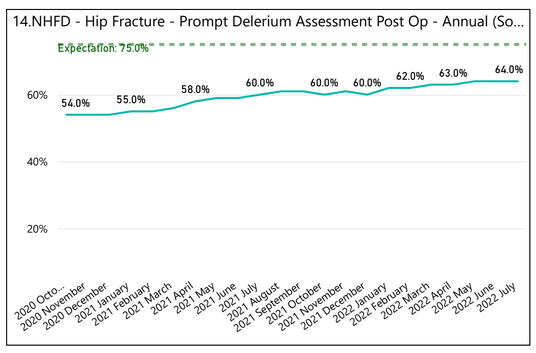


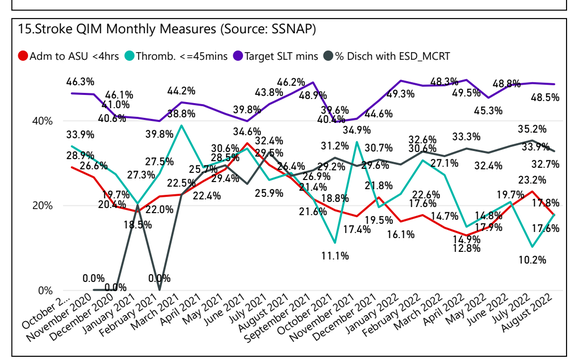




Major Conditions

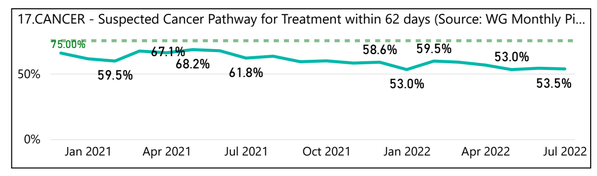




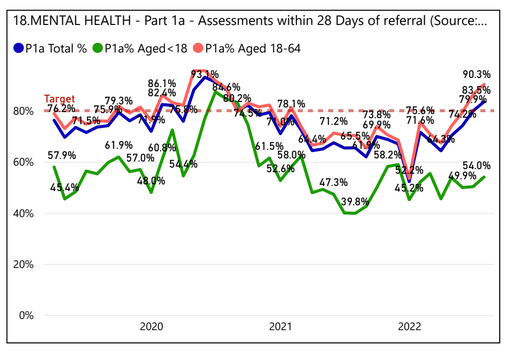


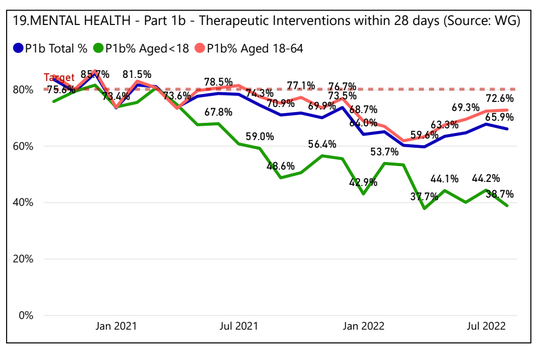
16. Total No. of Patients with a target date but no booked appointment

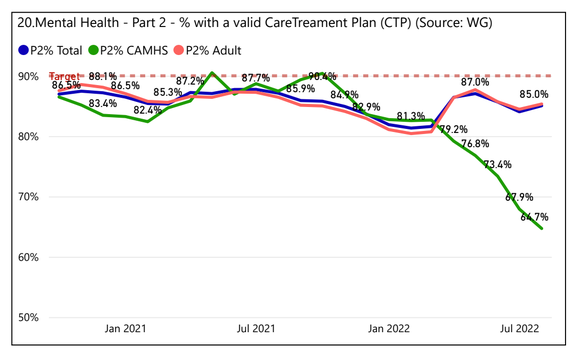
Date	Dermatology	ENT	Ophthalmology	Trauma & Orthopaedic	Urology
30 April 2022	12354	17066	57555	31984	18823
31 May 2022	12014	17079	57509	30694	18985
30 June 2022	12435	17371	60056	31278	18985
31 July 2022	12874	17662	61370	32660	19351
31 August 2022	13020	18102	61821	33035	19621

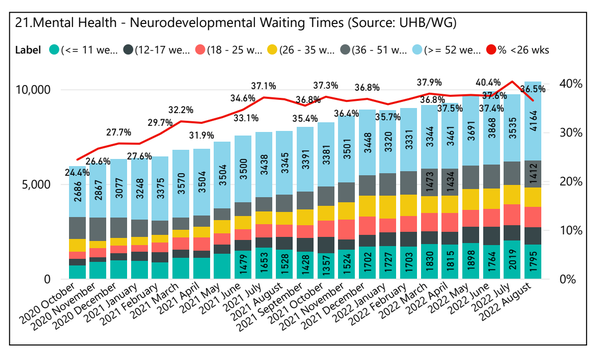


Mental Health

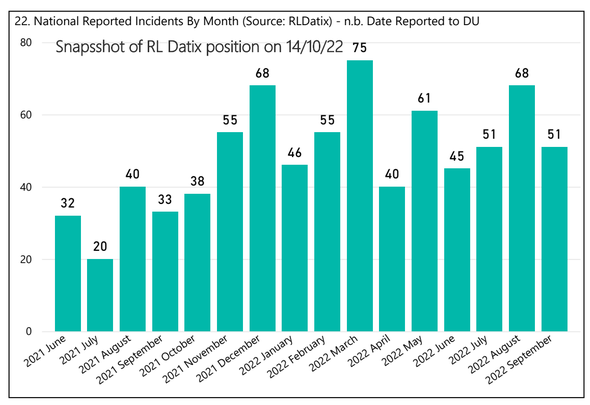


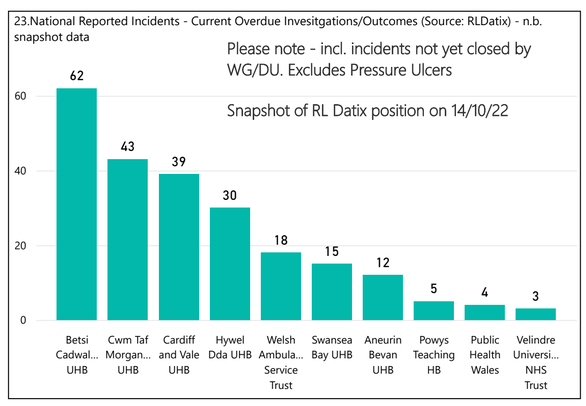






Patient Safety

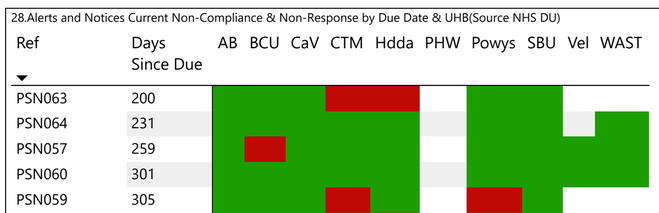


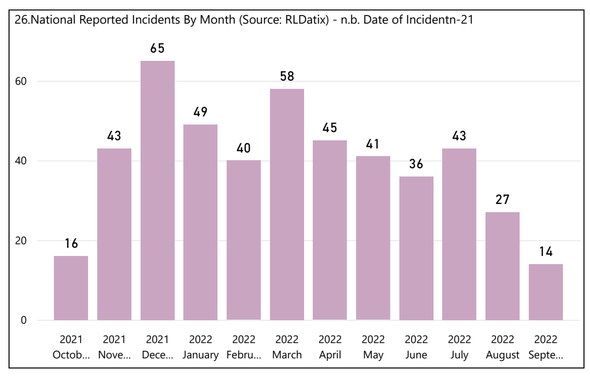


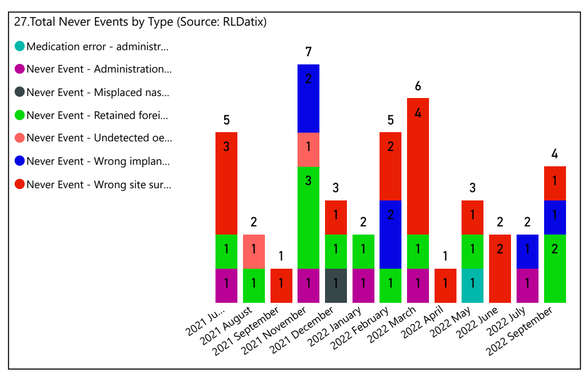
24.Alerts and Notices Current Non-Compliance & Non-Response (Source NHS DU)

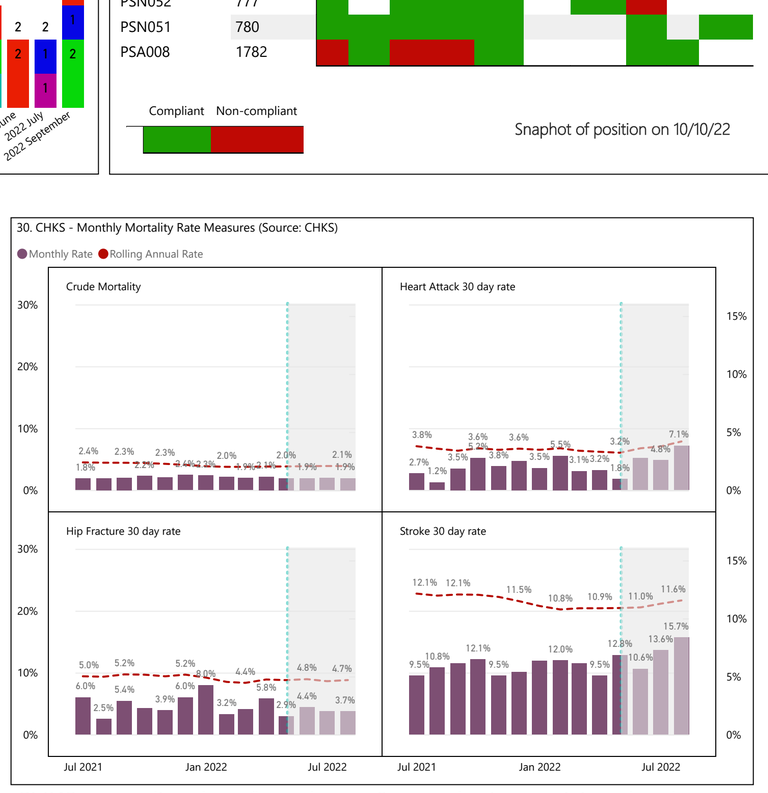
Status	AB	BCU	CaV	CTM	Hdda	Powys	SBU	Vel	**Total**
Non-compliant	2	1	2	3	2	2	1	1	**14**
Total	**2**	**1**	**2**	**3**	**2**	**2**	**1**	**1**	**14**

Snaphot of position on 10/10/22

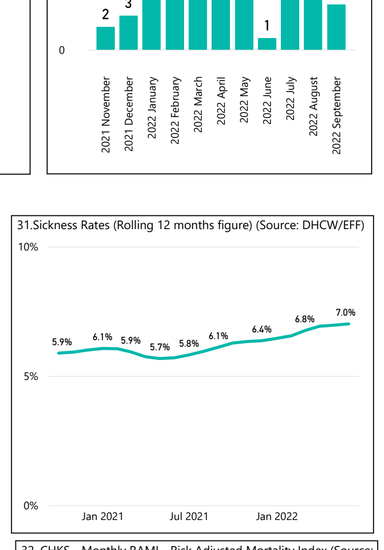


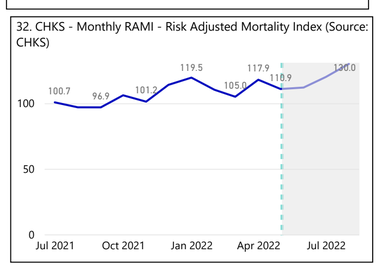






CHKS mortality data from latest 3 months is provisional only





GIG CYMRU NHS WALES | Delivery Unit Uned Gyflawni

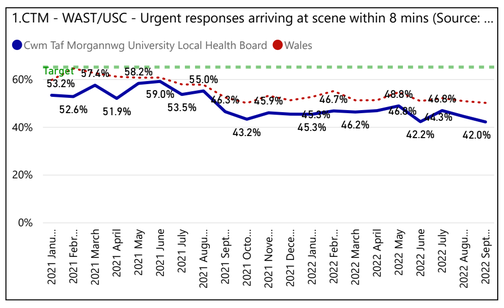
Cwm Taf Morgannwg UHB Summary UHB Level Monthly Performance Measures Dashboard (selected measures)

17/10/2022 19:28:55
Last Refreshed

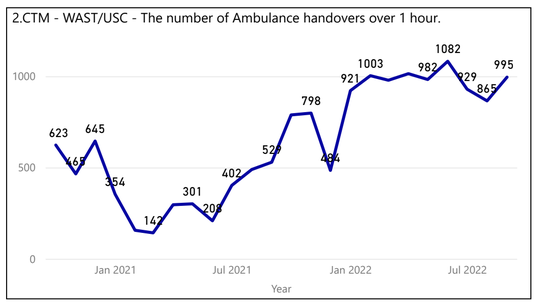
WAST

Site Level Data

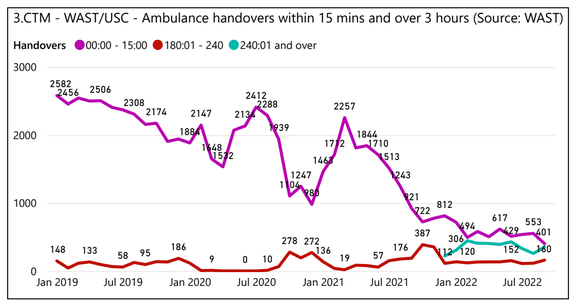
1.CTM - WAST/USC - Urgent responses arriving at scene within 8 mins (Source: ...



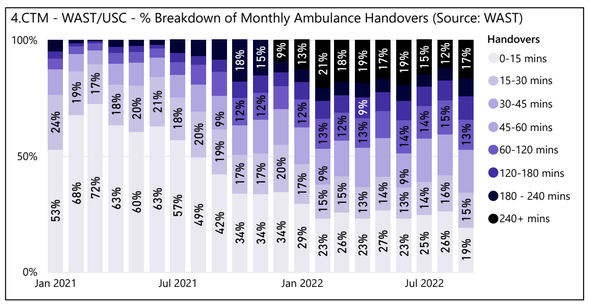
2.CTM - WAST/USC - The number of Ambulance handovers over 1 hour.



3.CTM - WAST/USC - Ambulance handovers within 15 mins and over 3 hours (Source: WAST)



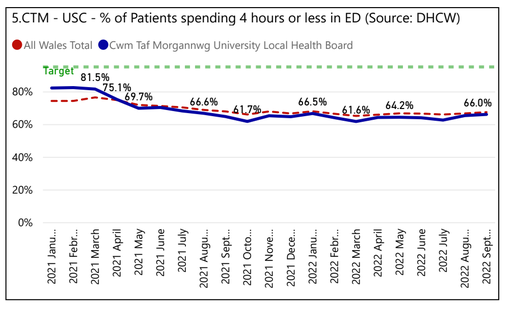
4.CTM - WAST/USC - % Breakdown of Monthly Ambulance Handovers (Source: WAST)



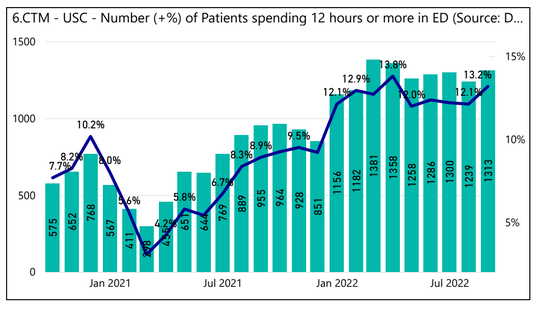
USC

Site Level Data

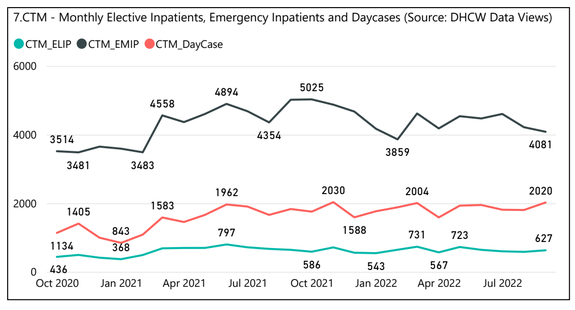
5.CTM - USC - % of Patients spending 4 hours or less in ED (Source: DHCW)



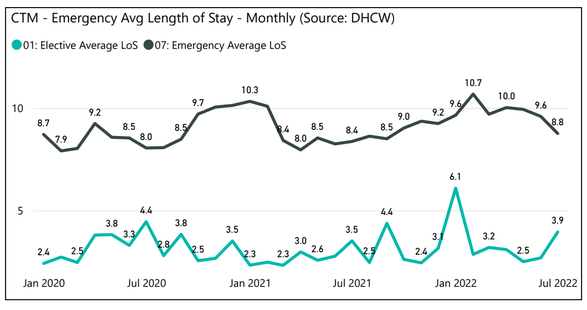
6.CTM - USC - Number (+%) of Patients spending 12 hours or more in ED (Source: D...



7.CTM - Monthly Elective Inpatients, Emergency Inpatients and Daycases (Source: DHCW Data Views)

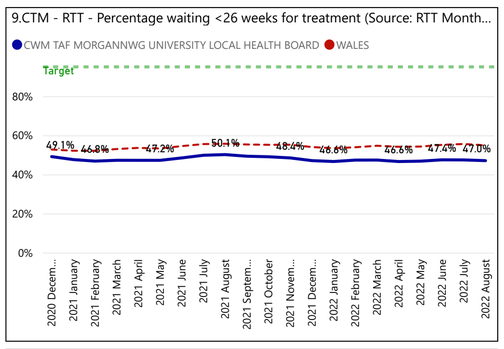


CTM - Emergency Avg Length of Stay - Monthly (Source: DHCW)

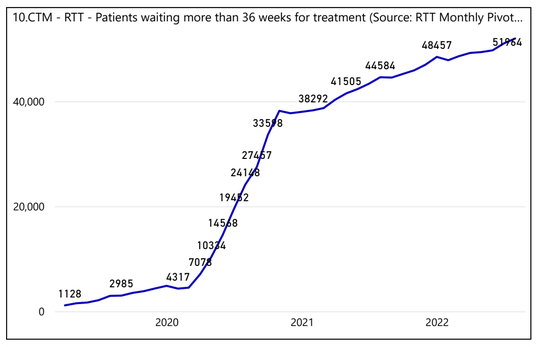


Planned Care

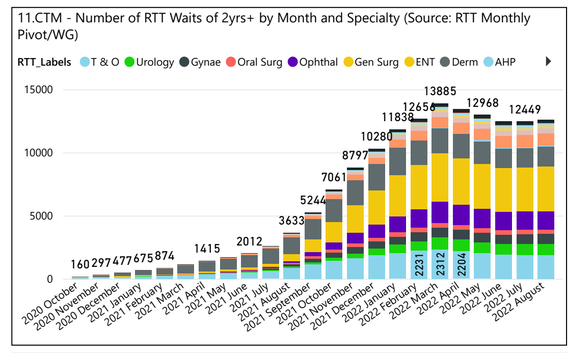
9.CTM - RTT - Percentage waiting <26 weeks for treatment (Source: RTT Month...



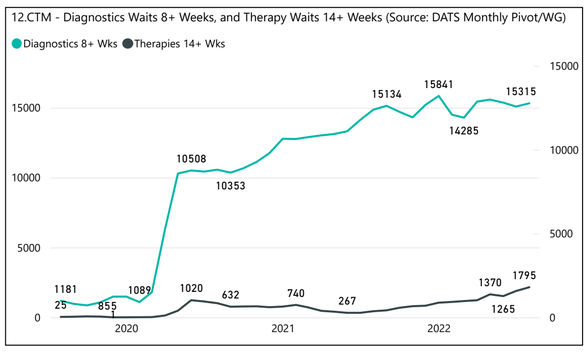
10.CTM - RTT - Patients waiting more than 36 weeks for treatment (Source: RTT Monthly Pivot...



11.CTM - Number of RTT Waits of 2yrs+ by Month and Specialty (Source: RTT Monthly Pivot/WG)

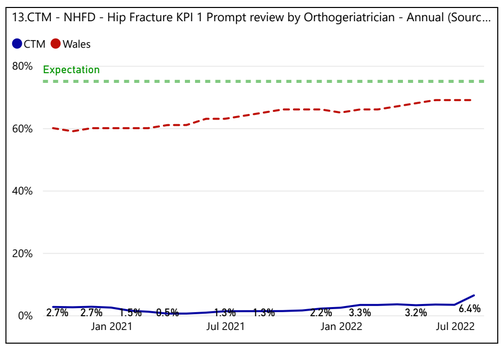


12.CTM - Diagnostics Waits 8+ Weeks, and Therapy Waits 14+ Weeks (Source: DATS Monthly Pivot/WG)

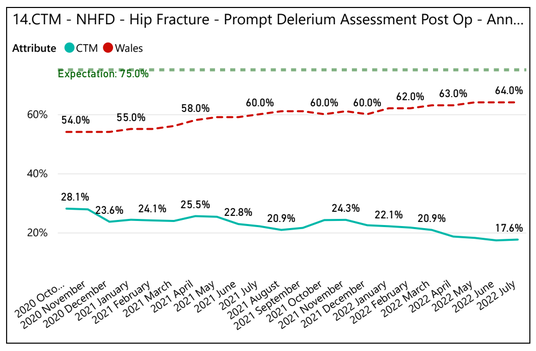


Major Conditions

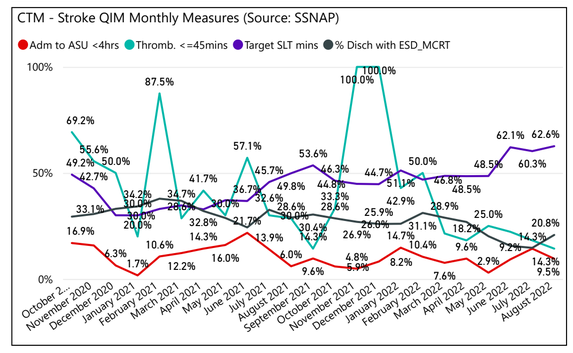
13.CTM - NHFD - Hip Fracture KPI 1 Prompt review by Orthogeriatrician - Annual (Sourc...



14.CTM - NHFD - Hip Fracture - Prompt Delerium Assessment Post Op - Ann...



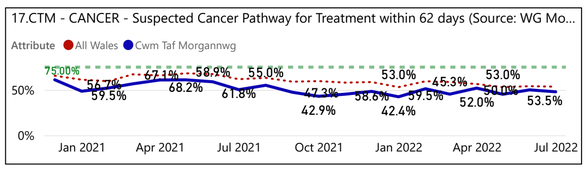
CTM - Stroke QIM Monthly Measures (Source: SSNAP)



16. CTM - Total No. of Patients with a target date but no booked appointment

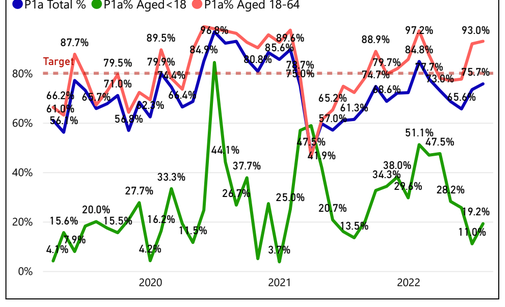
Date	Dermatology	ENT	Ophthalmology	Trauma & Orthopaedic	Urology
30 April 2022	1336	2246	10743	7715	1593
31 May 2022	1225	2144	10665	7413	1571
30 June 2022	1241	2390	10772	7372	1649
31 July 2022	1282	2454	10941	7544	1669
31 August 2022	1272	2583	10852	7485	1765

17.CTM - CANCER - Suspected Cancer Pathway for Treatment within 62 days (Source: WG Mo...

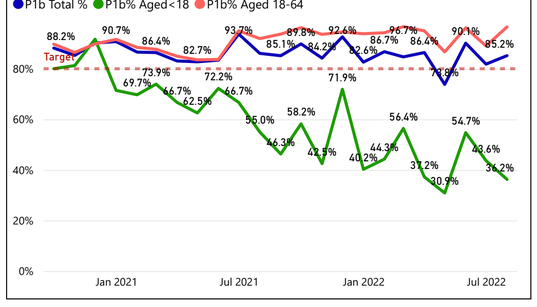


Mental Health

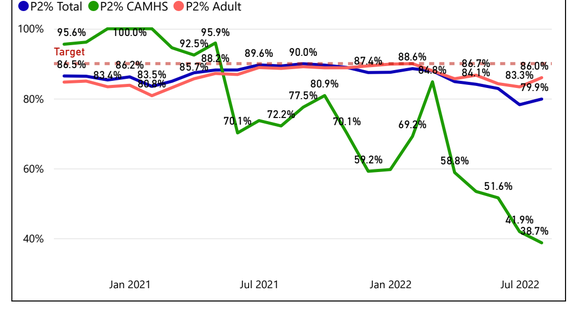
18.CTM - MENTAL HEALTH - Part 1a - Assessments within 28 Days of referral (S...



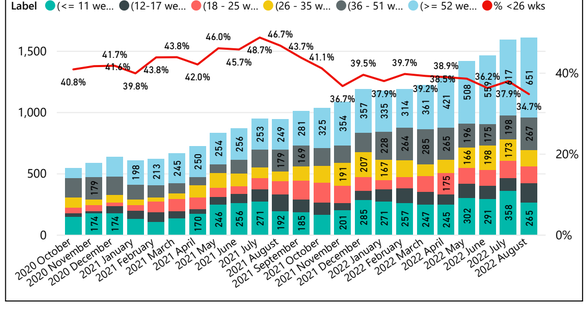
19.CTM - MENTAL HEALTH - Part 1b - Therapeutic Interventions within 28 days (Sour...



20.CTM - Mental Health - Part 2 - % with a valid CareTreament Plan (CTP) (Source: WG)

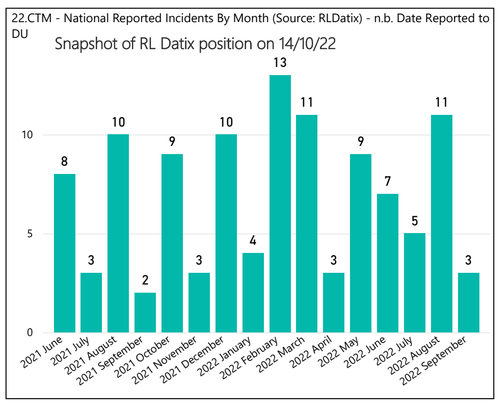


CTM - Mental Health - Neurodevelopmental Waiting Times (Source: UHB/WG)

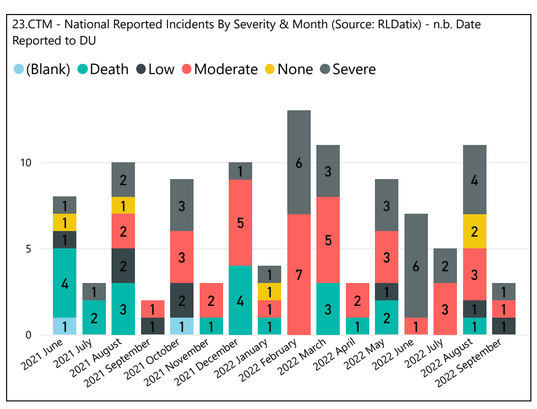


Patient Safety

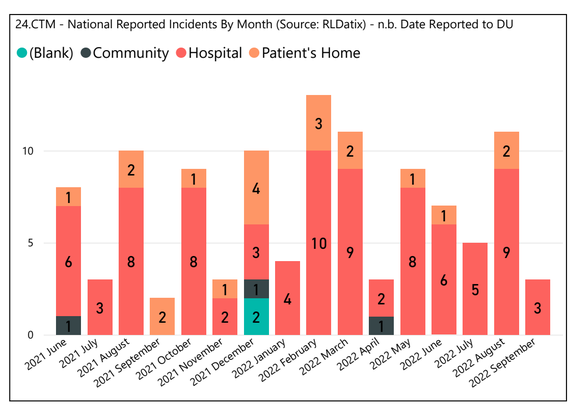
22.CTM - National Reported Incidents By Month (Source: RLDatix) - n.b. Date Reported to DU



23.CTM - National Reported Incidents By Severity & Month (Source: RLDatix) - n.b. Date Reported to DU



24.CTM - National Reported Incidents By Month (Source: RLDatix) - n.b. Date Reported to DU

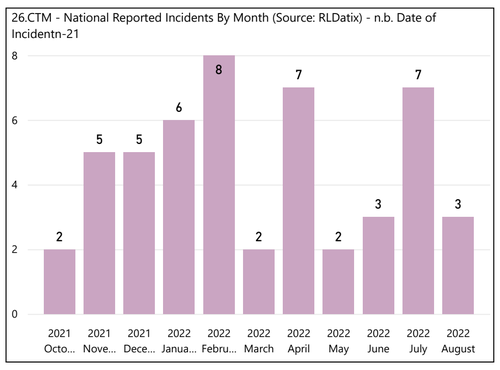


25.Alerts and Notices Current Non-Compliance & Non-Response by Due Date (Source NHS DU)

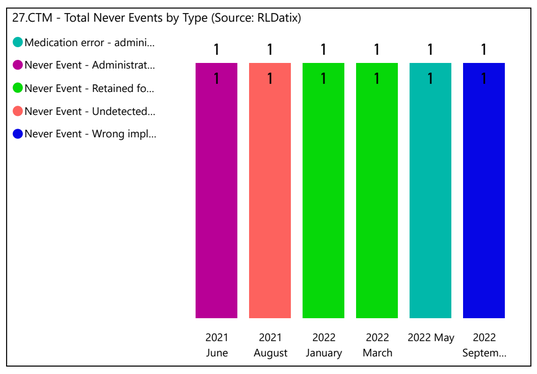
Status	Date Due	Ref	Title
Non-compliant	31 March 2022	PSN063	Deployment of NRFit (ISO 80369-6) compliant devices in Wales (2021)
Non-compliant	16 December 2021	PSN059	Eliminating the risk of inadvertent connection to medical air via a flowmeter
Non-compliant	30 November 2017	PSA008	Nasogastric tube misplacement: continuing risk of death and severe harm

Snapshot of position on 10/10/22

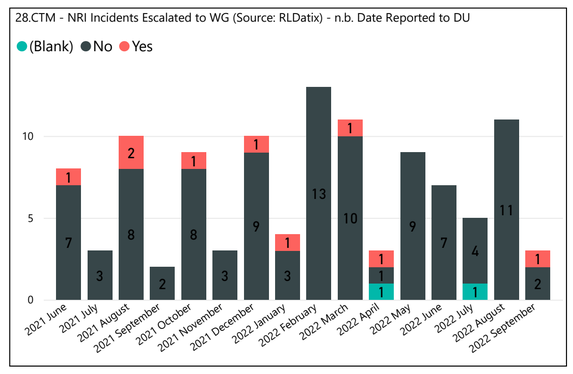
26.CTM - National Reported Incidents By Month (Source: RLDatix) - n.b. Date of Incidentn-21



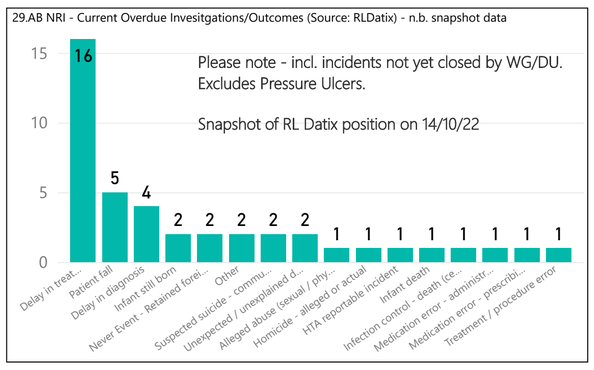
27.CTM - Total Never Events by Type (Source: RLDatix)



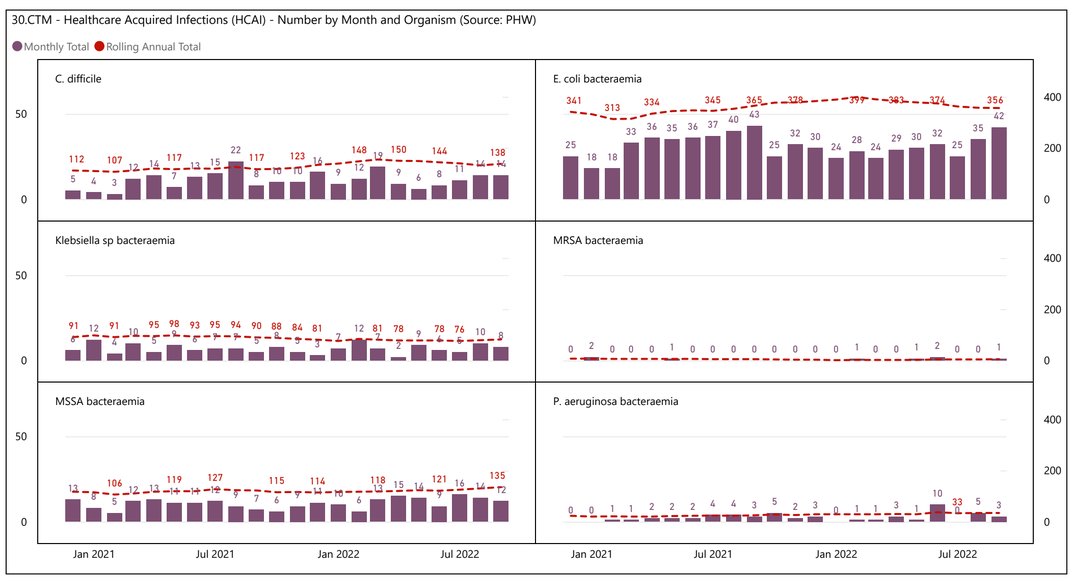
28.CTM - NRI Incidents Escalated to WG (Source: RLDatix) - n.b. Date Reported to DU



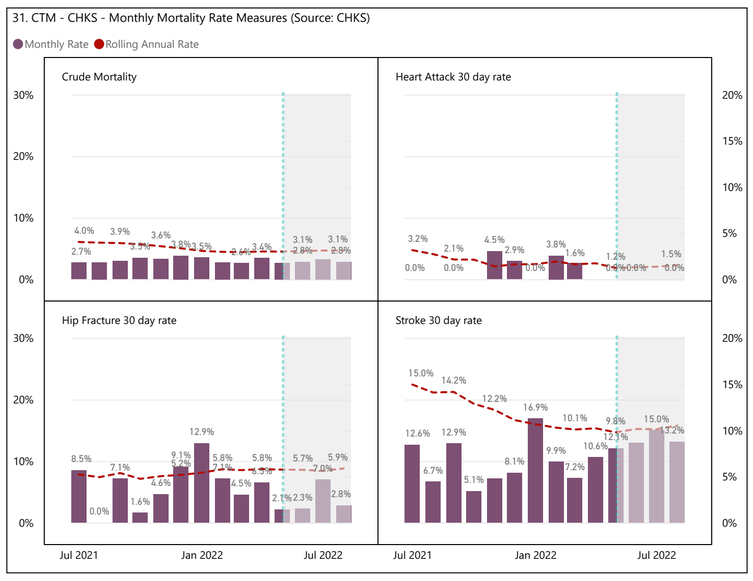
29.AB NRI - Current Overdue Invesitgations/Outcomes (Source: RLDatix) - n.b. snapshot data



30.CTM - Healthcare Acquired Infections (HCAI) - Number by Month and Organism (Source: PHW)

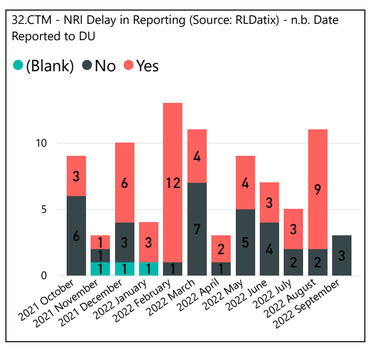


31. CTM - CHKS - Monthly Mortality Rate Measures (Source: CHKS)

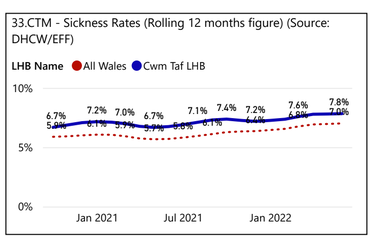


CHKS mortality data from latest 3 months is provisional only

32.CTM - NRI Delay in Reporting (Source: RLDatix) - n.b. Date Reported to DU



33.CTM - Sickness Rates (Rolling 12 months figure) (Source: DHCW/EFF)



Compliance against Patient Safety Solutions Wales - Alerts - Issued after April 2014

10/10/2022

	Alerts as at: 10/10/2022											
PSA No:	**Title of Safety Solution**	**Compliance Date**	**ABHB**	**BCUHB**	**C&VU**	**CTMUHB**	**HDHB**	**Powys**	**PHW**	**SBUHB**	**Velindre**	**WAST**
PSA001	Legionella and heated birthing pool filled in advance of labour in home settings.	**30/06/2014**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A
PSA002	The prompt recognition and initiation of treatment for sepsis for all patients.	**28/11/2014**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant
PSA003	Update to the NPSA alert for safer spinal (intrathecal), epidural and regional devices	**01/07/2016**	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	Compliant	N/A
PSA004	Ensuring the Safe Administration of Insulin	**28/10/2016**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A
PSA005	Minimising the risk of medication errors with high strength, fixed combination and biosimilar insulin products	**14/10/2016**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A
PSA006	Risk of death and severe harm from error with injectable phenytoin	**10/03/2017**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A
PSA007	Restricted use of open systems for injectable medication	**01/08/2017**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A
PSA008	Nasogastric tube misplacement: continuing risk of death and severe harm	**30/11/2017**	Non-compliant	Compliant	Non-compliant	Non-compliant	Compliant	N/A	N/A	Compliant	Compliant	N/A
PSA009	Wrong selection of orthopaedic fracture fixation plates	**15/05/2019**	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	N/A	N/A
PSA010	Interruption of high flow nasal oxygen during transfer	**10/04/2020**	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	N/A	N/A
PSA011	Blood control safety cannula & needle thoracostomy for tension pneumothorax	**15/04/2020**	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	N/A	N/A
PSA012	Deterioration due to rapid offload of pleural effusion fluid from chest drains	**01/07/2021**	Compliant	Compliant	Non-compliant	Compliant	Compliant	N/A	N/A	Compliant	Compliant	N/A
PSA013a	Ligature and ligature point risk assessment tools and policies	**07/07/2021**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	Compliant
PSA013b	Ligature and ligature point risk assessment tools and policies	**01/09/2021**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	Compliant
PSA014	Inappropriate anticoagulation of patients with a mechanical heart valve	**28/10/2021**	Compliant	Compliant	Compliant	Compliant	Non-compliant	Compliant	N/A	Compliant	N/A	N/A

Compliance against Patient Safety Solutions Wales - Notices - Issued after April 2014

10/10/2022

Notices as at: 10/10/2022												
PSN No:	**Title of Safety Solution**	**Compliance Date**	**ABHB**	**BCUHB**	**C&VU**	**CTMUHB**	**HDHB**	**Powys**	**PHW**	**SBUHB**	**Velindre**	**WAST**
PSN001	Risk of harm relating to interpretation and action on Protein Creatinine Ratio (PCR) results in pregnant women. NB not part of returns compliance.	**31/07/2014**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A
PSN002	The Surgical Management of Urinary Incontinence (UI) and Pelvic Organ Prolapse (POP)	**31/07/2014**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A
PSN003	Placement devices for nasogastric tube insertion DO NOT replace initial position checks	**30/01/2015**	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	N/A	N/A
PSN004	Risk of death and serious harm from delays in recognising and treating ingestion of button batteries	**19/01/2015**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant
PSN005	Risk of distress and death from inappropriate doses of naloxone in patients on long-term opioid/opiate treatment	**30/01/2015**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant
PSN006	Risk of hypothermia for patients on continuous renal replacement therapy	**30/04/2015**	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	N/A	N/A
PSN007	Risk of death or serious harm from accidental ingestion of potassium permanganate	**31/05/2015**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A
PSN008	Risk of death from asphyxiation by accidental ingestion of fluid/food thickening powder	**28/05/2015**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A
PSN009	Awareness of NICE clinical guidelines on head injuries	**31/05/2015**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant
PSN010	Failure to act on known contraindications to Low Molecular Weight Heparins	**25/06/2015**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A
PSN011	Risk of associating ECG records with wrong patients	**18/06/2015**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant
PSN012	Adrenal insufficiency (addison's disease) in adults - information for general practitioners	**12/06/2015**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A
PSN013	Managing risks during the transition period to new ISO connectors for medical devices used for enteral feeding and neuraxial procedures	**13/08/2015**	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	Compliant	N/A
PSN014	Residual anaesthetic drugs in cannulae and intravenous lines	**31/08/2015**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A
PSN015	The storage of medicines: Refrigerators	**31/08/2015**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A
PSN016	Risk of inadvertently cutting in-line (or closed) suction catheters	**31/08/2015**	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	N/A	N/A
PSN017	Risk of using vacuum and suction drains when not clinically indicated	**31/08/2015**	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	N/A	N/A
PSN018	Risk of severe harm and death from unintentional interruption of non-invasive ventilation	**31/08/2015**	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	N/A	N/A

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PSN019	Harm from delayed updates to ambulance dispatch and satellite navigation systems	**30/09/2015**	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	N/A	Compliant
PSN020	Minimising risks of omitted and delayed medicines for patients receiving homecare services	**27/11/2015**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A
PSN021	Risk of death and serious harm from falling from hoists	**15/02/2016**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A
PSN022	Risk of death from the inappropriate use and disposal of fentanyl patches	**31/01/2016**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A
PSN023	The importance of vital signs during and after restrictive interventions/manual restraint	**12/02/2016**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant
PSN024	Risk of using different airway humidification devices simultaneously	**01/03/2016**	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	N/A	N/A
PSN025	Risk of death or severe harm due to inadvertent injection of skin preparation solution	**04/04/2016**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A
PSN026	Positive patient identification	**13/05/2016**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A
PSN027	Risk of severe harm or death when desmopressin is omitted or delayed in patients with cranial diabetes insipidus	**08/04/2016**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A
PSN028	Medicine Reconciliation - Reducing the risk of serious harm	**31/03/2016**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A
PSN029	Standardising the early identification of acute kidney care	**08/04/2016**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A
PSN030	**THIS HAS BEEN REPLACED BY PSN055** **The safe storage of medicines: Cupboards**											
PSN031	Risk of Patient Safety Incidents resulting from errors in the British National Formulary for Children 2015-16 and British National Formulary 70	**31/05/2016**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A
PSN032	Risk of Patient harm from an interaction between miconazole and coumarin anticoagulants	**10/06/2016**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A
PSN033	Risk of death and serious harm from failure to recognise acute coronary syndromes in Kawasaki disease patients	**29/07/2016**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A
PSN034	Supporting the introduction of the National Safety Standards for Invasive Procedures	**28/09/2017**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A
PSN036	Reducing the risk of oxygen tubing being connected to airflow meters	**04/08/2017**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A
PSN037	Resources to support the safety of girls and women who are being treated with Valproate	**06/10/2017**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A
PSN035	Risk of death and severe harm from ingestion of superabsorbent polymer gel granules	**16/10/2017**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A
PSN038	Risk of severe harm and death from infusing Total Parenteral Nutrition too rapidly in babies	**08/12/2017**	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	N/A	N/A
PSN039	Safe Transfusion Practice - Use a bedside checklist	**15/02/2018**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A

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PSN040	Confirming removal or flushing of lines and cannulae after procedures	**12/09/2018**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A
PSN041	Risk of death and severe harm from failure to obtain and continue flow from oxygen cylinders harm	**23/04/2018**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant
PSN042	Risk of death or severe harm from inadvertent intravenous administration of solid organ perfusion fluids	**11/06/2018**	N/A	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	N/A	N/A
PSN043	**THIS HAS BEEN REPLACED BY PSN049 Supporting the introduction of the Tracheostomy Guidelines for Wales**											
PSN044	Resources to support safer care for full-term babies	**21/10/2018**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A
PSN045	Resources to support safer modification of food and fluid	**01/04/2019**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A
PSN046	Resources to support safer bowel care for patients at risk of autonomic dysreflexia	**29/03/2019**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A
PSN047	Management of life threatening bleeds from arteriovenous fistulae and grafts	**26/05/2019**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant
PSN048	Risk of harm from inappropriate placement of pulse oximeter probes	**29/03/2019**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant
PSN049	**THIS NOTICE REPLACES PSN043 Supporting the introduction of the Tracheostomy Guidelines for Wales - Adults & Children**	**01/07/2019**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant
PSN050	Assessment and management of babies who are accidentally dropped in hospital	**08/12/2019**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	Compliant
PSN051	Depleted batteries in intraosseous injectors	**28/08/2020**	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	N/A	Compliant
PSN052	Risk of death and severe harm from ingestion of superabsorbent polymer gel granules	**31/08/2020**	Compliant	N/A	Compliant	Compliant	Compliant	Compliant	N/A	Non-compliant	N/A	N/A
PSN053	Risk of harm to babies and children from coin/button batteries in hearing aids and other hearing devices	**05/11/2020**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A
PSN054	Risk of death from unintended administration of sodium nitrite	**12/11/2020**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A
PSN055	THIS NOTICE REPLACES PSN030 Safe Storage of Medicines: Cupboards	**30/09/2021**	Non-compliant	Compliant	Compliant	Compliant	Compliant	Non-compliant	Compliant	Compliant	Non-compliant	Compliant
PSN056	Foreign Body Aspiration during intubation, advanced airway management or ventilation	**01/07/2021**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant
PSN057	Emergency Steroid Therapy Cards: Supporting Early Recognition & Management of Adrenal Crisis in Adults and Children	**31/01/2022**	Compliant	Non-compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant
PSN058	Urgent assessment/treatment following ingestion of 'super strong' magnets	**13/10/2021**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	Compliant

PSN No:	Title of Safety Solution	Compliance Date	ABHB	BCUHB	C&VU	CTMUHB	HDHB	Powys	PHW	SBUHB	Velindre	WAST
PSN059	Eliminating the risk of inadvertent connection to medical air via a flowmeter	**16/12/2021**	Compliant	Compliant	Compliant	Non-compliant	Compliant	Non-compliant	N/A	Compliant	N/A	N/A
PSN060	Reducing the risk of inadvertent administration of oral medication by the wrong route	**20/12/2021**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant
PSN062	Elimination of bottles of liquefied phenol 80%	**25/02/2022**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A
PSN061	Reducing the risk of patient harm - standardised strength of phenobarbital oral liquid	**28/02/2022**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A
PSN064	Handlebar injuries in the paediatric abdomen	**28/02/2022**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	Compliant
PSN063	Deployment of NRFit (ISO 80369-6) compliant devices in Wales (2021)	**31/03/2022**	Compliant	Compliant	Compliant	Non-compliant	Non-compliant	Compliant	N/A	Compliant	N/A	N/A

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Monthly UHB Summary Dashboards - Further Details of Data Used (All Wales Dashboard)

Section	Chart Number	Title	Data Source	Further Details
WAST	1	1.WAST/USC - Urgent responses arriving at scene within 8 mins (Source: WAST)	WAST	Number of calls responded within 8 mins as % of total attendances Discrete monthly percentage figure Target 65% All Wales Figures also plotted on UHB charts
WAST	2	2.WAST/USC - The number of Ambulance handovers over 1 hour.	WAST	Number of ambulance handovers with a recorded delay of =>60 mins Discrete monthly absolute volume figure
WAST	3	3.WAST/USC - Ambulance handovers within 15 mins and over 3 hours (Source: WAST)	WAST	Number of ambulance handovers with a recorded delay of <15 mins and those =>180 mins. Data plotted on dual y axis line chart. Discrete monthly absolute volume figure
WAST	4	4.WAST/USC - % Breakdown of Monthly Ambulance Handovers (Source: WAST)	WAST	A breakdown of the monthly percentage distribution of ambulance handover delays broken down into specific time categories: 0-15 mins 15-30 mins 30-45 mins 45-60 mins 60-120 mins 120-180 mins 180 mins+ Data plotted as 100% stacked monthly column chart.
USC	5	5.USC - % of Patients spending 4 hours or less in ED (Source: DHCW)	DHCW	Number of patients spending 4 hours or less in ED as % of total ED attendances. Discrete monthly percentage figure Target 95%. All Wales Figures also plotted on UHB charts.
USC	6	6.USC - Number of Patients spending 12 hours or more in ED (Source: DHCW)	DHCW	Number of patients spending 12 hours or more in ED. Discrete monthly absolute volume figure.
USC	7	7.Monthly Elective Inpatients, Emergency Inpatients and Daycases (Source: DHCW Data Views)	DHCW	Number of elective inpatients, emergency inpatients and daycases. Discrete monthly absolute volume figure. Source DHCW data views (dw) - SQL script available upon request (email james.walford@Wales.nhs.uk).
USC	8	8.Emergency Avg Length of Stay - Monthly (Source: DHCW)	DHCW	Elective admission Average Length of Stay and Emergency admission Average Length of Stay (days). Discrete monthly figure. Source DHCW data views (dw) - SQL script available upon request (email james.walford@Wales.nhs.uk). Numerator / Denominator Numerator – sum of the duration of inpatient spells Denominator – number of inpatient spells
Planned Care	9	9.RTT - Percentage waiting <26 weeks for treatment (Source: RTT Monthly Pivot/WG)	WG	RTT Referral to Treatment waiting list figures - provided in monthly pivot. Source: WG monthly pivot. Numbers waiting <26 weeks for treatment as a percentage of total waiting patients. Discrete monthly figure. Target 95%. All Wales Figures also plotted on UHB charts.
Planned Care	10	10.RTT - Patients waiting more than 36 weeks for treatment (Source: RTT Monthly Pivot/WG)	WG	RTT Referral to Treatment waiting list figures - provided in monthly pivot. Source: WG monthly pivot. Numbers waiting >36 week. Discrete monthly absolute figure.
Planned Care	11	11.Number of RTT Waits of 2yrs+ by Month and Specialty (Source: RTT Monthly Pivot/WG)	WG	RTT Referral to Treatment waiting list figures - provided in monthly pivot. Source: WG monthly pivot. Numbers waiting >2 years broken down by specialty. Discrete monthly absolute figure.
Planned Care	12	12.Diagnostics Waits 8+ Weeks, and Therapy Waits 14+ Weeks (Source: DATS Monthly Pivot/WG)	WG	Diagnostics and Therapies waiting list figures - provided in monthly pivot. Source: WG monthly pivot. Diagnostics: Numbers waiting 8+ weeks total volume. Therapies: Numbers waiting 14+ weeks total volume. Discrete monthly absolute figure.
Major Conditions	13	13.NHFD - Hip Fracture KPI 1 Prompt review by Orthogeriatrician - Annual (Source: NHFD)	NHFD	Source: National Hip Fracture Database (NHFD) - public domain website. Performance against KPI1 - Prompt review by orthogeriatrician. Monthly - Rolling Annual Figure. Target - 75%. All Wales Figures also plotted on UHB charts.
Major Conditions	14	14.NHFD - Hip Fracture 30 Day Mortality Rate - Annual (Source: NHFD)	NHFD	Source: National Hip Fracture Database (NHFD) - public domain website. Performance against mortality measures. Data subject to review. Monthly - Rolling Annual Figure. All Wales Figures also plotted on UHB charts.
Major Conditions	15	15.Stroke QIM Monthly Measures (Source: SSNAP)	SSNAP	Source: SSNAP (Setinel Stroke Nationa Audit Programme) national programme data. Four key elements only listed: Admission to Acute Stroke Unit ,=4 hours (%). Thrombolyisis - Door to Needle in 45 mins (% of eligible patients). Attaining target level of mins with SLT (Speech Language Therapy). The percentage discharged with ESD/Community Therapy Multi-Disciplinary Team. Discrete monthly absolute figure.
Planned Care	16	16.Numbers Follow Up appointments booked or not booked past target date (Source: WG)	DHCW	Numbers Follow Up appointments booked or not booked past target date for specific specialties. Data source: WG
Major Conditions	17	17.CANCER - Suspected Cancer Pathway for Treatment within 62 days (Source: WG Monthly Pivot)	WG	% of Patients Treated within 62 days - as per measure details. Source: Welsh Government monthly pivot of data. Discrete monthly percentage figure Target 75% All Wales Figures also plotted on UHB charts
Mental Health	18	18.MENTAL HEALTH - Part 1a - Assessments within 28 Days of referral (Source:WG)	WG	% of Patients receiving mental health assessments within 28 days of a referral - as per measure details. Source: Welsh Government monthly pivot of data. Discrete monthly percentage figure Target 80%

Mental Health	19	19.MENTAL HEALTH - Part 1b - Therapeutic Interventions within 28 days (Source: WG)	WG	% of Patients receiving therapeutic interventions within 28 days of having an assessment - as per measure details. Source: Welsh Government monthly pivot of data. Discrete monthly percentage figure. Target 80%
Mental Health	20	20.Mental Health - Part 2 - % with a valid CareTreament Plan (CTP) (Source: WG)	WG	% of Patients with a valid are Treatment Plan (CTP) Source: Welsh Government monthly pivot of data. Discrete monthly percentage figure Target 90%
Mental Health	21	21.Mental Health - Neurodevelopmental Waiting Times (Source: UHB/WG)	WG	Details of neurodevelopmental servces waiting times broken down into specific time categories: 0-11 weeks 12-17 weeks 18-25 weeks 26-35 weeks 36-51 weeks >52 weeks Data plotted as stacked discrete monthly volumes column chart - with % of those waitng 26 eeks or less overlayed as line series. Source: Welsh Government monthly pivot of data. Target 80%
Patient Safety	22	22.National Reported Incidents By Month (Source: RLDatix) - n.b. Date Reported to DU	RL DATIX	National Reported Incidents as recorded on RLDatix. Based on date the incidents has been reported ot the NHS Wales Delivery Unit (via RLDatix). Snapshot of dynamic dataset and subject to revision. Discrete monthly figure.
Patient Safety	23	23.National Reported Incidents - Current Overdue Investigations/Outcomes (Source: RLDatix) - n.b. snapshot data	RL DATIX	National Reported Incidents as recorded on RLDatix. Based on date the incidents has been reported ot the NHS Wales Delivery Unit (via RLDatix). Snapshot of dynamic dataset and subject to revision. Discrete monthly figure. Records overdue - investigations not yet concluded by UHB beyond the recorded timescales.
Patient Safety	24	24.Alerts and Notices Current Non-Compliance & Non-Response (Source NHS DU)	NHSDU/UHB	Breakdown of current snaphot of compliance with Patient Safety Alerts (PSA) and Patient Safety Notices (PSN). Table displays a numerical summary of the number where PSN and PSA where UHB have recorded 'Not compliant', or where there has been 'No Response'.
Patient Safety	25	25.National Reported Incidents by Month (Source: RLDatix)	RL DATIX	National Reported Incidents as recorded on RLDatix. Based on date the incidents has been reported on the NHS Wales Delivery Unit (via RLDatix). Snapshot of dynamic dataset and subject to revision. **Suicide and Unexpected Incident Types ONLY.** Discrete monthly figure.
Patient Safety	26	26.National Reported Incidents By Month (Source: RLDatix) - n.b. Date of Incidents	RL DATIX	National Reported Incidents as recorded on RLDatix. **Based on date the incident occurred.** Snapshot of dynamic dataset and subject to revision. Discrete monthly figure.
Patient Safety	27	27.Total Never Events by Type (Source: RLDatix)	RL DATIX	Recorded National Reprted Incidents which resulted in a Never Event - by type. Snapshot of dynamic dataset and subject to revision. Discrete monthly figure. Based on Date Reported to NHSDU via RLDATIX
Patient Safety	28	28.Alerts and Notices Current Non-Compliance & Non-Response by Due Date & UHB(Source NHS DU)	NHSDU/UHB	Breakdown of current snaphot of compliance with Patient Safety Alerts (PSA) and Patient Safety Notices (PSN). Breakdown by individual PSN and PSA. Table displays those PSN and PSA where UHB have recorded 'Not compliant', or where there has been 'No Response'.
Patient Safety	29	29.Healthcare Associated Infections (HCAI) - Number by Month and Organism (Source: PHW)	PHW	Number of HCAI (Health and Care Associated Infections) currently recorded by PHW - by organism. Discrete monthly figure overlayed with roling annual total for comparison (annual figure in red).
Patient Safety	30	30.CHKS - Monthly Mortality Rate Measures (Source: CHKS)	CHKS	Data taken from CHKS extract. Discrete monthly figure. Monthly mortality data for the four measured listed: Stroke, Hip Fracture, Heart Attack and a Crude overall Mortality rate. Snapshot of dynamic dataset and subject to revision. Latest three months (90 days) data to be treated as provisional only - subject to substantial revision pending lag in coding.
Patient Safety	31	31.Incidents Not Closed and Overdue - by UHB (incidents reported from 2020-21 and 21-22 up till Jun-21 only)	NHSDU/WG	Legacy records comprising Serious Incident records recorded in 2020-21 and 2021-22 (up until Jun-21). These represent Serious Incidents and were therefore recorded under a different framework to the National Reported Incidents recorded since Jun-21. Records overdue - investigations not yet concluded by UHB beyond the recorded timescales.
Patient Safety	32	32.Sickness Rates (Rolling 12 months figure) (Source: DHCW/EFF)	DHCW	Data taken from EFF/DHCW extract. Discrete monthly figure. Subject to lag of several months in data becoming available.

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Major Conditions	15	15.Stroke QIM Monthly Measures (Source: SSNAP)	SSNAP	Source: SSNAP (Setinel Stroke Nationa Audit Programme) national programme data. Four key elements only listed: Admission to Acute Stroke Unit ,=4 hours (%). Thrombolyisis - Door to Needle in 45 mins (% of eligible patients). Attaining target level of mins with SLT (Speech Language Therapy). The percentage discharged with ESD/Community Therapy Multi-Disciplinary Team. Discrete monthly absolute figure.
Planned Care	16	16.Numbers Follow Up appointments booked or not booked past target date (Source: WG)	DHCW	Numbers Follow Up appointments booked or not booked past target date for specific specialties. Data source: WG
Major Conditions	17	17.CANCER - Suspected Cancer Pathway for Treatment within 62 days (Source: WG Monthly Pivot)	WG	% of Patients Treated within 62 days - as per measure details. Source: Welsh Government monthly pivot of data. Discrete monthly percentage figure Target 75% All Wales Figures also plotted on UHB charts
Mental Health	18	18.MENTAL HEALTH - Part 1a - Assessments within 28 Days of referral (Source:WG)	WG	% of Patients receiving mental health assessments within 28 days of a referral - as per measure details. Source: Welsh Government monthly pivot of data. Discrete monthly percentage figure Target 80%
Mental Health	19	19.MENTAL HEALTH - Part 1b - Therapeutic Interventions within 28 days (Source: WG)	WG	% of Patients receiving therapeutic interventions within 28 days of having an assessment - as per measure details. Source: Welsh Government monthly pivot of data. Discrete monthly percentage figure. Target 80%
Mental Health	20	20.Mental Health - Part 2 - % with a valid CareTreament Plan (CTP) (Source: WG)	WG	% of Patients with a valid are Treatment Plan (CTP) Source: Welsh Government monthly pivot of data. Discrete monthly percentage figure Target 90%

Mental Health	21	21.Mental Health - Neurodevelopmental Waiting Times (Source: UHB/WG)	WG	Details of neurodevelopmental servces waiting times broken down into specific time categories: 0-11 weeks 12-17 weeks 18-25 weeks 26-35 weeks 36-51 weeks >52 weeks Data plotted as stacked discrete monthly volumes column chart - with % of those waitng 26 eeks or less overlayed as line series. Source: Welsh Government monthly pivot of data. Target 80%
Patient Safety	22	22.National Reported Incidents By Month (Source: RLDatix) - n.b. Date Reported to DU	RL DATIX	National Reported Incidents as recorded on RLDatix. Based on date the incidents has been reported to the NHS Wales Delivery Unit (via RLDatix). Snapshot of dynamic dataset and subject to revision. Discrete monthly figure.
Patient Safety	23	23.National Reported Incidents By Severity & Month (Source: RLDatix) - n.b. Date Reported to DU	RL DATIX	National Reported Incidents as recorded on RLDatix. Based on date the incidents has been reported to the NHS Wales Delivery Unit (via RLDatix). Snapshot of dynamic dataset and subject to revision. **Breakdown by the recorded severity of the incident at the time of reporting.** Discrete monthly figure.
Patient Safety	24	24.National Reported Incidents By Month and Location (Source: RLDatix) - n.b. Date Reported to DU	NHSDU/UHB	National Reported Incidents as recorded on RLDatix. Based on date the incidents has been reported to the NHS Wales Delivery Unit (via RLDatix). Snapshot of dynamic dataset and subject to revision. **Breakdown by the recorded location of the incidents.** Discrete monthly figure.
Patient Safety	25	25.Alerts and Notices Current Non-Compliance & Non-Response (Source NHS DU)	NHSDU/UHB	Breakdown of current snaphot of compliance with Patient Safety Alerts (PSA) and Patient Safety Notices (PSN). Breakdown by individual PSN and PSA. Table displays those PSN and PSA where UHB have recorded 'Not compliant', or where there has been 'No Response'.
Patient Safety	26	26.National Reported Incidents By Month (Source: RLDatix) - n.b. Date of Incidents	RL DATIX	National Reported Incidents as recorded on RLDatix. **Based on date the incident occurred.** Snapshot of dynamic dataset and subject to revision. Discrete monthly figure.
Patient Safety	27	27.Total Never Events by Type (Source: RLDatix)	RL DATIX	Recorded National Reprted Incidents which resulted in a Never Event - by type. Snapshot of dynamic dataset and subject to revision. Discrete monthly figure. Based on Date Reported to NHSDU via RLDATIX
Patient Safety	28	28.National Reported Incidents Escalated to WG By Month (Source: RLDatix) - n.b. Date Reported to DU	NHSDU/UHB	National Reported Incidents as recorded on RLDatix. Based on date the incidents has been reported to the NHS Wales Delivery Unit (via RLDatix). Snapshot of dynamic dataset and subject to revision. **Breakdown of those Escalated to WG for consideration.** Discrete monthly figure.
Patient Safety	29	29.NRI - Current Overdue Invesitgations/Outcomes (Source: RLDatix) - n.b. snapshot data	RL DATIX	National Reported Incidents as recorded on RLDatix. Based on date the incidents has been reported to the NHS Wales Delivery Unit (via RLDatix). Snapshot of dynamic dataset and subject to revision. Discrete monthly figure. Records overdue - investigations not yet concluded by UHB beyond the recorded timescales.
Patient Safety	30	30.Incidents Not Closed and Overdue - by UHB (incidents reported from 2020-21 and 21-22 up till Jun-21 only)	NHSDU/WG	Legacy records comprising Serious Incident records recorded in 2020-21 and 2021-22 (up until Jun-21). These represent Serious Incidents and were therefore recorded under a different framework to the National Reported Incidents recorded since Jun-21. Records overdue - investigations not yet concluded by UHB beyond the recorded timescales.
Patient Safety	31	31.Healthcare Associated Infections (HCAI) - Number by Month and Organism (Source: PHW)	PHW	Number of HCAI (Health and Care Associated Infections) currently recorded by PHW - by organism. Discrete monthly figure overlayed with roling annual total for comparison (annual figure in red).
Patient Safety	32	32.CHKS - Monthly Mortality Rate Measures (Source: CHKS)	CHKS	Data taken from CHKS extract. Discrete monthly figure. Monthly mortality data for the four measured listed: Stroke, Hip Fracture, Heart Attack and a Crude overall Mortality rate. Snapshot of dynamic dataset and subject to revision. Latest three months (90 days) data to be treated as provisional only - subject to substantial revision pending lag in coding.
Patient Safety	33	33.NRI Delay in Reporting (Source: RLDatix) - n.b. Date Reported to DU	RL DATIX	National Reported Incidetns (NRI) for each discrete month broken down by recorded nature of any delay noted in reporting. For further clarification contact NHSDU Quality and Safety team.
Patient Safety	34	34.Sickness Rates (Rolling 12 months figure) (Source: DHCW/EFF)	DHCW	Data taken from EFF/DHCW extract. Discrete monthly figure. Subject to lag of several months in data becoming available.

AGENDA ITEM
6.3.1

QUALITY & SAFETY COMMITTEE

FIRST QUALITY AND SAFETY REPORT FROM MENTAL HEALTH CARE GROUP

Date of meeting	15/11/2022
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Ana Llewellyn, Nurse Director
Presented by	Ana Llewellyn, Nurse Director
Approving Executive Sponsor	Executive Director of Nursing
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
(Insert Name)	(DD/MM/YYYY)	Choose an item.

ACRONYMS USED IN PAPER AND APPENDIX	
AMaT	Audit Management and Tracking
AMHS	Adult Mental Health Services
CAMHS	Child and Adolescent Mental Health Services
COO	Chief Operating Officer
CTM	Cwm Taf Morgannwg
ESR	Electronic Staff Record
HIW	Health Inspectorate Wales
iCTM	Improvement Cwm Taf Morgannwg

LRI	Locally Reportable Incident
MH	Mental Health
MHLD	Mental Health and Learning Disabilities
MHM	Mental Health Measure
NRI	Nationally Reportable Incident
OAMHS	Older Adult Mental Health Services
PMVA	Prevention and Management of Violence and Aggression
PPF	Planning, Performance and Finance
QSRE	Quality, Safety, Risk and Experience
WARRN	Wales Applied Risk Research Network
WCCIS	Welsh Community Care Information System

1. SITUATION/BACKGROUND

1.1 This report provides committee members with the first Quality and Safety paper from the Mental Health and Learning Disabilities Care Group.

1.2 The focus of this report is solely on the provision of a high-level initial assessment of Adult Mental Health Services and Older Adult Mental Health Services that are delivered in CTM. Committee members already receive regular reports on pan-CTM and regional CAMH services, so for the purposes of this report CAMHS are excluded.

1.3 The Care Group is also responsible for the commissioning of Learning Disability services from SBUHB and for the commissioning of individual packages of care. These are also excluded from this initial assessment.

1.4 This report has some limitations in that it is an early overview of Mental Health Services set in the context of: well-known Datix challenges, quality governance teams not yet being aligned to Care Groups; and Care Group governance arrangements being in their early stages of development.

1.5 It is however informed by Deputy COO and Nurse Director visits to services, triangulated with soft intelligence and other data from internal and external stakeholders and sources.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

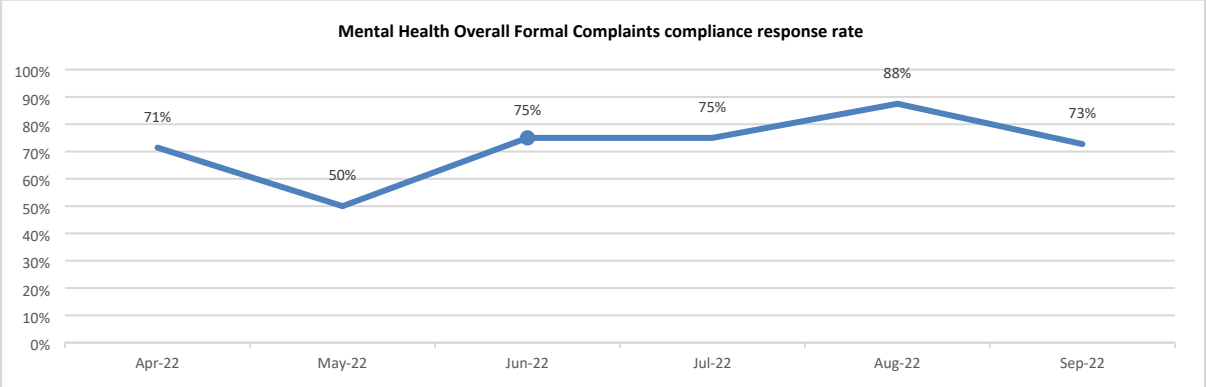
2.1 Update on Operating Model

2.2 The pan-CTM Care Group was formed at the beginning of September 2022 and is comprised of three locality based Mental Health Clinical Service Groups and the CAMH Service.

2.3 The Deputy COO and Nurse Director have responsibility for two care groups – Primary Care Community and Mental Health. The Mental Health quadrumvirate is made up of a Service Director, a Head of Nursing, a Medical Director and a Head of Psychology. The Medical Director and Head of Psychology have been recruited and are in post. The Service Director and Head of Nursing are in the process of being recruited to with interview dates pending for 29th November and 12th December respectively.

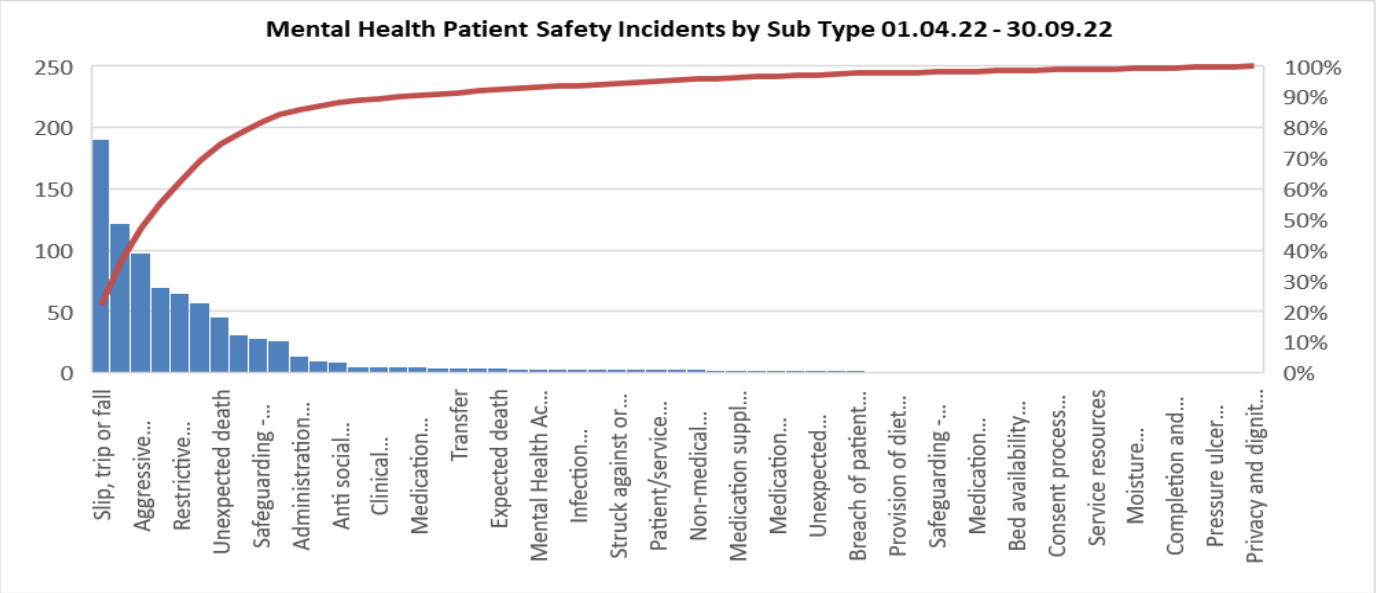
2.4 Quality Dashboard

2.5 Complaint closure compliance for the Care Group is as follows:

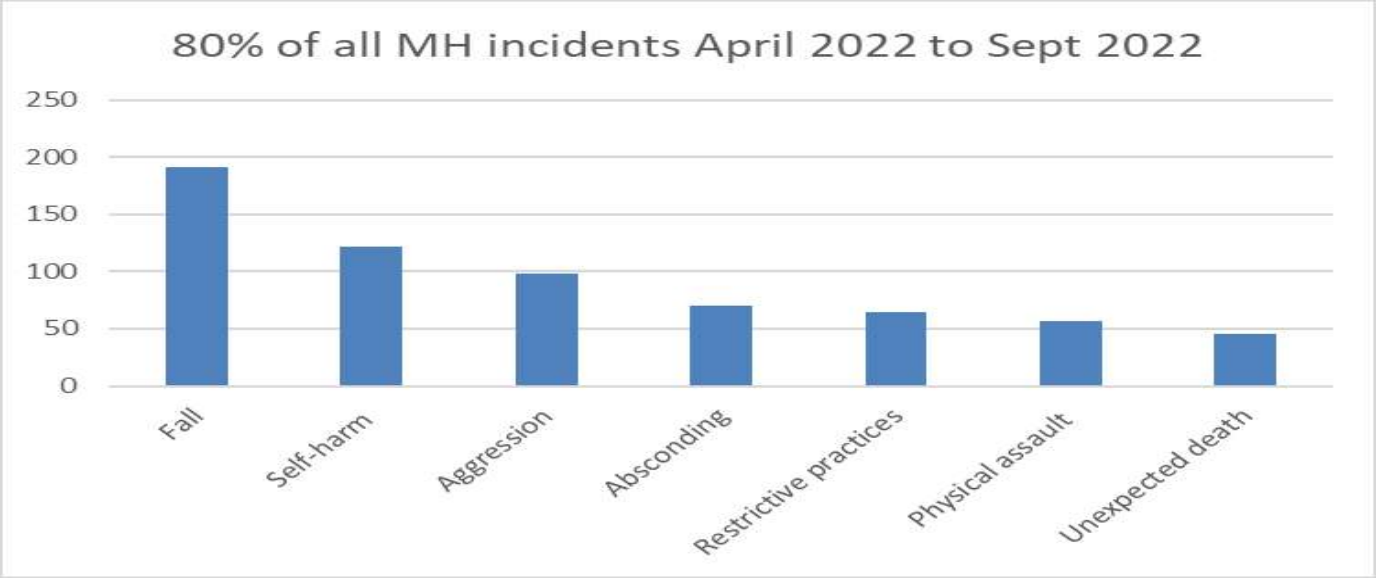


2.6 Due to the current limitations with Datix, it has not been possible for this report to provide an analysis of the key themes and trends that drive complaints in the Care Group. In September 2022 there were 3 MH cases open with the Public Services Ombudsman for Wales, this will be a key metric to monitor going forward as the Care Group aspiration will be to resolve complaints satisfactorily for people.

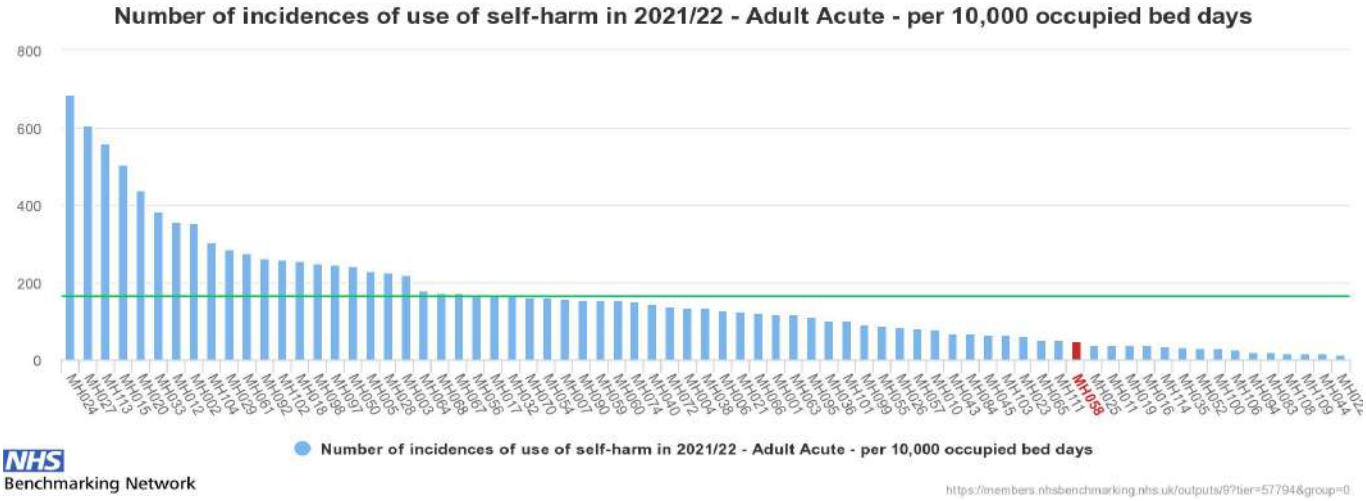
2.7 The following pareto chart is used to demonstrate that the top 7 reported patient safety incidents make up 80% of all MH patient safety incidents from April 2022 to September 2022.

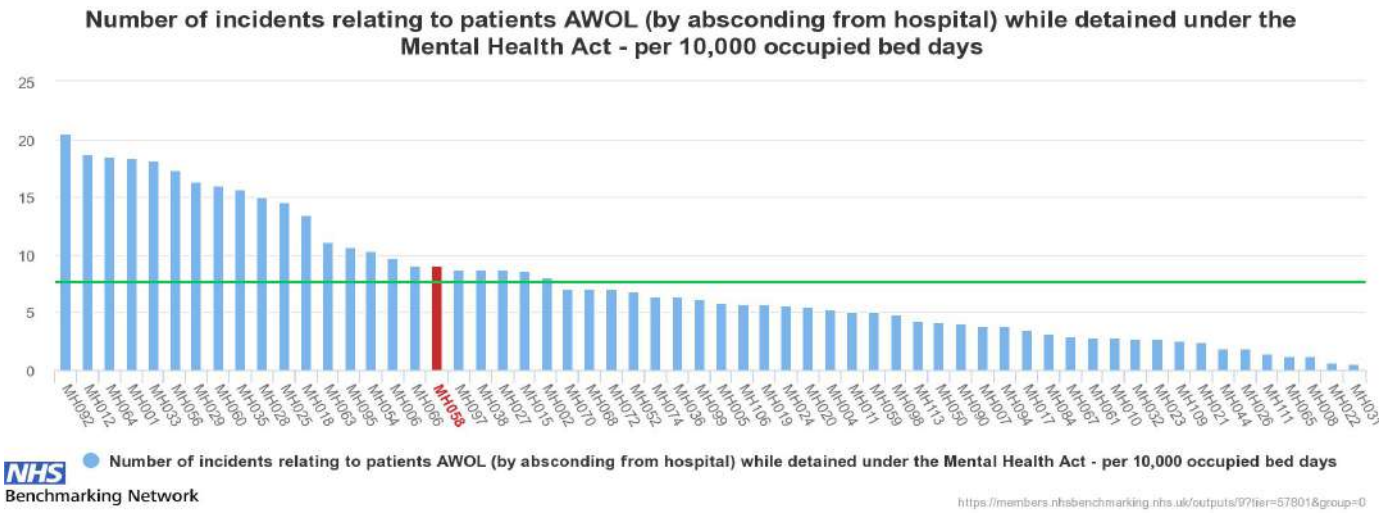


2.8 These top 7 incidents are detailed below. Committee members will note that only 2 of the incident themes (falls and absconding) are included in the CTM quality dashboard and that 1 of the incident themes (unexpected death) will always be subject to LRI / NRI review. That means that 4 remaining incident themes of concern have limited visibility outside of Mental Health Services so will need factoring into the MH & LD Care Group reporting.

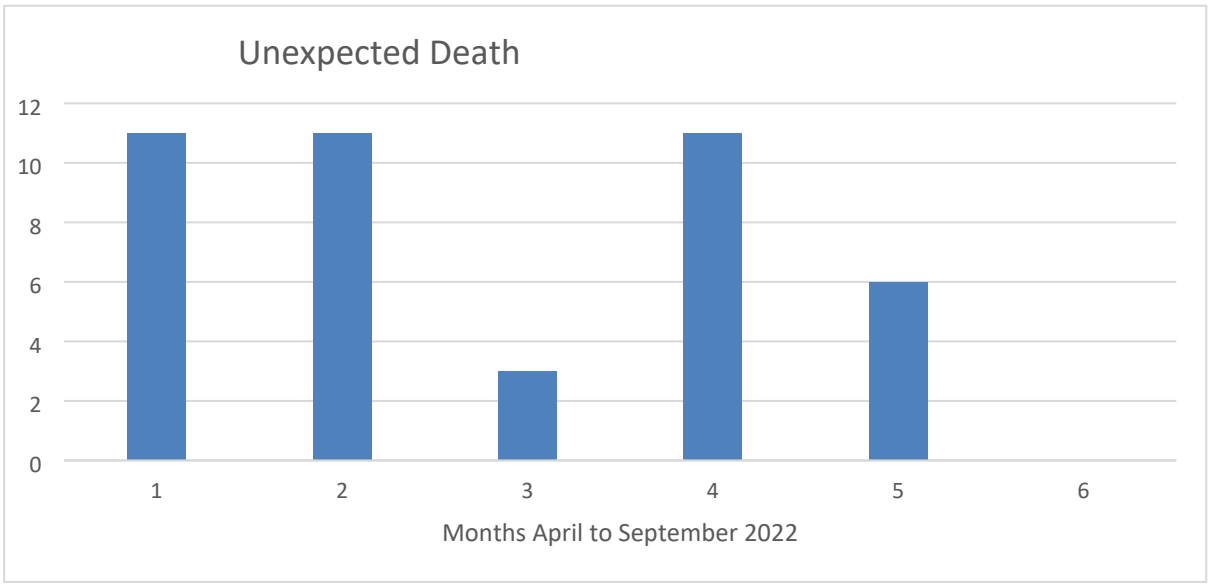


2.9 To provide some wider context for committee, this is consistent with other MH services in the United Kingdom. CTM participate in the MH NHS Benchmarking across England and Wales. The 2022 toolkit that was published at the end of October 2022 reports on self-harm, incidents involving ligatures, absconding, restraint and in-patient death. Self-harm and patient absconding per 10,000 bed days are shown below as examples of CTM's positioning for adult acute admission wards. Caution is required in the interpretation due to the absence of shared standards for reporting.





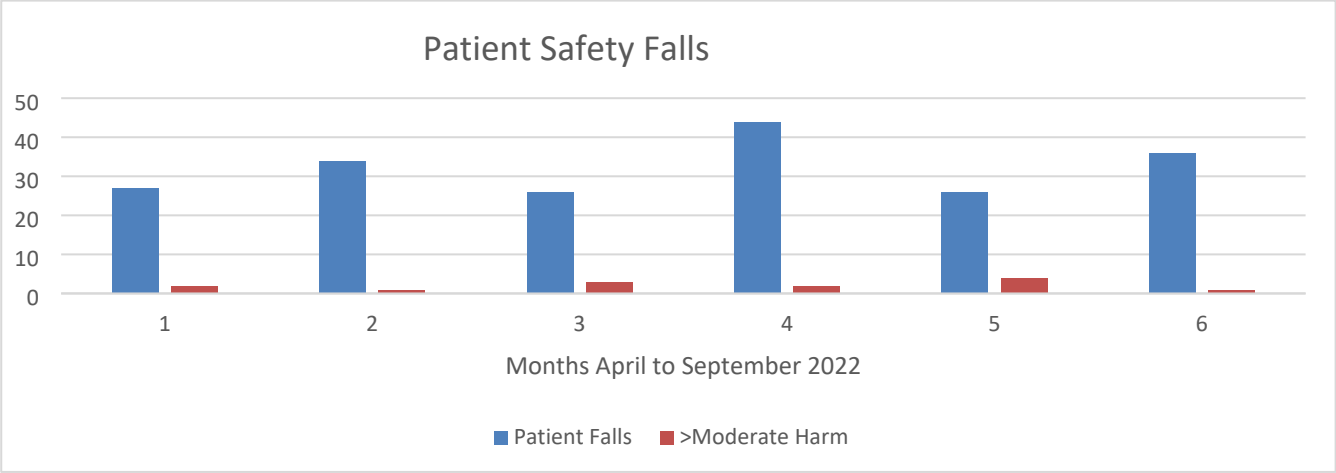
2.10 All Mental Health Services in England and Wales also report and review unexpected deaths. These are classified of deaths of patients within one year of contact with primary or secondary mental health services. Unexpected deaths can include deaths due to the use of substances, suicides and deaths from natural causes. These deaths are also reported to the National Confidential Enquiry for Suicide and Self Harm for wider learning and at a local level will all be subject to either LRI or NRI review. This profile of unexpected death is unfortunately consistent with the English and Welsh profile.



2.11 The recommendations from the annual National Confidential Enquiry into Suicide and Self-Harm form the basis of CTM's approach to reduce patient suicide. Mental Health Services also contribute to wider public suicide prevention work through the regional Suicide Prevention Steering Group.

2.12 Two OAMH wards are in the top 5 across the health board for the reporting of falls. Both of these wards support patients with cognitive impairment who are encouraged to be ambulant. A falls quality improvement programme is underway in one of the wards with the intention that this work is progressed across the care group.

2.13 Although the numbers of reported falls are high, the numbers of falls that result in moderate harm is low.



2.14 **Internal Quality Assurance Assessment**

2.15 A pan-CTM mental health shared learning group was in place prior to the formation of the care group but other than CTP audit there were limitations to the proactive internal oversight of the quality of mental health services in CTM.

2.16 The management of quality is reported to be predominantly a nursing matter with limited engagement from the wider therapy and medical workforce, other than some notable and well-engaged exceptions.

2.17 The CTM ward assurance development using AMaT has to date focussed on audit questions that pertain more to acute hospital environments rather than mental health services. This is being addressed with mental health specific audits in development.

2.18 There is good engagement in some of the national mental health work streams, such as dementia standards and the development of community mental health standards. However, there are other key work streams such Person-centred Safety Planning and Patient Reported Outcome Measures where opportunities have been missed to engage fully.

2.19 Visits to mental health adult in-patient services during September and October highlighted significant challenges to mental health environments, variance in models and approaches and multi-disciplinary therapeutic programmes. Notwithstanding the extensive ligature programme which is currently underway, the mental health estate (most notably at Royal Glamorgan Hospital) is both tired and untherapeutic and is not conducive to modern mental health care.

2.20 The capacity to have oversight of Mental Health specific policies and procedures is limited and as such there are out of date policies requiring update.

External Quality Assurance

2.21 There are no external regulatory reports published for consideration by Committee in this report.

2.22 A HIW action plan lookback commenced by RTE ILG has highlighted some key issues from reports dating back to 2016 that are still not fully addressed: progress to develop an integrated single patient record (WCCIS) and a robust programme of PMVA and WARRN training that is recorded on ESR – both essential to the safety of both staff and patients.

2.23 HIW are currently undertaking a review of adult in-patient discharge and it is anticipated that this will be published in January. An immediate assurance action plan was submitted prior to the formation of the Care Group and highlighted concerns in relation to patient risk management, management of safe discharge and the absence of a single patient record.

2.24 **Quality Improvement**

2.25 There are pockets of quality improvement practice in CTM Mental Health Services, most notably in OAMHS with an established falls project in Angelton Clinic in Bridgend that is supported by iCTM. In addition the Head of Psychology is engaged in quality improvement within psychological therapies.

2.26 There are significant opportunities for the introduction of a strategic approach to quality improvement for the Care Group and this is considered as part of the development of the Care Group Quality and Safety Framework further in this report.

2.27 **People's Experience**

2.28 Patient concerns are currently the main way in which the Care Group is able to determine the experience of people using CTM Mental Health Services. Advocacy services are also available to patients subject to detention under the Mental Health Act and support individual patients to engage with services, although this provision was disrupted somewhat during the pandemic. Thematic reporting of advocacy feedback will be important to address through the Care Group's quality governance arrangements.

2.29 The Health Board is committed to the CIVICA patient experience system to obtain feedback from people. The MHLD Care Group leaders plan to engage with iCTM colleagues who are leading this work to ensure that the CIVICA questions are suitable for people who use mental health services.

2.30 A CTM strategic programme for service user, carer representation, engagement and involvement is being progressed and is aligned to the 2021 Wales Service User Engagement Best Practice Guidance. The CTM Together for Mental Health Partnership Board have published a review and the CAMHS Head of Nursing will support the implementation for the Care Group to ensure that lived experience is central to service delivery.

2.31 **The Development of a Care Group Quality and Safety Framework**

2.32 A quality and safety workshop was held with MHLD clinical leaders and a Head of Quality and Safety on 4th October in order to shape the Care Group's approach to QRSE.

2.33 A draft Quality, Safety, Risk and Experience framework has been developed and will be led by the Nurse Director and proposes proactive oversight of issues previously outlined in this paper. This draft framework will be ratified at the first formal meeting of the QSRE Board on 7th December. The expectation is that there will be full multi-disciplinary engagement in the QRSE agenda and professional leaders are planning a programme of engagement with their colleagues.

2.34 A corresponding draft Planning, Performance, Finance Board has been developed and will be led by the Deputy COO. The draft governance arrangements for both QRSE and PPF can be viewed here: Mental Health Care Group Governance - Draft Structure.pptx

2.35 There will also be a Quality Improvement Board for MHLD, with two priorities for improvement in 2022/2023: adult in-patient services and older adult in-patient falls.

2.36 A Quality Improvement workshop is planned for 20th December to launch the adult in-patient quality improvement programme with the expectation that work streams will be developed focussing on:

- Admission Pathways
- A Skilled Workforce
- Therapeutic Interventions
- Therapeutic Environments
- Restrictive Interventions
- Discharge Arrangements

2.37 A MHLD specific quality dashboard will be developed with the aim of gaining oversight of the key MH quality metrics, informed both by the most reported incidents in CTM and the standard NHS Benchmarking MH quality metrics.

2.38 A programme of weekly patient safety visits by the Deputy COO and Nurse Director has also commenced and will be further progressed.

2.39 The Mental Health Service Improvement Fund will be utilised to create a learning and improvement team who will lead the proactive oversight of MH specific issues: PMVA, WARRN, MHM audit, MHLD policies and internal quality assurance / peer review. The available resource is being considered in order to determine the optimum skill-mix for this team. These new posts will progress to recruitment in December 2022.

2.40 A proposal to address the protracted absence of an integrated patient safety record is being progressed to the Executive Team for consideration in conjunction with the Digital Director A priority for the MH Learning and Service Improvement Team will be to further develop risk mitigation approaches until an electronic system is fully implemented.

2.41 **Performance Oversight and Planned Care Recovery**

Having assessed key areas of core business delivery and consequences on patient experience as part of developing the new MH & LD Care Group, to provide further oversight and assurance against key areas of performance a Mental Health & Learning

2.42 Disabilities Performance Oversight and Planned Care Recovery Board has been established. The first meeting was held on the 24th October.

2.43 Key areas for improvement on initial assessment are set out below. Recovery plans have been received and schemes to improve the performance and critically the experience for people awaiting a service agreed. The schemes are funded through the WG Service Improvement Fund 2022-2023.

2.44 The waiting list/ time recovery schemes agreed are as follows:

- Local Primary Mental Health Support Service – Merthyr & Cynon
- Local Primary Mental Health Support Service – CAMHS
- Local Primary Mental Health Support Service - Part B Interventions Adult
- Psychology waiting list pan CTM
- Out-Patients Modernisation, Bridgend
- Memory Assessment Service – Diagnosis
- Memory Assessment Service – Assessment.

2.45 The next meeting will also focus on Care and Treatment planning in CAMHS as another area most struggling to achieve national targets.

2.46 At each meeting, recovery scheme leads will provide an update against an agreed plan and trajectory and any risks to achieving delivery. In addition, the Board reviews the Mental Health Performance Dashboard to highlight any areas, which are below target or with a deteriorating position so that actions are agreed to drive improvement.

2.47 The Board provides a scrutiny and onward assurance function on behalf of Mental Health Care Group and a full report is scheduled for the Planning, Performance and Finance Committee in December.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 The report outlines a number of areas for improvement and the emerging plans to address them.

3.2 In this early stage in the Care Group's development, two matters outside of the direct control of the Care Group require escalation to the Board for oversight and support: the long-standing absence of an integrated patient record and the implications of this on patient safety and also the poor condition of the mental health estate and the

impact of this on both patient experience and patient outcome. Both are on the Organisational Risk Register.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	The quality and safety of care for people in receipt of mental health services is central to this report.
Related Health and Care standard(s)	Choose an item.
	If more than one Healthcare Standard applies please list below: Safe Care, Individual Care, Timely Care Governance, Leadership and Accountability Dignified Care, Effective Care
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below)
	No new, changed or withdrawn policies or services outlined
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	Yes (Include further detail below)
	There are resource implications for the additional workforce proposed to underpin the internal oversight of mental health services. New posts are funded from recurrent the Mental Health Service Improvement Fund,
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

5.1 Members of the Committee are asked to consider, discuss and note this initial assessment of CTM Mental Health Services set in the context of a developing Care Group.

5.2 Members are asked to note the priorities for improvement and the plans in place to address them.

AGENDA ITEM
(INSERT NUMBER)

QUALITY & SAFETY COMMITTEE

Chief Operating Officer's Report on Overarching Q&S Issues within the COO Portfolio

Date of meeting	Tuesday 15 November 2022
FOI Status	Open/Public
If closed please indicate reason	Choose an item.
Prepared by	Lucy Timlin, Head of Business Support
Presented by	Gethin Hughes, Chief Operating Officer
Approving Executive Sponsor	Executive Director of Operations
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Quality & Safety Meeting	September 2022	SUPPORTED
Planned Care and Unscheduled Care Boards	Various	SUPPORTED

ACRONYMS	
HIW	Healthcare Inspectorate Wales
PCH	Prince Charles Hospital
RGH	Royal Glamorgan Hospital
POWH	Princess of Wales Hospital
YCC	Ysbyty Cwm Cynon

MIU	Minor Injuries Unit
SDEC	Same Day Emergency Care
ED	Emergency Department
WAST	Welsh Ambulance Service Trust
D2RA	Discharge to Recover / Assess

1. SITUATION / BACKGROUND

This brief paper provides an overarching update on a range of issues within the remit of the Chief Operating Officer.

Issues considered include:

- Update on the Ophthalmology Plan
- Community and Primary Care Issues including the Dental Contract Handbook, HIW Inspection, OOH Adastra Outage
- Update on Cancer Assurance Process
- Update on the Unscheduled Care / Six Goals Project
- Ambulance Handover Delay Update

These issues continue to provide a key focus for colleagues across the UHB. The full details of the matters outlined in this COO Report are covered in more depth within individual reports or available via the appropriate Department.

It is anticipated that Committee members will be reassured to hear that the issues outlined in this report are included (where appropriate) within the UHB's Risk Register. Review of the Register has further progressed by Care Group, with some risks updated and others being examined in detail – further information is of course available if required.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 Ophthalmology Plan Update

The situation for patients waiting for a range of Ophthalmology services remains a matter of concern for the UHB with significant number of patients waiting for first outpatient appointments, operative treatment and also follow ups.

I can confirm for committee members that there is a clear plan in place the implementation of which is underway. This plan includes the delivery of additional capacity both within the UHB and also with Independent Sector Providers, clinical validation of the waiting list and the movement of patients into more appropriate community based services. The service remains under the highest level of scrutiny

and is monitored via the Executive Leadership Group and further updates will be provided to this committee.

2.2 Community Issues

Progress is reported in a range of areas as follows:

- **Pencoed Medical Practice HIW Visit**

  HIW undertook a remote quality assessment for Pencoed Medical Centre, Bridgend, which has a list size of approximately 11,500, four GP Partners and is a training practice.

  Four key areas were assessed (the environment, Infection Prevention & Control, Governance and Staffing) and the outcome report was very positive.

  This is a very encouraging result for the practice, and colleagues there are to be congratulated.

- **Dental Contact Handback**

  Following the contract hand back for Broadlands Clinic, a tender exercise has been undertaken which closed on 31 October 20022. A good response was received with four interested parties submitting applications. Next step is a meeting with Procurement colleagues, scheduled for 19 November 2022 to go through tenders and select new provider.

  Members of the committee will be reassured to hear that mid-year letters have gone to the 'red flagged practices' which are identified as under-achieving. Contracts will be reduced where assurance cannot be given for recovery plans and the activity will be contracted elsewhere.

- **Out-of-Hours (OOH) Adastra Outage**

  In August this year, a cyber-attack resulted in the Adastra software system being disabled nationally. The Leadership team in OOH were quick to respond and put in place manual processes to accept calls from 111 and to transfer information to OOH teams, Primary Care Out of Hours Centres and to practices and a temporary electronic record fix was put in place.

  The Adastra software has been partially reinstated apart from the electronic feed (concentrator) from 111 service. This is still manual.

  The OOH Service did sterling service to keep patients safe, involving a considerable amount of hard work and effort in and out of hours and the UHB is grateful. Colleagues will be kept updated with further development.

Further information is available on these issues if required.

2.3 Revised Cancer Assurance Flow Chart

A revised flow chart has been implemented within Cancer Services for use across all Care Groups.

Colleagues will be interested to hear that this will standardize the process for ensuring scrutiny of cancer waiting times at a high level of detail with the Service Groups leading the actions taken. The Flow Chart highlights times and also escalations to Executives.

It is anticipated that this chart and the actions that go with it will smooth the generation of reports and the actions to be taken to look after this important group of patients.

2.3 Unscheduled Care and Six Goals Work

The work of the Programme Board for the Six Goals for Urgent and Emergency Care continues across a broad range of areas and projects.

Some of the highlights from the workstream working which have been rated as green include:

- Plans for the **opening of the MIU at YCC** – this is scheduled to happen on Monday 07 November, with daytime opening hours – it is anticipated that this will make a contribution to a reduction in pressure at PCH;

- A plan is in place for the **Surgical SDEC Service** (aimed at resolving issues for patients who may need intervention on that day) will start at RGH on 17 November 2022;

- The **D2RA** launch is planned for 05 December 2022 – a scheme aimed at further improving and refining effective and timely discharge which is aimed at improving flow safely across sites;

- D2RA will be supported by the formulation of a **Self-Administration of Medication** Policy – again across the UHB.

Looking ahead, there are plans to look at:

- The Frailty Model
- Further improvements to Bed Management and Flow
- Work on Discharge Lounges at PCH and RGH

Future progress will be reported at forthcoming meetings including the Quality & Safety Committee.

2.4 Ambulance Handover Delay Update

Following on from very significant issues around long waits for ambulance handovers at the Board's Emergency Departments, an operational response plan has been developed which includes timescales and rigorous review on a regular basis.

This is a multi-faceted matter with interconnecting issues and additional information will be reported in future reports. Issues of note include:

- A Handover Delay plan is now linked to the Six Goals Workstream – another key focus for the UHB;
- Work is ongoing through the Emergency Department Task and Finish Group to support clinical decision making – this includes standard principles for ED staff to follow;
- Out of the total number of patients admitted to our Intensive Care Units, 50% are walking in to our EDs, which indicates that the acuity within Departments is significant, and highlights the size of the challenge faced;
- Pre-Emptive Boarding Standard Operating Procedures are now in draft to support the early conveyance of patients to wards and the subsequent decongestion of the Emergency Departments.

3. KEY RISKS / MATTERS FOR ESCALATION TO BOARD/COMMITTEE

A summary of the key areas of risk / matters for escalation for the COO's portfolio continue to be as follows:

- Planned Care Recovery;
- Cancer Services and the imperative to improve performance in all areas;
- The activity in and challenge for the EDs across the Health Board;
- The safe improvement of flow.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	The paper considers a number of key quality, safety and patient experience issues
Related Health and Care standard(s)	Safe Care
	If more than one Healthcare Standard applies please list below:
Equality impact assessment completed	No (Include further detail below)
	Not yet completed.
Legal implications / impact	Yes (Include further detail below)
	Any matter which results in patient harm (for example delayed follow up) has a potential legal impact.

Resource (Capital/Revenue £/Workforce) implications / Impact	Yes (Include further detail below)
	Any matter which results in patient harm (for example delayed follow up) has a potential financial impact.
Link to Strategic Well-being Objectives	Provide high quality, evidence based, and accessible care

5. RECOMMENDATION

Members of the Committee are asked to note the content of this review.

WHSSC Joint Committee
8 November 2022
Agenda Item: 4.4.2

Reporting Committee	**Quality Patient Safety Committee (QPSC)**
Chaired by	**Ceri Phillips**
Lead Executive Director	**Director of Nursing & Quality**
Date of Meeting	**25 October 2022**

Summary of key matters considered by the Committee and any related decisions made

1.0 Patient Story

The committee heard a patient video/story from a couple who had accessed neonatal intensive care for their two children. The family were very complimentary of the service they received both from the tertiary and local unit focusing on the importance of communication and bringing care as close to home as soon as possible. The family were thanked for sharing their story and how the issues they raised can feed into the current work being undertaken re cot configuration.

2.0 Welsh Kidney Network (WKN)

QPS members were advised of 3 high risks on the WKN risk register. One risk referred to the introduction by Welsh Government of a Quality Statement for kidney disease and the capacity of the WKN as currently configured to ensure delivery of all components of the Statement. They noted that further clarity is being sought from Welsh Government regarding the role of the WKN in this regard. Two further high risk relate to vascular access capacity at BCUHB and dialysis capacity at Ysbyty Glan Clwyd. Members were informed of actions being undertaken to mitigate these risks. A Peer Review on vascular access has recently been undertaken at BCUHB. The report and subsequent action plan is in the process of being completed. The actions are intended to address the vascular access capacity issue. With regard to dialysis capacity, members noted that this facility is independent sector provided and discussion are ongoing with the provider and the HB regarding options to increase capacity. Members noted that patients access to dialysis is not being compromised whilst these discussions conclude.

Members were also informed that a governance review of the WKN had recently been completed, an action plan was being developed and this would be brought to the Joint Committee in January 2023. They were also appraised of the recent Annual Audit Day held by the Network which was well attended and an informative learning event.

3.0 Commissioning Team and Network Updates

Reports from each of the Commissioning Teams were received and taken by exception. Members noted the information presented in the reports and a summary of the services in escalation is attached to this report. The key points for each service are summarised below:

- **Cancer & Blood**

The risk register for the commissioning team was presented to the committee. There was one new risk relating to the management of outreach clinics delivered by St Helen's & Knowsley NHS Trust on two sites in Betsi Cadwalader University Health Board. Assurance and progress were provided against the two services that are in escalation and further information is provided in the summary of services in the escalation table, which is attached.

- **Cardiac**

The risk to bariatric services remain unchanged; however conversations with an alternative provider remain ongoing. WHSSC is still awaiting the Royal College of Surgeons' report for Swansea Bay University Health Board. The committee requested that this was escalated if not received shortly.

- **Neurosciences**

A neurosciences update was received by the committee. Members noted that the risk that patients were being prevented access to the Thrombectomy services in North Bristol, due to the current 3D biotronics-imaging platform not meeting the current Welsh Government cyber security credentials was now resolved and had subsequently been closed by the Commissioning team in October 2022. The risk relating to neurosurgery in South Wales had also been lowered, due to an improvement in both theatre and bed capacity and will be monitored over the coming months. The committee was informed that the Community Health Council (CHC) had undertaken a positive visit to the spinal unit in Llandough Hospital and the report would be published shortly. The quality team would follow this up with CVUHB.

- **Women & Children**

The committee was updated re the risks and, in particular, the risk regarding Paediatric surgery and noted the ongoing work being undertaken. Information had been requested from the Health Board and options regarding outsourcing were continuing to be explored and a detailed recovery paper was due to go to Joint Committee on the 8th November 2022.

It was noted that there is now a Commissioning Assurance Group meeting for each specialised paediatric service at CHfW. There is a rolling monthly schedule, to capture every service. Within the Quality agenda, work is currently being undertaken to address how assurance is reported with the aim of creating a dashboard to gain assurance for each specialised service.

The committee received a progress update on Paediatric neurology and pathology, noting an improved position and the work that was ongoing to secure a longer term sustainable position.

- **Mental Health & Vulnerable Groups**

The committee received a report on any Quality and Patient Safety issues for services relating to the Mental Health & Vulnerable Groups Commissioning Team portfolio. This included a summary of the services in escalation which contained a progress update on the work being undertaken in Tŷy Llidiard.

Members were provided with an update regarding service on Eating Disorders. Following the end of the contract with Cotswold House on 31st August 2022, arrangements have been made to secure beds with the Priory Group for Welsh patients. These arrangements are in place until January 2023, in the first instance, with options to extend this arrangement. In the interim, options are being scoped and considered to inform an options appraisal exercise for long term sustainable options for eating disorder services, through the Specialised Services Strategy for Mental Health, and a medium term solution to stabilise services for the next 3-5 years.

In July 2022, in response to the recommendations of the Cass Review Interim Report, NHS England took the decision to de-commission the Tavistock and Portman NHS Foundation Trust and introduce two early adopter providers from Spring 2023. The committee was assured that WHSSC are involved in the NHS England programme work and noted that the interim service specification has been released for a 45-day consultation. An update paper on GIDS has been submitted to Corporate Directors Group Board and Management Group for information.

The committee was pleased to note that NHS England has provisionally allocated £5m capital funding to the North West Mother Baby Unit scheme at Chester. It is expected that the provider, Cheshire & Wirral Partnership Trust, will develop a full business case for submission to NHS England in next 3 months.

The Committee noted the work that the Commissioning Team was undertaking and felt it would be helpful to receive a deep dive and invite the newly appointed Director of Mental Health to present the work at the next meeting. The Secure Services review was also outstanding and would therefore be an opportune time to fully understand how the strands will fit in the Mental Health Strategy going forward.

- **Intestinal Failure (IF) – Home Parenteral Nutrition**

A detailed report was received by the committee. Reassurance was received regarding the substantial work that had been undertaken and it was pleasing to note that the risk had reduced since the last report. A query was raised regarding the invoicing position, which would be addressed outside of the meeting and reported in the next report if there were ongoing concerns or had an impact on quality and patient safety issues.

4.0 Other Reports Received

Members received reports on the following:

- **Services in Escalation Summary**

WHSSC currently has seven services in escalation. The status of each service in escalation remains unchanged. However, the Cardiac services are making good progress and it is hoped that WHSSC will be in a position to de-escalate these over the next few months. The North Wales Adolescent Unit is also waiting for the NCCU review and should also be in a position to be de-escalated. The template for reporting would alter from next year in line with the work presented at the Development Day.

- **CRAF Risk Assurance Framework**

Members were provided with an updated positon regarding the WHSSC CRAF and noted the proposed engagement work to support the IPFR risk. Members noted the risk workshop that had taken place on September 20th and the SWOT analysis undertaken on each risk to support the process of review and updating.

- **Care Quality Commission (CQC)/ Health Inspectorate Wales (HIW) Summary Update**

The committee received the report and agreed that any inspections undertaken by the CHC would be included in the future.

- **Incident and Concerns report**

An update report was noted and received by the committee for assurance. There have been 10 new incidents reported to WHSSC over the period July 2022 to end September 2022.

- **Development Day summary report**

A second Development Day was held on the 16th September 2022. Committee members received a summary from each of the sessions and a copy of the presentations. Six out of the seven Health Boards were represented and positive comments were received regarding the content of the day. An evaluation of the day had been circulated and will be used to consider the content for forthcoming days and any improvements that could be made.

- **WHSSC Quality Unit Final Internal Audit Report**

A copy of the Final Internal Audit report, undertaken in June 2022, was received by the Committee. Substantial assurance was received with one matter requiring management attention:

  - There was limited evidence to suggest that Health Boards are submitting the WHSSC Quality and Patient Safety Chair's report to their own quality committee meetings for scrutiny and assurance.

The agreed management plan has been accepted and a discussion was initiated at the Development Day. It was agreed that the report would to be considered by the All Wales Health Board Chairs QPS Committee and future auditing of compliance would be monitored through that group. Assurance was received that Health Boards do already have reporting systems in place to address the issue. A copy of the report is attached.

- **Quality Newsletter**

A copy of the second Quality Newsletter was received by the committee and is an Appendix to this report

5.0 Items for information:

Members received a number of documents for information only:

- Chair's Report and Escalation Summary to Joint Committee 6 September 2022,
- Welsh Risk Pool and Legal & Risk Services Annual Review
- QPSC Distribution List; and
- QPSC Forward Work Plan.

Key risks and issues/matters of concern and any mitigating actions

Key risks are highlighted in the narrative above.

Summary of services in Escalation (Appendix 1 attached)
WHSSC Quality Unit Final Internal Audit Report (Appendix 2 attached)
Quality Newsletter (Appendix 3 attached)

Matters requiring Committee level consideration and/or approval The committee requested that the findings of the Quality Internal Audit Report were noted and considered by the Health Boards.	
Matters referred to other Committees As above	
Confirmed minutes for the meeting are available upon request	
Date of next scheduled meeting:	23 January 2023 at 13.00hrs

Appendix 1

SERVICES IN ESCALATION

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position 18.10.2022	Movement from last month
November 2017	North Wales Adolescent Service (NWAS)	BCUHB	2	• Medical workforce and shortages operational capacity • Lack of access to other Health Board provision including Paediatrics and Adult Mental Health. Number of Out-of- Area admissions	• QAIS report outlined key areas for development including the recommendation to consider the location of NWAS due to lack of access on site to other health board provision – This is being considered in the Mental Health Specialised Services Strategy. • Bed panel data submitted electronically • NCCU undertook Annual Review on 29th June 2022 report yet to be published. • Escalation status will be considered thereafter.	

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position 18.10.2022	Movement from last month
March 2018 Sept 2020 Aug 2021	Ty Llidiard	CTMUHB	4	• Unexpected Patient death and frequent SUIs revealed patient safety concerns due to environmental shortfalls and poor governance • SUI 11 September	• Escalation meetings held monthly, Exec Lead identified from Health Board. Last escalation meeting 11th October • Improvement Board established to oversee delivery of an integrated improvement plan • Emergency SOP has been fully implemented • Majority of posts recruited to or start dates agreed. • Candidate withdrew from Physician Associate post and further advertisement to be progressed. • Psychologist/Family Therapist post interviews scheduled for w/c 17th October • JD under development for Psychology Assistant post with recruitment to progress following the appointment of the Family Therapist • Improved leadership evident via escalation meetings	⟷

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position 18.10.2022	Movement from last month
September 2020	FACTS	CTMUHB	3	• Workforce issue	• Last escalation meeting was held on 01/09/22 • Next meeting is on 09/11/22 • Consultant Psychiatrist Interviews are on 1st November and will be followed by Clinical Lead appointment • Recommendation will be made to CDGB on November 7th that service is de-escalated to level 2 if all outstanding issues are addressed at next escalation meeting	

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position 18.10.2022	Movement from last month
July 2021	Cardiac Surgery	SBUHB	3	• Lack of assurance regarding current performance, processes and quality and patient safety based on the findings from the Getting It Right First Time review	• Continued six weekly meetings in place to receive and monitor against the improvement plan. • The service was de-escalated on delivery of the immediate actions required by the GIRFT recommendations (per	

					March update), but has remained in level 3 whilst the impact of these actions is ascertained. • The escalation level was discussed again in October 2022 and significant progress towards the GIRFT benchmarks was noted. • WHSSC is waiting for the final report of the recent Royal College of Surgeons of England (RCS England) Invited Service Review to be submitted, with the Health Board's response, after which the potential for further de-escalation and revised monitoring arrangements will be considered in line with the Escalation Framework.	

July 2021 (original escalation) April 2022 (escalated from 2-3)	Cardiac Surgery	C&VUHB	3	• Lack of assurance regarding processes and patient flow which impact on patient experience	• C&VUHB had previously agreed a programme of improvement work to address the recommendations set out in the GIRFT report. • In view of a failure to provide the requested GIRFT improvement plan and HEIW report, the service was re-escalated in April 2022. • The service has now provided both GIRFT improvement plan and HEIW report (and action plan), and WHSSC has developed de-escalation criteria based on the GIRFT recommendations and action plans. • The de-escalation criteria will be discussed at the next escalation meeting. • Level 3 meetings were held in June and July, and a meeting was scheduled for September, but this was postponed due to staff availability. • In view of the following meeting being scheduled for November, an updated action plan was requested	

					(due for submission 11 October 2022)	
Date of Escalation	**Service**	**Provider**	**Level of Escalation**	**Reason for Escalation**	**Current Position 19.10.2022**	**Movement from last month**
November 2021	Adult burns	SBUHB	3	At the time of initial escalation, the burns service at SBUHB was unable to provide major burns level care due to staffing issues in burns ITU. An interim model was put in place allowing the service to reopen in February 2002. The current escalation concerns the progress of the capital case for the long term solution and sustainability of the interim model	• Escalation monitoring meetings held on 12th August and 27th September 2022. • The current timeline for completion of the capital works to enablerelocation of burns ITU togeneral ITU at Morriston Hospital is the end of 2023. • The next escalation monitoring meeting is arranged for 1st December 2022.	⟷

February 2022	PETIC	Cardiff University	3	• Concern over management capacity within the service to ensure a safe, high quality timely service is maintained for patients. • Recent suspension of population of PSMA due a critical quality control issue identified during MHRA inspection. Service slow to address impact on service for patients. • Failure to undertake a timely recruitment exercise leading to isotape production failures. • Failure to produce a business case of sufficient quality in a timely manner for replacement of the scanner.	• PETIC is taking forward the agreed actions with regard to increasing management capacity within the service and clarifying the governance arrangements for the service. • The next escalation monitoring meeting is arranged for 5th December.	

Level of escalation reducing / improving position

Level of escalation unchanged from previous report/month

Level of escalation increasing / worsening position

Welsh Health Specialised Services Commissioning NEWSLETTER

2nd Edition, Autumn 2022

GIG CYMRU NHS WALES
Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru
Welsh Health Specialised Services Committee

South Wales Neonatal Units

This is the 2nd edition of the Quality newsletter from the Welsh Health Specialised Services team in Wales. Our plan is for these to be published on a quarterly basis to supplement reports and data already provided through different forums into Welsh Health Boards.

This Newsletter is available in Welsh on request. Mae'r Cylchlythyr hwn ar gael yn Gymraeg ar gais.

This gives an overview of some of the work we are involved with, and presents some of the highlights from a commissioning perspective. The services commissioned from Welsh Health Specialised Services Committee (WHSSC) are provided both in Wales and in England this will only provide a snapshot of our work.

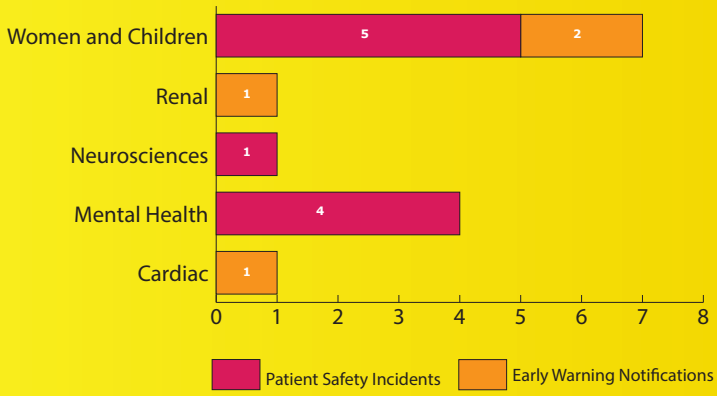
GIG CYMRU NHS WALES
Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru
Welsh Health Specialised Services Committee

Contents

Reporting for the Last Quarter

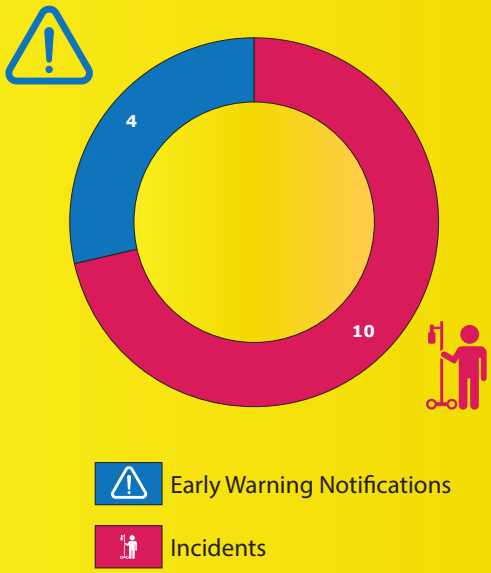
WHSSC do not investigate incidents but are responsible for supporting the investigations into these alongside the monitoring and reporting to the Health Boards. WHSSC are responsible for ensuring the delivery of safe services and ensure that trends or themes arising from concerns have actions plans which are are completed and support learning. WHSSC facilitates the continued monitoring of commissioned services and work with providers when issues arise.

Type by Commissioning Team



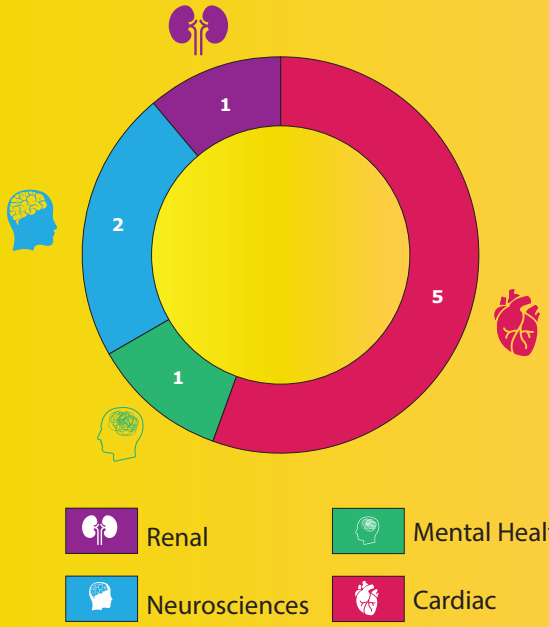
Patient Safety Incidents and Early Warning Notifications

Between March to July 2022, there were **10** Patient Safety Incidents and **4** Early Warning Notifications logged:



Patient Safety Incidents

Between March to July 2022, there were **9** Patient Safety Incidents closed:



Concerns raised with WHSSC may involve a direct response from the organisation or involve a joint response with the commissioning Health Board or WHSSC may need to ask the Health Board to respond directly.

Concerns

Incidents

Putting Things Right

Complaints

Update from the Patient Care Team IPFR (Individual Patient Funding Request)

The Patient Care Team receives and manages individual patient funding requests for healthcare that falls outside of agreed range of services.

An overview of IPFRs processed in Quarter 1 2022-23:

	Number of Requests discussed as Chairs Actions	Number of Requests discussed by All Wales IPFR Panel
April 2022	16	-
May 2022	7	14
June 2022	2	10

Welsh Gender Service

The Welsh Gender Service published their first ever Newsletter in Spring 2022 and a Summer edition is to follow. For now though, please see the Spring edition here:

Welsh Gender Service: Spring Edition Newsletter April 2022

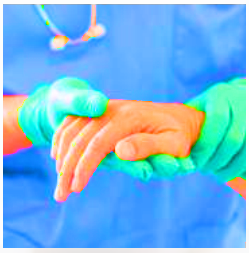
April and June 2022 Patient Safety Updates

Patient Safety Update: 5 April 2022

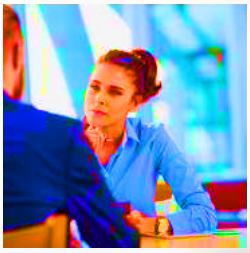
Patient Safety Update: 28 June 2022

Quality and Patient Safety Development Day

WHSSC will be holding a Quality and Patient Safety Development Day on 26th September 2022. Quality Clinical Colleagues and Independent member from across Welsh Health Boards will be in attendance. The day will feature data systems presentations from NHS England, the data team in WHSSC and presentations from the Delivery Unit team and NWSPP. A recap and feedback from the day will be provided in the next newsletter!



Patient Safety Incidents



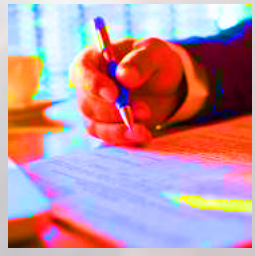
Listening

Never Events

Reassurance

Reporting

Learning



Compliance

Quality

Culture

Assurance

Feedback

Experience

Improving

Developing

Innovation

Ty Llidiard Co-production Event

Ty Llidiard have recently hosted a co-production event that involved young people, their carers and the staff based at Ty Llidiard. The event focused on the four C's: Compassionate, Calm, Confident and Caring.

Through consultation with Staff and the Young People who use Ty Llidiard, Scarlett Design came up with 4 potential design proposals with examples of how we would like to use them to create an internal and external philosophy and identity.

TŶ LLIDIARD
CARING · COMPASSIONATE
CALM · CONFIDENT

The day was split into 3 sessions:-

- ✓ Former service users and their families along with external stakeholders.
- ✓ The young people who were admitted at the time.
- ✓ The Ty Llidiard staff.

Over 70 people attended on the day with another 50 giving feedback electronically and by using the feedback forms and box that was left in the Ty Llidiard foyer for 6 weeks after.

The main themes to come from the young people were reducing boredom through engagement and activities and from the staff it was around communication and support.

Over 100 people voted on the visual identity / logo with nearly 70% voting on this design. The next steps are to use the agreed logo on uniforms, signage and on the exterior of Ty Llidiard. Positive feedback was received from the Director General of Health & Social Services/Chief Executive NHS Wales.

North Wales Adolescent Unit

There are positive developments for Children & Young People (CYP) who are being treated for Eating Disorders (ED) within the service. Over time, there has been a recognition that, the needs of young people admitted to Kestrel ward with an eating disorder have changed. Historically, Kestrel ward had a high proportion of admissions associated with Anorexia Nervosa (AN).

Across North Wales, there has been an increase in young people presenting with complex presentations around eating who require intervention. This is in line with the referrals and presentations seen within the inpatient context.

Kestrel ward have historically followed a weight restoration model for eating disorders, there has been no formal review of the ED pathway completed within the last decade. The recognised change in presentation of CYP has driven the change of pathway from one of weight restoration to a pathway with a stronger focus on Young People engagement. The inpatient ward is committed to developing an Autism friendly environment working alongside the National Autistic Society (NAS). The journey to accreditation with NAS has begun with the first meeting taking place in August 2022. Following a review of the environment, the NAS advisor was able to make suggestions as to what could be developed to ensure that the service could improve meeting the needs of CYP with a diagnoses of Autism Spectrum Disorder. The development of the environment is clinically led by the nursing team and operationally partnered by the broader MDT.

The service has welcomed a new role this year, the Patient Liaison Officer role was developed following a trend in concerns noted by CYP & families that recognised how communication between the service and families was not as effective as it could be.

The liaison officer has taken an active role in enhancing parts of the admission pathway including the information that is distributed to CYP & families pre admission, this includes the development of an North Wales Adolescent Service (NWAS) specific website.

There is a strong emphasis on what the role is and how this can support the CYP & family journey. In addition, the liaison officer is also closely linked to the regional Betsi Cadwaladr University Health Board (BCUHB) Child and Adolescent Mental Health Services (CAMHS) patient experience leads who have developed an action plan for improved patient experience in practice.

The liaison officer supported the children's charter events held by the CAMHS BCUHB patient experience leads, building on the existing principles of CYP engagement and enhancing the focus of patient centred care.

The development of the Advanced Nurse Practitioner (ANP) pathway is now complete, the service currently has 4 ANP trainees with a 5th joining in December, all of which are in the final phase of their academic studies, during their training phase the trainees are undertaking advanced level nursing tasks under supervision to ensure that they able to meet all 4 pillars of their advanced level training.

Ty Llewellyn Medium Secure Unit

A meeting with the quality team in WHSSC took place with Ty Llewellyn Medium Secure Men's Adult Mental Health Unit in July 2022. An update was provided on the progression of the environmental, workforce and quality developments which have been underway to support a more therapeutic environment and clear recognition of physical health monitoring in mental health patients.

These have included the development of a more robust handover, physical health check monitoring, NEWS training and access to medical cover 24 hours 7 days a week and a policy to support individual therapeutic monitoring.

Staff sessions on physical health checks have included further training around sepsis management and the recognition and monitoring of side effects which may occur following the long term use of medications.

A culture of openness and transparency is continuously being encouraged and supported.

Outcome measure training is being facilitated for some of the staff and there are some further developments within the unit to capture patient experience, which will be shared once completed.

Moondance Awards

The Moondance Cancer Awards 2022 held on June 16th to celebrate 'brilliant people across NHS Wales and its partners who maintained, and innovated, cancer services despite the extraordinary circumstances of the last two years'.

Among the lucky shortlist of delegates eagerly awaiting the results were colleagues from the All Wales Positron Emission Tomography (PET) Advisory Group who submitted an application to the 'Achievement: Working Together' category and All Wales Genomics Oncology Group (AWGOG), All Wales Medical Genomics Services (AWMGS) and Velindre Cancer Centre (VCC) who submitted a co-application to the 'Innovation in Treatment' category.

Presiding over judging of the innovation category were an esteemed panel of judges including UK Medical Director of the Telemedicine Clinic, Cancer Clinical Director for Wales Prof Tom Crosby, CEO of Tenovus Judi Rhys MBE and Prof Neil Mortensen, President of the Royal College of Surgeons.

The judges were reportedly *"delighted and humbled by the number and quality of submissions received".*

WHSSC staff enjoying the Moondance Awards, from left to right: Professor Iolo Doull, Dr Andrew Champion and Sarah McAllister. Dr Champion and Sarah McAllister were part of the shortlisted All Wales PET Advisory Group!

Upon declaring the winning result to the AWMGS/AWGOG/VCC application, the judges noted the formidable achievements of each of the following three initiatives commissioned via WHSCC:

1. The DPYD gene testing pilot in collaboration with VCC saw Wales become the first UK nation to routinely offer DPYD pharmacogenetic screening for cancer patients in receipt of certain types of chemotherapy
2. The All Wales Genetics Oncology Group (AWGOG) since its formation has published timely clinical guidance on NTRK gene and FGFR2 gene fusion diagnostic testing for cancer treatment following NICE recommendations
3. Cymru Service for Genomic Oncology Diagnosis (CYSGODI) launched in 2021 offer high-quality oncology precision medicine services using next generation sequencing technology to screen for targeted genes in a tumour and haematological malignancy.

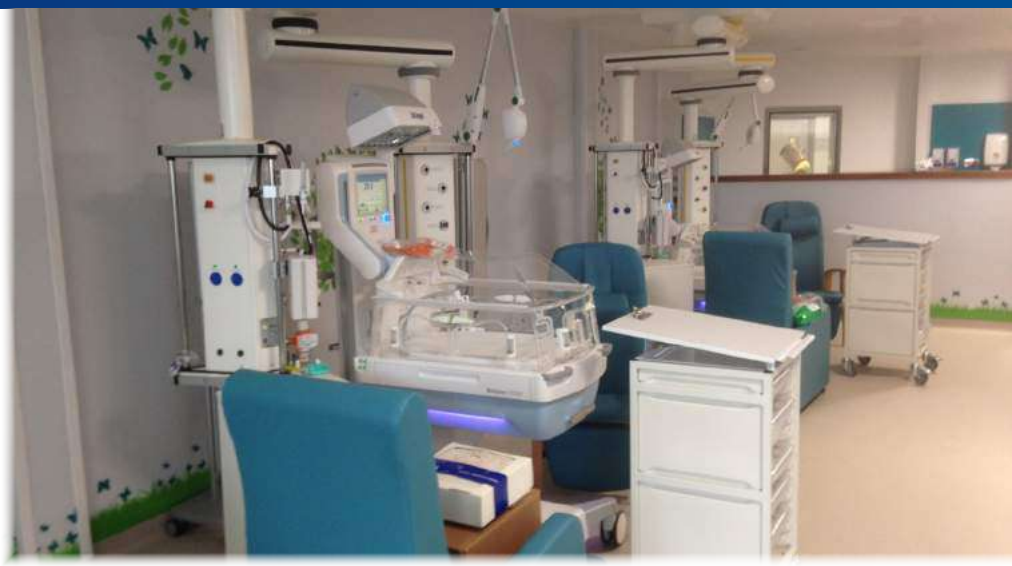
A huge congratulations to The All Wales Genomics Oncology Group for winning the Innovation in Treatment Award and also to The All Wales PET Advisory Group for being shortlisted in the Working Together category!

South Wales Neonatal Units

The WHSSC Quality team are undertaking scheduled neonatal visits within South Wales. The face to face meetings are intended to strengthen relationships and to develop an understanding of the role of the quality team within commissioning. WHSSC are responsible for commissioning the ITU and HDU cots in South Wales.

This is alongside supporting the importance of reporting and data collection in light of publications such as the Independent Maternity Services Oversight Panel (IMSOP) and Ockenden report and an awareness that the services have had a great deal of activity and had a number of workforce pressures. During the visits, the units have been encouraged to share evidence of Quality Improvement, good practice alongside areas of concern including workforce plans and recruitment.

Discussions have also included capturing patient experience and signposting to the Health Board team to support facilitation of this.



During the visits there was evidence of inspiring innovations to benefit patients, families and the staff and we have asked that this be continuously shared with WHSSC.

Alongside some workforce initiatives to utilise some of the current vacancies more successfully into advanced practice role development and Band 4 role development. To date the team have visited Hywel Dda University Health Board (HDUHB), Cwm Taf Morgannwg University Health Board (CTMUHB), Swansea Bay University Health Board (SBUHB) and Cardiff and Vale University Health Board (CVUHB).

HDUHB

HDUHB provided the WHSSC Quality team with the opportunity to visit the new unit and to meet with the neonatal team. It was evident moving into a better environment and managing the care of neonates within the new facility had a positive impact on the team.

CTMUHB

Very positive visit to the team in CTMUHB, it provided the opportunity to understand how the team have worked to address the issues identified by Independent Maternity Safety and Oversight Panel. There was evidence of practice development and support for the clinical team alongside the rotation of staff into different clinical areas and support to work with the regional Centres.

SBUHB

The Team have recently had nurses join them from overseas and are in the process of supporting their development with specific clinical programs. These have included the development of Objective Structured Clinical Examinations to enable a smooth transition into the workforce and to meet the NMC requirements. During the visit alongside meeting the Neonatal Intensive Care Unit (NICU) team the Quality team met with the midwifery team who demonstrated the work which had been undertaken with a Neonatologist and maternity to enable the Transitional care model to be better utilised to support a model of more rapid step down from Special Care Baby Unit (SCBU).

CVUHB

The NICU visit provided the Quality team with an opportunity to understand how the Operational Team are continuously addressing the daily priorities of managing the ever changing clinical picture. This was demonstrated through their facilitation of a twice daily huddle and their reporting to the Clinical Board. The clinical team welcomed an opportunity to share their concerns regarding workforce, repatriation and training issues.

These included the difficulties of sometimes having families who had become dependent on the regional Centres and their concerns about being repatriated back to their local health boards, due to a perceived lack of understanding on how their particular specialist needs would be met. This concern was highlighted form both a family perspective and the clinical teams perspective. The clinical team raised concern around local skill and knowledge in relation to managing some of the more complex surgical cases.

There had been recent recruitment event with some success at external recruitment. A number of nursing vacancies exist within the team and there is a plan to support student streamlining with over recruitment into some of these vacancies.

Maternity and Neonatal Safety Summit

Sue Tranka, Chief Nursing Officer for Wales has launched the Maternity and Neonatal Safety Support Programme to improve safety, experience and outcomes for mothers and babies in Wales. Maternity and neonatal champions will be appointed to every health board in Wales to improve the quality of services and to support the Maternity Five Year Vision.

The Programme aims to create national standards to ensure that all pregnant individuals, babies and their families will experience safe, high quality health care along with influencing their decisions regarding the care they receive.

The Maternity and Neonatal Safety Summit was held in August 2022 and was well attended both in person and remotely. There was engagement from the participants, who were encouraged to submit online questions to the presenting panel. This identified collaborative themes amongst the audience and facilitated an opportunity to network in person.

Welsh Pharmacy **Awards 2022**

The Blueteq High Cost Drugs (HCD) software programme was procured for NHS Wales by the WHSSC and the Welsh Government via the Advanced Therapies Wales Board, to support the implementation of Advanced Therapy Medicinal Products (ATMPs) and other HCDs commissioned by WHSSC. A Blueteq Project Working Group piloted the system in May 2021. In January 2022, the system went live for all WHSSC commissioned HCDs.

This new system allows NHS Wales to audit the initiation of complex HCDs in line with evidence based health technology appraisal recommendations, to support clinical data collection and evaluation and to strengthen financial governance.

A Blueteq form is created for all WHSSC commissioned National Institute for Health and Care Excellence (NICE) Technology Appraisals, Highly Specialised Technologies and All Wales Medicines Strategy Group approved medicines by the WHSSC Medical team in collaboration with Welsh clinical experts.

The implementation of Blueteq ensures equitable and timely access to specialised HCDs for eligible patients across Wales. The Blueteq project has been shortlisted as a finalist in the Welsh Pharmacy Awards 2022, which is a fantastic achievement.

Well done team!

Quick Round up of Commissioning Teams

Mental Health

5 year strategy being developed and well underway with excellent engagement and support from the Welsh Clinical Teams.

Women and Chidren's

Paediatric Strategy is gaining momentum and out for consultation.

Neurosciences and long term condition

All Wales strategy to improve outcomes and experience of patients receiving specialised rehabilitation is underway.

Cancer and Blood

Thoracic and Inherited Bleeding Disorder Service Improvement and Innovation Day to be organised. ENETS won a Patient Experience award and will be hosting a celebration event on 13th October.

Cardiac

Cystic Fibrosis Service Improvement and Innovation Day scheduled for 11th November 2022.

Intestinal Failure

Ongoing work being undertaken with the recently formed Intestinal Failure commissioning team and as a result of the Intestinal Failure review and Service Improvement and Innovation Day.

Recognition of significant events, thank you's and useful links

Adele Roberts, Head of Quality at WHSSC, receives a special parcel from a patient who was supported through the NHS England Gender pathway:

Lieutenant Colonel

On behalf of the whole military in Wales I am very grateful for the enhance patient care the systems providers and for the friendly, flexible and efficient way it is administered by you and Catherine. Patients enjoy fantastic care from the providers in Wales. The options for select-ed individuals to be seen quickly in order to make them fit for duty and progress their care is transformational…….This support to the military in Wales is envied by my colleagues in other parts of the UK

Ministry of Defence (MOD)

A thank you from a Lieutenant Colonel with the MOD was received into WHSSC by the Director of Finance Stuart Davies and Catherine Dew IPFR manager.

Useful Links

- Welsh Health Specialised Services Committee

Public Health Wales - 30 month implementation evaluation for NIPT (Non-invasive Prenatal Testing) evaluation

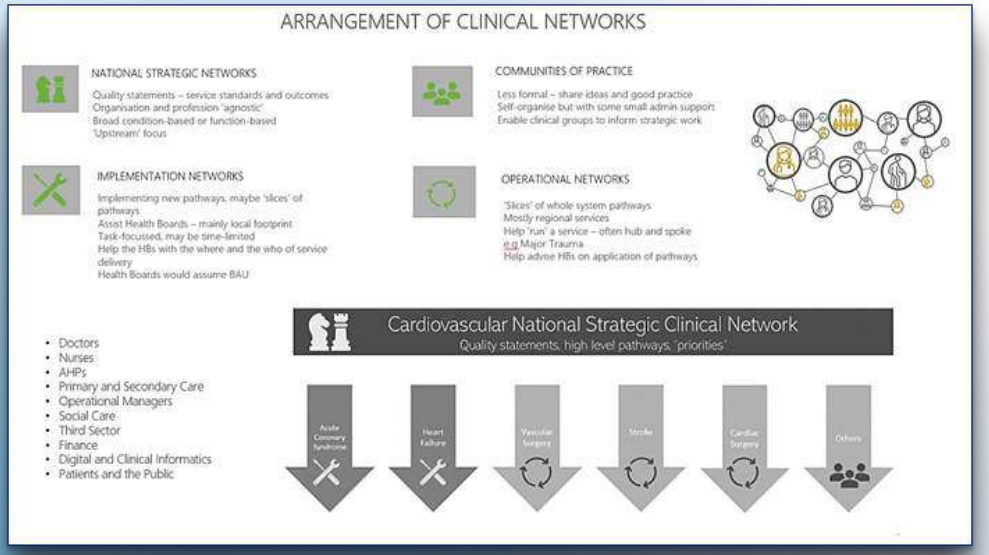
WHSSC commission NIPT and were informed by Public Health Wales of the evaluation findings from the first 30 months following the implementation of this as a contingent test as part of the antenatal Screening programme in Wales were formally published in the May edition of Prenatal Diagnosis, a peer reviewed journal.

Implementation of non-invasive prenatal testing within a national UK antenatal screening programme: Impact on women's choices - Bowden - 2022 - Prenatal Diagnosis - Wiley Online Library

GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales

Clinical Network Programme

As part of the strategy work WHSSC has been working closely with the Clinical Network Programme and whilst the names and arrangements of networks in the diagram below are still under discussion we felt it would be helpful to share as part of the stakeholder engagement that has been undertaken over the past year. The Clinical Networks Programme is part of the National Clinical Framework implementation within the NHS Executive.



NETS

South Wales Neuroendocrine Cancer Service has received a Centre of Excellence Accreditation with ENETS (European Neuroendocrine Tumour Society) – a massive congratulations to Dr Mohid Khan:

ENETSCoE
ASSURING QUALITY SINCE 2009

DR Mohid Khan, Cardiff and Vale University Health Board

A well-done from Dr Sian Lewis, Managing Director for WHSSC the neurosciences commissioning team received substantial assurance form the Audit and Assurance team and to the pharmacy team Eleri Schiavone, Dr Andy Champion and Professor Iolo Doull on reaching the pharmacy finalist awards.

"Well done team we are proud of you!"

PDF **ENETS Audit Checklist/ Report Cardiff**

GIG CYMRU NHS WALES
Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru
Welsh Health Specialised Services Committee

Welsh Health Services Specialised Commissioning

NEWSLETTER

GIG CYMRU NHS WALES
Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru
Welsh Health Specialised Services Committee

whssc.nhs.wales

Autumn 2022

For queries or detail on any aspect within this Newsletter, contact Adele Roberts, Head of Patient Safety and Quality or Leanne Amos, Quality Administration Support Officer.

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GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Shared Services Partnership

Designed by NHS Wales Shared Services Partnership Communications

Quality Assurance Reporting
Final Internal Audit Report

October 2022

Welsh Health Specialised Services Committee

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Contents

Review reference:	CTMUHB-2223-32
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Fieldwork completion:	9 September 2022
Draft report issued:	15 September 2022
Management response received:	4 October 2022
Final report issued:	6 October 2022
Auditors:	Lucy Jugessur, Internal Audit Manager Emma Samways, Deputy Head of Internal Audit
Executive sign-off:	Carole Bell, Director Nursing Quality
Committee:	Audit & Risk Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors

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

Disclaimer notice - please note
This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit and Risk Committee.

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

Executive Summary

Purpose

To evaluate and determine the adequacy of the systems and controls in place within WHSSC in relation to quality assurance reporting.

Overview

We have issued substantial assurance on this area.

There was one matter requiring management attention:

- There was limited evidence to suggest that Health Boards are submitting the WHSSC Quality and Patient Safety Chair's report to their own quality committee meetings for scrutiny and assurance.

Report Opinion

Substantial

Few matters require attention and are compliance or advisory in nature.

Low impact on residual risk exposure

Assurance summary[1]

Objectives		Assurance
1	Roles and responsibilities of the Quality and Commissioning teams	Substantial
2	Processes and mechanisms to allow the Quality and Commissioning teams to co-ordinate the quality monitoring	Substantial
3	Effective quality assurance reporting arrangements in place	Reasonable

[1]The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Monitoring of WHSSC quality matters in Health Board committee meetings	3	Operation	Medium

1. Introduction

1.1 Our review of quality assurance reporting within the Welsh Health Specialised Services Committee (WHSSC) was completed in line with the 2022/23 Internal Audit Plan for Cwm Taf Morgannwg University Health Board (the 'Health Board').

1.2 WHSSC is responsible for the joint planning of specialised services on behalf of the Local Health Boards in Wales. Their strategic aim is to ensure that there is equitable access to safe, effective and sustainable specialised services, as close to patients' home as possible, within available resources. The quality of care and experience that patients and their families receive is central to the commissioning of specialised services. The specialised services commissioned by WHSSC are managed though five programme commissioning teams and include areas such as mental health, cancer & blood and neurosciences.

1.3 In 2014 a WHSSC Quality Framework was developed to provide an infrastructure around quality assurance. The framework has since been revised and renamed the Commissioning Assurance Framework (CAF) to encompass components necessary to provide assurance. A quality team was set up in 2019 to strengthen the focus of quality monitoring, improvement and reporting. The quality team have a pivotal role in the co-ordination of quality monitoring, interventions and reporting across the commissioned services. In turn, relevant quality information is required by health boards from WHSSC so they can meet their responsibilities to deliver high quality, safe healthcare services for all their citizens.

1.4 The risks considered in this review were:

- Serious concerns and performance related issues are not identified meaning remedial action cannot be taken.
- WHSSC is unable to provide assurance to health boards on the quality of care it commissions on their behalf.

1.5 We focussed on the role performed by the Quality function, and not the CAF as a whole.

2. Detailed Audit Findings

Objective 1: The role and responsibilities of the Quality team and the Commissioning service teams in relation to quality monitoring and reporting have been captured.

2.1 The CAF identifies that the Quality team was appointed in 2019 to "strengthen the focus on quality monitoring and improvement". It further details their role in the co-ordination of quality monitoring and interventions within commissioned services.

2.2 The Quality team comprises of a small number of staff, with each providing support to a number of commissioning teams. Their role is integral in the Commissioning teams and they provide quality information from internal and external reports and visits to the service providers, on matters such as infection control, serious untoward incidents (SUIs) and patient experience. Our testing has not identified

any concerns with the current set up of the team, though should the remit of their work expand in the future, the current resource and set up of having a shared quality lead overseeing a few commissioning teams may need to be reviewed.

2.3 The Quality team do not carry out the investigations into complaints and SUIs, this is undertaken by the service provider. However, the team link in with the provider and ensure that investigations are carried out in a timely manner, that responses address the issues of concern, and that lessons learnt are shared and themes are considered. They will also advise the Health Board who are commissioning the service of any complaints or SUIs.

2.4 The Quality team have been involved in re-introducing Service Improvement & Innovation Days (previously called Audit and outcome days). The days are to "support and strengthen the reporting of patient outcomes and experience, sharing of best practice and benchmarking across commissioned services". At the time of our audit, four improvement days had been hosted for Intestinal Failure, Sarcoma, Gender and Traumatic Stress Wales (TSW) Services, and there were key learnings and actions taken from the events.

2.5 The Quality team have recently produced a quarterly Quality Newsletter. The newsletter is to highlight some of the work that the team are involved with from a commissioning perspective and includes an update on the Service Innovation & Improvement Days, data about the number of incidents and complaints and short updates in relation to each of the Commissioning Teams.

Conclusion:

2.6 The roles and responsibilities of the Quality team members within the Commissioning teams is clearly set out. The Quality team have embedded quality monitoring and quality reporting within the commissioning services. The team have progressed since they were established, ensuring that quality and quality monitoring is a key priority in all commissioning teams. We have provided a Substantial assurance rating for this objective.

Objective 2: Processes and mechanisms are in place that allow the Quality and Commissioning teams to co-ordinate the quality monitoring and interventions within commissioning teams to enable reporting.

2.7 There are service specifications and Service Level Agreements (SLAs) in place for each of the services commissioned and these are monitored through SLA meetings with the provider. Prior to the meeting, the quality team review any available data on the services of the provider. During the meetings updates are provided on the services being commissioned and issues are discussed including actions to resolve the issue.

2.8 The WHSCC Quality team also meet with the health boards to discuss the services that WHSSC have commissioned on their behalf. These meetings allow the health boards to feedback concerns they may have, and for WHSSC to update the health boards about the commissioned services.

2.9 Where quality issues are identified with a service provided, an escalation process is in place that allows for enhanced monitoring to ensure issues are resolved as

soon as possible. The Corporate Directors Group Board are responsible for placing services in escalation. The escalation steps are aligned to a tiered approach:

- Level 1 – Enhanced monitoring. This is for any quality or performance concerns that have been identified and will be reviewed by the Commissioning Team.
- Level 2 – Escalated Intervention – For services where Level 1 Enhanced Monitoring identifies the need to further investigation/ intervention.
- Level 3 – Escalated Measures – Evidence that the action plan developed following Level 2 has failed to meet the required outcomes or a serious concern is identified.
- Level 4 – Decommissioning / Outsourcing – Services that have been unable to meet specific targets or demonstrate evidence of improvement a number of actions need to be considered at this stage.

2.10 WHSSC are in the process of enhancing the process by developing an 'Escalation on a page' document. We understand that this will provide greater detail on the escalation status, highlighting a trajectory showing movements within the escalation level, to allow for more granular monitoring.

2.11 We reviewed the quality monitoring arrangements for Adult Gender Services and Cardiac Services, to ensure that there were appropriate processes in place and in line with the CAF. Both services had specifications in place, albeit one was in draft, which detailed the quality indicators and key performance indicators for the provider. There was evidence of meetings with the provider to discuss the services. Both commissioning teams for these services reported into the WHSSC Quality Patient Safety Committee (QPSC) and detailed reviews undertaken by other external functions and services that were in escalation. They also reported actions that had been taken since the previous review and the current position.

Conclusion:

2.12 There are appropriate processes and mechanisms in place that allow the Quality and Commissioning teams to review the providers and services in place. Where there have been issues with a service, an escalation process was in place. We have provided a Substantial assurance rating for this objective.

Objective 3: Effective quality assurance reporting arrangements are in place.

2.13 The CAF details the required quality reporting mechanisms. We confirmed that the QPSC receive consistent update reports from the Commissioning teams including information on services in escalation and any actions taken, quality visits and meetings undertaken, details of serious incidents, safeguarding concerns, complaints and compliments.

2.14 Following each QPSC meeting, a Chair's report is produced. We reviewed the minutes and papers of the WHSS Joint Committee and confirmed the Chair's report of the QPSC was presented at each Joint Committee meeting. A 'Services in Escalation' report was also provided detailing the current position of these services.

2.15 The QPSC Chair's report is also issued to health boards for inclusion on the agenda of their respective quality committees. Our review of a sample of Health Board quality committee meetings identified that for some of the health boards' Chair's report was not always presented to the committee. **(Matter Arising 1)** We acknowledge the Independent Members and officers from health boards sit on the WHSS committees and are therefore made aware of quality matters. However, the regular inclusion of the Chair's report in health board committee papers ensures that the information contained in the reports is available for review and scrutiny by a wider audience, including the public.

2.16 Our review of the minutes and papers from the QPSC identified a number of other quality update reports including:

- Reports that had been undertaken by Health Inspectorate Wales (HIW) and Care Quality Commission (CQC) on the commissioned services.
- An update report and action plan on one of the services within Mental Health & Vulnerable Groups that was at escalation level 4.
- Information in relation to the recent QPSC development day. The day consisted of an update on the CAF and how the Quality team are able to obtain assurance through areas such as SLAs, Service Specifications and performance & escalation.

2.17 We also saw a copy of the QPSC annual report which is provided to health boards. The report provided an update of the areas that were reported to the Joint Committee in the Chair's report, which included updates on the commissioned services.

Conclusion:

2.18 We recognise that there are sufficient quality assurance reporting arrangements on the commissioned services within WHSSC. However, the onward reporting of the quality of commissioned services is not always evident within the health boards. We have provided a Reasonable assurance for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Monitoring of WHSSC quality matters in Health Board committee meetings (Operation)	**Potential Impact**
The Quality and Patient Safety Committee (QPSC) Chair's report provides an update from each of the Commissioning Teams and a summary of services that are in escalation. Chair's reports from each QPSC are presented at the Joint Committee meetings and are forwarded onto the health boards for inclusion within the papers of their respective Quality Committee meetings. We reviewed the papers of the last four quality committees for four health boards and found: • In one health board the Chair's report was an agenda item on three out of four of their quality committee meetings. • In two health boards the Chair's report was an agenda item on only one of their four meetings. • One health board did not appear to have the Chair's report as an agenda item at any of the quality committee meetings that we reviewed.	WHSSC is unable to provide assurance to health boards on the quality of care it commissions on their behalf.

	Recommendation	**Priority**
1.1	We acknowledge that the action of including Chair's reports on health board quality committee agendas is outside of WHSSC's control. However, WHSSC should liaise with health boards to communicate to them the importance of their committees being sighted on this information in order to scrutinise, and gain assurance from it, on behalf of their local population. WHSSC should work with the health board officers and Independent Members who sit on WHSSC committees to facilitate this.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
1.1	Consider the draft report in QPS Development Day.	26/10/2022	Director of Nursing & Quality
	Present Final report and Management Action Plan to WHSSC QPS Committee.	25/12/2022	Director of Nursing & Quality
	Appendix report to QPS Chairs report for submission and consideration by WHSSC Joint Committee.	8/11/2022	Chair WHSSC QPS Committee
	Report to be considered by All Wales Health Board Chairs QPS Committee.	Nov 2022	Chair WHSSC QPS Committee
	Future auditing of compliance to be monitored by the above committee.	Ongoing	All Wales Chairs QPS Committee

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

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

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AGENDA ITEM
6.6

QUALITY & SAFETY COMMITTEE

LEARNING FROM MORTALITY REVIEWS

Date of meeting	15/11/2022
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Esther Flavell – Clinical Lead for Mortality Review, Natalie Morgan Thomas – Deputy Head of CA&QI & Lead Nurse for Clinical Effectiveness and Matthew Smith – Clinical Audit Manager
Presented by	Dom Hurford, Interim Medical Director
Approving Executive Sponsor	Executive Medical Director
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
(Insert Name)	(DD/MM/YYYY)	Choose an item.

ACRONYMS	
MR	Mortality Review
ME	Medical Examiner
PCH	Prince Charles Hospital
RGH	Royal Glamorgan Hospital
PoWH	Princess of Wales Hospital
HMR	Hospital Mortality Review (Previously Called Stage 2 Mortality Review)
CA&QI	Clinical Audit & Quality Informatics

1. SITUATION/BACKGROUND

1.1 The purpose of this report is to update the Quality and Safety Committee of the way Cwm Taf Morgannwg University Health Board captures and disseminates the learning from mortality reviews to ensure lessons learnt are shared to improve the quality of patient care.

1.2 Cwm Taf Morgannwg University Health Board are in line with the All Wales Learning From Mortality Review Model Framework (September 2021). The advent of Medical Examiners (MEs) has given an opportunity for NHS Wales to look at how mortality reviews can be conducted to maximise learning, prevent future harm and improve the experience of patients, families and NHS staff. The Framework aims to provide a co-ordinated and systematic all wales approach to the mortality review process to enable local and national implementation of learning.

1.3 MEs are independent to organisations, HBs and Trusts and will review all deaths other than those that are covered by HM Coroners. They will refer any concerns identified at their initial review, to the relevant Health Board. This provides an objectivity to the reviews undertaken

1.4 Upon receipt of an ME referral, the organisation will decide on the most appropriate process for managing cases that have been sent to them by the ME. This is the responsibility of the CTM Multidisciplinary Mortality Review Screening Panel that went live on 1st April 2022. This coincided with the "Go Live" date for the Mortality Review module within DATIX that assists with capturing this information in a more systematic way as well as themes for learning opportunities. This is a whole Cwm Taf Morgannwg University Health Board Panel ensuring all deaths that need to be reviewed follow the same process within each Service Group.

The table below outlines the number of deaths referrals received from 1st April 2022 to 30th September2022, the number currently in progress and the number closed.

	Total Referrals	Awaiting Screening Panel	Under Investigation/ Action Required	Closed Pending Feedback	Closed
CTMUHB	**610**	**21**	**255**	**2**	**332**

1.5 Every stage of the mortality review process provides an opportunity for learning and recognizing notable practice. The learning captured is shared via a quarterly newsletter. Immediate

make safe cases are instantly communicated to the directors of the Service Groups and Directors of nursing if required. Going forward the mortality review module within DATIX will assist us with capturing this information in a more systematic way and each learning point will have an action plan assigned to it.

2023 will see the introduction of biannual learning from MR events across CTM. In addition, quarterly lunch and learn events will be established quarterly to promote the newly released newsletter.

Learning from Mortality Reviews

1.6 Medical Examiner Service is currently reviewing approximately 95% of all Cwm Taf Morgannwg University Health Board, in hospital deaths. Accident & Emergency Departments remain the final areas to utilise this service. These deaths are still currently reviewed via the Universal Mortality Review (UMR) process, previously known as Stage 1 Mortality Review.

The table below outlines the number of deaths for each of the 3 localities from 1st April 2022 to 30th September2022, the number where an initial review has been undertaken (either by ME or UMR), and the number and percentage outstanding.

	Total Deaths	Number Reviewed	Number Outstanding	Percentage Outstanding
Bridgend	490	475	15	3%
Merthyr	485	473	12	2%
Rhondda	535	521	14	3%

1.7 Hospital Mortality Review (HMR) panels, previously known as Stage 2 Mortality Review, have continued in RGH & PCH, albeit within a limited capacity due to the availability of clinical reviewers during the Covid19 pandemic. POW has very recently established a weekly panel and is in the process of clearing the backlog of cases. The table below shows the number of cases identified for HMR for each of the 3 localities from 1st April 2022 to 30th September2022, the number where the review has been completed and the number and percentage outstanding.

	Number of HMR	Number Complete	Number Outstanding	Percentage Outstanding
Bridgend	88	30	58	66%
Merthyr	78	37	41	53%
Rhondda	119	40	79	66%

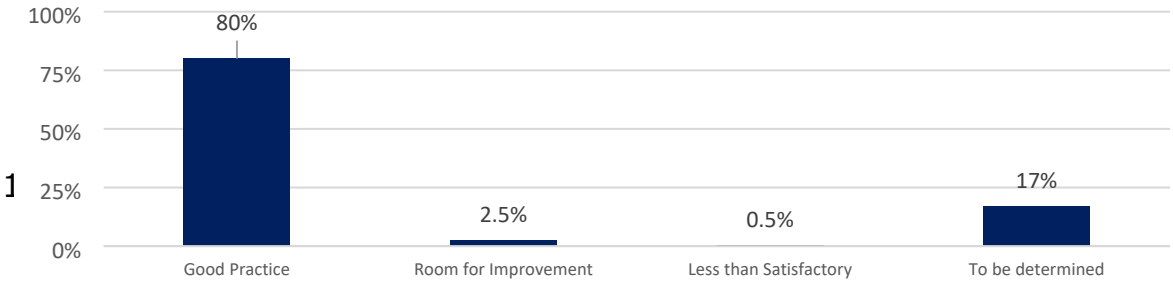
It should be noted that HMR panels are assisting with the completion of Wave 1 Hospital Acquired Covid reviews. This has impacted on the number of post April 2022 deaths that can be reviewed in each session

There are also a number of cases outstanding from:
2021-22 - Bridgend 87, Merthyr 104 & Rhondda 58.
2020-21 - Bridgend 178, Merthyr 68 & Rhondda 139. **290 of these cases relate to Hospital Acquired Covid-19 and will be completed by the Central Covid Team*

1.8 Stage 3 Mortality Review panel was suspended during phase 1 & 2 of the Covid19 pandemic. Panels are now held on a monthly basis via Teams. There are currently 33 cases either waiting to be reviewed or in progress. Stage 3 functionality will be reviewed upon completion of the current backlog.

1.9 The DATIX mortality review module triangulates learning from mortality reviews with incidents and complaints to provide a complete picture. Action plans can then be devised considering all elements of the findings, and assurances given with progress made against the action plan. Mortality review findings are collated on completion. An Outcomes section is currently in development and expected 1/10/22. Upon release this will enable us to create a Mortality Dashboard for easier access to learning from death and wider dissemination. The graph below highlights Mortality Findings for 2022-23 so far.

Graph MR01: Mortality Findings as a % of All Deceased Patients



- Communication - many referrals could be avoided with improved communication with patients and relatives. Ensure clear communication regarding diagnosis to better prepare for decision making in regard to the patient
- Peri-operative Physician – previously noted to the Health Board as an urgent concern. Cases continue to highlight the lack of this service in RGH & PCH, which does not comply with Welsh Government standards on provision of care. It should be noted an Orthogeriatrician has been appointed at POW and are taking over the care of all fractured neck of femur patients soon, so it's likely that there may be improvements seen there. Arrangements continue to obtain Orthogeriatric services in PCH too.
- Improvements in End of Life Care - De-escalation / celling of care should be discussed and agreed earlier in the patients' admission in many cases being reviewed. Continuation of observations/NEWS after the decision was made for TLC only. ME service regularly notes NEWS (National Early Warning Score) continuing inappropriately when SEWS (Symptom Early Warning Score) should be considered. Inappropriate/Unnecessary investigations for patients who are being kept comfortable for end of life care. Missed opportunities to alert family members of deteriorating patient enabling them to attend the ward when end of life is imminent.
- Offload Delays at A&E Departments – highlighted as a concern for patients whose observations are worsening. Severe pressures on A&E Departments are noted
- Improvements in DNACPR Process – DNACPR discussions could take place earlier in patient's episode of care. In many occasions recently, DNACPR forms have been completed by junior doctors only without countersignature by Consultant/Senior doctor
- Gentamicin Prescribing and Monitoring – noted to be less prone to gentamicin error at RGH/PCH as there is a well-established practice involving a separate chart that prompts levels and has a nomogram to assist dosing. This is not the case in POW. Antimicrobial guidelines are currently in the process of being consolidated in to one health board wide guidance.
- Sepsis protocols need to be followed - There have been a number of recent cases recently where this has not been initiated soon enough. Immunosuppressants should be discontinued when treating a patient with sepsis.

- Frailty - Improved care in the community for patients with known frailty would reduce the number of potentially avoidable admissions

1.11 Currently, learning opportunities are fed back to the clinical teams or to the heads of nursing directly. With the use of the new DATIX module and the learning element of that system, this will allow clinical teams opportunities to devise action plans for sharing with the wider clinical work force. All actions will be routinely updated on the DATIX system to provide the required assurance for the organisation.

1.12 When a case has not been resolved in the first two levels a proportionate investigation should be arranged. The scale and scope of the investigation should be proportionate to the case to ensure resources are effectively used. Cases which indicate the most significant need for learning to prevent serious harm should be prioritised.

1.13 CTM will progress to level 3 when key issues and corrective actions have been identified, which could ultimately prevent or reduce the likelihood of the case recurring, providing assurance that risks have been reduced so far as is reasonably practicable, to ensure that appropriate control measures have been identified.

1.14 In line with the principles of Putting Things Right, we should investigate once and investigate well, ensuring the investigation is thorough, systematic and avoids shortcuts that negatively impact on the final outcome of the quality and findings of the investigation.

1.15 A summary of the learning from mortality reviews are shared throughout the Health Board via a quarterly newsletter and uploaded to SharePoint, noting common issues that have occurred within specific services or sites and across multiple services or sites. There will also be bi-annual learning events held in Cwm Taf Morgannwg University Health Board to discuss the learning from mortality reviews. These findings may lead to further thematic reviews of cases that share common factors. Direct feedback is provided to clinical and nursing teams as and when required.

1.16 Learning is often considered as a 'one off' event where the problem is focused upon for a short time but moves onto new priorities as they emerge, often losing sustained learning. Consequently the action plans made following mortality reviews should be measured over time as part of a core clinical governance review programme. Until the Once For Wales/DATIX system is fully utilized, all action plans as a result of mortality reviews should be maintained by governance teams and feedback

should be given to the Clinical audit team, for assurance and transparency.

1.17 Work is in progress to link the findings from the MR process with the Health Board quality improvement programme of work.

Ongoing Development

1.18 Cwm Taf Morgannwg University Health Board wide Mortality Review Screening Panel live from April 2022, consisting of representatives from each Locality (Clinical and non-clinical, Primary Care, Palliative Care, Welsh Ambulance Service and Local Authority. Process maps continue to be developed in light of organisational restructure. Feedback templates and procedures for next of kin feedback (where requested) also currently in development.

1.19 Discussions are ongoing to ensure all ME Referrals are available to, and involving local teams as a first off for investigation of deaths so learning starts with them

1.20 DATIX Mortality Module updated 1st October with the inclusion of Outcomes section. Training continues to be delivered to all personnel with a responsibility for inputting to / updating / maintaining the module.

1.21 Further recruitment of clinical reviewers across CTMUHB to attend mortality review sessions in order to undertake all hospital mortality reviews, as identified by screening panel, in a timely manner. Training is available and will be provided to each reviewer. Approximately 75 members of staff across CTMUHB have received Mortality Review training. MR training is available to clinical teams and the nursing workforce via MST monthly. Bespoke training is also available on request. Recent feedback provided by Senior Nursing staff in POW has highlighted that those staff that have attended Mortality Review panel have enjoyed and felt that being involved is useful to their own practice and being able to use their knowledge and experience to support decisions.

The Medical Director currently finalising plans to make MR part of Consultant appraisal. It's likely to take a while to embed this but will play a major role in improved engagement.

1.22 It has been agreed that a resource is required for coordination of Mortality review activity across Cwm Taf Morgannwg University Health Board, but there is no funding currently available. This is an important role in triangulating, all activity from point of Medical Examiner referral onwards, including coordination of screening panel, oversight of DATIX module, coordination of hospital mortality review sessions, ensuring actions are completed and

dissemination of information and learning. Resource paper submission to suitably resource service needs

1.23 From 1st April 2023 all deaths with the Community will be reviewed by the Medical Examiner Service. It is felt this will have a substantial impact on the current Mortality Review Service as the number of ME referrals will likely increase considerably. This needs to be taken into account for future resource planning.

Baseline Population Numbers

1.24 The population CTM health board serves comprises the local authority areas of Bridgend, Rhondda Cynon Taf and Merthyr. The total population for each region of population density is shown in the table below. This is taken from the Office for National Statistics (ONS) using their 2021 dataset as the latest whole year published.

Estimated data from 2020 for population of local areas to Cwm Taf Morgannwg University Health Board

Area	Estimated pop 2020	People/km 2020
Bridgend	147 539	588
RCT	241 873	570
Merthyr	60 424	542

1.25 The table below shows the number of deaths per area for each month of 2022 for each local authority area. Again, the data sets are form the ONS using their 2022 dataset.

Deaths per region 2022(taken form ONS website)

Area	Jan	Feb	March	Apr	May	June	July	Aug
Bridgend	135	128	148	131	147	117	124	132
RCT	218	186	219	176	241	186	234	219
MCT	65	57	70	66	53	67	42	46

ONS data for deaths per month for Wales 2022

Month	Deaths	COVID	Age SMR
Jan	3262	237	311
Feb	2730	121	196
March	3203	133	207
April	2894	166	255
May	2992	100	150
June	2740	37	62
July	2638	106	176
August	2931	87	144

1.26 We would also like to reassure the committee that Wales has a robust MR Service looking at all deaths via the medical examiner. This is unlike the system in England where a proportion of deaths is looked at rather than each one. As a result of this, we are in contact regularly with the medical examiners who raise thematic concerns such as particular drugs or infections of concern. We are not aware of any highlights of specific specialties of concern to date.

1.27 SHMI and HMSR are versions of RAMI (Risk Adjusted Mortality Index) used in England. We have not used RAMI as a way of measuring Mortality in Wales since the 2014 Palmer Report which stated that All Deaths should undergo review (which we were already doing). England is still sampling.

From Gov.Wales: *"In July 2014, Professor Stephen Palmer's review of the use of risk-adjusted mortality data in NHS Wales was published. He concluded the risk-adjusted mortality index (RAMI) was not a meaningful measure of hospital quality in Wales and its use could divert attention away from more meaningful approaches to measuring and improving hospital care"*

1.28 The ONS does not publish data on days of admission, only days of death. We are unable to look at data such as day of admission and effect on death rates or deaths per specialty at the current time. This could be incorporated into further reports but would require more administration time and notes reviews. It should be noted though, that as all hospital deaths in Wales are reviewed, themes of relevance such as sepsis are sought, and there is a good working relationship with the medical examiners office, highlighting areas of concern.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 The Health Board is asked to note that a "National Learning from Deaths" Programme will be developed to maximise learning, using two key approaches:

2.2 **Extrinsic:**

- Regular national meetings, e.g. monthly, which look at both processes & quality, as well as themes e.g. suicides, peri-operative deaths
- Multiple Sources (e.g. Medical Examiners, Clinical Reviews, Coroners Inquests and Regulation 28s, Serious incidents etc.)

- Communication via safety alerts, newsfeeds via DU Website and briefings into local bulletins

2.3 **Intrinsic:**

- A system of regular peer review of organisations to facilitate formative assessment and learning prompted by colleagues
- This coordinated approach to analysing information from different sources will help target and prioritise the key risks that require local and national attention.

3. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below: Safe Care, Effective Care, Dignified Care Timely Care, Staff and Resources
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If no, please provide reasons why an EIA was not considered to be required in the box below.
	Not required
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goal	Improving Care

4. RECOMMENDATION

4.1 That the Committee **NOTE** the contents of the paper.

AGENDA ITEM
6.7

QUALITY & SAFETY COMMITTEE

QUALITY STRATEGY

Date of meeting	17/11/2022
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Melanie Barker, Assistant Director of Therapies and Health Science
Presented by	Lauren Edwards, Executive Director of Therapies and Health Science
Approving Executive Sponsor	Executive Director of Therapies & Health Sciences
Report purpose	FOR APPROVAL

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Executive-led Patient Safety Group Executive Leadership Group	24.10.22 21.10.22	SUPPORTED

ACRONYMS	
CTM	Cwm Taf Morgannwg University Health Board

1. SITUATION/BACKGROUND

Quality is at the heart of Cwm Taf Morgannwg University Health Board (CTM) and our aim is to improve outcomes for our people, whoever they are and wherever they live.

Following engagement with our key stakeholders to ensure that our quality goals and objectives are reflective of their priorities and concerns, our CTM Quality Strategy for 2022-2025 has been developed using an iterative approach.

Aligning to the ambitions of our organisational strategy *CTM 2030: Our Health Our Future,* CTM Quality Strategy articulates our focus on quality. It demonstrates to our colleagues, communities and our partners the ways in which our ambitious and bold quality commitments will enable us to work in partnership to create health, improve care, inspire people, and sustain our future.

As Quality is central to every individual, team, service and directorate across CTM, our Quality Strategy articulate our quality vision, mission, pledge and ambitions. Our quality ambitions are based upon the 6 characteristics of quality outlined within the Quality and Safety Framework published by Welsh Government in 2021

An associated annual work plan will be developed to compliment the quality strategy and articulate how SMART quality objectives will be used to ensure delivery of our quality ambitions. Objectives will be monitored through our governance structures, inclusive of feedback and collaboration with our stakeholders, and will form part of our formal reporting structures.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING

To consider and endorse CTM Quality Strategy 2022-2025.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

The CTM Quality Strategy will support CTM colleagues in delivering our Quality Pledge to continuously improve by working in partnership and by placing people at the centre of what we do, so that we can consistently deliver high quality care for everyone.

The development of an associated annual quality work plan, aligned to the CTM Quality Strategy and detailing SMART quality objectives, will provide robust assurance of delivery against our ambition.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	Improvement expected in quality, safety and patient experience through delivery of the SMART objectives of the Quality Strategy.
Related Health and Care standard(s)	Safe Care
	All aspects of quality care
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below)
	No implications
Legal implications / impact	Yes (Include further detail below)
	Improvement expected in quality, safety and patient experience through delivery of the SMART objectives of the Quality Strategy
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Improving Care

5. RECOMMENDATIONS

- That the Committee **endorse** the Quality Strategy.

Cwm Taf Morgannwg University Health Board Quality Strategy 2022 - 2025

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Welcome

We want to improve health and wellbeing, deliver better care, and better value across the diverse communities that we serve.
We want to be considered an outstanding organisation by everyone: people who use our services, their families and carers, our colleagues, our communities and our partners. This is what drives our commitment to place quality at the heart of everything that we do.

Putting quality and safety above all else is the first NHS Wales core value. This focus has been strengthened through the Health and Social Care (Quality and Engagement) (Wales) Act (2020), the National Clinical Framework for Wales (2021), and the Quality and Safety Framework (2021). Collectively, these set out an aspiration for quality-led health and care services, underpinned by prudent healthcare principles, value-based healthcare and the quadruple aim.

Cwm Taf Morgannwg University Health Board (CTM) is passionate about ***putting quality and safety above all else and providing high-value, evidence-based care for our patients at all times***.

How we will deliver high–quality care

Quality is at the heart of CTM and our aim is to improve outcomes for our people, whoever they are and wherever they live.

We want to make sure that we are meeting the health and care needs of all our communities. We will achieve this by:

- Working with our communities and partners to reduce inequality, promote well-being, and prevent ill-health
- Provide high quality, evidence-based, data-driven, and accessible care
- Ensure sustainability in all that we do: economically, environmentally, and socially
- Co-create a learning and growing culture

Delivering high-quality care consistently across all our services is no easy task; it requires a strong commitment to working in partnership with all our key stakeholders.

We want to enable our excellent people to deliver high quality care to every person, every day, across all of our services. **Our organisational values help us to be at our best**. They bring us together and make us a stronger team.

By living up to our values at every opportunity, we can achieve our quality vision and ambitions.

Introduction

Cwm Taf Morgannwg University Health Board, established in 2019, provides primary, community, inpatient, and mental health services to the 450,000 people living in three County Boroughs: Bridgend, Merthyr Tydfil, and Rhondda Cynon Taf.

We are situated between Wales' capital city, Cardiff, to the south, the coastal town of Porthcawl to the west, and the stunning scenery in the Brecon Beacons National Park to the north. We operate within a vibrant community, rich with history and heritage.

With almost 12,500 colleagues, **our workforce is the lifeblood** not only of our University Health Board, but also of the communities that we serve, as almost 85% of our colleagues live within our footprint.

We take our role as one of the largest employers in the area very seriously. This is evident in our wide-ranging partnership working, dedication to our corporate social responsibilities, and the importance we place on **building relationships** with our colleagues and community.

Welsh Government increasingly expects the NHS in Wales to ensure that health spending benefits the Foundational Economy, and we are committed to reflecting this ambition within our strategic planning, as this also supports the goals of the Well-being and Future Generations Act.

Our region faces a number of challenges to ensuring that the foundations of a healthy life are strong: access to good work, quality housing, good educational attainment, and thriving communities. These challenges were made all the more visible by the COVID-19 pandemic.

Our Quality Strategy supports us to build on our achievements to date and deliver the best quality care in collaboration with our communities in order to maximise our influence on **social value** as an employer, purchaser and capital owner.

CTM 2030 Our Health, Our Future

This Quality Strategy does not sit in isolation. Quality is one of 8 'golden threads' that will run through everything that we do, in order to deliver the ambitions of our Health Board.

Our organisational strategy, **CTM 2030: Our Health, Our Future**, outlines how we will develop our services to meet the needs of our population as we look to 2030 and beyond. We will work with our communities to ensure that **local people can live happier and healthier lives**.

The 4 aims of CTM 2030 are:

Defining Quality

We describe quality using the framework outlined by the Institute for Healthcare Improvement.

Our Health Board is committed to supporting the vision articulated in *A Healthier Wales* (WG, 2018): that everyone in Wales should have longer, healthier and happier lives. **A clear and sustained focus on quality will help us to achieve this for the benefit of our people and our communities**.

But defining quality alone does not guarantee success. We know that great care does not happen by accident, but by design and from a commitment to working together. Key to the delivery of our plans is a *Quality Management System* approach in order to embed **a culture where people listen, think, feel and act 'quality'** - promoting openness and learning, continuous improvement and service transformation.

When considering quality in CTM, our focus will be on **people, patients, and place**.

Quality Strategy on a page

Our Quality Vision

We want to improve health and wellbeing, deliver better care, and better value across the diverse communities that we serve.
We want to be considered an outstanding organisation by everyone – people who use our services, their families and carers, our colleagues, our communities, and our partners.

Our Quality Mission

For our excellent people to deliver high quality care to every person, every day, in every setting.

Our Quality Pledge

We will continuously improve by working in partnership and by placing people at the centre of what we do, so that we can consistently deliver high quality care for everyone.

Our Quality Ambitions

Safe Care	• everyone can be confident that our care will cause no harm
Timely Care	• people have timely access to care when they need it
Effective Care	• people receive care that is appropriate and based on evidence/research
Equitable Care	• everyone can be confident of positive health outcomes, regardless of geography or status
Efficient Care	• people will receive value-based healthcare, where waste is avoided
Person-Centered Care	• people will be supported to be actively involved in their care as equal partners

Quality Improvement in CTM

Over recent years CTM has experienced significant change, along with challenges relating to quality and the COVID-19 pandemic. Our organisation recognises the ongoing challenges that we face. We are committed to improving quality and have a dedicated improvement directorate (iCTM).

The iCTM directorate builds capacity for change across our organisation, co-ordinates improvement and innovation activity, and engages with our colleagues, patients, communities and partners to drive the adoption and spread of the most impactful improvement and innovation options, all underpinned by the principles of Prudent and Value Based Healthcare and co-creation.

This commitment to provide ALL our people with the knowledge, skills and support to make changes will drive quality improvement initiatives throughout CTM.

We will implement a number of community of practice and community of interest groups to support our people to collaborate to drive high-quality care at every level. These communities will include:

- Change Community of Practice
- Improvement Community of Practice
- Value Based Healthcare Community of Interest.

Quality Partners

We work closely with external partners such Improvement Cymru, Healthcare Inspectorate Wales (HIW), Audit Wales, higher and further education institutes, and many others. We will demonstrate an open culture and always seek out opportunities to learn and improve for the benefit of our people, our patients, and our communities. **We will develop, deliver and embed system-wide improvements** across health and social care in order to create a healthier Wales.

Harnessing our people's ideas

Often, the best ideas for improving quality comes from those delivering the services. In 2022, CTM implemented our staff ideas scheme called 'The Idea Factory'. We have and will continue to develop 'challenges' and ask our people to help form and develop solutions to problems relating to our Quality Ambitions.

Duty of Quality

The duty of quality comes into effect in April 2023 and supports us to actively consider whether our decisions improve quality and outcomes for our population.

When discharging the duty of quality, we will take into account the Health and Care Standards: the national framework that helps us to demonstrate that we are doing the right thing, in the right way, in the right place.

The roll-out of our Quality Strategy and our commitment to the delivery of our quality ambitions will support people's understanding of the duty of quality. Our regular progress reports

will ensure **we are accountable to each other and to our partners**.

Quality monitoring and reporting

Our Quality Strategy sets out our quality ambitions and our quality goals, structured around the six dimensions of quality for 2022-25. We have undertaken stakeholder engagement to ensure that these chime with the views and priorities of our stakeholders.

Each year, we will devise an **Annual Quality Work Plan to focus our efforts on the delivery of SMART quality objectives**. Identification of these annual objectives will be data-driven and risk-stratified to ensure a targeted approach to improving quality.

As an organisation, we will monitor and report our progress against the SMART quality objectives that we have committed to achieve. We will do this at regular intervals and will adapt our plans based upon progress and learning.

Within CTM, we ensure that our **quality performance monitoring is 'always on'**. Our Quality Management System will ensure that quality performance data is readily available in order to ensure rapid identification and response to any early warning indicators.

Quality and safety is everyone's business, but senior accountability and responsibility has been strengthened within CTM through the collective responsibility being shared across our four clinical Executive Directors. Our operating model ensures clearly defined structures for quality governance across the Care Groups, and professional groups have identified leads for quality.

The CTM Quality and Patient Safety Governance Framework defines responsibilities at service level through to the Executive Level. Our Incident Reporting and Management Framework offers clarity to ensure effective reporting and learning from incidents. Our Listening and Learning Framework ensures that we actively seek feedback, positive or negative, as we see this as an opportunity to learn and improve quality. Resources have been strengthened through the introduction of strategic roles to support quality and patient safety within the nursing management team and Allied Health Professions, as well as the office of the Medical Director.

A well-defined quality governance structure is established within CTM, with the Quality and Safety Committee receiving assurance and providing scrutiny on quality, patient safety and patient experience.

In addition to the Quality and Safety Committee, an Executive Director-led Patient Safety meeting is held each week, where an 'At-A-Glance' dashboard of quality-related matrices is presented to facilitate a timely review of the previous week's quality performance. The Director of Improvement and Innovation attends this meeting so that any themes and trends are used to inform improvement interventions via iCTM.

Immediately following this weekly meeting, the clinical Executive Directors and the Director of Corporate Governance update the wider Executive Team on the key quality and safety concerns, ensuring that all Executive colleagues are sighted.

PLACEHOLDER: quality governance structures.

Each year we publish the Health Board's Annual Quality Statement, providing an overview of our quality achievements, reporting on issues identified through our quality management system, and setting specific annual quality improvement goals.

Our quality reporting structure provides a way for us to set progressive implementation plans, adapt plans based on experiences and learning, and monitor progress against our strategic goals.

Our Quality Journey

In developing our Quality Strategy, we have spent time reviewing and reflecting on our journey so far. We have engaged with people and listened to their thoughts, concerns, and ideas about high quality care in CTM.

Engagement and coproduction

This strategy has been developed collaboratively, through informal discussion and formal stakeholder engagement sessions. We place high importance on the learning, contributions and feedback obtained and have included all the key themes within this strategy.

Managing risks and challenges to quality

We recognise the difficulties with delivering our quality ambitions in the challenging times we currently face. National and local plans for recovery from the impact of the Covid-19 pandemic, time-frames, and resource pressures make it more difficult to deliver solutions for large- and small-scale system changes and complex issues. Re-energising our colleagues for transformation, changes to operational structures, and national workforce shortages also add to the challenge.

We will aim to reduce the impact and risk of these by prioritising the wellbeing of our people and investing in the development of their skills and knowledge. Our continuing drive to innovate, increase integrated working, and engage regularly and effectively with our communities and partners will ensure that we understand each other's challenges and work together to find solutions and mitigations.

Our Quality Ambitions and Strategic Quality Goals

Our 6 inter-dependant quality ambitions are based on the 6 dimensions of quality and shape our strategic quality goals. These in turn provide the framework for our Annual Quality Work Plan, containing SMART objectives (Specific, Measurable, Achievable, Realistic, and Timed) against which we monitor and report our progress at regular intervals, adjusting our plans as required. Where appropriate, priorities have been mapped against NHS Wales Performance Framework & Guidance Document 2022-23.

OUR QUALITY AMBITIONS	OUR STRATEGIC QUALITY GOALS	CTM 2030 GOAL
SAFE CARE: everyone can be confident that our care will cause no harm	Develop and empower our colleagues to deliver outstanding care. Develop a Just Culture that promotes safety through supporting people to speak up, with an effective Listening and Learning Framework.	• Inspiring People • Improving Care
TIMELY CARE: people have timely access to care when they need it	Improve access to urgent and emergency care. Support people whilst they are waiting, optimising their health and wellbeing in order to achieve the best possible outcomes.	• Creating Health • Improving Care • Inspiring People
EFFECTIVE CARE: people receive care that is appropriate and based on evidence	Develop evidence-based models of care with our partners, making the most effective use of skills and resources. Contribute to research in practice. Measure the impact and effectiveness of what we do, building on what works well and making brave decisions about what doesn't	• Improving Care • Inspiring People • Sustaining Our Future
EQUITABLE CARE: there are no avoidable, unfair or remediable differences in the care we give to people who have similar health needs	New models of care are designed using population health data and reflect local need. We regularly and effectively engage with our patients, communities and stakeholders to understand barriers to seeking early help for health needs.	• Improving Care • Creating Health • Inspiring People
EFFICIENT CARE: we will focus on outcomes that matter to people and maximise those outcomes for every pound we spend on providing care	Enable our colleagues to do tasks/roles that they are best suited to do, thus cutting out waste. Support our colleagues to stay well and reduce agency use across CTM.	• Inspiring People • Improving Care • Sustaining our Future
PERSON-CENTERED CARE: people will be supported to be actively involved in their care as equal partners	Increase co-production across CTM, delivering care that is responsive to people's needs and wishes. Reduce variability in how well we engage and support patients, carers and families.	• Inspiring People • Improving Care • Sustaining our Future

Our Quality Ambition - Safe Care

Everyone can be confident that our care will cause no harm.

Our Strategic Quality Goals:

- Develop and empower our colleagues to deliver outstanding care
- Develop a Just Culture that promotes safety through supporting people to speak up, with an effective Learning Framework.

Our True North	What our journey to success looks like
No avoidable harm (e.g. from falls, pressure ulcers, medication errors)	➢ Training packages developed with increasing numbers of attendances ➢ Effective cascade of good practice ➢ Assurance process for embedded learning ➢ Relaunch of Falls Strategy ➢ MDT review of all incidents to ensure holistic learning and actions ➢ QMS ensures rapid identification of outliers, triggering a deep dive and action plan
A Just and Restorative Culture across CTM	➢ Launch of programme, with visible Board level and senior leadership support ➢ Just and Restorative Culture Champions ➢ Policies reviewed at point of renewal to ensure they are conducive to a Just and Restorative Culture approach ➢ Positive feedback from colleagues ➢ Reduction in formal disciplinary and grievance numbers; improved retention rates
Complaints, inquests, claims and external reviews receive prompt and robust responses. All learning is swiftly embedded with assurance regarding sustainability.	➢ Improved responsiveness to complaints and claims ➢ Our stakeholders are assured of our open and learning culture ➢ Listening & Learning Framework embedded ➢ Team aware of their local learning as well as organisational themes

CTM 2030 Goals: Inspiring People and Improving Care

CASE STUDY Safe Care: Community Acquired Pressure Ulcer Improvement Collaborative

Background: Patient safety is a top priority in CTM. With previous attempts to focus on reducing the incidence of avoidable incidents being less impactful than hoped, it was recognised that a new QI approach was needed to reduce these types of incidents.

Challenges: getting all stakeholders on board with using a new collaborative approach and obtaining consistent data from all areas.

Objectives: to reduce the number of patient safety incidents and increase both the capacity/capability of front-line staff to improve the care they deliver using QI methodology.

Solutions: Evidence based approach, training on multiple systems to ensure standardised data collection and planned launch event ensuring continued stakeholder engagement & participation.

Impacts: the collaborative action learning will help reduce avoidable pressure ulcer incidents and will help create more awareness within Teams on pressure damage. This will have a positive impact on average length of stay and improve patient outcomes.

Learning: We are at the beginning of this journey and the collaborative is aimed to have action learning after each session. All our learning will be recorded and actioned and will also be reflected in our final evaluation so that it can be used for further work.

Contributors: L. Jenkins, S .Reed, A. Thomas, L. Mann, B. Gammon, F. Navabjan

Our Quality Ambition - Timely Care

People have timely access to care when they need it.

Our Strategic Quality Goals:

- Improve access to urgent and emergency care.
- Support people whilst they are waiting, optimising their health and wellbeing in order to achieve the best possible outcomes.

Our True North	What our journey to success looks like
Everybody receives prompt care in the most appropriate setting and from the most appropriate person	➢ Successful delivery of the 6 Goals for Urgent and Emergency Care ➢ ↑ usage of primary/community services ➢ ↑ advanced and consultant practitioners (nursing, AHP, healthcare science, pharmacy, physician's associates) ➢ Effective use of a skilled support workforce ➢ Partnership working with voluntary sector ➢ Regional solutions for pathology and radiology ➢ ↑ cancer pathway performance ➢ Successful delivery of Planned Care Recovery & transformation programmes
Our acute hospitals experience no ambulance handover delays, no delays for assessment and admission, and no delayed discharges.	➢ ↓ handover delays; ↓ ED waits >12hrs ➢ ↑ discharges before midday; ↓ LoS ➢ ↑ numbers on D2RA pathways within 48hrs ➢ Partnership working with Social Care and Welsh Ambulance Service Trust
Everybody on our waiting lists is optimised to achieve the best possible outcomes (waiting well, patient activation, prehab)	➢ Project to review services for: long-term conditions; rehabilitation; reablement ➢ ↓ numbers waiting >14 wks for therapies ➢ A supported self-management offer; shared decision making; motivational interviewing ➢ Comprehensive prehab offer; MECC

CTM 2030 Goals: Creating Health, Improving Care and Inspiring People

CASE STUDY FOR TIMELY CARE: Radiology Navigator

The need for this new role was identified by clinical leaders at the Princess of Wales Hospital. Thanks to a successful application through the Bevan Commission's Planned Care Innovation Programme, a new Radiology Navigator role has been created.

The aim of the Navigator role is to significantly reduce delays between diagnosis and treatment for cancer patients, leading to better outcomes and survival rates. The Navigator acts as a guide for patients and combining several diagnostic tests into one visit to the Radiology department. The Navigator is a crucial link between Radiology and the clinical teams, being a point of contact and involved in multidisciplinary team meetings.

The Radiology Cancer Navigator at the Princess of Wales Hospital. She said: "I am delighted to begin my role as Radiology Cancer Navigator, and I am already finding making a positive difference for patients extremely rewarding''.

This is an exciting new venture for all involved. Our joint vision it to provide a seamless diagnostic journey for cancer patients without delay. Every patient should be afforded a streamlined process which in turn will provide the earliest diagnosis possible following suspicion of cancer

Our Quality Ambition – Effective Care

People receive care that is appropriate and based on evidence.

Our Strategic Quality Goals:

- Develop evidence-based models of care with our partners, making the most effective use of skills and resources.
- Measure the impact and effectiveness of what we do, building on what works well and making brave decisions about what doesn't

Our True North	What our journey to success looks like
Consistent use of Friends and Family Test (FFT), PROMs and PREMs across our physical health and mental health services	➢ Programme for gradual roll-out of FFT, Patient Rated Outcome Measures and Patient Rated Experience Measures ➢ Feedback data shared with teams to ensure a clear understanding of what works well and opportunities for improvement ➢ Patient and carer feedback triangulated with quality indicators to identify outliers, triggering deep dive and action plan
All services developments informed by data and evidence (clinical and non-clinical)	➢ Increased Research & Development activity ➢ Increased QI skills and capacity across services ➢ Increased working with our academic partners ➢ Active partners in supporting community and voluntary sector developments
Continuous development and transformation of our people	➢ Consistent improvement in training compliance ➢ Increased uptake of leadership courses ➢ Wellbeing offers developed in response to local need

CTM 2030 Goals: Improving Care, Inspiring People, and Sustaining Our Future

An Example of Effective Care – Leadership & Management at CTM

Leadership & Management PROGRAMMES

CTM recognises the importance of continuous development and transformation of our people. Through the CTM Leadership & Management Programmes, colleagues are able to access a range of inspirational courses, designed to generate future leaders and managers.

CTM have created three leadership courses IGNITE, ASPIRE and INSPIRE that are grounded in the realities of the challenges our managers and leaders are facing right now.

Our Quality Ambition – Equitable Care

There are no avoidable, unfair or remediable differences in the care we give to people who have similar health needs.

Our Strategic Quality Goals:

- New models of care are designed using population health data and reflect local need.
- We regularly and effectively engage with our patients, communities and stakeholders to understand barriers to seeking early help for health needs.

Our True North	What our journey to success looks like
Population health data informs our service developments	➢ Profile of service usage by socioeconomic determinants of health (SEDH – income, health, education, employment, housing) ➢ Lifestyle campaigns developed and driven by data ➢ Targeted programmes to ↓health inequalities ➢ ↑ performance in Welsh-medium care provision
High engagement with vaccination campaigns across all geographical locations within CTM	➢ Annual ↑ in uptake of COVID-19 vaccinations ➢ Annual ↑ in uptake of flu vaccinations ➢ Annual ↑ in children who receive 3 doses of the hexavalent '6 in 1' vaccine by age 1 ➢ Annual ↑ in children who receive 2 doses of the MMR vaccine by age 5
Low levels of smoking and obesity across our footprint	➢ ↑ percentage of adults losing clinically significant weight through the All Wales Weight Management Pathway ➢ ↑ percentage of babies who are exclusively breastfed at 10 days old ➢ ↑ percentage of adult smokers who make a quit attempt via smoking cessation services ➢ ↑ projects with Leisure Centres and local community activity groups
Equitable health outcomes for people experiencing mental ill health	➢ Annual ↓ in patients waiting >28 days for a first appointment for CAMHS ➢ Annual ↑ in the percentage of adult mental health assessments undertaken within 28 days of referral

CTM 2030 Goals of Improving Care, Creating Health, Inspiring People

An example of provision of Equitable Care - CTM Weight Management Service

In Wales, 62% of adults were classified as overweight or obese (BMI 25+) in 2021-22. Across CTM, 67% of adults were classified as overweight or obese.

Given the incidence of people who are overweight and obese, CTM is developing a new and innovative integrated weight management service. The service takes a tiered approach to care and provides assessment and support in line with the All Wales Adult Weight Management Pathway. The service builds on existing services and pathways to enhance brief advice and self-directed support, and also new multi-component weight management programmes addressing diet, physical activity and supporting behavioural change. A specialist multi-disciplinary weight management service (Level 3) includes support from medical, dietetic, psychological, nursing and physiotherapy specialist services. Throughout the development of these services, the health board will engage with patients, stakeholders and the third sector to shape delivery and ensure that they are easily accessible and delivered as close to home as possible.

Our Quality Ambition – Efficient Care

We will focus on outcomes that matter to people and maximise those outcomes for every pound we spend on providing care

Our Strategic Quality Goals:

- Enable our colleagues to do tasks/roles that they are best suited to do, thus cutting out waste.
- Support our colleagues to stay well and reduce agency use across CTM.

Our True North	What our journey to success looks like
High-quality information and education supports people to stay well and/or seek early help	➢ Relaunch of the FAST campaign to support early recognition of stroke symptoms ➢ Development of a suite of high-quality patient education programmes and information to support effective self-management ➢ Work with partners to ensure a directory of support services available in our communities
Low reliance on agency staff	➢ ↑ uptake of wellbeing offers resulting in ↓ sickness and turnover rates across CTM ➢ Delivery of Nursing and Medical Productivity Programme aims and outputs ➢ ↑ number of shifts filled by Staff Bank
A highly skilled support workforce	➢ Project SEARCH interns transitioning to paid employment. ➢ Annual ↑ in support workforce completing AGORED training ➢ Annual ↑ in support staff workforce who have completed level 1 competencies of the Core Skills and Training Framework ➢ Support skills development in care workers
Strategic Programme for Primary Care :'*Primary and Community Care First'* approach across our communities	➢ ↑ uptake of urgent primary care offers ➢ ↑ range of services available via Primary Care ➢ ↑ integrated community teams ➢ Early intervention and advanced practice models across our communities

CTM 2030 Goals of Inspiring People, Improving Care, and Sustaining our Future

CASE STUDY FOR EFFICIENT CARE – Utilising Undergraduate Radiography Data at PCH
Objectives: Currently data collected annually by undergraduate students is only used for their projects**.** This CTM Project aims to utilise collected data to inform improvement projects**.**
Solutions: Through partnership working with Cardiff University and obtaining appropriate R&D permissions, students were given projects in order of organisational priorities.
Benefits: Mutually beneficial for students, departments & patients; gets the most out of data that's already being collected which saves precious resource and inspires a range of improvement projects

Our Quality Ambition – Person-Centered Care

People will be supported to be actively involved in their care as equal partners

Our Strategic Quality Goals:

- Increase co-production across CTM, delivering care that is responsive to people's needs and wishes.
- Reduce variability in how well we engage and support carers.

Our True North	What our journey to success looks like
Care is designed in partnership with patients and their families	➢ ↑ training in co-production ➢ Voice of the patient evident in care and treatment plans ➢ Carers Support Programme and training ➢ Patient and carer feedback is used to inform service developments ➢ Roll-out of co-produced Children's Charter
Care is always personalised	➢ Bereavement and dying well service developments ➢ Increased patient-rated engagement measures within Ty Llidiard, CAMHS Tier 4 ➢ External reviews of our services report evidence of person-centred care

CTM 2030 Goals: Creating Health, Improving Care, Inspiring People and Sustaining Our Future

PLACE HOLDER - CASE STUDY FOR PERSON-CENTRED CARE

The Quality Cycle

Quality is a concept commonly discussed in healthcare, but improvement needs to be part of a bigger process – a Quality Management System (QMS).

Everyone must be understand the quality cycle and their role in the quality system. Our people, patients, communities, and partners must be able to contribute to each part of the cycle (through feedback and co-production) to ensure that outcomes are meaningful to those who are impacted.

Continuous learning is central to the quality cycle, and so our CTM Listening and Learning Framework is a key enabler for our Quality Strategy.

Our Quality Management System

Place holder – Diagram our Quality Management System

Enabling, monitoring and evaluating delivery

Our 3 year Quality Strategy sits alongside our IMTP and annual plans.

Progression towards delivering our objectives will be monitored through our governance structures, inclusive of feedback and collaboration with our stakeholders, and will form part of our formal reporting structures. Through regular review, our Board and Quality and Safety Committee will ensure that our Quality Strategy and annual quality work plans continue to meet the needs of our organisation and our communities.

There are a number of ways in which we will measure our progress and adjust our objectives as necessary in order to achieve our ambitions. These include external reviews from HIW, feedback from CHC and other partners, internal reviews, and also our Quality Management System and quality governance structures.

References

NHS Wales Performance Framework & Guidance Document 2022-23
Health and Social Care (Quality and Engagement) (Wales) Act (2020)
National Clinical Framework for Wales (2021)
Quality and Safety Framework (2021)
CTM 2030: Our Health, Our Future
A Healthier Wales (WG, 2018)

AGENDA ITEM
6.8

QUALITY & SAFETY COMMITTEE

CIVICA - PEOPLE'S EXPERIENCE FEEDBACK SYSTEM

Date of meeting	15th November 2022
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Jenny Oliver, Head of People's Experience Samantha Connell, Program Manager, CIVICA
Presented by	Sharon O'Brien, Assistant Director of Nursing & People's Experience
Approving Executive Sponsor	Executive Director of Nursing
Report purpose	FOR DISCUSSION / REVIEW

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
(Insert Name)	(DD/MM/YYYY)	Choose an item.

ACRONYMS	
PROMS	Patient Reported Outcome Measures
PREMS	Patient Reported Experience Measures
VBHC	Values Based Healthcare

1. SITUATION/BACKGROUND

The Welsh Government's Framework for Assuring Service User Experience (2015), requires Health Boards in Wales to provide multiple, accessible methods for service users to feed back about the care and services, including primary care services, received.

In response to recommendations identified in relation to a number of external reports, the Health Board has recognised the importance of strengthening the means by which service user feedback is captured and analysed to inform improvements in quality and experience.

An All Wales procurement process was undertaken to acquire a service user feedback system for implementation with NHS Wales and in October 2020 the software system CIVICA was procured via NWSSP on an All Wales basis to enable Health Board's to introduce a patient feedback mechanism that allows an insight into services provided and to enable the communities we support to have a voice on how these are working. Thus enabling the Health Board to have qualitative and quantitative data that can be built upon to improve our services and share learning. The system allows delivery of surveys through a number of channels:-

- Automated SMS / email
- QR codes / web based links
- Tablets
- Paper upload
-

The aim of this report is to provide and update on progress to date and describe the phases of developing robust mechanisims for capturing peoples experience and how this can be used to inform the services and care we provide.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

Implementation

Phase 1

Initially, a suite of four maternity surveys were introduced via SMS messaging (October 2021) to allow the Health Board to monitor feedback along the patient's/partners journey through our service.

Shortly after this in November 2021, the Paediatric All Wales Survey was added to the system. However, as it has not been possible to automate this survey via the use of the SMS messaging, feedback is currently reliant on patients/families engaging with staff who will highlight the availability of this patient feedback mechanism.

Key staff were nominated by the Locality Group Directors and Governance Leads to receive training on the system, to date 94 staff have received the training however further training is required as CIVICA is rolled out wider across the Health Board.

Phase 2

In January 2022, the Health Board introduced an electronic version of the 'have your say' cards onto the CIVICA system. Supported by the HB Communications team, via the use of social media, internet, intranet and third party stakeholders, patient/carers/families have also been given an opportunity to complete an additional more detailed 'All Wales' questionnaire. Information posters which include the 'QR codes' that link to the surveys have been distributed across the Health Board promoting this service and encouraging uptake.

The 'have your say' card allows the patient/family/carer to identify which specialty they have interacted with and to leave feedback via a standardised set of questions. Once completed, they are then asked to complete a further 'All Wales questionnaire' that asks for more detail regarding the care provided.

There are also a number of specialty specific surveys that have been added to the system which include a number of set questions from the 'All Wales questionnaire'. This enables the HB to draw on comparators across all specialties in relation to basic standards of care including, were you treated with dignity and respect, provided with food and water, understood and involved with your care and treatment?

During 2022, a number of additional Patient Reported Experience Measure (PREMs), questionnaires, which contain the same questions, were added alongside live Value-Based HealthCare (VBHC) projects, across CTM.

List of specialty specific surveys

Area	Survey Name	Created Date	Start Date
	Safety Culture	04/07/2021	Not in use
	Patient Safety Culture Snapshot Survey	26/05/2022	27/06/2022
Maternity	Antenatal - Phase 1	31/03/2021	30/09/2021
Maternity	Antenatal - Phase 2	31/03/2021	30/09/2021
Maternity	Labour birth and postnatal care - Phase 3	31/03/2021	30/09/2021
Maternity	Postnatal community - Phase 4	31/03/2021	30/09/2021
Maternity	Prem Questionnaire for Birth partners	26/07/2021	30/09/2021
Maternity	Maternity Staff Vision Questionnaire	11/01/2022	01/01/2022
Maternity	A vision for the future | CTM Maternity Services Survey	24/11/2021	01/01/2022
CTM Patient Experience	CTM Patient Experience Questionnaire	08/10/2021	16/01/2022
CTM Patient Experience	Have your say	17/06/2021	16/01/2022
A&E	Emergency Department - Prince Charles Hospital	02/03/2022	01/03/2022

Cardiology- Heart Failure	Family Reported Outcome Measure (FROM-16)	21/06/2022	Awaiting approval
Cardiology- Heart Failure	Heart Failure-PREM Survey	28/10/2021	01/12/2021
Cardiology- Heart Failure	Supportive Care Team PREM	20/07/2022	Awaiting approval
Cardiology- Heart Failure	Heart Failure Cardiac Rehabilitation	28/09/2022	Awaiting approval
Cardiology- Heart Failure	HUMA Evaluation Phase 1 July- Oct 2021	07/06/2022	01/07/2022
Cardiology- Heart Failure	HUMA Patient Experience Questionnaire Phase 2	21/06/2022	29/07/2022
Community	Frailty Nurse Service	03/02/2022	01/02/2022
Community	Health Visitor PREM Survey - 27 Months	06/10/2022	Awaiting approval
Community	Health Visitor PREM Survey - 6 Months	05/10/2022	Awaiting approval
Community	Homecare Service- Have Your Say	02/08/2022	Awaiting approval
Transformation	Integrated Cluster Survey	21/03/2022	01/04/2022
Community	Lymprem Questionnaire	22/06/2022	07/07/2022
Paediatrics	Paediatrics- Evaluation Questionnaire	23/06/2022	27/06/2022
Paediatrics	Parents/Carers Questionnaire	03/05/2022	01/05/2022
	Patient / Service User Experience Survey	31/03/2021	01/04/2022
Endoscopy	Patient Experience Survey - Endoscopy	19/07/2022	Awaiting approval
Oral and Maxillofacial Surgery	Quality of emergency admission patients' experience questionnaire (Infective)	29/03/2022	01/04/2022
Oral and Maxillofacial Surgery	Quality of emergency admission patients' experience questionnaire (Trauma)	29/03/2022	01/04/2022
Community	RIW Digital Assessments	20/06/2022	20/06/2022
Community	Specialist Nurse – Homeless & Vulnerable Adults	25/08/2022	Awaiting approval
Therapies	Therapies patient experience survey	28/09/2022	01/03/2022
PCH	Visiting Survey - Patient	16/03/2022	01/04/2022
PCH	Visiting Survey- Staff	17/03/2022	01/04/2022
Community	Wellness Improvement Service (WISE) Questionnaire	25/05/2022	27/07/2022
	Wellness Survey	09/03/2022	01/04/2022
	YCC Staff Survey	21/04/2022	01/05/2022
Paediatrics	Your Time in Hospital - Childrens Survey 11 years and upwards	22/09/2021	01/05/2022
Paediatrics	Your Time in Hospital - Children's survey aged 4-11 Years	05/10/2021	01/05/2022
	Safety Culture	17/06/2021	01/07/2021
	Easy Read - Your NHS Care	17/08/2022	Awaiting approval
Community	Mental Health Clinic - Patient Experience Survey	11/10/2022	Awaiting approval
Pathology	Pathology	01/02/2022	01/02/2022
Therapies	Patience Experience Survey - Therapies	10/01/2022	Awaiting approval
T&O	Trauma and Orthopaedic (T&O) Patient Experience Questionnaire	21/06/2022	Awaiting approval
VBHC	WREM Survey- Support staff PREMs	28/10/2021	01/12/2021
VBHC	WREM - Platform Experience Outcome Measures	10/05/2022	07/07/2022

Figure 1
The graph below highlights the number of responses the HB has received via the surveys listed above throughout the course of the implementation of CIVICA.

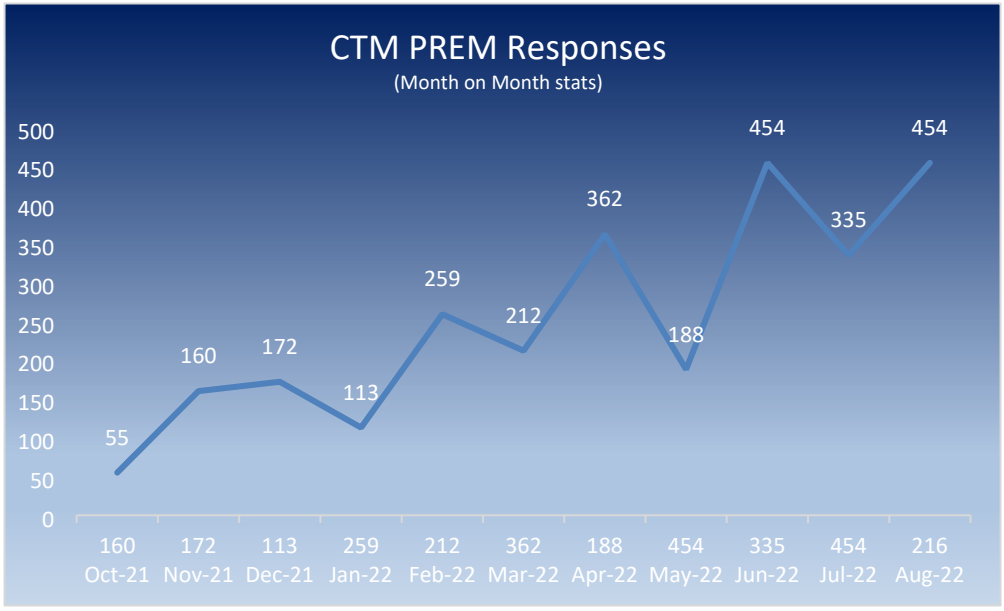
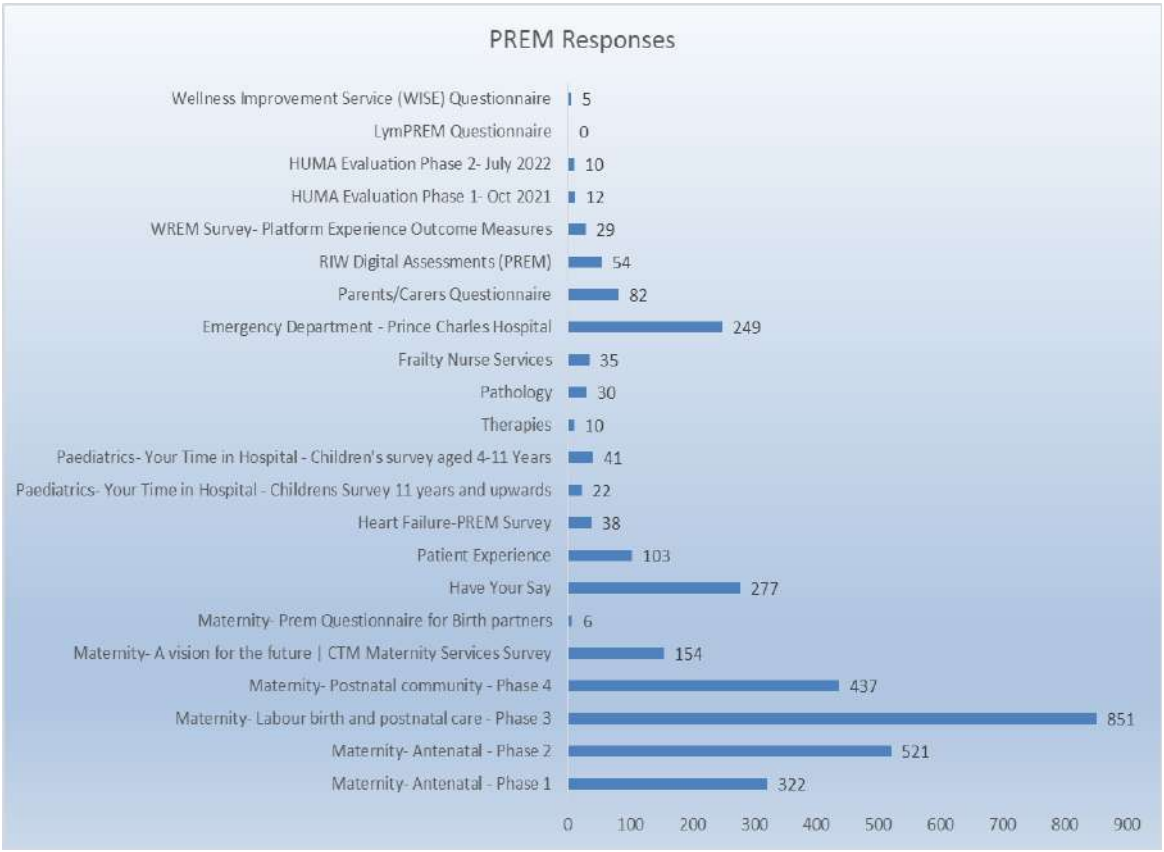


Figure 2
The graph below provides the number of surveys per specialty patients/families/carers have completed.



To date 13,235 SMS messages have been sent to patients and currently there are 36 active surveys on the system.

Next steps

The CIVICA Program Lead and Head of People's Experience are currently setting up a push report mechanism within the functionality of the system that will allow clinical managers to have sight of reports automatically sent to them via email which will provide the qualitative and quantitative data and feedback. An example of the Heat Map push report is included in Appendix A.

Volunteer patient feedback teams have been created, to support the increase in collection of patient feedback via the use of the CIVICA system across the acute sites. A roll out programme is being developed with the first wards identified as Wards 19, 20 and 8 in the Princess of Wales Hospital.

Currently the CIVICA reporting processes and system management sit with the Head of People's Experience with the Assistant Director of Nursing & People's Experience as the strategic professional lead. The Program Lead is part of the wider Values Based Healthcare, (VBHC) team within iCTM, with a responsibility to embed a VBHC approach across the Health Board. The collation, analysis and use of patient feedback against Patient Reported Outcome Measures, (PROMS) and PREMS are key measures for demonstrating and evidencing high value care. To maximise the ability of the CIVICA system to provide more detail around people's experience as a whole within CTM UHB and to support CTM 2030, Our Health Our Future, the system and service will transfer to sit within the Values Based Healthcare Service. As both services remain with the Director of Nursing's portfolio the Assistant Director of Nursing and People's Experience will remain the strategic professional lead.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

In order to gain patient feedback at a level that will allow an accurate/reflective insight from the amount of data provided, the Health Board needs to have an automated structure in place that will allow the sending of SMS messages once a patient has interacted with our services, encouraging and providing a link to the specific patient survey. Currently there has only been the capacity to automate 8 surveys due to IT and staffing capacity to manage this element. This is having an impact with the amount of data the Health Board is able to receive.

CIVICA workforce

As the potential for CIVICA grows within the HB, there is a need for the temporary Program Lead post to become a permanent post supported by a dedicated CIVICA administrative team.

Conclusion

The CIVICA system presents an exciting opportunity for the Health Board to engage and develop the trust of our communities by ensuring they have a voice and remain at the heart of what we do. The ability to learn from and benchmark our services not only within the Health Board but across Wales is an even greater step that can be utilised to improve our services, learn and grow. However, investment is required in the IT infrastructure together with a dedicated CIVICA workforce to develop the system to its maximum capacity, which will enable CTM UHB to provide multiple, accessible methods for service users to feed back about the care and services, received.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
Related Health and Care standard(s)	Individual Care
	Safe Care
Equality impact assessment completed	Not required
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	Yes (Include further detail below)
Link to Strategic Goal	Improving Care

5. RECOMMENDATION

The Quality & Safety Committee is asked to:

- **Note** the content of the report
- **Support** the direction of travel in developing a wider reach of people's experience reporting.

Monthly Performance Heat Map

Showing: Survey results for chosen area displayed as a heat map. For twelve months previous to date selected.

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Scores of 90 - 100

Scores of 80 - 89

Scores of 0 - 79

Start Date: 10/1/2021 12:00:00 AM End Date: 9/30/2022 11:59:00 PM

		2021	2021	2021	2022	2022	2022	2022	2022	2022	2022	2022	2022	
Question:	Survey	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Benchmark
1. Do you feel that you were treated with Dignity & Respect?	CTM Patient Experience Questionnaire	100	-	63	80	100	80	100	95	100	100	99	91	85
2. Do you feel that you were Listened to?	CTM Patient Experience Questionnaire	75	-	71	85	100	75	100	83	89	91	98	88	85
3. Given all the information you needed?	CTM Patient Experience Questionnaire	25	-	71	85	100	75	100	84	84	95	95	69	85
4. Do you feel that you were given enough privacy?	CTM Patient Experience Questionnaire	25	-	54	95	100	50	100	87	96	89	100	84	85
5. Given the support you needed to help with any communication needs?	CTM Patient Experience Questionnaire	100	-	67	81	100	75	100	90	93	100	100	25	85
6. Able to speak in Welsh or your preferred language to staff if you needed to?	CTM Patient Experience Questionnaire	-	-	79	25	100	100	-	60	100	100	100	-	85
7. How clean was it?	CTM Patient Experience Questionnaire	-	-	79	94	100	92	100	99	95	96	99	91	85
8. Did you see staff clean their hands before they cared for you?	CTM Patient Experience Questionnaire	-	-	63	100	100	92	100	99	92	100	100	75	85
9. Did you feel that everything you needed for your care was available?	CTM Patient Experience Questionnaire	-	-	83	100	100	100	100	90	93	98	99	81	85

Report Generated: 05/10/2022 11:35:13 AM

Scores of 90 - 100

Scores of 80 - 89

Scores of 0 - 79

Start Date: 10/1/2021 12:00:00 AM End Date: 9/30/2022 11:59:00 PM

10. If you asked for assistance did we respond in a timely manner?	CTM Patient Experience Questionnaire	-	-	92	75	100	83	100	88	92	99	99	75	85
11. Did you feel safe in our care?	CTM Patient Experience Questionnaire	-	-	46	100	100	83	100	96	95	100	99	84	85
12. Were you involved as much as you wanted to be in decisions about your care including discharge?	CTM Patient Experience Questionnaire	-	-	79	81	100	92	100	88	88	99	93	88	85
13. Were things explained to you in a way that you could understand?	CTM Patient Experience Questionnaire	-	-	58	94	100	92	100	93	95	95	97	78	85
14. Did you feel you understood what was happening in your care?	CTM Patient Experience Questionnaire	-	-	92	94	100	100	100	84	95	93	94	78	85
15. Were you involved as much as you wanted to be in decisions about your care including discharge?	CTM Patient Experience Questionnaire	-	-	83	94	100	83	100	83	95	92	93	78	85
16. Were things explained to you in a way that you could understand?	CTM Patient Experience Questionnaire	-	-	63	92	100	92	100	78	100	92	94	81	85
17. Did you feel you understood what was happening in your care?	CTM Patient Experience Questionnaire	-	-	67	92	100	83	100	100	98	92	97	72	85
18. Were you given help with your hygiene needs when you needed it?	CTM Patient Experience Questionnaire	-	-	67	-	100	100	100	92	91	95	100	25	85
19. Were you given help with feeding and drinking if you needed it?	CTM Patient Experience Questionnaire	-	-	83	-	100	-	100	100	100	98	100	25	85

Scores of 90 - 100

Scores of 80 - 89

Scores of 0 - 79

Start Date: 10/1/2021 12:00:00 AM End Date: 9/30/2022 11:59:00 PM

20. If you needed help to use the toilet did we respond quickly and discreetly?	CTM Patient Experience Questionnaire	-	-	63	-	100	100	100	97	93	100	100	0	85
21. Did staff explain to you the importance of changing your position regularly to prevent you getting pressure sores?	CTM Patient Experience Questionnaire	-	-	50	-	100	50	100	89	100	95	94	75	85
22. Do you feel that you were kept comfortable and free from pain as far as possible?	CTM Patient Experience Questionnaire	-	-	63	100	100	100	100	99	100	100	99	71	85
23. Do you feel that you were able to get as much sleep and rest at night as you needed?	CTM Patient Experience Questionnaire	-	-	63	-	88	100	100	63	83	80	97	67	10
24. Using a scale of 0-10 where 0 is very bad and 10 is excellent, how would you rate your overall experience?	CTM Patient Experience Questionnaire	-	-	80	77	100	87	100	88	88	89	95	79	85
Overall:		65	-	70	88	100	83	100	89	94	95	97	78	
Respondents:		1	0	6	5	3	5	1	26	14	21	20	8	

Questions

1	Do you feel that you were treated with Dignity & Respect?	CTM Patient Experience Questionnaire
2	Do you feel that you were Listened to?	CTM Patient Experience Questionnaire
3	Given all the information you needed?	CTM Patient Experience Questionnaire
4	Do you feel that you were given enough privacy?	CTM Patient Experience Questionnaire
5	Given the support you needed to help with any communication needs?	CTM Patient Experience Questionnaire
6	Able to speak in Welsh or your preferred language to staff if you needed to?	CTM Patient Experience Questionnaire
7	How clean was it?	CTM Patient Experience Questionnaire
8	Did you see staff clean their hands before they cared for you?	CTM Patient Experience Questionnaire

Scores of 90 - 100

Scores of 80 - 89

Scores of 0 - 79

Start Date: 10/1/2021 12:00:00 AM End Date: 9/30/2022 11:59:00 PM

9	Did you feel that everything you needed for your care was available?	CTM Patient Experience Questionnaire
10	If you asked for assistance did we respond in a timely manner?	CTM Patient Experience Questionnaire
11	Did you feel safe in our care?	CTM Patient Experience Questionnaire
12	Were you involved as much as you wanted to be in decisions about your care including discharge?	CTM Patient Experience Questionnaire
13	Were things explained to you in a way that you could understand?	CTM Patient Experience Questionnaire
14	Did you feel you understood what was happening in your care?	CTM Patient Experience Questionnaire
15	Were you involved as much as you wanted to be in decisions about your care including discharge?	CTM Patient Experience Questionnaire
16	Were things explained to you in a way that you could understand?	CTM Patient Experience Questionnaire
17	Did you feel you understood what was happening in your care?	CTM Patient Experience Questionnaire
18	Were you given help with your hygiene needs when you needed it?	CTM Patient Experience Questionnaire
19	Were you given help with feeding and drinking if you needed it?	CTM Patient Experience Questionnaire
20	If you needed help to use the toilet did we respond quickly and discreetly?	CTM Patient Experience Questionnaire
21	Did staff explain to you the importance of changing your position regularly to prevent you getting pressure sores?	CTM Patient Experience Questionnaire
22	Do you feel that you were kept comfortable and free from pain as far as possible?	CTM Patient Experience Questionnaire
23	Do you feel that you were able to get as much sleep and rest at night as you needed?	CTM Patient Experience Questionnaire
24	Using a scale of 0-10 where 0 is very bad and 10 is excellent, how would you rate your overall experience?	CTM Patient Experience Questionnaire

Scores of 90 - 100

Scores of 80 - 89

Scores of 0 - 79

Start Date: 10/1/2021 12:00:00 AM End Date: 9/30/2022 11:59:00 PM

Available Filters:

Note: The available filter selection is dependent on the report that is being generated.

Filter Option	Selection
Site	Community Clinic / Health Centre,Dental Practices,Dewi Sant Hospital,Glanrhyd Hospital,GP Practice / Medical Centre,Keir Hardie Health Park,Maesteg Community Hospital,Neath Port Talbot Hospital,Optometry Practices,Pharmacy,Prince Charles Hospital,Princess of Wales Hospital,Rehabilitation Unit,Respiratory Mobile Unit,Royal Glamorgan Hospital,Tonteg Site,Ty Elai ,Unmapped,Ysbyty Cwm Cynon,Ysbyty Cwm Rhondda,Ysbyty George Thomas Hospital
Locality	Bridgend Locality ,Corporate Function / Operations ,Merthyr & Cynon Locality ,Primary Care - Bridgend,Primary Care - Merthyr & Cynon,Primary Care - Rhondda & Taff,Rhondda & Taff Locality ,Unmapped
Service Group	Clinical Support Serivces ,Clinical Support Services,Community ,Facilities ,Medicine,Mental Health ,Mental Health ,Pharmacy & Medicines Management ,Primary Care,Primary Care - Bridgend ,Primary Care - Merthyr & Cynon ,Primary Care - Rhondda & Taff,Surgery, Anaesthetics, Theatres and Critical Care,Therapies,Unmapped,Wellness Improvement Service,Women & Children
Specialty	Adult Mental Health ,CAMHS ,Catering,Community Hospital Inpatient ,Critical Care,Dental Services ,Dietetics ,Dispensing Services ,District Nursing,Emergency Care ,General Medicine ,General Surgery ,Gynaecology ,Head & Neck,HSDU,Independent Contractors - General Practitioner,Independent Contractors -Optometrist,Lymphadema Service,Obstetrics,Occupational Therapy ,Older persons Mental Health ,Outpatients ,Paediatrics ,Pain Management ,Pathology,Patient Education,Physiotherapy ,Podiatry ,Pre-assessment,Primary Care,Psychosis Team,Radiology,Sexual Health,Specialist Palliative Care ,Speech & Language ,Speech and Language Therapy ,Theatres,Trauma & Orthopaedics ,Unmapped,Urgent Primary Care Access,Urgent Primary Care Access (Out of Hours) ,Wound Care Service
Sub specialty	Arthritis,Audiology ,Biochemistry ,Blood Bank ,Breast ,Breast Care ,CAMHS - Cwm Taf Morgannwg ,CAMHS - Tier 4 In-patient,Cardiac ,Cardio Pulmonary ,Cardiology ,Catering,Cellular Pathology ,Children's Outpatients ,Colo-rectal ,Community Drug & Alcohol,Community Drugs & Alcohol,Community Hospital Inpatient ,Community Mental Health ,Community Mental Health Team,Community Midwifery,Crisis resolution Home Treatment ,Critical Care,CT,Dental,Dermatology ,Diabetes,Dietetics,Dispensing Services ,District Nursing,Early Intervention Psychosis Team ,Emergency Care ,Endoscopy,ENT,Fibromyalgia,Gastroenterology,General Medicine,General Surgery ,Gynaecology ,Haematology ,Histology ,HSDU,Immunology,Independent Contractor (Dental) ,Independent Contractors - General Practitioner,Independent Contractors -Optometrist,In-patient rehabilitation services ,In-patient Services ,Lymphadema,Maternity ,Maxillo Facial,Mental Health,Microbiology,Mortuary,MRI,Neo-nates ,Occupational Therapy ,Older persons Mental Health ,Ophthalmology,Orthoptics,Outpatients ,Outreach & Recovery ,Pain,Pain Management ,Pathology,Physiotherapy ,Podiatry ,Pre-assessment,Primary Care,Primary Care Mental Health ,Psychiatric Rehabilitation ,Radiology,Respiratory ,Rheumatology,Sexual Health,Specialist Palliative Care ,Speech & Language ,Speech and Language Therapy,Stoma,Stress and Anxiety,Stroke,Support recovery ,Supported Recovery ,Teaching,Theatres,Trauma & Orthopaedics ,Ultrasound,Unmapped,Urgent Primary Care Access,Urgent Primary Care Access (Out of Hours) ,Urology ,Wound Care Service,x-ray
Location	All Filters Selected
Survey	CTM Patient Experience Questionnaire
Question	All Questions Selected
Response	All Responses Selected
Category	Standard
Start Date	01/10/2021 12:00:00 AM
End Date	30/09/2022 11:59:59 PM

Scores of 90 - 100

Scores of 80 - 89

Scores of 0 - 79

Start Date: 10/1/2021 12:00:00 AM

End Date: 9/30/2022 11:59:00 PM

AGENDA ITEM
6.9

QUALITY & SAFETY COMMITTEE

PEER REVIEW OF URGENT PRIMARY CARE (OUT OF HOURS AND UPCC) IN CWM TAF MORGANNWG

Date of meeting	15/11/2022
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Martine Randall – Head of Urgent Primary Care
Presented by	Julie Denley, Deputy Chief Operating Officer for PCMH
Approving Executive Sponsor	Chief Operating Officer (COO, DPCMH)
Report purpose	FOR DISCUSSION / REVIEW

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Quality & Safety Committee	(DD/MM/YYYY)	Choose an item.

ACRONYMS	
CTMUHB	Cwm Taf Morgannwg University Health Board
OOH	Out of Hours
UPC	Urgent Primary Care
UPCC	Urgent Primary Care Centre
PRT	Peer Review Team
MDT	Multi-Disciplinary Team
IPC	Infection Prevention Control
IP	Independent Prescriber
POW	Princess of Wales Hospital
PCH	Prince Charles Hospital
RGH	Royal Glamorgan Hospital

1. SITUATION/BACKGROUND

1.1 The purpose of this paper is to report the outcome of the May 2022 Peer Review of CTMUHBs Urgent Primary Care Services and to update on the progress against the associated local action plan.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 In May 2022 the Cwm Taf's Urgent Primary Care Services were subject to a national Peer Review from members of the National Primary Care Strategy Team. The purpose of the Peer Reviews is to act as a 'critical friend' to provide direct support and advice for staff and the executive team as the Health Board continues its re-organisation and stabilisation post COVID19.

2.2 The feedback from the Peer Review Team was extremely positive acknowledging the following key points:-

- Good work had taken place during the Covid 19 pandemic in re-designing the service and developing a cluster based Urgent Primary Care Centre.
- There was very good representation from both clinical and operational staff who constructively participated in the review and the various breakout sessions.
- The positive leadership shown both by clinical and operational managers.
- Praise for the strengthening clinical leadership in the OOH services and at the UPCC
- Of particular note, was the obvious mutual respect that staff show towards each other and the clinical and operational leadership team and the real sense of a truly multidisciplinary team, working together to provide the best care for patients.
- The development of a clear MDT workforce plan, increasing the GP workforce and engagement with other teams.
- The utilisation of data to assess demand and capacity inform further improvements leading to more responsive and better outcomes for patients. This was recognised as exemplar practice and the Panel recommended that this be shared with the National OOH Forum and other OOH clinical teams across Wales.
- The commitment shown by staff to delivering a high quality services.

- How OOH and UPC services have increasingly gaining visibility at board.

2.3 In the feedback report the Peer Review Panel made 13 recommendations and these are included in the attached action plan in Appendix 1. Good progress has been made to date to address the recommendations and only 4 recommendations remain amber as work continues to make progress. The amber actions include:

2.3.1 ***Demand and Capacity***

Action: 111 Programme Team and OOH to jointly collaborate on data outcomes to assist with future model.

Action: OOH to calculate capacity requirements based on demand data extracted.

CTM was commended by the Peer Review Panel for making the most progress across Wales in assessing demand and then capacity planning. This has been down to the knowledge, skill and enthusiasm from the current Interim Clinical Director for Urgent Primary Care (GP OOH). Unfortunately further progress of this work has been hindered by the National Cyber attack which took place in August 2022, which resulted in an outage of the services main OOHs data call handling and clinical software system, named Adastra.

The revised anticipated delivery date is December 2022, but this is dependent on full resumption of the functionality of the Adastra system.

2.3.2 ***System Governance (Patient Experience)***

Action: Undertake a survey in 2022/23 to cover all aspects of service in a subset patients.

Paper surveys were suspended during the pandemic based on the IPC guidance. Work is taking place to put in place a revised process to collect patient experience data via the new electronic Civica system and this will include the use of a simple QR code for patients to access the patient feedback questionnaires. Traditional methods of feedback will also remain for use by those patients who are not able to use the electronic versions. The action completion date is December 2022.

2.3.3 Urgent Primary Care and Integration of Services

Action: review service model and operating hours as part of the wider evaluation of UPCC, Review interface with MIU (and access criteria into MiU), Option to consider direct booking slots and links with ED.

A remodeling of the Urgent Primary Care is currently underway as part of Workstream 1 of the 6 Goals for Urgent and Emergency Care Programme and it will incorporate appropriate navigation to a comprehensive range of integrated services based on patient need. Recent work sees phased implementation by March 2023.

2.3.4 Workforce Developments

Action: Review baseline of IPs within the HB and the utilisation of the qualification and individual clinicians prior to requesting further funding.

A mapping exercise has commenced for all staff holding IP qualifications to assess if they are utilising their specialist skills and knowledge and working at the top of their competency levels.

Action: Executives need to challenge the historical resistance to development of such staff (HCSW) particularly for the OOH and UPCC given the difficulty in delivering sustainable services.

This work is an essential part of the Workstream 1 for the 6 Goals Urgent and Emergency Programme and the development of the navigation centre. Further opportunities are being explored as part of the development of new roles and enhanced skills as part of CTMs Training Academy for Primary Care. These include HCSWs, Advanced Practitioners and Associate Physicians. March 2023

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 Whilst the feedback report was extremely positive it noted the ongoing challenges for CTMUHB and these included:-

3.1.1 Workforce sustainability: This is a constant focus for the Urgent Primary Care service and is not unique to CTMUHB. A recent drive to recruit GPs has also been successful with 17 being taken on in past three months. Minor illness nurses are also being recruited to support service delivery in readiness for winter period.

3.1.2 Boundary Changes: The integration of the POW OOH into CTM brought with it historical low GP shift fill rates. A new cohort of

GPs have been recruited in the past couple of months and further opportunities are being explored with the consortium of GPs who provide the service in PCH OOHs Primary Care Centre.

3.1.3 Accommodation/Shared Space: It was noted by the Peer Review Panel that there are operational issues caused by the shared utilization of space in the GP OOHs Primary Care Centre sites (all are hosted in Out-patient Departments in the three DGHs). The issues relate to physical capacity, security and infection control due Covid pathways and associated limitations/restrictions. Since the report was issued improvements have been made with allocation of more storage space at two of the bases. Storage space at POW remains a challenge. However the service are currently looking at reducing stock levels held at the site and increasing replenishment on a more frequent basis to achieve further improvement.

3.1.4 Finance: The Peer Review Panel understood the current financial position of the Health Board but were keen that consideration be given to what could be achieved in terms of reducing pressure on the wider system if there were increased resources within OOH and the UPC.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	There are no specific quality and safety implications related to the activity outined in this report.
Related Health and Care standard(s)	Timely Care
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If no, please provide reasons why an EIA was not considered to be required in the box below.
	Service Review
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

5.1 The committee are asked to **NOTE** the contents of this report.

Appendix 1

Cwm Taf Morgannwg Peer Review Visit – 24th May 2022

Out of Hours/UPCC Peer Review Action Plan:

Present:	
Panel	**Cwm Taf Morgannwg University Health Board**
Individual Panel Names have been removed	Individual Names have been removed.

Key Issues to Address	Actions:	Lead	Timeframe	Progress /Issues
1 Escalation	When considering levels of escalation there appeared to be no visibility on 'system' escalation levels across in ED, 999 and 111 /OOHs – noting the intention to build a 6 goals dashboard. There are separate primary & secondary escalation policies and daily levels of escalation reported but unclear where detailed activity is co-ordinated at each level. DHCW data warehouse is not an option for improving system visibility as 111 data doesn't appear to be included. **Action: review escalation policies and reporting mechanisms and inclusion of detailed actions required at each level.**	MR	**Completed**	James Moore, Head of Performance & Information, is currently compiling all the KPIs across unscheduled care for the 6 Goals Board. The template of WG standards for GP Out of Hours services has been fed into this process. There is a visible dashboard on the CTM intranet home page but the updating of this can be variable by individual services. Escalation levels for GP OOHS are reported across the organisation regularly throughout the week via sit-reps.
2 Recruitment and Retention	Recruitment of GPs to cover hard to fill shifts needs to continue- (see point below).		**Completed**	Recruitment of GPs continues well with 11 recruited in past three months and 6 currently undergoing recruitment processes (checks & induction)

Key Issues to Address	Actions:	Lead	Timeframe	Progress /Issues
	Retention and development of HCA is a key priority for wider MDT working and sustainability particularly as majority of HCA engaged on a bank basis. **Action: Recruitment and effective deployment for APP, ANP and PAs all need to be considered as part of the wider workforce strategy** **Action: Urgent review of contracts for HCA now required to ensure workforce retention**			Currently introducing minor illness nurses into service delivery. Andrea Dorrington linking with HEIW programme for development of urgent care practitioners. ANPS are already a key component of the OOHs workforce particularly at weekends. An APP has also recently been recruited resulting in two APPS on the roster. Recruitment of HCAs is currently being evaluated and costed.
3 Sustainability of service	Overnight medical cover is still an outstanding issue from the previous review as the current system is heavily reliant on a single individual GP. Base shifts in POW are equally difficult to fill, especially at weekends and need further assessment /review. Base cover in PCH on weekends has been stabilised by procurement of a third party however sometimes cover on weekday (evenings) is challenging. Both RGH and PCH bases close at 12pm and it is known patients in Merthyr will not travel so potentially will have an impact on ED attendances in PCH. **Action: Timely review of cover against peak demand ahead of August /winter pressures.** **Action: Expand cover for overnight shift for longer term resilience plus use of wider MDT support.**	Clinical Lead Operational Manager Executive Lead	Completed	There are three GPs overnight covering the service and this has been in place for around 12 months. Shift fill for the Bridgend locality remains problematic particularly on weekends. Consideration is being given to replicating contracted out model similar to the offering for weekends at PCH. PCH contract due to be renewed as due to expire in January 2023. It is not technically correct to say both PCH and RGH bases are closed ad midnight as these are opened up based on patient demand by the overnight doctor/mobile doctor. In the event patients from Merthyr need to travel for an appointment a taxi is offered. There have been no complaints or issues raised by ED colleagues.

Key Issues to Address	Actions:	Lead	Timeframe	Progress /Issues
	Action: Consider the opportunities that re-procurement of third party may offer **Action: Consider opportunity from wider MDT to improve overnight resilience**			Conversely ED colleagues have been positive regarding the 8Medical model and the regular/stabilised GP input. There is wider MDT support during the overnight period as the overnight district nursing team is now integrated with the OOHs overnight service.
4 **Demand and Capacity**	Data extraction on understanding workflow is now illustrating where demand is within the system, how the capacity is organised and whether this is fit for purpose (or not). Wider issues on flow between 111 & OOHs also need to be utilised in real time and linked to wider national forums. Calculations regarding demand and capacity differs between UPCC and OOH In UPCC the demand is managed by the capacity that is available in the service. In OOH the demand coming across from 111 cannot be "turned off" based on the capacity available in the service at any given time. **Action: 111 Programme team and OOH to jointly collaborate on data outcomes to assist future model** **Action: OOH to calculate capacity requirements based on demand data extracted.**		December 2022	This is an ongoing piece of work which is now in work flow due to the Cyber attack in August 2022 which resulted in an outage of the services main data system, Adastra.
5	Good data analysis has now enabled visibility of performance against agreed targets on a regular basis.	**Clinical Lead**	Completed	Allocation of P1 to both home visits and base visits is very low.

Key Issues to Address	Actions:	Lead	Timeframe	Progress /Issues
Performance Standards	Performance on P1 home visits and P1 PCC appointments is below agreed thresholds however it is postulated that geography of the CTM footprint contributes to this and whether the targets are applicable. **Action: Review P1 HV and P2 PCC to determine source of sub threshold performance and applicability of thresholds to CTM.**	**Operational Lead Head of Primary Care**		Geography and incorrect prioritisation are the main contributing factors to P1 for home visits and PCCs falling outside of agreed thresholds. Communications have been sent to triaging GPs advising that if prioritising a P1 the reason for the prioritisation should be stated within the triage notes.
6 System Governance (Patient Experience)	Patient Survey in 2019 focused on PCCs, there was a recommendation from the last peer review to conduct surveys for all aspects of the service and undertake yearly reviews on specific groups. **Action: Undertake a survey in 2022/23 to cover all aspects of service in a subset of patients.**	**Clinical Lead/Operational Lead/Quality and Safety Lead**	Jan	During Covid we were unable to issue the usual paper surveys due to IPC guidance. This year the UHB introduced the new electronic Civica system for patient feedback purposes. We have been working with the Governance/Concerns team to adapt Civica to include the GP Out of Hours service so that there is a standardised approach to the collection of patient feedback. Once this work is complete patients will be issued a QR code to complete the survey.
7 DATIX Reporting	Similar to other organisations, DATIX reporting remains extremely low to the number of cases seen on a monthly & yearly basis. Does this reflect what is happening within the organisation? **Action: Methodology and approach should be reviewed to assess how improved data gathering can be supported.**	**Clinical Director**	Completed	Datix reporting is embedded within service delivery. We have provided a "datix-light" form to make the process easier. A new version of datix has recently been rolled out. Training session have also been offered to all staff via Teams.
8 Urgent Primary Care and Integration of services	**UPCC –** timely opportunity to review the scope and function of the UPCC given the priority and funding under 6 Goals Programme. Key opportunities should be considered around the interface between in-hours and OOHs and interface with MIU /ED. **Action: review service model and operating hours as part of the wider evaluation of UPCC**		March 2023	Notice has been served on the current UPCC model and remodelling of the UPC and integrated services is taking place under workstream 1 of the 6 Goals Programme.

Key Issues to Address	Actions:	Lead	Timeframe	Progress /Issues
	Review interface with MIU (and access criteria into MiU) **Option to consider direct booking slots and links with ED**			
9 Workforce developments	There is clear development of an MDT approach in both OOH and UPCC. There is support to develop IP clinicians however there is no baseline or consideration of what is already in the system. **Action: Review baseline of IPs within the HB to review utilisation of the qualification and individual clinicians prior to requesting further funding.** There is a desire to develop roles for non-clinical staff such as HCA however there is resistance from areas of the Health Board to this. **Action: Executives need to challenge the historical resistance to development of such staff particularly for the OOH and UPCC given the difficulty in delivering sustainable services.**	**AMD/Clinical Leads Operational Leads**	Dec	Contacting Andrew Davies to establish list of those with IP qualification. Will canvass them to see if any are interested in Urgent Primary Care working. There is already a career pathway for HCAs ranging from Band 2 – Band 4 – dependent upon their skills. There are limitations to what an HCA can undertake in an UPC setting due to their training and qualification. However, CTMs OOHs service has already introduced the role of the Band 3 HCA as they were trained to undertake additional tasks during Covid, e.g. point of care testing Lumiridx. Many of the HCA also undertake reception duties. Andrea Dorrington Lead Nurse is meeting with Esther Lomas, HEIW, to explore the role of the PA further (skills/competencies, etc) and to assess the potential fit for Urgent Primary Care

Key Issues to Address	Actions:	Lead	Timeframe	Progress /Issues
10 Service Sustainability	Both OOH and UPCC have developed their MDTs and are offering training to clinical and non-clinical staff as well as supporting the wider community development e.g. IP community Pharmacists. There are 3 Pas in the health board but these have not been deployed into UPCC or OOH and also other re-deployed staff have not been offered to support the OOH services. **Action: Pas to be offered to rotate into OOH/UPPC as a pathfinder.**	**Clinical Director Operational Leads**	Completed	There are currently three PAs within the UHB. Due to their individual circumstances none are currently available to work during the OOHS period. The service may look to recruit PAs as part of the wider MDT development. Andrea Dorrington Lead Nurse linking with Esther Lomas HEIW to take this forward
11 Mental Health Practitioner model	***Action: MH practitioners support OOH at weekends although this has been sporadic due to staffing levels. In order to provide a consistent service consideration expressions of interest should be placed for existing staff to work at weekends and midweek eves.*** ***Action: The Mental Health Team are working towards introducing the 111 P2 model although progress has been slow and there needs to be some urgency to ensure a Quarter 3 "Go Live" is achieved***	***Clinical Director Clinical Nurse Lead***	Completed	The Mental Health "111 Press 2" service model is about the launch in CTM. The team will be hosted in the Ty Elai call centre. The plan is on track for the service to be 24/7 by end of financial year with the team being introduced in phases commencing mid-January 2023
12 Physical Clinical Environment	Environments for both UPCC and OOH need to be reviewed in terms of numbers of rooms available to carry out /expand the services and provide safe working environments. **Action: Estates need to be aware that cleaning services to maintain infection control in RGH toilet in green area should be in place and staff need to be reminded of infection control procedures.**	**CD and Exec team**	Completed	The OOHs service is hosted in the OPDs of the three DGHs – there are currently sufficient rooms for service delivery at all sites. Cleaning services are in place at all OOHS bases as they are hosted in OPD departments. Additional cleaning has also been put in place to ensure IPC at weekends.

Key Issues to Address	Actions:	Lead	Timeframe	Progress /Issues
	Action: Security of receptionist in PCH Rhymney Ward to be reviewed as door to reception cannot be secured and receptionist is isolated. **Action: UPCC co-location with MIU in YCR needs to be reviewed.**			IPS have reviewed our operational environment, procedures and protocols at regular intervals and have advised that our IPC standards were extremely high. Security of receptionist in Rhymney block has been addressed as the cage around the reception area is now lockable.
13 Operational Issues	Printers in a number of bases not working so prescriptions being handwritten which is a potential patient safety risk. POW,RGH Drugs cupboard in POW not big enough **Action: work with IT to troubleshoot issue of printers not working or order new printers** **Action: source new drugs cupboard for POW and stick as per the other bases** Technical issues within Ty Elai (local authority site) prevent use of any remote consultation. video consultations **Action: Review options for improving ability to undertake video consultations with IT? installation of HB IT into an LA building**	Operational leads	Completed	A new drug cupboard has been introduced at POW and stock medication is being reviewed for all bases. GPs at POW are now able to dispense a wider variety of drugs directly to patients – this is beneficial to patients particularly at those times when pharmacies are closed. This has been looked at by IT colleagues on numerous occasions. The prescription printers issue arises due to a nomenclature convention within the Adastra schema which cannot be changed.

AGENDA ITEM
6.10

QUALITY & SAFETY COMMITTEE

WARD BASED NURSING ASSURANCE REPORT

Date of meeting	15/11/2022
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Head of Nursing Professional Standards & Education. Lead Nurse for Professional Practice and Quality Assurance
Presented by	Head of Nursing Professional Standards & Education. Lead Nurse for Professional Practice and Quality Assurance
Approving Executive Sponsor	Executive Director of Nursing
Report purpose	FOR DISCUSSION / REVIEW

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
(Insert Name)	(DD/MM/YYYY)	Choose an item.

ACRONYMS	
WNCR	Welsh Nursing Clincal Record
AMaT	Audit Management and Tracking
Safecare	A staffing software Programme that review staffing levels to patient acuity
ILGs	Integrated locality Groups
CTM UHB	Cwm Taff Morgannwg Health Board
NSLWA	Nursing Staffing Levels Wales (2016) Act

1. Situation/Background

Ward Accreditation Frameworks provide a structure to bring together key measures of nursing and clinical care into one overarching framework to provide a comprehensive assessment of the quality of care at ward, unit or team level. Accreditation is then provided depending on these results.

There is a focus on digital technology across the Health Board seeing the roll out programmes for Welsh Nursing Clinical Record (WNCR), Safecare and Audit Management and Tracking (AMaT) systems. These enablers have created the opportunity to develop a standardised framework for nursing ward assurance. However, there are several phases required, and implemented to ensure the framework is validated and fit for purpose.

This aim of this paper is to describe the phases of developing a robust nursing ward assurance framework and progress to date.

Phase 1 is to ensure there is a suite of agreed clinical audits in place across the Health Board. Clinical audits are a key component of the wider clinical governance framework. This information will allow the Quality and Safety committee Executive Board to receive an oversight of nursing and midwifery ward assurance using standardised audit templates and processes.

The Chief Nursing Officer has recognised the benefits of standardised core audit tools to support comparative data analysis across Wales. While each Health Board will use their own digital platform for data collection and presentation an All Wales task and finish group has been set up to work alongside the service experts and clinical leads to develop some standardised templates to provide a 'Once for Wales' approach.

CTM UHB's platform of choice is the AMaT software system for all nursing /multiple disciplinary activity, which supports the use of standardised audit templates to be used across the Health Board. It also enables data collection electronically, which produces detailed data analysis of ward audits. The platform ensures predetermined data collection and the ability for users to access data, results, action plans electronically and instantly. With the ability to provide at a glance Health Board wide dashboards, supporting the ethos of Ward to Board assurance.

2. Specific Matters for consideration by this Meeting (Assessment)

By way of establishing a baseline, a scoping exercise was undertaken during June 2022 across all clinical areas, which includes Paediatrics, all Adult in patient wards and maternity, where 6 standardised templates were used and the data inputted into AMaT (see Appendix A for audit results). Mental health is not included in phase one of the project as due to the specialist nature of this service group. A sub group is being set up to plan and review audits specific to Mental health and when agreed these will added to AMaT to allow detailed data capture.

This has been the first time that the Health Board has undertaken a ward assurance audit using one single digital platform. The data analysis focused on key quality care metrics using a RAG rating system.

RAG – (Red - < 50%, Amber >50 < 75, Green > 90%). Average compliance figures varied between 100% 85% compliance across all audits. Any ward/area that scored below these pre-set values would then be required to produce and set an action plan for improvement.

The audits undertaken were:

- Controlled Drug and medication storage
- Documentation
- Environment
- Glucose monitoring
- Hand Hygiene/ Bare Below elbow (BBE)
- Adherence to the All Wales Uniform policy

Each audit templates is set up on AMaT and the auditor at ward level inputs data directly onto the digital platform. The data analysis's is available immediately and allows comparative analysis from previous audits as well as the ability to update action plans and learning. This audit data is then used as a quality measure and evidence to support and empower the staff at ward level to take ownership of learning and improvements.

2.1 Summary of the overall compliance for the Health Board against the set point review standards

AMaT has the ability to allow the user to drill down into each criterion to a local level of an analysis supporting areas to focus across areas. The table below shows an example of the high-level dashboard reports that will form part of a report for executive assurance reports going forward. More detailed reports which drill down into more detail are referred to in the appendices. These can be used at ward level to allow for very focused action plans and areas of development work to take place.

Audit overview

Audit	Compliance over last 6 periods						Current
POINT REVIEW: Presentation (uniform) audit	99.3%	98.5%	98.8%	98.6%	98.8%	94.9%	95.2%
Hand hygiene and bare below the elbow audit	99.0%	99.6%	99.5%	98.3%	98.1%	94.9%	97.1%
Controlled drug medicines and storage audit	98.1%	97.8%	97.8%	98.2%	99.2%	95.2%	98.3%
POINT REVIEW: Documentation and Record Keeping Audit (V.4)	86.8%	82.1%	89.9%	81.3%	83.7%	80.8%	87.2%
POINT REVIEW: Environmental audit V5	92.8%	92.9%	92.8%	93.5%	95.5%	83.9%	91.5%
POINTS REVIEW Glucose Monitoring Audit	96.2%	87.5%	91.7%	90.9%	96.3%	83.7%	98.0%

2.2 Highlights for Committee

Noted below are some key findings:

Due to the limited role out of AMAT for ward assurance and collating audit data electronically, there was limited comparative data available.

This is the first time that AMAT that a digital platform has been used to collate and compare the audit data across all areas of the health board. Analysis of this data

did reveal some themes of good practice and areas for immediate improvement. Going forward the audits will be completed monthly directly onto AMAT that will allow for comparison at ward level as well as across the health board.

Areas of good Practice:

- High compliance with the blood glucose standards and audit across all community and acute sites.
- High compliance with the entire All Wales Manual Handling passport completed, bed rail assessment and purpose T pressure ulcer assessments.
- The environmental audit demonstrated that there was high degree of compliance with cleaning including ward, toilets and bathrooms. In relation to the environmental safety metrics such as fire exists, sharp boxes and arrest trolley also demonstrated high compliance.

Areas requiring improvement and actions

- ID badges were not always visible or on their person. Ward manages have reminded staff and will perform local audits in low compliance areas.
- There were two areas highlighted in the environmental audit, which affected the majority of areas that took part were due to clutter and storage. This saw bathrooms used to store bulky equipment such as hoists and commodes.
- There was a low compliance of single sex toilets across the acute wards mainly. Ward managers immediately rectified this by identifying toilets on the wards to same sex near the male and female bays.
- Overall, cosmetic infrastructure was poor such as paint peeling off walls and floor covering lifting. Estates have been notified as part of a wider action plan.

3. Key Risk/matters for Escalation to Board/Committee.

Currently not all digital platforms in place across the Health Board interface with each other creating gaps and duplication of data being collated. Ongoing discussions how this can be improved is being disused and reviewed as part of the wider digital agenda.

There is inconsistency between the Health Board's medication policy and the essential data sets collated on the audit. This is being reviewed by pharmacy.

3.1 Next Steps (Phase 2)

- Agreement to continue the 6 core audits monthly and input data onto AMAT to provide ongoing assurance.
- Continue representation at the All Wales Task and Finish Ward Assurance group
- Continue the CTM Ward Assurance project group to provide a governance framework regarding the development and implementation of new audits, ensuring consistency and validation.
- Implementation of the Safe care digital platform across CTM
- Continue to validate and imbed new audits and compliance via the ward assurance forum and build on the dashboard.

- Consider a suite of support reviews, data and audits to contribute to the assurance framework such as:
  - Ward Climate – 15 steps, external inspection, staff survey and patient surveys (CIVICA). Datix and care metrics (dash boards, NSLWA)
  - Observation of care – Point review, peer audits, HSE, HIWs, Executive Director & IM Walkarounds
  - Rostering efficiency – Safe care, Allocate, HB Workforce meetings.

4. Impact Assessment

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
Related Health and Care standard(s)	Governance, Leadership and Accountability
	Safe, Individual and timely care
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) This is not a new policy. It is an assurance paper
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	Yes (Include further detail below)
	Financial impart will be seen through estates issues mainly across CTM for building and cosmetic work.
Link to Strategic Goals	Improving Care

5. Recommendation

5.1 Members of the Quality and Safety Committee are asked to:

- **Note** the content of the report
- **Support** the direction of travel in developing a wider reach of quality reporting and locality based assurance reports

Appendix A

The following Appendices are available in the Document Folder in Admincontrol.

Medication Point review	InsightDetail (1) Medication baseline
Bare below the Elbow and Hand hygiene Point Review	InsightDetail bare below elbow.pdf
Documentation Point Review	InsightDetail documentation.pdf
Environmental Point review	InsightDetail Environment.pdf
Glucose Monitoring Point Review	InsightDetail Glucose.pdf
Uniform Point Review	InsightDetail Uniform.pdf

Appendix B

WNCR Point of care documentation Audit	WNCR 2022 Point of Care Documentat